USAID Integrated Health Program

Desk Review on Gender and Social Inclusion Issues Affecting Health in the Federal Capital Territory, Nigeria

Submission Date: September 29, 2020; v2 January 5, 2021

Contract Number: 72062018D00001/72062020F00005
Activity Start Date and End Date: April 1, 2020 to March 31, 2025
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This document was produced for review by the United States Agency for International Development Nigeria Mission (USAID/ Nigeria).

ACRONYMS AND ABBREVIATIONS

ADS	Automated Directives System
AIDS	Acquired immunodeficiency syndrome
AOP	Annual operational plan
ANC	Antenatal care
ART	Antiretroviral therapy
BA-N	Breakthrough ACTION-Nigeria
BHCPF	Basic Health Care Provision Fund
CHEW	Community Health Extension Worker
CHO	Community Health Officers
CSJ	Centre for Social Justice
CSO	Civil society organization
DEC	Development Experience Clearinghouse
FBO	Faith-based organization
FCT	Federal Capital Territory
FCTA	Federal Capital Territory Administration
FGM/C	Female genital mutilation/cutting
FIDA	International Federation of Women Lawyers
FLHE	Family Life and HIV Education
FMC	Facility Management Committee
FMOH	Federal Ministry of Health
FSW	Female sex worker
GBV	Gender-based violence
GDP	Gross domestic product
GHSC-PSM	Global Health Supply Chain-Procurement Supply Management
GII	Gender Inequality Index
GRB	Gender responsive budgeting
GESI	Gender and social inclusion
HDI	Human Development Index
HFC	Health Facility Committee
HHSS	Health and Human Services Secretariat
HIV	Human immunodeficiency virus
HMB	Hospitals Management Board
HP+	Health Policy Plus
HPN	Health, Population, and Nutrition
HPV	Human papilloma virus
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
JCHEW	Junior Community Health Extension Worker
JICA	Japan International Cooperation Agency

LACVAW	Legislative Advocacy Coalition on Violence Against Women
LARC	Long-acting reversible contraceptive
LGA	Local Government Area
LGHA	Local Government Health Authority
M&E	Monitoring and evaluation
MCSP	Maternal and Child Survival Program
MDA	Ministries, departments, and agencies
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, neonatal, and child health
MTCT	Mother-to-child transmission (of HIV)
MWASD	Ministry of Women Affairs and Social Development
MSM	Men who have sex with men
NAPTIP	National Agency for Prohibition of Trafficking in Persons
NBS	National Bureau of Statistics
NDHS	Nigeria Demographic and Health Survey
NHMIS	National Health Management Information System
NHRC	National Human Rights Commission
NPHCDA	National Primary Health Care Development Agency
NSCDC	Nigeria Security and Civil Defence Corps
NSCIP	Nigeria Supply Chain Integration Project
NURHI	Nigeria Urban Reproductive Health Initiative
OVC	Orphans and vulnerable children
PHC	Primary health center
PHCB	Primary Health Care Board
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission (of HIV)
PWD	Persons with disabilities
PWID	Persons who inject drugs
RMNCAH+N	Reproductive, maternal, neonatal, child, and adolescent health, plus nutrition
SGBV	Sexual and gender-based violence
SHDP II	Strategic Health Development Plan II
SHIA	State Health Insurance Agency
SHOPS Plus	Sustaining Health Outcomes through the Private Sector Plus
SRHR	Sexual and reproductive health and rights
STEM	Science, technology, engineering, and mathematics
STI	Sexually transmitted infection
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional birth attendant
TFR	Total fertility rate
TO	Task Order
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
VHDC	Village Health Development Committee
WDC	Ward Development Committee

Contents

EXECUTIVE SUMMARY

Purpose. The United States Agency for International Development (USAID) Integrated Health Program (IHP) Task Order (TO) 7, led by Palladium International, LLC, is positioned to contribute to improving health systems in the Federal Capital Territory (FCT), Nigeria. IHP works in FCT 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 FCT, gender is intricately linked to access to health services and information 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) improvements, and to better understand the health status of women, men, girls, and boys in FCT and the social, economic, and political factors that influence health outcomes, including gender inequalities. This report presents the findings of the IHP FCT Gender and Social Inclusion 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 the quality of primary health care in FCT. The desk review will be used to inform the development and implementation of a GESI strategies under IHP and for the FCT, in collaboration with Territory leadership and stakeholders, including how to measure and monitor progress against the strategy.

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 initial research questions, which 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 FCT?

(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 FCT 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 primary healthcare 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 qualitative and quantitative data (and when possible age-disaggregated). The desk review included 155 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: 56 peer-reviewed journal articles; 43 pieces of grey literature (e.g., working papers, program documents, gender assessments); 27 local, national, or international policies, guidelines, plans, laws, strategies, or tools (six of which were selected for inclusion in the policy analysis); 23 sources of quantitative data; and six sources of background information. The team also collected relevant and available Territory-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 objective areas under IHP (health systems, access to PHC services, and 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 FCT: (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* (2019) from the USAID Health Policy Plus (HP+) Project and (2) *Sustaining Health Outcomes Through the Private Sector (SHOPS) Plus Nigeria Family Planning Program: Gender Assessment* (2018) from the USAID SHOPS Plus Project (Pappa, 2019; *Nigeria FP Program*, 2018). Key findings from the HP+ analysis highlight gaps in overall awareness of gender in the Territory, 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, 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 present aggregate information for the four states analyzed. Findings from the SHOPS Plus analysis identified that providers in FCT have limited training on gender-sensitive provision of care and lack awareness about laws and policies relating to gender (including gender-based violence [GBV]) and social inclusion, sex-disaggregated data are not collated above the facility level, and family planning services are largely not inclusive of men. It is important to note these findings are based on data collection only in Abuja, and are also based on data collected in Jos, Plateau State; these factors may limit the generalizability of the findings to other areas of FCT. Further, neither the SHOPS Plus nor HP+ analysis presented sex- or age-disaggregated data relating to gender and social inclusion, nor did they present a review of existing literature relating to gender and social inclusion and health systems, health access, or quality of health services. Findings from these analyses informed the gender strategy for both activities. IHP reviewed available HP+ and SHOPs Plus 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 six FCT-specific health- and gender-related policies and laws to assess for different aspects of gender and social inclusion: *FCT Primary Health Care Board (PHCB) 2019 Annual Operational Plan (AOP)*, *FCT PHCB HRH Policy (2019-2024)*, *FCT PHCB HRH Strategy (2019-2024)*, *FCT Strategic Health Development Plan (SHDP) II (2017-2021)*, *National Gender Policy* (2006), and the *Violence Against Persons (Prohibition) (VAPP) Act* (2015). Based on analysis of the policies using the IHP

gender and social inclusion policy checklist, there is an overall lack of utilization or collection of sex- and age-disaggregated data, 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. While the National Gender Policy and VAPP Act, Federal-level documents which also apply directly to FCT, both recognize the role of gender in society and provide for gender and social inclusion relation actions and protections, this desk review did not identify information about the level of implementation or success in effecting change in FCT.

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 (FCT HHSS, 2017),
- gender imbalance in certain cadres of the health workforce and poor distribution of the health workforce to meet the needs of rural populations (FCT HHSS, 2017; FCT PHCB, 2019),
- limited collection of sex- and age-disaggregated data (as evidenced by the policy analysis) and a lack of evidence about the use of data,
- poor supply and distribution of RMNCAH+N commodities (UNFPA, 2018), which has disproportionate effects on women who need to access contraceptive methods of choice, nutritional supplements and tetanus toxoid vaccines in pregnancy, and life-saving drugs to prevent and treat complications of pregnancy and delivery, such as uterotonics (UN, 2012),
- no evidence of gender-responsive budgeting (GRB) (Amakom, 2020), and
- little consideration for gender and social inclusion in leadership and governance (as evidenced by the policy analysis).

Different groups face varied challenges in access to care. For example, for women and girls, evidence suggests that cost of health services, transportation, needing permission from a male family member, cultural beliefs about the nature of sexual health concerns, and limited awareness all impede access to health services (NPC & ICF, 2019; Al-Mujtaba et al., 2016; Jamda et al., 2018). There is a general dearth of information about quality of care in FCT, especially as related to gender and social inclusion, but available evidence suggests moderate levels of satisfaction with care, despite concerning information about provider attitudes and behavior in the context of RMNCAH+N, including obstetric violence and verbal abuse (Lawal et al., 2018; Bohren et al., 2017; Okonofua et al, 2017).

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 at the Territory level, including men's, youth's, and PWD's experience in accessing health services. Further, despite FCT's position as the capital of the nation, there are still wide gaps in knowledge about gender norms, health status, and health outcomes, and little evidence about interventions to improve RMNCAH+N outcomes and services in the Territory.

Discussion and Recommendations. The findings of the rapid desk review not only contributed answers to the original research questions proposed by the research team, but also highlight gaps for IHP and Territory leadership to consider in efforts to strengthen the health system and improve access to and quality of primary healthcare 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 FCT? The different roles and expectations of men, women, and youth have great influence on health access and outcomes in FCT. Evidence suggests that, while women in FCT enjoy greater levels of decision-making than women in the rest of Nigeria, gender norms still inhibit women from making decisions about their own wellbeing, finances, and health, and can also expose them to risk of GBV. Norms about masculinity, though not well studied in the Territory, deter men from seeking health services and also encourage them to participate in high-risk behaviors like unprotected sexual activity and substance use. Limited evidence about youth in FCT indicates that youth struggle to access the resources and information needed to protect their own health. IHP will consider and respond to these gender roles and expectations as we provide technical assistance and capacity building in the FCT, 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 system perspective, women and other marginalized persons are often not included in planning and decision-making, nor are their opinions 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. These deep-seated norms and beliefs also affect the quality of care offered in the health system and can prevent providers from offering a full range of services or from providing gender-sensitive, inclusive care, resulting in low levels of health service 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 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 FCT. There is some indication that women are reliant on male family members to access health services and that men influence whether a woman accesses antenatal care (ANC), delivery or other services. Even when men are included in family planning, 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 FCT will have equitable impact 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 people with disabilities (PWDs) face increased challenges in accessing health services, which if not addressed could prevent them from benefiting from improvements in the quality of services resulting from IHP capacity building. 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 by building the capacity of providers and institutionalizing gender equity and social inclusion in Territory 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 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 Territory 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 Territory Governments, USAID, 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 Territory.

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 collect and apply age- and sex-disaggregated data newly required in the 2019 NHMIS registers and summary reports, IHP will support the Territory to analyze service utilization by age and sex to identify any biases or gaps in service delivery. These data will help 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 strengthen the health system to be responsive to need and relevant to context.

- **Continue Territory-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 for the Territory-level adoption of GESI-related national guidelines and policies and capacity building for Territory 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 integrating gender equity and social inclusion in the existing HRH Policy and HRH Strategy 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 contraceptives**.** Efforts will include the provision of targeted technical assistance 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.
- **Increase capacity for GBV prevention and response in the health system and collaborate with Territory-level actors to strengthen multi-sectoral GBV response**. These efforts will enhance PHC services and GBV 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 for 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 joint decision-making around family planning and encouraging resource sharing that allows women to better support their families' health.
- **Engage religious and traditional leaders 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 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 FCT Health and Human Services Secretariat (HHSS) and other relevant Territory actors to promote gender equity and social inclusion in their outreach and enrollment efforts.

The recommendations and findings from this broad and overarching desk review aim to inform gender equitable, socially inclusive, 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 all women, men, girls, and boys in FCT.

1. INTRODUCTION

The Federal Capital Territory (FCT) of Nigeria, faces large disparities in levels of development. Despite progress in urban environments, women and men in FCT experience entrenched gender norms that restrict women's opportunities and access to resources, education, and economic opportunities. Marginalized groups in FCT, 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 Territory, and the nation as a whole.

The United States Agency for International Development (USAID) Integrated Health Program (IHP) Task Order (TO) 7, led by Palladium International, LLC, is positioned to contribute to improving health systems in FCT, Nigeria. IHP works in FCT to reduce child and maternal morbidity and mortality and to increase the capacity of the health system 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 7, addressing gender and social inequities related to primary health care and related health and social factors, including adolescent health, gender-based violence (GBV), and child and forced marriage. IHP will provide technical assistance (TA) to mainstream gender at the Territory level in FCT, focusing on gender equality and equity in policies and guidelines for health and 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 FCT 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 underlying 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 presents the findings of the IHP FCT Gender and Social Inclusion 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 the quality of primary health care in FCT. The desk review will be used to inform the development and implementation of a GESI strategies under IHP and for the FCT, in collaboration with Territory leadership and stakeholders, including how to measure and monitor progress against the strategy.

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 key 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 FCT?
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 the Territory, including Health Policy Plus (HP+) and Sustaining Health Outcomes through the Private Sector (SHOPS) Plus, 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 FCT, identifying any gaps in information. This ensured that existing information was synthesized and fully considered within the FCT context, and then filled gaps with broader resource analysis.

Using the research questions and gaps identified in prior gender and social inclusion analyses to guide the research, the team identified the following key search words under FCT 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 included:

- Reproductive health and family planning
- Maternal health
- Obstetric fistula
- Newborn and child health
- Nutrition
- Human immunodeficiency virus (HIV) / Acquired immunodeficiency syndrome (AIDS)
- 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 TO2 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 FCT.

Inclusion criteria. Materials reviewed during the desk review included 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, Territory health and gender policy and strategy documents available online, donor-funded program documents, 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. 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 key gender policies that have been domesticated at the Territory level.

Using the inclusion criteria and search terms as described, the following documents were selected for inclusion in the desk review: 56 peer-reviewed journal articles; 43 pieces of grey literature (e.g., working papers, program documents, gender assessments); 27 local, national, or international policies, guidelines, plans, laws, strategies, or tools (six of which were selected for inclusion in the policy analysis); 23 sources

of quantitative data; and six sources of background information. A full, categorized list of the 155 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 FCT.

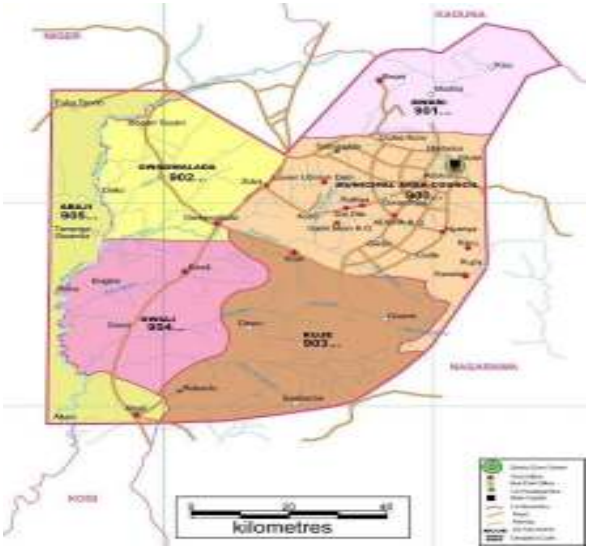
Organization of findings. Based on the review, findings were organized to first present information from prior gender and social inclusion analyses (Section 2.1). As the analysis was guided by USAID (2012) Gender Equality and Female Empowerment Policy (2012) and USAID (2017) Automated Directives System (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 and collect and present additional information relating to key gaps these 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 objectives of IHP: strengthened 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), improved access to primary healthcare services (Section 2.6), and increased quality of primary healthcare services (Section 2.7).

1.3 Background and overview of the Federal Capital Territory, Nigeria

The Federal Capital Territory (FCT), also known as FCT-Abuja or the Abuja Federal Capital Territory, holds the national capital of Nigeria ("Federal Capital Territory," 2018). Located at the heart of the country in the North Central Zone, it is bordered by the states of Niger, Kaduna, Nasarawa, and Kogi. The FCT has a landmass of approximately 7,600 square kilometers (*Nigerian States: FCT,* n.d.). The Territory is made up of six Area Councils, namely: Abaji, Abuja Municipal Area Council, Bwari, Gwagwalada, Kuje, and Kwali. The six Area Councils function like the Local Government Areas (LGAs) in the other 36 states of Nigeria.

Figure 1. Map of the Federal Capital Territory, Nigeria



Note. Reprinted from *Map of Abuja Showing the Six Area Councils*, ResearchGate, https://www.researchgate.net/figure/Map-of-Abuja-showing-the-six-area-councils_fig1_318653677

The most recent population projections from the Nigeria National Bureau of Statistics (NBS) estimate that FCT had a population of 3,564,126 residents in 2016, with the vast majority living in the capital city of Abuja (NBS, 2018a). Estimates indicate that, as of 2018, Abuja accounted for nearly 2.9 million of the FCT's residents (UN DESA Population Division, 2019). Abuja is one of the fastest growing cities in the world; between 1990 and 2018, the city's population increased by 7.8% per year, and the growth is anticipated to increase at a rate of 4.7% per year until 2030.

