



# Gender Analysis Report

Strengthening Community  
Engagement and Accountability  
for Primary Healthcare Project

# About BudgIT

BudgIT is a civic tech organization that uses creative technology to simplify public information, stimulating a community of active citizens and enabling their right to demand accountability, institutional reforms, efficient service delivery and an equitable society.

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# Executive Summary

Strengthening health systems in Nigeria has evolved beyond policies and funding; there is a dire need for community engagement to improve health delivery across the country. Community-led advocacy for improved PHC utilization, funding, service delivery and infrastructure development is required to improve Nigeria's health sector completely. This report presents a comprehensive gender analysis showing the current state of PHC utilization across gender and age groups, reproductive health, family planning and child spacing landscape across five states: Gombe, Kaduna, Kano, Niger, and Yobe.

## Key Findings

### PHC Utilization Across Gender and Age Groups

The utilization of PHC facilities exhibits distinct patterns across gender and age distributions, as indicated by the responses from 1,776 individuals. A significant majority, 72% (1,282), are females, and the remaining 484 respondents are male. Regular monthly visits to these facilities are reported by 43.6% of respondents, underscoring the consistent demand for healthcare services. The facilities offer various services, including safe spaces, support groups, and specialized services, often a combination of two or all. Notably, 75.6% of the users fall within the reproductive age group of 20–44 years, highlighting the critical role these facilities play for this demographic. However, only 7.2% of respondents have disabilities, and of these, 64% report a lack of adequate provisions for their needs. While some facilities offer provisions such as free healthcare services, transportation support, sign language interpreters, and suitable accommodation structures, including ramps and wheelchairs, there remains a substantial accessibility gap for persons with disabilities.



**1,776**

Individuals



**43.6%**

have regular Visits to the healthcare centre



**7.2%**

have disabilities



**64%**

lack adequate provisions for their needs

## Reproductive Health

The reproductive health segment of the survey reveals critical insights into the utilization and preferences of maternal healthcare services. Among the respondents, 22.1% are expectant mothers, and 22.3% are nursing mothers, with a significant majority, 81%, being married. Antenatal care adherence is relatively high, with 43.2% monthly visits from pregnant women, aligning with the WHO's recommendation of eight visits. However, despite the availability of healthcare services, 18% of respondents still prefer traditional or home birth attendants over hospital or healthcare birth attendants. Alarming, one of the studied facilities reported a maternal mortality rate exceeding 50 deaths in the six months covered by the survey, underscoring a critical area for intervention and improvement in maternal health services.

## Family Planning and Child Spacing

Regarding child spacing and family planning, the study reveals significant gaps and cultural influences impacting the uptake of family planning services. A substantial 71.6% of respondents are unsubscribed to any child spacing option, with only 28.4% participating in such programs. Notably, Kano has the lowest subscription rate at just 4%. Among male respondents, 74.7% do not use any child spacing methods, highlighting the prevalent patriarchy in Northern Nigeria, while 69.8% of female respondents do not also use any child spacing options. The methods used by those subscribed include condoms, withdrawal, abstinence, implants/IUDs, Sayana/traditional methods, pills, injections/Depo-Provera, and calendar marking. Additionally, 56% of the 78 surveyed facilities cited age as a barrier to accessing family planning, with minimum ages for access ranging from 15 to 18 years. Furthermore, 52% of the facilities indicated that adolescent girls require third-party permission or consent to access family planning services, underscoring significant barriers to autonomous reproductive health decision-making for young women.



**71.6%**

of respondents are unsubscribed to any child spacing option



**28.4%**

of respondents are participating in such programs



**74.7%**

of the male respondents do not use any child spacing methods



**69.8%**

of female respondents do not also use any child spacing options.

## Recommendations

To address the identified issues in utilizing PHC facilities, reproductive health, child spacing, and family planning, several recommendations have been proposed.

**First**, enhance the accessibility and inclusivity of healthcare facilities by ensuring provisions for persons with disabilities are uniformly available and adequately publicized.

**Second**, increase awareness and education on the importance of antenatal care and institutional births to reduce maternal mortality rates and shift preferences from traditional birth attendants to healthcare professionals.

**Third**, implement comprehensive family planning education and services, focusing on overcoming cultural barriers and promoting male involvement in child spacing options. Additionally, lower the age barriers for accessing family planning and eliminate third-party consent requirements to empower adolescent girls to make informed reproductive health decisions.

**Finally**, strengthen community engagement and outreach programs to foster a supportive environment for reproductive health and family planning services, particularly in regions with low uptake like Kano.

# Background

*The Strengthening Community Engagement and Accountability for PHC (SCEAP) Project seeks to improve primary health care delivery in Nigeria through community-led advocacy and monitoring of service delivery, financing, and technology infrastructure deployment to improve access and utilization of healthcare services through community advocacy and strengthening the government's commitment to fund and deliver quality healthcare.*

# 1



## 1.1 Project Scope

The Strengthening Community Engagement and Accountability for PHC (SCEAP) Project seeks to improve primary health care delivery in Nigeria through community-led advocacy and monitoring of service delivery, financing, and technology infrastructure deployment to improve access and utilization of healthcare services through community advocacy and strengthening the government's commitment to fund and deliver quality healthcare. The SCEAP project will empower community actors to promote transparency and improvements in healthcare facilities and services through equal participation and inclusive involvement, especially for vulnerable persons and members of the target communities. This is meant to be achieved by working with the communities and other stakeholders as key drivers of change and catalysts for the project objectives.

## 1.2 Proposed Outcomes

- 1 Strengthen the use of data and evidence to drive institutional engagement on fiscal issues and accountability for primary healthcare.
- 2 Strengthen citizen and community voice and participation in PHC advocacy and accountability processes (service delivery, financing, and infrastructure) in 75 communities with presence of PHC facilities.
- 3 Improve community tracking and feedback mechanisms using the PHC Accountability Tracka (PAT) with government stakeholders and systems within LGAs, State Assemblies, SPHCDAs, and broader health financing ecosystem (for example, PHCUOR, BHCPF gateway organizations, etc.).
- 4 Support 20 community-based organizations (CBOs) (50% women-led/owned) to mainstream community reporting, feedback systems, and awards into existing community structures.
- 5 Influence social behaviors and institutional accountability through an incentivized program for healthcare workers and PHC service delivery via PHC Facility and Workers Awards event.





