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USAID Integrated Health Program

Desk Review on Gender and Social Inclusion Issues Affecting Health in Ebonyi State, Nigeria

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ACRONYMS AND ABBREVIATIONS

AOP	Annual Operational Plan
ANC	Antenatal care
ARI	Acute respiratory infection
ART	Antiretroviral therapy
BA-N	Breakthrough ACTION-Nigeria
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
CBO	Community-based organization
CIRDDOC	Civil Resource Development and Documentation Centre
CSJ	Centre for Social Justice
CSO	Civil society organization
DEC	Development Experience Clearinghouse
ESACA	Ebonyi State Agency for the Control of AIDS
ESHIA	Ebonyi State Health Insurance Agency
ESHMB	Ebonyi State Hospital Management Board
ESPHCDA	Ebonyi State Primary Health Care Development Agency
ESMOH	Ebonyi State Ministry of Health
ESMOWSD	Ebonyi State Ministry of Women Affairs and Social Development
FBO	Faith-based organization
FC+	Fistula Care Plus
FGM/C	Female genital mutilation/cutting
FMC	Facility Management Committee
FMOH	Federal Ministry of Health
GBV	Gender-based violence
GHSC-PSM	Global Health Supply Chain-Procurement Supply Management
GII	Gender Inequality Index
GRB	Gender-responsive budgeting
GESI	Gender and social inclusion
HC3	Health Communication Capacity Collaborative
HCT	HIV Counseling and Testing
HDI	Human Development Index
HFC	Health Facility Committee
HP+	Health Policy Plus
HPN	Health, Population, and Nutrition
HRH	Human resources for health
HSS	Health systems strengthening
HWFC	Health Workers for Change
IGWG	Interagency Gender Working Group
IHP	Integrated Health Program
IUD	Intrauterine device
IYCF	Infant and young child feeding
LGA	Local Government Authority
JICA	Japan International Cooperation Agency
LGHA	Local Government Health Authority

MCSP	Maternal and Child Survival Program
MDA	Ministries, departments, and agencies
MICS	Multiple Indicator Cluster Survey
MMR	Maternal mortality ratio
MNCH	Maternal, neonatal, and child health
MOU	Memorandum of Understanding
MTCT	Mother-to-child transmission (of HIV)
NBS	National Bureau of Statistics
NDHS	Nigeria Demographic and Health Survey
NGO	Nongovernmental organization
NHMIS	National Health Management Information System
NURHI	Nigeria Urban Reproductive Health Initiative
OIC	Officer-in-charge
PAC	Post-abortion care
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission (of HIV)
PWD	Persons with disabilities
RDT	Rapid diagnostic testing
RMNCAH+N	Reproductive, maternal, neonatal, child, and adolescent health, plus nutrition
SGBV	Sexual and gender-based violence
SHDP II	Strategic Health Development Plan II
SHMIS	State Health Management Information System
STEM	Science, technology, engineering, and mathematics
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
TA	Technical assistance
TB	Tuberculosis
TBA	Traditional birth attendant
TFR	Total Fertility Rate
TO	Task Order
UHC	Universal health coverage
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
USD	United States dollars
VAPP	Violence Against Persons (Prohibition) Act
VLS	Viral load suppression
WDC	Ward Development Committee
WHO	World Health Organization

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EXECUTIVE SUMMARY

Purpose. The United States Agency for International Development (USAID) Integrated Health Program (IHP) Task Order (TO) 6, led by Palladium International, LLC, is positioned to contribute to improving health systems in Ebonyi State, Nigeria. IHP works in Ebonyi to reduce child and maternal morbidity and mortality and to increase the capacity of health systems to sustainably support improved access to and quality of primary health care (PHC) services. Globally, in Nigeria, and in Ebonyi, gender is intricately linked to health access and reproductive, maternal, neonatal, child, and adolescent health, plus nutrition (RMNCAH+N) outcomes. For example, imbalances in gender and power mean that many women face obstacles exercising autonomy about choice of sexual partner, contraception, number and spacing of children, and utilization of health services, each and all of which increases their risk for pregnancy complications, maternal deaths, infectious diseases, and exposure to violence. IHP conducted this desk review to identify gender and social inclusion issues affecting service quality, health access, and health systems strengthening (HSS) outcomes, and to better understand the health status of women, men, girls, and boys in Ebonyi and the social, economic, and political factors that influence health outcomes, including gender inequalities. This report contains the findings of the rapid desk review, along with recommendations for mainstreaming gender and social inclusion (GESI) in health policies and strategies and integrating GESI throughout service delivery to strengthen health systems, improve access to primary health care, and improve quality of primary health care in Ebonyi. The findings will inform the development and implementation of GESI strategies under IHP and for Ebonyi State in collaboration with State leadership and stakeholders, including how to measure and monitor progress.

Methodology. To assess the gender and social inclusion facilitators and obstacles to access to and quality of health services, this desk review was guided by a series of initial research questions:

> (1) How will the different roles and expectations of men, women, and youth facilitate or hinder IHP objectives to strengthen the health system and improve quality of and access to PHC health services in Ebonyi?
> (2) What are the underlying causes of gender and social inclusion challenges? How will underlying causes of these challenges, including societal and cultural factors, facilitate or hinder IHP objectives?
> (3) How does male engagement in health seeking and service utilization influence women's and children's access to health services and health outcomes?
> (4) How might the anticipated results of IHP interventions affect men, women, and youth differently?
> (5) What are potential evidence-based strategies and approaches to respond to the identified gender and social inclusion related constraints and opportunities? Where have gender and social inclusion related interventions been most effective in strengthening health systems for sustained access to and quality of PHC services?

Recognizing past gender analyses completed under USAID projects in Nigeria, this review first synthesized previous gender- and social inclusion-related analyses in Ebonyi to expand on those targeted studies. In doing so, this review aimed to understand how gender-based, age-based, or social marginalization constructs hinder or facilitate access to and quality of health services and health outcomes and where opportunities lie to make measurable improvements. Using these prior analyses and the research questions, the team designed a search strategy and document inclusion criteria to identify gaps in knowledge and conducted a desk review to address these gaps, compiling available sex-disaggregated

(and when possible age-disaggregated) qualitative and quantitative data and examining a wide range of gender and social inclusion analyses and assessments, peer-reviewed publications, policies, guidelines, public health budgets, grey literature, and other relevant materials. The desk review included 148 documents, and, using the inclusion criteria and search terms as described in detail in the full report, the following documents were selected for inclusion in the desk review: 55 peer-reviewed journal articles; 50 pieces of grey literature (e.g., working papers, program documents, gender assessments); 22 local, national, or international policies, guidelines, plans, laws, strategies, or tools (five of which were selected for inclusion in the policy analysis); 16 sources of quantitative data; and five sources of background information. The team also collected relevant and available State-level policies, laws, and guidelines to complete a gender and social inclusion policy analysis using a policy checklist developed for IHP TOs 02-05 (the checklist can be found in Annex 1). The desk review and policy analysis were guided by USAID's Gender Equality and Female Empowerment Policy (2012) and USAID Automated Directives System (ADS) Chapter 205 (USAID, 2012; USAID, 2017). Based on the content identified through the review, findings were organized to first present information from prior gender and social inclusion analyses, including additional information to fill knowledge gaps based on these reviews, then to organize findings around gender and health according to the three objectives under IHP (Strengthened health systems, improved access to PHC services, and increased quality of PHC services) to facilitate operationalization of recommendations, including the definition of indicators to measure progress, in the subsequent phase of strategy development.

Findings. This desk review identified two recent gender analyses that included specific information for Ebonyi: (1) *Gender and Equity Considerations Under the Basic Health Care Provision Fund: State-level Gender and Equity Analysis Findings for FCT, Abia, Osun and Ebonyi State* from the USAID Health Policy Plus (HP+) Project; and (2) *Gender-Based Violence (GBV) Assessment and Service Mapping Report for MCSP-supported facilities in Kogi and Ebonyi States, Nigeria* from the USAID Maternal and Child Survival Program (MCSP) (Pappa, 2019; Oduenyi et al., 2017). Key findings from the HP+ analysis highlight gaps in overall awareness of gender amongst state-level stakeholders in Ebonyi, a lack of women's representation in leadership and decision-making in health, barriers to access for women and persons with disabilities (PWDs) linked to poor infrastructure and limited supplies and/or equipment, women's lack of access to health information, preferences for traditional birth attendants (TBAs), religious barriers to care, and poor provider attitudes that negatively affect women and adolescents. However, these findings have a limited scope as they are focused on the implementation of the Basic Health Care Provision Fund (BHCPF), and also present aggregate information for the four states analyzed. Findings from the MCSP analysis identified low levels of knowledge of GBV amongst health providers and an absence of referrals to services for GBV survivors. There is evidence that health facilities in Ebonyi provide GBV survivors with a range of medical services, and stakeholders in Ebonyi believe that GBV survivors, especially women, do not seek services due to stigma, fear for their safety, and the geographic and financial inaccessibility of broader support services that are predominantly located in larger towns. There are also gaps in the availability of certain services, like shelters and psychosocial support, and a lack of knowledge about GBV protection amongst law enforcement officials. Findings from these analyses informed the gender strategy for both activities. IHP reviewed available Health Policy Plus (HP+) and Maternal and Child Survival Project (MCSP) reports, end of project summaries, and evaluations to document reported changes or improvement in contexts following the implementation of analysis-based strategies by these activities. The review did not identify information about implementation progress for key gender strategies reviewed.

The desk review identified and analyzed five Ebonyi-specific health- and gender-related policies and laws to assess for different aspects of gender and social inclusion: *Ebonyi State 2019 Annual Operational Plan (AOP) for the Ebonyi State Primary Health Care Development Agency (ESPHCDA)*, *Ebonyi State Law on the*

Abolition of Harmful Traditional Practices against Women and Children (2001), *Ebonyi State Primary Health Care Human Resources for Health (HRH) Policy (2019)*, *Ebonyi State Strategic Health Development Plan (SHDP) II (2018-2022)*, and the *Ebonyi State Violence Against Persons (Prohibition) (VAPP) Law (2018)*. Based on analysis of the policies, using the IHP gender and social inclusion policy checklist, there is evidence in some policies that Ebonyi State collects sex-disaggregated data, but no evidence of the collection of age-disaggregated data and no guidance on how these data are to be used. There is limited recognition of the role of gender and social inclusion in health access and utilization, few actions to address gender and social inclusion factors affecting health, and little consideration for gender and social inclusion across the HRH pipeline or in health financing or budgeting. The 2019 AOP does suggest the prioritization of adolescent-friendly care, though there are limited activities. The VAPP Law, a domestication of the Federal-level act, and the Law on the Abolition of Harmful Traditional Practices both provide robust legal frameworks to protect against GBV in Ebonyi; however, this desk review did not identify information about the level of implementation or success in effecting change in Ebonyi. Neither of these laws establishes a systematic process for policy enforcement, survivor referral, or the cross-sectoral collation of information in a state-level database.

Based on gaps identified in prior gender analyses, and guided by IHP objectives, the desk review collected and organized findings about gender and social inclusion factors affecting health access, quality of health services, and the health systems that support and sustain both. Illustrative challenges faced in the health system include:

- a lack of guidelines to improve or monitor service delivery in general and in relation to gender and social inclusion (ESMOH, 2017),
- a lack of information on gender balance in HRH and poor working conditions for the health workforce (ESPHCDA, 2019b),
- limited information about the collection and use of sex- and age-disaggregated data, poor supply, and distribution of RMNCAH+N commodities (Eneze et al, 2020),
- little evidence of gender-responsive budgeting (GRB) (Agu, 2020), and
- little consideration for gender and social inclusion in leadership and governance (as evidenced by the IHP policy analysis).

Different groups face varied challenges in access to care. For example, for women and girls, evidence suggests that costs of health services, needing permission from a male family member, and isolation and embarrassment can prevent women from accessing RMNCAH+N services (NPC & ICF, 2019; Oshi et al., 2016; Population Council, 2018). Evaluations of the quality of care in Ebonyi indicate low levels of respect in care, and there is even evidence of verbal abuse and neglect in health facilities (Oduenyi, 2017). Providers are also affected by their own gender biases, undermining women's autonomy in choosing contraception and failing to recognize and include the reproductive health needs of men (MCSP, 2019b).

While it is clear that gender and social and cultural norms heavily influence health access in Nigeria and the Northern States (Faramand et al., 2020a; 2020b; 2020c), based on the findings of this desk review, some gaps in knowledge are apparent in Ebonyi, including the experiences of men and people with disabilities (PWDs) in accessing health services. Furthermore, there are still wide gaps in knowledge about gender norms, particularly as they relate to masculinity.

Discussion and Recommendations. The findings of the rapid desk review not only contributed answers to the original research questions proposed by the research team and highlight gaps for IHP and State leadership to consider in efforts to strengthen the health system and improve access to and quality of health services.

How will the different roles and expectations of men, women, and youth facilitate or hinder IHP objectives to strengthen the health system and improve quality of and access to PHC health services in Ebonyi? The different roles and expectations of men, women, and youth have a great influence on health access and outcomes in Ebonyi. Evidence suggests that women in Ebonyi have limited access to assets and financial resources, and experience concerning levels of controlling behaviors in marital relationships. Women face restrictive norms that limit their ability to make decisions about their own wellbeing, finances, and health. In Ebonyi, women's status also exposes them to risk of gender-based violence (GBV) with some of the highest levels of sexual violence in the country. While men have greater decision-making power and access to resources, norms about masculinity, though not well studied in the State, deter men from seeking health services and encourage them to participate in high-risk behaviors like unprotected sexual activity. Youth in Ebonyi have few opportunities for education or economic independence and have limited knowledge of access to health services, especially for sexual and reproductive health matters. IHP will consider and respond to these gender roles and expectations as we provide technical assistance and capacity building in the State, offering targeted approaches to enhance access to and the quality of services to empower women, meet the unique needs of men, and offer inclusive care for youth and other marginalized groups.

What are the underlying causes of gender and social inclusion challenges? How will underlying causes of these challenges, including societal and cultural factors, facilitate or hinder IHP objectives? Existing evidence, though limited, indicates that traditional norms, beliefs, and practices are strong contributors to the gender and social inclusion challenges identified in this desk review. From the health systems level, women and other marginalized persons are often not included in planning and decision-making, nor are their perspectives considered, which undermines the ability for health systems leaders and decision makers to further policies and plans that are gender-responsive and socially inclusive. Norms that place men in a decision-making role at the household level also undermine women's ability to access healthcare for themselves and their families. Additionally, in Ebonyi, the church and religion have been cited as deterrents to health access. These deep-seated norms and beliefs also affect the quality of care offered in the health system and can prohibit providers from offering a full range of services or from providing gender-sensitive, inclusive care, resulting in low levels of health utilization. These norms can undermine efforts toward gender equality and social inclusion, ultimately resulting in practices that inhibit equitable and inclusive health access and outcomes. In recognition of these norms, beliefs, and practices, IHP, in coordination with BA-N and other actors, will facilitate linkages between primary health care facilities and women's empowerment groups, religious leaders, and male champions to promote positive norms that improve access to PHC services.

How does male engagement in health seeking and service utilization influence women's and children's access to health services and health outcomes? At present, there are still gaps in knowledge about the influence of male engagement in the health system in Ebonyi. There is some indication that men's opinions, knowledge, and control of resources also influence whether a woman accesses ANC/delivery or care for a sick child. Men are often not proactively included in family planning and reproductive health and, if they are, providers may reinforce negative norms and stereotypes that place decision-making in the hands of men. IHP will incorporate strategies to empower women, provide safe spaces for women to express their desires and needs for childspacing and limiting, along with nonjudgmental counseling on family planning. IHP will also engage men in the health system, including training on gender-sensitive provision of care for providers and identifying male champions, to strengthen men's support of their families' health and counter negative norms, stereotypes and misinformation, increase men's access to health services, and improve the quality of care men receive.

How might the anticipated results of IHP interventions affect men, women, and youth differently? With well-designed, targeted, and inclusive interventions, the anticipated results of IHP interventions in Ebonyi will have equitable impacts for women, men, youth, and other marginalized and vulnerable populations, decreasing health disparities and promoting women's empowerment, gender equity and social inclusion. As the program aims to address and reduce leading causes of maternal and child morbidity and mortality, there is risk of reinforcing the notion that the PHC health system is designed only to meet the needs of women and children. Furthermore, efforts to promote reproductive and maternal health may exclude or not meet the needs of youth and adolescents, who can face stigma and bias from providers in accessing this care. Importantly, rural populations and PWDs face increased challenges in accessing health services, which could restrict them from accessing the benefits of IHP's approaches. However, in recognizing these potential risks, IHP will plan for inclusive and equitable approaches that deliver results that reach even the most vulnerable and marginalized through capacity building for providers and implementing partners and technical assistance to advance gender equity and social inclusion in State level policies and practices.

What are potential evidence-based strategies and approaches to respond to the identified gender and social inclusion related constraints and opportunities? Where have gender and social inclusion related interventions been most effective in strengthening health systems for sustained access to and quality of PHC services? This desk review identified a range of evidence-based strategies and approaches to respond to gender and social inclusion constraints and opportunities, offering insights on where these have been most effective in strengthening health systems to sustain access to and quality of PHC services. Promising, evidence-based approaches to promote gender equity and social inclusion in the health system include adopting transparent, equitable mechanisms for HRH production and retention and improving commodity supply chains to offer a full range of contraceptive options. To promote access, involving influencers and positive deviants, including religious leaders and male and female champions, has been demonstrated to increase women's and communities' access to health services. Additionally, harmonizing health messaging that beneficiaries receive in their communities and from health facilities has successfully increase health knowledge for women, men, girls, and boys, thus improving health access. Finally, complementing clinical training with training on approaches for gender sensitivity and inclusion in service delivery has shown promising results in advancing both quality of and access to health services. IHP will build on this evidence, offering tailored technical assistance to the State to implement these evidence-based approaches.

Considering the findings from this desk review and supported by global gender and social inclusion best practices, several recommendations to address gender and social inclusion issues in RMNCAH+N and health systems, access, and quality become clear. These actionable recommendations, which are explained in greater detail in the body of the review, are not for IHP to address alone, but rather are suggestions for the Federal and State Governments, development partners, IHP and other implementing partners in support of overall improved health outcomes for all. The discussion of findings and accompanying recommendations will be used to inform subsequent strategy development and implementation in the State.

Recommendations coming out of the desk review:

- **Use sex- and age-disaggregated data and gender-sensitive indicators to inform more effective leadership and governance and improved health information systems.** By coaching providers and facility managers to document age- and sex-disaggregated data required in the NHMIS 2019 service delivery registers, IHP will support the State to analyze service utilization by age and sex to identify any biases or gaps in service delivery. These data will help will improve existing policies

and plans and mainstream GESI where applicable, establish more accurate benchmarks against which to measure improvements and outcomes, guide interventions so that they are unique to the target populations to which they are directed, and to strengthen the health system to be responsive to need and relevant to context.

- **Continue State-level support for gender-responsive and socially inclusive policy development, implementation, and budgeting to improve service delivery, leadership and governance, and health financing.** This support will include advocacy with the Ebonyi State Ministry of Health (ESMOH), Ebonyi State Primary Health Care Development Agency (ESPHCDA), and other State-level actors for the adoption of GESI-related national guidelines and policies and capacity building for State leadership to enable those policies, as well as health strategies for broader equity, with gender responsive budgeting.
- **Promote gender balance and gender-sensitivity across the HRH pipeline to strengthen the health workforce.** This will include working with the ESPHCDA and the new USAID Health Workforce Management Project to integrate gender equity and social inclusion in the existing and upcoming HRH Policies to enhance gender balance and diversity in HRH distribution and to encourage both women and men to enter, advance, and stay in the health workforce.
- **Reinforce health systems' and facilities' abilities to stock a full range of RMNCAH+N commodities**, with an emphasis on promoting a full method mix of modern contraceptives, including methods being introduced in Nigeria for the first time such as the LNG IUS**.** Efforts will include the provision of targeted technical assistance to ESMOH, ESPHCDA, and Local Government Health Authority (LGHA) leadership to mobilize and distribute commodities to improve access to family planning options and essential medicines.
- **Complement skills-based training with training on gender-sensitive and socially inclusive care**, including adolescent-friendly approaches to care and competencies to provide care to PWDs. This will be achieved by integrating gender and social inclusion into IHP trainings and supportive supervision approaches to clarify providers' values and build skills to counsel women, men, girls, and boys in RMNCAH+N care by providing a non-judgmental, safe space to discuss reproductive goals and contraceptive options.
- **Increase capacity for GBV prevention and response in the health system and collaborate with State-level actors to strengthen multi-sectoral GBV response**. These efforts will enhance PHC GBV services and referral pathways to respond to the needs of survivors. IHP will provide technical assistance to build providers' capacity to offer first line GBV care and strengthen health facilities ability to refer to other services for comprehensive GBV response (e.g., psychosocial support, legal counsel).
- **Build capacity for improved quality of care sensitive to the needs of adolescents to increase their utilization of services**. IHP will raise awareness of health providers of the unique needs of adolescents and train them to adopt evidence-based adolescent-friendly practices, such as offering flexible appointment times, providing private counselling, and offering a full range of contraceptives to adolescents.
- **Generate capacity across the health system to implement male-friendly approaches to care.** Male-friendly approaches include establishing accommodating environments for men to accompany their partners for ANC and private, facility-based delivery areas so women may invite partners to participate in the birth, when that is a woman's preference. IHP will also train providers to contribute to women's empowerment as part of their service delivery by promoting both independent and joint decision-making (depending on the desire and preference of the woman) around family planning and encouraging resource sharing that allows women to better support their families' health.

- **Engage religious leaders and traditional medical practitioners at the facility level** in Facility Management Committees, Quality Improvement Teams and Ward Development Committees so they will influence the availability and quality of high impact primary health care services for adolescents and women (e.g., modern contraceptives, early ANC, facility delivery, postnatal care) that will increase access to and utilization of health services.
- **Promote awareness and uptake of available health insurance schemes, particularly for vulnerable populations and women** who have less access to financial resources to fund access to health services. IHP will provide targeted technical assistance to the Ebonyi State Health Insurance Agency (ESHIA) and other relevant State actors to promote gender equity and social inclusion in their outreach and enrollment efforts, with the aim to increase insurance enrollment and thus health access.

The recommendations and findings from this broad and overarching desk review, as well as a future in-country landscaping, aim to inform more equitable, effective, and efficient RMNCAH+N strategies, activities, and sustainable change. This desk review will inform the strategy for integrating gender and social inclusion into program design and implementation and mainstreaming gender into organizational culture and practices. IHP partners, led by Palladium, and a wide range of public and private actors have critical roles to play to ensure sustainable and equitable progress to reduce preventable morbidity and mortality and promote social wellbeing and development for women, men, girls, and boys in Ebonyi State.

1. INTRODUCTION

Ebonyi State struggles to match levels of development in other states in southern Nigeria. Women and men in Ebonyi experience entrenched gender norms that restrict women's opportunities and access to resources, education, and economic opportunities. Marginalized groups in the State, including adolescents and persons with disabilities (PWDs), face increased challenges to inclusion in society. These restrictions and barriers affect access to and utilization of health services, contributing to negative health outcomes and low health access for women, men, boys, and girls. Not only do these health concerns affect individuals, but they contribute to undermining the health, wellbeing, and prosperity of families, communities, the state, and the nation as a whole.

The United States Agency for International Development (USAID) Integrated Health Program (IHP) Task Order (TO) 6, led by Palladium International, LLC, is positioned to contribute to improving health systems in Ebonyi State, Nigeria. IHP works in Ebonyi to reduce child and maternal morbidity and mortality and to increase the capacity of public and private health systems to sustainably support access to and quality of primary health care (PHC) services. Palladium partner WI-HER, LLC is responsible for gender integration and social inclusion within IHP and TO 6, addressing gender and social inequities related to primary health care and related health and social factors, including adolescent health, fistula, gender-based violence (GBV), and child and forced marriage. IHP will provide technical assistance (TA) to mainstreaming gender at the State-level in Ebonyi, focusing on gender equality and equity in access to and quality of social services. Further, IHP will advance gender and social integration at the facility- and community-level, targeting integration of gender and social inclusion issues that impact service delivery and clinical care.

