NATIONAL GENDER IN HEALTH POLICY

Federal Ministry of Health, Nigeria

2021-2025

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Acknowledgements

Acknowledgement

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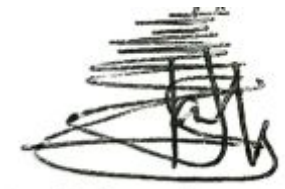

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AOPs	Annual Operation Plans
AYFSRH	Adolescent and Youth friendly Sexual and Reproductive Health
BHCPF	Basic Health Care Provision Fund
CHEWs	Community Health Extension Workers
CSOs	Civil Society Organisations
DQA	Data Quality Assurance
EmOC	Emergency Obstetric Care
ESRCs	Emergency Support Response Centres
FBO	Faith-Based Organization
FCT	Federal Capital Territory
FGM	Female Genital Mutilation
FH	Family Health
FMoA	Federal Ministry of Agriculture
FMoBNP	Federal Ministry of Budget and National Planning
FMoF	Federal Ministry of Finance
FMoH	Federal Ministry of Health
FMWA&SD	Federal Ministry of Women Affairs & Social Development
FMoWR	Federal Ministry of Water Resources
GAM	Gender Analysis Matrix
GAQ	Gender Analysis Questions
GDOs	Gender Desk Officers
GE	Gender Equality
GHAGs	Gender and Health Action Groups
GHMIs	Gender Health Maps and Indicators
GBV	Gender-Based Violence
GERHE	Gender equality and rights health education
HA	Health Assistant
HCFs	Healthcare Facilities
HCPs	Healthcare Providers
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HMB	Health Management Board
HRH	Human Resources for Health
ISS	Integrated Supportive Supervision
LGA	Local Government Authority

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LTOT	Local Trainer of Trainers
M&E	Monitoring and Evaluation
MDAs	Ministries Departments and Agencies
MDGs	Millennium Development Goals
MHM	Menstrual Hygiene Management
MM	Maternal Mortality
MMR	Maternal Mortality Ratio
MNCH	Maternal, New-born and Child Health
MSS	Midwives Service Scheme
NDLEA	National Drug Law Enforcement Agency
NGO	Non-Governmental Organisation
NIS	Nigeria Immigration Service
NPC	National Population Commission
NPHD	National Primary Healthcare Development
NPHCDA	National Primary Health Care Development Agency
NDHS	Nigerian Demographic Health Survey
OOP	Out of pocket
PHC	Primary Health Care
PHCB	Primary Health Care Board
PLWHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PRRINN	Partnership for Reviving Routine Immunization in Northern Nigeria
QISS	Qualitative Integrated Supportive Supervision
RH	Reproductive Health
SBA	Skilled Birth Attendant
SDGs	Sustainable Development Goals
SMoF	State Ministry of Finance
SMoH	State Ministry of Health
SMoWR	State Ministry of Water Resources
SPHCDA	State Primary Health Care Development Agency
SRH	Sexual and Reproductive Health
SMWASD	State Ministries of Women Affairs & Social Development
STIs	Sexually Transmitted Infections
STOT	State Trainer of Trainers
TBA	Traditional Birth Attendant
TCAM	Traditional Conventional and Alternative Medicine
TOT	Trainer of Trainers
VAPP	Violence Against Persons Prohibition (Act)
VAWG	Violence Affecting Women and Girls

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WFH	Women for Health
WHO	World Health Organization
WRA	Women of Reproductive Age (15-49 years of age)

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Definitions

Adolescent-Youth Friendly Services recognize that male and female adolescents and youth have specific needs and rights. "Adolescents" refer to girls and boys between the ages of 10-19 while "youth" refers to adolescent girls and boys and young women and men between the ages of 15-24. In line with WHO's five standards, adolescent-youth friendly services should be: i) readily **accessible** so that any male or female adolescent or youth is able to obtain the health services available**;** ii) **acceptable** in terms of male and female adolescents and youth being willing to access the services available; iii) **appropriate** in meeting the specific needs and health problems of male and female adolescents and youth; iv) **effective** in terms of being provided correctly in the right way and make a positive contribution to the health of male and female adolescents and youth; and v) **equitable** to assure any male or female adolescent or youth, regardless of sex, age, social status, urban/rural location, disability, religion or ethnicity, is able to access health services available.

Gender refers to the social interpretations and values given to a woman, man, girl or boy and learned through socialization. Gender is socially constructed, culturally specific, and changes over time. It is different from male or female sex which is biological, universal and difficult to change.

Gender-aware approaches aim to improve the daily condition of women and girls and men and boys based on their practical gender needs (i.e. women's water-access) by addressing and responding to gender norms, roles and differences in access to resources in so far as needed to reach project goals. They do not try to change unequal gender power relations.

Gender-blind approaches ignore gender inequalities and tend to reinforce and even worsen gender-based discrimination.

Gender equality refers to women and men, girls and boys having the same entitlements to all human rights; to enjoy the same level of respect in the community; and to have equal abilities, power and opportunities to access, participate and make decisions to reach their full potential regardless of their gender. Incorporating strategies to address gender inequality can lead to more successful health programming and better health outcomes.

Gender equality integration is premised on the understanding that male and female community members have different needs and often-unequal status both at community demand and supply side levels of a health system. It requires integration of gender-specific and gender equality mainstreaming principles and interventions

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into all aspects of the program to address gender-based discrimination and inequalities. This involves gender analysis and gender mainstreaming considerations in staffing, budgeting, project design, implementation, monitoring, evaluation and learning to promote gender equality and equitable health.

Gender equity is about being fair to women and men, girls and boys in all their diversity and may require specific measures to address and correct social, economic, material or political discrimination faced by women and girls and or men and boys. Gender equality is the goal; and gender equity is the process towards that goal.

Gender-exploitative approaches take advantage of rigid gender norms and power imbalances to achieve program objectives intentionally or unintentionally; and may worsen existing gender inequalities and do harm to girls and women.

Gender-responsive approaches aim to transform unequal gender relations to promote shared power, control of resources, decision-making, and support women's empowerment. In a gender responsive intervention or program, GE integration is a core strategy for promoting gender equality and achieving positive development outcomes.

Gender-responsive health programming seeks to promote gender equality by taking into account how gender dynamics influence and impact on health outcomes in a given context.

Gender-transformative approaches aim to improve both practical and strategic gender issues. There is an explicit intention to transform unequal gendered powerrelations for equality between and among women, men, girls and boys in all their diversity.

Gender-sensitive refers to components or tools of a program wherein gender norms, roles and inequalities have been considered and awareness of these issues has been raised, although appropriate actions may not necessarily have been taken.

Gender discrimination is a situation when people are treated unfavorably because of being identified as male or female and denied rights, opportunities or resources associated with that gender because of these differences. It is systemic when it affects all or most social relations and has deep social and political roots.

Gender mainstreaming (Gender Integration) is the process of assessing the implications for women/girls and men/boys of any planned action, including

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legislation, policies or programs, in all areas and at all levels. It is a strategy for making women's/ girls' as well as men's/ boys' concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women/girls and men/boys benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality.

Gender relations are typically hierarchical relations of power between women and men and boys and girls based on gender discrimination. Women and girls tend to have less power in decision-making and access and control of resources.

Gender stereotypes are a generalized view or preconception about attributes or characteristics that are or ought to be possessed by, or the roles that are or should be performed by women and men and or girls and boys.

Male engagement in sexual reproductive maternal and newborn health (SRMNH) is about men taking on a positive and supportive role in their female partners and children's health, as much as their own health, as fathers, husbands and community role models. It requires culturally sensitive approaches to shift negative social norms, attitudes and practices about being a man (masculinities) towards more respectful and egalitarian attitudes and behaviours in SRMNH . To promote male engagement in health, men and boys must understand the harmful effects of certain toxic male stereotypes such as being tough on health outcomes, be better informed of SRMNH issues and realize the importance of their roles as fathers, husbands and role models.

Practical gender needs are the immediate needs identified by women to assist their survival in their socially accepted roles, within existing power structures.

Sexual reproductive health and rights (SRHRs) as the right of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence. Specifically, SRHRs ensure individuals are able to choose whether, when, and with whom to engage in sexual activity; to choose whether and when to have children; and to access the information and means to do so.

Strategic gender interests are needs identified by women that require strategies for challenging male dominance and privilege. These needs may relate to inequalities in the gender division of labor, in ownership and control of resources, in participation in decision-making, or to experiences of domestic and other sexual violence.

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Women's empowerment is about women and girls gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources and actions to transform the structures and institutions which reinforce and perpetuate gender discrimination and inequality.

1 Background and Policy Context

1.1 Global Trends in Gender and Health Policy

1.2 National Health Policy Initiatives and Landmarks

1.3 The Policy Drafting Process

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1 Background and Policy Context

Nigeria has an estimated population of 190.9 million (51% female/49% male). More than half of this population are girls and boys 17 years of age and younger (52%). Almost half (49.4%) of this population live in urban areas and about two-thirds (65%) live below the poverty line. In fact, in 2018, Nigeria overtook India as the country with the largest proportion of its populace living in abject poverty. Health indicators for Nigeria are among the worst in Africa. According to the World Health Organization'scountryhealth sector performance ranking (WHO, 2018), Nigeria is rated 187 out of 190 country health systems. This is a direct reflection of its health expenditure, ranging from a mere 3.3% to 3.7% of GDP between 2011 and 2015 and only 4% of the overall 2018 budget. The poor state of health services and infrastructure nationwide is exacerbated by the absence of a robust social safety net system to help Nigerian women and men cushion the effects of a dysfunctional health service system.

Since the 1994 International Conference on Population and Development, there has been growing global attention to the need for health and livelihood indicators to capture gender-related factors to health and well-being. For instance, according to the Global Health Observatory, as of 2016, mortality rates per 1000 adults, were higher for men at 371.1 compared to 333.0 for women . Similarly, women live longer than men. Life expectancy rates for men and women stand at 53.7 and 55.4 years respectively based on WHO (2018) estimates. These differences are partly due to sex-based biological differences in growth, metabolism, reproductive cycles, sex hormones and ageing processes.4 Even when men and women are equally exposed to a risk or disease, the health consequences may be different for each sex.

From a gender perspective, men's lower life expectancy relates to gender-based differentiated live styles that influence the health and well-being of men and women over the life course. Men's high rates of heart disease, road injuries, lung cancers, stroke, liver problems, and prostate cancer are both biologically determined and gender-related. Moreover, women's additional years, are not always healthy. They may suffer from breast or cervical cancer or maternal conditions and deeper poverty and loneliness related to unequal gender roles (WHO World Health Statistics, 2019).

Biologically specified health needs of men and women differ in terms of vulnerability to and experience of ill-health and disease. For example, in Nigeria, available data suggests that if adult women and men were equally exposed to malaria, they would equally be vulnerable to infection. An exception to the rule is pregnant women and pregnant adolescent girls, who are at risk of severe malaria in most endemic areas related to biological factors. In relation to social positioning within a predominantly

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patriarchal society, women/girls and men/boys are ascribed roles and privileges that produce significantly gendered outcomes regarding their vulnerability to ill-health and disease. These same gender dynamics influence differences and inequalities to be able and willing to access health services, products and technologies.

While there are gendered determinants of health for women and men, girls and boys, due to socially-based lower valuing of women and girls, they tend to face more gender-related obstacles to health and are limited in their ability to seek health care services due to lower decision-making power and financial dependency on men. In the case of malaria, pregnant women and pregnant adolescent girls suffering from severe malaria may face more barriers to accessing health services due to lack of decision making power and economic resources to access health services. These sex and gender based differences and inequalities contribute to low maternal and child health outcomes. Nigeria accounts for nearly 20% of all maternal deaths in the world, with approximately 145 Nigerian women and adolescent girls dying in childbirth every day.

Beyond accessibility issues, the Nigerian health system is organized primarily as a bio-medical practice focused on the technical aspects of healthcare. Consequently, health inequities and inequalities arising from imbalances in the social relations of gender and other related social forms of discrimination, i.e., education or wealth status, tend not to be readily accommodated. Statistical evidence attests to the negative impacts of gender determinants and gender-blindness in the health system. For example, it is estimated that 145 Nigerian women of reproductive age (WRA) (15-49 years of age) die daily in child birth; a maternal mortality rate of 560/100,000 live births ranging from 165/100,000 live births in the South West to as high as 1,549/100,000 live births in North East Nigeria. This is higher than the sub-Saharan African average of 545/100,000. WHO (2019) estimates that between 2005 and 2015, 600,000 Nigerian WRA died in child birth, partly due to inequities in health services and other socioeconomic determinants. In the Nigerian socio-cultural context, gender-differentiated indicators are relevant health indicators across all six building blocks of the health system:

- **Service delivery**: From the level of community-based to tertiary care, gender-based inequities and inequalities negatively affect quality of health services from health promotion to preventive and curative health services. This includes the provision of quality services defined as integrated, safe, effective, acceptable, equitable and evidence-based. Ensuring gender equity in access for all crosscuts all these standards. For example, safety standards relate to safe medical procedures and treatment for all as well as the need for procedures to

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reduce risk of sexual harassment or abuse both for clients and health providers.

- **Information and research**: The 'gender neutrality' of the Nigerian health system and the technical orientation of medical practice impede the collection, collation, analysis and use of sex-disaggregated data that could help health care managers and providers to better respond to gender-related health barriers and issues. Gender neutrality translates to gender blindness in the allocation of resources by preventing appropriate targeting of gender-specific needs.

- **Medical products and technologies**: Ensuring gender equitable access to essential medicines, vaccines, screening and technologies includes looking at different needs of women, men, girls and boys across the life course. Regular pap smear screening of women reduces mortality from cervical cancer. Screening with the HPV DNA or HPV RNA test detects high-grade cervical dysplasia, a precursor lesion for cervical cancer. For breast screening sessions, mammography centres that meet high professional standards of safety and quality are required. Similarly, regular PSA tests in conjunction with a digital rectal exam (DRE) to test asymptomatic men for prostate cancer screening are recommended for men over 46.

- **Health and social workforce**: Promoting gender-transformative policies and strategies that address gender biases and inequities in the health workforce and ensure decent work for all health and social care workers is a growing concern. This involves gender equity measures in health sector education, training, employment and career progression with special attention to promoting more women in decision-making positions due to their lower representation in these senior levels

- **Health care financing**: Achieving universal access to health services while ensuring gender equity in access to financial protection strategies. Promoting gender budgeting and financial risk assessments.

- **Leadership and governance**: Supporting good health governance and gender mainstreamed public health policies and governance structures, promoting gender-sensitive strategies and supportive legislation in terms of being responsive, fair and efficient. Promoting gender parity at leadership levels, and ensuring health systems are accountable to everyone.

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- **Education and Childhood Health:** Higher education levels enhance quality of life and longevity of women, men, girls and boys. The health effects of education are intergenerational. Childhood health and well-being lays the foundation for good health over a person's lifespan. The National Gender in Health Policy shall adopt an inter-sectoral and inter-generational approach that supports child nutrition (including school-based nutrition), immunisation, counselling, safe school and other anti-gender based violence (GBV) initiatives to address negative social health determinants that contribute to poor health outcomes. The evidence is clear: as WRA's education and wealth status increase, so does their health status improve as well as the health of their children and grandchildren.

In recognition of the foregoing, the Federal Ministry of Health (FMoH) has made concerted efforts in recent years to introduce a gender perspective into healthcare delivery consistent with the objectives of the National Health Policy and National Gender Policy. This is in acknowledgement of the centrality of gender to successful health system performance, particularly in improving healthcare delivery outcomes. Furthermore, the gender-differentiated indicators underlying the country's health profile constitute the basis for urgent, intentional and concerted policy action.

1.1 Global Trends in Gender in Health Policy

There is growing global recognition that gender is a key determinant of health inequities and health sector performance. The Sixtieth World Health Assembly in 2007 adopted resolution WHA60.25 urging Member States to formulate national strategies for addressing gender issues in health policies, programmes, research, and planning processes. It also urged Member States to ensure that a gender-equality perspective and strategy is incorporated into all levels of health-care delivery and services and is fully implemented, monitored and evaluated. These country strategies serve to enhance, expand and institutionalize capacity to analyse the role of gender and sex-based factors in health, and to monitor and address systemic and avoidable gender-based inequalities in health.