The Federal Capital Territory Administration (FCTA), which is a ministry of the Federal Government of Nigeria, administers the Federal Capital Territory of Nigeria (*Structure of the Federal Capital Territory Administration*, n.d.). Unlike other states in Nigeria, which have an elected governor as the head of state, the President of Nigeria also serves as the Governor of FCT. The President delegates these powers to an appointed Minister. FCT does not have its own designated legislative branch; instead the National Assembly serves as the legislative body for the FCT. FCT does have its own judiciary, but courts in FCT function at the federal level.

Abuja and the FCT are a melting pot for the nation's cultural diversity and a home to many ethnic groups and tribes in the country. The Territory hosts residents from a variety of ethnic groups, including the Gbagyi (Gwari), Afo, Bassa, Fulani, Hausa, Ganagana, Gwandara, and Koro ("Federal Capital Territory," 2018). The Gbagyi, also spelled as Gwari or Gbari, are considered to be the original inhabitants of the FCT prior to its designation as the nation's capital (Onyeakagbu, 2020). Like other areas in the North Central Zone, FCT has a relatively even balance between Christian and Muslim residents (Sampson, 2014).

FCT hosts a wide variety of economic activity, ranging from small-scale agriculture to tourism to construction and infrastructure development (*Nigerian States: FCT*, n.d.). According to calculations from the NBS, between 2013 and 2017 the FCT had the highest gross domestic product (GDP) of any state in Nigeria at 10,627,397.86 million Naira (NBS, 2019c). Non-oil related manufacturing and industry and the service sector contribute most strongly to GDP. In more rural areas and amongst groups indigenous to

FCT, agriculture and fishing are prominent activities (FCT HHSS, 2017). Government and civil service also represent a significant proportion of employment opportunities in FCT.

FCT is marked by high levels of development and there are typically more opportunities for residents of FCT in terms of education and economic empowerment. The Human Development Index (HDI),[1] which measures progress in human development, in FCT was 0.629 in 2016 (UNDP, 2018). However, according to the revised absolute poverty calculations for 2019, 38.66% of the population in FCT still live at or below the poverty line (NBS, 2019b). As of Quarter 3 of 2018, FCT had the third highest unemployment rate in the North Central Zone at 24.4% (NBS, 2019a). An additional 16.1% of the population in FCT is classified as underemployed. FCT has seen a net decrease in job creation in recent years. In the last Nigeria Demographic and Health Survey (NDHS), 46.6% of women in the Territory had not been employed in the prior 12 months, which was higher than national levels of women's unemployment (31.6%) and nearly double men's unemployment in FCT (22.8%) (NPC & ICF, 2019).

In FCT, the literacy rate for adults was 67.0% in 2010 (NBS & Nigeria Information Highway, n.d.). Literacy in FCT is consistently higher than other states in northern Nigeria, which is likely linked to high levels of school attendance in the Territory (NPC & RTI International, 2011). However, there is a stark difference in literacy between men and women. As of 2018, 67.8% of women were literate, compared to 84.7% of men (NPC & ICF, 2019). There are also clear gaps in levels of educational attainment for women and men in the Territory. Nearly one in five women ages 15 to 49 years have not attended any schooling (18.6%), while one-quarter have completed secondary school. For men in FCT, only 8.6% have never attended school and 39.8% have completed secondary school.

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

2.1 Findings from previous gender and social inclusion analyses

Before beginning the desk review, the IHP team reviewed recent gender and health-related research existing from other USAID HPN projects to identify relevant findings and gaps in knowledge. Through the process of the desk review and as noted in the methodology, two documents were located that were determined to contain relevant, Territory-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 Territory-specific information (Morel-Seytoux et al., 2014; Fontaine et al., 2016; Mitsubishi UFJ Research & Consulting Co., 2011).

[1] *HDI is a summary measure for assessing long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living.*

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 FCT 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 Health Policy Plus (HP+) project with funding from USAID. 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)[2] in Nigeria. Successful BHCPF rollout relies upon understanding the challenges, opportunities, and gaps of each interconnecting group 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 and the USAID Gender Equality and Female Empowerment Policy to guide the gender analysis. The methods used to generate the analysis included a desk review of existing analyses and documents to gather relevant content and ensure the analysis was not duplicative, key informant interviews to gain insight into State- and Territory-level context, and analysis of information gathered. Of the 95 key informants interviewed in the analysis, 21 were from the FCT. Key informants represented key stakeholder groups, including various State- and Territory-level health agencies, Ward Development Committees (WDC), Local Government Health Authorities (LGHA), and civil society organizations (CSOs) and community leaders. Final analysis of information was not state-specific and combined key issues from findings across the four states to guide BHCPF rollout. These key topics covered general BHCPF awareness and level of understanding of gender and equity and its importance to BHCPF implementation; core functions, roles and responsibilities, and gender and equity considerations for relevant state institutions and entities; and gender and equity barriers and potential impacts on BHCPF implementation across the four states.

Despite the general nature of the findings in this analysis, many are relevant to the implementation of IHP in FCT. 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 gender as it relates to what health services women need, especially those relating to pregnancy and children's health.

The analysis indicated that leadership structures within health agencies in FCT follow gendered patterns of leadership and decision-making. Leadership positions in the FCT PHCB are mainly male dominated; the governing board and executive secretaries of FCT PHCB are all males, while the management team have some females. Similar imbalances exist in the FCT Social Health Insurance Agency (SHIA), but the FCT SHIA has nearly achieved a 50:50 gender balance in staff positions. Furthermore, the FCT has not met guidelines to include the required number of women in WDC positions. Stakeholders claim women in FCT are not

[2] *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.*

interested in WDC positions. The analysis did not include information about the representation of marginalized or vulnerable groups in leadership and decision-making.

Quality and availability of services, including necessary equipment, pose key challenges to equitable service delivery in the FCT. In many PHC facilities in FCT, staff are expected to supply their own equipment (e.g., blood pressure machine). The analysis also revealed key gaps in health worker staffing, expertise to address health issues of patients, availability, and demeanor. PHC facilities themselves are frequently in need of additional rooms and space; the rooms are often too small and lack privacy, including rooms designated for delivery. Additionally, the PHC facilities and equipment are not conducive to provide accessible services to PWD and require structural improvements. One key stakeholder in FCT noted that barriers to service access are especially challenging for women with disabilities. Across the four states, key stakeholders noted an absence of services specific to PWDs, adolescent girls, men, and GBV survivors.

The analysis also identified several key gender and equity barriers to BHCPF implementation. Lack of information or access to information was cited as a key barrier to women choosing to access health services. Poverty and limited economic decision-making power also influence women's ability to access health services. Provider attitudes are a deterrent to both women and adolescents accessing health services; key informants noted gaps in health worker and provider training that results in limited confidentiality and inabilities to provide adequate, gender-sensitive care. Finally, there are gaps in efforts to engage men as clients and as partners and family members, which influence BHCPF understanding and uptake.

The findings from the analysis led to several key recommendations, which will also be beneficial to IHP implementation in FCT:

- Build gender and 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 accessible 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 a number of useful findings and recommendations, it is important to note that the findings of the analysis are focused on key gender and equity considerations within the context of BHCPF implementation. While some gender and 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 FCT and its unique demographics. For example, in reviewing gender and equity barriers to BHCPF implementation, there was not information specific to FCT to understand the relevance and applicability of the findings. 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. Finally, the analysis did not

present any information on norms, beliefs, and practices relating to gender and social inclusion in FCT, nor did it include background information or quantitative or qualitative data on RMNCAH+N health outcomes in FCT.

Sustaining Health Outcomes Through the Private Sector Plus Nigeria Family Planning Program: Gender Assessment

In 2018, the USAID-funded SHOPS Plus program undertook a gender assessment to analyze gaps, barriers, and opportunities for the implementation of the family planning program (*Nigeria FP Program*, 2018).[3] The assessment relied on a literature review and key informant interviews in Abuja and Jos to answer ten research questions. These questions focused on exploring the role of gender norms in provider training and service provision, gender-related content provided in existing trainings for providers, the influence of provider's attitudes about gender on family planning uptake, the relationship between sex and service provision and supervision, and facility-level protocols and practices relating to gender. The data collection and analysis resulted in recommendations to address the identified gaps, barriers, and opportunities, including indicators for gender-related results.

Many of the findings from the SHOPS Plus analysis will be relevant to IHP's approaches to improve the provision of family planning care and increase uptake of family planning in FCT. Gender norms influence the gender-mix of providers who participate in trainings, but do not affect the effectiveness of the trainings. However, gender norms likely do impact clinical effectiveness, and many providers allow their own beliefs and perceptions to influence service delivery. This bias may result in stigmatizing youth access to family planning, discouraging married women who do not have children from accessing long-acting reversible contraceptives (LARCs), and promoting the use of implants and injectables over IUDs in observance of women's modesty.

Not only do norms and bias influence the provision of family planning care, but so does the lack of both clinical and non-clinical skills to provide family planning. Providers interviewed in FCT indicated that there is only limited training related to gender and the provision of care; they also expressed an interest in gaining increased knowledge and skills on gender for clinical situations. At the facility level, protocols under the Federal Ministry of Health (FMOH) cover gender and family planning counseling with focus on the engagement of men and youth. However, providers had very low awareness of laws and policies relating to the provision of rights-based or gender-responsive care. Facilities and health posts do collect sex-disaggregated data, but the data are not passed to higher levels for analysis. Findings represent an opportunity for IHP to introduce greater understanding of gender and social inclusion among providers and to build capacity of providers to integrate gender-related factors into their service delivery for improved quality of care.

Practically, facilities offer family planning in "women's spaces." This means that facilities are more oriented to women as clients as they also combine family planning provision with ANC and other services for women. Though these services are provided in "women's spaces," they do not meet the needs of all women, most notably those who work in agricultural and market roles and those who observe *purdah* (Muslim practice of seclusion or avoidance of male gaze) and need private spaces away from possible exposure to male providers, staff, or patients.

[3] *The analysis presented is based on summary slides produced for the assessment; the desk review team was not able to access the full text of the assessment during the course of review. This limits the level of detail available from the assessment.*

Men's reproductive health and family planning needs are largely not considered. Notably, providers expressed engaging men in family planning by reaching out to male partners to both seek permission and promote joint decision-making. This is likely due to the finding that men in FCT will only attend family planning services if invited with a partner. There is also a lack of male-friendly spaces to encourage confidential counseling and service provision, which may deter men from seeking care.

The findings from the SHOPS Plus analysis resulted in recommended practices for the program to use to address the gender-related issues identified in the assessment. These recommendations may still be relevant to IHP's approach to improving family planning services:

- Cultivate gender-sensitive knowledge and skills amongst providers.
- Address bias amongst providers to encourage the provision of gender-sensitive and inclusive care through training on skills, such as patient counseling, and provider supervision and attitudes, to ensure men and youth are properly included in care.
- Train providers to involve men as joint decision-makers and provide men with confidential, private areas for counseling.
- Raise providers' awareness of the potential linkages between family planning use and violence, and work to reduce this threat (though, specific approaches are not provided).
- Implement provider recruitment and training approaches that promote gender-balance, remove barriers to training access, and encourage the participation of both men and women.
- Offer supportive supervision so facilities meet the gendered needs of their providers.
- Deliver training with gender-related modules and on the provision of appropriate and culturally sensitive messaging on care; this may include involving community leaders in training to develop and tailor messaging for communities.
- Build providers' knowledge on laws and policies as it relates to family planning on GBV.

It is important to note that the findings from this assessment combine information from Abuja, FCT and Jos, Plateau State. In only a few instances are findings specific to FCT. Additionally, as Abuja is an urban area, these findings may not apply to family planning provision in rural areas in FCT. The assessment did note that supervisors located in Abuja and Jos faced challenges in accessing health posts in rural areas, indicating that there are gaps in supervision in more rural areas. 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 FCT, nor did it include background information or quantitative or qualitative data on RMNCAH+N health outcomes in FCT.

2.2 RMNCAH+N overview and outcomes in FCT

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 FCT in relation to RMNCAH+N. Like much of Nigeria, health conditions in the FCT generally need sustained effort for improvement for all residents. However, FCT tends to perform better on key measures of health than many of the other 36 states in Nigeria (NPC & ICF, 2019). Main challenges in the FCT health system include planning, coordination, and lack of resources and funding (FCT HHSS, 2017). FCT performance on key health indicators and their relationship with gender are summarized in Table 1 below. Overall, in comparison to national averages, FCT tends to perform better on health indicators across RMNCAH+N, including under-five and maternal mortality, adolescent pregnancy, and childhood malaria, diarrhea, and stunting.

Table 1. Key RMNCAH+N health indices in FCT

Indicator	FCT		National	
Life expectancy at birth (years)	52	(2016) [1]	54.3	(2018) [2]
Life expectancy at birth (years), Female	55	(2016) [1]	55.2	(2018) [2]
Life expectancy at birth (years), Male	50	(2016) [1]	53.5	(2018) [2]
Infant mortality rate (per 1,000 live births)	46	(2018) [3]	67	(2018) [3]
Under-five mortality rate (per 1,000 live births)	75	(2018) [3]	132	(2018) [3]
Maternal mortality ratio (per 100,000 live births)	83.6	(2016) [4]	512	(2018) [3]
Total fertility rate (births per woman)	4.3	(2018) [3]	5.3	(2018) [3]
Percentage of teenage women (15-19) who have begun childbearing	10.6%	(2018) [3]	19%	(2018) [3]
HIV/AIDS prevalence (15-64 years)	1.6%	(2018) [5]	1.5%	(2018) [6]
Malaria prevalence among children under 5 years (rapid diagnostic testing [RDT]	31.3%	(2018) [3]	36.2%	(2018) [3]
Diarrhea prevalence among children under 5 years	8.2%	(2018) [3]	12.8%	(2018) [3]
Prevalence of stunting among children under 5 years (below -2 standard deviations [SD])	21.2%	(2018) [3]	25.2%	(2018) [3]

Data Sources: [1] NBS, 2019d; [2] World Bank, n.d.; [3] NPC & ICF, 2019; [4] NBS, 2018; [5] NACA, 2019b; [6] NACA, 2019a

Reproductive health and family planning

In FCT, on average, both women and men begin initiating sexual intercourse before their first marriage. Women typically begin engaging in sexual intercourse at 18.2 years, which is younger than men's age of sexual debut (20.8 years) (NPC & ICF, 2019). The median age of first marriage for young women is 21.5 years, which is higher than the national average (19.1 years) and higher than in the North Central, North West, and North East Zones. The average age at first marriage for men is much higher at 29.8 years, which is also long after the median age of sexual debut.

Women of reproductive age in FCT believe that the ideal family size is 4.7 children, which is lower than most states in Nigeria (NPC & ICF, 2019). In comparison to other states, FCT also has a relatively low total fertility rate (TFR) at 4.3 children per woman of reproductive age. This may be due in part to the fact that, across Nigeria, women in urban areas and with higher levels of education tend to both prefer and actually have smaller families.

The contraception prevalence in FCT is 23.6%, which is higher than the national contraceptive prevalence of 17% and slightly higher than the contraceptive prevalence in the North Central Zone of 16.2%, but still concerningly low (NPC & ICF, 2019). Contraceptive prevalence has seen a slight decline between 2013 and 2018. Prevalence for any method has reduced from 25.2% to 23.6% (NPC & ICF, 2014). Around one in five women use a modern method of contraception (NPC & ICF, 2019). The most common forms of modern contraception in the Territory are injectables (7.0%), implants (4.3%), external ("male") condoms (3.8%), and pills (3.2%). A small number of women also use traditional methods (3.6%). Despite FCT's high levels of contraceptive use in comparison to the rest of the nation, there is still a high unmet need for family planning.

Nearly one in five women (19.1%) have an unmet need for family planning for either child spacing or limiting (NPC & ICF, 2019). IHP and partners will need to consider and address the multiple factors influencing low levels of contraceptive use in FCT in its work to improve RMNCAH+N outcomes in the

Territory. This unmet need may be due in part to lack of knowledge and awareness about family planning. Nearly seven in ten women in FCT have never been exposed to family planning messages from any media source (radio, television, newspaper/magazine, or mobile phones) (NPC & ICF, 2019). Men have even less exposure to family planning messages in FCT. Women are most likely to have heard family planning messages on the radio (24.2%) or television (21.7%). For those men and women who have been exposed to family planning messages, they are most likely to have heard messaging about internal ("female") condoms. In addition to a lack of exposure to public messaging, women who do not use family planning also rarely discuss it with health providers. In the 12 months preceding the NDHS, 82% of women who do not use family planning had not discussed family planning with a health provider or fieldworker. 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 in ten women who visited a health center in the last 12 months received counselling about family planning.

Decisions about family planning in FCT tend to be made jointly by husbands and wives, both for women who currently use family planning and those who don't (NPC & ICF, 2019). For women who currently use family planning, over half decided jointly with their husbands (58.5%), but 13.3% reported their husband was the main decision-maker. Amongst women who do not currently use family planning, a higher proportion reported their husbands decided not to use family planning (15.5%). 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.