1.1 Purpose

This desk review collates information to identify the social, economic, and political factors that influence health outcomes, including gender inequalities. It includes an analysis of existing policies, strategies, and guidelines to identify gender-related gaps and opportunities. It builds upon prior research and analysis completed under USAID-funded projects in Nigeria and Ebonyi to collect relevant findings and gather evidence to address gaps in knowledge. This desk review will provide evidence to inform recommendations centered on strengthening health systems, access, and quality, and identify entry-point opportunities for sustainable interventions and long-term improvements in health status. The recommendations will also inform IHP's gender and social inclusion (GESI) strategy, which will address root causes of health disparities, including child marriage, lack of male engagement in health, GBV and female genital mutilation/cutting (FGM/C), and low adolescent service utilization. The strategy will integrate gender and social inclusion into program design and implementation and mainstream gender and social inclusion into organizational culture and institutional practices, fulfilling the tenets of USAID's Gender Equality and Female Empowerment Policy (2012).

This report contains the findings of the rapid desk review, along with recommendations for mainstreaming gender and social inclusion (GESI) in health policies and strategies and integrating GESI throughout service delivery to strengthen health systems, improve access to primary health care, and improve quality of primary health care in Ebonyi. The findings will inform the development and implementation of GESI strategies under IHP and for Ebonyi State in collaboration with State leadership and stakeholders, including how to measure and monitor progress.

1.2 Methodology

The analysis examines gender and social inclusion considerations at all levels of reproductive, maternal, neonatal, child, and adolescent health, plus nutrition (RMNCAH+N) programming within the health system (generally corresponding to the World Health Organization [WHO] health systems building blocks) to identify challenges and opportunities for enhancing gender considerations and related impact (WHO, 2010). This analysis was guided by initial research questions, which were designed based on prior gender and social inclusion desk reviews conducted in IHP TOs 03, 04, and 05 (Bauchi, Kebbi, and Sokoto States, respectively). These initial research questions were:

1. How will the different roles and expectations of men, women, and youth facilitate or hinder IHP objectives to strengthen the health system and improve quality of and access to PHC health services in Ebonyi?
2. What are the underlying causes of gender and social inclusion challenges? How will underlying causes of these challenges, including societal and cultural factors, facilitate or hinder IHP objectives?
3. How does male engagement in health seeking and service utilization influence women's and children's access to health services and health outcomes?
4. How might the anticipated results of IHP interventions affect men, women, and youth differently?
5. What are potential evidence-based strategies and approaches to respond to the identified gender and social inclusion related constraints and opportunities? Where have gender and social inclusion related interventions been most effective in strengthening health systems for sustained access to and quality of PHC services?

Strategy for document collection. Recognizing the recent gender analyses and studies completed under USAID-supported Health, Population, and Nutrition (HPN) projects in Ebonyi, including Health Policy Plus (HP+) and the Maternal and Child Survival Program (MCSP), the research team did not duplicate existing analyses. As a first step in the review, the team identified, collected, and reviewed existing gender and social inclusion analyses for Ebonyi, identifying any gaps in information. This ensured that existing information was synthesized and fully considered within the Ebonyi context, and then filled gaps with broader resource analysis.

Using the research questions and gaps identified in prior gender and social inclusion analyses, the team identified the following key search words/phrases under Ebonyi and Nigeria, which were used to identify documents for inclusion in the review:

- Gender
- Female
- Women's issues
- Women's health
- Women's rights
- Male and female relationships
- Male health
- Male engagement
- Girls' issues
- Adolescent health
- Persons with disabilities (and PWD)
- Marginalized populations
- People on the move

- Emergent themes were identified and used to guide the document structure and organize citations.

Primary topics guided the headings and sub-headings of the document; however, where information on each theme was sparse, themes were condensed and combined. Themes include:

- Reproductive health and family planning
- Maternal health
- Obstetric fistula
- Newborn and child health
- Nutrition
- HIV
- Gender norms, roles, and responsibilities
- Girls' education
- Gender-based violence
- Female genital mutilation/cutting (and FGM/C)
- Marriage and divorce (and child or early marriage)
- Gender norms related to sexuality
- Men and masculinities
- Governance and the health system
- Financing and budgeting
- Human Resources for Health
- Policies and guidelines about gender-sensitive care and service delivery
- Healthcare access and challenges
- Youth-friendly services
- Access to medication
- Social inclusion and vulnerable populations

Given the robust IHP TO 2 federal level desk review and analysis provided through the state-level desk reviews for USAID IHP TOs 03, 04, and 05 (Bauchi, Kebbi, and Sokoto States, respectively) (Faramand et al., 2020a; 2020b; 2020c), the research team did not collect additional national-level information that was not specific to Ebonyi.

Inclusion criteria. Materials reviewed include peer-reviewed publications from journals, policy papers, gender analyses, case studies, literature reviews, publicly available data, project evaluations, government and international policies and strategy documents, State health and gender policy and strategy documents available online, donor-funded program documents, grey literature, and other relevant materials. To the extent possible, only literature from the past 10 years were considered, along with the most recent publicly available policies, strategies, and guidance documents. In addition, documents for review were identified using Google Scholar, through open access journals, the USAID Development Experience Clearinghouse (DEC), and Google searches for reports from over the last five years from key global organizations (including United Nations International Children's Fund [UNICEF], CARE International, United Nations Entity for Gender Equality and the Empowerment of Women [UN Women], United Nations Population Fund [UNFPA], and WHO). The report also included a listing and high-level assessment of gender policies that have or have not been domesticated at the State level.

Using the inclusion criteria and search terms as described, the following documents were selected for inclusion in the desk review: 55 peer-reviewed journal articles; 50 pieces of grey literature (e.g., working

papers, program documents, gender assessments); 22 local, national, or international policies, guidelines, plans, laws, strategies, or tools (five of which were selected for inclusion in the policy analysis); 16 sources of quantitative data; and five sources of background information. A full, categorized list of the 148 documents referenced in this review can be found in *Annex 2: Documents referenced*.

The team also compiled publicly available sex- and age- disaggregated, qualitative, and quantitative data and background information related to gender and social inclusion to complement subsequent data collection. Finally, the team collected and analyzed, using a policy checklist developed for IHP TOs 02-05, relevant policies, laws, and guidelines covering health, gender, and/or social inclusion in Ebonyi.

Organization of findings. Based on the content identified through the review, findings were organized to first present information from prior gender and social inclusion analyses (Section 2.1). As the analysis was guided by USAID (2012) Gender Equality and Female Empowerment Policy (2012) and USAID (2017) Automated Directives System (ADS) Chapter 205, the research team then used USAID's five gender domains (laws, policies, regulations, and institutional practices; cultural norms and beliefs; gender roles, responsibilities, and time use; access to and control over assets and resources; and patterns of power and decision making) as a framework to identify, collect and present additional information relating to key gaps from existing analyses (Sections 2.2 and 2.3).

Guided by the research questions, search and inclusion criteria, and IHP's focal areas, the team organized the findings relating to challenges and opportunities for equitable health improvements to correspond with the three objective areas of IHP: health systems (health service delivery, health workforce, health information, essential medicines/commodities, health financing, and health leadership and governance) (Section 2.4 and 2.5), access to primary healthcare services (Section 2.6), and quality of primary healthcare services (Section 2.7).

1.3 Background and overview of Ebonyi State

Ebonyi State is one of 36 states in Nigeria and is in the southeast. It has a land area of 6,400 square kilometers ("Nigerian States: Ebonyi State," n.d.). Ebonyi was created from Enugu and Abia States in 1996. The capital is in Abakaliki, which is also the largest city in the State ("Ebonyi State Profile," n.d.). Ebonyi State is bounded by Cross River, Benue, Enugu, Imo, and Abia States. Ebonyi State has 13 local government areas (LGA) which are further grouped into three senatorial districts (North, Central, and South).

Figure 1. Map of Ebonyi State, Nigeria

Note. Reprinted from Ebonyi State Post Codes/ Zip Codes, Nigeria Postal Codes, https://nigeriapostalcodes.com/ebonyi-state-post-codes-zip-codes.html

The most recent population projections from the Nigeria National Bureau of Statistics (NBS) estimate that Ebonyi State had a population of 2,880,383 residents in 2016 (NBS, 2018a). Just over half of the population is male (51%), and the estimated population growth rate is 2.7% ("Nigerian States: Ebonyi State," n.d.; HP+ Project Nigeria, 2017). Notably, over 40% of the population is under the age of 15. It is a predominantly Igbo state, with few minority ethnic groups from its neighboring states. However, there are indigenous, non-Igbo speaking peoples present in the State ("Nigerian States: Ebonyi State," n.d.). Like much of the southeast, habitants are mostly Christians with few Muslims and few persons who practice traditional religions ("Nigerian States: Ebonyi State," n.d.).

Following the Nigerian national governing system, the Ebonyi State governing system is overseen by the executive, legislative, and judiciary branches. The executive branch is headed by the Executive Governor of Ebonyi State, His Excellency David Umahi ("Nigerian States: Ebonyi State," n.d). The governor oversees the State and takes key decisions including policy ascensions.

Ebonyi State has been blessed with many mineral resources including crude oil, salt, lead, and natural gas ("Nigerian States: Ebonyi State," n.d.). It is largely agrarian with a good number of citizens being farmers. Popular crops in Ebonyi are yam, maize, beans, potatoes, cassava, and rice. Ebonyi State is popularly known for its bagged locally produced "Abakaliki Rice." Over the last years there have been increases in the solid mineral mining activities with the opening of quarries in the three senatorial districts in the State. According to NBS calculations, between 2013 and 2017 Ebonyi State had a gross domestic product (GDP) of 1,327,104.09 million Naira, ranking as one of the least productive of the 22 states included in the analysis (NBS, 2019c). The services and agriculture sectors contribute the most strongly to State GDP.

Ebonyi experiences low levels of development and higher levels of poverty in comparison to other states in Nigeria and the South East Zone. The Human Development Index (HDI), * which measures progress in human development, was 0.434 in 2016 (UNDP, 2018). Ebonyi had the fourth highest level of poverty in Nigeria in the 2019 revised absolute poverty calculations, with 79.76% of the population being classified as poor (NBS, 2019b). Women and girls are also affected by poverty due to the non-inheritance culture in the State (Bako & Syed, 2018). As of Quarter 3 of 2018, Ebonyi State had an unemployment rate of 21.1%, which was the highest in the South East Zone (NBS, 2019a). Additionally, 19.7% of employed persons are classified as underemployed. In the last Nigeria Demographic and Health Survey (NDHS), 94% of women in the State had been employed in the prior 12 months, as compared to 88% of men (NPC & ICF, 2019).

In Ebonyi State, the literacy rate for adults was 62.5% in 2010 (NBS & Nigeria Information Highway, n.d.). Ebonyi has consistently had lower literacy rates amongst both adults and children in comparison to other states in southern Nigeria. This is due in part to having some of the lowest levels of school attendance in southern Nigeria (NPC & RTI International, 2011). There are also clear gaps in levels of educational attainment for women and men in the State. More than one in ten women ages 15 to 49 years have not attended any schooling (11.9%), and only 5.2% have completed more than secondary education; for men in Ebonyi, only 2.6% have never attended school and 8.9% have completed education beyond secondary institutions.

2. FINDINGS: GENDER, SOCIAL INCLUSION, AND HEALTH IN EBONYI

2.1 Findings from previous gender and social inclusion analyses

Before beginning the desk review, the research team reviewed recent gender- and health-related research from other USAID HPN projects to identify relevant findings and gaps in knowledge. Through the desk review process, and as noted in the methodology, two documents were located that were determined to contain relevant, State-specific knowledge for this analysis. Summaries of these two efforts, including relevant findings and gaps, are reviewed in this section. Three other gender analyses, including the *USAID/Nigeria Gender Analyses for Strategic Planning,* the *President's Emergency Plan for AIDS Relief (PEPFAR) Nigeria Gender Assessment*, and the Japan International Cooperation Agency (JICA) *Country Gender Profile: Nigeria Final Report*, were reviewed, but did not include State-specific information (Morel-Seytoux et al., 2014; Fontaine et al., 2016; Mitsubishi UFJ Research & Consulting Co., 2011).

Gender and Equity Considerations Under the Basic Health Care Provision Fund: State-level Gender and Equity Analysis Findings for FCT, Abia, Osun and Ebonyi States

The most recent gender analysis completed in Ebonyi located during this desk review was the *Gender and Equity Considerations Under the Basic Health Care Provision Fund: State-level Gender and Equity Analysis Findings for FCT, Abia, Osun and Ebonyi States* (Pappa, 2019). This research was conducted under the USAID-funded Health Policy Plus (HP+) Project. The analysis brought to light gender and social equity considerations, potential challenges and opportunities, and key recommendations related to the rollout of the Basic Health Care Provision Fund (BHCPF)[*] in Nigeria. Successful BHCPF rollout relies upon understanding the challenges, opportunities, and gaps of each interconnecting groups of potential beneficiaries to ensure they are reached adequately. Information found in the desk review was to be used to ensure gender and equity measures are integrated throughout the implementation of BHCPF, and that vulnerable groups like pregnant women, children under five, and PWDs were included in the rollout.

HP+ used the Interagency Gender Working Group (IGWG) gender analysis framework as their main gender analysis tool. A desk review was carried out by gathering all previous USAID Nigeria gender assessments and analyses, to identify relevant content, and ensure the state-level analyses were not duplicative. In addition, key informant interviews were carried out in the three states and the FCT, with 30 completed in Ebonyi State. The stakeholders used for the key informant interviews were representatives of various state-level health agencies, Ward Development Committees (WDCs), Local Government Health Authorities (LGHAs), and civil society organizations (CSOs) and community leaders.

Many of the findings of this analysis are relevant to the implementation of IHP in Ebonyi State. Notably, most stakeholders that took part in key informant interviews did not have a good understanding of gender, and many thought the term gender meant "women only." This belief was apparent in the stakeholders' perspectives on gender in health service provision, with many stakeholders focused on

[*] *The BHCPF is a mechanism to increase the level of available resources for health in Nigeria. Funds are distributed to each state for the establishment of a health insurance scheme to ensure access to a basic package of services, and funds are also distributed to improve human resources for health (HRH), the provision of commodities, and infrastructure.*

gender as it relates to what health services women need, especially those relating to pregnancy and children's health.

Overall, health facilities were seen as the domain of women and children. This extends to management structures in facilities, with most Officers-in-Charge (OICs), who oversee and manage day-to-day facility operations, being women. The OIC position is considered "less desirable" as it is considered to be in the women's domain. However, although women are involved in the core work of health service provision, men are more represented in high-level leadership and decision-making. Women were not well represented in higher-level leadership positions in the Ebonyi State Primary Health Care Board (ESPHCB) (e.g., governing board member or Chairman, Executive Secretary) but, unlike other states, women make up a larger proportion of the ESPHCB management team, which is led by the Executive Secretary. In addition to the lack of leadership, none of the State Social Health Insurance Agencies (SSHIA), including in Ebonyi, had a gender focal person at the time of the analysis.

Stakeholders noted various gaps to health access and the provision of health services. In all states, including Ebonyi, stakeholders identified poverty amongst women as a barrier to health access. It was described that women typically do not control household spending and must seek permission to spend the household's money on health services or transportation to reach health facilities. Further, stakeholders also believe women's inadequate access to information prevents health access, though the causes of this inadequate access were not described. A key informant interviewed for the HP+ analysis in Ebonyi explained that many women choose to use traditional birth attendants (TBAs) even if there are health facilities available. This may be related in part to religious beliefs in Ebonyi; in some cases, women believe God will grant a health delivery and, in other cases, churches opposed the use of health facilities for ANC or delivery. However, the analysis does not provide details about why churches opposed the use of health facilities for ANC and delivery, nor did it explore all possible reasons women in Ebonyi may prefer to use the services of TBAs.

Finally, key informants interviewed for the HP+ analysis noted gaps in service availability and provision. Overall, key informants saw limitations in the coverage and availability of health workers as a barrier to health access, as was the poor distribution of female and male health workers to meet patients' preferences. One key informant in Ebonyi State expressed the need for more male-focused services within the Basic Minimum Package of Health Services (BMPHS) as the services seem to be more targeted at women. Stakeholders also identified the absence of coordinated GBV services (e.g., counselling, treatment, referral) across all four states, including Ebonyi. Finally, there was an overall lack of understanding of the needs of PWDs in health facilities in all four states.

Additionally, the recommendations from the analysis that will prove useful for IHP include efforts to:

- Build gender and social equity understanding and knowledge among key stakeholders.
- Expand services and training to adequately care for and respond to the needs of PWDs, survivors of GBV, and men as supportive partners and service users.
- Ensure equitable availability of male and female health workers in PHCs to meet the needs of patients,
- Make efforts to provide free and accessibly transportation.
- Improve representation of women in leadership and decision-making. While the analysis recommends the implementation of gender quotas across state- and local-level institutions as a means to promote women's leadership, there is little evidence to support the efficacy of quotas in health leadership; overall, the evidence for gender quotas is mixed, and some evidence from the private sector suggests that quotas may be harmful (Deschamps, 2018; Bauer & Burnet, 2013).

Though this analysis has several useful findings and recommendations focused on gender and social equity considerations within the context of BHCPF implementation. While some gender and social equity considerations related to universal health coverage (UHC) were considered in the desk review, this analysis does not emphasize broader considerations in health care provision, access, or utilization that are not related to BHCPF implementation. Additionally, as findings are presented largely in aggregate across the four states, it is difficult to identify and unpack those gender and equity challenges specific to Ebonyi State. For example, no specific information is included to indicate if there is a gender focal person at the ESPHCB. Finally, while poverty and limited financial decision-making are mentioned as barriers to health access for women, the analysis did not propose any recommendations to address these concerns. Further, the analysis did not present any information on norms, beliefs, and practices relating to gender and social inclusion in Ebonyi, nor did it include background information or quantitative or qualitative data on RMNCAH+N health outcomes in Ebonyi.

Gender-Based Violence (GBV) Assessment and Service Mapping Report for MCSP-supported facilities in Kogi and Ebonyi States, Nigeria

In 2017, the USAID-funded Maternal and Child Survival Program (MCSP) completed gender-related research to produce the *Gender-Based Violence (GBV) Assessment and Service Mapping Report for MCSP-supported facilities in Kogi and Ebonyi States, Nigeria* (Oduenyi et al., 2017). The main aims of the rapid assessment and mapping were to determine the availability of GBV prevention and response services and/or strategies in the states and assess the perceptions, knowledge, and attitudes of health workers in MCSP-supported facilities toward GBV. The assessment also resulted in a GBV referral directory for each state to ensure GBV response is prompt and apt.

The assessment employed qualitative and quantitative data collection methods with a variety of key stakeholders. In Ebonyi, 78 key informant interviews were held with representatives from the Ebonyi State Ministry of Health (ESMOH), Ebonyi State Ministry of Women Affairs and Social Development (ESMOWSD), local government and community leadership, community-based organizations (CBOs) and faith-based organizations (FBOs), legal and law enforcement agencies, and health facilities. MCSP selected 30 health facilities in Ebonyi State (10 per senatorial zone) that had high patient volume and were easy to access for facility-level data collection. There were 19 primary health facilities, 10 secondary health facilities, and one tertiary health facility selected in Ebonyi. During interviews, key informants were asked to describe the context of GBV and support services and were also asked quantitative questions to measure GBV knowledge, attitudes, and perceptions.

The findings from this assessment will be critical to reference and consider in planning for GBV response services in IHP. Health facilities and social welfare units in Ebonyi State are under-equipped and providers are insufficiently trained to offer GBV services, with only 57% of the health worker showing a fair knowledge of GBV and 20% having poor knowledge. Most health workers interviewed had not received any training on GBV response or referral. No health provider interviewed in Ebonyi had ever referred a client to the social welfare unit for psychosocial support, and only two providers had made referrals to any sort of support services (police). However, providers in the selected facilities did provide a range of medical support services in GBV cases. In fact, providers often felt their only role in GBV response was to provide medical care, and they did not want the “extra workload” associated with other forms of response or referral.

Health providers perceived that a lack of services combined with survivors' concerns about their safety and the high rate of stigma have resulted in very few survivors currently seeking service. The assessment did not include a quantitative assessment of cases seen in health facilities or on the types of GBV included in those cases. 42% of respondents thought rape was the common GBV incidence experienced in the State. Stakeholders reported seeing high numbers of GBV cases when doing community outreach but lacked the training to follow-up on these cases. In Ebonyi, where the prevalence of FGM/C has been high and a number of efforts have been made to curtail its incidence, one key stakeholder explained that GBV and FGM/C are now considered synonymous in communities, resulting in a need for renewed outreach on other forms of GBV. Some factors that enable the continuous occurrence of GBV in Ebonyi State as mentioned by the interviewers include poverty, inadequate implementation or enforcement of laws to address GBV issues, and the stigmatization of survivors.

While there are structures and services in place for GBV response and referral in Ebonyi, the systems face gaps and challenges in the provision of services. Most services are located in urban areas, providing barriers to access for rural GBV survivors. The cost of services, including transportation to reach urban areas, was cited as a key challenge preventing survivors from accessing all types of support and response services. Psychosocial support is only available and provided in some cases of sexual violence. Legal services exist, but there are low levels of prosecution. Law enforcement officials in Ebonyi were unaware of available laws that can be used in addressing GBV issues while preparing legal prosecution, and law enforcement also lacks funding to respond to GBV. There is no State-owned shelter, but there are two safe houses led by nongovernmental organizations (NGO) and one emergency shelter in Ebonyi. Ebonyi, unlike Kogi, does offer some limited economic empowerment and skill acquisition projects through State and local government efforts. Referrals are limited to the ESMOWSD and NGOs.

Several of the recommendations proposed within the assessment will be beneficial for IHP implementation and these include efforts to:

- Increase advocacy and sensitization amongst stakeholders providing services to improve knowledge and awareness of GBV and available support services.
- Prioritize training for health workers to enhance the capacity of staff and health facilities to respond appropriately to GBV incidences and make necessary referrals.
- Establish direct linkages between health facilities and all other available support services (e.g., legal, law enforcement, psychosocial, housing).
- Institute monitoring mechanisms in facilities to ensure GBV survivors are referred to and access services.
- Improve access to services by addressing transportation costs and providing services in rural locations.

Due to the purposive sampling used in the assessment, it is possible that the information found from health facilities in Ebonyi does not reflect the context of clinics in hard-to-reach areas, or those with lower patient volume. Outside of clinics, key informants were predominantly located in urban areas. Additional information will be needed to ensure these findings and recommendations apply outside of the contexts of this research. Finally, the information presented on service utilization, service quality, GBV prevalence, and the experiences of GBV survivors was collected from health workers and key stakeholders, who may not have a full understanding of individual- and community-level factors. Additionally, like the HP+ analysis, this analysis did not present any information on overall norms, beliefs, and practices relating to gender and social inclusion in Ebonyi, nor did it include background information or quantitative or qualitative data on RMNCAH+N health outcomes in Ebonyi.

2.2 RMNCAH+N overview and outcomes in Ebonyi

Based on gaps in information presented in the prior gender analyses identified in the previous section, this desk review identified gender- and social inclusion-related health concerns and outcomes experienced in Ebonyi in relation to RMNCAH+N. Health outcomes in Nigeria and Ebonyi State are a reflection of the poverty level, low expenditure on health, and inadequate health infrastructure. Though southern Nigeria and the South East Zone typically exhibit higher performance on indicators of health and development, Ebonyi State is often highlighted for its lower levels of performance in areas of development, including health (UNDP, 2018). Ebonyi State is classified as one of the poorest states in Nigeria, and it is important to note that, in Nigeria, poverty is directly linked to citizens' ability to access quality care. Inadequate financial resources, low levels of awareness, and harmful norms and practices all contribute to low levels of service utilization and, thus, poor health outcomes for women, men, girls, and boys in the State (ESPHCDA, 2019c).