***The project narrows down to the primary healthcare (PHC) facilities situated in these communities to track the quality of services being provided and the effectiveness of resource allocation to the facilities.***

This project is deeply rooted in the community. It adopts a bottom-top approach to the improvement of primary health care service delivery in the focus states. The project will work in 75 communities (15 communities per state) across five states (Kano, Kaduna, Gombe, Niger, and Yobe). The project narrows down to the primary healthcare (PHC) facilities situated in these communities to track the quality of services being provided and the effectiveness of resource allocation to the facilities. This includes providing a platform for community members to share their PHC experiences while strengthening local structures like the Ward Development Committees (WDCs) and the Community-Based Organizations (CBOs) to serve as support systems for community members, especially women and others, that advocate and demand accountability from the respective authorities.

This Gender Analysis assesses the level of gender inclusion and women's participation in the delivery of primary health care services in the project's focus states and provides a rationale for and approach to mainstreaming gender into the implementation of the project. This report, therefore, assesses certain aspects of inequalities women have experienced at various facilities and ensures active participation through gender mainstreaming through the intentional inclusion of women in the design phase of the project, its conceptualization, and its implementation.



## 1.3 Methodology

This Gender Analysis was conducted across five focus states and mapped the communities involved. The methodology included:

1

**Desk Reviews:** We conducted desk research on current levels of PHC utilization, barriers that hinder women from accessing PHC facilities and services in Nigeria, especially within the focus states, and the dynamics of gender disaggregated services in PHC facilities. This research informs the survey questions, which are administered at the facility and community level through various data collection tools.

2

**Sampling:** A community mapping across all five states was conducted, and relevant data with regards to the population size of the communities was collected, informing the selection of the focus communities and PHC facilities to be engaged.

3

**Surveys and Questionnaires:** We developed surveys and questionnaires to collect quantitative data on gender representation in PHC accountability roles, decision-making power, and resource allocation. We ensured the surveys were gender-sensitive and took into account the perspectives of both women and men. We used digital survey tools such as KobotoolBox and Google Forms for data entry and analysis, while trained survey enumerators on gender sensitivity and ethics were engaged to ensure unbiased and respectful interactions with respondents.

4

**Interviews:** We administered the survey questionnaires using an interview method. The technology tool used (KobotoolBox) allows for interactive engagements with the respondents while their responses are entered into the toolbox. We conducted face-to-face interviews with the selected respondents, such as the PHC facility officials, while the community members helped to ensure accurate data collection. Respondents who were under the age of 18 were interviewed with consent and presence of another adult family member or neighbourhood member.

5

**Data Analysis:** Through pivoting, disaggregation of the collected dataset was carried out to outline the dynamics of service delivery in the PHC facilities and interpret the specific patterns, as well as the barriers and challenges faced by the facility staff and the community.

6

**Report:** A comprehensive report is prepared summarizing the survey findings, qualitative insights, and gender mainstreaming framework to be applied.



## 1.4 Limitations of the research

1

**Geographic Scope and Generalization:** The research covers five focus states, but healthcare challenges can vary significantly between regions in Nigeria. The findings may not fully represent the diversity of healthcare experiences across the country. The findings and recommendations may not be directly applicable to other regions with different healthcare systems and cultural contexts.

2

**Sampling Bias:** While conducting community mapping to select focus communities and PHC facilities, there could still be sampling bias. As certain communities might be inadvertently excluded or underrepresented, it could affect the generalizability of the findings for each of the states.

3

**Data Collection Method:** The use of digital survey tools and face-to-face interviews is valuable but requires a lot of time and resources. The limited time proved to be a limitation on the amount of data that could be collected. Budget constraints and logistical challenges limited the scope of the research, impacting the depth and breadth of data collected.

4

**Survey Respondents:** In the first phase of the in-person interviews, we surveyed 480 respondents (478 women and two men) and 61 PHC facilities across the five states. In the second survey, we interviewed 1,286 respondents at the community level and 78 respondents from 78 facilities across the five states. Note that phase two of this survey includes some respondents who were interviewed in phase one and other completely new respondents. This is also the case for the facilities interviewed. The 61 facilities interviewed in phase one were part of the 78 facilities interviewed in phase two. The second phase was crucial in identifying gaps and strengthening gender analysis.

# Assessment of Gender Inclusiveness in PHC Service Delivery

*The survey aimed to understand the gender dynamics within the communities and identify any specific challenges or disparities related to healthcare access and services.*

A large, bold white number '2' is positioned on the right side of the page. In the background, a stethoscope is visible, with its chest piece on the left and the tubing extending across the bottom. The entire scene is set against a dark, textured background.

2

## 2.1 Respondents' Characteristics and Surveyed Facilities

We conducted in-person interviews and surveys to provide valuable insights into the context of gender inclusiveness in the PHC facilities in the five focus states. The survey aimed to understand the gender dynamics within the communities and identify any specific challenges or disparities related to healthcare access and services. The findings will guide our programmatic interventions aimed at promoting gender equity and improving healthcare services for women within the PHC system. Our study focused on collecting data from 1,766 individuals, comprising 1,282 women and 484 men. We conducted our research in 78 facilities located across five states, namely Yobe (18), Kaduna (17), Kano (15), Gombe (15), and Niger (13). Our sample was limited to citizens who use Primary Health Care (PHC) facilities situated in their respective communities.

**Table 1: State Distribution of Respondents by Gender**

State	Female	Male	Total
Gombe	302	126	428
Kaduna	199	27	226
Kano	259	169	428
Niger	324	58	382
Yobe	198	104	302
<b>Total</b>	<b>1282</b>	<b>484</b>	<b>1766</b>



*Based on age, 6.32% (111 out of 1,766) of the respondents are adolescents (Table 2). While the age bracket (25–34) represents our biggest sample size at 31%, findings from the survey show that a substantial proportion of the respondents (75.6%) utilising PHC facilities fall within the reproductive age range of 20–44 years. This also corroborates the results from phase one of the research, which shows that a substantial proportion of the female respondents (58.3%) utilising PHC facilities fall within the reproductive age range of 20–44 years. This validates that the PHC plays a crucial role in providing healthcare services related to reproductive health, including antenatal care, family planning, and maternal healthcare in the states.*