In framing the Sustainable Development Goals and 2030 Global Agenda for All, it was widely recognized that integrating gender equality and women and girls' empowerment perspectives into policies and programmes is important to the achievement of global commitments and targets. . More precisely, global best practices in health care delivery demonstrate that gender mainstreaming and human

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rights-based approaches lead to better health outcomes for men and women, boys and girls.[1] They also promote better overall health sector performance with more sustainable and equitable results in healthcare practice as well as in the health status of health service users (See 2030 Sustainable Development Goals (SDGs) 3 and 5). All 17 SDGs incorporate gender as a cross-cutting issue, with specific focus on women's specific health and development needs in the area of gender equality and empowerment of women and girls, maternal and child health, sanitation, water and hygiene and environmental resource use. Nigeria formally subscribed to the SDGs in 2015. Hence, the goals and strategies outlined for their achievement inform this National Gender in Health Policy.

1.2 National Health Policy Initiatives and Landmarks

Nigeria has a wide range of regulatory frameworks and health sector policies designed to regulate provision of excellence in health service delivery to all. Some of them focus on gender-specific health concerns focused on women and girls: medical and psycho-social support services tailored to gender-based violence survivors including for female genital mutilation to issues around food and nutrition and sexual reproductive health and rights.

1.2.1 The 1999 Nigerian Constitution

As the grand norm and premise for all national policies, the 1999 Constitution recognizes health as a fundamental human right and the right to health applies to all human beings irrespective of sex, gender, ethnicity, language, religion, birth, income, political and any other social affiliations. The 1999 Constitution of Nigeria prohibits discrimination on the grounds of sex, but customary and religious laws continue to restrict women's rights. The combination of federation and a tripartite system of civil, customary and religious law makes it very difficult to harmonize legislation and remove discriminatory practices. Adherence to some Islamic and customary laws reinforces practices that are harmful to female health, particularly those relating to freedom of movement, early marriage, and inheritance. Although the Constitution prohibits discrimination on the grounds of sex, customary and religious laws continue to undercut constitutional provisions, restrict women's rights and to endanger their health.

1.2.2 The National Gender Policy

[1] https://www.who.int/bulletin/volumes/96/9/18-211607/en/.

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The 2006 National Gender Policy (NGP) takes as its point of departure, ratified international instruments such as the 1979 Convention on the Elimination of All Forms of Discrimination against Women (ratified in 1985), and its Optional Protocol (2004); the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (ratified in 2005), and the 2003 Child Rights Act. The policy focuses on women's empowerment while also making a commitment to eliminate discriminatory norms and practices that are harmful to women and girls. The NGP draws attention to deficiencies in health sector governance arising from the under-representation of women in decision-making bodies and policy formulation processes. It highlights how this gender blindness hinders the health sector's responsiveness to gender equality considerations.

The policy, however, lacks comprehensive legislative backing across its multi-sector framework and the political leadership and human and financial resources. As a result, significant gender gaps in education, economic empowerment and political participation persist. An 'Abolition of all Forms of Discrimination against Women in Nigeria and other Related Matters Bill', A "Sexual and Reproductive Health Bill" and a "Gender and Equal Opportunities Bill" were considered in 2004, 2005 and 2016 respectively. However, the National Assembly did not pass any of them, ostensibly on cultural and religious premises. It passed, however, a "Violence Against Persons Prohibition Bill (VAPP)" into law in 2015. Consequently, the NGP has fallen far short of expected targets. While progress towards gender parity in primary school education has been made, there remains significant political, wage and labour force participation gender gaps. More specifically, discriminatory laws and practices, violence against women and girls and negative gender stereotypes pervade both informal attitudes and practices and formal health services structures. Until these deep-seated gender inequalities are recognized and addressed through political will and material investments, progress towards gender health equality will remain sub-optimal. Nigeria has an alarmingly high maternal mortality rate and low level of women's participation in their own health related decision making (66% of married women and married adolescent girls do not participate in decisions regarding their health care), , particularly in rural areas, that cannot go under-recognized as a gender and human rights issue[2]

1.2.3 National Health Act (2014)

Nigeria's National Health Act 2014 (NHA 2014) was signed into law on October 31, 2014. It provides a legal framework for the regulation, development, and management of Nigeria's Health Care System. It sets standards for provision of

[2]Nigeria Demographic Health Survey 2018 (published 2019).

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health services in the country. Gaps remain, however, because the NHA fails to recognize and respond to gender-related health issues.It does provide provisions for female representation on certain health committees and adopts a woman-centric focus on specific health needs of women in terms of sex-based factors to health. The problem with such a lens on women's health only is that it tends to reflect socially-based assumptions that SRMNH is a "women's only issue." From a gender perspective, pregnancy, immunization against infectious diseases and vulnerable groups in fact concern women, men, girls and boys. The result of focusing SRMNH interventions on women only, is to exclude men and deny them services for their SRH needs and to encourage them to play active roles as fathers, husbands and role models.

1.2.4 The National Health Policy

The NHP (4.1.6.6) has an explicit commitment to gender equality and guarantees access to gender-sensitive health services irrespective of sexual orientation with the following specific objectives:

- Promote gender mainstreaming in all national health policies, programmes and plans;
- Promote gender-sensitive education and capacity building, thereby ensuring technical expertise and positive gender culture; and
- Promote the empowerment of women through equitable access to needed health services.

1.2.5 National Reproductive Health Policy

In 2017, the FMoH carried out a 3rd review of the 2001 National Reproductive Health Policy to benchmark it with current country realities and global perspectives. Sexual and Reproductive Health and Rights (including the right to health for all) remain a subject of political, social and policy debates because of its potential for poverty reduction and sustainable development. Previous reproductive health policies focused on population control but the new policy aims to be person-centred, placing the individual, male or female, at the centre. It pays particular attention to fertility management, healthy pregnancy and childbearing, gender equality, human rights, healthy sexual development and sexuality, integrated reproductive health service and education, especially the education of girls.

Sexual Reproductive Health and Rights (SRHR) play an important part in improving the health of women, men, girls and boys in all their diversity and promoting

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women's economic and social empowerment. For this reason, it is essential that sexual and reproductive health be given closer attention. This can be achieved by legislation and incorporating sexual and reproductive health in the National Gender in Health Policy, and ensuring that budgetary allocation is made for the delivery of these services. Government shall leverage on the Sustainable Development Goals that have explicitly incorporated Sexual and Reproductive Health and Rights. Increased and improved access to these rights is driven by the SDG targets for health (SDG 3), education (SDG 4) and gender equality (SDG 5). It is essential that the key provisions and guidelines of the Reproductive Health Policy be implemented in tandem with the National Gender in Health Policy.

1.2.6 National Strategic Health Development Plan II (2018 – 2031)

The Federal Executive Council approved this plan in September 2018. It has 15 thematic areas, 48 strategic objectives and 282 interventions aimed at improving healthcare delivery in Nigeria. This includes a target of a 31% reduction in maternal mortality.

1.2.7 Violence Against Persons Prohibition Act

The VAPP law criminalizes specific acts of gender-based violence including rape, female genital mutilation, forced financial dependency or economic abuse, forced isolation from family or friends, harmful traditional practices, spousal battery, stalking, abandonment, incest and deprivation of liberty. These and other related GBV acts have significant impact on the mental, spiritual and physical health status of male or female survivors. Accordingly, in its "Standards and Guidelines for the Medical Management of Victims of Violence in Nigeria", the FMoH earmarked the reproductive health components of violence as having deep and long-lasting implications requiring skilled management. The National Gender in Health Policy (NGHP) goes beyond the sole demarcation of reproductive health components to a comprehensive view of all forms of GBV as being implicated in health and wellbeing.

The NGHP considers both sex-based and gender-related factors in health and needed gender-sensitive provisions as defined in the existing health policy framework. It does not replicate them. Rather, it is positioned to facilitate tackling gender health needs, concerns and priorities as a centralized strategy rather than it being a mere add-on or tangential issue into the mainstream of health sector planning, programming and delivery.

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1.3 Policy Drafting Process

The drafting of the National Gender in Health Policy involved a multi-stakeholder process with cross-sectional focus and participation. This process involved the following:

- A stakeholder meeting of relevant actors in the health sector to conceptualize the basic parameters of a Gender in Health Policy.

- A desk review to scope the policy terrain in relation to gender equality and health.

- A preliminary fact-finding and consultation meeting between senior officers of the FMoH, JHPEIGO and the consultant to agree on the Policy goal and thrust.A situation analysis of the current status of gender equality in the Nigerian health sector and among women, men, girls and boys. The stakeholder meeting and situation analysis provided the baseline information for designing suitable policy interventions and guidelines. To carry out the situational analysis, thirty-two Gender Desk Officers (GDOs) and other health sector workers in 31 states and FCT participated in an open and close-ended opinion survey to elicit practitioner perspectives on an appropriate national gender in health policy for Nigeria. GDOs, in particular, are uniquely positioned within the health sector to serve as inter-agency and cross-sectoral liaison officers for articulating and addressing gender-related health issues in a holistic manner.
- Opinion survey results derive from the responses of a cross-section of gender desk officers based in various states of Nigeria. Although limited in scale and therefore not generalizable, their professional perspectives affirmed the relatively low level of gender responsiveness within the health system in the country as shown in Table 1.1 below.

- Two policy communication workshops, involving a validation workshop as well as a finalization workshop to present the first and reviewed drafts of the policy. The overall objective of both workshops was to seek the input of a broad range of stakeholders into the policy document. Stakeholders included health practitioners, health administrators, health development workers and gender desk officers in the FMoH.

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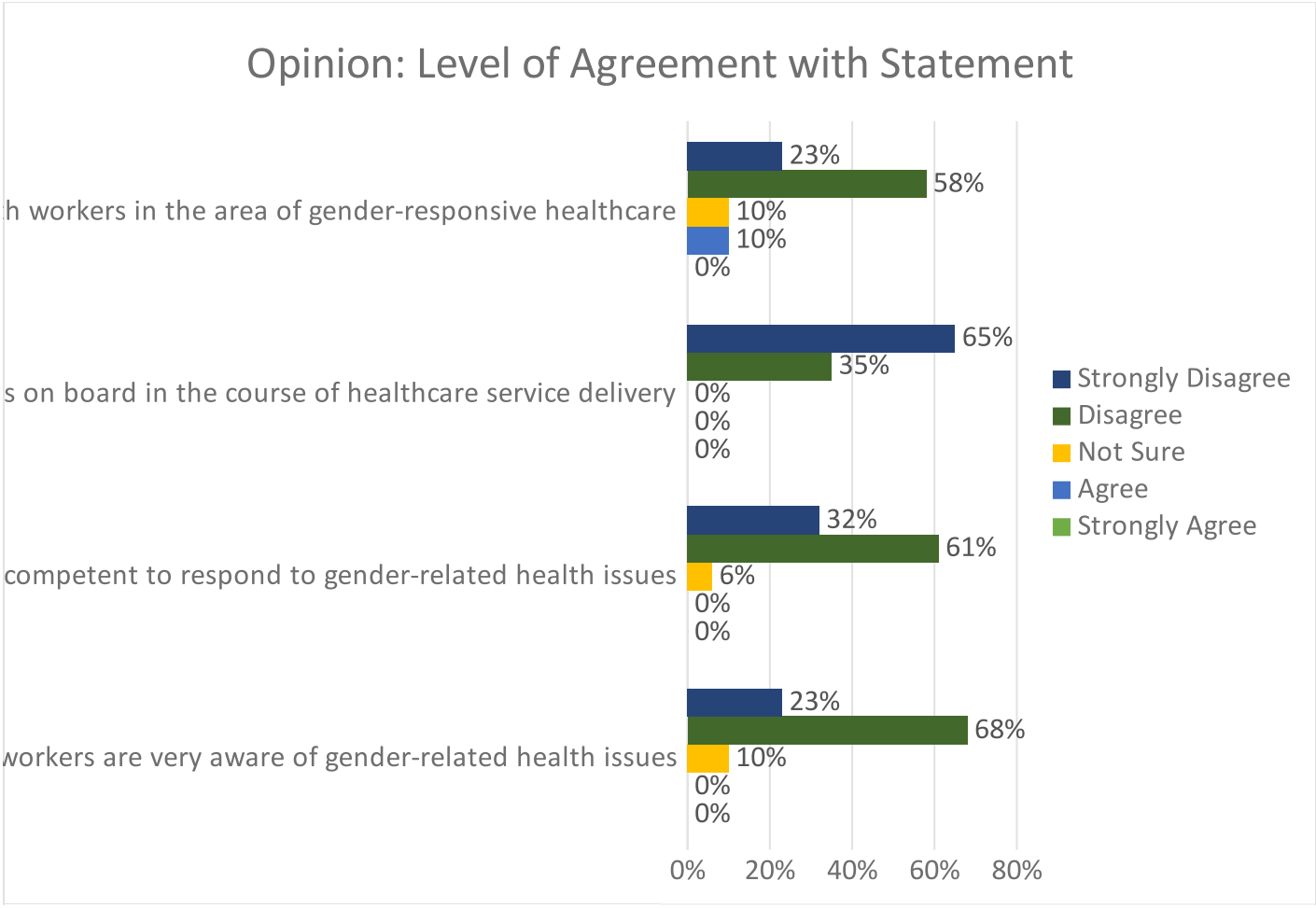

Figure 1: **Cross-Section of Opinion Survey Data Showing Level of Gender Integration in the Nigerian Health Sector**

2 Situation Analysis and Rationale

2.1 General Gender-differentiated Health Indicators

2.2 Critical Issues in Girl's and Women's Health

2.3 Critical Issues In Boy's and Men's Health

2.4 Policy Rationale

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2 Situation Analysis and Rationale

2.1 Framework of the Analysis

Gender refers to the identity, intrinsic worth, roles and status that society confers on individuals on account of their biological sex or gender identity. Gender intersects with the health status and profile of populations in various ways. The differential allocation of value, power and prestige to people on the basis of being male or female gives rise to discrimination and marginalisation. In this way, gender determines incidence and prevalence rates of diseases, treatment and outcomes in terms of recovery, morbidity and mortality. A general pattern is for women and girls to face more forms of discrimination due to their lower social status compared to men and boys. By considering other intersecting forms of discrimination such as ethnicity, migration and social status and disability, among the category of women, there are differences and inequalities between and among women themselves. This same analysis holds true for the category of men. No social grouping is homogenous.

The situational analysis below uses a gender-based analysis combined with a socio-economic analysis to understand the relationships between men and women, boys and girls across various cross-cutting social categories, by gender, sex, age, wealth and education, their access to resources, their activities, and the constraints faced relative to and compared to each other, and among social groups. An analysis of gender relations provides information on the different conditions that women and men and girls and boys face, and the different effects that health policies and programs may have on their health due to varying practical needs and strategic interests. Such information can inform and improve health policies and programs, and is essential in ensuring that the different needs and interests of both women and men, boys and girls, in all their diversity, are met by the healthcare system.

At the local level, gender analysis makes visible the varied roles women, men, girls and boys play in the family, in the community, and in economic, legal and political structures that determine risks to ill health and shape health-seeking behaviors and situations. A gender perspective focuses on the reasons for the current division of responsibilities and benefits and their effects on the distribution of rewards and incentives based on three inter-related domains: gendered determinants of health; gendered health behaviors of men and women, boys and girls; and gendered nature of the healthcare system. This is depicted in Figure 2 below.