The North Central Zone, where FCT is located, has lower rates of unplanned births compared to other zones. This may be due in part to higher levels of contraceptive use. In the North Central Zone, of the proportion of pregnancies, 8% result in unplanned births, 65% result in planned births, and 16% in miscarriage (Guttmacher Institute & University of Ibadan, 2015). However, cross-sectional data from women enrolled in antenatal care (ANC) at University of Abuja Teaching Hospital in Gwagwalada indicate a higher prevalence of unplanned pregnancy (16%) coupled with low awareness of contraception (Agida et al., 2016). This variation may be due in part to the population from which the data was collected (women who chose to remain pregnant). Though abortion is illegal in Nigeria (except to save the life of the mother), an estimated 12% of pregnancies in the North Central Zone result in abortion; however, due to the illegality of abortion in Nigeria, this is likely an underestimation (Guttmacher Institute & University of Ibadan, 2015). This results in an abortion rate of at least 27 per 1,000 pregnancies in the North Central.

Maternal health

In FCT, women begin childbearing in their early 20s, with the median age at first birth at 21.8 years (NPC & ICF, 2019). Women have a median birth interval of 31.6 months, which is above the recommended minimal interval of 24 months. However, one in five women still have birth intervals below 24 months. Around one in ten young women between the ages of 15 and 19 have begun childbearing, which is much lower than national levels.

Over one-third of women still give birth at home in FCT (NPC & ICF, 2019). This represents a slight increase in home births from the 2013 NDHS (NPC & ICF, 2014). As of 2013, the main reasons for not delivering in a health facility were the sudden onset of labor (33.2%) and believing it was not necessary (29.5%). This is despite relatively high levels of ANC attendance (NPC & ICF, 2019). Nearly nine in ten pregnant women received ANC care from a skilled birth attendant in FCT. Data from the 2016-17 Multiple Indicator Cluster Survey (MICS) indicate slightly lower levels of ANC attendance (83.9%), with most women attending four or more visits in total (75.2%) (NBS & UNICEF, 2018). The median months pregnant at first ANC visit was

4.0 months. Of women receiving ANC, 96% or more had a blood pressure measurement, blood sample taken, or urine sample taken (NPC & ICF, 2019).

FCT also experiences high levels of skilled birth assistance when compared to the rest of Nigeria, with 71.6% of women receiving skilled assistance during delivery (NPC & ICF, 2019). However, around one in five births are attended to only by a relative, and 2.3% are attended by traditional birth attendants (TBAs). More women who choose facility-based births choose public facilities (26.9%) than private facilities (16.2%). Transportation may also serve as a barrier to women accessing facilities for deliveries; around one-quarter of women must rely on walking to attend to a health facility to give birth.

Nigeria is marked by high levels of maternal mortality, but FCT experiences lower levels of maternal mortality than the rest of the nation. It will be vital for IHP and partners to address those factors influencing maternal morbidity and mortality to improve overall health in the Territory. Some of the underlying factors contributing to maternal mortality include poverty, unsafe abortion, inadequate health facilities, and limited skilled birth attendance; however, in FCT, the high levels of ANC attendance and skilled delivery may mitigate some of these risks. Data from a rapid survey conducted by the NBS in 2016 reflect an MMR of 83.6 deaths per 100,000 live births,[4] significantly lower than the national MMR of 567.5 deaths per 100,000 live births (NBS, 2018).

Between the 2013 NDHS and 2018 NDHS, FCT has seen some concerning reductions in indicators of maternal and reproductive health (Table 2). For example, the contraceptive prevalence rate in the Territory has decreased, as has skilled delivery and attendance to postnatal care. There has also been an increase in adolescent childbearing. It will be important for FCT 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 FCT

Indicator	2013 NDHS[1]		2018 NDHS[2]	
	FCT	**National**	**FCT**	**National**
Contraceptive Prevalence Rate	25.2%	15%	23.6%	17%
Married women who had heard of any one modern method	92.7%	82.8%	*No data*	93.9%
Unmet need for family planning (married women)	19.7%	16%	19.1%	18.9%
Total fertility rate	4.5	5.5	4.3	5.3
Adolescents who have begun childbearing	9.2%	22.5%	10.6%	18.7%
Any ANC care from a skilled provider	88.5%	61%	87.7%	67%
Delivery in health facility	69.1%	36%	63.2%	39%
Maternal mortality ratio (per 100,000 live births)	*No data*	576	*No data*	512
Postnatal check-up in first 2 days after birth	79.6%	40%	60.9%	41.8%

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

HIV/AIDS is a key factor to consider in the context of both maternal and reproductive health in FCT, and there is an opportunity for IHP and partners to integrate considerations about HIV into its efforts to improve reproductive, maternal, and child health. Like much of Nigeria, HIV prevalence tends to be higher amongst women than men in the North Central Zone (NACA, 2019b). Longitudinal analysis of women

[4] *This was the only figure located for MMR in FCT. However, given the lack of data points for comparison, there is a need for a greater understanding of maternal mortality in FCT to determine the reliability of this finding.*

attending ANC at National Hospital Abuja, which draws women from a wide variety of ages and backgrounds in FCT, indicates concerning trends for HIV prevalence amongst pregnant women in FCT (Agboghoroma, & Iliyasu, 2015). Among women attending ANC who were also tested for HIV, prevalence was measured at 11.5%, which is much higher than population-level measures for HIV prevalence amongst women in Nigeria and in the North Central Zone. Prevalence of HIV tended to be higher amongst younger mothers, which could be due to lack of knowledge and awareness about HIV prevention methods. HIV prevalence tended to be lower amongst women in higher socioeconomic classes. Data from the 2013 NDHS indicate moderate levels of knowledge about the prevention of mother-to-child transmission (PMTCT) of HIV (NPC & ICF, 2014). Around six in ten women and five in ten men know that HIV can be transmitted during breastfeeding, but fewer men and women are aware that the risk of mother-to-child transmission (MTCT) can be reduced by taking medication.

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

Table 3. HIV prevalence and HIV/AIDS knowledge in FCT

Indicator	FCT		National	
	Men	Women	Men	Women
Knew condoms and having one partner without HIV reduces risk [1]	83.6%	72.3%	74.1%	70.7%
Knew that HIV can be transmitted via breastfeeding [1, 2]	55.4%	62.1%	69.7%	77.6%
Knew that MTCT risk can be reduced with medication [1, 2]	48.8%	55.3%	62.7%	71.5%
HIV prevalence [3, 4]	1.1%*	2.8%*	1.1%	1.9%
People living with HIV with VLS [3, 4]	63.0%*	66.7%*	40.9%	46.2%

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

Newborn and child health

Indicators of newborn and child health in FCT are more similar to those of the southern states of Nigeria, which tend to perform better than northern states on indicators of health and development. In the five years preceding the 2018 NDHS, the under-5 mortality rate was 75 deaths per 1,000 live births (NPC & ICF, 2019). Infant mortality stands at 46 deaths per 1,000 live births. Neonatal and infant mortality may be linked to low levels of postnatal care. Around one-third of women (32.7%) and newborns (36.5%) never received a postnatal check in FCT. For those mothers and newborns who do receive a postnatal check, most occur within the first 24 hours after birth. However, postnatal care for newborns is not robust in FCT, with only 28.3% of newborns receiving checks of two signal functions and only 41.6% being weighted. This suggests the need for IHP and partners to address barriers to access and challenges with quality of newborn care.

Most under-five mortality in FCT occurs within the first week of life and is linked to complications of pregnancy and delivery, highlighting the link between quality of maternal care and child survival (Rhoda et al., 2019). Recent analysis of the demographic and socioeconomic factors influencing under-5 mortality in FCT highlight a range of circumstances that perpetuate child mortality in the Territory. Higher levels of child mortality are linked to mothers who have lower educational attainment and lower monthly income. Mothers who were employed were also less likely to have experienced child mortality. There were

differences between experiences of child mortality by ethnicity, with women in the Gbagyi, Hausa, and Fulfulde groups experiencing higher levels of child mortality. These findings highlight the need to address gaps in women's and girls' education and employment opportunities as a key mechanism to improving the wellbeing of children.

There are higher levels of health-seeking behavior for children in FCT, which are likely linked to the higher levels of overall development in the Territory. Nearly three-quarters of children in FCT (73.9%) have received all basic vaccinations, but only half of children have received all age appropriate vaccinations (NPC & ICF, 2019). Only 9.1% of children have received no vaccinations at all. Eight in ten parents sought treatment for their child when their child experienced fever or diarrhea.

Nutrition

In Nigeria, several populations struggle with receiving adequate nutrition, including children and women. Despite FCT's high levels of development, the Territory has concerning indicators for nutrition. Infant and young child feeding (IYCF) practices are key to promoting long-term development for children. Nearly all (98.1%) of children in FCT are ever breastfed, and most are breastfed for the first time within one day of birth (NPC & ICF, 2019). A cross-sectional survey of working mothers in Abuja Municipal Area Council indicated that the women surveyed had high levels of knowledge and awareness of breastfeeding practices and the benefits of breastfeeding, and higher levels of knowledge were associated with higher levels of continued breastfeeding (Omuemu, & Adamu, 2019). Most women received this information from hospitals (85.0%). Around half of the women surveyed demonstrated correct practices of exclusive breastfeeding and followed appropriate timing for the initiation of complementary foods. Women who did not have supportive partners, were not giving maternity leave, or did not have an on-site area for breastfeeding were less likely to continue breastfeeding their children. Another survey of women in rural suburbs of Abuja also indicated that about half of women practiced exclusive breastfeeding (Egneti et al., 2018). Of women who did not practice exclusive breastfeeding, it was most likely due to a lack of awareness (21.1%), stress (18.1%), the nature of their work (11.4%), or a low culture of acceptability (11.4%). Skilled birth attendance and hospital delivery were associated with exclusive breastfeeding practices.

Only 12.7% of children between the ages of 6-23 months are fed the minimum dietary diversity, and 36.0% receive the minimum meal frequency (NPC & ICF, 2019). Only 4.5% of children receive a minimum acceptable diet. This is likely linked to poor nutritional outcomes. Six in ten children between the ages of 6-59 months have any level of anemia in FCT. Less than half of children have access to vitamin A rich foods (41.2%) or iron rich foods (36.6%), and there are even lower levels of vitamin A and iron supplementation. In addition, half of women in FCT experience any level of anemia. 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.

2.3 Gender and social inclusion considerations in FCT

As noted, the prior gender analyses conducted in FCT 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 Territory. 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 FCT.

The Gender Inequality Index (GII),[5] which provides a measurement of inequality in the experiences of men and women, in FCT is 0.504 (UNDP, 2018). This places FCT as the eighth most gender equal locality in Nigeria; however, the index value for FCT still represents significant gender disparities in health, representation in leadership, education, and economic activity.

Gender norms, roles, and responsibilities

Beliefs about gender, including norms and roles, are "powerful root causes" of gender inequality across Nigeria and in FCT (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 FCT (Morel-Seytoux et al., 2014; Fontaine et al., 2016; UN Women, 2020). However, there is some Territory-specific data from the 2018 NDHS highlighting the influence of gender norms in FCT. Understanding and considering these gender norms will be important to IHP's efforts to improve access to and quality of health services in FCT.

Women's independence and economic empowerment are deeply affected by gender norms, and they are key factors to consider in the provision of health services. As noted, women face steep levels of unemployment in Nigeria and even higher levels of unemployment in FCT (NPC & ICF, 2019). Most married women in FCT also report that their cash earnings are less than their husbands', and very few women (less than one in ten) own their own land or homes in FCT. Many women who are employed and make cash earnings make decisions about how to spend their own earnings (69.8%). In one-third of families, husbands and wives decide together how to spend a wife's cash earnings, while in 6.2% of cases husbands make decisions alone. This is in stark contrast to decisions about married men's earnings; two-thirds of men control their own earnings, and only one in five include their wife in decisions about their earnings. Furthermore, only one-third of women in FCT have their own 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.

Women in FCT experience higher than average levels of participation in decision-making in their families (NPC & ICF, 2019). Around two-thirds of women participate in decisions about their own healthcare and in decisions about household purchases. Three-quarters of women participate in decisions about visiting friends or family. This indicates higher levels of independence and autonomy in comparison with other states in Nigeria, which could suggest women face reduced barriers to healthcare access in FCT. However, there is still a stark gap in women's ability to make decisions about their own lives in comparison to men. Over 98% of men indicate that they participate in decisions about their own health and household purchases in FCT, which is much higher than the approximate 67% of 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 FCT. 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. Two-thirds of women feel

[5] *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).*

that women are justified in refusing sex if they know their husbands engage in sexual relationships with other partners; however, only one-third of men agree that this is acceptable (NPC & ICF, 2019). 64.9% of women feel that they can refuse sex to their husband for any reason. Eight in ten women believe a wife is justified in asking her husband to use a condom if he has an STI, and three-quarters of men also agree. Just over half of married women felt comfortable asking their husband to use a condom for any reason.

However, despite women's higher levels of autonomy in decision-making, there are still concerning patterns of controlling behavior in marriages. In FCT, nearly half of ever married women report that their husband insists on knowing where she is going at all times (NPC & ICF, 2019). Four in ten women report that their husbands become jealous or angry if they interact with another man, and three in ten women are not permitted by their husbands to meet female friends. One in ten women report that their husbands limit their ability to see their 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 discourage 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 FCT. In FCT, there are data to indicate high-risk sexual behaviors may be common amongst both women and men (NPC & ICF, 2019). Women in FCT have on average 5.7 sexual partners, while men tend to have 2.5 sexual partners on average. Of women who engaged in sexual intercourse with someone who was not a partner in the 12 months preceding the NDHS, less than six in ten used a condom. There was limited information from men who had engaged in sexual intercourse outside of partnerships.

Gender-based violence

Across Nigeria, there are concerningly high levels of GBV, including extreme forms of violence like severe physical mutilation and femicide. Violence is an important factor to consider in relation to gender inequality and health outcomes in Nigeria and in FCT. In FCT, over one-third of women have experienced physical violence since the age of 15 (NPC & ICF, 2019). Only 3% of women have ever experienced sexual violence. Of ever married women, 16.3% have experienced some form of spousal or intimate partner violence (IPV), the most common forms being emotional (12.7%) and physical (7.4%). There are low levels of violence during pregnancy, however, with only 1.3% of women reporting that they have experienced violence during pregnancy. There are also low levels of self-reported perpetration of violence by women against their husbands (1.6%). It is important to note that stigma and acceptance of violence may lead to both under-reporting and unwillingness to discuss violence.

High levels of violence are compounded by low levels of help-seeking behavior in FCT. Three-quarters of women who have experienced violence never told anyone about the violence, nor did they ever seek help.[47] Around 15% of women told someone about the violence but did not seek help in relation to the violence. Only one in ten women ever sought help for violence. There is a lack of information about GBV survivors' experience seeking health services in FCT; this gap in knowledge will be important to address as FCT, IHP, and partners seek to improve identification and response to GBV in the health system and across sectors.

Despite the high levels of violence in FCT, the levels of acceptance of violence amongst women and men are not as high (NPC & ICF, 2019). Almost one in ten (9.7%) of 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, goes out without telling her husband, or refuses to have sexual intercourse with her husband. Men are even less likely to accept violence; 4.6% of men reported they felt that violence was acceptable in one of the five scenarios. Men are most likely to believe violence is acceptable if a wife goes out without telling her husband or refuses sexual intercourse with her husband.

In comparison to national averages, women in FCT face lower levels of GBV and slightly higher levels of controlling behavior (Table 4). They are less likely to believe that a husband is justified in beating his wife.

Table 4. Gender-based violence in FCT

Description of Violence	FCT	National
Physical abuse from husband or partner (ever-married women between 15 and 49)	7.4%	19.2%
Sexual abuse from husband or partner (ever-married women between 15 and 49)	1.4%	7.0%
Emotional abuse from husband or partner (ever-married women between 15 and	12.7%	32.3%
Controlling behavior: women whose husbands become jealous if they talk to other men	44.5%	44.2%
Controlling behavior: women whose husbands must know where they are at all times	46.3%	40.7%
Controlling behavior: women whose husbands try to limit when they see their families	10.5%	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)	9.7%	28.0%
Data Source: NPC & ICF, 2019		

Between December 2018 and November 2019, the Legislative Advocacy Coalition on Violence Against Women (LACVAW) in Nigeria completed a baseline assessment of sexual and gender-based violence (SGBV) across the Area Councils of the FCT (LACVAW, 2020). During the time period of the assessment, the police and Nigeria Security and Civil Defence Corps (NSCDC) documented a combined total of 65 cases (58 female and 7 male) of SGBV. Health facilities documented a total of 121 cases (118 female and 3 male) of SGBV. These lower than expected numbers of reported cases are likely associated with the lack of help-seeking behavior described above. FCT faces challenges in strengthening institutions to implement laws and policies in relation to SGBV prevention and response. However, FCT has taken key steps to improve response to GBV. The passage of the Violence Against Persons (Prohibition) Act 2015 (VAPP Act) and the establishment of the FCT SGBV Response Team in 2017 represent progress towards improving GBV response and referral, and FCT, IHP, and its partners can harness this progress to promote coordinated, multisectoral GBV response and referral.