**Table 2. State Distribution of Respondents by Age**

State	Gender	15 - 19 years	20 -24 years	25 - 34 years	35 - 44 years	45 - 54 years	55 years above
Gombe	Female	23	87	123	47	16	6
	Male	4	15	20	42	30	15
Kaduna	Female	13	42	61	54	19	10
	Male	0	3	4	9	3	8
Kano	Female	23	78	84	40	23	11
	Male	9	30	42	36	34	18
Niger	Female	21	93	109	51	24	25
	Male	1	8	18	10	15	7
Yobe	Female	10	52	66	44	17	9
	Male	7	10	27	30	17	13
<b>tTotal</b>		<b>111</b>	<b>418</b>	<b>554</b>	<b>363</b>	<b>198</b>	<b>122</b>



*Of the total 1,766 respondents surveyed, only 128 (7.2%) indicated that they have disabilities, as seen in Table 3. Our survey data shows 128 respondents have disabilities. We had a high proportion of women (68%), with the majority of respondents from Kaduna, Kano, and Niger States. The data also raises questions about awareness and outreach efforts for PWDs regarding the availability and benefits of PHC services. There may be a need for targeted awareness campaigns and community engagement initiatives to reach this population more effectively.*



**Table 3. Utilization of PHC Services by PWDs**

State	No		Yes	
	Female	Male	Female	Male
Gombe	295	117	7	9
Kaduna	172	23	27	4
Kano	243	156	16	13
Niger	297	53	27	5
Yobe	188	94	10	10
<b>Total</b>	<b>1195</b>	<b>443</b>	<b>87</b>	<b>41</b>

## 2.2 PHC Utilization by PWDs

Although the minimum standard for primary health care services prescribed by the National Primary Health Care Development Agency does not explicitly state the minimum standard for services to be provided for PWDs, in our research with regards to the utilization of PHC services by people with disabilities, 82 out of 128 respondents (64%) mentioned that there were no provisions in the facilities tailored for them. With 46 respondents confirming the presence of provisions for PWDs in the PHC facilities they visit across the five states, this amounts to just 35.93% of the PWD respondents, suggesting that there may be limited or no provisions for PWDs in the PHC facilities visited by the respondents. With 24 out of 46 respondents, Kaduna had the highest number of affirmations indicating that the PHC facilities have provisions in place for PWDs.



**Table 4. Provisions for Persons with Disabilities in PHC facilities**

State	No		Yes	
	Female	Male	Female	Male
Gombe	6	3	1	6
Kaduna	6	1	21	3
Kano	11	10	5	3
Niger	25	4	2	1
Yobe	6	10	4	-
<b>Total</b>	<b>54</b>	<b>28</b>	<b>33</b>	<b>13</b>

Only 21 out of 46 people who affirmed the presence of services for people with disabilities were specific about facility provisions. Services, which range from wheelchairs, accommodating structures, sign language interpreters, and support groups, are provided in Table 5 below:

**Table 5. PHC Facility Provisions for PWDs**

State	Health Services/provisions	Respondents
Gombe	Support groups and special attention from the facility	4
	Free access to health care services	1
	Quality and friendly health care providers	1
Kaduna	Free health services, especially for reproductive care	1
	Support groups and special attention from the facility	1
	Accommodating structures and wheelchairs	2
	Sign language Interpreters	1
Kano	Accommodating Structure (ramps)	1
	Wheel chairs	2
	Free access to health care services	1
	Sign language Interpreters	1
Niger	Quality and friendly health care providers	1
	Frees access to health care services	2
Yobe	Accommodating Structure (ramps)	1
	Free access to health care services	1
<b>Total</b>		<b>21</b>



# Maternal Health Assessment across PHC Facilities

# 3

*A majority of the PHC facilities (68.8%) recorded more than 200 female patients visiting the facilities on a monthly basis, indicating a significant demand for healthcare services among women.*



### 3.1 PHC Facility Utilization by Women

According to the community mapping conducted for this project with 61 facilities responding to this question, on average, each PHC facility attends to about 300–500 patients on a monthly basis. Across the 61 facilities surveyed, table 6 below shows that there is a high utilization of healthcare services by women across the focus states. A majority of the PHC facilities (68.8%) recorded more than 200 female patients visiting the facilities on a monthly basis, indicating a significant demand for healthcare services among women.

**Table 6. Female Patient PHC Utilization**

State	Average record of female patients in the PHC facilities on monthly basis	Facilities
Gombe	1- 100	1
	101- 200	0
	> 200	10
Kaduna	1- 100	0
	101- 200	5
	> 200	5
Kano	1- 100	0
	101- 200	3
	> 200	8
Niger	1- 100	1
	101- 200	1
	> 200	11
Yobe	1- 100	4
	101- 200	4
	> 200	8

## 3.2 PHC Facility Visits by Respondents

The survey revealed that women visited PHC facilities at varying frequencies, as analysed in Table 7. Monthly visits were the most common, with 610 female respondents and 160 male respondents reported visiting the PHC facilities on a monthly basis. Based on ratios, these visits suggest that PHC facilities are the primary service providers when women need to access healthcare services. It also indicates a commitment, on the part of the women, to regular healthcare check-ups while ensuring the maintenance of their overall well-being.

Following monthly visits, 255 female respondents reported visiting the PHC facility on a quarterly basis. Weekly visits by women were reported by 93 respondents. Despite representing only about 7% of the women surveyed, it suggests a need for more frequent medical attention or ongoing monitoring of health conditions, as may be necessary for women managing chronic illnesses or seeking antenatal care that necessitates regular check-ups and follow-up appointments.

Among male respondents, monthly visits to PHC facilities are also common, with 160 men indicating monthly visits. This indicates that men, like women, recognize the importance of regular healthcare check-ups and services. Male respondents also exhibit diverse visitation patterns, including 123 respondents with quarterly visits, 58 male respondents visited twice in a month, 14 twice-a-week, and 30 weekly visits. This suggests that men, too, have varied healthcare needs and priorities. While men also utilize PHC facilities, the data shows a lower overall utilization rate (89%) compared to women (95%). This could be due to a variety of factors, including differences in healthcare-seeking behavior.



**Table 7. Frequency of visitation to the PHC Facilities**

	Respondents		
	Female	Male	Total
Daily	97	44	141
Twice in a week	90	14	104
Weekly	93	32	125
Twice in a month	104	58	162
Monthly	610	160	770
Quarterly	233	123	356
Never	55	53	108
<b>Total</b>	<b>1282</b>	<b>484</b>	<b>1766</b>

### 3.3 Maternal Status of Respondents

The insights provided by the respondents in Table 8 regarding their current maternal status or that of their spouses revealed that they are at various stages of motherhood, which require specialized support and care. With 391 (22.14%) and 389 (22.03%) respondents, accounting for expectant and nursing mothers, PHC facilities play a crucial role in monitoring pregnancies, providing prenatal check-ups, offering prenatal education, preparing women for a healthy childbirth experience, providing lactation counseling, providing information on proper nutrition, and providing guidance on maintaining the well-being of both the mother and the newborn.