This desk review address gender-related health concerns and outcomes experienced in Ebonyi State in relation to RMNCAH+N. Ebonyi State performance on key health indicators and their relationship with gender are summarized in Table 1 below. Overall, like other states in Southern Nigeria, Ebonyi tends to perform better than the national average on key RMNCAH+N indicators, though performance on some child health indicators like malaria prevalence and stunting trails behind national levels.

Table 1. Key RMNCAH+N health indices in Ebonyi State

Indicator	**Ebonyi**		**National**	
Life expectancy at birth (years)	48	(2016) [1]	54.3	(2018) [2]
Life expectancy at birth (years), Female	52	(2016) [1]	55.2	(2018) [2]
Life expectancy at birth (years), Male	47	(2016) [1]	53.5	(2018) [2]
Infant mortality rate (per 1,000 live births)	64	(2018) [3]	67	(2018) [3]
Under-five mortality rate (per 1,000 live births)	91	(2018) [3]	132	(2018) [3]
Maternal mortality ratio (per 100,000 live births)	218-576*	(2016) [4] (2017)[4]	512	(2018) [3]
Total fertility rate (births per woman)	5.4	(2018) [3]	5.3	(2018) [3]
Percentage of teenage women (15-19) who have begun childbearing	8.2%	(2018) [3]	19%	(2018) [3]
HIV/AIDS prevalence (15-64 years)	0.8%	(2018) [5]	1.5%	(2018) [6]
Malaria prevalence among children under 5 years (rapid diagnostic testing [RDT])	49.3%	(2018) [3]	36.2%	(2018) [3]
Diarrhea prevalence among children under 5 years	10.5%	(2018) [3]	12.8%	(2018) [3]
Prevalence of stunting among children under 5 years (below -2 standard deviations [SD])	36.8%	(2018) [3]	25.2%	(2018) [3]
**There are wide variations in estimates for the maternal mortality ratio in Ebonyi. The most conservative estimate is presented in this table, while the section below* (Maternal Health) *contains a discussion of other estimations of maternal mortality.*				
Data Sources: [1] NBS, 2019d; [2] World Bank, n.d.; [3] NPC & ICF, 2019; [4] NBS, 2018 & ESMOH, 2017; [5] NACA, 2019b; [6] NACA, 2019a;.				

Reproductive health and family planning

Women of reproductive age make up 22% of the Ebonyi State population (ESPHCDA, 2019a). In Ebonyi State the median age of first marriage for young women is 21 years, which is higher than the national average (19.1 years) (NPC & ICF, 2019). However, the average age at first marriage for men is much higher at 28.2 years. The median age for women's sexual debut is 18.1 years, while it is 19 years for men.

Women of reproductive age in Ebonyi believe that the ideal family size is 5.9 children, which is larger than the other states in the South East Zone (NPC & ICF, 2019). Ebonyi State also has the highest total fertility rate (TFR) in the South East Zone at 5.4 children per woman of reproductive age. Ebonyi State is largely populated by Igbo communities, but the Ebonyi TFR is higher than that of Igbo communities (4.55 children per woman) (NBS & UNICEF, 2018). There appears to be a link between high levels of fertility and the rural, agrarian nature of Ebonyi State; many Ebonyi residents rely on subsistence farming as a means of survival and having additional children can contribute to "extra hands" on the farm (Akamike et al., 2019).

The contraception prevalence in Ebonyi State is 8.3%, which is much lower than the national contraceptive prevalence of 17% and the contraceptive prevalence in the South East of 28.3% (NPC & ICF, 2019). Unfortunately, contraceptive prevalence has seen a decline between 2013 and 2018; prevalence for any method has reduced from 15.7% to 8.3% (NPC & ICF, 2014). Only 5.9% of women in Ebonyi are using any modern method of contraception (NPC & ICF, 2019). The most common forms of contraception in the State are implants (2.6%), traditional methods (2.3%), and injectables (1.6%). Less than one percent of women in the State use any other contraceptives, including pills, intrauterine devices (IUDs), or external ("male") condoms. Low levels of contraceptive use are not linked entirely to lack of desire for contraception; in fact, nearly one in four women in Ebonyi has an unmet need for contraception. A longitudinal study of IUD uptake in the Federal Teaching Hospital in Ebonyi revealed increasing levels of contraception uptake over time. However, levels of IUD uptake remained low, with around one in ten women who received contraceptive counseling and chose to use contraception selecting an IUD (Igwe, 2016). Most women who selected IUDs were multiparous (98%), and women were most likely to discontinue IUD use to become pregnant. IHP and partners will need to consider and address the multiple factors influencing low levels of contraceptive use in Ebonyi in its work to improve RMNCAH+N outcomes in the State.

Low contraception uptake and use may be due in part to lack of knowledge and awareness about family planning. Four in ten women in Ebonyi have never been exposed to family planning messages from any media source (radio, television, newspaper/magazine, or mobile phones) (NPC & ICF, 2019). The most common source of family planning messaging is the radio. Both men and women in Ebonyi are most likely to have been exposed to messaging about child spacing. Furthermore, over two-thirds of women had not discussed family planning with a health provider or fieldworker in the 12 months prior to the NDHS, indicating low levels of outreach. Only one-quarter of women who had visited a health center in the last 12 months received counseling on family planning.

Because Ebonyi is a largely agrarian state, many women are involved in selling agricultural products in markets, making market women an important demographic to consider in health outreach efforts in Ebonyi. A study among market women (women who are traders or own shops), most of whom were married (92.4%), in Abakaliki reflects high levels of contraceptive awareness amongst these women; 83.3% had heard of contraception (Egede et al., 2015). However, only half of those who had heard of contraception were aware of the purpose of contraception. One in three market women had ever heard about contraception from a health worker, but the most common source of information for contraception was friends (38.8%). Market women may be in a unique situation to become exposed to messaging about

family planning and contraception due to their positionality and frequent interactions with other women. Despite knowledge about contraception, very few women actually used contraception – 28.3% used any method, and 16.3% used a modern method. 69.4% of the women approved of contraception, and the most common reasons to disapprove of contraception were beliefs that it is harmful, religious reasons, and husband's disapproval of contraception. A husband's influence was also cited as a reason for up taking contraception for 12.4% of women, and a reason to discontinue contraception in 9.1% of cases.

A recent study in health facilities in three LGAs in Ebonyi (Izzi, Ezza South, and Ikwo) analyzed the knowledge, attitudes, and preferences of postpartum women who were contraceptive users (Anaba et al., 2018). Of the sample (n=123), 33% of women surveyed from were from Ezza South, 36.5% from Ikwo, and 30.5% from Izzi. These contraceptive users were more likely to be married, have completed secondary education, be employed, and have young children (under 7 months). Only one-third knew that contraception could be used to both to delay pregnancy and limit the number of children a family has. When asked about community perceptions of family planning, 28% said their communities did not think it was important, and 18.7% said their communities thought contraception can be harmful. While half of the surveyed women thought family planning was beneficial to themselves and society, one-third still reported they did not think it was necessary. Women preferred using implants (32.3%), injections (32.3%), and condoms (22.9%) for a variety of reasons, including effectiveness, STI protection (condoms), recommendations from friends (implants and injectables), and low side effects (implants). Similar studies about knowledge, attitudes, and preferences of non-contraceptive users in Ebonyi were not located during the course of this desk review; collecting such data from non-users would provide critical information to understanding why women do not choose to use contraceptives.

Among women who do use family planning, two-thirds report that they made the decision to initiate family planning with their husband (NPC & ICF, 2019). Only five percent indicated that their husband was the main decision-maker. However, for women who do not use family planning, one quarter report that their husband decided not to use family planning. This information is critical to consider when planning for outreach into communities to promote family planning use, as outreach targeted to women alone may not be successful. Confirming suspected root causes of high fertility rates, such as lack of knowledge and need for children to support agricultural livelihoods. and understanding the dramatically declining rate of contraceptive use will help Ebonyi to design evidence-based interventions to raise awareness of family planning options and benefits and to advance economic empowerment. Targeted interventions should result in improved quality of care, increased contraception prevalence, and improved maternal health, as well as improved social and economic indicators.

Due to low levels of contraceptive coverage and access, the rate of unplanned pregnancy is known to be high in Ebonyi State. In the South East Zone, where Ebonyi is located, of the proportion of pregnancies, 12% result in unplanned births, which is higher than the national level (Guttmacher Institute & University of Ibadan, 2015). Though abortion is illegal in Nigeria (except to save the life of the mother), an estimated 14% of pregnancies in the South East Zone result in abortion; however, due to the illegality of abortion in Nigeria, this is likely an underestimation. This results in an abortion rate of at least 31 per 1,000 pregnancies in the South East.

There are high levels of post-abortion complications in Nigeria, which pose a risk to women's health and a burden to the health system. In Ebonyi State Teaching Hospital in Abakaliki, complications from abortion represented 41.1% of all gynecologic admissions between 2004 and 2009 (more recent or State-level data are not available) (Kalu et al., 2012). In the hospital, abortion accounted for 11.5% of maternal mortalities. There are also low levels of training on post-abortion care (PAC) amongst health providers, and poor

linkages between emergency care and reproductive health services like family planning. Research from the same time period in the Federal Medical Center in Abakaliki indicated that few women who sought care for complications of induced abortion had ever received contraceptive counselling, and there was low awareness of contraception (Ikeako et al., 2014). This suggests a need for IHP and partners to strengthen contraceptive counselling to prevent complications from induced abortion, and also the need to integrate contraceptive counselling into PAC to prevent repeated unplanned pregnancies. Comprehensive PAC is a critical step to provide care for women who may experience complications from unsafe abortion. Global evidence, including evidence from Nigeria, indicate the importance of high-quality PAC, including voluntary family planning counseling (Huber et al., 2016). Efforts to provide family planning in PAC must ensure informed consent and must also provide women with information on family planning before they leave the health facility.

Maternal Health

In Ebonyi State, women begin childbearing in their early 20s, with the median age at first birth at 21.7 years (NPC & ICF, 2019). The median birth interval in Ebonyi is 28.6 months, which is higher than the recommended 24 months but lower than the national average of 30.9 months. One-quarter of births in Ebonyi still occur less than 24 months after a prior birth. 8.2% of young women between the ages of 15 and 19 have begun childbearing, which is much lower than national levels and in line with trends in other states in the South East Zone.

There are still many births happening at home in Ebonyi State. As of 2018, four out of every ten births 41.6% occur at home (NPC & ICF, 2019). This represents a slight increase in home births from the 2013 NDHS (NPC & ICF, 2014). This is despite relatively high levels of antenatal care (ANC) attendance (NPC & ICF, 2019). 70.3% of pregnant women received ANC care from a skilled birth attendant. Data from the 2016-17 Multiple Indicator Cluster Survey (MICS) indicate slightly higher levels of ANC attendance (78.4%), with most women attending four or more visits in total (57.7%) (NBS & UNICEF, 2018). The median months pregnant at first ANC visit was 4.0 months. Of women receiving ANC, most received a blood pressure measurement (93.8%), only 66.2% had a blood sample taken, and 81.6% had a urine sample taken (NPC & ICF, 2019).

Ebonyi experiences much lower levels of skilled birth attendance that other states in the South East; only 52.1% of births are assisted by skilled birth attendants (NPC & ICF, 2019). Other births are attended by TBAs (9.3%), relatives (15.4%), or community health extension workers (11.7%). Fort those births that do occur in a health facility, a higher proportion take place in public facilities (35.7%) than private facilities (20.8%). A low number of births occur through Caesarean section (3.7%). There is a strong indication that many women are managing pregnancy and delivery at home, as 96.5% of the complicated cases referred to health facilities came directly from their homes, while only 2.4% were referred from other health facilities. Women must also overcome transport barriers to access health facilities in general and during childbirth. Walking and motorcycles/scooters are the most common means used to access health facilities for childbirth.

Nigeria is marked by high levels of maternal mortality, and some evidence suggests Ebonyi State also experiences extreme levels of maternal mortality. It will be vital for IHP and partners to address those factors influencing maternal morbidity and mortality to improve overall health in the State. Some of the underlying factors contributing to maternal mortality include poverty (which prevents health access), unsafe abortion, inadequate health facilities (limited supplies and space), and limited skilled birth attendance (Uneke et al., 2014). There are wide variations in estimates of the maternal mortality ratio

(MMR) in Ebonyi State. Estimates from 2010 suggest the MMR in Ebonyi State was 602 deaths per 100,000 live births, which was higher than the national level of maternal mortality. However, data from a rapid survey conducted by the NBS in 2016 reflect an MMR of 218 deaths per 100,000 live births, significantly lower than prior estimates (NBS, 2018b). More recent data from ESMOH in 2017 are more aligned with earlier estimations and indicate that the MMR in Ebonyi is 576 deaths per 100,000 (ESMOH, 2017).

There has been a slight reduction in early childbearing between the 2013 and 2018 NDHS (NPC & ICF, 2014; 2019). The inability for youth and adolescents to access adequate information and services for sexual and reproductive health services contributes heavily to early childbearing, and it also negatively affects the health of young mothers (MCSP, 2018a). Adolescent girls do not utilize health services as much as older women; 46% of mothers under 20 did not access ANC and only 26% of adolescent girls delivered with a skilled provider.

Between the 2013 NDHS and 2018 NDHS, Ebonyi has seen some concerning reductions in indicators of maternal and reproductive health (Table 2). For example, the contraceptive prevalence rate in the State has decreased drastically, as has skilled delivery, ANC attendance, and attendance to postnatal care. There has also been an increase in the unmet need for family planning. It will be important for Ebonyi State to understand the causes for these reductions, which contradict overall improvements on these indicators in Nigeria.

Table 2. Trends in reproductive and maternal health indicators for Ebonyi State

Indicator	2013 NDHS[1]		2018 NDHS[2]	
	Ebonyi	**National**	**Ebonyi**	**National**
Contraceptive Prevalence Rate	15.7%	15%	8.3%	17%
Married women who had heard of any one modern method	88.8%	82.8%	*No data*	93.9%
Unmet need for family planning (married women)	20.5%	16%	23.0%	18.9%
Total fertility rate	5.3	5.5	5.4	5.3
Adolescents who have begun childbearing	9.6%	22.5%	8.2%	18.7%
Any ANC care from a skilled provider	85.1%	61%	70.3%	67%
Delivery in health facility	59.6%	36%	56.5%	39%
Maternal mortality ratio (per 100,000 live births)	*No data*	576	*No data*	512
Postnatal check-up in first 2 days after birth	55.3%	40%	50.2%	41.8%

Data Sources: [1] NPC & ICF, 2014; [2] NPC & ICF, 2019

HIV/AIDS is an important factor to consider in the context of both maternal and reproductive health in Ebonyi State, and there is an opportunity for IHP and partners to integrate considerations about HIV into its efforts to improve reproductive, maternal, and child health. In the South East Zone, HIV prevalence is higher than the national average (NACA 2019a; 2019b). HIV prevalence is also higher amongst women than men. However, Ebonyi State has a lower HIV prevalence than the rest of the South East Zone at 0.8% (NACA 2019a; 2019b). Just over one-third of people living with HIV in Ebonyi are virally suppressed; low levels of viral load suppression (VLS) have implications for HIV transmission in the State.

Data from the 2013 NDHS suggest high levels of awareness of mother-to-child transmission (MTCT) of HIV, with around eight in ten women and men know that HIV can be transmitted in breastmilk (NPC & ICF, 2014). There is less awareness amongst both women and men about preventing MTCT by taking medication. Ebonyi State has made great strides in the prevention of mother-to-child transmission

(PMTCT) of HIV. Ebonyi is the only state in Nigeria to have achieved over 80% coverage of HIV Counseling and Testing (HCT) in PMTCT (NACA, 2016). In a recent survey of mothers living with HIV enrolled in the PMTCT clinic at the Federal Teaching Hospital in Abakaliki, most had good adherence to medication (89.2%) and had good knowledge of PMTCT (89.0%) (Joseph et al., 2018). Most women in the survey began taking antiretroviral therapy (ART) during their pregnancy and not before. One in five women surveyed indicated that fear of being identified as a person living with HIV prevented them from adhering to ART. Partner's support was significantly positively associated with a woman's adherence to ART.

Men in Ebonyi tend to have greater knowledge about preventing HIV through limiting partners and using condoms, and about HIV transmission through breastfeeding and PMTCT (Table 3). However, women and men in Ebonyi tend to have lower levels of knowledge about PMTCT in comparison to the rest of Nigeria.

Table 3. HIV prevalence and HIV/AIDS knowledge in Ebonyi State

Indicator	Ebonyi		National	
	Men	Women	Men	Women
Knew condoms and having one partner without HIV reduces risk [1]	87.8%	73.5%	74.1%	70.7%
Knew that HIV can be transmitted via breastfeeding [1, 2]	81.3%	78.2%	69.7%	77.6%
Knew that MTCT risk can be reduced with medication [1, 2]	46.1%	45.7%	62.7%	71.5%
HIV prevalence [3, 4]	1.5%*	2.2%*	1.1%	1.9%
People living with HIV with VLS [3, 4]	38.8%*	37.8%*	40.9%	46.2%

**Information presented for the South East Zone as information for Ebonyi State is not available.*
Data Sources: [1] NPC & ICF, 2014; [2] NPC & ICF, 2019; [3] NACA, 2019b; [4] NACA, 2019a

Newborn and Child Health

Ebonyi State experiences high levels of under-5 mortality. In the five years preceding the 2018 NDHS, the under-5 mortality rate was 91 deaths per 1,000 live births, which was higher than the rest of the South East Zone (NPC & ICF, 2019). Infant mortality stands at 57 deaths per 1,000 live births. Neonatal and infant mortality may be linked to low levels of postnatal care in Ebonyi. Half of women and half of newborns in Ebonyi never attend a postnatal care check. However, of women who do attend postnatal care, most do so within the first 4 hours after giving birth. For newborns, postnatal care is most likely to occur within 1 to 23 hours after birth. Postnatal care for newborns appears to be weak in Ebonyi; in only 35% of postnatal checks were two signal functions performed. Further, only one in five newborns in Ebonyi are weighed at birth. This suggests the need for IHP and partners to address barriers to access and challenges with quality of newborn care.

There are varying levels of health seeking behavior for children in Ebonyi. Four in ten children in Ebonyi have received all basic vaccinations, but only one-quarter of children have received all age-appropriate vaccinations (NPC & ICF, 2019). Around two-thirds of parents sought treatment for their child when their child experienced fever. Half of parents seek treatment when their children experience diarrhea. In the South East Zone, around half of parents seek care and treatment when their child experiences symptoms of acute respiratory infection (ARI). As women are typically primary caregivers in Ebonyi and also face restrictions on movement and decision-making, they may also be unable to access care for their children, which has negative effects on the wellbeing of their families. Recent qualitative research from Ebonyi and Kogi States indicates that intra-household decision-making around care seeking for children is deeply affected by gendered power dynamics in families (Dougherty et al., 2020). While women are expected to care for the children in the family, men must provide finances for health care and, thus, hold decision-

making power about when to seek care. Women who have financial autonomy have greater decision-making power. In some instances, if mothers take their children to care without the permission of fathers, fathers may refuse to pay the bill for care or send the mother back to her family because of her disobedience.

Nutrition

In Nigeria, several populations struggle with receiving adequate nutrition, including children and women. In Ebonyi, like much of Nigeria, undernutrition is a more prevalent concern than over nutrition, though over nutrition does exist. A recent survey in Abakaliki indicated that 15.7% of in-school children between the ages of 6 and 12 years were undernourished (Umeokonkwo et al., 2020). Males and those living in rural areas were more likely to be undernourished. This aligns with findings from an earlier survey in rural areas of the State, which indicated that among in-school children, ages 5 to 14, there was a prevalence of underweight of 23%, and a prevalence of moderate to severe stunting of 42.5% (Ene-Obong & Ekweagwu, 2012). This survey also suggested that school-aged children in rural areas lack dietary diversity to ensure the proper balance of both micro- and macro-nutrients.

Between the ages of 6 and 23 months, around half of children are fed the minimum dietary diversity and meal frequency, but only one-quarter of children receive a minimum acceptable diet (NPC & ICF, 2019). This may contribute to poor nutrition outcomes in the State. Eight in ten children between the ages of 6-59 months have any level of anemia in Ebonyi, with half experiencing moderate anemia. Children in Ebonyi do have good access to Vitamin A and Iron rich foods but are rarely provided with vitamin supplements or deworming medication. In addition, women in Ebonyi face high levels of anemia, with seven in ten women experiencing any level of anemia, much higher than the national prevalence of anemia amongst women (57.8%). Among pregnant women, only two in ten receive deworming medication during the course of their pregnancies. IHP and partners can consider both the needs and the roles of women, men, girls, and boys in addressing poor nutrition outcomes in the State.

The Federal Government of Nigeria has taken several actions to improve the nutritional status of all Nigerians by promoting infant and young child feeding (IYCF) practices. Exclusive breastfeeding has been highly encouraged with the establishment of the National Food and Nutrition Policy and the National Strategic Plan of Action for Nutrition (2014 – 2019) (Ministry of Budget and National Planning, 2016; FMOH, 2014). In Ebonyi, nearly all children are ever breastfed (98.3%) (NPC & ICF, 2019). One-third of children born in the State were breastfed within one hour of birth, while 87.9% were breastfed within one day of birth. There is little information on awareness of breastfeeding among mothers in Ebonyi. A facility-based, cross-sectional survey of mothers who delivered in the Federal Teaching Hospital in Abakaliki suggested near universal knowledge of exclusive breastfeeding (98%), with one-quarter of women surveyed practicing exclusive breastfeeding between 4 and 6 months after their child's birth (Nwali et al., 2016). Women reported that their main source of information about breastfeeding was the hospital. Older women and women with higher levels of education were more likely to practice exclusive breastfeeding for longer durations.

2.3 Gender and social inclusion considerations in Ebonyi

As noted, the prior gender analyses conducted in Ebonyi did not present overarching information on gender and social inclusion considerations, including gender norms, roles, and responsibilities, including those relating to sexuality; GBV; marriage and divorce; men and masculinities; and context on vulnerable

groups in the State. This desk review collected information in each of these areas, which will be critical to consider and understand in addressing health disparities and improving health outcomes in Ebonyi.

The Gender Inequality Index (GII)*, which provides a measurement of inequality in the experiences of men and women, in Ebonyi is 0.504 (UNDP, 2018). This places Ebonyi as the fifth most gender equal locality in Nigeria; however, the index value for Ebonyi still represents significant gender disparities in health, representation in leadership, education, and economic activity.

Gender norms, roles, responsibilities

Beliefs about gender, including norms and roles, are "powerful root causes" of gender inequality across Nigeria and in Ebonyi (Voices4Change, 2015). Gender norms, roles, and responsibilities play a predominant role in society, affecting women, men, girls, and boys across their lifespan in ways that are intricately tied to their health and well-being. Most studies of gender norms, roles, and responsibilities in Nigeria take place at an aggregated, national level, leaving little information specific to explore nuanced beliefs and behaviors in Ebonyi (Morel-Seytoux et al., 2014; Fontaine et al., 2016; UN Women, 2020). However, there is some State-specific data from the 2018 NDHS and other studies highlighting the influence of gender norms in Ebonyi. Understanding and considering these gender norms will be important to IHP's efforts to improve access to and quality of health services in Ebonyi.