Over the years, the Federal Government of Nigeria has intensified efforts towards the prohibition of FGM/C with a view to eliminate this harmful traditional practice (United Nations Committee on the

Elimination of Discrimination against Women, 2016). Awareness raising activities including campaigns have been carried out by key stakeholders. Although at present there is no legislation at the Federal or FCT level prohibiting FGM/C, there are extant laws in 26 states. The most recent national-level figures report that 12.3% of women aged 15-19 had some variety of the procedure performed on them, compared to 27.6% of women aged 45-49 (NBS, 2019d). These data suggests that the practice may be fading, since it is typically performed on girls when they are younger. The practice of FGM/C is less pronounced in the FCT as only 5.1% of women experienced some form of FGM/C (NPC & ICF, 2019).

As FCT has experienced rapid growth in population and expansion, the population of female sex workers (FSW) has been increasing (Fawole, & Dagunduro, 2014). Women report engaging in sex work due to lack of financial resources and lack of support from other sources. Global data indicate that FSW are at higher risk for all forms of GBV. A cross-sectional, mixed methods study in FCT indicated that over half of FSW in the Territory had experienced some form violence, many of whom experienced repeated instances of violence (three or more). Sexual violence was most prevalent, followed by economic and physical violence. FSW in FCT have high levels of awareness of different types of violence, but nearly seven in ten FSW saw violence as a part of their job. Clients and staff were the most common perpetrators of violence, but 6.3% of FSW reported experiencing violence from police officers. Notably, FSW appear to be more likely to seek help or support then they experience violence. Over six in ten sought support from their brothel's chairwoman, and four in ten reported the violence to the police.

Marriage and divorce

There is little Territory-specific information available about practices of marriage and divorce in FCT. Across Nigeria, there is a prevailing belief that women have little influence in choosing whom they marry (UN Women, 2020). The practice of polygyny, or having multiple wives, is more common in Northern Nigeria than in the rest of the nation. In FCT, around one-quarter of married women (25.9%) report having co-wives (NPC & ICF, 2019). Only one in ten men in FCT report having multiple wives. There are also large gaps in marital age between men and women. Four in ten women ages 20 to 24 in the North Central 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.

Early and forced marriage

Early marriage is also common in Northern Nigeria, particularly in the North East and North West (Federal MWASD, 2016). In the North Central Zone, where FCT is located, fathers are seen as the main drivers of early marriage. However, there is an increasing number of mothers becoming involved and incorporating social committees to help prevent early and forced marriage of their children. Yet, girls are still encouraged to accept early marriage, and there is a pervasive "culture of silence" that prevents them from speaking out if they are forced to be married.

Education and early marriage and critically intertwined in Nigeria. In FCT, early and forced marriage have been identified as one of the factors most likely to discourage girls from attending or completing schooling. Seven in ten teachers and principals in FCT have identified early and forced marriage as the main reason girls stop attending school (Omoniyi & Oloruntegbe, 2014). Additionally, in a cross-sectional survey of parents across the six Area Councils of FCT, over eight in ten agreed that early marriage negatively affects girls' attendance to school (Osagiobare et al., 2015). There may also be a fear that higher levels of education deter men from wanting to marry women, resulting in girls leaving school. Lack of education has key implications for women's and girls' lives and health, as lower levels of education have been associated with negative health outcomes in Nigeria and in FCT. However, as education levels have

been increasing in the North Central Zone, there is a general perception that early and forced marriage is reducing (Federal MWASD, 2016).

Religious and cultural factors are strongly linked to early marriage in FCT and across Nigeria. Expectations that a woman's role in society encourages parents to pursue marriage for daughters and young ages to ensure they are fulfilling their obligations (Osagiobare et al., 2015). Misunderstandings about religious principles, especially in Islam, have also been identified as factors that detract from girls' education and promote early marriage. Religious leaders are highly influential in the North Central Zone and have been key agents of change in involving their faith communities and parents in conversations about early and forced marriage (Federal MWASD, 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 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 FCT. 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 HIV, tuberculosis (TB), and STIs (NPC & ICF, 2019; Fontaine et al., 2016; Biya et al., 2014). Because of these norms, health facilities are commonly considered the domain of women and children (Fontaine et al., 2016; Pappa, 2019).

Recent research, which included data collection in the FCT, reflects a strong link between perceptions of masculinity and religion in Nigeria (ChristianAid Nigeria, 2015). In communities, religious texts provide models of masculinity, positioning men as heads of household, and imbue them with power from God to make decisions on behalf of their families. However, despite these expectations, religion was not identified as a factor explicitly defining gender roles and responsibilities for men and women in the household. Religious leaders are emerging in both Christianity and Islam that promote these more equitable views amongst men, though leaders who enforce traditional norms remain influential. Information from younger men suggest a shift amongst the younger generation to embrace more equitable views of gender and gender roles. Men did not see religion as a factor impeding or affecting health seeking behavior amongst men; in fact, participants believed both Christianity and Islam encouraged health conscious behavior. Men saw religion as a powerful influence in society and recommended that religious leaders and communities be engaged in efforts to promote gender equality and positive masculinities.

This study also explored broader-based beliefs about masculinity (ChristianAid Nigeria, 2015). Most respondents believed that men were created to be superior to and even dominant over women and were seen as having more strength. Men are also vested with the responsibility to marry, protect, and provide for women and children and pay the bride price in marriage. Women were believed to provide support to men's roles, including cooking and caring for the family, and providing for the family in the absence of a man. When it comes to norms about masculinity – especially related to health – that could be considered "harmful" to men or their families, respondents believed that if there was peace at home men would suffer no health implications from their ascribed roles and responsibilities. In addition, they believed that women were at the risk of depression, leading to substance abuse and suicide because of being denied the opportunities to partake in roles ascribed to men. Some believed that there were health implications

such as hypertension among men due to work overload, and obesity among women due to their sedentary lifestyles. They believed role sharing among men and women would help to ease this burden.

Social inclusion and vulnerable populations

In addition to concerns around gender inequalities in FCT, 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 key vulnerable populations in FCT; additional information about these populations' access to health can be found in the section *Healthcare access and challenges.*

Youth and adolescents

While Nigeria has a high population of youth and adolescents, FCT has a distinctly older population. Less than three percent of the population is between the ages of 10 and 24 (UNFPA, 2020). This may be due to high levels of migration into FCT at older ages and lower levels of fertility in the Territory. However, like youth and adolescents across Nigeria, youth and adolescents in FCT likely face unique challenges, including access to education, limited knowledge of sexual and reproductive health, early marriage, and high levels of unemployment, among other factors. This desk review did not locate any FCT-specific information about the general status of youth and adolescents in FCT, which is a critical gap in knowledge and represents an opportunity for IHP to pursue greater understanding to influence adolescent-responsive services.

Internally displaced persons

Nigeria experiences high levels of internal displacement, and FCT has seen an increase in the number of internally displaced persons (IDPs) creating and living in informal settlements or slums in FCT and around Abuja (Isumonah et al., 2018). There are between 21 and 40 informal settlements and camps in FCT. For example, Kuchigoro, a settlement around Abuja, is predominantly populated by IDPs who have fled violence in Borno State, but it is also inhabited by urban, poor residents of Abuja. A recent assessment of vulnerable groups in the context of internal displacement documents multiple manifestations of inequalities and explores how marginalization is compounded by intersecting factors such as gender, ethnicity, religious norms, class, cultural expectations, demographic factors (such as age), and conflict. In FCT, IDPs are highly vulnerable due to a variety of factors (UNHCR et al., 2015). Many IDPs lack proper documentation, which can prevent them from seeking employment or sending children to school. Women and girls in informal settlements are subjected to high levels of GBV, though many IDPs are unwilling to disclose or report these experiences, which may prevent them from seeking any form of care.

Persons with disabilities

In FCT, around one in ten women and one in ten 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. This act provides for full integration of persons with disabilities into society, establishes the National Commission for Persons with Disabilities, and vests that commission with responsibilities for the education, health care, and social, economic, and civil rights of persons with disabilities. This act applies directly in the FCT but has not been domesticated in any of the other 36 states of Nigeria. This desk review did not identify information about the current status of the implementation of the Act in FCT.

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

Nigeria has an extensive and complex policy environment related to gender, social inclusion, and health, with corresponding national ministries responsible for planning, implementation, and monitoring. The health system in Nigeria is decentralized, therefore State- and Territory-level authorities adopt national policies/internationally adapted treaties and adapt them within their local context. The level of adoption and adaptation depends on context and varies depending on the priorities of the State or Territory, cultural influences, and religious sentiments. Several national level policies do not exist at the FCT level, while others are unavailable to the public for policy analysis. During the course of the desk review, the team sought out FCT-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). An overview of findings is presented below; complete checklists for each of the Territory-level policies can be found in *Annex 1: Gender-responsive checklists for health policies and guidelines in FCT, Nigeria*.

Table 5. Territory-Level Policies Analyzed

FCT Primary Health Care Board 2019 Annual Operational Plan (2019b)	The FCT PHCB 2019 Annual Operational Plan (AOP)[6] was developed by FCT PHCB with support from the National Primary Health Care Development Agency (NPHCDA), FCT HHSS, and technical partners such as HP+ and Solina Group. The AOP guides the implementation of PHC activities and the development of the budget. The 2019 AOP was the first AOP for the PHCB, filling a gap in planning and budgeting for activities for the FCT. The AOP has the goal to provide community driven, equitable, integrated PHC services of high quality to attain UHC. The AOP was developed based on the provisions of the FCT SHDP II (2018 – 2023). Of the 38 strategic objectives and 118 activities, none of the objectives specifically focused on gender equality or takes into consideration the needs of marginalized groups such as PWD. The AOP does not include gender equality as a health determinant nor utilize sex- or age-disaggregated data. The AOP included a priority area on gender mainstreaming under the RMNCAH+N services but did not include specific objectives, interventions, activities, and indicators to capture gender-related outcomes or gender inequalities across the FCT. However, the plan does provide for sensitization on

[6] *The FCT PHCB 2020 AOP was not available during the course of the desk review.*

	dangers of early marriage/early pregnancy, the importance of ANC, fistula prevention and care, child abuse and neglects, GBV prevention and response, and the health needs of adolescents. The AOP is missing specific activities to meet the health needs of men, engage men as partners in health, and provide for the needs of PWD. The AOP did not make specific budgetary allocation for gender actions but rather made provisions for RMNCAH+N services which cover women (especially pregnant women), adolescents and children only. There was no provision for increasing women in leadership positions in FCT and the M&E Plan was not gender-responsive or inclusive of marginalized groups.
FCT Primary Health Care Board Human Resources for Health Policy (2019-2024) (2019c)	The goal of the FCT PHCB Human Resources for Health (HRH) Policy is to work towards UHC and accessible, human-centered primary health care serviced through the provision of competent, motivated health professionals by investing in HRH strengthening. The policy is based upon an HRH gap audit, but the results of the gap audit, including any results relating to gender gaps, are not presented in the policy. While it was developed through a "comprehensive and consultative process" with key stakeholders, key gender-related stakeholders like the Gender Unit of the FCT Social Development Secretariat or the Federal Ministry of Women Affairs and Social Development (MWASD) were not involved in the process. Overall, the FCT HRH Policy is gender blind and lacks robust features to improve gender equality and social inclusion in HRH recruitment, distribution, and management. The vision and mission statements, guiding principles, policy objectives, and monitoring and evaluation (M&E) plan do not reflect gender sensitivity in HRH or in the implementation of the policy. Mentions of gender and social inclusion are vague, at best, and reflect no actionable items to address HRH-related gender and social inclusion issues. For example, the policy references the need to consider "sociocultural peculiarities" in HRH distribution and mix but does not define the factors considered. Where gender is mentioned as a factor to consider for distribution, it is only mentioned to "meet staffing norms," not to meet the needs of communities. The policy does include a protection against gender-based discrimination in the provision of support and resources in the HRH exit management system.
FCT Primary Health Care Board Human Resources for Health Strategy (2019-2024) (2019d)	The FCT PHCB HRH Strategy operationalizes the FCT PHCB HRH Policy by adding intervention areas, activities, and outputs to the policy's objectives. Like the HRH Policy, the strategy was developed in collaboration with key stakeholders, but no gender focal points or representatives from agencies tasked with gender integration or social inclusion were involved. Many of the gender and social inclusion gaps identified in the FCT HRH Policy are also pertinent to the FCT PHCB HRH Strategy. The strategic plan is largely gender blind as it does not recognize unique, gendered needs in terms of service access as it relates to HRH. The need for accessible, unbiased care is expressed in vague terms with little reference to social groups experiencing barriers to access or high levels of bias. Citizens living in urban slums are the only group for which the strategy explicitly recognizes challenges in service access, and children under 5 are the only defined group for which the strategy mentions actions to improve access. The intervention areas, activities, and outputs also do not reflect gender-sensitivity or social inclusion in HRH production, recruitment, distribution, or management. There is no data included on gender gaps in the HRH workforce. Equitable HRH distribution is prioritized to meet the

	"sociocultural expectations" of the population, but these expectations are not defined or described. Production, recruitment, and distribution are prioritized in terms of HRH skill-mix and cadre without reference to gender or social inclusion needs. The strategy does reinforce the protection against gender-based discrimination in the HRH exit management system, which was established in the HRH policy, but does not include any details about enforcement. The strategy adds an action to prioritize the inclusion of HRH trainees from remote areas with the intended outcome of improving health access in rural areas. The M&E plan as described does not suggest that gender and social inclusion-related indicators will be collected in the implementation of the plan, but the strategic plan located during this desk review did not include the strategy's annex with detailed indicators.
FCT Strategic Health Development Plan II (2017-2021) (2017)	This plan was developed in collaboration with a variety of stakeholders in FCT under the coordination of the FCT HHSS. The plan provides guidance to improve health systems and service delivery by creating an enabling environment, increasing utilization of essential health services, strengthening the delivery of essential health services, protecting from health emergencies and risks, and establishing predictable financing and risk protection to achieve targeted health outcomes. The plan utilizes very little sex- and age-disaggregated data and does not prioritize gender as a social determinant of health. Gender equality is included as a priority area only under RMNCAH. However, there is a lack of specific interventions, targets, or indicators to address gender inequalities in health. Protecting the rights and meeting the unique needs of specific groups such as men, adolescents, people with disabilities, and sexual priorities are not explicitly addressed or prioritized. Women's unique health needs are prioritized only in the context of reproductive and maternal health. Gender equality and social inclusion are not considered in HRH or health financing approaches.
National Gender Policy (2006)	The Federal MWASD developed the National Gender Policy in 2006, which was followed by a strategic framework for its implementation in 2008 (Federal MWASD, 2008). This federal policy applies directly in FCT under the oversight of the Federal MWASD and FCT Gender Department. Along with the National Women Policy (2000), the policy aimed to make gender equality a driver of growth; promote health, survival, and freedom from violence; and create an inclusive society devoid of gender discrimination. The policy mandated all federal MDAs to appoint a gender focal person within their directorate and supported the collection of sex-disaggregated data at all levels. The strategic framework also prioritizes violence against women and children as a key issue and identifies specific actions to prevent and respond to this violence through a national referral pathway which identifies stakeholders in each state for the referral of GBV cases (World Bank, 2019). The policy recognized that its efficacy was dependent on political will, recognizing gender as a core value for transforming the Nigerian society, confronting patriarchy and coordination, and networking and monitoring. While the policy has been in existence for over a decade, there is limited information about the status of its implementation. Both the Federal MWASD and FCT Gender Department plan to undertake a

	review of the policy, and the FCT Gender Department has begun the development of a Territory-specific gender policy.
Violence Against Persons (Prohibition) Act (2015)	The *Violence Against Person (Prohibition) (VAPP) Act* is a national-level policy document with aims to eliminate and prohibit all forms of violence. It also provides protections for survivors of violence and offers penalties for perpetrators of violence. The policy expressly prohibits multiple forms of violence, including physical, sexual, emotional, and financial violence as well as FGM/C and harmful widowhood practices. This national-level policy applies directly to FCT and, unlike in other states, does not have to be domesticated in order to be applied. The VAPP Act explicitly grants that only the High Courts in Abuja have jurisdiction to hear or grant applications under the act. Notably, the act recognizes that violence can be perpetrated against both men and women, which represents progress from prior laws prohibiting violence. The act identifies key stakeholders responsible for implementing and upholding its provisions, including the National Agency for Prohibition of Trafficking in Persons (NAPTIP) (the designated regulatory body responsible for the act), FCT Sexual & Gender Response Team, the National Human Rights Commission (NHRC), the International Federation of Women Lawyers (FIDA), and other CSOs and faith-based organizations (FBOs). However, the Act does not provide guidance for enforcement nor does it offer guidelines to establish services or referral pathways for GBV survivors. Despite the act's existence for five years, there is very limited information about the status of its implementation. Reporting data from NAPTIP indicate that the agency did not make any arrests or prosecutions under the act between 2015 and 2017 (NAPTIP, 2016; 2017; 2018). In 2018 and 2019, the agency began reporting on instances of "violence against persons." In 2018, NAPTIP received 42 cases of violence against persons, none of which were fully investigated (NAPTIP, 2019). Only 25 suspects were apprehended in these cases, and none were prosecuted. In 2019, there were 79 arrests made for violence against persons, but no information was presented about the number of cases received or prosecuted (NAPTIP, 2020).