Additionally, the survey identified 173 respondents as mothers to toddlers, highlighting the importance of PHC facilities in providing essential healthcare services for this vulnerable age group. These services may include immunizations, growth monitoring, nutrition counseling, and early childhood development support to ensure optimal physical and cognitive development. Women in their menopause stages, comprising 107 respondents, require specialized support to manage the physical and emotional changes associated with this life stage. PHC facilities can offer counselling, hormone replacement therapy, and health screenings to address menopausal symptoms and promote overall well-being.

Overall, females within the child-bearing age range but not pregnant or without children make the highest visits to PHCs, accounting for 30% of the respondents. This provides insights that women at this period might need counseling on child-bearing, family planning, and contraception methods for those females below 19, among other services.

**Table 8. Maternal Status of Women and Wives Visiting PHC Facilities**

Current Maternal Status	Respondents	Percentage
At Menopause	107	6.0%
Mother to a teenager (still menstruating)	175	9.9%
Mother to a toddler	173	9.8%
Not Pregnant	531	30.0%
Nursing Mother	389	22.0%
Pregnant	391	22.1%

Further analysis showed that 1,440 (81%) of the respondents are married, out of which 348 (24%) are of childbearing age and are not pregnant. 372 (26%) are pregnant, while 364 (25%) are nursing mothers. There are also 95 (79%) out of 121 women in domestic partnerships who are not pregnant.

**Table 9. Cross-tabulation of current maternal status versus marital status**

Current Maternal Status	Divorced	In a domestic partnership	Married	Single	Widowed
At Menopause	3	14	49	15	26
Mother to a teenager	8	2	146	5	14
Mother to a toddler	6	0	161	1	5
Nursing Mother	7	5	364	11	2
Pregnant	7	5	372	8	1
Not Pregnant	19	95	348	47	20
<b>Total</b>	<b>50</b>	<b>121</b>	<b>1440</b>	<b>87</b>	<b>68</b>





### 3.4 Antenatal Care Insights

Among the 391 pregnant women surveyed, 287 further responded to their frequency of visits for ANC; 124 of the individuals (43.2%) make antenatal care (ANC) visits on a monthly basis. According to the WHO recommendation on antenatal care for a positive pregnancy experience, “a minimum of eight contacts are recommended to reduce perinatal mortality and improve women’s experience of care”. The WHO guidelines further specify the minimum content of the monthly visits aimed at monitoring the health of both the mother and the developing fetus. Our research findings also reveal a wide range of visitation patterns, indicating that different individuals have diverse healthcare behaviors during pregnancy. These patterns include bi-monthly visits (every two months), twice in a month, weekly visits, and even daily visits. One hundred and twenty four respondents (43%) visited ANC facilities on a monthly basis; 67 (23%) reported visiting only when they were sick, while nine (3%) indicated that they never visited an ANC facility during pregnancy. This suggests that there may still be a lack of awareness regarding the importance of regular antenatal care during pregnancy.

1. WHO. WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: WHO Press, 2016. <http://apps.who.int/iris/bitstream/handle/10665/250796/9789241549912-eng.pdf?sequence=1>.



**Table 10. Frequency of visits by pregnant women for ANC**

Frequency of Visits of Antenatal Care	Respondents
Daily	12
Twice in a week	12
Weekly	27
Twice in a month	36
Monthly	124
Only when sick	67
Never	9
<b>Total</b>	<b>287</b>

*Further data analysis shows that in Gombe State, out of 100 respondents, 53% indicated visiting an ANC on a monthly basis, compared to other states Kaduna (58%), Kano (20%), Niger (57%), and Yobe (35%). The low levels of response to the question on frequency of visit for ANC show most pregnant women visit the PHC facilities at least on a monthly basis and when sick, suggesting the need for a shared understanding of the importance of regular prenatal care.*

**Table 11. Frequency of visits by pregnant women for ANC by State**

How frequently do you or your partner visit the PHC facility for antenatal care?	Gombe	Kaduna	Kaduna	Kaduna	Kaduna	Kaduna
Bi-monthly	9	-	6	2	-	17
Daily	1	1	-	-	10	12
Monthly	53	18	14	20	19	124
Never	1	-	6	2	-	9
Only when sick	29	-	5	9	24	67
Twice in a month	4	2	12	1	-	19
Twice in a week	-	-	11	1	-	12
Weekly	3	10	14	-	-	27
<b>Total</b>	<b>100</b>	<b>31</b>	<b>68</b>	<b>35</b>	<b>53</b>	<b>287</b>



*Upon cross tabulation of the data, it is evident that 34% of the adolescent respondents (15 -19 years) visit ANC facilities only when they are sick; it is 19% for the 20-24 years respondents, 27% for the 25-34 years, and 19% for the 35-44 years. The data underscores the importance of ANC services for women of various ages and the need for accessible and comprehensive prenatal care. Efforts to promote consistent ANC attendance should consider tailoring education and outreach strategies to address the needs and behaviors of different age groups.*

**Table 12. Cross-tabulation of frequency of visits to the PHC facilities for ANC versus age distribution**

<b>Frequency of Visits</b>	<b>15 - 19 years</b>	<b>20 -24 years</b>	<b>25 - 34 years</b>	<b>35 - 44 years</b>	<b>45 - 54 years</b>	<b>55 years above</b>
Daily	0	1	7	2	2	0
Twice in a week	2	3	5	2	0	0
Weekly	2	6	10	6	3	0
Twice in a month	2	12	10	9	2	0
Monthly	9	41	44	24	3	3
Only when sick	8	16	29	10	3	1
Never	0	4	3	0	2	0
<b>Total</b>	<b>23</b>	<b>83</b>	<b>109</b>	<b>53</b>	<b>15</b>	<b>4</b>

### 3.5 Facility Survey on Family Planning Services

Based on the in-person interviews at 77 facilities, the most common minimum ages reported by facility officers are 18 years and 15 years, each accounting for 40% and 26%, respectively. Although the National Family Planning/Reproductive Health Policy (2005) in Nigeria does not specify the minimum age of access to family planning services in Nigeria, the policy does provide that “In view of the increasing problems associated with adolescent sexuality and teenage pregnancies in Nigeria, it is considered appropriate that sexually active adolescents who seek contraceptive services shall be counselled and served where appropriate.” The policy is specific to the different family planning methods and the appropriate age for those who can adopt any of them. The method with the least age is the contraceptive implant method, which specifies “age less than 16 years, except in special circumstances.”.