Women's independence and economic empowerment are deeply affected by gender norms, and they are critical factors to consider in the provision of health services. Though many women in Ebonyi reported recent employment as of the 2018 NDHS, most women earn less than their husbands (78.9%) (NPC & ICF, 2019). Around one in five women in Ebonyi report that their husband mainly makes decisions about how their own cash earnings are spent, while 56.8% of women make joint decisions with their husbands about how their cash earnings ae spent. Conversely, half of men have sole control in deciding how their own cash earnings are spent, while 47.3% make joint decisions with their wives. Around half of women do not own their own assets (land or homes) in Ebonyi. While 27.2% of men own a house and 39.0% own land, only 7.5% of women own a house and 7.3% own land. Additionally, only one in ten women in Ebonyi have and use a bank account. Decisions about how to spend household income can affect women's ability to fund access for health services both for themselves and for their families, particularly if women do not have any income or assets of their own.

Norms and practices related to inheritance in Ebonyi have a profound impact on women (Bako & Syed, 2018; Chegwe, 2014). In Ebonyi and other eastern states of Nigeria, women are not permitted to inherit assets from their deceased husbands. Additionally, only male children are permitted to inherit their father's assets. If a man passes and he has only female children, his assets are passed on to his family and his widow and children are left without any form of support.

However, in Ebonyi, women have higher levels of participation in decision-making than national averages (NPC & ICF, 2019). Around seven in ten women participate in decisions about their own healthcare (71.9%), decisions about household purchases (76.6%), and decisions about visiting friends or family (74.9%). 65.6% of women participate in all three decisions, while 17.9% of women do not participate in any of these three decisions. This indicates higher levels of independence and autonomy in comparison

* *GII measures gender-based inequalities in three dimensions – reproductive health (measured by maternal mortality and adolescent birth rates), empowerment (measured by the share of parliamentary seats held by women and attainment in secondary and higher education by each gender), and economic activity (measured by the labor market participation rate for women and men).*

with other states in Nigeria, which could indicate reduced barriers to healthcare access. However, joint decision-making does not guarantee independence, and there is still a stark gap in women's ability to make decisions about their own lives in comparison to men. Nearly all men indicate that they participate in decisions about their own health (94.5%) and household purchases (95.6%) in Ebonyi, which is much higher than women's levels of participation and indicates higher levels of autonomy for men.

Patterns around decision-making in sexual relationships are also critical to understand health outcomes for both women and men in Ebonyi. Decisions around engaging in sexual intercourse and using protective methods have important implications for both women's and men's health as it relates to sexually transmitted infections (STIs), including HIV, and pregnancy and childbearing. Around 70% of women and men believe that women are justified in refusing sex if they know their husbands engage in sexual relationships with other partners (NPC & ICF, 2019). Nearly all women (92.1%) feel that they can refuse sex to their husband for any reason. Two-thirds of women believe a wife is justified in asking her husband to use a condom if he has an STI, and nine out of ten of men also agree. However, only half of women felt comfortable asking their husband to use a condom for any reason.

However, despite women's moderate levels of autonomy in decision-making, there are still concerning patterns of controlling behavior in marriages. Half of ever married women report that their husband insists on knowing where she is going at all times and that they become jealous if she is talking to another man (NPC & ICF, 2019). One quarter of women report that their husbands prohibit them from meeting their female friends and that they frequently accuse them of being unfaithful. For 12.8% of women, their husbands try to limit their contact with their own families. These patterns of control limit women's autonomy and ability to make decisions for themselves and their families and may also be linked with escalation to experiences of violence.

Traditional gender norms tend to be linked with conservative norms about sex and sexuality in Nigeria. This may in turn influence the provision of sexual and reproductive health care through bias or stigma amongst providers about "appropriate" sexual behavior, and it may also discourse men, women, boys, and girls from seeking sexual health care. There is a lack of formal analysis of norms about sexuality as they specifically pertain to Ebonyi. In Ebonyi, there is some data to indicate high-risk sexual behaviors may be common, especially amongst men. While women have on average 1.6 sexual partners, men tend to have 8.3 sexual partners on average, which is double the national average (NPC & ICF, 2019). 9.1% of men had had two or more partners in the two months preceding the 2018 NDHS. Of women who engaged in sexual intercourse with someone who was not a partner in the 12 months preceding the 2018 NDHS, only 15.8% used a condom. There was limited information from men who had engaged in sexual intercourse outside of partnerships.

Sexuality and sex are often considered taboo subjects in Ebonyi. A recent mixed methods study in six LGAs in Ebonyi determined that half of adolescents ages 13 to 18 had never discussed sex with anyone (Mbachu et al., 2020). If adolescents have discussed sex with anyone, it was most likely to be with friends (77.7%). Only 1.4% had ever discussed sex with a health worker. In qualitative discussions with parents and children, both groups explained that the content of conversations about sex vary for male and female children. Girls are more likely to learn about the importance of abstinence and preventing pregnancy, while boys can receive lessons on making choices in regard to sex and using contraceptives like condoms. There is also an expectation that mothers will discuss sex with daughters and fathers will discuss sex with sons, but mothers are considered to be primarily responsible for teaching children about sex.

Gender-based violence

Across Nigeria, there are concerningly high levels of GBV, including extreme forms of violence like severe physical mutilation and femicide. Just over half of women in Ebonyi have experienced physical violence since the age of 15 (NPC & ICF, 2019). Ebonyi has extremely high levels of sexual violence when compared to the rest of Nigeria; 20.8% of women have ever experienced sexual violence, and 10.6% of women experienced sexual violence in the twelve months preceding the 2018 NDHS. The lifetime prevalence of sexual violence in Ebonyi is double the national prevalence. Notably, in an analysis of sexual assault cases at the Federal Teaching Hospital in Abakaliki, most perpetrators of sexual assault were known to the victim (only 9.7% of perpetrators were strangers) (Felix et al., 2019). Neighbors (25.8%) and acquaintances (19.4%) were the most common perpetrators. Of ever married women, 53.9% have experienced some form of spousal or intimate partner violence (IPV), the most common forms being emotional (44.4%) and physical (41.5%), and sexual (15.6%) (NPC & ICF, 2019). 8.1% of ever married women also report that they have perpetrated violence against their own husbands.

One in ten women reported experiencing physical violence during pregnancy in the 2018 NDHS (NPC & ICF, 2019). However, a survey of pregnant women enrolled in ANC in the Federal Medical Centre in Abakaliki revealed a much higher prevalence of violence during pregnancy when considering all forms of violence (Onoh et al., 2013). 44.6% of the women surveyed had experienced some form of violence during their most recent pregnancy. Verbal violence was most common (60.1%), followed by physical or sexual violence (17.5%) and economic violence (8.4%). Domestic issues and financial problems were cited as common triggers of violence. Very few of the women were willing to report the experience of violence (16.1%); most women did not want to report to preserve their marriage (47.2%). The church and parents were cited as central support systems for women.

Ebonyi does experience higher levels of help seeking for women who experience violence. 37.4% of women who have experienced violence never told anyone about the violence, nor did they ever seek help (NPC & ICF, 2019). Less than 1% of women told someone about the violence but did not seek help in relation to the violence. The remaining 61.9% of women sought help for violence.

Violence is considered to be acceptable in a number of cases in Ebonyi (NPC & ICF, 2019). Four in ten women agree that a husband is justified in beating his wife in one of five given scenarios (Burns the food; Argues with him; Goes out without telling him; Neglects the children; or Refuses to have sexual intercourse with him). Women are most likely to believe violence is justified if a wife neglects the children (30.1%), argues with her husband (29.5%), or goes out without telling her husband (28.1%). In Ebonyi and across Nigeria, men are less likely to report that they accept violence. 15.1% of men thought violence was acceptable in one of the five scenarios. Men are most likely to believe violence is acceptable if a wife argues with her husband (12.8%).

Ebonyi State had the third highest prevalence of FGM/C in Nigeria as of the 2018 NDHS (NPC & ICF, 2019). Just over half of women (53.2%) have experienced some form of FGM/C, which is more than double the national prevalence. As such, there have been focused efforts to understand, address, and prevent FGM/C in the State. A survey of women of reproductive age who were attending ANC and postnatal care in Abakaliki found a similar prevalence of FGM/C (49.6%) (Ibekwe Perpetus et al., 2012). Seven in then of the women surveyed had received messaging designed to prevent FGM/C. Most women (82.3%) did not support the continued practice of FGM/C. When identifying reasons why FGM/C has ever been practiced in Ebonyi, women cited traditional and culture (32.8%), reducing female sexual desire (21.9%), and increasing female hygiene (14.1%). Half of women were aware that FGM/C was still being actively practiced; when asked why FGM/C was still practiced despite increased efforts to prevent it, many women

did not know (39.3%), while some women believed culture (22.1%), ignorance (17.2%), and tradition(15.2%) contributed to the persistence of FGM/C. FGM/C has been linked to poor obstetric outcomes in the State, with women who have experienced FGM/C at higher risk for experiencing prolonged labor and for damage to the perineum (Anikwe et al., 2019).

In comparison to national averages, women in Ebonyi State face higher levels of GBV and controlling behavior (Table 4). They are also more likely to belief that a husband is justified in beating his wife.

Table 4. Gender-based violence in Ebonyi State

Description of Violence	Ebonyi	National
Physical abuse from husband or partner (ever-married women aged 15-49)	41.5%	19.9%
Sexual abuse from husband or partner (ever-married women aged 15-49)	15.6%	7.0%
Emotional abuse from husband or partner (ever-married women aged 15-49)	44.4%	31.7%
Controlling behavior: women whose husbands become jealous if they talk to other men	52.0%	44.2%
Controlling behavior: women whose husbands must know where they are at all times	50.7%	40.7%
Controlling behavior: women whose husbands try to limit when they see their families	12.8%	10.2%
Women who agree that a husband is justified in hitting/beating his wife for at least one specified reason (burns the food, argues with him, goes out without telling him, neglects the children, or refuses to have sex)	39.6%	28.0%

Data Source: NPC & ICF, 2019

Marriage and divorce

There is little State-specific information available about practices of marriage and divorce in Ebonyi. Across Nigeria, there is a prevailing belief that women have little influence on choosing who they marry (UN Women, 2020). The practice of polygyny, or having multiple wives, is more common in Northern Nigeria than in other parts of the nation, but in Ebonyi about 18.6% of women have one or more co-wives. Only 3.4% of men report having two or more wives (NPC & ICF, 2019). There are also large gaps in marital age between men and women. Four in ten women ages 20 to 24 in the South East Zone are married to men who are older than them by ten years or more (NBS & UNICEF, 2018). This difference in age has key implications for power differentials and decision-making in families. In the South East Zone, where Ebonyi is located, widows are not guaranteed rights to own land – nor are they guaranteed access to use the land. It is common practice that a deceased husband's family members will seize a widow's property (World Bank, 2019).

Early and forced marriage

Of women ages 20 to 49 in Ebonyi, 6.5% were married before the age of 15 and 17% were married before the age of 18 (NBS & UNICEF, 2018). The Ebonyi State Government has made strides to address child marriage and has reported a reduction in its incidence (Federal MWASD, 2016). In fact, leaders in Ebonyi have noted that the high prevalence of teenage pregnancy is a more pressing concern than early marriage in the State. Parents in the South East Zone tend to accept early marriage out of necessity due to poverty,

and girls are likely to agree to marriage if they become pregnant out of wedlock. Early marriage in Ebonyi has also been linked to preferences to educate male children, and societal pressures not to waste resources on female children. Early marriage, combined with poverty and early pregnancy, has been associated with high levels of secondary school departure for girls in Ebonyi (Achilike & Achilike, 2016).

Men and masculinities

At the broadest levels, widely held ideas about masculinity and femininity are powerful root causes of gender inequality and violence against women in all its forms. Often, men in Nigeria are pressured to fulfil societal constructs of masculinity such as playing roles of breadwinner, protector, and figurehead of the family, which can normalize male aggressiveness and covertly permit male promiscuity (Otive-Igbuzor, 2014). Norms about men and masculinities have a significant effect on the health of men, boys, and their families in Nigeria and in Ebonyi. Men are expected to be strong and seeking support for health concerns undermines this expectation. This prevents men from seeking health services for prevention, testing, and treatment of key health concerns, including tuberculosis (TB) and HIV (Oshi et al., 2015; Fontaine et al., 2016). Because of these norms, health facilities are commonly considered the domain of women and children (Fontaine et al., 2016; Pappa, 2019). This desk review did not identify any studies on expectations around masculinity specific to Ebonyi State, which is a critical gap in knowledge.

Social inclusion and vulnerable populations

In addition to concerns around gender inequalities in Ebonyi, there are other vulnerable and marginalized groups that are often excluded from society. This exclusion has negative effects on the health of these groups. The following sections explore important vulnerable populations in Ebonyi. Additional information on health access for these groups can be found in *Access to primary health care services*.

Youth and adolescents

Youth and adolescents in Ebonyi face a variety of challenges, many of which impact their health directly or indirectly. Ebonyi State is a very youthful state as over 40% of its population is under 15 years (HP+ Project Nigeria, 2017). Ebonyi has relatively low rates of school attendance, particularly when compared to other southern states (NPC & RTI International, 2011). Only 68% of primary school-age children are enrolled in primary school. Only 4 in 10 secondary school-age adolescents are enrolled in secondary school. Ebonyi also has the highest proportion of children who have never attended school (10%) out of all southern states. This low level of schooling has direct impacts on youth and adolescents across their life course.

This large youth population faces will face growing challenges in engaging in gainful employment in the midst of an already challenging economic context in the State. There are increasing levels of adolescents and youth engaging in “street hawking,” or the sale of goods on streets and roads, in Ebonyi (Elom et al., 2019). Youth often engage in street hawking due to financial hardships in their families, and parents may push their children into street hawking as a means to support their families. The practice of street hawking can also intersect with sexual exploitation, and adolescent street hawkers are at high risk for negative health and development-related outcomes. Additional details on youth and adolescents’ access to health can be found in the section below, *Access to primary health care services*.

Persons with disabilities

In Ebonyi, around 7% of women and 9% men experience some form of difficulty in one domain of disability (e.g., seeing, hearing, walking, and communicating) (NPC & ICF, 2019). Nigeria has passed into law the Discrimination Against Persons with Disabilities (Prohibition) Act 2018, which states, among other things,

that an individual with a disability shall not be discriminated against on the grounds of his or her disability by any person or institution in any manner or circumstance (Federal Government of Nigeria, 2018). However, this act has not been domesticated in Ebonyi or in any other states. Women with disabilities are at increased risk for sexual violence and assault in Nigeria and in Ebonyi (Etieyibo & Omiegbe, 2016). Some cultural beliefs suggest that engaging in sexual relationships with women with disabilities can bring good luck or fortune, leading to sexual violence.

2.4 Policy analysis: existing gender, social inclusion, and health laws, policies, and guidelines in Ebonyi

Nigeria has an extensive and complex policy environment related to gender and health, with corresponding national ministries responsible for planning, implementation, and monitoring. The health system in Nigeria is decentralized, therefore state level authorities adopt national policies/internationally adapted treaties and adapt them within their local context. The level of adaption on context varies by state depending on the priority of the state, cultural and ethical influence, and religious sentiments. A number of national level policies do not exist at the Ebonyi State level, while others are unavailable to the public for policy analysis. During the course of the desk review, the team sought out Ebonyi-specific or applicable versions of the following national policies, laws, and guidelines: SHDP II; Gender Policy; Task-Shifting and Task-Sharing Policy for Essential Health Care Services; HRH Policy; Implementation Guidelines for Primary Health Care Under One Roof or Primary Care Policy; Policy on Emergency Medical Services; Surgical, Obstetrics, Anaesthesia & Nursing Plan; Standing Orders for Community Health Officers/Community Health Extension Workers; Violence Against Persons (Prohibition) Act; Guidelines for the Implementation of Community Case Management of Malaria; Policy on Food and Nutrition; Policy on Sexual and Reproductive Health and Rights of Women and Girls with Disabilities; Reproductive Health Policy and Strategy; Adolescent Health Policy; Youth Sexual and Reproductive Health Strategy; Family Planning/Reproductive Health Policy Guidelines and Standards of Practice; Reproductive Health/Family Planning Clinical Service Protocol; Family Planning Blueprint (Scale-Up Plan); Strategic Framework for the Elimination of Obstetric Fistula in Nigeria; and the Costed Implementation Plan for Family Planning.

Below is an analysis of the key policies identified relating to gender, social inclusion, and health, but it is not an exhaustive list. Based on the search described, the following policies were available and analyzed for gender integration (see Table 5). A brief overview of findings is presented below; complete checklists for each of the State-level policies can be found in *Annex 1: Gender-responsive checklists for health policies and guidelines in Ebonyi State, Nigeria.*

Table 5. State-Level Policies Analyzed

Ebonyi State 2019 Annual Operational Plan for the Ebonyi State Primary Health Care Development Agency (2019a)	The 2019 Annual Operational Plan (AOP)* for the ESPHCDA was developed in 2017 in collaboration with the ESMOH and key local government health authorities, with technical and financial support from the USAID-funded HP+ Project, Breakthrough ACTION-Nigeria (BA-N), Tip-Top Project, Global Health Supply Chain- Procurement Supply Management (GHSC-PSM), and WHO. The AOP proposes high impact, costed strategies and interventions to improve PHC services in 14 strategic priority areas, which are aligned with the pillars of the Ebonyi State SHDP II (2018-2022). While the AOP does not explicitly recognize

* *The ESPHCDA 2020 AOP was not available during the course of the desk review.*

	barriers to access based on gender, age, disability, or other areas, there are specific activities to address some barriers to access for women and adolescents. It does not address improving access for PWD. The engagement of men is prioritized as a means to improve women's access and utilization of reproductive and maternal health services, but men's own health is not prioritized. The plan also addresses some important gendered health issues in the State, including GBV prevention and care and fistula treatment and care, but does not address other priority areas like FGM/C or adolescent pregnancy. There are limited efforts to include women and men equally in community outreach efforts. The plan does not cover the provision of gender-sensitive or inclusive care (e.g., for adolescents), nor does it address gender in health provider recruitment, distribution, retention, or management.
Ebonyi State Law on the Abolition of Harmful Traditional Practices against Women and Children (2001)	This law was passed by the Ebonyi State House Assembly in 2001. The Civil Resource Development and Documentation Centre (CIRDDOC), an NGO with operations in Ebonyi, led the process of drafting and lobbying for the law with funding from UNFPA (CIRDDOC, n.d.). This law was a response to the numerous challenges women and girls faced due to high incidences of harmful traditional practices in Ebonyi State. Example of such practices as FGM/C, harmful widowhood rites, and forced or early marriage. However, the law forbids the use of any practice that violates the basic human rights of a woman or child. The law has clear definitions for the harmful traditional practices prohibited within the law and includes explicit fines or punishment for those who violate the law. However, the fine and punitive measures are minimal. CIRDDOC has also released a comprehensive guide for the use of the law in practice.
Ebonyi State Primary Health Care Human Resources for Health Policy (2019b)	The Ebonyi State Primary Health Care (PHC) Human Resources for Health (HRH) Policy was developed in 2019 by the ESPHCDA in collaboration with key stakeholders with technical and financial support from the USAID HP+ project. The objective of the policy is to strengthen the performance of the PHC system and improve health outcomes in Ebonyi State by providing an equitably distributed, well-trained, and well-managed HRH workforce. This policy and the included strategies are designed as the main document to guide HRH production, recruitment, distribution, performance, management, and retention for ESPHCDA. The policy includes some recognition of the gender and social inclusion related gaps and issues present in HRH, yet this recognition is not accompanied by strategies or lines of action. The policy recognizes "gender disparities" in HRH distribution, but does not define or describe these disparities. Although data on the current HRH workforce is not disaggregated by sex or age, the policy does require the establishment of an HRH workforce database to include sex-disaggregated data, which should also be used for decision-making. Similarly, gender-responsive targets and indicators are to be include in the HRH Monitoring, Evaluation, Learning, and Accountability plan, although examples are not given in the policy document. Gender and other elements of social inclusion are not considered in HRH production, retention, or

	management approaches or strategies. The application of principles of equity, inclusiveness, and accessibility, which is limited to physical/geographic accessibility, are applied to the population in general without consideration of the unique needs of certain social groups.
Ebonyi State Strategic Health Development Plan II (2018-2022) (ESMOH, 2017)	The Ebonyi Strategic Health Development Plan II (SHDP II) was developed in 2017 by the ESMOH in collaboration with various government agencies and key stakeholders with technical and financial support from the Federal Ministry of Health, the Government of Nigeria's Saving One Million Lives Programme for Results, WHO, and the USAID-funded Maternal and Child Survival Project, HP+ Project, and Health Communication Capacity Collaborative (HC3). The SHDP II was an outcome of the review and critique of the implementation of the SHDP I. The plan aims to facilitate the achievement of the State's health targets, with emphasis on vulnerable and underserved populations, while strengthening health systems and providing affordable health care. Each objective under the five strategic areas in the plan is accompanied by specific strategies for achievement. Although equity and gender sensitivity are principles of the plan, it is largely gender blind in the actions it proposes. The plan recognizes some gendered barriers to health access affecting women and the need to improve access for women, men, girls and boys, but does not propose actions to address the unique access needs of these groups or other vulnerable groups like PWDs. The plan does include targets to ensure adequate representation of women at the WDC level (women should hold half of membership positions and one executive position); however, the plan does not state how this will be achieved, and this is the only mention of women's inclusion in leadership or decision-making.
Ebonyi State Violence Against Persons (Prohibition) Law (2018)	In 2018, Ebonyi passed a State-level adaptation of the nationally adopted Violence Against Persons (Prohibition) (VAPP) Act, which was signed in 2015. This law has the Ebonyi State contextualized definitions of prohibited violent actions, including rape; physical, emotional, psychological, and economic abuse; sexual assault; sexual harassment and intimidation; and spousal battery. While the list of definitions is quite extensive, there are some areas of uncertainty. For example, when defining harmful traditional practices, the law provides some examples but leaves the term open to interpretation. Like the Law on the Abolition of Harmful Traditional Practices against Women and Children (2001), this law integrates and reemphasizes the prohibition of FGM/C, harmful traditional practices, and harmful widowhood practices. The law is well structured with sections defining terms, providing interpretation, allow for fines and punitive measures, setting up a coordinating body, and establishing rights and entitlements for the support and protection for survivors. However, the punitive measures and fines in the law may not be commensurate to the gravity of the offense. In addition, several measures in the law impose penalties for false reporting, which could pose a risk to individuals and deter them from making complaints under

	the law if they fear they will not be believed. The law is a helpful tool to raise community awareness about violence, particularly GBV, in Ebonyi State. Yet, the Law does not provide guidance for enforcement nor does it offer guidelines to establish services or referral pathways for GBV survivors.

2.5 Health systems: considerations for gender and social inclusion

Leadership and governance

Understanding the health-related leadership and governance structures in Ebonyi State is key to IHP's goals to strengthen health systems supporting PHC services. While the Nigeria Federal Ministry of Health (FMOH) provides national-level strategies, policies, and guidance to improve health in the nation, the ESMOH guides the State-specific approaches to offering and improving health services. The ESMOH sets the strategic mission and vision for the health system in the State, which has been documented most recently for 2018 to 2022 in the Strategic Health Development Plan II (SHDP II). The plan guides the State's efforts to achieve its goal of providing quality, affordable health services to improve the health of all citizens (ESMOH, 2017).

The health system in Ebonyi is comprised of the ESMOH along with several departments and agencies. The ESMOH also provides oversight for three parastatal agencies: the Ebonyi State Hospital Management Board (ESHMB), Ebonyi State Primary Health Care Development Agency (ESPHCDA), and Ebonyi State Traditional Medicine Board (Ebonyi State Government, n.d.). The Ebonyi State Health Insurance Agency (ESHIA), which is responsible for coordinating health insurance schemes, was recently established with support from the HP+ Project in Ebonyi (HP+ Project, 2020). The ESMOH also provides oversight for the Ebonyi State Agency for Control of AIDS (ESACA), School of Health Technology (Ngbo), and School of Nursing and Midwifery (Ubure).