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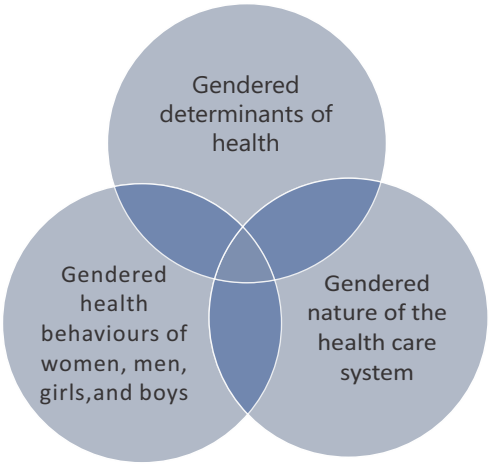

Figure 2: Domains of Gender in Health

2.2 Gendered Determinants of Health

Nigeria features diverse religious and custom-based gender norms and practices rooted in a pervasive patriarchal culture. Several gender norms and practices serve as critical risk factors that impact significantly the health status and general well-being of women, men, girls and boys across the lifecourse in different ways. This has far-reaching implications for health sector planning and health service delivery. Despite the existing, wide-ranging policy framework for achieving health goals and targets, as previously noted, Nigeria still has one of the poorest sets of gender-related health indices in the world. It accounts for 20% of the world's maternal deaths, and has the highest numbers of child early forced marriages globally. 19% of adolescent girls 15 to 19 years of age have begun childbearing and are among the highest at risk age groups of maternal mortality and complications in pregnancy and childbirth.

There is clear evidence that gender influences health and wellbeing across the three domains: gendered determinants of health and gendered health behaviours and the gendered nature of the health system response depicted in Fig. 2 above.

Nigeria's gender-related and sex-based differences in vulnerability and risk to ill-health, barriers to health-service access, and health outcomes are well documented in the 2008, 2013 and 2018 National Demographic Health Surveys. There are wide country variations in gender and sex-disaggregated indices, and these have demonstrable and overlapping relationships to health outcomes. Variations are particularly visible in the pattern of maternal mortality rates by wealth, education and geographic location of WRA. In the more conservative northern part of the country, the maternal mortality rates are three times the national average (currently 545/100,000 live births) and have generally poor gender indices, In considering common national trends and regional variations, a national policy framework is

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necessary to improve the structure, financing, delivery, measurement, and evaluation of services established to address gender-related issues and barriers to good health and wellbeing.

2.3 Gendered Nature of the Health Care System

Gender based discrimination and biases influence all dimensions and levels of health care systems including patient-health care provider interactions, service provision, policies and employment, working conditions and career trajectories of health and social care workers (WHO, 2018). Gender biases, rooted in customary and religious norms and practices, inadvertently infuse health system approaches and treatment of users of health facilities, products and services negatively affecting health outcomes. For instance, the majority of health care providers are women and are found in the lower-echelons of the health care system, while men are more likely to dominate higher paying, decision-making positions. Women make up 70% of global healthcare workforce but hold only 25% of senior roles. Gender biases constrain women's leadership and seniority and men from entering certain female-stereotyped occupations (i.e. nursing). Large proportion of women health care workers face bias and sexual harassment causing harm, ill health, stress and low morale.[3] Cultural/religious gender biases may be held by male and female health care providers themselves and negatively influence their treatment and interactions with adolescent girls or boys seeking sexual or reproductive health information and services. (more on this below).

Understanding how complex societal interactions between norms, culture, socioeconomic status and sex-related biological differences impact health is essential at all levels and across all dimensions of health administration and care. Recognition of gender-specific health risks of particular social groups must inform health sector research and programme planning for prevention, treatment and care towards better health outcomes for women, men girls, boys and other gender identities.

2.4 Critical Issues in Girls' and Women's Health

2.4.1 Maternal Mortality

On average, a Nigerian woman gives birth to 5-6 children in her lifetime (4.5 in urban areas and 5.9 in rural areas (NDHS 2018). Maternal mortality ratios across Nigeria

[3] https://apps.who.int/iris/bitstream/handle/10665/311322/9789241515467-eng.pdf?ua=1 .

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range between 545-1350 per 100,000 live births and an under-five mortality rate of 117 per 1000 live births. Over the last 10 years, Nigeria has alternated between having the highest or second highest maternal mortality rate worldwide. The daily loss of 145 women in child birth amounts to an annual maternal death rate of 52,925! Women must access safe, skilled and respectful maternity care in pregnancy, at delivery and the puerperium to stay healthy and reduce risks of complications. However, only 39% of births in Nigeria were delivered in Health care facilities, with lowest rates in the North central and eastern states, below 10%, and highest in South Western states (NDHS 2018). By 2017, healthdata.org indicated that neonatal disorders were the second leading cause of death in the country. According to the Nigeria Health Watch (2017), pregnant women and pregnant adolescent girls in Nigeria are dying in droves. The Nigerian DHS indicates that sexual debut is roughly 15 years of age among adolescent mothers in Nigeria, while men aged 15-49 have on average four sexual partners with attendant risks of Sexual Transmitted Infections (STIs) and HIV and AIDS. In a country where sexual assault and incest with minors as young as a few months old are becoming endemic, these figures may be highly conservative. In Northern states, where girl-child marriage is prevalent, sexual debut could be as early as nine years (NDHS, 2013, 2018).

Over 1.25 million abortions were procured in Nigeria annually between 2016 and 2018 as outcomes of 56% of unplanned pregnancies. About 4-6% of WRA have had a likely abortion.[4] Data on the volume of unsafe abortions and related deaths is still largely unavailable. Evidence suggests it is inordinately high, unsafe and lead to complications for which WRA seek postabortion care at a health facility.[5] All these call for making family planning information and services available to women, men and adolescents through various accessible routes combined with offering safe postabortion care.

Contributory factors to high maternal mortality that need to be addressed include:

- **Lack of Universal Healthcare Coverage**: The absence of UHC has made the Nigerian Out-of-pocket health expenditure 95 % of private expenditure on health and 77.6% of total health expenditure, ranking the nation the highest in the world in out of pocket payment expenses (OOPE). This also affects WRA's ability and motivate to access maternity services. In most parts of the country, maternity services are paid for as OOP expenses, with non-regressive patterns given that the rich and the poor pay same amounts. This cost related barrier

[4] https://www.pma2020.org/sites/default/files/AbortionModule_Brief_111518.pdf.
[5] https://www.pma2020.org/sites/default/files/AbortionModule_Brief_111518.pdf.

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may explain lower levels of facility-based births among less educated and wealthy women compared to those with a higher education and wealth status (NDHS 2018). Funded maternity services, health insurance and social security services must be prioritized especially to regions were gender dimensions limit agency and empowerment of women and girls. Making health services more male-friendly is another important dimension, espeically for men and boys who are at risk of adverse health outcomes on account of constructions of masculinity such as high rates of death among men, particularly young men, to road traffic accidents.

- **Gender-biased Healthcare Worker (HCW) Attitudes:** It is not uncommon for patients to tell stories that reflect how healthcare workers often transfer their own gender biases to clients/patients, which create barriers to accessing quality healthcare. Internalized and unchallenged cultural norms discriminate against health users, especially women and girls, more so when they are people with disabilities, HIV/AIDS, of lower socioeconomic status or different ethno-religious or sexual identity and behaviour. In the predominantly Muslim North, having a male HCW may be culturally unacceptable for female clients but such gender-related issues may be ignored by formal health care practice. Research is needed to generate precise data on health worker bias in Nigeria and its impact on access to health. Furthermore, cultural/religious norms that promote gender bias in the health care system need to be deconstructed through training and engagement of healthcare workers and communities.

- **Harmful Traditional Practices (HTPs)**: As already noted, pervasive HTPs constitute an aspect of gender-based violence and form the substructure of gender-based health inequities and inequalities. A 1999 Baseline Survey on Harmful Traditional Practices in Nigeria commissioned by the Federal Ministry of Women Affairs demonstrated how various HTPs remain prevalent in the different parts of the country. Today, the Nigerian cultural landscape still commonly includes HTPs, rooted in unequal gender norms. For some HTPs, there is hard evidence such as female genital mutilation/cutting (20% of WRA today (NDHS 2018), down from 25% from the 2013 NDHS); girl-child marriage (23% of adolescent girls 15-19 years of age are married or living with partner); polygyny (31% of women have co-wives) domestic violence (36% of ever-married WRA have experienced spousal physical, sexual, or emotional violence). Other HTPs are common but very little data is available including offensive widowhood practices, son preference, female disinheritance, killing of twins and babies with disabilities, witchcraft accusations against women and children, breast ironing, torture and maltreatment of people living with

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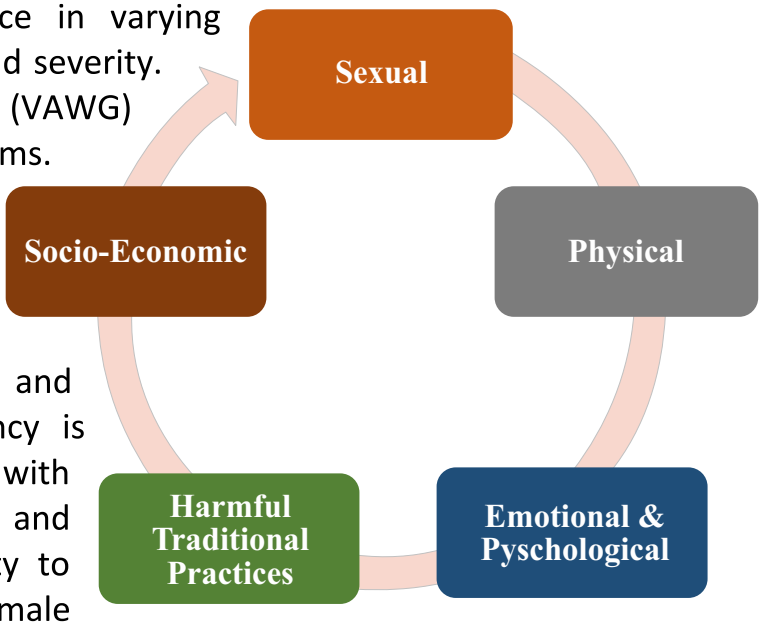
disabilities (M/F), those living with HIV (53% of women and 50% of men would not buy fresh vegetables from a shopkeeper with HIV), among others (NDHS 2018).

2.4.2. Gender-Based Violence

The 1993 United National Declaration on Violence Against Women defines gender-based violence as any act of form of "violence that targets and individual or group because of their sex." It identifies five types of violence: Physical, sexual, socio-economic, psychological/ emotional and harmful traditional practices. High tolerance for and prevalence of gender-based violence characterize the Nigerian socio-cultural and political environment. Violence affecting women and girls is deeply entrenched in customary and religious norms and practices, and shrouded in secrecy, stigma, shaming and shunning of the victim. Thus, the closeted nature of Nigerian society causes acts of violence meted out against women and girls to frequently go unreported to law enforcement or HCPs.



Women and men experience violence in varying dimensions and degrees of intensity and severity. Violence against women and girls (VAWG) comprises both structural and direct forms. Structural violence occurs when formal and informal societal institutions embody norms, laws and practices that systematically perpetuate inequality, inequity and injustice. Female economic dependency is also a form of structural violence with negative outcomes for both women and their children. It obstructs their ability to access healthcare independent of male support. This has proven fatal is many instances. Structural violence engenders direct violence in the form of intimate partner violence, sexual assault, human trafficking, intimidation, deprivation, political and electoral violence, taking advantage and maltreatment of persons will disabilities, among others. Both structural and direct forms of violence are rife in Nigeria and are not uncommon within the health sector, where female patients, especially girl-children and people with disabilities, have reported abuse by both male and female health workers. Women and girls are often at greater risk of violence and insecurity in places where they should be safest: in homes, schools, IDP camps, hospitals and other spaces where they go to seek help or refuge.

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The public support system for providing protection and redress for victims, survivors or people at risk of GBV, is weak, disjointed or non-existent. There is a general lack of domestic violence/ child abuse counselling, shelters, rape crisis services, special services and infrastructure (e.g. ramps, braille, hearing aids etc.,) for people with disabilities and other such facilities to assist those in need and reduce their vulnerability. The Gender in Health Policy shall support resource mobilization and other initiatives towards GBV prevention and response through the establishment of an integrated support system. For the purposes of effective health sector planning and policy implementation, there is also a need to generate sex-disaggregated data on gender-based violence through the development of a comprehensive database to map the incidence and prevalence of its diverse forms of across Nigeria.

2.4.2 Adolescent Behaviour, Sexuality and Teenage Pregnancy

Substance abuse is growing in spread and intensity among male and female adolescents aged 15 to 19 years of age due to social, economic and psychological causes. Adolescent sexual activity in Nigeria is also on the rise – both consensual and forced (Sowewimo et al., 2017). Teenage pregnancy is rated very high all over the country – whether in or outside a marriage union. Access to sex education, reproductive services and modern contraceptives is low and culturally frowned at as an encouragement of promiscuity. Across all reproductive health indicators, teenagers fare worse than older women. At 19 years, 37% of teenagers have started giving birth with wide regional variations ranging from 5.5% in the South West, 8.8% in the South East, 10.6% in the South South, 16.3% in the North Central and 24.5% in the North East, and 28.5% in the North West. In the north, cultural and religious factors combine to predispose female adolescents to early marriage and attendant risk of vesico-vaginal fistula (VVF).

Regional variations in teenage pregnancy also occur in relation to educational levels, rural/urban location and socioeconomic status. Teenagers with secondary education or less, living in rural areas and from low-income backgrounds are more likely to get pregnant. According to the 2018 National Nutrition and Health Survey, only 37% of births from teenagers received care from a skilled birth attendant. Pregnant teens also record the lowest level of antenatal care with only 68% visiting an antenatal facility at least once compared to 75% for older women (NNHS, 2018). These health indicators have dire implications for child health as well. Evidence shows that children born to teenage mothers are at increased risk from illness and death.

Another critical issue for teenage girls relates to menstrual hygiene management. Many girls (and women) in Nigeria, particularly those in rural areas, encounter

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numerous barriers to health, education and employment on account of inadequate support through their menstrual cycle. Poverty, ignorance and gender bias challenges to girls' menstrual hygiene include unavailability of sanitary pads, missing school during menstrual cycle, getting teased by boys (shaming), and psychological trauma. The policy shall support innovative approaches to MHM training for girls and low-income women to enhance self-sufficiency to manage their periods with dignity and to build resilience and overall health in menstrual hygiene.

2.4.3 Mental and Physical Stress

Stress levels among Nigerian women and men, boys and girls are drastically rising due to numerous stress factors in the Nigerian environment: insecurity, unemployment, poor public service delivery, poverty, harmful traditional practices, among others. Nigerian women bear a triple development burden that spans domestic and public domains. Women and girls provide unpaid care, which includes child and elderly care, domestic tasks and reproduction. This non-monetized household-based healthcare provisioning has extensive impacts on health because multiple tasks are done manually and have been associated with conditions like high blood pressure, arthritis, diabetes, stress, and cardiac arrest, among others. The unpaid nature of reproductive care work limits female purchasing power and the ability to access appropriate healthcare, which is 90% paid as OOPE.

2.5 Critical Issues in Boys' and Men's Health

2.5.1 Boys' Health

Boys experience a variety of health problems deriving from biological predisposition and harmful gender norms. Globally, infants and under-five boys have biologically determined higher mortality rates. Nigerian boys and adolescents are at additional risk from unsafe circumcision practices, street hawking, street begging under the *almajiri* system, predominant in Northern Nigeria, enlistment as boy-soldiers by militants and insurgents, drug addiction, child trafficking and forced gang conscription and criminality. . Boys are typically socialized to be tough and such social expectations can put pressures on boys of all ages to take unnecessary risks such as having multiple sexual partners without using a condom. Positive gender norms, attitudes and practices can help socialize boys to be caring and respectful fathers, husbands and role models of good health practice.

2.5.2 Men's Health

Despite having had most of the social determinants of health in their favour, adult men have higher mortality rates for all 15 leading causes of death. Men often suffer

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and die more and at a younger age from cardiovascular diseases, respiratory diseases, accidents and male-on-male violence than women. Socio-economic factors, social status, diet, smoking, alcohol, drug-taking, unsafe and unhealthy sexual practices, suicide, accidents, violence, hereditary factors, as well as occupational hazards, can be important for morbidity and mortality. In the patriarchal framings of men as sole bread winners/providers, they are exposed to many hours of work and occupations that put them at increased risk of accidents and ill health.