Our research findings corroborate this policy position with the responses collected from the facility workers that adolescents can access family planning services at these ages. The

variations in reported minimum ages across the focus states highlight the importance of understanding the local context and cultural norms when designing family planning programs for adolescents. Unlike Yobe State, more facilities in Gombe and Kaduna stated that patients at the age of 15 can access family planning services.

**Table 13. Minimum age of access to family planning services by States**

Minimum age	Gombe	Kaduna	Kano	Niger	Yobe	Total	%
14	3	1	0	2	0	5	7.8%
15	6	9	0	4	1	20	25.9%
16	2	6	0	1	1	10	12.9%
18	2	1	7	5	16	31	40.3%
19	1	0	1	0	0	2	2.6%
20	0	0	4	1	0	5	6.5%
21	0	0	2	0	0	2	2.6%
25	0	0	1	0	0	1	1.3%
<b>Total</b>	<b>14</b>	<b>17</b>	<b>15</b>	<b>13</b>	<b>18</b>	<b>77</b>	<b>100.00%</b>

While the National Family Planning/Reproductive Health Policy (2005) in Nigeria is silent on the issue of consent for adolescents, the majority of facilities surveyed in Gombe (10) and Kaduna (16) responded that adolescents do not require a third party or adult consent to access family planning services. In contrast, in other states, such as Yobe, a significant proportion of facilities (10), Niger (10), and Kano (15) reported that adolescents need a third party to access family planning services. This could indicate cultural norms or barriers that require them to seek external support or permission when accessing reproductive healthcare services.

The data raises questions about the barriers that might limit adolescents' autonomy in accessing family planning services. These barriers could include cultural norms, a lack of awareness, or a fear of stigma. Ensuring adolescents have the autonomy to access family

planning services is crucial for their reproductive health and rights. It allows them to make informed choices about their bodies and reproductive futures. Interventions should focus on empowering adolescents with knowledge about their reproductive health rights and choices. Additionally, efforts can be made to engage parents, guardians, and communities in understanding and supporting adolescents' reproductive health decisions.

**Table 14. Adolescent third party requirements for family planning services**

State	No	Yes
Gombe	10	5
Kaduna	16	1
Kano	0	15
Niger	3	10
Yobe	8	10
<b>Total</b>	<b>37</b>	<b>41</b>



### 3.6. Child Spacing

Based on the survey of the 1,286 respondents, a significant number of 921 (71.6%) do not subscribe to any child-spacing method, while only 365 (28.4%) do so. While Kano State accounts for the highest with 31.4% of those who do not use a child-spacing method, Kaduna State has the lowest at 4.1%. Conversely, Gombe State at 36.2% and Niger State at 9.9% account for the highest and lowest respondents, respectively, who subscribe to a child-spacing method. This points to the possibility that factors such as negative social norms, unfavorable cultural beliefs, and personal preferences play an integral role when it comes to reproductive care.

**Table 15. Respondents' subscription to child-spacing options**

State	No	%	Yes	%
Gombe	196	21.3%	132	36.2%
Kaduna	38	4.1%	88	24.1%
Kano	289	31.4%	59	16.2%
Niger	246	26.7%	36	9.9%
Yobe	152	16.5%	50	13.7%
<b>Total</b>	<b>921</b>	<b>100%</b>	<b>365</b>	<b>100%</b>

### Child spacing options by gender

Child spacing is often a family decision; however, considering the impact of patriarchy as well as negative social, religious, and cultural norms that are prevalent in the northern part of Nigeria, it necessitates the assessment of male voices as regards the child-spacing option. Thus, of the 1,286 respondents, 482 (37.5%) are male, and of this number, a whopping 360 (74.7%) do not subscribe to child-spacing options, while only 122 (25.3%) do so (see Table 17). The data on the adoption of child-spacing options by gender and state provides several insights. In total, out of 804 women surveyed, 561 (69.8%) do not subscribe to child-spacing compared to males (74.7%). Compared to Kaduna State, which has the fewest (38), Yobe (152), and Gombe (196), Kano State has the highest number of people (246) who do not use child spacing options. On the other hand, 132 individuals in Gombe State have the highest number of persons who subscribe to child-spacing options,



while Niger State has 36 respondents subscribing to child-spacing options. Disaggregation by gender across states, therefore, indicates that Kano State at 146 and Kaduna State at 11 male respondents have the highest and lowest, respectively, of male respondents who do not subscribe to child spacing options. In the same vein, 196 respondents in Niger State, as opposed to 27 in Kaduna State, are female respondents who say they do not subscribe to any child-spacing option. On the other hand, 49 in Gombe State, compared to 8 in Niger State, are male respondents who subscribe to child-spacing methods. While 83 in Gombe State as opposed to 22 in Yobe State are the female respondents who adopt child-spacing options.

**Table 16. Subscription to child-spacing by Gender**

State	No			Yes			% (No)	% (Yes)
	Female	Male	Total	Female	Male	Total		
Gombe	119	77	196	83	49	132	59.7%	40.2%
Kaduna	27	11	38	74	14	88	30.1%	69.8%
Kano	143	146	289	36	23	59	83.0%	16.9%
Niger	196	50	246	28	8	36	87.2%	12.7%
Yobe	76	76	152	22	28	50	75.2%	24.7%
<b>Total</b>	<b>561</b>	<b>360</b>	<b>921</b>	<b>243</b>	<b>122</b>	<b>365</b>	<b>71.6%</b>	<b>28.4%</b>

## Child-spacing options used by respondents

Out of the 1,286 respondents, only 516 responded to the question on the type of child spacing option they adopt. A significant number of respondents (79) indicated they have a 2-5 years child gap between births, which is aligned with family planning goals to ensure optimal health for both mothers and children. Although they did not indicate what child spacing options they subscribed to, which aided them in achieving this gap, 38 respondents are subscribed to using condoms as their child spacing option, which is a popular choice for family planning due to their effectiveness in preventing both pregnancy Sexually Transmitted Infections (STIs). Other contraceptive options subscribed to by

respondents include depo-provera injection with 13 respondents, other injections (43), contraceptive implants (38), and pills (36).