2.5 Health systems: considerations for gender and social inclusion

Leadership and governance

Understanding the health-related leadership and governance structures in FCT is key to IHP's goals to strengthen health systems supporting PHC services. While the Nigeria FMOH provides national-level strategies, policies, and guidance to improve health in the nation, there are FCT-specific ministries, departments, and administrations (MDAs) working to provide health care in the Territory. The FCT Health and Human Services Secretariat (HHSS) guides the Territory-specific approaches to offering and improving health services. The FCT HHSS is further sub-divided into the following departments: Health Planning, Programme Formulation, Budget and Procurement and Due Process, and Research, Monitoring & Evaluation of Programmes and Projects (Federal Capital Development Agency, n.d.). The FCT HHSS sets the strategic mission and vision for the health system in the Territory, which has been documented most recently for 2017 to 2021 in the Strategic Health Development Plan (SHDP II) (FCT HHSS, 2017). The plan guides the Territory's efforts to achieve its goal of providing quality, affordable health services to improve the health of all citizens.

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). At the local government level, women have held only one out of 27 positions as Local Government Chairperson between 1999 and 2015, and only 12 out of 266 positions as Local Government Councillor (NBS, 2019d). As noted and 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 FCT.

Shifts in leadership and opaque decision-making processes negatively affect the ability of health agencies in FCT to function well and instill trust in systems (FCT HHSS, 2017). Furthermore, communities in FCT are often not involved or represented in decision-making about health in FCT. Structures like the WDC, Village Health Development Committees (VHDC), and Health Facility Committees (HFC) are intended to act as links between the health system and the community to facilitate demand creation and health access (FCT PHCB, 2019b). However, these structures, where they exist, are often weak and experience low levels of community owner. In addition, though there are intentions and even requirements to include women in these structures, these requirements are not often met (Pappa, 2019). This desk review did not identify efforts to actively include other vulnerable groups, including youth and PWDs, in these community structures. FCT, 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 Territory.

Service delivery

The health system in FCT is structured with three-tiers: primary, secondary, and tertiary (FCT HHSS, 2017). The majority of accredited health facilities in the Territory are private health facilities (500 out of 754), which receive oversight from the FCT HHSS but are not operated by the FCT. Different parastatal organizations in FCT operate facilities at the primary, secondary, and tertiary level. PHCs are operated by the FCT PHCB, secondary facilities are operated by the FCT Hospitals Management Board (HMB), and the tertiary facilities in the state are owned and operated by the Federal Government. There are reduced numbers of facilities available at the higher levels of care (secondary and tertiary), and these facilities tend to be concentrated in urban areas, though FCT has undertaken efforts to build new facilities to meet rural needs.

There is a slightly higher availability of PHCs in FCT than in the rest of the nation. There are 18.5 PHC facilities per 100,000 residents in FCT, as compared to the 16.6 PHC facilities per 100,000 residents at the national level (Makinde et al., 2018). FCT has a high concentration of secondary care facilities (2.97 per 100,000) due to the number of secondary care facilities in Abuja, but a low concentration of tertiary facilities (0.018 per 100,000). There is currently a total of 235 PHC facilities in FCT that fall under two classifications: PHC Clinics and PHC Centres. Most of the PHC facilities (190) are smaller PHC Clinics, which also have lower staffing requirements and offer less advanced services, while the remaining 45 facilities are PHC Centres, which require higher levels of staffing and more skilled care (FCT HHSS, 2017; FCT PHCB, 2019c). Though most of the 62 wards have at least one functioning PHC facility, there are two wards that lack a PHC facility (FCT PHCB, 2019c). On average, these facilities complete two community-level outreach visits per month, which are a key mechanism to overcoming gaps in access. However, there is no information available about how outreach is conducted or if it ensures all community members are reached with appropriate messaging about available services.

While IHP is focused on the provision of primary care, additional detail about the role of secondary and tertiary facilities is important to consider in the context of referral and coordinated response amongst different levels of health care. PHCs must refer patients requiring specialized care to secondary facilities, including for specialty obstetric and gynecologic care and pediatric care (FCT HHSS, 2017). There is some overlap between the services available in secondary and tertiary facilities in the state, but tertiary facilities typically offer the most specialized forms of care.

There has been a longstanding lack of guidelines in the Territory to provide for service delivery, including guidelines for monitoring and improvement of service delivery (FCT HHSS, 2017). This desk review did not identify any policies or guidelines in FCT governing service delivery in general or as it relates to gender and social inclusion in RMNCAH+N services.

Health information

Health information systems in FCT are challenged by poor infrastructure and limited human and technical capacities to collect, manage, and use health information (FCT HHSS, 2017). FCT was not able to fully implement any of the health information strategies under the SHDP I, but has made progress in implementing electronic health (also known as eHealth) applications in around one in ten PHC facilities. As described in the policy analysis, few of the FCT policies located and analyzed presented sex- or age-disaggregated data, and none required the collection of sex- or age-disaggregated data in health information systems. 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.

FCT uses the National Health Management Information System (NHMIS) Tools for health information collection; these tools are distributed to all facilities and the FCT HHSS reports that most monitoring and evaluation officers have been trained in the use of these tools (FCT HHSS, 2017). 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, except for 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. Qualitative information from selected facilities in Abuja collected during the SHOPS Plus analysis indicate that sex-disaggregated data is collected in those facilities, but not collated or analyzed at higher levels (*Nigeria FP Program: Gender Assessment*, 2018). However, the collection of sex- and age-disaggregated data is only one component of integrating gender and social inclusion into health information systems. 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 FCT HHSS and PHCB, 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

Financing and budgeting for health in FCT follows a unique process in comparison to other states in Nigeria. Budgets for FCT MDAs are linked to the passing of the national budget, which is often prolonged and delayed (FCT PHCB, 2019b). Additional health financing challenges in the Territory include a lack of direct budget lines for PHC, low levels of government spending on health, and a weak policy environment (FCT HHSS, 2017; 2019). Improving health financing and budgeting has been a high priority in FCT since the development of SHDP I; however, of the nine health finance activities proposed in SHDP I, none were fully implemented and three were never initialized (FCT HHSS, 2017). In SHDP II, FCT continues to plan to improve health financing through targeted activities, including the development of a Health Financing Policy and Strategy, improving sources of revenue for health, and to strengthen legal and coordinating frameworks.

Nigeria has low levels of transparency in budgeting, which directly affects the availability of detailed budget information from FCT (International Budget Partnership, 2020). As noted, budgeting for health in FCT falls under the budgeting process for the FCTA. The FCTA budget is reviewed and approved at the national level during the appropriations process. However, in the publicly available versions of federal appropriations bills, the entire budget for FCTA is included as one line item and is not disaggregated to indicate budget by sector, including health budget (Federal Republic of Nigeria, 2019; 2020b). The only FCT-related activities and projects included in line items are those relating to infrastructure development and improvement (Federal Republic of Nigeria, 2020a; 2018).

A key limitation to achieving health-related goals in FCT is the limited level of health funding available, and available information indicates that there are low levels of health budgeting and spending in FCT (Carlson et al., 2019). Health spending in FCT has consistently represented less than 15% of the overall budget for the FCTA, falling below the threshold established in the Abuja Declaration (FCT HHSS, 2017). Between 2009 and 2016, health spending has ranged between 9.6% (2009) to only 3.4% of the budget (2010). FCT also exhibits low levels of performance in health expenditure. Between 2011 and 2016, the Territory only spent on average 69.9% of the budget allocated to the HHSS. There were even lower levels of expenditure when looking at the FCT PHCB. In 2018, only 38.8% of the funds budgeted for primary care were spent (FCT PHCB, 2019b). Budget allocation for the FCT PHCB indicates that there was no funding allocated to or spent for maternal and child health services, and none of the funding budgeted to family planning was spent. Furthermore, government health spending per capita falls well below the recommended level of $89 United States Dollars (USD) per capita (FCT HHSS, 2019). In 2013, FCT spent $28 USD per capita, which was reduced to $12 USD per capita in 2016.

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 FCT'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 FCT does not yet have a health financing policy or strategy, it is not possible to assess for provisions relating to gender-responsive budgeting in the health sector. Furthermore, without detailed budgets for health-related MDAs in FCT, it is not possible to assess the gender-responsiveness of those budgets.

FCT HHSS has recently developed a FCT Health Sector Resource Mobilisation Plan (2018–2022), which aims to identify new opportunities to mobilize resources for FCT health spending (FCT HHSS, 2019). This plan does not identify approaches to gender-responsive resource mobilization or mobilizing resources to provide gender-sensitive care or address gender-related gaps in service provision, access, and utilization. Similarly, it does not address mobilizing resources to address issues of social inclusion for marginalized or vulnerable groups. FCT HHSS, 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 FCT budgets from 2016 to 2019 to determine gender-responsiveness in relation to SGBV and sexual and reproductive health and rights (SRHR) (Amakom, 2020). Between 2016 and 2018, less than one percent of the FCT budget was allocated to efforts related to SGBV, including addressing harmful traditional practices, or SRHR. Allocations were categorized into four types of activities: economic empowerment, SGBV, child rights, and SRHR. Of these, child rights consistently received the highest level of budget allocations, with SRHR receiving the most budget in 2018. CSJ was unable to locate information on actual expenditures toward activities focused on SGBV and SRHR; however, the low levels of overall budget performance combined with low allocations toward these activities suggest that little funds were spent toward SGBV and SRHR.

Gender lens on health budgets

As noted, there is little official information to facilitate analysis of budgets in FCT, nor is there information available to assess actual expenditures towards gender- or social inclusion-related activities. In the absence of detailed health budgets, the costing estimations from the FCT PHCB 2019 AOP and the SHDP II provide information about funding priorities in health. The FCT SHDP II does not include lines of action relating specifically to gender or social barriers to care or the sensitive provision of care, but does provide for health services specific to women (FCT HHSS, 2017). The SHDP II plans to assign costs to lines of action relating to maternal health, reproductive health, and family planning under the umbrella of RMNCAH+N. However, the 2019 AOP does propose actions to address some gender- and age-specific health concerns and barriers to care, including adolescent access to care and GBV services (FCT PHCB, 2019b). These actions are costed but the plan does not include detail on sources of funding.

Health insurance and gender

High levels of out-of-pocket spending pose a challenge to health access and utilization across all of Nigeria. However, there is no information about current levels of out-of-pocket health expenditures in FCT; in fact, there is some question about whether health systems in FCT currently receive out-of-pocket spending from households (Carlson et al., 2019). FCT 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 FCT SHIA,[7] establishing an equity fund for health insurance, increasing state health insurance enrollment by 70%, meeting readiness requirements for the BHCPF, increased outreach to raise awareness about the BHCPF, and enrolling over 40,000 residents in 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 key source of funding for health services for vulnerable populations (pregnant women, children under-five, elderly, PWD, the poor). At present, there is no publicly available sex-, age-, or social group-disaggregated data on current enrollment in state health insurance schemes in FCT; thus, it is not possible to assess for levels of gender-balance or social inclusion.

Health workforce

An adequate supply of well-trained HRH is an important component of Nigeria's and FCT's progress towards UHC. Though FCT is better positioned in terms of HRH in comparison to the other states of Nigeria, the Territory still faces challenges in recruiting, retaining, training, and managing an adequate health workforce (FCT HHSS, 2017). One of the primary challenges FCT faces in HRH is securing sufficient and sustainable sources of funding, but the Territory also struggles to implement evidence-based planning, low levels of production of new health workers, and a high concentration of health workers in urban areas (FCT PHCB, 2019d). The newly adopted HRH Policy and Strategy identify actions to address these challenges.

FCT has the second-highest number of health providers in Nigeria, but still lacks a sufficient quantity or the appropriate skill-mix of cadres to meet the needs of its residents (FCT HHSS, 2017). This is due in part to low levels of production in the Territory in addition to challenges in retention and long delays in replacing health providers. Due to limited availability of health providers, only 33 of the 237 PHC facilities offer the minimum health care package (FCT PHCB, 2019d). FCT will need to train, recruit, and hire over 1,000 new providers to meet the needs of PHC facilities. The largest gaps in supply at the PHC level are for nurses/midwives, with a gap of 336 personnel needed to meet minimum standards, and Junior Community Health Extension Workers (JCHEWs), with a gap of 569 personnel.

There is a current imbalance of distribution of health providers between rural and urban areas of the Territory, with insufficient HRH in rural areas and an abundance of health workers in urban areas (FCT PHCB, 2019d). This contributes to inequities in the health system, with rural residents facing less access to care. The inadequate distribution of providers in FCT affects not only quality of care but also efficiency of health spending (Carlson et al., 2019). FCT has prioritized the redistribution of health workers as a key measure to achieve more efficient health spending.

FCT has collected and present sex-disaggregated data on health professionals, most recently in the SHDP II (FCT HHSS, 2017). Across the Territory and all cadres, over 60% of providers are female. Women hold the majority of nurse/midwife and Community Health Extension Worker (CHEW) positions, while men are better represented in higher level positions like medical doctors. Abaji Area Council is the only Area Council that has more male HRH, and Kwali Area Council has near gender-balance in the health workforce. The existing HRH Policy and Strategy do not identify plans to distribute providers based on achieving gender-balance (FCT PHCB, 2019c; 2019d). As the Territory seeks to address gaps in the health workforce, it can consider adopting gender-sensitive and socially inclusive approaches to distribution.

[7] *As of July 2020, the FCT SHIA has been passed into law but not signed by the president.*

Education, recruitment, training, and compensation

In addition to the low supply of health workers, very few existing providers have received any training in their core required areas (FCT PHCB, 2019d). Approximately one-third of CHEW, doctors, nurses, or nurses/midwives have received in-service training, and more than half of JCHEWs and midwives have never received training. The adequate supply and training of all of these positions is key to providing quality RMNCAH+N care and has been identified as a major obstacle to improving quality of care in FCT. There is a lack of information available about the experiences of HRH in FCT as it relates to equity in education, recruitment, training, or compensation. 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 FCT actors can consider addressing to strengthen the health system.

A recent facility-based survey of all public and private facilities offering family planning in FCT indicates that the majority of health workers in these facilities are CHEWs or Community Health Officers (CHOs) or nurses/midwives (Aminu et al., 2018). Further, CHEWs and CHOs are most likely to be the providers offering family planning services to clients in FCT. Less than one-quarter of personnel in all cadres offering family planning in FCT have received any in-service training. Improving training coverage in FCT will be an important step for the Territory, IHP, and its partners 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, 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 ability to stock and manage supplies of medications and other health commodities has been identified an influential weakness in the FCT health system (FCT HHSS, 2017). Current assessments of PHCs in FCT reveal there is sporadic and limited stocking of essential commodities (FCT PHCB, 2019a). FCT procures health commodities in small amounts on the open market, which contributes to high levels of spending on a small supply of commodities and an inability to meet demand for health commodities (Carlson et al., 2019). Gaps in ensuring access to medication include lack of coordinated systems and limited capacity of HRH. Qualitative research in FCT with a small sample of health workers in different cadres (pharmacists, laboratory scientists, and logisticians involved in commodity management) supports the need to address

critical challenges in the supply of commodities and medications for HIV/AIDS (Ibegbunam & McGill, 2012). Health workers interviewed identified a need for a robust system for the integrated management of commodities, the development of HRH and infrastructure, and improved data management to improve the supply of commodities for HIV/AIDS. More recently, a survey of pharmacists in Abuja highlights their limited awareness of and readiness for supply chain management; one-third of pharmacists surveyed had never been involved in supply chain management. Around seven in ten pharmacists had experienced stock outs of vital and essential medicines in their pharmacies.

UNFPA has identified significant bottlenecks to the distribution of family planning and reproductive health commodities in FCT and Kaduna State as part of UNFPA's support for the Nigeria Supply Chain Integration Project (NSCIP) (UNFPA, 2018). Public health facilities faced challenges in the accurate quantification and estimation demand and need for commodities with procurements typically based on available funding as opposed to demand. Delays from customs clearance procedures and the inability to hold frequent review meetings have results in delays in distribution and stock outs. In the case of stock outs, there are not often the adequate back-up supplies or fuel to provide emergency distribution. Staff also lack capacity to adequately report on commodities and use software to manage commodities, resulting in poor management and stocking of supplies (Chukwu et al., 2017).