Across Nigeria, women are often not represented in leadership and decision-making positions. In fact, Nigeria has one of the largest gender gaps in women's political empowerment and leadership in comparison to other nations (World Economic Forum, 2019). Ebonyi State has seen some progress towards women's political participation, though it is limited. A small proportion of women have held seats as State Legislators between 1999 and 2015, with only five women serving as State Legislators in 2015 (out of 22 seats). However, the current Minority Leader and Clerk of House are both women ("The Legislative Arm," n.d.). Between 1999 and 2015, Ebonyi has not had a female Governor or Deputy Governor (NBS, 2019d). At the local government level, 25 out of 105 Local Government Chairs are female, but only 153 out of 1,073 Local Government Councillors are female.

As described in the gender and equity analysis from the HP+ Project, women are rarely represented in high-level leadership and decision-making positions in the health sector in Ebonyi, though women are well represented in management roles (Pappa, 2019). Ebonyi State also reports high levels of community participation and ownership, including the presence of several active WDCs and Health Facility Committees (HFC) (ESMOH, 2017). There are some efforts being made at the State level to ensure women are involved in community-level decision-making related to health, including a recent commitment from State and LGA Social Mobilization Committees to establish quotas in WDCs, though there is not information available on the success of this initiative. Information about efforts to involve marginalized or vulnerable communities, including youth and PWDs, in leadership and decision-making for health in the State was not located during this desk review. Ebonyi, IHP, and partners can explore opportunities to

include the voices of women, youth, PWDs, and marginalized groups in health leadership and decision-making to ensure health services meet the needs of all groups in the State.

Service delivery

Like many states in Nigeria, Ebonyi uses a three-tiered approach to health service delivery (ESMOH, 2017). There is a higher concentration of facilities at the primary care level, with 171 PHCs in the State. The ESMOH manages PHCs and health posts in coordination with local government and the ESPHCDA. At the secondary level, there is one hospital in each of the 13 LGAs, and ESMOH is solely responsible for the management of services in these hospitals. There are also three tertiary facilities in Abakaliki (Federal Teaching Hospital, National Obstetric Fistula Centre, and the Virology Center). The Federal Government of Nigeria manages the Federal Teaching Hospital and the National Obstetric Fistula Centre.

Ebonyi has a slightly higher concentration of PHC facilities than the national average. There are 18.8 PHCs per 100,000 residents in Ebonyi, as compared to the 16.6 PHC facilities per 100,000 residents at the national level (Makine et al., 2018). However, it has a lower concentration of secondary care facilities (1.75 per 100,000) and tertiary care facilities (0.109 per 100,000). In a study in southeastern Nigeria, which included Ebonyi and Anambra States, residents identified a variety of factors affecting healthcare access (Nnonyelu & Nwankwo, 2014). Half of respondents believed there was an insufficient supply of health facilities and that cost negatively affected access. Further, citizens believe that those who are in higher socioeconomic status and living in urban areas have greater access to health care services. Respondents also disagreed that men have greater access to health care than women. Low levels of income and education were identified as the predominant barrier to health access, though 12.6% of respondents believed distance to health facilities negatively affected access.

This desk review did not identify any policies or guidelines in Ebonyi governing service delivery in general, or as it relates to gender and social inclusion in RMNCAH+N services. However, service delivery has been identified as a key challenge in Ebonyi, with poor monitoring and a lack of supportive supervision undermining service delivery in the State (ESMOH, 2017).

Health information

Health information in Ebonyi is captured in the State Health Management Information System (SHMIS) (ESMOH, 2017). Though Ebonyi has a strong SHMIS and has trained personnel managing the collecting and reporting of data, the State struggles to collect data from private facilities. Additionally, the State lacks an adequate number of personnel to collect and manage health information and lacks funding to advance technology-based health information management. As described in the policy analysis, though some of the Ebonyi policies located and analyzed presented and required the collection of sex- or age-disaggregated data, only the HRH Policy required the collection of sex-disaggregated data in a health information system. There is also a lack of gender-sensitive or socially inclusive indicators. In addition, despite years of investment in RMNCAH+N, there are gaps in data collection that inhibit evidence for informed improvement strategies. The lack of processes to collect, monitor, and make decisions using data at the facility-level inhibits the ability to develop localized, sustainable quality improvement practices, and also serves as a barrier to the aggregation of data at higher levels.

Ebonyi uses the National Health Management Information System (NHMIS) Tools for health information collection (ESPHCDA, 2019a). The 2019 NHMIS tools reflect the collection of some sex- and age-disaggregated data. For example, the Health Facility Monthly Summary Form (Version 2019) disaggregates general attendance, out-patient attendance, in-patient attendance, and mortality by sex and age (FMOH,

2019e). Only one indicator of ANC is age-disaggregated (ANC attendance), and there is no reporting on male involvement in ANC; no indicators for delivery are age-disaggregated or collect information on male involvement. Most newborn and child health indicators, including nutrition indicators, are sex-disaggregated with the exception of immunization. Family planning indicators for counseling, acceptance, and the receipt of condoms are sex-disaggregated but not age-disaggregated, and the uptake of modern contraceptives is age-disaggregated at the aggregate level but not for each contraceptive. Data for noncommunicable diseases and TB diagnostics and care are sex-disaggregated but not age-disaggregated, while data on malaria are presented for under-five, over-five, and pregnant women. Indicators for fistula are age-disaggregated, and indicators for GBV are both sex- and age-disaggregated. The facility registers (Health Facility Daily ANC Attendance Register Version 2019, Health Facility Inpatient Care Register Version 2013, Child Immunization Register Version 2019, Birth Register Version 2019, Health Facility General Attendance Register Version 2019, and Health Facility Nutrition/Growth Monitoring and Promotion Register Version 2019) collect data to feed into the monthly summary form; these registers include places for health workers to indicate sex and age for indicators that require sex- and age-disaggregation (FMOH, 2019a; 2019b; 2019c; 2019d; 2019f).

Despite the requirements to collect and present some sex- and age-disaggregated indicators, there was not any available information about adherence to the use of these tools to collect data, and no information about the use of these data in decision-making or quality improvement. There is no evidence to suggest the collection, analysis, or use of other gender and social inclusion related indicators in the health system, including data about GBV. The ESMOH and ESPHCDA, along with IHP and its partners, can work to better understand if and how sex- and age-disaggregated data, as well as additional indicators relating to gender and social inclusion, are being collected and used, and also facilitate the aggregation and analysis of these data at higher levels.

Health financing and budgeting

Ebonyi State has long recognized health finance as an area of weakness. Health finance was included as a priority area in the SHDP I, but Ebonyi State did not complete any activities toward improving health finance in the implementation of SHDP I (ESMOH, 2017). Improving health finance remains a priority in SHDP II. However, the State faces challenges in health financing, included limited transparency, a lack of focus on finance and equity, and limited infrastructure to support the state health insurance scheme. The State has included eight interventions to improve health financing in Ebonyi in the SHDP II, including establishing health financing and equity units, strengthening coordination, creating a health financing policy, advocating for increased health spending, and strengthening laws and capacity for health insurance provision.

Health spending in Ebonyi has been historically low (Eneze et al., 2020). In 2017, Ebonyi State spent only $3 United States dollars (USD) per capita on health, well below the global target of $89 USD per capita. Health spending represents 0.6% of State GDP, also falling short of the target of 5%. The State also allocates far less than 15% of its budget to health spending, which is the target set in the Abuja Declaration. Between 2013 and 2017, health spending represented 5% of the State budget on average.

Like much of Nigeria, Ebonyi State has until very recently had limited transparency with their budgets and makes very few budgeting documents available to the public (CIRDDOC, 2016; International Budget Partnership, 2020). The Ebonyi State Government has published its budgets for 2015 to 2018 on its website, though the files are no longer publicly accessible (“Ebonyi State Budget,” n.d.). Budgets for 2019 or 2020 for Ebonyi State budgets for gender- or health-related ministries, departments, and agencies

(MDAs), were not available from official sources during this desk review. However, a local Nigerian CSO committed to improving budget transparency (BudgIT) in Nigeria has published the approved 2020 Ebonyi State government budget, which has also recently been added to the Ebonyi State Government website (Ebonyi State Government of Nigeria, 2019; "Ebonyi State Budget," n.d.). The budget was released as part of a Memorandum of Understanding (MOU) signed between the Ebonyi State Government and BudgIT in 2018 to promote open budgeting (BudgIT, 2019).

The 2020 Ebonyi State Government budget includes summary budgets for relevant MDAs, including the ESMOH, ESPHCDA, ESHIA, tertiary care facilities, and provider training facilities (Ebonyi State Government of Nigeria, 2019). Additionally, the document includes budgets and expenditures for 2018 and 2019 (January to December). Combining budget allocations for all health-related MDAs, * health spending represented only 7.6% of the 2020 State budget. This is well below the recommended 15% threshold included in the Abuja Declaration (WHO, 2011). This is especially concerning as data on expenditures demonstrate that the State has not consistently met the level of expenditures for which it has budgeted for health (Ebonyi State Government of Nigeria, 2019). For example, in 2018, the ESMOH spent only 5% of its allocated budget; however, ESMOH expenditures for 2019 more closely match the budget.

Commitment to gender responsive budgeting

Gender-responsive budgeting (GRB) is an approach to support gender mainstreaming and institutionalization whereby policies and programs not only consider gender as an abstract concept but also direct funds to rectify historical and structural inequalities. No information about Ebonyi State's commitment to GRB was located during this desk review, nor has there been much progress made on GRB at the national level. Further, as Ebonyi State does not yet have a health financing strategy, it is not possible to assess for provisions relating to gender-responsive budgeting in the health sector. The information available on Ebonyi State budgets and expenditures for 2018 to 2020 does not indicate gender-responsiveness in budgeting. ESMOH, IHP, and partners can increase the capacity to budget and mobilize resources for gender and social inclusion activities in future efforts.

The Centre for Social Justice (CSJ), a Nigerian CSO focused on social justice, undertook an analysis of Ebonyi State budgets from 2016 to 2019 to determine gender-responsiveness in relation to sexual and gender-based violence (SGBV) and sexual and reproductive health and rights (SRHR) (Agu, 2020). Only four MDAs had budgets lines associated with SGBV, including the prevention of harmful traditional practices, or SRHR (ESMOWSD, ESPHCDA, ESMOH, and the Office of the Special Assistants to the Governor on Women & Child Development). Other MDAs tasked with protecting the rights of women and girls did not budget for such activities, including the Ministries of Justice, Education, and Law Enforcement. Of those activities budgeted, many are vaguely worded without concrete details on implementation, and there are no activities specifically designed to prevent violence, engage men and boys in SRHR or SGBV prevention, provide economic opportunities for women, or provide shelter and support services for GBV survivors. Most of the activities were targeted to the provision of SRH services (e.g., maternal health, family planning). As noted above, there were low levels of expenditure towards these budgeted items between 2016 and 2018, with no expenditures being made towards any of the items in 2018.

Gender lens on health budgets

The budgets for health-related MDAs in Ebonyi reflect gendered needs in health, predominantly through line items allocating funds to women's health services, including maternal health, reproductive health, and family planning (Ebonyi State Government of Nigeria, 2019). This frames women as "objects" of health care targeted only to improve health indices, but without considerations for the provision of gender-sensitive or inclusive care. Additionally, "gender health services" and "adolescent health services" appear

as line items in the 2018 and 2019 ESMOH budgets, but the State did not see any expenditures towards those efforts and did not budget for either item in 2020.There were no other line items for activities relating to gender or social inclusion in health-related budgets.

There are several other budget areas relevant to gender and social inclusion in the 2020 Ebonyi State Government budget (Ebonyi State Government of Nigeria, 2019). Though there are budget allocations for activities under the ESMOWSD, records of expenditure indicate that only a proportion or none of the budgeted funds for these activities were used in 2018 and 2019. This includes training, welfare packages, a "gender" line item (no detail), a rehab center, a drop-in center, child development, and sensitization on FGM/C. There are no budget lines allocated to prevention or response to GBV or other forms of violence. "Gender" is also included as a line item without allocations in the budgets for the Department of Religion and Welfare Matters and Ministry of Finance and Economic Development. The State government does run a "Women Development Centre," which has received budget between 2018 and 2020, but no details on the activities of the center are provided in the budget. Women Development Centres were started as a Federal Government initiative in 1995 with the intention of providing skills training, but the Ebonyi State center now largely functions as an event space for hire (JICA, 2014; "Women Development Centre, Abakaliki," n.d.).

Health insurance and gender

The cost of health services is a crucial barrier to achieving UHC in Ebonyi State. Like much of Nigeria, residents of Ebonyi have high levels of out-of-pocket expenditures on health services (Eneze et al., 2020). There is not a significant difference in overall spending between males and females; however, there is significantly more health spending on male children (ages 0 to 14). This may suggest that families prioritize the health of male children over that of female children. Further, there are low levels of spending on child health overall, which is cause for concern as it suggests children's health needs are not being met. For adults ages 15 to 49, there is higher health spending for females. This is likely due to covering the cost of reproductive and maternal health needs but may also coincide with men's limited utilization of health services. Elderly residents of Ebonyi (ages 50 and over) have considerably higher health spending, though sex-disaggregated data on health spending is not available. Higher socioeconomic statuses are associated with higher levels of health spending, as is urban residence.

Ebonyi State has made immense strides toward implementing a state health insurance scheme in recent years, largely with support from the USAID-funded HP+ Project (HP+ Project, 2020). Accomplishments include the establishment of the ESHIA, meeting readiness requirements for the BHCPF, and increased outreach to raise awareness about the BHCPF. The review of the *Gender and Equity Considerations Under the Basic Health Care Provision Fund: State-level Gender and Equity Analyses Findings from Abia, Osun, Ebonyi and the FCT* summarizes key findings relating to gender and the establishment of the BHCPF, which is intended to serve as a source of funding for health services for vulnerable populations (pregnant women, children under 5, elderly, PWD, the poor). At present, there is no information on current enrollment in state health insurance schemes in Ebonyi State; thus, it is not possible to assess for levels of gender-balance or social inclusion. Overall, women in Nigeria are less likely to be covered by health insurance than men, but in the South East Zone a higher proportion of women are enrolled in health insurance, though there are low levels of enrollment for both men and women (NPC & ICF, 2019). Data do indicate that informal sector enrollment in the Ebonyi Health Insurance Scheme is much lower, which has implications for health access for informal workers, a high proportion of which are women and youth (Eneze et al., 2020).

Human resources for health

Ebonyi State, like the rest of the nation, faces significant challenges in recruiting, retaining, training, and managing an adequate health workforce. These challenges include inadequate stock and density of health providers, high levels of vacancy, poor distribution, low output in training, poor planning and management, limited capacity to maintain data on the health workforce, and weak financial commitment to HRH (ESPHCDA, 2019b). The recent Ebonyi State HRH Policy seeks to address a number of concerns but has only recently been adopted.

Stakeholders have identified the low stock, high vacancies, and inadequate distribution of the health workforce as key priorities to address in improving the health system in Ebonyi. The current availability of health providers falls well below WHO guidelines to have 228 skilled health workers per 100,000 population; Ebonyi has only two skilled health workers per 100,000 population (ESPHCDA, 2019b). Within PHCs in the State, most health workers (89.7%) are of lower skills or cadres. Only one in every 30 PHCs has a nurse/midwife or doctor on staff. There is a total of 16 doctors and 55 nurses or midwives in the State, resulting in a density of 0.5 doctors and 1.7 nurses or midwives per 100,000 residents. Most PHCs experienced a vacancy rate of 80-90%, and also have a poor mix of different levels of health workers. Higher-skilled cadres tend to be more concentrated in urban areas. Between 2015 and 2017, around one quarter of doctors in Ebonyi State were female (NBS, 2019d). There is a lack of comprehensive sex-disaggregated HRH data for other cadres, though the ESMOH has recently committed to establishing an HRH information system to collected sex-disaggregated data (ESPHCDA, 2019b). As the State seeks to address gaps in the health workforce, it can consider collecting this sex-disaggregated data and adopting gender-sensitive and socially inclusive approaches to distribution.

Education, recruitment, training, and compensation

Poor systems of recruitment, replacement and retention, combined with a moratorium on public hiring for health services, contribute to the low stock of HRH (ESPHCDA, 2019b). In addition, there is a widespread conception that PHCs provide poor work conditions, making it challenging to attract and retain health providers. The State's training institutions have weak capacity to train different cadres of health workers and some lack accreditation. Furthermore, health professionals in the system lack continuous training opportunities to enhance their skill or learn new approaches due to non-availability of a strategic system for training and the lack of requirements for continuous training. Management of health providers is marked by abuse and intimidation of staff, non-availability of structures for coaching or mentoring, and a lack of State-led governance of HRH (ESPHCDA, 2019b). These factors also contribute to the poor retention of health workers, which exacerbates the already low stock of HRH. There are no current guidelines in place to promote the gender-equitable or socially inclusive education, recruitment, training, management, or compensation of HRH, which IHP, its partners, and Ebonyi State actors can consider addressing to strengthen the health system.

Though gender has long been recognized as a critical factor to consider in health workforce planning, there have been few sustained efforts to undertake a great understanding of the gender dimensions of HRH or how to effectively promote gender-equitable HRH practices (Newman, 2014). Emerging evidence from the United States suggests that gender diversity, and more specifically the inclusion of women providers, has beneficial effects on health outcomes and the quality of service delivery (Tsugawa et al., 2017). Global evidence indicates that women in the health workforce are held back by occupational segregation, large gender pay gaps, limited access to leadership positions, and discrimination, harassment, and bias (WHO, 2019). Multi-level strategies to improve gender equity in the health workforce have proven to be more effective as they seek to improve policies, practices, and training (Ng et al., 2012). This includes establishing robust anti-harassment policies, making provisions for parenting

members of the health workforce, and providing equal opportunities to people of all genders. Promising practices include the establishment of institutional gender or equal employment opportunity centers or units, which provide coordinated support for policy transformation, gender sensitization, and anti-harassment training. The practice of providing mentoring and coaching for women was even more promising. However, more research is needed to understand the varying effects of these different approaches. There is an opportunity for IHP to harness emerging evidence and promising practices to implement gender-equitable and socially inclusive approaches in the context of HRH, contributing to the development of global knowledge in these areas.

Access to essential medicines and RMNCAH+N commodities

The regular supply of commodities for RMNCAH+N services is a crucial factor impacting the ability of women, men, girls, and boys in Ebonyi to access and receive care. The inability to provide appropriate commodities also affects quality of care in Ebonyi. For example, MCSP identified that facilities were not properly acquiring and utilizing chlorhexidine for newborn umbilical cord care (MCSP, 2019a). Access to medication in Ebonyi State is affected both by challenges in sourcing medication and challenges in transportation and delivery of medication to the appropriate health facilities. Inefficient distribution of drugs not only leads to wastage that negatively affects health facilities but can also lead to a lack of essential commodities in health facilities (Eneze et al., 2020). The USAID DELIVER Project, which was piloted in Ebonyi and Bauchi States between 2012 and 2014, established a Direct Delivery and Capture (DDIC) system in both states as a last mile delivery option to ensure adequate supply of commodities for family planning, maternal, neonatal, and child (MNCH) health, and malaria (USAID DELIVER, 2014). Before beginning the project, health facilities in Ebonyi experienced high stockout rates for these commodities; most facilities had stockout rates of 70% or above. After implementing the DDIC system, stockout rates dropped to less than 5% for all commodities by improving transportation and sourcing. After the two-year pilot under the DELIVER Project, the transportation network in Ebonyi remains in place and resilient, though it does face some challenges in managing factors related to time used to complete deliveries and delays (USAID DELIVER, 2015). There is some indication that health facilities in Ebonyi are only familiar with the DDIC system for commodity management, which indicates that, if and when systems are changed and updated, health workers will need increased training to ensure data quality in supply chain management remains high (UNFPA, 2018). At present, the USAID-funded GHSC-PSM project provides support in procurement and distribution of commodities for family planning, MNCH, TB, HIV/AIDS, and malaria in Ebonyi State. Information about stocking to provide a full mix of contraceptive methods in Ebonyi was not located during the course of this desk review.

Improving access to RMNCAH+N commodities is a key pathway towards achieving improved health outcomes for Ebonyi's citizens as it affects all aspects of private and public life. Key consumers of RMNCAH+N commodities, including women and adolescents, are disproportionately impacted by poor supply and management of these commodities, including modern contraceptives, preventative nutritional supplements and tetanus toxoid vaccines in pregnancy, and life-saving drugs during complications of pregnancy and delivery, such as uterotonics (UN, 2012). Thus, weaknesses in the supply chain for RMNCAH+N commodities often have a gendered impact, undermining women's and adolescents' ability to access crucial commodities and medication for maternal and reproductive health. Furthermore, while global evidence indicates providers' own beliefs about gender norms can impact the provision of RMNCAH+N commodities like contraception, there is a lack of evidence about how providers' beliefs affect contraceptive access in Ebonyi (Solo & Festin, 2019). It will be important for IHP to gain a deeper understanding of whether these biases exist amongst providers in Ebonyi to better promote the supply and provision of RMNCAH+N commodities.

2.6 Access to primary health care services: considerations for gender and social inclusion

Access for women and girls

Women in Ebonyi State still face immense challenges in accessing health facilities. Much of the challenge is linked to poverty and lack of financial assets. Seven in ten women of reproductive age in Ebonyi State have faced at least on major challenges in accessing health care (NPC & ICF, 2019). The most common challenge women faced in accessing health care was a lack of access to financial resources to pay for care (65.0%). The distance women have to travel to a health facility is also a barrier for around one-third of women. However, the desire not to go alone to the health facility and the inability to receive permission to attend to health services affect less than 10% of women.

A qualitative analysis of the factors influencing women's ability to access TB care in Ebonyi highlights many of the key access challenges women face in the State (Oshi et al.., 2016). For overall health care and for TB care, women report the need to seek permission from their husbands to attend to the health facility. There are indications that access to education also plays a role in reinforcing deep-rooted, unequal gender power relations affecting women's access to health care; women who had attained secondary education were more able to participate in decisions about seeking care in partnership with their husbands. For women with less than secondary education, they relied more strongly on their husbands to guide their decisions. Even widows are expected to obtain permission from their deceased husbands' families to seek health care. Permission-seeking is linked strongly to the need to request financial resources for health care; many women lack their own finances and need support from their husbands or families to pay for care. Even for those women who do work, they are most likely to be involved in low-paying subsistence farming and do not have disposable income for health care. Women must also weigh the opportunity costs of seeking healthcare as inconvenient clinic hours may prevent them from attending to their household responsibilities.

Formative research from the USAID-funded Fistula Care Plus (FC+) Project in Ebonyi identified a range of factors impacting women's access to fistula services in the State and also demonstrated successful efforts to improve access (Warren et al., 2016). Women experiencing fistula in Ebonyi described being negatively affected by fear, stigma, and shame, which, when coupled with low levels of knowledge about fistula and limited awareness about services, prevented them from seeking services. This aligns with earlier qualitative research in the State; women explained that one of the terms used to refer to fistula as a curse from God or a charm/poison (*"Nsi*"), and also reported that they sought care from a wide variety of sources, including TBAs, herbalists, and churches, before attending to health services (Emma-Echiegu, 2014). Some women also reported that they received counseling from health workers that fistula could not be repaired (Warren et al., 2016). Families, communities, and health care providers also exhibited low levels of knowledge about fistula. Implementation research from FC+ in Ebonyi indicates that addressing these barriers with mobile hotlines, strong networks of community volunteers, and transport vouchers can all increase access to fistula services and referrals for specialized care (Population Council, 2018). The program also targeted PHC providers, offering an initial training, supportive supervision, and refresher training, which included jobs aids and other reference materials. These trainings increased providers' knowledge of fistula; for example, in intervention facilities, the proportion of providers able to recognize leaking urine as a symptom of fistula doubled. The intervention facilities also saw strengthened referral

practices with 15% more of providers making referrals for fistula cases. Importantly, there were also significant reductions in women's perceived barriers to access to care, including feelings of isolation (9% reduction) and lack of support (30% reduction). IHP can consider replicating these approaches to address barriers to access to care both in the context of fistula and other RRMNCAH+N services.