Men's health may be linked to risk-taking and unhealthy behaviour, and especially so for younger men. Research has shown that, owing in part to a culture-based 'macho-man' syndrome, men are over-optimistic regarding their own health. This has especially been observed with diseases like prostate cancer, diabetes, high blood pressure and stroke. There is need for educating men that it takes nothing away from them to seek medical help early. The Policy shall address culture-aware modalities for improving men's health practices, appropriate use of health services and reduction in high-risk behaviours. These can be achieved by making provision for strategies to heighten health awareness.

2.6 Gendered Nature of Health System Response

The top echelon of executive and management decision-making in the Nigerian health sector consists predominantly of men. In addition, health training programmes across all areas of specialization and staff cadres do not integrate gender equality and women's empowerment as a critical component in healthcare knowledge, attitudes and practices. Patient care in Nigeria revolves essentially around a bio-medical approach that pays insufficient attention to socio-cultural factors such as gender, which underpin people's health status. As a result, the healthcare system in Nigeria lacks adequate and appropriate gender response mechanisms. This affects the organizational culture of health care facilities, providers and regulators. As noted earlier, the situation is further compounded by culture-based gender bias informed by patriarchal values that permeate the health system at all levels. Such biases take the form of discriminatory HCW attitudes, failure to respond to signs of GBV and general gender insensitivity. Even female health workers are not immune to the preponderance of culture-based gender prejudice.

The FMoH has carried out a number of ad-hoc training interventions to promote more gender-responsive approaches within the sector. Nevertheless, there is need to institutionalize systematic and targeted mechanism to create a health system that meets the needs of all regardless of gender or any other social categorization.

2.6.1 Governance & Decision-Making

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Nigeria has a poor data collection, collation and retrieval system as well as a weak research base. Hence, an accurate ratio of male to female staff at the three levels of the health care system is unknown. However, anecdotal evidence indicates that the female population tends to be higher in the nursing, midwifery and community health worker cadres. These professions constitute the majority of the health workforce and when viewed globally, it would appear that there is greater female representation in health. Despite this, the ratio of women in specialised professions such as medicine, dentistry, pharmacy, the laboratory services and hospital administration, management and health sector regulation is significantly lower than of men. Women often occupy lower salaried and lower status positions in the healthcare sector as shown in the core health workforce per 1,000 population of some other African nations (WHO, 2017). The Nigerian picture probably simulates this picture shown in the graph below.

WHO Spotlight on statistics - A fact file on health workforce statistics; Gender and health workforce statistics, WHO Issue No. 2 - February 2008, https://www.who.int/hrh/statistics/spotlight2/en/

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Such disparities are related to the difference in the educational opportunities afforded to women to enable them aspire to become highly skilled professionals and the demands of unpaid care work. Other factors are gender discrimination within the system that inhibits the rise of women into these professions and positions of influence. Women do feature in leadership positions but the ratio is skewed in favour of men. The under-representation of women in managerial and decision making positions often leads to less attention to and poorer understanding of both the particular features of working conditions that characterise much of women's employment, and the health care needs specific to women. These gaps will be found as much in the national health care system broadly as in facility and community based health care services. It is imperative that the low level of sex and gender-disaggregated data and research on gender-related health issues in the Nigerian health sector is addressed in order to bridge gender gaps and prevent disparities. This gender-sensitive and sex and age dis-aggregated data is relevant both in terms of making health services gender responsive for Nigerian women, men, girls and boys and creating a fair and just system for women as much as men to reach their potential in the health sector.

S/N	AREA	GENDER-BASED INFLUENCE ON HEALTH ISSUES AND OUTCOMES
		SOCIO-DEMOGRAPHIC
1.	Demography	Female life expectancy is higher than for men but often marked with disabling health issues.
2.	Socio-cultural norms	• Customary norms and practices that affect women and girls' health: girl-child marriage, widowhood rites, FGM, polygamy, sex-segregated domestic labour, male/son preference, polygamy, gender-based violence, among others. • Customary norms that affect men and boys' health: Breadwinner role, cultural license or permissiveness to indulge in unhealthy behaviour e.g. drinking, smoking, sexual promiscuity, and sex-segregated occupations such as transportation sector and mining • Because Nigeria is a 'closeted' society issues around sex, sexuality, sexual orientation and gender identity are not freely discussed promoting sexual exploitation, teen pregnancy and neglect of high risk groups such as female sex workers,

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		PLWHIV/AIDS and LGBTQIs.
COMPONENTS OF HEALTH		
1.	Maternal Health	•Maternal mortality ratio (650 -1000 per 100,000 live births)
2.	Child Health	•Under-5 Mortality Rate: Female: 98 per 1000 Live Births (2016) •Under-5 Mortality Rate: Male: 110 per 1000 Live Births (2016) https://www.ceicdata.com/en/nigeria/health-statistics/
3.	Teenage Pregnancy	19% of adolescent girls 15 to 19 years of age have begun childbearing and are among the highest at risk age groups of maternal mortality and complications in pregnancy and childbirth.
4.	HARMFUL TRADITIONAL PRACTICES	
4.1	Early & Forced Marriage	• Despite enactment of the 2003 Child Rights Act, early marriage and resultant VVF is prevalent in Northern Nigeria (i.e. Women in the North West marry at a much earlier age (15.8 years) than women in the South East (23.6 years) (2018 NDHS). • WHO and UNICEF ranked Nigeria as the highest prevalence of VVF in the world in 2018 (ICIR, 2018)
4.2	FGM	• Cultural norms and taboos persist despite anti-FGM legislation and campaigns • Prevalence of FGM ranges from the highest prevalence in the South East (35%), going up as high as 51-62% in Imo and Cross-River states to lowest in the North East (6%) but high in Kaduna state (38-50%) (NDHS 2018).
5.	Nutrition	• Cultural taboos around gender-differentiated nutritional needs are prevalent, particularly in rural areas, causing under-nutrition among female infants and girls. • In some cultures nutrient-rich foods like eggs, some meats, etc. are forbidden for women and girls. This has negative effects on pregnant women and pregnant adolescent girls' health. • There are direct correlations between women's

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		empowerment and children's nutrition health. Children whose mothers are thin (a body mass index [BMI] below 18.5) are more likely to be stunted, wasted, or underweight than children whose mothers have a normal BMI and children whose mothers are overweight or obese. The prevalence of stunting in children whose mothers are thin is twice that (49%) of children whose mothers are overweight or obese (23%) (NDHS 2018)).
6.	Cancer	• The absence of well-coordinated cancer screening policy and programme makes cancer, particularly cervical cancer, one of the leading causes of female mortality in Nigeria (Sowemimo et al., 2017). • Cervical cancer is the most common gynaecological cancer among women in sub-Saharan Africa and the second most common cancer in Nigeria and second to breast cancer among its female population.[6]
7.	HIV/AIDS	• Unequal male/female power relations determining sexual activity and GBV, impact on women and girls' higher risk and vulnerability to HIV • Low female access to HIV awareness and protection • Prevalence of HIV in Women is 1.30 % and in Men is 0.70 % in the age group 15 - 24 years. (World Bank, 2014) • 30 % of Pregnant Women Living with HIV • 32 % of Pregnant Women Living with HIV are on Antiretroviral Therapy Coverage Source: World Bank Data, 2017
8.	Tuberculosis	• Estimated TB incidence – Female 150,000 (72–228,000) • Estimated TB incidence – Male 268,000 (128–408

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6098589/

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		2017
9.	Malaria	• Estimated cases: 53.7 million (36.3 - 75.9 million) • Estimated deaths: 79,800 (62.500 - 97,000) Source: World Health Organisation, 2017
10.	Hygiene & Environmental Sanitation	• Poor access to potable water and good sanitation affects women and girls who are traditionally responsible for fetching and hauling water (and firewood). • Bush clearing, burning and cooking with firewood are typically done by females, with attendant negative health effects.
11.	Work-related accidents	
12.	Substance Abuse	Drug abuse among young people is on the rise, with a disproportionally higher rate among female youth in northern Nigeria.
13.	Reproductive Health	• Only 11% of women of reproductive age have access to modern family planning methods. • Inappropriate abortion laws cause high rate of unsafe abortions – approximately one million annually (Ajiboye, 2018) • Cultural norms prohibit women from having control over their reproductive activity.
14.	Mental Health	Mental health illnesses such as depression, mental breakdown, PTSD and schizophrenia disproportionately affect Nigerian women. Six out of 10 women and 4 out of 10 men suffer from mental illness (Auwal, 2019)
15.	GENDER-BASED VIOLENCE	
15.1	Sexual Violence	The lifetime prevalence of sexual violence was 30%
15.2	Physical Violence	The lifetime prevalence of physical violence was 15%. Domestic violence, particularly intimate partner violence, constitutes the highest form of violence experienced by females.
15.3	Emotional Violence	The lifetime prevalence of controlling behaviour was

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		high with a significant proportion of women reporting exposure to at least one form of controlling behaviour (63%) by their husband/male partner Source: http://www.biomedcentral.com/1471-2458/11/511
CROSS-CUTTING OPERATIONAL COMPONENTS OF HEALTH SYSTEM		
1.	LOGISTICS	
1.1	Logistics & Supply	
2.	LEADERSHIP & GOVERNANCE	
2.1	Policies, Strategies & Guidelines	• The top echelon of decision makers in the health sector and policy making in general consists of men. • 4 Bills to promote reproductive health and women's human rights were thrown out by Nigeria's over 90% male National Assembly between 2002 and 2016 (Para-Mallam, 2017). • Safe Motherhood Initiatives have helped to reduce maternal and infant mortality ratios.
2.2	Health Infrastructure	• The lack of ambulances and access roads to health facilities severely diminishes the capacity of health service users to reach HCFs, notably in labour emergencies. • There is low investment in health equipment and technologies for detecting and treating gender-specific diseases like cervical and breast cancer
3.	HMIS	
3.1	Strategic Information: M&E	
4.	HUMAN RESOURCES	
4.1	Human Resource Development	• Low female human capital development (education and health) undermines both the quantity and level of female labour force participation in the health and other sectors. • The prevalence of mental health illnesses among Nigerian women undermines female labour productivity.
5.	FINANCE	

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5.1	Healthcare Financing	• In the absence of a robust universal health coverage plan most Nigerians lack access to health insurance and spend OOP. Female economic dependency puts women at additional risk of hardship and poor health outcomes.
5.2	Health Insurance	Men are the larger proportion of federal workers and enrolees under the National Health Insurance Scheme. However, their wives and 4 children have access.
5.3	Health Budget	A 2005 Gender Analysis of The national health budget (Soetan, 2005) showed wide disparities to the detriment of female health. This trend has persisted over the years.

2.7 Policy Rationale

From the foregoing, it is clear that health is a sex-based and gendered experience. Despite the myriad of gender-related health needs and concerns elaborated above, Nigeria is yet to put in place appropriate mechanisms to address gender-based discrimination and inequalities in healthcare. Access to Healthcare facilities and affordable health services remains a major challenge for the country, and for women and girls in particular. In the context of rising poverty and insecurity, declining health sector funding and human resources and attendant poor health system performance, the challenges of gender inequalities and inequities surrounding access to and utilization of health services make this policy imperative. Consequently, a gender-responsive strategy in the form of this Gender in Health Policy and Strategic Framework for its implementation articulates the Government of Nigeria's commitment to ensure strategic gender mainstreaming in all health plans, strategies and practices in the country.

The National Health Policy, while acknowledging the importance of gender and gender mainstreaming within the health system, does not elaborate on how to practically integrate gender perspectives into planning, data collection and analysis, implementation and M&E. The FMoH, with an overarching mandate to ensure successful implementation of the National Health Policy, recognizes the need for gender-responsive strategies in implementing the NHP's gender-related

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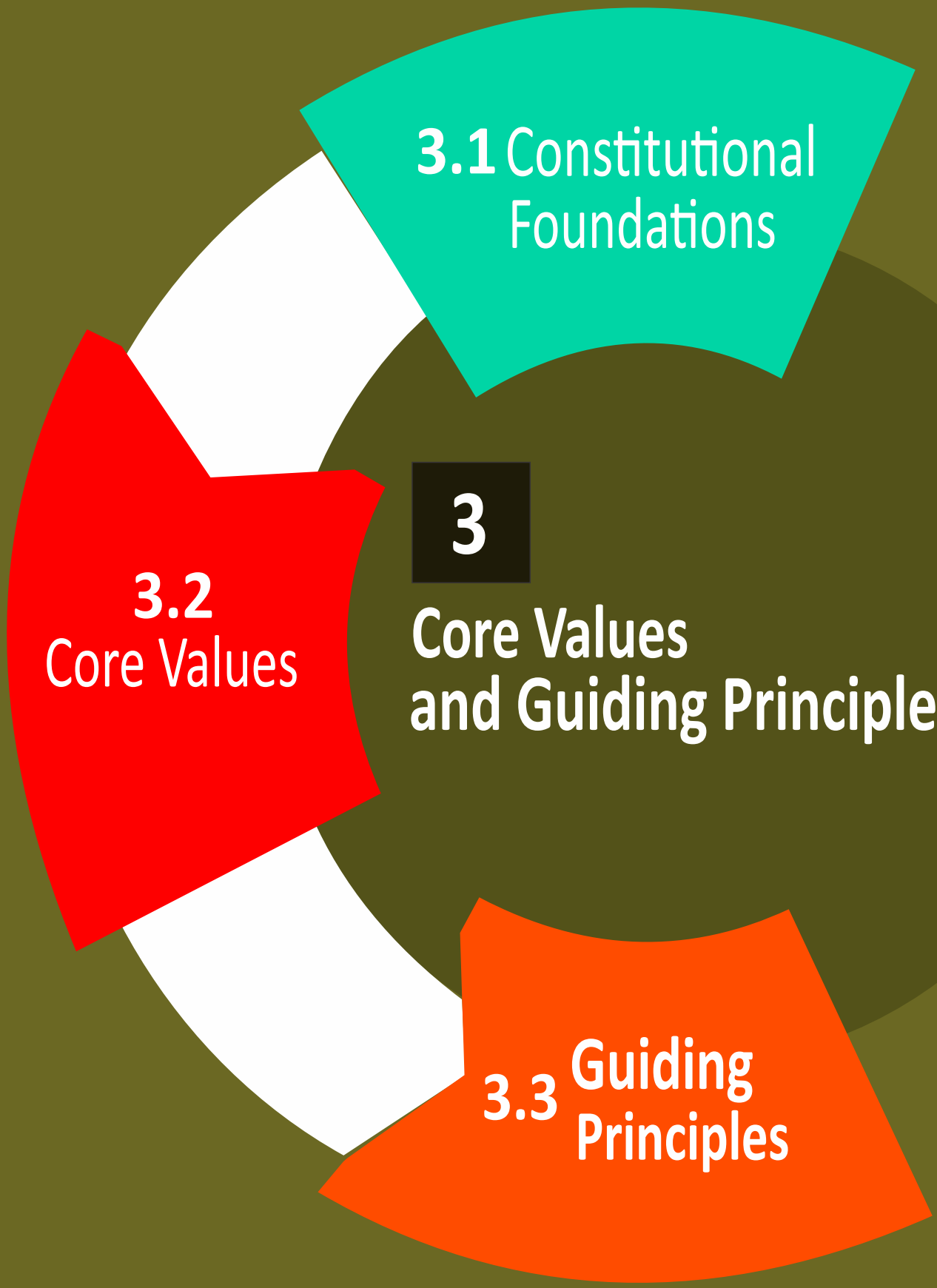
commitments. Similarly, the National Gender Policy calls for the adoption of gender-sensitive approaches to ensure access to Healthcare facilities and affordable health services, especially for women and girls. This National Gender in Health Policy shall outline evidence-based measures to create a gender-responsive health system in the country.


3.1 Constitutional Foundations
3
Core Values and Guiding Principles
3.2 Core Values
3.3 Guiding Principles

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3 Core Values and Guiding Principles

3.1 Constitutional Foundations

The core values and guiding principles of the National Gender in Health Policy derive from the general principles and fundamental rights enshrined in Nigeria's 1999 Constitution. They lay the foundation for the people of Nigeria to live in a harmonious society where government undertakes to provide for the welfare of all persons based on the values of ***freedom***, ***equality*** and ***justice***. The fundamental rights established in Chapter IV of the Constitution stipulate the right of every citizen to life, dignity of human person, personal liberty, freedom of movement, and freedom from discrimination, among others. These bear particular relevance to gender-related needs and concerns in healthcare service delivery. Hence, the National Gender in Health Policy paves the way for reform of current health sector strategies in Nigeria as a prerequisite for human rights protection, equality and justice for women and men, boys and girls.