Improving access to RMNCAH+N commodities is a key pathway towards achieving improved health outcomes for FCT'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 services 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 FCT (Solo & Festin, 2019). It will be important for IHP to gain a deeper understanding of whether these biases exist amongst providers in FCT 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 FCT still face immense challenges in accessing health facilities. Much of the challenge is linked to poverty and lack of financial assets. Just over half of women of reproductive age in FCT have faced at least one major challenge 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 (47.6%). The distance women have to travel to a health facility is also a barrier for one-fifth 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.

Recent qualitative analysis of women in FCT and Nasarawa State, which borders FCT, provides greater detail on those factors influencing women's access to health services (Al-Mujtaba et al., 2016). Women were interviewed who were of reproductive age, currently pregnant and attending ANC, or living with

HIV. Though women expressed a preference for facility-based delivery, they faced challenges in accessing skilled delivery, including rapid onset of labor, distance to clinics, and high cost of transportation. Women were also challenged when a male family member or partner were not present to travel with them. In some instances, male partners' opinions or preferences can also deter women from attending skilled ANC. However, for women interviewed, the gender of providers did not influence the acceptability of the services provided; instead, the skills, competencies, and friendliness were more influential on preference. In discussing barriers to care, women did not identify religion or religious factors as influencing their decision to seek care.

An emerging sexual and reproductive health concern for women and girls in FCT is the increasing prevalence of human papilloma virus (HPV). A recent analysis of women attending cervical cancer screening in Abuja found an HPV prevalence of 37% (Akarolo-Anthony et al., 2014). There was a significant association between younger age and a higher risk for HPV. Mixed methods analysis of women's knowledge of and access to care for HPV in Gwagwadala, an urban center in FCT, reveals low levels of awareness of HPV (Jamda et al., 2018). Of women ages 15 to 45 who completed a quantitative survey assessing their knowledge, only 8.2% had ever heard of HPV, and all had learned about it from a health worker. Four percent of women knew that HPV could be linked to cervical cancer. The survey also assessed women's preferences for health access and health communications. Most women preferred accessing public PHC facilities (44.5%), with the remaining preferring private facilities (18.7%), pharmacies (22%), and traditional healers (10%). For those women who prefer private facilities, they cite wait time at public facilities as the main deterrent to accessing care there. Women preferred to receive information about HPV, sexual health, and other STIs from religious groups (30%), electronic media (28.5%), and traditional healers (12.2%).

Religious and cultural beliefs can be influential in informing health knowledge and access for women in FCT. In the mixed methods analysis of HPV awareness, women in focus groups identified prevalent beliefs that STIs are considered to be "punishment from God" or "spiritual attacks" (Jamda et al., 2018). There are also beliefs that traditional charms (or spells) can prevent STIs like HPV. Because of these beliefs, women are also inclined to treat STIs using traditional or herbal medicines because they do not believe PHC facilities or hospitals can address the negative ramifications of curses or punishments. STIs have also been linked to promiscuity, which women believe is caused by poverty as it encourages women to engage in transactional sex.

Despite community-level beliefs linking sex work to STIs, amongst FSW in Bwari Area Council in Abuja, there are low levels of awareness about HPV and STIs in addition to low levels of screening (Ilesanmi & Kehinde, 2018). Only seven in ten FSW were aware of HPV screening, and less than four in ten had ever been screened for HPV. Of those who had been screening, only one-third received the results of their screening. Lack of knowledge about screening services was the main barrier to access. This limited access to sexual health screenings amongst FSW has implications for the health of women, men, and children in FCT giving the increase in transactional sex in the Territory.

Evidence from the Nigeria Urban Reproductive Health Initiative (NURHI), which worked in six urban areas in Nigeria including Abuja to shift gender inequitable norms and improve family planning utilizations, indicates that improving gender equitable views on household decision-making is associated with increased uptake and utilization of modern contraceptives (Okigbo et al., 2018). Improvements in women's perceptions on couples' joint decision-making in family planning and in their own self-efficacy around family planning were also associated with increased uptake and utilization of contraception. This suggests that interventions focused on shifting norms that may restrict or hinder women's ability to access

contraception can address uptake gaps, especially amongst women in urban settings in FCT, and IHP and its partners can learn from these results.

A pilot study evaluating the effects of a conditional cash transfer program on uptake of maternal, neonatal, and child health (MNCH) services in nine states of Nigeria, including FCT, 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, 76.2% of beneficiaries in FCT returned to the health facility after one ANC visit, indicating some level of retention in care. Additionally, 81.3% of beneficiaries enrolled in PHC facilities with conditional cash transfer schemes returned to the PHC facility 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.

A combination of task-shifting and community-level outreach has also proven promising to increase family planning uptake in FCT (UNFPA, 2018). UNFPA, in partnership with the Planned Parenthood Federation of Nigeria, provided training to CHEWs on the provision of *Sayana Press* (an injectable contraceptive) as part of efforts to increase access through task shifting. In addition, CHEWs and community mobilizers were trained to provide door-to-door community outreach to educate community members on injectable contraceptives and provide contraceptives in the community at no charge. The initiative saw an increased uptake of contraceptives, particularly among women and girls who were not prior users of contraceptives. Additionally, the SHOPS Plus program implemented a package of quality improvement approaches (including training, mentoring, and supervision) to improve contraceptive access and uptake. Between 2018 and 2019, the program saw an increase in the number of facilities offering LARC services (from 44 to 183) and an increase in the number of women accessing LARC services (from 1,745 to 2,556). Additional details on the full range of quality improvement interventions implemented under SHOPS Plus can be found in *Section 4.7: Quality of primary health services*. IHP and partners can identify opportunities to build on this evidence in its efforts to improve contraceptive access and uptake in the Territory.

Access for men and boys

There is a lack of FCT-specific information regarding the health of men and boys in FCT, including their ability to access health services. Like women, men face unique health challenges due to their positions and roles in society and family life. For example, norms in Nigeria expect men to be able to perform sexually, which can be linked to increased engagement in risky sexual behaviors (Voices4Change, 2015). Men in the North Central Zone, where FCT is located, are more likely to engage in pre-marital sex than their peers in other regions, and they engage in sexual activity more frequently (Oyediran et al., 2011).

This has important implications for sexual health in FCT, especially as men in the North Central Zone are significantly less likely to use condoms than men in other regions of Nigeria.

Across Nigeria and in FCT, persons who inject drugs (PWID) are more likely to be men (Eluwa et al., 2013). The prevalence of lifetime injection drug use for men in the North Central Zone is 6.3% (Adamson et al., 2015). This exposes men to unique health risks and challenges, and emerging evidence about men who inject drugs in FCT indicate they are more likely to be engaged in high-risk sexual behaviors (Eluwa et al., 2013). Men in FCT who inject drugs are more likely to engage in transactional sex, with 38% paying for sex, and rarely practice consistent condom use; only one-third of men use condoms consistently with their partners, half of men use condoms consistently during casual sexual intercourse, and two-thirds use condoms consistently with FSW. Men who inject drugs in FCT also have a higher prevalence of HIV (9.7%) than the general population. Given men's low utilization of health services, including HIV testing and counseling, these trends have concerning implications for the health of men, their families, and their communities (Fontaine et al., 2016).

Most information on men's access to health services in FCT is focused on men who have sex with men (MSM) in the context of HIV prevention, testing, and treatment (Balogon et al., 2020; Charurat et al., 2015). Importantly, MSM in FCT report being questioned about and discriminated against based on their sexual orientation when accessing health services for STI prevention and treatment, which is often a barrier to access. Men have reported experiencing hostile behavior from care workers, preventing them from seeking treatment or preventive care. These patterns of invasive questioning and hostile behavior from health care workers likely have implications for all men seeking care, especially in the context of sexual health.

If health services are to be more equitable and efficacious, there is a need for recognizing gender-based barriers and designing gender-responsive health services that more holistically cater to the unique health needs of men and women (Watts & Seeley, 2014). Health, however, has too often been viewed as under the purview and responsibility of women, and health messages and services are oftentimes not inclusive of men and sensitive to their needs, leading to continued negative outcomes for both sexes. As detailed in the gender assessment conducted under the SHOPS Plus project, men are rarely actively included in family planning efforts in FCT; when they are included, they are often involved in family planning that reinforces negative gender roles and stereotypes that place men in control of their partners' and families' health (*Nigeria FP Program: Gender Assessment*, 2018).

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). Ingrained socio-cultural norms and beliefs often support the practice of male partners having sole decision-making authoring over health seeking behavior for their families, but this is a double-edged sword. Male engagement is therefore a key pathway to improving the delivery, access and uptake of RMNCAH+N services for more equitable outcomes (Fotso 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

As described, FCT has a distinctly older population in comparison to the high proportion of youth and adolescents in the other 36 states in Nigeria. Yet, though there is little available information about the status of youth and adolescents in FCT, existing evidence does indicate the youth and adolescents living in FCT face barriers and challenges to their health and in accessing health services. For example, across Nigeria, adolescents have low uptake of HIV testing (Mohammed et al., 2019). Amongst adolescents ages 10 to 18 who tested for HIV in Abuja between 2013 to 2018 in FCT, there was an HIV prevalence of 14.1%, indicating epidemic levels of HIV. In following national trends, HIV prevalence was also higher amongst adolescent females than males (prevalence of 8.6% and 5.5%, respectively). This evidence, in combination with early ages of sexual debut, high levels of adolescent sexual activity, and low levels of HIV and sexual health education in FCT (NPC & ICF, 2019), demonstrates an urgent need to increase adolescents' access to vital health services and commodities, and for adolescents to feel empowered to make informed health decisions.

Limited awareness of sexual and reproductive health and services available has been identified as a barrier to access for care for adolescents. Nigeria has undertaken efforts to improve education on sexual and reproductive health for adolescents. For example, the Family Life and HIV Education (FLHE) Program, which was initiated in 2003, was designed to fill the gap in available sexuality education (Huaynoca, 2014). Yet, as of 2014, the program had reached only 13% of in-school adolescents nationally. In FCT, only four in ten schools have been provided with the curriculum or materials for FLHE (Udegbe et al., 2015). Further, evidence of FLHE's effectiveness has been mixed, partly as there are no systematic monitoring and evaluation processes for the program (Cortez et al., 2015).

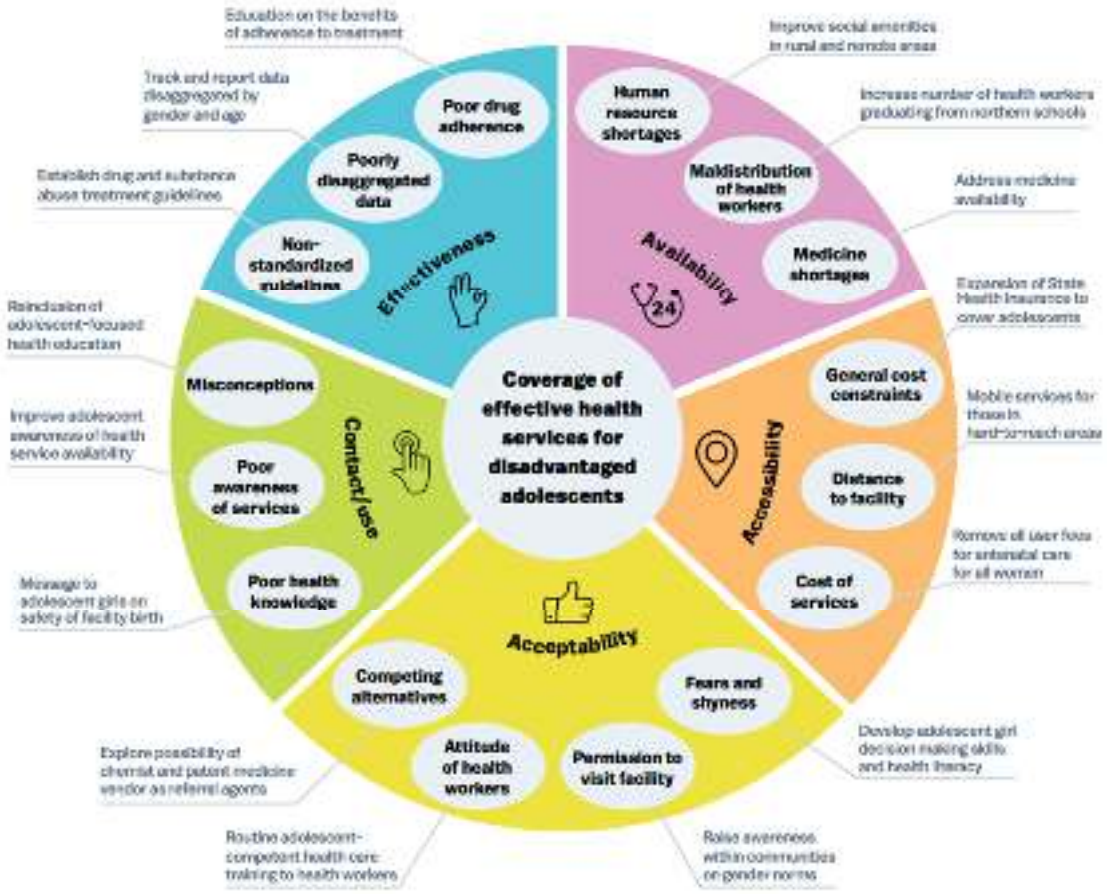
Out-of-school adolescents and youth in FCT also face barriers to health access. Qualitative data collected across Nigeria, including in FCT, suggest that out-of-school youth have even fewer opportunities to access education and information about sexual and reproductive health (Isiugo-Abanihe et al., 2015). Out-of-school youth face barriers to health access as a result of the geographic distance to health services, low funding, inadequate human resources, poor integration of adolescent and youth services within sexual and reproductive health and family planning services, high cost or unavailability of RMNCAH commodities at facilities, and a lack of gender-responsive sexual education provision.

A promising approach to improving adolescents' health knowledge, attitudes, and behaviors is the gamification of health content. This approach has been studied in relation to adolescents' nutritional status in FCT (Ezezika et al., 2018). The study found that providing adolescents with non-digital game-based approaches to gaining health knowledge, including board games, club activities, and vouchers, not only increased their knowledge but shifted their attitudes and behaviors. Students involved in the intervention reported adopting an improved diet, increased physical activity, and increased knowledge of nutrition. There was also some evidence of increased dissemination of knowledge, as the adolescents' reported sharing the information gained with their peers. 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.

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 in FCT, 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 FCT. The figure below (Figure 2) provides a summary of these national-level barriers to access organized around WHO's pillars of youth- and adolescent-friendly health care.

Figure 2: 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 FCT, and IHP should consider those groups most impacted by barriers and how to address those barriers in its programming. Information from the HP+ Project highlights that

PWDs in FCT face challenges in accessing health services (Pappa, 2019). Many health facilities lack the proper infrastructure and training to provide care to FCT. Cost is also a barrier to access for many PWDs. There are low levels of awareness about the Physically Challenged Persons Social Health Insurance Programme (PCPSHIP) that is part of the National Health Insurance Scheme (NHIS), which PWDs in FCT could access to reduce out-of-pocket spending on their healthcare (*Vulnerable Group Social Health Insurance Programmes*, n.d.). National-level information on women with disabilities' ability to access sexual and reproductive health identify a wide range of barriers (FMOH, 2018). These include providers' lack of knowledge and understanding of disability issues and disability rights, socioeconomic and cultural challenges, public stigmatization, discrimination and denial of human rights, healthcare provider's negative attitude, lack of disability-related clinical services, poor health infrastructure, lack of accessible transportation, exclusion of PWDs in national planning and decision making bodies, and lack of funding, including health insurance.

A recent inventory of primary health provision also identified a gap in provision of mental health services in FCT (Obembe et al., 2017). Less than one-quarter of health workers surveyed identified mental health services as a service offered in their facility. There is also a lack of elderly care services in FCT. Less than half of health workers in the Territory indicated that their facility offered tailored services for the elderly population.

There have also been reports of IDPs in FCT being denied access to services to which they are entitled, including essential health services and medicines (UNHCR et al., 2015). This is especially pronounced for pregnant and lactating women, children, the elderly, and PWDs. In some settlements, pregnant women have no access to ANC or facilities for delivery, and other vulnerable groups are unable to seek either routine or specialized care for injuries or existing conditions.

People living with HIV (PLHIV) in FCT face significant challenges in accessing care for antiretroviral therapy (ART) (Olaleye et al., 2013). Though awareness of available services tends to be high, with seven in ten PLHIV aware of available services, women are much less likely than men to know about services. PLHIV in urban areas and those of higher socioeconomic status are also more likely to know about services. This predisposes rural PLHIV to a higher incidence of poor health outcomes. Rural PLHIV and those in lower socioeconomic classes are forced to travel long distances to access HIV care. Women living with HIV and PLHIV in lower socioeconomic classes were also significantly more likely to face catastrophic health expenses than men or wealthier PLHIV.