Less commonly used child spacing options are IUD (12), Abstinence (8), Sayana Press/Traditional Method (6), Withdrawal Method (5), and Calendar Marking (4). A significant proportion of respondents (234 out of 516) indicated that they are not using any specific child spacing option. This suggests that these groups are not actively practicing family planning or are using non-conventional methods. Overall, fewer people (365 out of 1,286) subscribe to child spacing options compared to those who do not (921 out of 1,286). This suggests that improved and consistent health education and awareness will play pivotal roles in informing individuals about the various family planning options, including options, convenience, and effectiveness. More efforts should be made to encourage more males to understand and consider child spacing options in view of the many benefits to the health status and quality of life of both mothers and children, which ultimately have advantageous impacts on the family.

**Table 17. Child-spacing options used by respondents**

Child Spacing Option	Respondent	%
Delay for 2–5 years child spacing	79	15%
Condoms	38	7%
Calendar marking	4	0.8%
Depovera Injection	13	3%
Abstinence	8	2%
Withdrawal Method	5	1%
IUD	12	2%
Implants	38	7%
Pills	36	7%
Injections	43	8%
Sayana press/traditional method	6	1%
None	234	45%
<b>Total</b>	<b>516</b>	

## Limitations to Accessing Family Planning

Seventy-eight PHC facilities were surveyed to ascertain the limitations on accessing family planning services based on various factors such as age, marital status, gender, religious belief, cultural norms, and economic status, providing insights into the barriers individuals face in accessing family planning services in different states. Significantly, many facilities agreed that there were no limitations to accessing family planning services based on their marital status, gender, religious beliefs, cultural norms, and economic status. However, 44 (56%) facilities mentioned that there is a consideration for age in delivering family planning services.

For instance, of the 67 respondents who indicate limitations to accessing family planning services on the basis of gender, Yobe State with 18 (26.9%) respondents has the highest, while Niger State with 8 (11.9%) respondents has the lowest. In contrast, no respondents in Kaduna or Yobe States mentioned having a gender-based restriction on access to family planning, while five respondents in Niger State confirmed a gender-based restriction. Additionally, on the question of limitations to accessing family planning services on the basis of age, 15 (34.1%) respondents in Yobe State and only one respondent (4.4%) in Kaduna State answered in the affirmative. Our findings also show the negative impact of cultural norms on accessing family planning options. Eight respondents (57.1%) in Kano State confirm that cultural beliefs impede their accessibility to family planning services, while no respondent in Kaduna State indicates an impediment.

This data, therefore, highlights the importance of addressing these impeding factors through sensitization and health education, including transforming cultural beliefs that hinder the uptake and access to family planning services. Understanding and addressing these limitations is essential to ensuring equal and equitable access to family planning services and supporting individuals in making informed reproductive health decisions. Policy and programmatic interventions should be designed to mitigate these limitations and promote access to family planning services for all individuals, regardless of age, marital status, gender, religious belief, cultural norms, or economic status.

**Table 18. Facility Survey on Limitations to Accessing Family Planning**

State	Limitations on accessing family planning services based on age		Limitations on accessing family planning services based on marital status		Limitations on accessing family planning services based on Gender		Limitations on accessing family planning services based on religious belief		Limitations on accessing family planning services based on cultural norms		Limitations on accessing family planning services based on economic status	
	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
Gombe	9	6	10	4	12	2	11	4	11	4	13	2
Kaduna	16	1	17	0	17	0	16	0	16	0	16	0
Kano	3	12	14	1	12	3	7	8	7	8	7	8
Niger	3	10	8	5	8	5	13	0	12	1	13	0
Yobe	3	15	16	2	18	0	18	0	17	1	17	1
<b>Total</b>	<b>34</b>	<b>44</b>	<b>65</b>	<b>12</b>	<b>67</b>	<b>10</b>	<b>65</b>	<b>12</b>	<b>63</b>	<b>14</b>	<b>66</b>	<b>11</b>

### 3.7.1 Child Births and Vaccination in PHC Facilities across States

In the course of this research, it was imperative to ascertain respondents' disposition towards childbirth and child vaccination considering the UNICEF MIC's 2021 report shows that neonatal deaths and postnatal deaths still account for 34 per 1000 live births and 42 per 1000 live births, respectively, in Nigeria, with the focus states accounting for an average of 10 per 1000 live births on neonatal mortality and 29 per 1000 live births on under-5 mortality, which is still slightly higher than the SDG target of 25 per 1000 live births. Across the 78 facilities surveyed in the focus states, a total of 12,558 children were born over the period of November 2022 to April 2023 - six months prior to the survey exercise. On average, there were 2,093 births per month.

**Table 19. Total child deliveries in the facilities (November 2022 - April 2023)**

Total number of child deliveries in the last six months (November 2022 - April 2023)						
State	November	December	January	February	March	April
Gombe	112	87	203	281	501	436
Kaduna	641	613	700	736	568	461
Kano	545	379	483	437	474	408
Niger	254	218	226	208	231	269
Yobe	530	457	542	510	495	553
<b>Total</b>	<b>2,082</b>	<b>1,754</b>	<b>2,154</b>	<b>2,172</b>	<b>2,269</b>	<b>2,127</b>

### 3.7.2 Child Vaccination across 78 PHC facilities in the last six months

This study demonstrates that 28,503 children received vaccinations throughout the six-month period (November 2022 - April 2023), despite the fact that 12,558 births were officially registered during that time. This suggests the possibility that some children born outside of the facilities were brought in for immunizations. Additionally, it raises the likelihood that the immunizations were given during community or house-to-house outreach programs, and it might also mean that children who were not born during the time period under study received their vaccinations during that time. While this data may be indicative of an awareness and update of child vaccination in the facilities and possibly outside of the facilities, there is a need for continuous awareness raising and vaccination campaigns.



**Table 20. Total child vaccination/immunisation across the facilities in the last six months**

Total number of child vaccinations/immunizations in the last six months (November 2022 - April 2023) by gender						
State	November	December	January	February	March	April
Gombe	629	776	1,183	2,820	2,982	3,055
Kaduna	923	691	624	653	683	413
Kano	407	390	455	414	508	427
Niger	1,482	994	1,239	1,082	1,280	487
Yobe	791	665	585	590	624	651
<b>Total</b>	<b>4,232</b>	<b>3,516</b>	<b>4,086</b>	<b>5,559</b>	<b>6,077</b>	<b>5,033</b>

### 3.8 Maternal Mortality

Based on the data collected from the PHC facilities in the five states, it is evident that the majority of the facilities, specifically 88.5% of them, had not reported any maternal deaths in the last six months. This is a positive indication of efforts to achieve effective maternal health care and the successful prevention of maternal mortality in these PHC facilities. However, there were a few facilities in Kano, Kaduna, and Yobe States that reported a lower number of maternal deaths accounting for 9.8% of facilities.