3.2 Core Values

3.2.1 Right to Health for All

Health is a fundamental human right and gender is a principal determinant of health status and outcomes. Men and women, boys and girls in Nigeria shall have the right to the highest attainable standards of physical, mental, social and spiritual health. This entails the right to access sexual and reproductive health services, information and products that are appropriate, accessible, safe, equitable, efficient and affordable. Women and girls as well as men and boys shall be free to exercise personal liberty in choosing and accessing health services and products. Gender dimensions of healthcare provisioning must be considered within the broader context of other socioeconomic determinants of health. These determinants range from access to potable water and sanitation, food and nutrition, housing, a safe and secure f living environment, decent work and pay, education and culture.

3.2.2 Gender Equality

Gender equality does not mean that women and men have identical health needs and priorities. It implies that everyone, irrespective of their sex, sexual orientation or gender identity, shall have equal right to access health services and be treated with equal respect and dignity by male and female health care providers. To the extent that gender identity intersects with other social identity markers such as socioeconomic status, ethnicity, religion, disability, geographic location, among

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others, health needs and concerns must be considered within a broad social context and social relations analytical framework. Other social differences based on race, ethnicity or wealth status may intersect with gender inequality to further accentuate unequal relationships in terms of those who have privilege and those who lack power.

3.2.3 Gender Equity

The diverse health needs and priorities that women and men and girls and boys have at various stages of life shall be attended to equitably and fairly on the basis of the equal worth, dignity and rights of both sexes and diverse gender identities.

3.2.4 Life-course approach to health

Women and men have different life stages and the relationship between adverse or health promoting circumstances across the life course can increase risk of ill-health or chronic disease. This approach recognises that the needs and rights of individuals and social groups vary by age and circumstances. Such an approach understands the link between adverse circumstances and higher risk of chronic illness or early mortality. Gender inequality is one determinant factor of the different life course for women, men, girls and boys and other gender identities within a given society or community. Age-related health issues and concerns shall be integrated with gender considerations in all aspects of healthcare provisioning, administration and management.

3.2.5 Professionalism

Health sector workers shall be equipped with the competencies and skills required to deliver gender responsive qualitative care in an efficient manner to all users of health services irrespective of their sex, sexual identity or socioeconomic status.

3.2.6 Gender Justice

Healthcare providers (HCPs) in Nigeria shall work actively and constructively to mitigate discriminatory customs and practices that cause gender-based inequalities and inequities in access to healthcare services and products.

3.2.7 Participation

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Healthcare providers shall furnish women and men, boys and girls with sufficient information with respect to their health status, requirements and options to facilitate informed participation in their healthcare management.

3.2.8 Inclusiveness and Non-Discrimination

Healthcare services at community, facility and policy levels of the health system shall be extended to all users as a basic right regardless of biological sex, sexual orientation, gender identity or social, cultural, ethnic, racial, religious, economic, political or other background without favouritism or any form of discrimination.

3.3 Guiding Principles

3.3.1 Human Rights-Based Approach

Uphold human rights in conformity with international standards and rights-based best practices in healthcare delivery. Women and men, boys and girls in all their diversity shall have the right to access healthcare services that are responsive to their specific needs, realities, preferences and circumstances. As duty-bearers, healthcare decision-makers, providers and practitioners shall respect, protect and promote the rights and dignity of healthcare users without prejudice to sex, gender identity, sexual orientation, socioeconomic status, ethnicity, religion, migration status or geographic location. In particular, they shall accord male and female users of healthcare services the same level of importance, dignity and respect whether they are urban or rural dwellers, high or low-income earners, educated or illiterate, a youth person or of an older generation, persons living with disability or belonging to any other marginalized or vulnerable socioeconomic category.

3.3.2 Gender-Responsive Approach

Take measures to identify and address gender inequities and inequalities that impact on health status and ability to seek and access needed health care. Healthcare providers and services shall be capacitated to have the competencies in gender responsiveness to offer gender-specific service provision in targeting the peculiar health needs of women and men, boys and girls. They shall be gender-sensitive in terms of awareness of the different and often unequal gender perspectives, norms and roles that influence women, men, boys and girls' ability to

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make health choices and to act upon them to both access services and negotiate their health care needs and concerns.

Beyond mere awareness, healthcare providers shall take measures to respond effectively and efficiently to gender-specific health needs, issues and concerns. Healthcare administrators and providers shall also promote gender responsiveness and safety in the design of operational guidelines and procedures that shape the health sector workforce and environment. At the level of patient care, this involves creating a gender-responsive health sector environment where male and female patients in all their diversity are able to exercise their rights to quality services such as choice of male or female or native-language speaker-health provider, a provider-client interaction that is private, confidential, non-judgemental and client-centred, and physical environments that are safe and inclusive. This may include sex-segregated washrooms, male and family-friendly waiting areas, flexibility in hours of operation, among other aspects, at Healthcare facilities. As a long-term health promotion strategy, openness and commitment to gender-transformative action plans aimed at addressing the causes of gender-based health inequity by transforming harmful traditional practices and gender norms will be promoted in partnership with community-based actors.

3.3.3 Gender Mainstreaming

Mainstream gender-responsive approaches into the entire healthcare system. Gender mainstreaming is a policy strategy and guiding principle. A gender-responsive approach to health sector planning, programming and service delivery shall be integrated into all aspects and processes of the healthcare system, at primary, secondary and tertiary levels. This will be done through operationalizing gender responsive standards, participatory feedback mechanisms for male and female clients and HCWs and capacity building of health care providers in gender responsiveness. This is to ensure that gender-responsive approaches to healthcare are institutionalized within the organisational structure and culture of the entire healthcare system in Nigeria.

3.3.4 Gender, Health and Development Approach

Carry out health promotion activities to guarantee equal and equitable development outcomes for women and men, boys and girls. Health administrators and providers shall design and implement plans and programmes targeted at ensuring that users of health services and facilities can acquire the mental and physical health capital needed to contribute maximally to the growth and

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development of communities and nations. Mechanisms that will be put in place include increasing the participation of male and female clients in all their diversity to provide feedback and direction on health facilities and to strengthen multi-sector linkages to address gender and other social determinants of poor health.

4 Policy Goal, Objectives and Targets

4.1 Goal

4.2 Objectives

4.3 Targets

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4 Policy Goal, Objectives and Targets

4.1 Goal

The National Gender in Health Policy provides a clear framework to guide health sector integration and mainstreaming of gender in all health plans, systems and practices. The overarching purpose is to ensure that men and women, boys and girls in all their diversity are able to have equal and equitable access to quality, gender responsive healthcare free of gender based discrimination.

This goal is in keeping with the policy thrust of the 2006 National Gender Policy, which calls for the mainstreaming of a gender perspective in all government plans, policies and programmes. The National Gender in Health Policy is situated at the intersection of gender and health to facilitate the integration of gender into all aspects of health sector governance: health care planning, programming, delivery and monitoring and evaluation. A critical mechanism will be the adoption of gender-responsive budgeting and planningto mainstream gender considerations into all health governance, resource mobilization processes and specific programs that target female, male or specific vulnerable and key populations'specific health needs. Gender-responsive budgeting is an international good practice standard in gender mainstreaming to ensure adequate funds and human resources allocation. With proper capacity building in this area, health sector regulators, managers and administrators, supported by gender desk officers (GDOs), shall promote the development of gender-responsive budgets to ensure that human, physical, technological and financial resources are expended on a gender equitable basis. An accountability framework with clear roles and responsibilities and lines of reporting on gender-responsive budgeting will be part of this change process.

Gender-inclusive research, development and innovation (RDI) is another vital component of gender mainstreaming in the health sector. It requires that health training and research institutions engage in efforts that lead to effective and appropriate health interventions, which factor in the unique health needs and experiences of men, women, boys and girls in diverse socioeconomic contexts.

4.2 Objectives & Targets

4.2.1 Health & Well-being

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Objective 1: Ensure good health and promote well-being for men, women, girls and boys of all ages in line with Sustainable Development Goals and Targets (SDGs 3.0 and 5.0).

Target 1.1: Affordable and accessible healthcare for men and women, boys and girls through universal healthcare coverage for all at all levels by 2025

Target 1.2: Incorporate gender equality and rights health education (GERHE) to health education curricula at primary and secondary school level by 2022

Target 1.3: Promote gender equality and rights health education (GERHE) in informal educational settings such as ante-natal clinics, community outreaches, social media platforms etc., by 2023

4.2.2 Gender-Responsive Healthcare Services

Objective 2: Facilitate the integration and delivery of gender-responsive healthcare services at primary, secondary and tertiary levels by 2024. This shall include services that respond professionally and holistically (i.e. medical, psycho-social, counselling and referral services) to survivors of various forms of GBV visiting healthcare facilities for these services.

Target 2.1: All health sector institutions and actors adopt and adapt gender-sensitive, gender-specific and gender-transformative policies, programmes and practices by 2023.

Target 2.2: Develop and deploy national, regional and state-based Gender Health Maps and Indicators (GHMIs) for use in healthcare centres by 2022.

Target 2.3: Use GHMIs to design location-specific health services that respond to the gender-specific needs of health service users by 2024. These shall include emergency response services and toolkits such as one-stop sexual assault and rape crisis centres, domestic violence/adolescent counselling services, among others.

Target 2.4: A user-friendly and cost-effective summary of gender-responsive guidelines to healthservice provisions and policy making translated into Hausa, Igbo, Yoruba and pidgin English, and disseminated widely among health service users, also by 2024.

Target 4.2: Facility and community level scorecard for measuring level of gender-responsive healthcare practice in HCFs developed for use by 2024.

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4.2.3 Mitigate Critical Risk Factors

Objective 3: Mitigate critical risk factors that increase the burden and vulnerability of women, men, girls and boys in all their diversity to ill health and disease.

Target 3.1: Established a functional integrated support system covering health, security, law enforcement, educational, social welfare and labour institutions to handle gender-based violence of children and women of all ages by 2024. This includes special services and technologies for people with disabilities such as identified under Objective 2 Target 3.

Target 3.2: Increased institutional capability to meet gender-specific needs of people living with disabilities, HIV/AIDS, IDPs, LGBTQI, female sex workers and other high risk populations by 2024. This shall include the development of relevant technical expertise among male and female healthcare workers.

Target 3.3: Raised level of awareness and responsiveness to gender-specific health issues among male and female health users, involving culture-sensitive community awareness campaigns, gender-related health education and promotion of the participation and leadership of women and marginalized groups in community-level health decision-making.

4.2.4 Gender-Responsive Healthcare Practitioners

Objective 4: Support the training and development of gender-responsive healthcare practitioners who encourage and enable men, women, boys and girls to make appropriate practical and strategic health choices.

Target 4.1: Gender-responsive health principles and practices mainstreamed into all health and health-related sector educational and on-the-job training curricula by 2025.

4.2.5 Gender-Friendly Work Environment

Objective 5: Initiate specific measures to promote a gender-friendly environment within public and private health sector workspaces.

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Target 5.1: Achieve relative gender parity and equity in recruitment, deployment, promotion and career development in all health sector institutions at all levels of health care delivery by 2025.

Target 5.2: Institute measures to address structural violence and promote gender equity using gender-based incentives such as introduction of two weeks paternity leave, workplace creche/breast feeding rooms for lactating mothers, performance-based flexi-hours for parents with young children, female leadership promotion strategy, among others.

4.2.6 Gender-responsive Health Sector Planning

Objective 6: Facilitate gender-responsive health sector planning through the development of an integrated database of sex and age-disaggregated health-related statistics and indicators.

Target 6.1: Institutionalize gender-responsive budgeting as an integral part of health sector budgeting processes by 2023.

Target 6.2: Develop state and local government-level health population profiles, programme inventories and participatory programme reviews for use in primary, secondary and tertiary healthcare facilities by 2023.

Target 6.3: Develop a capacity-building plan on gender-responsiveness for the entire health sector workforce by 2023
Target 6.4: Promote equal gender-representation in health sector governance to achieve gender parity by 2025.

4.2.7 Monitoring, Evaluation and Learning (MEL) Culture

Objective 7: Institutionalize a monitoring, evaluation and learning (MEL) culture and practice in health systems and service delivery towards results-oriented gender-responsive health sector programming.

Target 7.1: Develop set of gender-specific and gender-sensitive indicators to measure and compare performance of healthcare providers, services, facilities by 2022.

Target 7.2: Institutionalize routine annual health sector gender compliance surveys using locally developed and adapted tools including WHO Gender Responsive

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Assessment Scale and Tool, Gender and Health Program and Planning Tool, Gender Analysis Questions (GAQs), the Gender Analysis Matrix (GAM)).

Target 7.3: Ensure the sector-wide development and use of coordinated gender mainstreamed strategic plans and Annual Operation Plans (AOPs) by second quarter of 2022

Target 7.4: Train all M&E officers in gender-specific MEL skills as a core competency and component within conventional M&E frameworks and processes.

4.3 Gender-Responsive Healthcare Delivery Guidelines

A cardinal objective of the National Gender in Health Policy is to provide internationally benchmarked guidelines for ensuring gender-responsive healthcare delivery at all healthcare facilities and by all healthcare Providers. Such standards would include those set out under JHPEIGO's General Standards for Gender-Responsive Services (2018) and WHO's Guidelines for Gender-Responsive Services for HIV.[7] It is important to note that health care regulators, administrators and providers are expected to adapt the guidelines to their specific sociocultural and organizational contexts. This should be done in ways that promote gender equality and equity as well as guarantee optimal health outcomes for men and women, girls and boys. The guidelines set out below seek to promote a flexible, equitable and professional approach to delivering health services that are of high quality and relevant to the gender-specific health needs of women, men, boys and girls throughout their lives.

- Adopt a personalized approach that emphasizes patient-centred care and takes account of life histories and gender-differentiated experiences as well as other intersecting differences based on age, disability, ethnicity and so on, of male and female patients.
- Introduce gender-sensitive diagnostic approaches in patient care by taking account of sex-based bio-medical, andpsychopharmacological differences combined with consideration of gender-based determinants to health for women, men, girls and boys.
- Facilitate full participation of male and female patients in the diagnosis and management of illness by providing services based on rights-based principles of respect, non-discrimination, confidentiality, privacy, freedom of expression and accurate, appropriate and accessible information and consultation.

[7] (http://resources.jhpiego.org/system/files/resources/Gender%20Standards%20Facilitation%20Guide.pdf. and (https://www.ncbi.nlm.nih.gov/books/NBK143046/).

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- Operate an effective, user-friendly and confidential gender-responsive response and referral system for addressing all forms of GBV tailored to all ages. This includes the use of appropriate language.
- Ensure equitable gender representation in the leadership of health facilities.
- Ensure visual and audio privacy for patients in treatment and labour rooms
- Ensure confidentiality of service and health records for male and female patients regardless of socioeconomic or health status or sexual orientation
- Make it easy for female and male health service users of all ages and walks of life to access professional counselling services at healthcare facilities

- Prioritize the use of sex-disaggregated information and data in all aspects and phases of patient care and health care system decision making.
- Provide for the supply of gender responsive, adequate and appropriate toilet, hygiene and sanitary facilities and kits at accessible locations in healthcare facilities and in IDP (i.e. sex-segregated safe and well-lit washrooms).

5 Policy Implementation

5.1 Core Stategies

5.2 Roles and Responsibilities

5.3 Monitoring, Evaluation and Learning.

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5 Policy Implementation

In the context of strong cultural counter currents and institutional resistance to gender transformation, the process of implementing gender-related health policy objectives must of necessity be innovative, flexible and creative. This section outlines three core strategies for policy implementation:

- Gender Mainstreaming
- Capacity Building
- Resource Mobilization

In addition, the section also describes the roles and responsibilities of key stakeholders and outlines a framework for policy monitoring, evaluation and learning.