Mixed methods research with caregivers of orphans and vulnerable children (OVCs) in FCT and Cross River State indicates that women are significantly more likely to be selected as caregivers for OVCs (Gana et al., 2016). Caregivers in FCT are also quite young and have had low levels of educational attainment. Caregivers have limited economic means and limited support from family, which they identified as a barrier to seeking care for the children under their watch. This has also prevented caregivers from being able to access ART for the children in their care, and one-fifth of OVCs were not able to access free health care. Caregivers for OVCs were more likely to reside in urban areas, where they live in "slums" without access to basic needs like running water or proper infrastructure.

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 FCT, including a lack of providers, poor infrastructure in facilities, and inadequate health financing. The quality of services 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. There is also widespread evidence at the national level of pervasive abuse and disrespect from providers in childbirth (Ishola et al., 2017). Evidence from across Nigeria and in FCT also demonstrates that quality of health care is deeply tied to beliefs and norms about gender, adolescence, and sexuality (MCSP, 2019). 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 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.

Though there is little information available on the quality of primary health care in FCT, recent qualitative research with health providers and women of reproductive age in FCT revealed a number of behaviors constituting mistreatment of pregnant women in secondary health facilities in the Territory (Bohren et al., 2017). In discussing quality of care in qualitative interviews, both women and providers spontaneously raised the issue of mistreatment; women shared their own experiences or observations of mistreatment, and health providers offered examples in which they perpetrated mistreatment. Neglect in the health system was often linked to limited capacity and resources and overcrowding in the health system as opposed to intentional harm. Providers interviewed often complained about the demeanor of women in the labor and delivery wards, citing this behavior as reason not to provide compassionate care. Both women and providers recounted instances of physical violence in facilities, including slapping, beating and tying women down to hospital beds, to "gain compliance" from women in labor. Younger women and women of lower socioeconomic status are more likely to receive this negative treatment due to bias amongst providers against younger women and women of lower socioeconomic status and their higher level of vulnerability. In general, women perceived providers to be rude and experienced variations of verbal abuse and shaming from providers. Women living with HIV were hesitant to disclose their status to providers for fear of judgement and discrimination. Women often experienced neglect and abandonment, again linked to understaffing and overcrowding, in addition to limited privacy in labor and

delivery wards. This lack of privacy and exposure is in direct contradiction to some women's religious practices. All of these factors combined to discourage some women from seeking care and skilled delivery in facilities, as they believed they would receive better, more attentive care from home delivery.

A national-level, qualitative study on quality of maternal care in referral hospitals, which included data from FCT, confirms many of these concerns (Okonofua et al., 2017). While women in Abuja were satisfied with the services available to them in the facilities, they identified concerning behaviors amongst health providers affecting quality of care. Women cited the frequency of verbal abuse and negative attitudes towards mothers in facilities in Abuja. The availability of resources and infrastructure was also identified as a key concern in Abuja. Women referenced the advanced technology and laboratory services available in private facilities; in public facilities, women were often referred out for laboratory testing and were not able to access more advanced scanning procedures that allowed them to feel more autonomy when receiving care.

A quantitative survey of patient experience in twelve public secondary facilities (3 urban, 5 suburban, and 4 rural) in FCT identified an overall high level of satisfaction with the quality of secondary care, with most patients assigning intermediate level scores for domains of care (Lawal et al., 2018). Sixty percent or more of patients thought nurses and doctors treated them with respect, with doctors receiving higher ratings on communication domains than nurses. Patients were least satisfied with the promptness in care from nurses (59.5% said they were satisfied with this care) and feeling valued and appreciated as a patient (60.5% were satisfied). The majority (two-thirds) of patients surveyed were women, aligning with trends in health care access, but there was no significant difference between the satisfaction of men and women. Patients who reported that providers listened carefully to them and valued and appreciated them were most likely to be satisfied with care.

In the context of family planning in both public and private PHC facilities, providers in FCT and three other states (Plateau, Oyo, and Akwa Ibom) are aware they bring bias into their care (SHOPS Plus Project, 2020a). For example, providers identified that they treat adolescents, young women, and unmarried women differently when providing family planning services. However, they were unaware that these biases can limit access to family planning.

This desk review did not locate any FCT-specific policies, guidelines, or strategies governing quality improvement or quality of care in general or as it relates to the provision of gender-sensitive, adolescent-friendly, or other forms of inclusive health care. In fact, the FCT HHSS has acknowledged that a main weakness of the health system is a lack of an overarching service delivery strategy for improvement, monitoring, and evaluation (FCT HHSS, 2017). This will be an important gap to address, and actors in FCT, 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 FCT 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.

There have been some recent efforts in the Territory to promote the gender-sensitive provision of RMNCAH+N services, and IHP, partners, and FCT actors can build on these efforts to improve quality of care. The SHOPS Plus Project has taken a two-pronged approach to improve quality of care in family planning facilities in FCT by combining approaches on technical capabilities and long-term support for quality care (SHOPS Plus Project, 2020b). Training combines clinical skill-building for family planning with new training on gender-responsive principles for care and addressing provider bias. Importantly, trainings also incorporated a focus on constructive male engagement to address providers' tendency to include men in family planning in ways that reinforce harmful power dynamics (SHOPS Plus Project, 2020c). This initial training is enhanced through follow-up visits and supportive supervision (SHOPS Plus Project, 2020b). Through SHOPS Plus, Territory-level and master trainers were identified and prepared to cascade trainings across FCT, and family planning coordinators in each Area Council provided supportive supervision (SHOPS Plus Project, 2020c). It will be important to monitor the sustainability and institutionalization of these training approaches after the completion of the SHOPS Plus Project, and it will also be beneficial to monitor the long-term impact of these interventions on utilization of services.

The initial trainings and ongoing coaching under SHOPS Plus have resulted in increased capacity to deliver care and increased uptake of family planning in FCT; for example, the use of LARCs in facilities supported by SHOPS Plus increased by 6% during the course of the intervention (SHOPS Plus Project, 2020c). Further, qualitative interviews with providers have identified that they are more likely to advocate for improvements to facility infrastructure and services offered to meet the needs of their clients after attending the training (SHOPS Plus Project, 2020b). Providers in FCT reported integrated gender-responsive and inclusive approaches to identify gaps in adolescent knowledge and access to services, instigating outreach into local schools, and also reported adapting their own trainings to include gender (SHOPS Plus Project, 2020a). Providers responded positively to efforts to identify and address their own biases, including gender biases, which negatively affect quality of care in family planning in FCT (SHOPS Plus Project, 2020c). Additionally, the use of adult learning methods was critical to ensure knowledge retention for both clinical and soft skills.

WHO has also partnered with FCT and the FMOH to support training and peer-to-peer learning exchanges with health workers in 10 facilities (seven PHCs and three secondary care facilities) to improve quality of care (*Healthcare workers in Federal Capital Territory*…, 2019). These quality improvement-focused trainings have resulted in improved MNCH health outcomes in the Territory, including a 76% reduction in newborn hypothermia and a 66% increase in the use of uterotonics to reduce postpartum hemorrhage. To complement these technical efforts, WHO has also launched the Quality of Care Quality, Equity, and Dignity network across several nations, including Nigeria, to bring a renewed focus on equitable, people-centered care. Results of this new initiative have not yet been reported in Nigeria.

Efforts have also been made in other states in Nigeria to promote the provision of gender-sensitive care, which also offer important evidence for IHP and its partners. In Ebonyi and Kogi States, the USAID-funded Maternal and Child Survival Program (MCSP) 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 (MCSP, 2019). HWFC has achieved robust results across sub-Saharan Africa, and there are promising results from its implementation in Nigeria. 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 HCFW approach was implemented in tandem with other quality improvement efforts in Nigeria, 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, 2018a). In facilities receiving this collection of interventions, providers not only improved their counseling in ANC on birth preparedness, postpartum 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 LARCs in FCT, 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, 2018b). 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 to evaluate the sustainability of this approach. Further analysis is also needed to understand the impact of these approaches on quality of care in male engagement and GBV services.

3. DISCUSSION AND RECOMMENDATIONS

Though FCT performs better than the rest of Nigeria on most health indicators, there are still concerning imbalances in and barriers to progress. The rapid growth and influx of new residents has implications for FCT's infrastructure, including the capacity of health facilities to adequately meet needs; the Territory also faces increasing levels of unemployment and poverty. Power dynamics and entrenched gender norms mean that many women in FCT 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 Territory, including youth and adolescents, IDPs, survivors of GBV, impoverished populations, and PWDs, face barriers to social inclusion and, as a result, limited access to health services. In addition, FCT experiences unique and emerging social challenges which further jeopardize health and well-being particularly for the vulnerable – those include increasing prevalence of sex work, drug use, and HPV. Despite FCT's position as the capital of the nation, there are still wide gaps in knowledge about gender norms, health status, and health outcomes, and little evidence about interventions to improve RMNCAH+N outcomes and services. Furthermore, there is often a lack of FCT-specific health information and research into health interventions. Existing evidence suggests poor distribution of health services and providers, high cost of services, and low quality of services prevent residents of FCT from accessing care, with an increased impact on women, girls, and vulnerable groups.

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 FCT?

The different roles and expectations of men, women, and youth have great influence on health access and outcomes in FCT. Evidence suggests that, while women in FCT enjoy greater levels of decision-making than women in many other states in Nigeria, gender norms still prohibit women from making decisions about their own wellbeing, finances, and health. Women's subordinate status also exposes them to risk of GBV, and women are increasingly becoming involved in sex work due to lack of employment opportunities. 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 and substance use. There is limited evidence about the status of youth in the Territory, but what is known indicates that youth struggle to access the resources and information needed to protect their own health. IHP will consider and act upon these different roles and expectations as it provides technical assistance to the Territory, 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 FCT and have been shown to play a dual role, both in enforcing restrictive gender norms but also in influencing progress towards gender equity. Deep-seated norms and beliefs 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 service utilization. For example, providers' beliefs about who should be able to access family planning negatively affect unmarried women and adolescents. Entrenched 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 build capacity of PHC facilities to strengthen their linkages with 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 FCT. There is some indication that women are reliant on male family members to access health services. Men's opinions, knowledge, and control of resources also influence whether a woman accesses ANC or other care. Men are often not proactively included in family planning and reproductive health counseling

or outreach, 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 technical assistance in FCT will lead to 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 raise awareness of gender and social inclusion and deliver results that reach even the most vulnerable and marginalized.

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. 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 through Territory policies and from health facility providers has successfully increased 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 Territory to implement these effective, evidence-based approaches.

3.2 Recommendations

Based on the findings of this rapid desk review, a number of recommendations become clear. Recommendations below leverage opportunities in FCT 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 Territory 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

Territory-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 Territory 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.** Most of the FCT policies reviewed in this analysis (e.g., the 2019 FCT PHCB AOP, the FCT SHDP II) do not prioritize the collection or utilization of sex- or age-disaggregated data. There evidence to suggest that facility-level data collection tools collect some sex- and age-disaggregated data, but this desk review did not locate evidence about how these data are used or if they are indeed collected outside of Abuja. 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 end line 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 document and apply age- and sex-disaggregated data, the Territory 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 Territory-level support for gender-responsive and socially inclusive policy development, implementation, and budgeting to improve service delivery, leadership and governance, and health financing.** FCT has made 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 can continue to catalyze progress in the development of these policies and encourage the adoption and implementation 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, National Policy on Health and Development of Adolescents and Young People in Nigeria). FCT faces greater challenges in the implementation of policies and plans, including budgeting and spending. IHP's technical assistance efforts will develop the Territory'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. Actors in the Territory can continue the work of the HP+ Project to support FCT 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. Mobilizing new resources in the Territory can help address the current gaps in budgets and expenditures toward health and gender-related activities. At the Territory level, stakeholders should build capacity for

incorporating gender and social inclusion into recruitment, hiring, management, and promotion practices and policies, and provide technical assistance and advocacy to amend policies and procedures that inhibit equitable utilization of the health system. 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 Territory 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.** FCT faces steep challenges in addressing the inadequate supply, distribution, and training of HRH in the Territory. In addressing these concerns, IHP will provide technical assistance 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 Territory, including the FCT Education Secretariat, 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. The existing HRH Policy and HRH Strategy in FCT miss opportunities to address gender in the distribution of HRH, practices to promote retention, and techniques for management and supervision, though it does provide for gender equity in exit management. IHP will also support the Territory with technical assistance to collect sex-disaggregated HRH data and to design and collect gender-sensitive indicators in the HRH Monitoring and Evaluation 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 Territory 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.** The health system in FCT faces substantial challenges and bottlenecks to ensuring an adequate supply and distribution of essential commodities. In collaboration with the USAID-funded Global Health Supply Chain-Procurement Supply Management (GHSC-PSM) Project, IHP will provide TA to the FCT PHCB and HHSS to strengthen 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 have strong preferences about contraceptive options. In order 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, andprovision, and addressing provider and other common biases to encourage informed choice and uptake. The Territory can measure success by enumerating the number of facilities maintaining consistent stock of RMNCAH+N commodities.

- **Identify opportunities to engage with religious and traditional leaders at the facility level to promote cultural and social practices that will increase access to health services.** Religious leaders carry great influence over health-seeking behavior and health access in FCT. IHP will identify opportunities to engage with religious leaders 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 in the Territory. Evidence from NURHI, which worked in three states and FCT, indicates that women are more likely to uptake contraception when exposed to messaging from religious leaders (Okigbo et al., 2018; Adedini et al., 2018). Engaging religious leaders is particularly important as they can organize contributions to revitalizing and maintaining PHCs and support premiums for vulnerable populations in the BHCPF or other insurance schemes. 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 FCT, and there are low levels of knowledge about the existing health insurance schemes available in the Territory. 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 Territory, and evidence also suggests that PWDs in the Territory are unaware of the schemes available to them. Building on the foundational work of HP+ in FCT, IHP will work in collaboration with the FCT HHSS and PHCB 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 Territory 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 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 Territory 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 FCT 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 FCT. Actors in the Territory, including the FCT Education Secretariat 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 Territory 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 FCT 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 FCT, but evidence from Nigeria suggests that incorporating gender-sensitive and socially inclusive approaches to care can improve service delivery quality and outcomes. As identified in the USAID-funded SHOPS Plus Program gender assessment, there are tremendous opportunities to build and maintain capacity amongst the health workforce in FCT, 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 FCT 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 and SHOPS Plus in Nigeria to begin to

cascade quality of care training in FCT 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.

- **Increase capacity for GBV prevention and response in the health system and collaborate with Territory-level actors to strengthen multi-sectoral GBV response so that PHC services and GBV referral pathways respond to the needs of survivors.** Although FCT has taken steps to address GBV (e.g., the passage of the VAPP Act in 2015 and the establishment of the FCT SGBV Response Team in 2017), there is a need for increased capacity to respond to and coordinate referrals for GBV care in the Territory. Though GBV services and pathways exist in FCT, many women and girls (particularly in rural and semi-urban areas) do not know how to access them, or of the legal protections that exist for them. IHP will include first-line response to GBV survivors in existing skills-based training for health providers. Further, as recommended under the SHOPS Plus analysis, FCT 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. IHP will work with other sectoral leaders, especially the FCT Gender Department, to enhance and update any existing GBV referral pathways to strengthen the ability of all sectors to respond to GBV. The Territory can measure the success of these efforts by tracking the number of people reached with and referred to GBV services (with sex- and age-disaggregation).

- **Generate capacity across the health system to implement male-friendly approaches to care.** Facilities in FCT implementing male-friendly approaches to care have seen improvements in RMNCAH+N service delivery outcomes and satisfaction. IHP will continue the foundational work of SHOPS Plus and integrate approaches from MCSP to encourage the use of male-friendly approaches to care that 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 can 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 FCT 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 barriers to care (Ogu et al., 2018). Based on information collected during this desk review and additional priority-setting from the FCT HHSS and PHCs, IHP will help facility staff to identify those evidence-based youth-friendly practices most relevant 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 (Leslie et al., 2017), addressing challenges related to infrastructure is one component of advancing quality of and access to care in FCT. 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 FCT. IHP will partner with the FCT HHSS and other agencies to provide technical assistance, as needed, to the Territory'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 FCT. 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 FCT 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 FCT, and analysis of Territory-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 Territory-level support for PWDs. To that end, IHP will support the Territory to identify and define measurable improvements and promote access to quality care for PWDs. The Territory can demonstrate evidence of success by the fulfillment of a Territory-level function and the increased knowledge and capacity of health workers and Territory representatives around access and quality of health services for PWDs.