Specifically, less than 25 maternal deaths were recorded in these PHC facilities, accounting for five of the total PHC facilities surveyed. Although this is a relatively small proportion, it signifies the need for further investigation and targeted interventions to address the factors contributing to maternal deaths in these specific areas.

Additionally, the data revealed that only one of the assessed PHC facilities in Yobe State reported a higher number of maternal deaths, specifically 51–75 deaths, during the last six months. A further follow-up on this facility revealed that the major source of death was attributed to a delay in arriving at the PHC facility resulting from limited means of transportation (vehicles) to the facilities. Most women in this community prefer non-skilled attendants for home birth and only visit the facility in case of complications. This figure highlights a concerning situation that requires immediate attention and robust strategies to address the underlying causes and improve maternal health outcomes in specific PHC facilities.

**Table 21. Maternal Deaths Records in 61 PHC Facilities**

State	None	Less than 25	51-75
Gombe	11	0	0
Kaduna	7	3	0
Kano	9	2	0
Niger	12	0	0
Yobe	15	1	1
<b>Total</b>	<b>54</b>	<b>6</b>	<b>1</b>

### 3.9 Mode of Birthing

The table below shows that 82% of the assessed population prefer hospitals and healthcare as their mode of birthing. Hospital births attended by healthcare providers are the most preferred mode of birth across all states among both female and male respondents, indicating trust in medical facilities and trained professionals for childbirth. "Others" is the least preferred option, with 2% preference across the states and genders, suggesting that respondents generally prefer well-defined healthcare settings or traditional home births. Traditional home births, especially those attended by traditional birth attendants, are preferred by a notable 278 (16%) out of 1,766 respondents, particularly in Kano and Niger States. These preferences reflect the need for healthcare systems to provide accessible and safe childbirth options, including skilled healthcare providers and traditional attendants, to meet the diverse needs and preferences of communities. Utilization of traditional healthcare and other practices can be influenced by factors such as cultural beliefs, religious considerations, quick accessibility, and personal preferences. It is important to recognize and respect the diversity of healthcare practices within a population and ensure that healthcare services are designed to accommodate and integrate cultural, traditional, and religious considerations where appropriate, provided such practices are not negative in processes and outcomes nor repugnant to universal human rights principles and standards.

**Table 22. Preferred Mode of Birthing**

State	Hospitals (healthcare providers)		Others		Traditional (Home and traditional birth attendants)	
	Female	Male	Female	Male	Female	Male
Gombe	272	120	2	2	30	4
Kaduna	162	25	1	0	34	2
Kano	195	100	11	13	53	56
Niger	257	45	4	2	63	11
Yobe	175	95	5	2	18	7
<b>Total</b>	<b>1061</b>	<b>385</b>	<b>23</b>	<b>19</b>	<b>198</b>	<b>80</b>

### 3.10 PHC Facility Services

The assessment of 1,286 respondents for other specialized services provided by the PHC facilities shows the availability of special intervention services in PHC facilities across the focused states. Kano State has the highest number of 138 respondents who affirm the existence of specialized services for treating HIV and TB patients, with 316 (25%); Niger State is second with 85 affirmations. In terms of whether they have safe spaces, 243 (19%) respondents affirmed, with Kaduna (26) and Gombe (44) States having the lowest number of respondents. With respect to support groups, 245 (19%) respondents agreed to having this service in the PHC facility during their visit. It is worth noting that 386 (30%) respondents affirmed having a combination of two of these services present in their facilities, with the bulk of respondents coming from Gombe State (159). Furthermore, 96 (7%) affirmed having a combination of all three services in the facility they use. The presence of these services suggests efforts to address specific healthcare needs and conditions, particularly those related to HIV, TB, and support for vulnerable groups. It's essential for healthcare facilities to offer a wide range of services to cater to the diverse healthcare needs of communities while ensuring inclusion and reducing stigmatization that comes with these health needs through community-based health care.

**Table 23. Respondents' views of the special intervention services offered at the PHC facility**

State	Safe spaces	Support groups	Specialized services (HIV Clinic, TB clinic)	Combination of two Services	Combination of three Services
Gombe	44	76	11	159	38
Kaduna	26	31	9	44	16
Kano	56	83	138	67	4
Niger	66	53	85	58	20
Yobe	51	2	73	58	18
<b>Total</b>	<b>243</b>	<b>245</b>	<b>316</b>	<b>386</b>	<b>96</b>

The survey findings also confirmed the availability of various services offered to women and children with disabilities across the PHC facilities. Health education, friendly healthcare providers, accessible accommodation, and transportation support are among the services provided to address the specific needs of individuals with disabilities. For instance, with respect to accessibility of the PHC structures for women and children with disabilities, Niger State, with 56 (49%), records the highest number of respondents, while Kano State, with 4 (4%), records the lowest. Regarding the provision of transportation services to PHC facilities, Niger State also records the highest with 21 (31%), while Gombe State with 8 (12%) records the lowest. This notwithstanding, it is imperative to ensure that a myriad of essential specialized services are always and adequately available and accessible for persons with disabilities, especially women and children, in order to promote inclusivity in healthcare delivery and achieve, ultimately, healthcare equality and equity.

**Table 24. PHC services to women and children with disabilities**

State	Transportation support for the facility	Quality and Friendly health care providers	Health Education for persons with disability	Accessible PHC accommodation structure	Combination of Services	Others
Gombe	8	61	46	17	112	19
Kaduna	12	53	18	22	19	3
Kano	17	154	28	4	114	12
Niger	21	69	22	56	38	7
Yobe	10	55	42	15	91	44
<b>Total</b>	<b>68</b>	<b>412</b>	<b>156</b>	<b>114</b>	<b>356</b>	<b>82</b>

# Inclusivity and Diversity in PHC Service Delivery

*With the support of the Bill & Melinda Gates Foundation, BudgIT will ensure the integration of gender considerations (including those relating to children, elderly, and persons with disabilities) in order to strengthen community engagement and accountability in PHCs healthcare services delivery in the focus States.*

# 4



## 4.1 PHC Facility Staff Composition

This research considered the question of the staff composition of PHC facilities, particularly with respect to gender representation in their leadership structures.