As described, Ebonyi has a low rate of skilled birth attendance and low uptake of antenatal and postnatal care. Women in Ebonyi often rely on TBAs to provide care during and after pregnancy. Providing strong linkages between the provision of traditional medicine and health facilities can improve access to PHC. A recent randomized control study in Ebonyi assessed the impact of involving TBAs in the promotion of facility-based care (Chukwuma et al., 2019). TBAs were provided with monetary incentives for successful referral for maternal or neonatal postnatal care. The intervention increased postnatal care attendance by 15.4% for maternal care and 12.6% for neonatal care.

A pilot study evaluating the effects of a conditional cash transfer program on uptake of MNCH services in nine states of Nigeria, including Ebonyi, has shown promising, though preliminary, results (Okoli et al., 2014). In the pilot, PHCs were assigned to two intervention groups, one of which implemented a conditional cash transfer scheme, providing women who attended ANC, skilled delivery, and postnatal care with a cash entitlement of approximately $30 USD. PHCs in the other intervention arm received a standard package of supply upgrades, including improvements to infrastructure, commodities, and HRH. In facilities implementing the conditional cash transfer scheme, 85.4% of beneficiaries in Ebonyi returned to the health facility after one ANC visit, indicating some level of retention in care. Additionally, 89.8% of beneficiaries enrolled in PHC facilities with conditional cash transfer schemes returned to the PHC after their delivery for postnatal care. Across the nine states, retention in ANC improved as did skilled delivery in the PHCs implementing the conditional cash transfer program. Both intervention groups saw steady increases in the number of women attending first ANC visits. In facilities implementing the conditional cash transfer scheme, there was a significant increase in the average monthly demand for services (increase of 15.11 visits per 100,000 population) and retention in services (increase of 21.66 clients per 100,000 population), while there was not a significant increase in demand or retention in the facilities only receiving supply upgrades. The conditional cash transfer scheme did not have a statistically significant effect on increasing skilled delivery; however, in the facilities receiving the supply intervention, there was a significant increase in skilled deliveries after the intervention began (increase of 15.04 deliveries per 100,000 population). This suggests the need to consider and select the interventions implemented to increase access in alignment with the targeted outcomes.

Access for men and boys

There is a distinct lack of information about men's and boys' abilities to access health services in Ebonyi. Norms across Nigeria and in Ebonyi often deter men from seeking services for their own health or from prioritizing their own health (Voices4Change Nigeria, 2015). This is linked in part to the focus given to women and children in health systems at both the federal and state levels. Analysis of TB treatment and care in Ebonyi emphasizes the gendered difference in care-seeking in the State (Oshi et al., 2015). Males not only have a higher burden of TB in the State (aligning with global TB trends), but they are more likely to experience adverse treatment outcomes. Treatment failure is more than twice as common in male TB patients than in female TB patients. When comparing male and female TB patients who are being re-treated, men are much more likely to default on their treatment, meaning they did not continue care.

Men's lack of access to health care for themselves also has effects on their families. Male partners are generally expected to care for their families, including paying for health services. Fathers are responsible

for allocating resources to care for their children, and often make decisions related to when and where health care is sought (Dougherty et al., 2020). However, facilities are not designed to meet the needs of men as clients or as supporters of their families' health, and their involvement in care is limited to these roles as decision-makers and financers and not active participants in their family's health.

Increasing men's involvement in health services has promising results for their own health and for the health of their families and communities, including increased use of services, positive health behavior change, and increased emotional support (Doyle et al., 2018; Levtov et al., 2015). A review of evidence from low- and middle-income settings indicates that men desire to be involved in family planning programs, and men respond positively to programs that include them (Hardee et al., 2017). Encouraging men's participation in health services includes ensuring health facilities are designed to include men with safe and more appealing spaces (e.g., waiting rooms, male-friendly spaces, private delivery areas so men can attend with their partners) (The Partnership for Maternal, Newborn and Child Health, 2013). In Tanzania, facility-level approaches to engage men and provide male-friendly health services saw improvements in men's health care access and utilization, and there was also increased satisfaction among men and women (EngenderHealth, 2014). Approaches included capacity building for staff members for skills and referrals to male-friendly care, infrastructure developments, the development of communications materials, community-level outreach and education, and the inclusion of men in health planning and policy. However, unintended consequences must also be avoided when considering male engagement approaches; for example, the practice used in some countries of prioritizing couples over single women in ANC has had negative unintended consequences on health access for women. This evidence will be important to consider as IHP plans for efforts to include men in RMNCAH+N services.

Access for adolescents and youth

In general, adolescents in Ebonyi face high barriers to accessing health services, especially to receive sexual and reproductive health (SRH) information or services. Many of these are linked to cultural taboos about sexuality. Qualitative research in six LGAs in Ebonyi State identified a constellation of barriers across the socio-ecological model preventing youth and adolescent health access (Ezenwaka et al., 2020). At the individual level, youth and adolescents tend to have low levels of awareness and knowledge about SRH, and this feeds into fears associated with the side effects of contraceptives. Cost is often an insurmountable barrier to health access for youth. These factors are compounded by low self-esteem and lack of confidence to seek care.

Low awareness and knowledge have been linked to low uptake of health care amongst adolescents. Quantitative analysis of secondary school students' knowledge of contraceptives in Abakaliki indicates that around two-thirds of students, both male and female, were aware of what contraceptives are (Ossai et al., 2019). Of those students who were aware of contraceptives, around half learned about them in school. There were low rates of contraceptive utilization when compared to rates of sexual activity; around one in five students were sexually active, but only one in ten had used contraceptives. Males were more likely to use contraceptives, which is likely because external condoms are most popular among adolescents. In addition, older students were more likely to use contraceptives, likely due to the increased autonomy due to their age. Youth in Ebonyi also have limited knowledge and misperceptions about STIs, including HIV, which prevent them from knowing or using prevention measures (Agu et al., 2020).

Because schools are a key socializing institution for youth, and also a main source of SRH knowledge, interventions in Ebonyi have evaluated the provision of health education and services at schools (Madubueze, 2018). A recent quasi-experimental study amongst public secondary school students in

Abakaliki evaluated the impact of peer education and offering onsite HIV counseling and testing services. Peer educators were trained on sexual health and HIV prevention approaches, and health workers were provided with training on youth-friendly care to offer on-site counseling and testing. From baseline to endline, the proportion of students in control schools who were sexually active increased by 20%, while in the intervention group there was only an increase of 1%. Students in the control group also saw increases in the frequency of sexual relationships and number of sexual partners, while the intervention group did not. At endline, students in the intervention group were more likely to have used condoms at last sex and to have consistently used condoms. There was also an increase in the willingness to test for HIV and actual testing for HIV in the intervention group, with most accessing testing at the on-site adolescent-friendly center. Students preferred using the center in their school because it was convenient, accessible, and they faced less stigma. Most students in the intervention group chose to access testing on the recommendation of a peer educator. This evidence can be useful as IHP considers opportunities to improve youth and adolescent access to and utilization of PHC services and, ultimately, improve adolescent and youth health.

A recent cross-sectional survey of adolescent (under 19 years) street hawkers in Abakaliki identified prominent barriers preventing them from accessing care (Elom et al., 2019). The largest barrier identified was a lack of knowledge about the services available, followed by perceived poor quality of services, lack of confidentiality and privacy, inconvenient hours and long wait times, judgmental staff attitudes, among others. When comparing male and female adolescents, lack of knowledge was more likely to serve as a barrier to access for males, while females were more strongly affected by facility location, lack of privacy and confidentiality, community norms about SRH services, and embarrassment about accessing services.

At the interpersonal level, limited parent-child interactions undermine youth's ability to seek care, which is often due to parents' belief that their children should not need SRH services (Ezenwaka et al., 2020). At the community level, norms about gender intersect with norms about youth, with community members holding the view that adolescent girls seeking SRH care are "wayward;" communities also shame adolescents who are seen to be sexually active. Religious teachings about abstinence are also a barrier to care for unmarried adolescents, as are misconceptions that contraception can cause infertility or other negative side effects.

An analysis of first-time young parents in Ebonyi revealed that parents and older family members have a strong influence on adolescents' ability and decisions to access health care (MCSP, 2018a). Parents can act as either barriers or facilitators to care; adolescents report that they often need permission to seek care from parents, and when parents are informed about the benefits of care, they are likely to advocate for access. The lack of financial independence is also a large obstacle to adolescents who wish to seek health care. Adolescents are rarely economically independent or engaged in any economic activity. For young mothers, limited financial resources often push them to use TBAs for pregnancy and delivery because of the lower costs associated. The male partner's role as decision-maker can be especially pronounced for adolescent girls, particularly when large age gaps exist between partners.

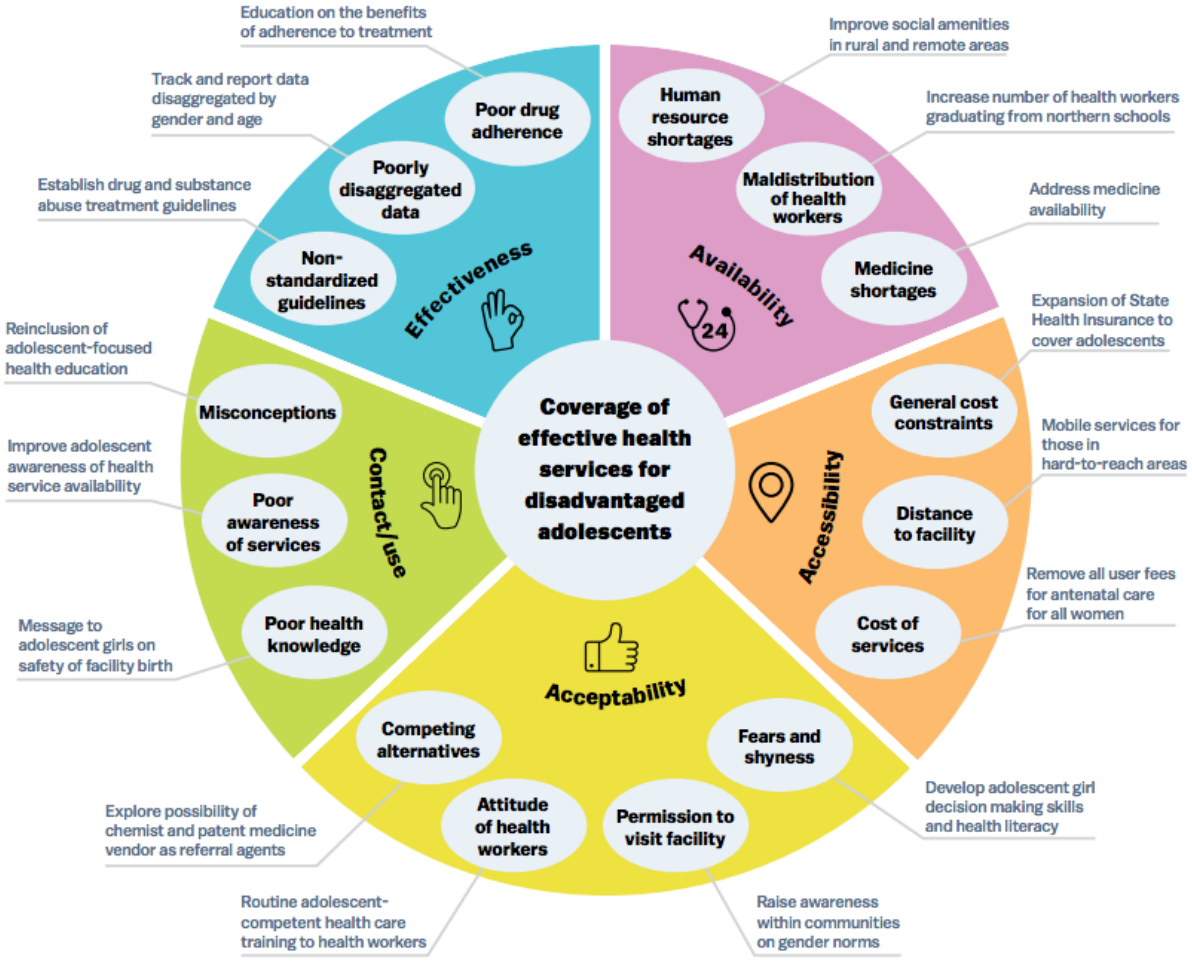
At the organizational level in Ebonyi, there are pervasive negative attitudes amongst health workers about unmarried adolescents and youth who seek SRH care (Ezenwaka et al., 2020). Adolescents have been shamed by health workers and have also been refused care. This is linked to a lack of privacy and confidentiality in facilities, which prevents youth from choosing to seek care. There has been limited support to date to establish youth-friendly centers or to train providers on youth-friendly care in Ebonyi. There is a lack of information about the level of youth-friendly care in Ebonyi. There has been at least on youth-friendly health center in the State located at Ebonyi State University Teaching Hospital in Abakaliki;

however, it has not been well utilized and even students at the university are unaware of its existence (Agwu et al., 2009). Societally, peers and social media may discourage adolescents from using contraceptives, relying on message about shame and sex. Schools often provide limited sexuality education, which is especially troubling given how many students report that school is their primary provider of SRH knowledge. Finally, there are no social networks or community support mechanisms for adolescents to access when they need health information.

Recent analysis from Ebonyi, which is still undergoing peer review, indicate that only 10% of in-school and out-of-school youth ages 13-18 in Ebonyi had access health facilities for SRH information or services (Okeke et al., 2019). Adolescent girls were slightly more likely to access health facilities for services, but less likely to seek out SRH information. Though this has a stark impact on the health of adolescent girls, adolescent boys are also negatively affected by norms about adolescence and health. Adolescent boys are more likely to seek information from health facilities and less likely to seek SRH services.

Emerging research from the WHO and the FMOH has identified the main barriers to health service coverage for adolescents in Nigeria, and also includes interventions targeted to overcome these barriers (WHO Regional Office for Africa, 2019). The analysis included key informant interviews with national-level stakeholders, but focused local data collection efforts in the other geopolitical zones of the nation. More information is needed to determine the applicability and relevance of these barriers and the associated interventions in Ebonyi. The figure below (Figure 1) provides a summary of these national-level barriers to access organized around WHO's pillars of youth- and adolescent-friendly health care.

Figure 1: Barriers to health service coverage for adolescents and suggested interventions in Nigeria



Note. Reprinted from *Assessment of barriers to accessing health services for disadvantaged adolescents in Nigeria*, by WHO Regional Office for Africa, 2019. Creative Commons License: CC BY-NC-SA 3.0 IGO.

Access for vulnerable or marginalized groups

The availability of services to meet the needs of vulnerable and marginalized groups is a key factor affecting access to PHC services in Ebonyi, and IHP should consider those groups most impacted by barriers and how to address those barriers in its programming. Health services in Ebonyi are largely inaccessible for PWDs due to gaps in infrastructure and the services offered in PHCs (Pappa, 2019). Additionally, providers in PHCs demonstrate gaps in knowledge about the needs of PWDs. A mixed methods analysis of the experience of older adults (above the age of 60 years) in Ebonyi reveals a number of health access challenges (Mbam & Emma-Echiegu, 2018). The distance to facility and high cost of services had profound detrimental impact on older adults' ability to access health services, especially for those living in rural areas. Older adults also displayed a strong preference for traditional medicine over formal health care. The gender of health care providers also affected older adults' comfort in attending care; older women preferred to speak with female providers, and older men preferred male providers.

2.7 Quality of primary health services: considerations for gender and social inclusion

There are a variety of factors undermining the quality of health care in Ebonyi, including a lack of providers, poor infrastructure in facilities, and inadequate health financing. The quality of care is inextricably linked to access to care. As described, many groups, including women, men, girls, and boys, are deterred from accessing health care due to its quality. Evidence from across Nigeria and in Ebonyi also demonstrates that quality of health care is deeply tied to beliefs and norms about gender, adolescence, and sexuality (MCSP, 2019b). These beliefs influence health workers' attitudes and ability to provide inclusive care and may also manifest in abuse in the health system (e.g., obstetric violence) or the denial of services (e.g., adolescent contraceptive access). Addressing these factors will be important to IHP and its partners ability to improve quality of PHC services.

Global evidence and evidence from Nigeria suggest perceived quality of care, including the provision of respectful care, is a key factor influencing the decision to seek RMNCAH+N services. In rural PHCs in Edo State of Nigeria, a cross-sectional survey of community members found that perceived high quality of care is a motivator to seek skilled delivery and antenatal care, while perceived low quality of care deters women from seeking these services (Okonofua et al., 2018). It is important to note that population perceptions of quality may differ, with individuals assigning different priorities to communication, facility environment, health workforce training, or other features. Survey data collected from community members in Imo and Enugu States in the South East Zone, where Ebonyi is also located, demonstrated significant associations between perceptions of the quality of services and actual use of those services; community members who perceived services to be of high quality were more likely to utilize those services, and facilities offering a broader range of services (an indicator of quality) were also given higher ratings and had higher service utilization (Onyeneho et al., 2016). In Ethiopia, for example, indicators of quality of care, including the availability of supplies, the education level of provider available (with a preference for doctors over CHEWS), and receptive and respectful provider attitudes, were most likely to influence a woman's choice to use a health facility for delivery (Kruk et al., 2010). There is similar evidence from Tanzania, where the most impactful predictor of facility preference was kind, respectful treatment from a doctor; further, factors relating to the technical and interpersonal quality of care were more highly prioritized than service inputs or infrastructure (Larson et al., 2015). Analysis of the impact of quality of care on utilization of services in Haiti found stronger positive effects in rural areas and weaker effects in urban areas (Gage et al., 2018). In rural areas, quality of service delivery and quality of infrastructure was strongly associated with the utilization of PHC services, including skilled delivery.

MCSP completed a quality of care baseline assessment in Ebonyi and Kogi States, which identified constraints and barriers to the provision of high-quality care in MNCH (Oduenyi, 2017). Many of these findings are critical to consider when addressing quality of care in IHP. Women are not usually expected to get fully acquainted with health providers as only 12% usually introduce themselves while giving care. Very few women are asked about how they want their ANC sessions to take place, including if they would want their partners to be available during sessions. Only 3% of women are asked who would be making decisions about their care. 63% of health care providers engaged in at least one harmful practice; some clients are shouted at and not properly attended to as well as some services denied based on personal beliefs. About 23% of providers are likely not to give unmarried clients family planning because of their beliefs.

The baseline identified promising evidence that most health workers in Ebonyi believe men should be included in RMNCAH+N care; however, this belief rarely manifests in practice as only 10% of health workers reported asking women if they would like a male partner involved in ANC (MCSP, 2019b). However, none of the health workers in the baseline provided information on GBV or referrals for GBV survivors. Only one in ten providers believe a woman should be given the right to choose contraception on her own.

There is also evidence to suggest low quality of postnatal care for both maternal and neonatal patients (Chukwuma et al., 2019). A recent intervention in Ebonyi relied on providers in PHC to provide postnatal care after receiving referrals from TBAs. However, providers neglected to cover a number of critical components of postnatal care, such as assessing for fever or hypothermia, which is especially concerning given the referred patients had home births. Parents rarely receive information about the care being provided to their newborn, and many providers engaged in harmful practices (e.g., slapping newborn, holding newborn upside down) or did not promote skin-to-skin contact for newborns (Oduenyi, 2017).

The inability to provide appropriate commodities also affects quality of care in Ebonyi. For example, the inability to stock and use chlorhexidine in facilities has undermined the quality of newborn care in the State (MCSP, 2019a). With a package of trainings (pre-service and in-service), operational plans, and monitoring plans, MCSP was able to increase chlorhexidine usage in supported facilities to 75% in 2018. This demonstrates a need to link systems-level supply chain improvements to better monitoring, management, training, and use of medicines at the facility-level.

An observational study of labor and delivery units in Ebonyi highlighted that hygiene negatively affects the quality of care in facilities (Buxton et al., 2019). Providers in the labor and delivery units rarely adhered to principles of hand hygiene, which place mothers and newborns at risk for infection that can lead to morbidity and mortality. There was a higher level of vaginal examinations and other invasive procedures than necessary which can also lead to infection.

The lack of ongoing training and supervision in Ebonyi is a critical factor undermining the quality of care in PHCs (Oduenyi, 2017). Only three in ten providers have received any sort of training in the last three years. Of those providers who do receive training, only one-third are trained on any issues related to gender, GBV, or human rights. While eight in ten health providers receive some level of supervision or support, this still represents a gap in oversight. There is also a gender gap in supervision; while most health providers are female (74%), a smaller proportion of supervisors are female (57%). While the implications of this imbalance for health workers have not been analyzed, it is representative of the overarching imbalance of women in leadership positions in health in Ebonyi. Seven in ten providers feel that they have equal opportunities when compared to providers of the opposite sex.

This desk review did not locate any Ebonyi-specific policies or guidelines governing the provision of gender-sensitive, adolescent-friendly, or other forms of inclusive health care. Providers are largely unaware of gender-related provisions and policies at the national level (Oduenyi, 2017). Providers in Ebonyi were not familiar with guidance on respectful maternity care, nor did they know national guidelines and referral standards for GBV. They were also not aware of the national VAPP Act (this analysis took place before the domestication of the VAPP in Ebonyi). This will be an important gap to address, and actors in Ebonyi, including IHP and its partners, can consider the adoption and adaptation of policies, guidelines, and strategies for quality improvement that are gender-sensitive and socially inclusive. The *National Strategy for Reproductive, Maternal, Newborn, Child and Adolescent Health Quality of Care in Nigeria*, developed by the FMOH and finalized in 2017, is the national-level document guiding quality of

RMNCAH care in Nigeria (FMOH, 2017). The strategy is focused predominantly on maternal and neonatal health and while it embraces principles to provide equitable care regardless of gender, ethnicity, race, geographic location, or socioeconomic status, there are not provisions promoting gender-sensitive, respectful, or adolescent-friendly RMNCAH. In considering the adaptation of this strategy to the Ebonyi context and the development of additional quality improvement policies and guidelines, IHP, its partners, and actors can incorporate specific lines of action, including indicators for measurement, relating to gender and social inclusion in quality of care.

However, efforts have been made in Ebonyi to promote the provision of gender-sensitive care, and IHP, partners, and Ebonyi State actors can build on these efforts to improve quality of care. MCSP, in close collaboration with ESMOH, utilized the Health Workers for Change (HWFC) approach, which uses a social and behavior change model to promote gender-sensitive and respectful care in PHC providers in Ebonyi (MCSP, 2019b). HWFC has achieved robust results across sub-Saharan Africa, and there are promising results from its implementation in Ebonyi. Providers involved in the training reported being more aware of their own biases and adopted more respectful and inclusive care practices after the training. Providers also identified and implemented facility-level changes after the training, including the creation of labor and delivery wards that offered women more privacy and allowed their partners to accompany them in the ward.

The HWFC approach was implemented in tandem with other quality improvement efforts in the State, including developing quality improvement plans (MCSP, 2020). At the PHC level, providers were offered on-site and off-site quality improvement training, supportive supervision, continued skills training, and support for the collection and use of relevant data for decision-making (MCSP, 2018b). In facilities receiving this collection of interventions, providers not only improved their counseling in ANC on birth preparedness, post-partum family planning, and preventive treatments but also saw increases in their ability to provide quality labor and delivery care (MCSP, 2020). UNFPA has also developed and implemented a standardized training curriculum for skills-based training on the insertion of long-acting reversible contraceptives (LARCs) in Ebonyi, but this desk review did not identify any publicly accessible evaluation data on the outcomes of this training program (UNFPA, 2018).