- **Sensitize providers on the rights of internally displaced persons and the need to provide gender-responsive care.** The lack of reproductive health services, including family planning and treatment for STIs, presents a significant threat to the mortality of women IDPs in Nigeria (Yerima & Singh, 2017). Evidence suggests that limited knowledge of health providers in FCT could contribute to barriers to health access for IDPs. IHP will encourage the Territory to incorporate gender and access considerations for IDPs in capacity building and sensitization efforts for providers to promote more comprehensive and equitable services for IDPs in FCT, providing technical assistance as needed. The Territory can measure success of these sensitization efforts by first determining if providers have increased capacity to offer care to IDPs, and then by evaluating to determine if providers apply and utilize knowledge and skills learned in their service delivery.

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 FCT 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 FOR HEALTH POLICIES AND GUIDELINES IN FCT, NIGERIA

FCT Primary Health Care Board 2019 Annual Operational Plan

	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	No. Only gender-specific indicators are presented (e.g., women of childbearing age).
2.	Are age-disaggregated data used/presented?	0	No. Only age-specific indicators are presented (e.g., population of under 5 children).
3.	Is gender equality considered a health determinant?	0	No.
4.	Does the description reflect gender-based constraints in access to services?	0	No. While women's health is prioritized, the AOP does not acknowledge constraints in access based on gender. Universal access is promoted without consideration of unique needs of different groups.
5.	Does the description reflect disability-based constraints in access to services?	0	No. Universal access is promoted without consideration of unique needs of different groups.
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. Rights are not discussed in the AOP.
7.	Are specific objectives proposed to reduce gender inequalities?	0.5	Gender mainstreaming in health, including promoting gender equality and

			eliminating discrimination, are included as a priority area under Section 2.4.4 (RMNCAH+N).
8.	Are lines of action proposed to meet the different needs of women and men?	0.5	Health needs of women have been considered in relation to reproductive and maternal health under Section 2.4.4 (RMNCAH+N). Men's health is not discussed.
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	Though Section 2.4.4 (RMNCAH+N) includes gender mainstreaming as a priority area, there are no lines of action proposed to achieve this priority.
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	Section 2.4.4 includes a priority area on "Awareness creation/sensitization on harmful effects, child violence and Female Genital Mutilation (FGM)," though there is only one activity to raise awareness on FGM. There are also lines of action to increase awareness of and response to GBV. The AOP does not mention specific actions to address early marriage, pregnancy, or contraception access.
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 AOP did not mention strategies to improve accessibility to services for PWDs. It did include a priority

				area for care for the elderly and for promoting mental health, though there were no activities tied to the priority.
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. The AOP did not specify gender- sensitive service delivery approaches in training of health care workers.
16.	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0		No. The AOP recognizes the need to improve workplace conditions, but does not specify conditions relating to violence.
17.	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	5		No. The AOP recognizes the need for more equitable production and distribution in relation to rural areas but does not acknowledge or address gender-balance in HRH.
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?	0.5		Funds were allocated to RMNCAH + N services but did not explicitly focus on gendered needs and inequitable access to resources for health care.
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	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
		M	0	

	c. availability d. eligibility e. respectfulness f. physical accessibility g. geographic accessibility h. unbiased and nonjudgmental and nondiscriminatory	G	0.5	adolescents but does not address increasing availability. The AOP aims to increase geographic and financial access but does not link to specific activities to do so nor does it specific how to improve geographic or financial access for specific gender or age groups. Eligibility, respectfulness, physical accessibility, and the provision of unbiased care are not included in the AOP for any gender or age group.
		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		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. The M&E plan in the AOP document did not indicate the need for sex- disaggregated data; however, the full M&E Plan was not available with the AOP.
26.	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	0*		No. The M&E plan in the AOP document did not indicate the need for age- disaggregated data; however, the full M&E Plan was not available with the AOP.

27.	Does the M&E plan include indicators to measure gender-related outcomes?	0*	No. The M&E plan in the AOP document did not indicate the need to measure gender-related outcomes; however, the full M&E Plan was not available with the AOP.
28.	Does the M&E plan include indicators to measure outcomes relating to PWDs or disability?	0*	No. However, the full M&E Plan was not available with the AOP.
29.	Are funding mechanisms and other resource needs and sources for the gender actions identified?	0.5	Costing and funding sources are identified, but there is no detail about securing the funding or other resources needed.
30.	Does the M&E plan include what to do when M&E data reveal gender inequities?	0*	No. However, the full M&E Plan was not available with the AOP.
*Not available			

FCT PHCB Human Resources for Health Policy (2019-2024)

	Gender-responsive checklist for health policies, guidelines, service protocols, and other key government documents in Nigeria	**Score** [NO: 0 Somewhat: .5 YES: 1]	**Comments**
In the description of the general state of health of the population:			
1.	Are sex-disaggregated data used/presented?	0	No.
2.	Are age-disaggregated data used/presented?	0	No.
3.	Is gender equality considered a health determinant?	0	No. Equitable primary health services are listed as a priority in the policy, but there is no mention of gender equity or equality.
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	0	No.

	e. PWDs f. Sexual minorities (e.g., LGBTQ populations)		
7.	Are specific objectives proposed to reduce gender inequalities?	0	No. The policy does not suggest or include specific objectives to address/ reduce gender inequalities in HRH.
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. The policy does not suggest or include actions to address and/or reduce gender inequalities in HRH.
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	No.
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. Male involvement was neither identified nor planned for in the policy document.
13.	Does the policy include strategies to improve accessibility to services for PWD?	0	No. Despite prioritizing accessibility of care, there are no strategies to promote accessibility, nor are there strategies specific to PWDs.
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. While training efforts are described in detail, there is no mention of training on gender-sensitive or socially inclusive approaches to service delivery.
16.	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0	No. The policy has a section to protect the health and safety of health workers, but it only makes mention of occupational hazards associated with HRH and none for violence, harassment, or security.
17.	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	0.5	There is a policy statement on the production, distribution and retention of health workers, which includes improving recruitment and deployment of health workers with "appropriate gender to meet the demand of staffing norms." However, there are no strategies in place, and no details to describe gender sensitive production, distribution and retention of male and female health workers. One key result area for the policy is "Equitable distribution and mix accounting for socio-cultural peculiarities." Based on the text of the policy, it is difficult to determine if gender is considered a "socio-cultural peculiarity" that could be considered for HRH distribution and mix.
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	No. While the policy recognizes the need for staff of "appropriate gender to meet the demand of staffing norms" and the need for equitable and accessible health services, this is not explicated in relation to gender or age and health access.
		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. While the policy promotes capacity building for decision-making and leadership, there is no provision to include women.
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. While the policy promotes capacity building for decision-making and leadership, there is no provision to include women.
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 policy document does not include a robust M&E plan.
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. The policy does emphasize the need for data-driven decision-making, but there are no mentions of how to make data-driven decisions in general or related to gender.

FCT PHCB Human Resources for Health Strategy (2019-2024)

	Gender-responsive checklist for health policies, guidelines, service protocols, and other key government documents in Nigeria	**Score** [NO: 0 Somewhat: .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	Sex-disaggregated data is only presented for population demographics.
2.	Are age-disaggregated data used/presented?	0.5	Age-disaggregated data is only presented for population demographics.
3.	Is gender equality considered a health determinant?	0	No. While equity is mentioned as a priority for health access, gender equality or equity are not specifically mentioned.
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. Protecting human rights is a guiding principle for the strategy, but the statement does not specifically protect the rights of these groups.
7.	Are specific objectives proposed to reduce gender inequalities?	0	No. The strategy does not suggest or include strategic objectives to address/reduce gender inequalities in HRH or service provision and access within the FCT PHCB.
8.	Are lines of action proposed to meet the different needs of women and men?	0	No. The strategy recognizes the need to respond to the

			"sociocultural expectations of the population," but it does not describe what sociocultural expectations must be considered.
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 c. Early Pregnancy/Childbearing d. Access to contraception (Married or unmarried; Women/adolescents/PWD) e. Female genital mutilation	0	No.
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. Male involvement was neither identified nor planned for in the strategic plan.
13.	Does the policy include strategies to improve accessibility to services for PWD?	0	No. The strategy is focused on providing access for all members of the population and does not provide specific strategies for any key populations.
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 health care needs in FCT, and there is no mention of training for gender-

				sensitive or inclusive approaches to care. The process of defining health care needs is not described.
16.	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0		No. Health and safety of health workers is only discussed in the context of occupational hazards and risks.
17.	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	0.5		No. Strategies for production, distribution are based on skill- and cadre-related need.
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 M G B	0 0 0 0	No. The strategy is focused on providing access for all members of the population and does not provide specific strategies for any key populations. The strategy recognizes that there are populations with limited access to care but does not define any populations other than children under 5. The provision of unbiased care is explicitly mentioned as a guiding principle, but it is a general statement. The policy does encourage the recruitment of HRH trainees from remote areas to address issues of geographic access for all citizens.
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	0		No.

	g. geographic accessibility h. unbiased and nonjudgmental and nondiscriminatory		
22.	Does the policy include strategies to increase women's participation in leadership and decision-making roles in the health sector?	0	No. The strategy includes approaches to cultivate leadership and decision-making skills, but there are no specific provisions for women's participation and leadership in the health sector.
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. The strategy only aims to meet the sociocultural expectations of populations.
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*	The strategy document obtained during the course of this desk review does not include Annex I, which includes key indicators for the M&E plan. As described in the strategy document, there is no indication that sex-disaggregated data will be collected.
26.	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	0*	The strategy document obtained during the course of this desk review does not include Annex I, which includes key indicators for the M&E plan. As described in the strategy document, there is no indication that age-disaggregated data will be collected.
27.	Does the M&E plan include indicators to measure gender-related outcomes?	0*	The strategy document obtained during the course of this desk review does not include Annex I, which includes key indicators for the M&E plan. As described in the strategy document, there is no indication that there are gender-related outcome indicators.
28.	Does the M&E plan include indicators to measure outcomes relating to PWDs or disability?	0*	The strategy document obtained during the course of this desk review does not

			include Annex I, which includes key indicators for the M&E plan. As described in the strategy document, there is no indication that there are PWD-related outcome indicators.
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. The strategy does emphasize the need for data-driven decision-making, but there are no mentions of how to make data-driven decisions in general or related to gender.
*Not available			

FCT Strategic Health Development Plan II (2017-2021)

	Gender-responsive checklist for health policies, guidelines, service protocols, and other key government documents in Nigeria	**Score** [NO: 0 Somewhat: .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	Except for data on human resources for health, sex-disaggregated data is not used or presented.
2.	Are age-disaggregated data used/presented?	0.5	Data used and presented are not age-disaggregated. Some age-specific indicators are used (e.g., under 5 mortality).
3.	Is gender equality considered a health determinant?	0	No. Gender equality is only mentioned as a priority area under RMNCAH.
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. The policy only provides for the right to health service provision and does not consider other rights (e.g., the right to privacy/confidentiality) or the unique needs of these 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 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?		
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 proposed actions to raise awareness about FGM. There are no efforts for GBV, early or child marriage, early marriage, or contraceptives.
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. Male involvement was not identified and planned for in the policy document.
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. The SHPD II did not mention any strategy to improve accessibility to services for PWD. The plan only addresses the reduction of disability incidence.
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.

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. The policy provides for the production, distribution, and retention of health workers but it does not have provisions for gender equity.
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. Health financing strategic interventions, targets, and indicators do not address gendered needs or inequitable access to resources.
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	No.
		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. Gender responsive health services are not mentioned.
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?	0.5	HIV incidence is the only indicator with sex-disaggregation. There are some gender-specific indicators.
26.	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	0.5	HIV incidence is the only indicator with age-disaggregation. There are some age-specific indicators.
27.	Does the M&E plan include indicators to measure gender-related outcomes?	0	No. Indicators were not included
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. There are no gender actions. Interventions that meet women's health needs (e.g. MNCH, RH) were costed.
30.	Does the M&E plan include what to do when M&E data reveal gender inequities?	0	No.

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

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

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

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
Adamson, T. A., Ogunlesi, A. O., Iufemi Morakinyo, O., Akinhanmi, A. O., Onifade, P. O., Erinosho, O., ... & Somoye, E. B. (2015). Descriptive national survey of substance use in Nigeria. *Journal of Addiction Research & Therapy*, *6*(3). DOI: 10.4172/2155-6105.1000234	PR
Adedini, S. A., Babalola, S., Ibeawuchi, C., Omotoso, O., Akiode, A., & Odeku, M. (2018). Role of religious leaders in promoting contraceptive use in Nigeria: evidence from the Nigerian urban reproductive health initiative. *Global Health: Science and Practice, 6(*3), 500-514. DOI: 10.9745/GHSP-D-18-00135	PR
Agboghoroma, C. O., & Iliyasu, Z. (2015). HIV Prevalence and trends among pregnant women in Abuja, Nigeria: A 5-year analysis. *Tropical Journal of Obstetrics and Gynaecology*, *32*(1), 82-89.	PR
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Akarolo-Anthony, S. N., Famooto, A. O., Dareng, E. O., Olaniyan, O. B., Offiong, R., Wheeler, C. M., & Adebamowo, C. A. (2014). Age-specific prevalence of human papilloma virus infection among Nigerian women. *BMC public health, 14(*1), 656. DOI: 10.1186/1471-2458-14-656	PR
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Aminu, A., Okekearu, I., Baruwa, E., Adedoyin, J., Rosapep, L., Sarker, I., & Ndu, M. (2018). Biting Off More Than You Can CHEW: What a Baseline Assessment Reveals about Community Health Workers in FCT and Plateau State [Presentation]. https://www.shopsplusproject.org/sites/default/files/resources/Biting%20Off%20More%20Than%20You%20Can%20CHEW-%20What%20a%20Baseline%20Assessment%20Reveals%20about%20Community%20Health%20Workers%20in%20FCT%20and%20Plateau%20State.pdf	G
Balogun, A., Bissell, P., & Saddiq, M. (2020). Negotiating access to the Nigerian healthcare system: the experiences of HIV-positive men who have sex with men. *Culture, Health & Sexuality*, *22*(2), 233-246. DOI: 10.1080/13691058.2019.1582802	PR
Bauer, G., & Burnet, J. E. (2013). Gender quotas, democracy, and women's representation in Africa: Some insights from democratic Botswana and autocratic Rwanda. *Women's Studies International Forum, 41*, 103-112. DOI: 10.1016/j.wsif.2013.05.012	PR
Biya, O., Gidado, S., Abraham, A., Waziri, N., Nguku, P., Nsubuga, P., ... & Sabitu, K. (2014). Knowledge, care-seeking behavior, and factors associated with patient delay among newly-diagnosed pulmonary tuberculosis patients, Federal Capital Territory, Nigeria, 2010. *The Pan African medical journal, 18*(Suppl 1). DOI: 10.11694/pamj.supp.2014.18.1.4166	PR
Bohren, M. A., Vogel, J. P., Tunçalp, Ö., Fawole, B., Titiloye, M. A., Olutayo, A. O., ... & Idris, H. A. (2017). Mistreatment of women during childbirth in Abuja, Nigeria: a qualitative study on perceptions and experiences of women and healthcare providers. *Reproductive health, 14*(1), 9. DOI: 10.1186/s12978-016-0265-2	PR

Carlson, A., Falade, O., Sadiq, F., & Fagan, T. (2019). Fiscal Space for Health in the Federal Capital Territory of Nigeria. Palladium, Health Policy Plus. http://www.healthpolicyplus.com/ns/pubs/17373-17675_FiscalSpaceforHealthFCT.pdf	G
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Cortez, R., Saadat, S., Marinda, E., & Oluwole, O. (2015). Adolescent sexual and reproductive health in Nigeria. Health, Nutrition and Population Global Practice Knowledge Brief. World Bank. http://documents1.worldbank.org/curated/en/199031468290139105/pdf/950290BRI00PUB0geria0VC0ADD0SERIES0.pdf	G
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Egenti, N. B., Adamu, D. B., Chineke, H. N., & POU, A. (2018). Exclusive Breastfeeding among Women in Rural Suburbs of Federal Capital Territory, Abuja, Nigeria. *International Journal of Medical Research & Health Sciences*, *7*(1), 57-64.	PR
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Faramand, T.H., Foster, A.A., Dale, K., Roberts, K., Ivankovich, M., Hall, M. L., & Barrios Wilson, T. (2020b). *Desk review on gender and social inclusion issues affecting the USAID Integrated Health Program in Bauchi State, Nigeria*. Palladium International, LLC and WI-HER, LLC.	G
Faramand, T.H., Foster, A.A., Ivankovich, M., Dahanukar, M., Mickle, M., Barrios Wilson, T., Dale, K., & Zaki, N. (2020c). *Desk review on gender and social inclusion issues affecting the USAID Integrated Health Program in Kebbi State, Nigeria*. Palladium International, LLC and WI-HER, LLC.	G

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FMOH. (2019d). *NHMIS Health Facility General Attendance Register Version 2019.*	P
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