5.1 Core Strategies

5.1.1 Gender Mainstreaming

A gender mainstreaming strategy shall underpin the entire gender and health promotion process. Aligned to the NGP, it will involve integrating gender equality and equity concerns into all facets of health sector policy, planning, training, and professional practice in curative and preventive healthcare provision. As a policy and planning tool, gender mainstreaming shall serve to:

- Facilitate the elimination of gender-related health inequities that lead to unjust and preventable disparities in health status between men and women, boys and girls in all their diversity across Nigeria.
- Institute gender-transformative health policy interventions, tailored to the diverse and specific cultural contexts within and between states, that help to shift gender perspectives and concerns to the centre of the health agenda.
- Institutionalize gender-responsive budgeting (GRB) in health care for more effective resource redistribution to meet gender health needs and priorities. Gender-responsive budgeting shall constitute a key component of all health sector budgeting processes
- Incorporate gender equality and rights health education (GERHE) into pre- and post-training curricula, performance evaluations and supportive supervision for health/medical personnel at all levels (details below).

5.1.2 Capacity Building

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Gender mainstreaming in health practice begins with steps to incorporate gender-sensitivity education and training into school-based and workplace training curricula, performance evaluations and supportive supervision to promote gender-responsiveness as a critical component of healthcare systems, practices and services. Negative gender stereotypes must be addressed among male and female actors. Harmful gender norms and structures bleed into institutions and government to then become normalized and frustrate policy goals, objectives and targets. The Federal Ministry of Health and its development partners, with support from the Ministry of Women's Affairs, responsible for government-wide gender mainstreaming, shall establish guidelines for planning, conducting and supervising training and a system of performance review and supervision, of all health personnel, stakeholders and team members at all levels. They shall provide appropriate technical support for curriculum development, training, and continuing education to mainstream gender into health with emphasis in the following areas:

- Determining global best practices in gender and health training
- Developing skilled resource persons using adult learning principles
- Design the training content to address gender and health relationships, gender-sensitive prevention and treatment interventions and outcomes.
- Generating training modules on health and gender integration in Nigeria and mainstreaming them into all health sector training programmes
- Conducting training-of-trainers (TOT) and step-down trainings at regional/state/local government and MDA levels.

To support application of gender sensitivity among healthcare providers, the Ministry of Health will establish gender sensitivity standards and a monitoring and supervisory checklist to track ongoing gender sensitivity of healthcare providers and measuring of male and female satisfaction with health services and links to changes to use and access of male and female clients, in all their diversity, to health services offered.

5.1.3 Resource Mobilization

Past policies have been poorly implemented and have not translated into the required change on account of poor funding which is required for implanting different aspects of project implementation. Funding is required for printing and disseminating the policy documents, training for relevant officers, providing the Monitoring and Evaluation (M/E) tools, implementing M/E activities and conducting review meetings. In addition to increased government budget allocation to a gender responsive budget, government shall seek support from development partners, multinationals, and NGOs that will support government efforts to mainstream gender into the health sector programmes. Government shall also seek creative and

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constructive ways to gain support of the private sector. Funding partners shall be agreed upon and planned as part of annual work plans and implementation plans. Priority areas in resource mobilization include the following:

- **Health Sector Financing**: Improved health sector financing and resource management tracking are essential to promote gender-responsive budgeting (GRB) and efficient resource use. Less than 5% of Nigeria's population is currently covered by health insurance schemes. Therefore, weak health accountability systems, gender blindness and non-prioritization of health must be addressed at national, state and local levels. Locally adapted gender analysis and gender responsive budget (GRB) tools shall be developed and deployed for this purpose. Private sector investments in universal health coverage plans shall be encouraged in a means-tested framework that enables low-income male and female earners, particularly the most vulnerable and marginalized by geography, education, wealth, disability, etc.,to access quality service at affordable prices. Proven models from Nigeria and other countries for helping the most marginalized, such as community based health insurance schemes, will be explored to find innovative and sustainable solutions.

- **Fiscal Spending:** While there are as yet no clear estimates of the financial costs of gender equality, identification of sources of financing is an important task that is shaped by the way that we conceptualize the costs as well as benefits of gender equality. Well-targeted efforts can create fiscal space to promote gender equality. It is in this respect that the linkages between physical and social infrastructure spending are important. A frequently overlooked attribute of investment in gender equality is that such spending can be self-financing when effects are evaluated over a medium and long-term horizon.

- **Linkages between Physical and Social Infrastructure Spending**: Public expenditures in physical infrastructure can reduce women's care burden and free up time to spend in paid work. Social expenditures that promote gender equality in education and health contribute to economy-wide improvements in productivity and income. These are not discretionary spending but more appropriately characterized as social infrastructure because, by stimulating economy-wide improvements in living standards, such spending yields a stream of income (return on investment) in the future. This type of spending is an investment rather than a form of pure consumption. In the cases of both physical and social infrastructure spending, as incomes rise due to such public-sector investments, more resources are generated at the state level to finance

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sustainability efforts. Investments to promote gender equality also generate resources to address other sustainability targets.

5.2 Roles and Responsibilities

5.2.1 Federal Ministry of Health and Line Ministries

FMoH shall be the Lead Ministry in the implementation of the Gender in Health Policy with specific responsibilities as follows:

- Lead coordination of, and be overall responsible for, the Policy's Steering Committee (PSS) in implementation and M&E of activities in partnership with State Ministries of Women's Affairs (MoWAs). The specific functions of the PSS are set out under Section 6.2.2 of this Policy.
- Develop gender-responsive health programmes and intervention projects that provide direction for national healthcare delivery systems.
- Design appropriate gender-responsive health service protocols and support their implementation, M&E.
- Provide gender responsive tertiary healthcare and health intervention programmesaimed at promoting, protecting and preventing ill health of Nigerian women, men, girls and boys.
- Ensure effective implementation, accountability, monitoring and evaluation of the policy towards gender equality related health outcomes by:
    - Investing in gender responsive budgeting and resource mobilization to cover policy implementation costs.
    - Carry out capacity building of staff with gender responsive health service protocols.
    - Strengthen the capacity of Primary Health Care Development Agencies to offer gender-responsive counselling and emergency services in cases of gender-based violence.
    - Engage in advocacy at the national assembly to ensure its adaption of the policy.

Most importantly, this policy builds on the need for multi-sector coordination and sharing of efforts with other Ministerial policy mandates to address gender issues beyond the health sector. Consequently, this policy aims to complement other ministries' efforts to address gender inequalities and calls upon other ministries to ensure that their polices are gender responsive in order to address the existing gaps in gender and health that are relevant to their mandates. These ministries include:

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- **Federal Ministry of Women's Affairs** shall:
  - Collaborate and provide technical support in the provision of gender counselling services, capacity building and other areas of gender-related expertise.
- **Federal Ministry of Youth and Sports Development** shall:
  - Incorporate the guiding principles, values, objectives and targets of this Policy within relevant youth and sports programs using gender-aware approaches towards gender-sensitive and transformative outcomes for young women and men and adolescent girls and boys.
- **Federal Ministry of Justice** shall:
  - Promote the finalization, proper documentation and legislative backup of the Gender in Health Policy's commitments to provide holistic services for GBV survivors.
- **Federal Ministry of Education** shall:
  - Ensure the incorporation of gender equality rights and health education in curricula at all levels.
- Federal Ministry of Industry, Trade and Investment
- Federal Ministry of Agriculture and Rural Development,
- Federal Ministry of the Environment
- **Federal Ministry of Labour and Employment**: shall:
  - Institutionalize gender-friendly practices and spaces in the workplace.
- Federal Ministry of Finance.
- **Federal Ministry of Budget and Planning** shall:
  - Institutionalize gender-responsive budgeting in all its budgeting making and tracking processes and progress.
- Federal Ministry of Information
- **National Orientation Agency** shall:
  - Create awareness on the Gender in Health Policy among the general populace.
  - Provide feedback from the public to the Government with respect to its social acceptability and uptake.
- **National Primary Health Care Development Agency shall**:
  - Participate in the documentation of gender-related health issues and data.
  - Provide services, in all PHCs, to address gender-related health emergencies related to GBV cases including rape, child abuse, , domestic violence and other forms of GBV according to the Standards and Guidelines for the Medical Management of Victims of Violence in Nigeria, and other policies.

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This gender and health policy aims to strengthen the national response to sexual and reproductive health as it relates to GBV as a public health issue. Government policies play a pivotal role in addressing public health issues. Government prioritization and implementation processes for health policies are critical in disease prevention and decreasing mortality in Nigeria. The main policy actors will involvethe Ministers of Health and Women Affairs and those of other critical line ministries, as well as Permanent Secretaries and Directors of Reproductive Health (RH), Family Health (FH), Maternal, New-Born and Child Health, Social and Child Welfare Services, Traditional Complementary and Alternative Medicine (TCAM) and gender desk officers (GDOs) at national and state levels. These Ministries and Government Departments shall have primary responsibility for giving it political and public visibility. The judicial system shall be sensitized to expedite action, to coordinate closely with the Ministry of Health's relevant service providers to ensure GBV survivors, including child abuse cases, have safe appropriate justice services for all cases of gender-based violence. In line with the Ministry's of Education's own commitments to gender mainstreaming, it shall craft strategies to increase school enrolment and retention of girls and as well boys.

An integrated support system shall consist of a multi-stakeholder platform consisting of relevant desk officers from the Ministries of Health, Education, Women Affairs and Justice who shall be trained and equipped with GBV response skills, tools and facilities. Reproductive health (RH) Departments shall address the issues of unmet needs for family planning (FP), prevention and management of sexually transmitted infections (STIs) and other existing gaps in adolescent and youth RH services.

5.2.2 International and Local Non-State Actors

Government collaboration with other actors, social movements and societal construction of risk is a major determinant of successful policy outcomes. International development actors like WHO, the UN agencies, non-governmental organizations (NGOs) and others shall be engaged to provide technical assistance and other forms of support to develop new norms for transforming gender-biased structural and social processes. Other corporate stakeholders shall include social movements and civil society organizations like women groups (i.e. 100 Women's Groups), gender activists, community based and faith-based organizations, disability-focused organizations and organizations represented marginalized groups such as LGBTQI, to serve as advocates, pressure groups and community educators.

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Male and female community gatekeepers including traditional, religious and community leaders play crucial roles in grassroots mobilization for change. For example, community leaders have engaged the Nigerian Union of Road Transport Workers (NURTW) to transport women in labour to hospital at any hour of the day. For gender health promotion and support activities, male and female community gatekeepers shall be trained as gender advocates to deconstruct myths around men/women, encourage male engagement for reproductive health programmes, engage in peer education and provide community support systems for health.

In more specific terms non-state actors shall play the following roles:

- **International organizations** (WHO, the UN agencies, secular NGOs and others) shall:
  - Provide financial and technical support on issues related to the policy implementation.
  - Provide resource mobilization and capacity building on the policy implementation.
  - Carry out budget tracking.

- **Secular Local NGOs** shall:

  - Advocate at the federal, state and LGA's level to push for the implementation of the policy.
  - Engage in community mobilization and sensitization on the implantation of the policy.
  - Conduct independent monitoring of the implementation of the policy.
  - Carry out resource mobilization and capacity building on the policy implementation.
  - Carry out budget tracking.

- **Grassroots Associations (CBOs, FBOs and Cultural Groups)** shall:

  - Mobilize male and female community members in all their diversity at the grassroots for the policy implementation.
  - Advocate to put pressure on the various levels of government to ensure policy implementation, accountability and results.
  - Engage male and female Peer Educators at grassroots level to promote policy implementation, particularly gender sensitization and social behaviour change and communication in gender equality and health.
  - Set up accountability platforms to support policy implementation.

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- **Community Gate Keepers** shall:

    - Engage in grassroots mobilization to obtain community buy-in to the policy.
    - Collaborate in the operation of community support system for responding to gender-related health prevention and community responses to GBV, pregnancy and childbirth including incest, rape, sexual slavery, domestic violence, displacement, high risk pregnancy and emergency deliveries and transportation, etc.

5.2.3 Research Institutions

Universities, research institutes and research-oriented NGOs are critical to collect, collate and generate sex and gender-disaggregated data to inform, monitor and evaluate gender in health programmes. These include institutes like the Nigerian Institute of Medical Research and Gender Studies departments of tertiary institutions. Similarly, health and gender programme implementers like the Women for Health Programme of the Health Partners Group. These research entities with gender expertise who conduct research to identify gender related barriers to health access and implement gender sensitive health programmes and reforms, shall be enlisted to support the government in implementing programmes and scaling up gender sensitive health interventions.

5.2.4 Beneficiaries of the Gender in Health Policy

The policy beneficiaries include men, women, youth and adolescent groups, people living with disabilities (M/F), the elderly, girls and boys, LGBTQI, and low income earners and those faced with multiple barriers to accessing to health services and facilities due to geographic isolation, migration, conflict, ethnicity, sex, age, etc. Appropriate culture and gender-sensitive tools shall be designed to increase health awareness and ensure they participate in spaces where decisions about their health and lived lives are taken.

More specific delineations of roles and responsibilities for the integration of gender into all aspects of health care delivery are spelled out in the Strategic Implementation Framework in Annex 1.

5.3 Implementation Process: Monitoring, Evaluation and Learning

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Policy implementation shall be a function of the actors who are involved in gender and health matters. Priority MEL areas include: team building, Health Information Systems, gender analysis, and Human Resources for Health.

5.3.1 Team Building

Health providers shall set up carefully selected inter-departmental and inter-agency Gender and Health Action Teams (GHATs) consisting of persons who possess requisite knowledge and skills about health matters and gender sensitivity as they affect men, women, boys and girls, in all their diversity, in Nigeria. Each team must reflect inclusiveness, gender balance and diversity and shall be multi-sectoral in composition and have a mix of senior, middle range and junior staff as reflected in Fig. 5.1 below.

5.3.2 Research and Health Information Systems

Health Information Systems (HIS) shall be strengthened and disaggregated for sex and gender. Data should be utilized as an advocacy and stakeholder engagement tool to bridge gaps in health policy, planning and practice. Research is critical and the funding gaps should be addressed to train and target the country's health policy needs, with improvement in dissemination and utilization of evidence. Nigeria's paucity of anthropologic research and formative evaluations prevent understanding of local/contextual determinants of healthcare utilization. Consequently, there is need for context-specific gender-sensitive health research across the diverse socio-cultural groups to interrogate understandings of gender and health relationships.

5.3.3 Gender Analysis

GHATs and other implementing partners engaged in gender and health research in partnership with the MoH, shall use Gender Analysis Questions (GAQs), Gender Analysis Matrices (GAMs) and other relevant data collection and analysis tools to document and describe facts, information and figures that influence health as well as the implementation of effective health policies to ameliorate gender-based health determinants. All GAQs and GAMs shall incorporate culture analysis to ensure appropriate culture sensitivity and engagement in health interventions.

5.3.4 Human Resources for Health (HRH)

Nigeria is one of the world's 57 countries with HRH shortages. Densities of nurses, midwives and doctors (1.95/1,000) cannot effectively deliver healthcare. Ensuring availability of skilled birth attendants (SBA) during childbirth is a key indicator for reducing maternal and neonatal mortality. A major gender dimension of Nigeria's

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SBA shortage is lack of female health workers, for provision of quality MNCH services, especially in Northern Nigeria where male SBAs and non-indigenous female HCW are not culturally acceptable. The PRRINN-MNCH Program Study reports that dominant social and cultural norms of preferring marriage and family life over studying to be a HCW is an obstacle to more women studying to be doctors or nurses. It also documents widespread societal non-acceptability of girls living away from fatherly protection and requirement of obtaining fathers permission to study to be a HCW. Another challenge is the issue of working in more remote rural areas where husbands may not want to follow and lack of health, social and educational services for families, discourages female HCWs to work in rural clinics. Health sector bodies shall engage and educate male and female community gatekeepers to debunk cultural myths and work through well-designed culture-sensitive programmes to set up nursing and health technology schools in communities to address the challenge of inadequate training facilities.