In addition, MCSP focused on improving quality of care through male engagement and supportive services for GBV survivors (MCSP, 2018c). A selection of providers were trained on male engagement, and some facilities were provided with privacy screens to encourage male companionship during delivery. Facilities were also provided with communications materials promoting the role of men in family planning, ANC, labor and delivery, and the health of their families and children. Training also focused on the provision of first-line care and referrals for GBV survivors. Those providers were trained to cascade their knowledge; it will be important to understand to what extent this dissemination of knowledge has continued.

After the completion of MCSP efforts in Ebonyi, some quality of care features still remains as challenges (Oseni et al., 2019). The quality of infrastructure and availability of supplies for ANC is still a concern in many PHCs, including the provision of vaccinations for pregnant women. Many facilities still need delivery units that protect privacy and allow for companionship during delivery. There is also room for improvement to include men in family planning outreach and provide access to a full spectrum of family planning options. Finally, facilities in Ebonyi still face challenges in collecting, visualizing, and using data for decision-making.

2.8 Stakeholder mapping and review of previous gender, social inclusion, and community engagement efforts in Ebonyi

During the desk review, IHP identified those stakeholders working in gender, social inclusion, and community engagement in Ebonyi. Establishing linkages and partnerships with these actors will be critical to ensuring the success of IHP's approaches and also to promoting local ownership and sustainability.

Table 6: Stakeholders working in gender, social inclusion, and community engagement in Ebonyi

Organization	Area of Focus	Current activities
Women Aid Collective (WACOL)	Women, Gender, Community Mobilization, GBV	Legal aid and counseling, training and sensitization for community/government stakeholders on GBV and women's empowerment.
Catholic Diocese of Abakaliki Succour and Development Services Initiative (SUCCDEV)	HIV/AIDS, Gender and Community Mobilization	Training and community sensitization for traditional, community, and religious leaders on GBV; vocational skills training for vulnerable women.
The Civil Resource Development and Documentation Centre *(*CIRDDOC*)*	Women's empowerment, FGM, Gender Policy, Spotlite Initiative partner	Sensitization and trainings of stakeholders on FGM/C and GBV.
Society for Improvement of Rural People (SIRP)	Community Mobilization, Gender, Women empowerment	Vocational training for vulnerable women.
International Federation of Women Lawyers (FIDA)	GBV advocacy and prosecution	Legal counselling and aid for GBV survivors; training on legal instruments used for prosecution of GBV cases.
Family Reformation & Community Development (FARECOD) Initiative	Gender, GBV	Collaboration with ESMOWSD to offer vocational skills
Neighborhood Initiative for Women Advancement (NIWA)	Women's empowerment	Vocational Skills training for women, GBV services which includes legal aid/counselling.
Initiative for Social Change in Africa (VOFCA)	Youth and Community Mobilization	Training and technical support on GBV response including medical and legal. Technical support to some local CSOs like CIRRDOC on GBV response.
UNFPA	FGM, Gender, Reproductive Health, Spotlite Initiative partner	Rural sensitization on GBV and facilitate survivors to get legal aids

Mediating for the Less Privileged and Women Development (MEWOOD)	OVC, HIV/AIDS, GBV	Vocational Skills training for vulnerable women.
Economic and Social Empowerment of Rural Communities (ESERC)	Youth and Community Mobilization	Sensitization on Child Labour and Abuse. Child Defilement Response at State and community level.
Destiny Daughters Initiative of Nigeria (DEDAN)	Women's empowerment	Current activities
Hope for Girl Child Initiative (H4G)	Community mobilization	Legal aid and counseling, training and sensitization for community/government stakeholders on GBV and women empowerment.

3. DISCUSSION AND RECOMMENDATIONS

Though southern Nigeria tends to perform better than the rest of the nation on most health indicators, Ebonyi State stands out as an exception, with poor health and social outcomes. With an increasingly young population, high levels of poverty, and limited economic opportunities, the State faces a number of challenges in improving the health and overall wellbeing of its residents. Power dynamics and entrenched gender norms mean that many women in Ebonyi face obstacles exercising autonomy about choice of sexual partner, contraception, number and spacing of children, and healthcare, each and all of which increases their risk for high-risk pregnancies, maternal deaths, infectious diseases, and exposure to violence. Other vulnerable and marginalized groups in the State, including youth and adolescents, survivors of GBV, impoverished populations, and PWDs, face barriers to social inclusion and, as a result, limited access to health services. Existing evidence suggests poor distribution of health services and providers, high cost of services, and low quality of services prevent residents of Ebonyi from accessing care, with an increased impact on women, girls, and vulnerable groups. Much has been done in Ebonyi to address these factors, with promising results, but sustained efforts are needed to ensure long-term progress.

3.1 Discussion of research questions

This analysis was guided by initial research questions, which were designed based on prior gender and social inclusion desk reviews conducted in IHP TOs 03, 04, and 05 (Bauchi, Kebbi, and Sokoto States, respectively). Through the collection and analysis of documents, the desk review answered the following research questions:

How will the different roles and expectations of men, women, and youth facilitate or hinder IHP objectives to strengthen the health system and improve quality of and access to PHC health services in Ebonyi?

The different roles and expectations of men, women, and youth have great influence on health access and outcomes in Ebonyi. Evidence suggests that women in Ebonyi have limited access to assets and financial resources, and also experience concerning levels of controlling behaviors in marital relationships. Women face restrictive norms that limit their ability to make decisions about their own wellbeing, finances, and

health. Women's subordinate status also exposes them to risk of GBV, and Ebonyi has some of the highest levels of sexual violence in the country. While men have greater decision-making power and access to resources, the limited evidence available suggests that norms about masculinity deter men from seeking health services and can also encourage them to participate in high-risk behaviors like unprotected sexual activity. Youth in Ebonyi have few opportunities for education or economic independence and have limited knowledge of and access to health services, especially for sexual and reproductive health services. IHP will consider and act upon these different roles and expectations as it provides technical assistance to the State, offering targeted capacity building approaches to enhance access to and the quality of services to empower women, meet the unique needs of men, and offer inclusive care for youth and other marginalized groups.

What are the underlying causes of gender and social inclusion challenges? How will underlying causes of these challenges, including societal and cultural factors, facilitate or hinder IHP objectives?

Existing evidence, though limited, indicates that traditional norms, beliefs, and practices are strong contributors to the gender and social inclusion challenges identified in this desk review. Subjugated within a patriarchal cultural environment and without the autonomy to make decisions or finance their own health and livelihoods, women are held back from making progress and maintaining their own health. From the health systems level, women and other marginalized persons are often not included in planning and decision-making, nor are their perspectives considered, which undermines the ability for health systems leaders and decision makers to further policies and plans that are gender-responsive and socially inclusive. Norms that place men in a decision-making role at the household level also undermine women's ability to access healthcare for themselves and their families. Stigma about GBV further prevents survivors from accessing services, resulting in negative physical and psychosocial health outcomes. Religious beliefs contribute to gender norms and beliefs in Ebonyi and have been shown to play a dual role, both in enforcing restrictive gender norms but also in influencing progress towards gender equity; additionally, in Ebonyi, the church and religion have been cited as deterrents to health access. These deep-seated norms and beliefs also affect the quality of care offered in the health system and can prohibit providers from offering a full range of services or from providing gender-sensitive, inclusive care, resulting in low levels of health utilization. For example, providers' beliefs about who should be able to access family planning negatively affect unmarried women and adolescents. These norms can undermine efforts toward gender equality and social inclusion, ultimately resulting in practices that inhibit equitable and inclusive health access and outcomes. In recognition of these norms, beliefs, and practices, IHP, in coordination with BA-N and other actors, will facilitate linkages between PHC facilities and women's empowerment groups, religious leaders, and male champions to promote positive norms that improve access to PHC services.

How does male engagement in health seeking and service utilization influence women's and children's access to health services and health outcomes?

At present, there are still gaps in knowledge about the influence of male engagement in the health system in Ebonyi. There is some indication that women are reliant on male family members to access health services for themselves and their children. Men's opinions, knowledge, and control of resources also influence whether a woman accesses ANC or care for a sick child. Men are not proactively included in family planning and reproductive health and, if they are, providers may reinforce negative norms and stereotypes that place decision-making in the hands of men. IHP will incorporate strategies to engage men in the health system, including training on gender-sensitive provision of care for providers and identifying male champions, to strengthen men's support of greater women's empowerment and increased attention to their families' health, increase men's access to health services, and improve the quality of care men receive.

How might the anticipated results of IHP interventions affect men, women, and youth differently?
With well-designed, targeted, and inclusive interventions, the anticipated results of IHP interventions in Ebonyi will have equitable impacts for women, men, youth, and other marginalized and vulnerable populations, decreasing health disparities and promoting women's empowerment, gender equity and social inclusion. As the program aims to address and reduce leading causes of maternal and child morbidity and mortality, there is risk of reinforcing the notion that the PHC health system is designed only to meet the needs of women and children. Furthermore, efforts to promote reproductive and maternal health may exclude or not meet the needs of youth and adolescents, who can face stigma and bias from providers in accessing this care. Importantly, rural populations and PWDs face increased challenges in accessing health services, which could restrict them from accessing the benefits of IHP's approaches. However, in recognizing these potential risks, IHP will plan for inclusive and equitable approaches that deliver results that reach even the most vulnerable and marginalized through capacity building for providers and implementing partners and technical assistance to advance gender equity and social inclusion in State level policies and practices.

What are potential evidence-based strategies and approaches to respond to the identified gender and social inclusion related constraints and opportunities? Where have gender and social inclusion related interventions been most effective in strengthening health systems for sustained access to and quality of PHC services?
This desk review identified a range of evidence-based strategies and approaches to respond to gender and social inclusion constraints and opportunities, offering insights on where these have been most effective in strengthening health systems to sustain access to and quality of PHC services. Promising, evidence-based approaches to promote gender equity and social inclusion in the health system include adopting transparent, equitable mechanisms for HRH production and retention and improving commodity supply chains to offer a full range of contraceptive options. To promote access, involving influencers and positive deviants, including religious leaders and male champions, has been demonstrated to increase women's and communities' access to health services. Additionally, harmonizing health messaging that beneficiaries receive in their communities and from health facilities has successfully increase health knowledge for women, men, girls, and boys, thus improving health access. Finally, complementing clinical training with training on approaches for gender sensitivity and inclusion in service delivery has shown promising results in advancing both quality of and access to health services. IHP will build on this evidence, offering tailored technical assistance to the State to implement these effective, evidence-based approaches.

3.2 Recommendations

Based on the findings of this rapid desk review, several recommendations become clear to build upon opportunities in Ebonyi to advance gender equity and social inclusion in strengthening the health system and improving access to and quality of health services. These actionable recommendations are not for IHP to address alone, but rather are suggestions for the Federal and State Governments, USAID, IHP and other implementing partners in support of overall improved health outcomes for all, with an emphasis on women and marginalized persons. These recommendations will serve as the foundation to inform the development and implementation of an operationalized State-level strategy for gender equity and social inclusion. With each recommendation, the authors have provided examples of measurements of success. IHP will provide technical assistance in facilitating State strategies that include outcome indicators that demonstrate results.

- **Use sex- and age-disaggregated data and gender-sensitive indicators to inform more effective leadership and governance and improved health information systems.** While the policies reviewed in this analysis suggest Ebonyi State has made progress toward collecting and using sex-disaggregated data, there is room for continued improvement and a need for the collection and use of age-disaggregated data. Additionally, those policies that require the collection and use of sex-disaggregated data do not provide details on which indicators should be sex-disaggregated or how the data should be used for decision making. There is also a lack of evidence about how NHMIS data collection and reporting tools are used at the facility-level, and this desk review did not locate evidence about how these data are used or if they are indeed collected. The collection and use of such data are essential to identifying key gender and social inclusion challenges and opportunities to design and implement efficacious and sustainable interventions. Collecting gender-responsive and socially inclusive data from the onset of a project allows for the establishment of a baseline to inform the development of meaningful and feasible targets and allows for an endline analysis to measure the success of the intervention. Further, it can enhance ongoing monitoring and evaluation processes, help identify access barriers and which populations they affect, and increase funding opportunities through evidence-based efficacy analyses. IHP, through its own interventions and technical assistance, will build capacity to collect, analyze, use, and report sex- and age-disaggregated data. By coaching providers and facility managers to collect and apply age- and sex-disaggregated data, the State will be enabled to use evidence to improve existing policies and plans and mainstream GESI where applicable, establish more accurate benchmarks against which to measure improvements and outcomes, guide interventions so that they are unique to the target populations to which they are directed, and to strengthen the health system to be responsive to need and relevant to context. Successful achievement of this recommendation would be demonstrated through the institutionalization of sex- and age-disaggregation of data and the establishment of gender-sensitive indicators in health information systems, including facility registers, and through providers' demonstrated practice of recording sex- and age-disaggregated data.

- **Continue State-level support for gender-responsive and socially inclusive policy development, implementation, and budgeting to improve service delivery, leadership and governance, and health financing.** The Ebonyi State Government has made great strides in the development of gender-responsive and socially inclusive policies and plans, as evidenced in the domestication of national legislation and the integration of gender-responsive activities in the health sector. IHP will continue to catalyze progress in the development of these policies and encourage the domestication of other pieces of national legislation and guidance covering care for adolescents and PWDs (e.g., National Policy on the Sexual Reproductive Health of Persons with Disabilities with Emphasis on Women and Girls). Ebonyi faces greater challenges in the implementation of policies and plans, including budgeting and spending. IHP's technical assistance efforts will develop the State's capacity to plan for the implementation of all activities in the AOP, including those designed with a gender and social inclusion lens. Planning efforts can also ensure that commitments to gender and social inclusion are manifested in specific lines of action to address those commitments. State-level actors can continue the work of the HP+ Project to support the State in mobilizing resources to fund health policies and actions that increase quality of and access to care for women, men, girls, boys, PWDs, and other vulnerable groups and ensure funding is allocated to cover costs for ANC and postnatal care. Mobilizing resources in the State can help address the current gaps in budgets and expenditures toward health and gender-related activities. Health financing capacity-building efforts can also include efforts to promote GRB, ensuring that efforts to address gender equity and social inclusion received budget. Finally, while

there is some progress towards gender-sensitive monitoring and evaluation, IHP will leverage the increased emphasis on the collection of sex- and age-disaggregated data and other gender-responsive and inclusive indicators. Beyond the collection of this data, IHP technical assistance can provide support to use this data for decision-making and planning. To measure the success of these efforts, the State can evaluate whether policies include not only initiatives to directly address gender inequities but also include budget-supported strategies for implementation. This could be assessed using a contextually adapted version of the policy checklist employed in this desk review.

- **Promote gender balance and gender-sensitivity across the HRH pipeline to strengthen the health workforce.** Ebonyi faces steep challenges in addressing its low supply of HRH in the State. In addressing these concerns, IHP will provide technical assistance, in collaboration with the newly initiated Nigeria Health Workforce Management Activity, to promote gender balance and gender-sensitivity across the HRH pipeline – in education, recruitment, retention, training, management and supervision, and promotion. Global evidence demonstrates that women face unique barriers in each of these phases of the pipeline that can cause them to exit the workforce (Newman et al., 2012). Key actors in the State, including the Ebonyi State Ministry of Education, should work to increase the supply of women in the health field by promoting girls' retention in education and involvement in science, technology, engineering, and mathematics (STEM). These actors can also improve working environments to attract and retain health providers by promoting the development and adoption of institutional policies and practices that address barriers to employment for women and other vulnerable groups. An important opportunity to address gender in HRH is the development of the State-level HRH Strategy, which will be linked to the existing HRH Policy. The HRH Policy recognizes some gender barriers in HRH but misses opportunities to address gender in the distribution of the health workforce, practices to promote retention, and techniques for management and supervision. IHP will also provide technical assistance to support the State to follow-through on the HRH Policy's commitment to collect sex-disaggregated HRH data and to design and collect gender-sensitive indicators in the Monitoring, Evaluation, Learning, and Accountability plan. Promoting gender balance and gender-sensitivity across the HRH pipeline can also help address challenges to health access (e.g., ensuring patients have access to a provider of the gender of their choice) and challenges to quality of care. Furthermore, encouraging increased supply of women across the HRH pipeline can both advance economic opportunities and empowerment of women and increase the number of women available for selection for decision-making and leadership positions. The State can measure the success of these efforts by assessing for an increased gender balance in the recruitment, distribution, and retention of HRH and by monitoring changes in the representation of women in decision-making and leadership positions.

- **Reinforce health systems' and facilities' abilities to stock a full range of RMNCAH+N commodities to improve access to family planning options and essential medicines.** Ebonyi has made progress towards constructing a robust supply chain for essential commodities. In collaboration with GHSC-PSM, IHP will provide technical assistance to the ESMOH, ESPHCDA, and LGHA leadership to reinforce existing systems to ensure PHCs are able to maintain stock of a full range of RMNCAH+N commodities. This is especially important in the context of contraceptive provision. Evidence demonstrates that women in Ebonyi have strong preferences about the types of contraceptives that are preferential and acceptable to them. In order for facilities to increase contraceptive coverage, PHCs must offer a mix of contraceptive methods to respond to these preferences and provide a range of acceptable options. Guaranteeing true, informed choice in

contraception has been identified as an important approach to increase contraceptive coverage and also reduce threats of harm and coercion in the health system (Sonfield, 2017). Improving the supply of commodities should also be linked directly to increasing training for providers on contraceptive and family planning promotion, counselling, and provision, and addressing provider and other common biases to encourage informed choice and uptake. The State can measure success by enumerating the number of facilities maintaining consistent stock of RMNCAH+N commodities.

- **Identify opportunities to engage with religious leaders and traditional medical practitioners at the facility level to improve access to and utilization of health services.** Religious leaders and traditional medical practitioners, including TBAs, carry great influence over health-seeking behavior and health access in Ebonyi. Evidence suggests that many women and men in Ebonyi prefer accessing traditional medicine, and there are strongly held beliefs linking maternal health to religion. IHP will identify opportunities to engage with religious leaders and traditional medical practitioners, including TBAs, as part of Facility Management Committees (FMCs), WDCs, and Quality Improvement Teams and in facility-based outreach and awareness raising efforts to address barriers to access to and utilization of RMNCAH+N services in PHCs. This will help ensure the availability and use of high impact PHC services for women (e.g., modern contraceptives, early ANC, facility delivery, postnatal care). IHP will collaborate with BA-N to ensure these facility-level efforts complement BA-N's demand-side activities to promote harmonized and consistent approaches and messaging in the State. As described, engaging TBAs in referrals for postnatal care has proven to increase postnatal care attendance in Ebonyi. Evidence from the Nigeria Urban Reproductive Health Initiative, which worked in four states, indicates that women are more likely to uptake contraception when exposed to messaging from religious leaders (Okigbo et al., 2018). Engaging religious leaders is particularly important in addressing norms and beliefs that prevent men from accessing health care; in qualitative research in five states of Nigeria, men identified religious leaders as important allies to promote men's health and address stigma about health access (ChristianAid Nigeria, 2015). Successful implementation of this recommendation could be assessed by ascertained levels of sustained support from religious leaders as evidenced by their continued involvement in FMCs, WDCs, and Quality Improvement Teams to promote health access.

- **Promote awareness and uptake of available health insurance schemes, particularly for vulnerable populations like women and girls, with the aim to increase insurance enrollment.** Lack of funds to attend health services is a critical barrier to care in Ebonyi, and there are low levels of knowledge about the existing health insurance schemes available in the State. Women and marginalized persons who typically have lower levels of access to financial resources are more significantly impacted by financial constraints to accessing health care. There is a lack of evidence about the gender balance in enrollment in health insurance schemes in the State. Building on the foundational work of HP+ in Ebonyi, IHP will work in collaboration with the ESMOH, ESPHCDA, and ESHIA to continue to increase awareness of available health insurance schemes with the aim to increase gender equitable and socially inclusive insurance adoption and utilization and, thus, health access. The promotion of health insurance schemes can be incorporated across community engagement and outreach efforts. To measure success against this recommendation, the State can track the enrollment of women and vulnerable groups (e.g., PWDs) in health insurance schemes to determine if there is an equitable gender balance and representation of vulnerable groups amongst enrolled persons.

- **Involve male leaders, champions, and positive deviants to encourage male involvement in and access to RMNCAH+N services for themselves, their partners, and their families.** Men across Nigeria have low utilization of health services with their families and for themselves, which is influenced in part by gender norms and expectations and to perceptions about health facilities as "women's domains." IHP and partners will identify opportunities to involve male leaders, champions, and positive deviants in health facility and health systems planning and awareness efforts to increase the acceptability of men's access to and utilization of health services for their partners, their families, and for themselves. This, in combination with male-friendly service delivery and quality improvement approaches, can help improve men's support for their partners and families access to and utilization of PHC services. The State can measure success by assessing for an increase in men's utilization of health services in PHC facilities both as partners (e.g., for ANC) and as clients.

- **Provide new entry points and linkages to health services for adolescents and youth.** Adolescents and youth in Ebonyi face a variety of challenges in accessing health services. Evidence suggests schools and peer groups are influential in building health knowledge and awareness amongst youth and adolescents in Ebonyi. Actors in the State, including the Ebonyi State Ministry of Education and CSOs, can provide new entry points and linkages to health services for youth and adolescents. These could include peer education and clubs that involve health providers to build adolescents' knowledge of key health concerns (e.g., STIs, menstruation, contraception) and also link directly with health facilities to provide health services. This recommendation aligns with the existing *National Guidelines for the Integration of Adolescent and Youth Friendly Services in Primary Health Care Facilities in Nigeria*, which encourages stronger linkages between facilities and schools, community centres, CSOs, and other locations where youth gather. Along with the adoption of adolescent- and youth-friendly services delivery and quality improvement approaches, these new entry points and linkages can improve adolescent access to and utilization of PHC services, especially for sexual and reproductive health. To measure the success of these initiatives, the State could monitor the increased number of new acceptors of modern contraceptives who are adolescents or youth.

- **Connect efforts to improve women's economic empowerment and independence to efforts to improve health access.** Women's limited economic opportunities and restrictions on their independence undermine their ability to access health services. In addition to increasing efforts to promote women's economic empowerment and independence, actors in Ebonyi State should connect these efforts directly to efforts to improve health access. Health facilities, IHP, and its partners can leverage the influence of LGHA leadership and facility providers to promote greater empowerment of women in the household and community. Further, FMCs and WDCs provide fertile ground for awareness building and advocacy toward increased economic empowerment opportunities and improved health access for women. To assess the success of these efforts, LGHA leaders could deploy qualitative assessments to provide insight on progress towards women's empowerment.

- **Complement skills-based training with training on gender-sensitive and socially inclusive care.** Not only is it critical to address gaps in skills that affect the provision of quality care for women, men, girls, and boys in Ebonyi, but evidence in Ebonyi suggests that incorporating gender-sensitive and socially inclusive approaches to care can improve service delivery quality and outcomes. There are tremendous opportunities to build and maintain capacity amongst the health workforce in Ebonyi, particularly as they relate to gender and social inclusion. This includes hard and soft skills (e.g., gender-sensitive monitoring and evaluation, reporting, health messaging) that will

empower Ebonyi health workers and advance the health system toward more responsive policies and decisions that respond to the diverse needs of the clients they serve. At the facility-level, IHP will provide guidance for facility-based approaches to improving the accessibility and acceptability of health services. IHP will build on the foundational work of MCSP in the State to continue to cascade quality of care training focused on the provision of gender-sensitive, respectful care. This training should provide values clarification on norms and beliefs that may influence providers' ability to provide high-quality care to women, men, girls, and boys and should build capacity to integrate and monitor gender and social inclusion solutions into quality improvement processes. Finally, IHP will support the continuation of supportive supervision in the provision of gender-sensitive, respectful, and inclusive care. The success of these training efforts could be measured by first determining if providers have increased capacity to offer gender-sensitive and socially inclusive care, and then by evaluating to determine if providers apply and utilize skills and approaches learned in their service delivery.