6 Policy Sustainability and Review

6.1 Communication Strategy

6.2 Policy Review

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6 Policy Sustainability and Review

6.1 Communication Strategy

This communication strategy draws form the work of Rick Schell and the five key elements of a communications strategy in five main areas, which bear relevance to effective communication of gender-responsive principles and practices in health administration and healthcare delivery:

- **Audience**: the primary audience shall be the health institutions and secondary shall be the beneficiaries and end-users. Communication shall be tailored towards different levels of knowledge and needs.
- **Context**: The communications for the policy shall be context specific bearing in mind relevant historical perspectives, recent happenings in the sector and reasonable expectations for the future.
- **Outcomes**: this is the specific message that the policy seeks to convey, a call to action for the prevention or specific evidence relevant to a disease or to epidemics.
- **Media**: the type of medium used to convey the message shall depend on the audience, their preferred means of communication and their number. These shall include personal, impersonal, mass enlightenment or social media channels that are both gender- and culturally-sensitive.
- **Messengers:** The message may be conveyed through different messengers depending on the level of trust and acceptance of the audience. The messenger may be one of status, or one who demonstrates high knowledge of the subject matter and who is trusted due to credibility.

The FMoH shall develop an appropriate communication strategy along the above guidelines to facilitate nationwide buy-in among relevant sectors and actors towards the realization of NGHP goal, objectives and targets.

6.2 Policy Review

This policy shall be subject to periodic review to keep in step with contemporary issues and to adjust or improve strategies and interventions to respond to unfolding national, regional and global perspectives and best practices in gender and health.

6.2.1 Purpose of Periodic Policy Review

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The purpose of a comprehensive policy review is to take an in-depth look at existing administrative policies in order to:

1. Determine if a policy is still needed as a stand-alone policy or if it should be combined with another administrative policy. A Policy may mutually reinforce another.

2. Determine whether the policy is still relevant or purpose and goal of the policy is still being met. To determine if changed circumstances (legislation, resident population group, etc.) render them less relevant, or may become irrelevant due to the changing nature of a disease.

3. Ensure that the policy is implemented as intended in relation to stated policy objectives and targets.

4. Determine if changes are required to improve the effectiveness or clarity of the policy and procedures; and

5. Ensure that appropriate education, sensitization, monitoring and periodic review of the policy is occurring.

6.2.2 The Review Process

The policy will have a central Policy Steering Committee (PSC) for overseeing implementation and accountability of the policy. The Head of this PSC will be the Ministry of Health. The policy will also have a high-level technical working and advocacy group composed of health sector experts and gender and helath experts to provide technical input for policy implementation (see Accountability Framework under Section 6.3 below). The PSC shall draw up a road map for implementation, determine who the key implementers shall be and the sequencing and prioritisation of activities. Attached to the steering committee and the technical working/advocacy group will be a cross-sectoral external advisor group comprised of cross-sectoral experts in government, CSO and other stakeholders. Meetings with the external advisory group will meet biannually.

In addition, the committee shall ascertain the nature and extent of success on the basis of clearly specified performance indicators. To accomplish this, the committee shall highlight best practices and establish progress markers that show if policy implementation is on track. The timing of the review process shall be determined by the nature of the health issue being addressed. For example, a seasonal epidemic shall be fixed according to the relevant season.

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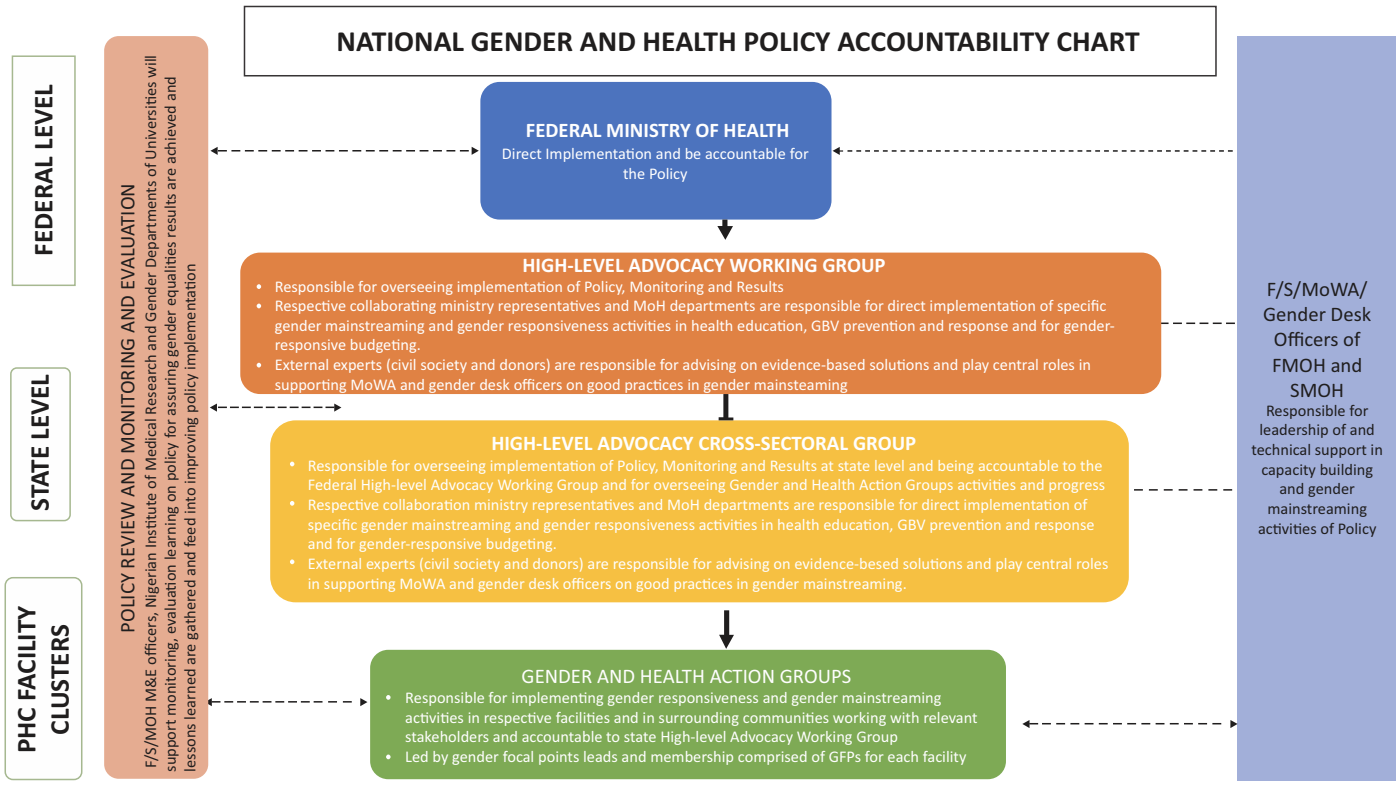
CSOs and experts in the field of health shall constitute Gender and Health Action Groups (GHAGs) to conduct independent monitoring and evaluation. The monitoring process shall assess the extent of policy compliance and gather responses on how accessible/practical the implementation process is. Both implementers and users of health services and facilities are expected to respond to the recommendations from the monitoring exercise.

6.3 Accountability Framework



ANNEX 1:

Strategic Implementation Framework

OBJECTIVES	ACTIVITIES	SUB ACTIVITY	PERFORMANCE MARKER	ROLES AND RESPONSILITIES SECTORS -Coordination -Technical - financial support	TIMELINE
OBJECTIVE 1: Ensure good health and promote well-being for women, men, girls and boys of all ages in line with sustainable development goals and targets (3 and 5).	Integration of gender sensitive messaging and gender equality (GE) in health in community-demand creation awareness raising, including GE in SRMNH, GBV, women's rights, male engagement, etc.) and right of every woman, man, girl and boy to health, regardless of age, sex, disability, wealth, etc., especially in high-risk pregnancy and childbirth	Family/household level gender-responsive health information with women and men as entry point(s), using gender responsive health information (the Women's Rights to health information (WORTHI) template and a male engagement in SRMNH, GBV, and health matters template)	Proportion of gender responsive messages transmitted Proportion of women/men who mention two key high-risk health factors in pregnancy and childbirth Proportion of women/men who mention two key GE factors to SRMNH and GBV, including child abuse	FMOH/SMOH /Nat. & SPHCDA/FINANCE / Advocacy & social mob. Unit NPHCDA, MWAN, WORTHI	2nd Quarter 2022
	Advocacy for the operationalization of Human Resource for Health (HRH) policy in the 36 states including FCT	Advocacy visits to relevant government, and male and female religious and traditional and community opinion leaders and organisations	No. of states with HRH policy and action plan	FMOH/SMOH /Nat. & SPHCDA/FINANCE GASHE division FMOH	2nd Quarter 2022
	Awareness creation for women and men on accessing health care at PHC as their first level of contact and role of women's decision making, and male	Multimedia interventions like phone in radio programmes Interpersonal communication and SBCC by male and female community health volunteers and community partners	Proportion of women/men who mention two key high-risk health factors in pregnancy and GEissues that affect the health of the household	FMOH/SMOH /Nat. & SPHCDA/FINANCE GASHE division FMOH	3rd Quarter 2022

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	engagement when seeking healthcare				
	Capacity building of healthcare providers to be gender responsive	Development of gender-responsive and transformative manuals and protocols on health; and on-the-job training and supportive supervision to track quality and effectiveness of gender responsiveness	No. of healthcare workers trained on gender responsiveness Proportion of male and female clients who report satisfaction with HCP services as gender responsive	FMOH/SMOH /Nat. & SPHCDA/FINANCE GASHE division FMOH	3rd Quarter 2022
	Capacity building and supportive supervision of healthcare providers to offer gender responsive communication on health	Training and development of annual workplan	No. of health care workers trained on gender responsive communication strategy Proportion of male and female clients who report satisfaction with HCP services as gender responsive	FMOH/SMOH /Nat. & SPHCDA/FINANCE /MWA&SD	4th Quarter 2022

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	Integrate campaign on gender related issues and non communicable disease screening in the routine PHC outreach services	Integrate gender sensitization on health and screening exercise in quarterly work plan	proportion of women and men reached with gender awareness raising and screened during campaign and outreach services	FMOH/SMOH/Nat. &SPHCDA/Information	1st Quarter 2023
	Provide gender responsive mobile clinic services including on gender related health issues (esp. GBV, family planning, male engagement, HTP awareness) especially in hard to reach populations.	Incorporate gender responsiveness in mobile clinic service in rural and hard to reach populations	No. of clients (M/F) reached through mobile clinic services No. of clients (M/F) report awareness of gender related health issues	FMOH/SMOH/Nat.& SPHCDA/Finance/ Transport Organizations/NEMA, law enforcement agencies and NOA	1st Quarter 2023
	Establish high level advocacy working group on gender and health at national and state levels	Request for nominations of designate and alternate working group members from relevant agencies and other stakeholders per state and nationally	No. of states with established gender and health advocacy working group	FMOH/SMOH/Nat. &SPHCDA/MWA&SD, NOA /FMoE/	1st Quarter 2022
	Conduct continuous advocacy at all levels to policy makers and stakeholders by Policy gender and health teams at all levels	Factor in advocacy and exchange visits in health sector budgeting, develop communication pieces and raise gender in health priorities by Policy gender and health teams at all levels	No. of advocacy conducted	FMOH/SMOH/Nat. &SPHCDA/Social welfare Department/ MOE/	2nd Quarter 2022

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	Integrate gender sensitive services at all levels of healthcare	Draft a gender integration protocol, train all staff on protocol and integrate into routine supervision and HCP service review	Number of health facilities providing gender sensitive services	FMOH/SMOH/Nat. & SPHCDA/FINANCE/Information/MWA&SD/Judiciary FMOH/SMOH/SPHCDA/HMB	1st Quarter 2023
	Establish/Implement gender aware health insurance schemes at all levels to cover gender related issues	Institute gender aware health insurance schemes	No. of State with functional gender-aware health insurance schemes	FMOH/NHIS/Information/MWA&SD/Judiciary/Legislature	1st Quarter 2023
	Ensure release and utilization of basic healthcare provision fund to the most vulnerable and marginalized women, men, girls and boys (BHCPF)	Produce copies and disseminate BHCPF	No. of states accessing BHCPF % of health insurance funds going to the most vulnerable women, men, girls and boys from BHCPF	FMOH/SMOH/Nat. & SPHCDA/FINANCE/Information/MWA&SD/Judiciary/Legislature/ NHIS	2nd Quarter 2022
	Gender responsiveness awareness creation on the benefits and accessability of package of health insurance schemes, with priority to the most vulnerable women, men, girls and boys	Produce and distribute relevant gender responsive IEC materials using gender responsive SBCC channels	Increase in uptake of health insurance services by the most vulnerable women, men, and girls and boys	FMOH/SMOH/NOA/Nat. SPHCDA/MOE/	2nd Quarter 2022
	Establishment of health focused women's gender	Establish gender transformative savings clubs as sub group of	No. of states with functional women's health focused gender transformative	FMOH/SMOH/NOA/Nat. &SPHCDA/MOE/MWA&S	1st Quarter 2023

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	transformative saving and loans clubs	already existing groupings	savings and loans clubs	D	
OBJECTIVE 2: Gender Responsive Health Care Services	Develop advocacy tools on gender responsive health care	Development of advocacy tools on gender responsive health care	Number of advocacy tools on gender responsive health care developed	FMOH/SMOH/Nat. & SPHCDA/FINANCE GASHE division FMOH	Advocacy visit: 2nd Quarter, 2022
	Advocacy visits on Gender in Health Policy, accountability and Results to policy makers, media, line ministries and other stakeholder	Advocacy visits on Gender In Health Policy, accountability and results carried out	Number of advocacy visits carried out on Gender in Health Policy, accountability and results	FMOH/SMOH/Nat. & SPHCDA	Advocacy visit: 2nd Quarter, 2022
	Sensitization meetings with identified stakeholders	Identify key stakeholders to be sensitized Development of gender responsive health care services IEC materials Carry out sensitization meetings	No of sensitization meetings carried out among formal and informal health workers at State and LGA levels on gender responsive health care services	FMoH/SMoH/FMWA&SD FMoE (Schools of Nursing/ Midwifery and other health institutions), SMoE, Civil Service Commission	Sensitization should be continuous in line with the existing integrated supportive supervision
	Training and retraining of healthcare workers and supervisors on provision of gender sensitive, gender-specific health care services	Request for nominations from relevant agencies Training of nominated participants from relevant agencies	Number and cadre of health workers (M/F) and supervisors (M/F) trained on the administration of gender-responsive, safe, respectful and high quality centered care Proportion of male and female health workers	FMOH/SMOH/NPHCDA/SPHCDA/HMB/Primary, Secondary and Tertiary health facilities/DP/NGOs/OPDs	Annual DQA

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			providing care and referrals to VVF survivors Proportion of male and female health workers providing care to FGM survivors		
	Develop gender-transformative policies on health, (i.e. Patient's Bill of Rights	Development of gender-transformative policies in health (i.e. Patient's Bill of Rights	Number of Health policies and plans that are gender responsive Number of states that have adopted the patients' bill of right	FMOH/SMOH/Nat. & SPHCDA/FINANCE/Information/MWA &SD	Annual DQA
	Integrated supportive supervision on provision of gender sensitive, gender-specific health care services	Development of ISS professional development scorecard IEC materials on provision of gender sensitive, gender-specific health care services	No of gender specific health services strengthened through ISS visits	FMOH/SMOH/NPHCDA /SPHCDA /HMB/Primary, Secondary and Tertiary health facilities/DP /NGOs/OPDs	Supervision should be continuous
	M & E				Ongoing
	Develop and validate Gender Health Maps and Indicators (GHMIs	Development of Gender Health Maps and Indicators (GHMIs) Validate GHMIs	No of Gender Health Maps and Indicators (GHMIs) developed	FMWA/SMWA/FMOH /SMOH/ NGOs/OPDs	2nd Quarter 2022
	Develop gender-sensitive M&E training manuals/tools	Development of gender sensitive M&E training manuals	No of training manuals developed and distributed to HCWs and supervisors	FMoH/SMoH Min of Budget and National Planning, Ministry of Finance,	2nd Quarter 2022

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	NTOT, STOT and LTOT on use of Gender Health Maps and Indicators (GHMIs)	Training of health workers on how to use the maps and indicators	Number of trained health workers on the use of Gender Health Maps and Indicators (GHMIs)	FMWA/SMWA/FMOH /SMOH/ NGOs/OPDs	2nd Quarter 2022
	Disseminate gender health maps and indicators at national, state and local government levels	Develop dissemination plan. Disseminate Gender Health Maps and indicators at national, state and local government levels	Number Developed and disseminated	FMoH/SMoH (Schools of Nursing/ Midwifery and other health institutions), FMoE	2nd Quarter 2022
	Use the gender health maps to design and institute gender specific services for varying health issues in relevant health facilities and geographic areas	Use the gender health maps	Number of health maps utilized Number of gender-specific services designed and instituted	FMOH/SMOH/National & State PHCB Partners	Biannual gender map updates
	Monitor and report on the number and gender specific needs provided by mapped health facilities	Health facility Monitoring and evaluation	Number of monitoring report reporting on GE specific needs and indicators	FMOH/SMOH/NPHCDA /SPHCDA /HMB/Primary, Secondary and Tertiary health facilities/DP /NGOs/OPDs	Quarterly
	Stakeholders' review meeting on the workability of the mapped mechanism	Convene review meetings using appropriate tools	Number of review meetings held	FMoH/GD/SMoH/GD National and State/ /FBOs/ CBOs/NGOs/DP/OPDs	Biannually

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OBJECTIVE 3 Mitigate critical risk factors that increase the burden and vulnerability of women, men, girls and boys to ill health and disease, particularly prevention and control of GBV and maternal newborn morbidity and mortality	Advocate to relevant stakeholders on GBV prevention and response to secure their buy-in and ownership	Conduct advocacy and awareness raising visits to relevant ministries, decision makers and civil society partners	Number of advocacy visits made. Number of stakeholders visited.	FMOH/GD/SMOH/GD National and State/PHCDA FMWA\ SMWA Social Sector Departments /FBOs/CBOs/ NGOs/DP/OPDs	2nd Quarter 2022
	Identify and strengthen existing inter-sectorial committees on GBV at National, State, LGA and facility levels.	Conduct an intersectional committee audit on GBV prevention and response.	Number of committees meeting regularly. Number of functional committees at all levels. Number of functional committees with participation and leadership of GBV survivor/women's rights organizations	FMOH/SMOH/National & State PHCB Partners Law enforcement Agencies (Military, Police, Civil Defense, Prisons, NDLEA, NIS, Customs)/MWA- Federal and States.	3rd Quarter 2022
	Review the unified directory for referrals for GBV survivors to reflect multi sectorial approach at all levels of care.	Convene consultative meeting for directory review	Published reviewed referral directory reflecting multi sectorial approach.	MWA-Federal, Partners, CSOs, and States.	4th Quarter, 2022

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	Train key stakeholders including HCWs, health care volunteers, Security agents, social workers and decision makers on standards and guidelines for the medical management for victims of violence including women and girls with disabilities	Using the relevant referral guidelines and protocols conduct training	Number of stakeholders trained disaggregated by sex and type of organization. Number of HCWs and supervisors that demonstrate competence responding to gender related health needs and concerns, particularly GBV including child abuse	FMOH/SMOH/NPHCDA/SPHCDA/HMB/Primary, Secondary and Tertiary health facilities/DP/NGOs/OPDs	2022-2025
	Conduct needs/baseline gender service assessment and accessibility audit to identify gaps in service delivery.	Source and commission reputable research team to conduct baseline gender service assessment	Number of facilities assessed.	FMOH/PRS/SMOH/ Research consultants Partners	3rd Quarter, 2022
	Establish/Strengthen existing GBV Referral Center/ sexual assault referral centre (SARC) that are disability inclusive in all the states and FCT	Provision of well-equipped and staffed shelters in every state budget	Number of GBV referral centers established. Number of rape kits procured and distributed across the health facilities	FMOH/FMWA/FMoJ Partners	2nd Quarter 2022

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	Build capacity of relevant government and non-government institutions working with people living with disability and HIV/AIDs on gender and disability inclusive services. Identify and engage GBV champions especially male champions	Capacity building training modules and facilitators identified Establish criteria for nomination of male champions including rural dwellers, social media enthusiasts and celebrities	Number of relevant government and non-governmental institutions whose capacity has been built. Number of male champions engaged	FMWA /SMWA /FMoH /SMOH Partners	2022-2025
	Incorporate issues of people living with disability and HIV/AIDs into national gender mainstreaming manual	Identify resource persons from community and national and state level civil society organizations to inform and review draft manual	Issues of people living with disabilities and HIV/AIDs incorporated into the National gender mainstreaming manual.	FMWA /SMWA /FMOH /SMOH Partners NACA	4th Quarter 2022
	Creating awareness and sensitization on gender specific issues through use of media: -Jingles -Radio discussion -Talk show -Sensitization of gate keepers (M/F) -Community dialogue with: -Male and Female Youth/men & women's groups -Faith Based	Identify media and communications specialists to develop gender transformative IEC materials for different impact groups (male and female youth, women's groups, men's groups, religious and traditional leaders (M/F), etc)	Number of jingles aired. Number of languages captured with jingles. Number of talk-shows and radio discussion programs. Number of gatekeepers sensitized. Number of community dialogues held. Number of youth/men/	FMOH /SMOH Partners Print and electronic media NOA	2022-2025

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	Organizations. Produce and distribute gender transformative IEC materials with gender transformative messaging on GE, male engagement, women's empowerment, gender in health, HTPs, GBV)		women and faith based organizations reached. Number of gender-transformative IEC materials produced.		
	Develop media strategy to raise awareness and mobilize Health users on gender specific issues	Desk review of strategies already in existence and scoring high reviews	Media strategy developed	FMOH /SMOH Partners Print and electronic media	2022-2023
	Involve the Media practitioners in all gender health activities	Inaugurate media practitioners in health committee	Number of gender health activities receiving media coverage	FMOH /SMOH Partners Print and electronic media	2022-2025
	Develop/Adapt/Adopt and produce IEC material on GBV	Conduct a messaging competition to determine age , culture and language appropriate messaging	Number of media organizations involved.	FMOH/SMOH/FMWA /SMWA Partners /OPDs	4th Quarter 2023

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	MEL: Conduct annual evaluation of gender mainstreaming activities	Contract independent evaluation team	Work-plans and budget that have been gender mainstreamed. Number of activities that include gender mainstream monitored.	FMWA/SMWA/FMOH /SMOH/ NGOs/OPDs	2022-2025
	Integrate gender into Integrated Supportive Supervision (ISS) tools	Convene consultative meeting for gender integration	Number of States with gender integrated ISS tools.	FMWA/SMWA/FMOH /SMOH Partners	1st Quarter, 2023
OBJECTIVE 4 Train and develop gender responsive healthcare practitioners	Identify all private and public stakeholders (professional bodies, health institutions, cadres of HCWs (M/F),) for building capacity in gender responsiveness	Conduct mapping exercise	Number of stakeholders identified	FMoH, SMoH and Partners such as CHAI, WHO, SFH, UNFPA, DRAC, USAID, DFID, CIDA	Quarterly
	Conduct sensitization meeting with key stakeholders to create awareness of policy	Produce sensitization materials	Number of sensitization meetings conducted Number of Stakeholder Sensitized	FMoH and Partners/NGOs	N/A
	Develop/ Adapt cadre specific guidelines and training manuals on gender responsive health care	Collate existing manuals with good practices and lessons	Number of Cadre-specific guidelines and training manuals adapted on gender responsive health care	- FMoH, Partners, Professional bodies (Medical doctors, public health nurses, nurses/midwives, CHEWs/ JCHEWs,	Once

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				Community Health Officers, TBAs, HAs) M&DCN, NM	
	Develop and incorporate gender responsiveness in health care services curriculum into professional institutions	Convene curriculum development and drafting committee	number of pre-service and Certified Medical Practice Experts (CMPE) curriculum containing gender-responsive education	FMoH, FMoE Partners, Professional Bodies such as NUC, NBTE	Once
	Conduct TOT and step down trainings	Identify master trainers	Number of TOT and step down trainings conducted	- FMoH and partners	Quarterly
	Sensitizatio n/training of lecturers on gender responsive and holistic care	Development of training manuals And facilitators guide Sensitization and training Health promotion	Number of health institutions with at least one lecturer trained on gender responsive health care delivery per state	- FMoH Partners, TOT	Annually
	Develop gender responsive health service standards and management protocol for pressing gender in health related issues (VVF and FGM)	Development of management protocols for specific conditions e.g VVF, FGM survivors	Proportion of male and female health workers providing care to VVF survivors Proportion of male and female health workers providing care to FGM survivors	- FMoH, SMoH and Partners	Annually

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	Build healthcare practitioner's capacity to manage gender, sexuality and human rights	Development of training manuals On sexuality and human rights	Proportion of healthcare practitioners trained in managing sexuality and human rights	- FMoH, Partners,	To be determined
	Develop two way referral process to help individuals (M/F)who experience violence to access both health and social services	Convene referral drafting committee	Number of referral forms developed Number of sectors included in referral form	- FMoH/SMoH FMoE (Schools of Nursing/ Midwifery and other health institutions),	Quarterly
	Engagement of TBAs, Health Assistants (Has), and Community volunteers as front line referral agents For VVF and FGM cases	Training sessions with TBAs	TBAs and community volunteers trained on gender related issues and able to successfully refer to facilities	- SMoH, State Primary Healthcare Board, PHC Coordinator	Biannually
OBJECTIVE 5 Initiate specific measures to promote a gender-friendly environment within public & private health sector works places	Gender responsive recruitment policies and selecting, hiring and promotion of health care workers, supervisors and senior decision makers carried out	Advertise posts and Conduct recruitment exercise	Number of health sector workers, supervisors and senior managers recruited disaggregated by sex	FMoH, State and Local Government Civil Service Commissions , SMoH, MDAs, Federal Character Commission, Private	4th Quarter, 2022

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	Deployment	Number of vacancies declared considering male/female having equal opportunities	Number of staff deployed based on skills competencies and need and gender responsive deployment criteria	FMoH, State and Local Government SMoH, MDAs, Private	1st Quarter, 2023
	Promotion	Performance management indicators, Pass the requisite examination for available vacancies	Number of men & women promoted on merit	FMoH, State and Local Government Civil Service Commissions, SMoH, MDAs, Private	2nd Quarter, 2023
	Career Development (training/re-training/ pre-service, in-service, post training, follow up & supportive supervision on-the-job	Pre-employment career progression and in-service training,disaggregated by sex and level	Evidence of career progression or updated scheme of service disaggregated by sex and level	- FMoH, State, Local Government Civil Service Commissions, SMoH, MDAs, Private	1st Quarter, 2023
	Monitor & evaluate gender- friendly environment within the public and private health work places.	Develop monitoring framework, employment data analysis/ interpretation, Data quality assessment	Number of men/women employed	- FMoH, SMoH, Local Government, Private	Annually

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	Improve Staff welfare within public and private health work places based on gender responsive and equity principles.	Establish a gender-inclusive inter-sectional welfare subcommittee	Number of staff satisfactory questionnaires/surveys adapted and administered with reports dissseminated	- FMoH, SMoH, LGA Agencies, Private	4th Quarter, 2022
OBJECTIVE 6 Facilitate gender-responsive health sector planning	Stakeholder mapping for identification of partners (professional bodies, NGOs, health institutions, WROs and relevant MDAs)	Conduct mapping Exercise	Number of stakeholders identified in each sector including numbers representing women's rights and diversity issues in health	FMoH/SMoH Primary Health Care Development Agency	1st Quarter 2022-2023
	Advocate for gender responsive budgeting	Carry out advocacy visits and participate in public hearings with house and senate committee on health	Number of advocacy visits carried out specifically for gender budgeting	FMoH/SMoH, FMoF/SMoF FMoBNP FMoA/ FMoE, SMoA/SMoE, FMoWR/ SMoWR, FMWA&SD CSOs	1st Quarter 2022-2023
	Training and retraining of Budget planning officers in the different departments of health sectors and line ministries on gender	Training of health workers finance experts and supervisors disaggregated by sex andlevel	Number of personnel trained disaggregated by sex and level	FMoH/SMoH Min of Budget and National Planning, Ministry of Finance,	Bi-annually

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	responsive budgeting				
	Gender units should leverage on existing QISS to monitor all units to ensure gender mainstreaming in their planning	Convene consultative meeting for gender units	Number of unit/departments incorporating gender issues in their budget	FMoH/SMoH	2022-2023
	Advocacy/sensitization to all policy makers and stakeholders on gender responsive budgeting	Draw up advocacy action plan	Number of advocacy visits carried out	FMoH/SMoH FMoE (Schools of Nursing/ Midwifery and other health institutions), SMoE, Civil Service Commission	3rd Quarter 2022-2025
	1. The FMOH and FMOE should work together at the point of admission into health institutions to ensure gender-responsive admission process. 2. FMOH in collaboration with the Civil service commission to ensure gender	Establish admission and promotion criteria and protocols	1. Number of males and females admitted 2.Number of males and female graduates 3.Number of male and female recruited 4. Number of males and females promoted	FMoH/SMoH FMoE (Schools of Nursing/ Midwifery and other health institutions),	3rd Quarter 2022-2025

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	balanced recruitment and promotion procedures. 3. Sensitization for girl/boy child education and career development. 4.Career guidance on gender equity in enrolment for pre-service education institutions				
OBJECTIVE 7 Institutionalize a Monitoring, Evaluation and Learning culture (MEL**)**	- Engage Consultant to develop a comprehensive M&E Framework - Develop a comprehensive M&E Framework for National Gender in Health Policy	- Constitute subcommittee from existing inter-sectorial committees - Identify multi sectorial stakeholders that will develop the indicators -Organize stakeholders meetings to develop the indicators -Organize stakeholders meeting to disseminate developed indicators	-Consultant engaged - M&E Framework developed -Number of stakeholders identified -Number of meetings held -Number of stakeholders present at meeting -Evidence of developed indicators	- FMoH **-**	3rd Quarter 2022

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	-Adopt a training manual and checklist for M&E officers -Organize capacity building programs for M&E officers at all levels qualitative integrated supportive supervision for M&E officers	Validation of training manuals	-Evidence of training manuals and checklist developed -Number of training held -Number of officers trained disaggregated by sex - Number of supervisory visits made	FMoH/SMoH	4th Quarter 2022 Followed by refresher training once a year
	-Identify stakeholders that will develop coordinated strategic plans and AOPs - Organize meetings for the stakeholders to develop the plans -Organize extended stakeholders meeting to disseminate the developed plans. -Advocate for domestication of developed plans at all levels to ensure compliance by HCPs. -Organize and undertake routine monitoring to facilities and HCPs to ensure use of developed strategic plans	Constitute subcommittee from existing inter-sectorial committees	-Number of stakeholders identified -Number of meetings held -Number of stakeholders present at meeting -Number of advocacy visits made -Number of states that have domesticated the developed plans -Number of monitoring visits carried out	-FMoH/SMoH Primary Health Care Development Agency	Last quarter of 2023

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	-Carry out review of locally developed GAQs and GAM to ensure that it conforms to acceptable standard -Carry out quarterly surveys across HCFs and HCPs -Carry out routine supervision to ensure compliance of HCPs at all levels	Establish review scoring criteria	Number of review meetings held Evidence of data collected Number of supervisory visits carried out	- FMOH/SMOH/National & State PHCB Partners	1st Quarter 2023

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LIST OF CONTRIBUTORS

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29. Osun – Adelowokan T. A
30. Oyo – Bilikisu Olawoyin
31. Plateau - Asabe Nwansat
32. Rivers – Lynda Nwankwoala
33. Sokoto – Sadiya Mohammed
34. Taraba – Titi Saleh
35. Zamfara – Hussaina Abdusalam
36. FCT – Dr. Christiana Samuel Kwabe

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4. Mr. Suleiman Nuhu
5. Mr. Abraham Sunday

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8. Nwankwo Steven
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