- **Generate capacity to engage men and implement male-friendly approaches to care.** Facilities in Ebonyi implementing male-friendly approaches to care have seen improvements in RMNCAH+N service delivery outcomes and satisfaction. IHP will continue the foundational work of MCSP to encourage the use of male-friendly approaches to care the encourage men's involvement in RMNCAH+N services for their partners and families, including establishing private areas that allow for male companionship for care and the promotion of joint decision-making for family planning to increase family planning uptake. IHP will also draw on global evidence for male-friendly practices to promote men's own use of health care, including the distribution of male providers and establishing male-friendly service locations. These practices can help overcome the perception in Ebonyi that health facilities are the domain of women and children. However, the principle of "do no harm" must be considered at all stages of implementation of male-friendly and male-responsive approaches to ensure they do not undermine the agency, independence, or safety of women or families. IHP will build capacity of PHC providers and facility managers to recognize and prevent unintended consequences as they develop and implement new approaches and interventions. Under this recommendation, success could be measured by first determining if providers have increased capacity to offer male-friendly care, and then by evaluating to determine if providers apply and utilize skills and approaches learned in their service delivery and in their facilities.

- **Build capacity for improved quality of care–for adolescents to increase their utilization of services.** IHP will also address the needs of other vulnerable populations, including adolescents and PWDs, in training approaches. Data from the United States suggests that training providers on evidence-based practices for youth-friendly care, including offering flexibility in appointment times, providing low-cost options, offering a wide range of contraceptives, and facilitating private counseling and care, improved the use of these evidence-based practices (Romero et al., 2017). In Rivers State, Nigeria, adopting youth-friendly health services approaches including provider training, peer education, community outreach, and facility infrastructure improvements resulted in higher levels of youth utilization of services and lower perceptions of barrier to care (Ogu et al., 2018). Based on information collected during this desk review and additional priority-setting from ESMOH and PHCs, IHP will help facility staff to identify those evidence-based youth-friendly practices most relevant in the Ebonyi context for their facility context and to test those approaches and monitor results. IHP and facilities could measure success by first determining if providers have increased capacity to offer adolescent-friendly care, and then by evaluating to determine if providers apply and utilize skills and approaches learned in their service delivery.

- **Improve infrastructure to overcome barriers to access.** Though evidence is clear that the assurance of high-quality infrastructure is not a guarantee for quality of care, addressing challenges related to infrastructure is one component of advancing quality of and access to care in Ebonyi (Leslie et al., 2017). Facility infrastructure prevents women from accessing maternal care and skilled delivery, impedes men's ability to participate in health services for their partners and families, and prevents PWDs from physically accessing facilities. Additionally, the poor distribution of facilities and high costs of transportation are a barrier for all residents of Ebonyi. IHP will partner with the ESMOH and other agencies to provide technical assistance, as needed, to the State's efforts to address these barriers to infrastructure through planning and resource mobilization, ensuring that health infrastructure is able to meet the needs of all residents of Ebonyi. Successful infrastructure improvements can be measured and demonstrated by determining if environments are safe and accommodating (e.g., cleanliness, physically accessibility, availability of equipment) and by evaluating the geographic distribution of available facilities.

- **Identify and address gaps in skills and competencies to provide care for PWDs.** Evidence suggests that providers in Ebonyi lack the skills and competencies to provide care for PWDs. There is a lack of information about PWDs current experience in the health system in Ebonyi, and analysis of State-level policies did not identify any provisions to provide for care for PWDs. Additional information is needed to understand the specific gaps in skills and competencies to design contextually relevant approaches to closing this gap in quality of care. IHP will contribute to the institutionalization of State-level support for PWDs. To that end, IHP will support the State to identify and define measurable improvements and promote access to quality care for PWDs. The State can demonstrate evidence of success by the fulfillment of a State-level function and the increased knowledge and capacity of health workers and State representatives around access and quality of health services for PWDs.

- **Increase capacity for GBV prevention and response in the health system and collaborate with State-level actors to strengthen multi-sectoral GBV response so that PHC services and GBV referral pathways respond to the needs of survivors.** There are still gaps in the availability and quality of health services for GBV survivors, including gaps in the knowledge and skills of health providers. Expanding on the work of MCSP, IHP will include first-line response to GBV survivors in existing skills-based training. Further, Ebonyi can ensure violence prevention is integrated into the provision of RMNCAH+N services, including family planning. However, the health system is only one feature of a robust response to GBV. Many health providers in Ebonyi are unaware of other available services to which they can refer GBV survivors, and there is a lack of a coordinated multi-sectoral GBV response in the State. IHP will work with other sectoral leaders to enhance and update the GBV referral pathway initially developed under MCSP to strengthen the ability of all sectors to respond to GBV. The State can measure the success of these efforts by tracking the number of people reached with GBV services (with sex- and age-disaggregation).

This desk review identified gender and social inclusion issues affecting service quality, health access, HSS outcomes, and examined the health status of women, men, girls, and boys in Ebonyi and the social, economic, and political factors that influence health outcomes, including gender inequalities. By analyzing existing policies, strategies, and guidelines to identify gender-related gaps and opportunities within the health system, it offers recommendations to address gender, social inclusion, child marriage, male engagement, and GBV that have the potential to promote progress towards gender equity and improved health outcomes. The engagement of a wide range of public and private partners is critical to ensure

consistent and sustainable progress to reduce preventable morbidity and mortality and promote social wellbeing and development.

ANNEX 1: GENDER-RESPONSIVE CHECKLISTS FORHEALTH POLICIES AND GUIDELINES IN EBONYI STATE, NIGERIA

Ebonyi State 2019 Annual Operational Plan for the Ebonyi State Primary Health Care Development Agency

	Gender-responsive checklist for health policies, guidelines, service protocols, and other key government documents in Nigeria	**Score** [NO: 0 Somewhat: 0.5 YES: 1]	**Comments**
In the description of the general state of health of the population:			
1.	Are sex-disaggregated data used/presented?	0.5	The only sex-disaggregated data presented are for life expectancy.
2.	Are age-disaggregated data used/presented?	0	No. There is no age-disaggregated data presented. Adolescent pregnancy rate (15-19 years) is the only age-specific indicator presented.
3.	Is gender equality considered a health determinant?	0	No. Gender equality is not included as a health determinant.
4.	Does the description reflect gender-based constraints in access to services?	0	No. The AOP works to address access issues for key areas of women's health but does not acknowledge the constraints affecting access.
5.	Does the description reflect disability-based constraints in access to services?	0	No.
In the health problems prioritized in the policy:			
6.	Are the rights of the following groups protected in the policy (score one point for each)? a. Women b. Men c. Adolescent girls d. Adolescent boys e. PWDs f. Sexual minorities (e.g., LGBTQ populations)	0	No. The AOP does not discuss rights of any groups.
7.	Are specific objectives proposed to reduce gender inequalities?	0	No.
8.	Are lines of action proposed to meet the different needs of women and men?	0.5	There are a number of activities in the AOP to meet the unique health needs of women. There are no lines of action for men's health; men are only included as

			stakeholders to improve reproductive and maternal health.
9.	Are lines of action proposed to meet the needs of youth and adolescents?	1	There are activities to integrate youth-friendly services in health facilities, provide outreach to youth, and promotion of menstrual hygiene amongst youth.
10.	Are lines of action proposed to reduce gender inequalities?	0	No.
11.	Does the policy include actions to address: a. Gender-based violence prevention and response/services b. Early/child and forced marriage c. Early Pregnancy/Childbearing d. Access to contraception (Married or unmarried; Women/adolescents/PWD) e. Female genital mutilation	0.5	There are several activities to promote GBV awareness amongst stakeholders and skills-training for providers, but there were no details on coordinated GBV response. Early and child marriage, including early or teenage pregnancy, are not address. There were no interventions specifically addressing FGM.
12.	Does the policy include strategies to engage men as clients, as supportive partners/ parents, and as agents of change in the following areas: a. sexual and reproductive health b. family planning c. maternal health d. newborn health e. child health f. maternal and child nutrition g. malaria	0.5	Men are to be engaged in the areas of reproductive health, family planning, and maternal health. There were no strategies to address men's involvement in newborn or child health, nutrition, or malaria.
13.	Does the policy include strategies to improve accessibility to services for PWD?	0	No.
14.	Are policies or strategies designed to address the needs of PWDs in the following areas: a. sexual and reproductive health b. family planning c. maternal health d. newborn health e. child health f. maternal and child nutrition g. malaria	0	No.
Health systems strengthening			
15.	Does the policy include strategies to train health workers in gender-sensitive service delivery approaches and techniques (pre-, in-service, refresher training)?	0	No. There were a number of trainings for health workers, but it did not include gender-sensitive service delivery and approaches.

16.	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0		No.
17.	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	0		No. There was an HRH mapping activity included, but no details on the goals of this activity.
18.	Does the policy require health information systems collect sex and age disaggregated data? a. If yes, does the policy require data to be used?	0		No.
19.	Does the policy include equitable financing strategies that recognize gendered needs and inequitable access to resources for health care seeking?	0		No.
20.	Does the policy ensure services are equitably accessible to women (W), men (M), adolescent girls (G) and adolescent boys (B) in terms of: a. acceptability b. affordability c. availability d. eligibility e. respectfulness f. physical accessibility g. geographic accessibility h. unbiased and nonjudgmental and nondiscriminatory	W	0.5	Activities are proposed to improve access to services for women and adolescents (both boys and girls). The AOP recognizes the limited availability of services for adolescents but does not address increasing availability. Affordability, eligibility, respectfulness, physical and geographic accessibility, and the provision of unbiased care are not included in the AOP for any gender or age group.
		M	0	
		G	0.5	
		B	0.5	
21.	Does the policy ensure services are equitably accessible for PWDs in terms of: a. acceptability b. affordability c. availability d. eligibility e. respectfulness f. physical accessibility g. geographic accessibility h. unbiased and nonjudgmental and nondiscriminatory	0		No.
22.	Does the policy include strategies to increase women's participation in leadership and decision-making roles in the health sector?	0.5		Several activities aim to involve women's group leaders in activities that influence decision-making. However, there are no strategies to improve women's representation in health sector leadership.

23.	Does the policy include strategies to increase youth's participation in decision-making in the health sector?	0.5	Several activities aim to involve youth leaders in activities that influence decision-making. However, there are no strategies to improve youth representation in health sector leadership.
24.	Does the policy include measures for accountability in providing gender-responsive health services?	0	No.
In the implementation and monitoring section:			
25.	Is the collection of sex-disaggregated data included in the monitoring and evaluation (M&E) plan? a. And are they used in decision making?	0*	No. The chapter on the M&E plan does not include specific information about indicators collected. The full M&E plan was not available during this desk review.
26.	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	0*	No.
27.	Does the M&E plan include indicators to measure gender-related outcomes?	0*	No.
28.	Does the M&E plan include indicators to measure outcomes relating to PWDs or disability?	0*	No.
29.	Are funding mechanisms and other resource needs and sources for the gender actions identified?	0*	No.
30.	Does the M&E plan include what to do when M&E data reveal gender inequities?	0*	No.
*Not available			

Ebonyi State Primary Healthcare Human Resources for Health (HRH) Policy

	Gender-responsive checklist for health policies, guidelines, service protocols, and other key government documents in Nigeria	**Score** [NO: 0 Somewhat: 0.5 YES: 1]	**Comments**
In the description of the general state of health of the population:			
1.	Are sex-disaggregated data used/presented?	0.5	Some sex-disaggregated health status indicators are presented (e.g., life expectancy), but no data on HRH is sex-disaggregated.
2.	Are age-disaggregated data used/presented?	0.5	Some age-specific information is presented on health status, but only for singular age groups (e.g., anemia prevalence amongst children). No data on HRH is age-disaggregated.
3.	Is gender equality considered a health determinant?	0	No. Equity is only mentioned broadly in some parts of the document as it relates to health access.
4.	Does the description reflect gender-based constraints in access to services?	0	No.
5.	Does the description reflect disability-based constraints in access to services?	0	No.
In the health problems prioritized in the policy:			
6.	Are the rights of the following groups protected in the policy (score one point for each)? a. Women b. Men c. Adolescent girls d. Adolescent boys e. PWDs f. Sexual minorities (e.g., LGBTQ populations)	0	No. While equity and inclusiveness are prioritized as goals of the policy, strategies are not specific to any of the groups listed.
7.	Are specific objectives proposed to reduce gender inequalities?	0	No. Gender disparities in HRH are mentioned, but no specific objectives are proposed to address those disparities.
8.	Are lines of action proposed to meet the different needs of women and men?	0	No.
9.	Are lines of action proposed to meet the needs of youth and adolescents?	0	No.
10.	Are lines of action proposed to reduce gender inequalities?	0	No.
11.	Does the policy include actions to address: a. Gender-based violence prevention and response/services	0	No.

	b. Early/child and forced marriage c. Early Pregnancy/Childbearing d. Access to contraception (Married or unmarried; Women/adolescents/PWD) e. Female genital mutilation		
12.	Does the policy include strategies to engage men as clients, as supportive partners/ parents, and as agents of change in the following areas: a. sexual and reproductive health b. family planning c. maternal health d. newborn health e. child health f. maternal and child nutrition g. malaria	0	No.
13.	Does the policy include strategies to improve accessibility to services for PWD?	0	No.
14.	Are policies or strategies designed to address the needs of PWDs in the following areas: a. sexual and reproductive health b. family planning c. maternal health d. newborn health e. child health f. maternal and child nutrition g. malaria	0	No.
Health systems strengthening			
15.	Does the policy include strategies to train health workers in gender-sensitive service delivery approaches and techniques (pre-, in-service, refresher training)?	0	No. All training described is to be based on critical needs and priority areas as they are identified, but there is no description about how needs and priority areas will be identified.
16.	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0	No.
17.	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	0.5	Under Policy Direction 3 ("Improving equitable distribution and utilization of HRH"), Strategy II aims to address gender disparities in HRH distribution. Gender equitable HRH production and retention are not mentioned in the policy.
18.	Does the policy require health information systems collect sex and age disaggregated data?	0.5	Strategy VI of Policy Direction 5 ("Strengthening HRH Stewardship in the PHC system")

	a. If yes, does the policy require data to be used?			requires the establishment of "a sex-disaggregated HRH database including modalities for re-dressing all forms of gender disparities in the health workforce." The policy does not require age-disaggregated data to be collected.
19.	Does the policy include equitable financing strategies that recognize gendered needs and inequitable access to resources for health care seeking?	0		No.
20.	Does the policy ensure services are equitably accessible to women (W), men (M), adolescent girls (G) and adolescent boys (B) in terms of: a. acceptability b. affordability c. availability d. eligibility e. respectfulness f. physical accessibility g. geographic accessibility h. unbiased and nonjudgmental and nondiscriminatory	W	0	The policy only seeks to address the availability and physical/geographic accessibility of services. Other dimensions of accessibility are not included. The strategies proposed to increase availability and physical/geographic accessibility are not unique to any groups based on age, gender, or other factors.
		M	0	
		G	0	
		B	0	
21.	Does the policy ensure services are equitably accessible for PWDs in terms of: a. acceptability b. affordability c. availability d. eligibility e. respectfulness f. physical accessibility g. geographic accessibility h. unbiased and nonjudgmental and nondiscriminatory	0		No.
22.	Does the policy include strategies to increase women's participation in leadership and decision-making roles in the health sector?	0		No.
23.	Does the policy include strategies to increase youth's participation in decision-making in the health sector?	0		No.
24.	Does the policy include measures for accountability in providing gender-responsive health services?	0		No.
In the implementation and monitoring section:				

25.	Is the collection of sex-disaggregated data included in the monitoring and evaluation (M&E) plan? a. And are they used in decision making?	0	No. This is not included in the M&E plan, though sex-disaggregated data is required for the HRH Database to be constructed as part of the policy implementation.
26.	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	0	No.
27.	Does the M&E plan include indicators to measure gender-related outcomes?	0.5	The HRH Monitoring and Evaluation, Learning, and Accountability plan is to be developed with gender responsive indicators and targets to monitor implementation progress, but the policy does not give any examples of what the gender responsive indicators or targets may include.
28.	Does the M&E plan include indicators to measure outcomes relating to PWDs or disability?	0	No.
29.	Are funding mechanisms and other resource needs and sources for the gender actions identified?	0	No.
30.	Does the M&E plan include what to do when M&E data reveal gender inequities?	0	No.

Ebonyi State Strategic Health Development Plan II (2018-2022)

	Gender-responsive checklist for health policies, guidelines, service protocols, and other key government documents in Nigeria	**Score** [NO: 0 Somewhat: 0.5 YES: 1]	**Comments**
In the description of the general state of health of the population:			
1.	Are sex-disaggregated data used/presented?	0.5	Some sex-disaggregated data was used and presented (e.g., population, life expectancy). There was limited sex-disaggregated data for social determinants of health, including economic and educational indicators. There is no sex-disaggregated data presented for the health workforce.
2.	Are age-disaggregated data used/presented?	0	Some age-specific information is presented, but only for singular age groups (e.g., child

			immunization, contraceptive prevalence). There is no age disaggregation for indicators of maternal health, including skilled birth attendance or pregnancy.
3.	Is gender equality considered a health determinant?	0	No. Equity and gender sensitivity are mentioned as values and principles for the implementation of the plan.
4.	Does the description reflect gender-based constraints in access to services?	0.5	Women's limited education, lack of decision-making power, and cultural taboos/norms are identified as barriers to service access, but not well explicated.
5.	Does the description reflect disability-based constraints in access to services?	0	No.
In the health problems prioritized in the policy:			
6.	Are the rights of the following groups protected in the policy (score one point for each)? a. Women b. Men c. Adolescent girls d. Adolescent boys e. PWDs f. Sexual minorities (e.g., LGBTQ populations)	0	Respect for human rights is a value of the plan, but rights are not specifically protected for any group.
7.	Are specific objectives proposed to reduce gender inequalities?	0	No. While equity and gender sensitivity are values for implementation of the plan, there are no specific objectives to address gender inequalities.
8.	Are lines of action proposed to meet the different needs of women and men?	0.5	The plan prioritizes addressing the needs of women, men, boys, and girls, but with limited lines of action. There are lines of action addressing women's health in the context of reproductive health and maternal health. Men's health needs are not explicitly addressed.
9.	Are lines of action proposed to meet the needs of youth and adolescents?	0	No.
10.	Are lines of action proposed to reduce gender inequalities?	0	No.
11.	Does the policy include actions to address: a. Gender-based violence prevention and response/services b. Early/child and forced marriage	0.5	While these issues were mentioned as State health challenges, the plan does not have actions to address them.

	c. Early Pregnancy/Childbearing d. Access to contraception (Married or unmarried; Women/adolescents/PWD) e. Female genital mutilation		
12.	Does the policy include strategies to engage men as clients, as supportive partners/ parents, and as agents of change in the following areas: a. sexual and reproductive health b. family planning c. maternal health d. newborn health e. child health f. maternal and child nutrition g. malaria	0	No.
13.	Does the policy include strategies to improve accessibility to services for PWD?	0	No. The plan only address reduction in disability incidence due to neglected tropical diseases (NTDs) and noncommunicable diseases (NCDs).
14.	Are policies or strategies designed to address the needs of PWDs in the following areas: a. sexual and reproductive health b. family planning c. maternal health d. newborn health e. child health f. maternal and child nutrition g. malaria	0	No.
Health systems strengthening			
15.	Does the policy include strategies to train health workers in gender-sensitive service delivery approaches and techniques (pre-, in-service, refresher training)?	0	No. There is no explicit mention of gender-sensitivity in trainings described for health workers.
16.	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0	No.
17.	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	0	No.
18.	Does the policy require health information systems collect sex and age disaggregated data? a. If yes, does the policy require data to be used?	0	No.
19.	Does the policy include equitable financing strategies that recognize	0	No.

	gendered needs and inequitable access to resources for health care seeking?			
20.	Does the policy ensure services are equitably accessible to women (W), men (M), adolescent girls (G) and adolescent boys (B) in terms of: a. acceptability b. affordability c. availability d. eligibility e. respectfulness f. physical accessibility g. geographic accessibility h. unbiased and nonjudgmental and nondiscriminatory	W	0	While equal accessibility is a principle of the plan, there are limited strategies to ensure accessibility in any of the listed domains. Where strategies are listed, they are specific to any gender or age group.
		M	0	
		G	0	
		B	0	
21.	Does the policy ensure services are equitably accessible for PWDs in terms of: a. acceptability b. affordability c. availability d. eligibility e. respectfulness f. physical accessibility g. geographic accessibility h. unbiased and nonjudgmental and nondiscriminatory	0		No.
22.	Does the policy include strategies to increase women's participation in leadership and decision-making roles in the health sector?	0.5		The plan does include targets to ensure adequate representation of women at the WDC level (women should hold half of membership positions and one executive position); however, the plan does not state how this will be achieved, and this is the only mention of women's inclusion in leadership or decision-making.
23.	Does the policy include strategies to increase youth's participation in decision-making in the health sector?	0		No.
24.	Does the policy include measures for accountability in providing gender-responsive health services?	0		No.
In the implementation and monitoring section:				
25.	Is the collection of sex-disaggregated data included in the monitoring and evaluation (M&E) plan? a. And are they used in decision making?	1		Yes.

26.	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	1	Yes.
27.	Does the M&E plan include indicators to measure gender-related outcomes?	0	No.
28.	Does the M&E plan include indicators to measure outcomes relating to PWDs or disability?	0	No.
29.	Are funding mechanisms and other resource needs and sources for the gender actions identified?	0	No.
30.	Does the M&E plan include what to do when M&E data reveal gender inequities?	0	No. While inequities are assessed through disaggregation, there is no plan to use the data.

Checklist adapted from:

Pan American Health Organization (PAHO). (2009). *Guide for Analysis and Monitoring of Gender Equity in Health Policies*. http://new.paho.org/hq/dmdocuments/2009/Guide_Gender_equity_.pdf

United States Agency for International Development (USAID). (2011). *USAID Gender Integration Matrix: Additional Help for ADS Chapter 201*. http://www.usaid.gov/sites/default/files/documents/1865/201sac.pdf

World Health Organization (WHO) Regional Office for Europe. (2010). *Checklist for Assessing the Gender Responsiveness of Sexual and Reproductive Health Policies: Pilot Document for Adaptation to National Contexts*. Denmark. http://www.euro.who.int/__data/assets/pdf_file/0007/76525/E93584.pdf

WHO. (2011). WHO Gender Responsive Assessment Scale: criteria for assessing programmes and policies. In *WHO Gender Mainstreaming Manual for Health Managers: a practical approach*. https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentScale.pdf

ANNEX 2: DOCUMENTS REFERENCED

Document Category codes: **PR** – Peer reviewed publication, **G** – Grey literature, **P** – Policy, Guideline, Plan, Strategy, or Tool, **Q** – Quantitative data source, **B** – Background information

Document	Code
Achilike, B. A., & Achilike, C. C. (2016). Causes of Female Students Dropout in Secondary Schools in Ebonyi State South East Nigeria: Psychological Implications. *Journal of Educational Policy and Entrepreneurial Research*, *3*(4), 103-110.	PR
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Agu, I. C., Mbachu, C. O., Okeke, C., Eze, I., Agu, C., Ezenwaka, U., ... & Onwujekwe, O. (2020). Misconceptions about transmission, symptoms and prevention of HIV/AIDS among adolescents in Ebonyi state, South-east Nigeria. *BMC Research Notes*, *13*, 1-5. DOI: 10.1186/s13104-020-05086-2	PR
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