**Table 25. PHC Facility Respondents (disaggregated by gender)**

State	Female	Male
Gombe	9	2
Kaduna	10	0
Kano	1	10
Niger	9	3
Yobe	7	10
<b>Total</b>	<b>36</b>	<b>25</b>

**36 (59%) of the 61 PHC facilities surveyed on this issue have female leadership members, while 25 (41%) do not. In contrast to Kano State, which has just one (9%) woman in charge of its 11 PHC facility leaders, all 10 PHC facilities in Kaduna State have female leaders.**

## PHC Facility Positions

This data demonstrates the wide range of positions held by both men and women within the PHC facilities, confirming some degree of gender inclusivity in leadership roles while also illuminating the various levels of responsibilities held by women. Out of 36 female respondents, 22 (61%) are officers-in-charge of the PHC facility, seven (19%) are Facility Managers, three (8%) are Deputy Officers-in-charge, and one (3%) each for Assistant Facility Manager, Revenue and Record Officer, Nurse, and Family Planning Officer. Across all the facilities surveyed, no female occupies the positions of Ward Focal Person, Pharmacy Technician, and Sanitation Officer.

**Table 26. PHC Leadership Positions by Gender**

State	Female Respondents	Male Respondents
Facility Manager	7	2
Assistant Facility Manager	1	1
Officer-in-Charge	22	11
Deputy Officer-in-Charge	3	5
Ward Focal Person	0	3
Pharmacy Technician	0	1
Revenue and Record officer	1	1
Nurse	1	0
Family Planning Officer	1	0
Sanitation Officer	0	1
<b>Total</b>	<b>36</b>	<b>25</b>

## 4.2 Ward Development Committees (WDCs) and Community-Based Organizations (CBOs)

This data shows that the Ward Development Committees (WDCs) in the respective communities were all headed by men at the time of the survey, although women formed part of the membership of the WDCs, serving as women leaders and female focal persons. Further engagement with the leaders of the WDCs revealed that the underrepresentation of women as heads of WDCs in communities is mainly due to cultural factors. One way of addressing this gender disparity in PHC leadership is for the SCEAP project team to propose and work with the CBOs in partnership with the WDCs to create opportunities for female-led health focal persons within the communities.

**Table 27. Summary of Ward Development Committees (WDCs) and Community-Based Organizations (CBOs) Engagement in the States by Gender**

State	No. of Community / Facilities	Presence of WDCs	WDCs that are male Led	WDCs that are female Led	Male-led CBOs working with facilities	Female led CBOs working with facilities
Gombe	15	10	10	0	2	2
Kaduna	15	10	10	0	1	3
Kano	15	15	10	0	1	3
Niger	15	11	11	0	2	2
Yobe	15	15	15	0	2	2

# Report Synthesis

*The data, analysis, and insights from this report bring to the fore key highlights that are imperative for achieving the objectives of the Strengthening Community Engagement and Accountability Project (SCEAP). These insights are based on four key themes: population served and services rendered by PHCs, sensitization and awareness, policy gaps, and the power of communities.*

# 5





## 5.1 Populations Served and Services Rendered by PHCs

The gender analysis report showed that the sampled PHCs cater to the healthcare needs of a wide range of populations and offer services based on the diverse health needs of the population. The populations served include pregnant women, newborns, adolescents, adults, and the elderly. Usage of the PHCs among the female gender was also higher than that of their male counterparts, with the majority of the persons being in the reproductive age groups (20-34 years). The research showed more males in the age range of 40 and above using the PHC facilities than males in the younger age group below 40 years of age.

Services rendered in the PHCs range from general consultation to specific tailored services for the different age groups, such as ante-natal care, family planning services, HIV care, voluntary counselling and testing, nutritional services among other services. The majority of the women who accessed these services sought ANC and reproductive care, nutritional services, as opposed to users of the different age groups who utilised the services for non-specific care such as general consultation. Family planning is a key service delivery in PHCs, being a vital component of reproductive health and one influenced by various factors and cultural dimensions. This report, however, reveals that access to and utilization of family planning are rather low across the focus states. For instance, the research examined child spacing across respondents, revealing that a significant proportion of respondents 72% do not subscribe to any child spacing method. Gender disparities in child spacing options were evident, with males generally not subscribed to any child-spacing methods compared to females.





Cultural beliefs, such as the misconception that “if you take family pills, it will affect the fertility rate if you want to conceive again”, others believe that family planning is used for sterilization, while other groups believe that the government is using family planning for population control. Also, because of the infant mortality rate, others believe in having plenty of children to cover for possible losses of infants, while at the extreme, some see family planning as a way of promoting promiscuity among unmarried women. These beliefs were also found to impede the uptake of and accessibility to family planning services in some of the states. Age was also a limiting factor, and although the National Family Planning/Reproductive Health Policy in Nigeria does not specify a minimum age for accessing these services, it emphasises that sexually active adolescents seeking contraceptive services should receive counselling and be served where appropriate. It is, therefore, imperative to state that in order to promote family planning and reproductive health in Nigeria, tailored interventions that consider the local context and cultural dynamics are essential.

## 5.2 Sensitization and Awareness

Across the different survey questions, responses, backed by data, showed a critical need for consistent sensitization and awareness. One such area relates to the data that raises concerns about the limitedness of and the need for awareness creation targeted at and tailored to PWDs regarding the availability and benefits of PHC services. The imperativeness of sensitization is also evident in promoting the importance of regular antenatal care during pregnancy, considering that data on visits to PHC facilities for antenatal care shows that 23% of respondents who visit the PHC facilities during pregnancy do so only when they are sick, while a few (3%) indicate not visiting the PHC facilities even during pregnancy. Additionally, awareness-raising is needed to eradicate or mitigate the effects of the requirement for adolescents to obtain third-party permission before accessing sexual and reproductive healthcare information and services. This not only limits their autonomy and reinforces stigma but also poses concerns as to the state of health of adolescent girls during such a critical phase of life. There is also a need for sensitization and the subsequent accessibility of child vaccination, and awareness-raising is also important for ensuring men and women are well-informed about family planning options so as to aid their decision-making on child spacing and the overall health and well-being of mothers, children, and the family as a whole.

## 5.3 Policy Provision and Implementation Gaps

One key highlight revealed in this research is how many of the PHC facilities surveyed fell short of the “minimum standard for primary healthcare in Nigeria” as laid down by the National Primary Health Care Development Agency (NPHCDA). For example, the policy requires a PHC to have, among others, “a detached building with at least 13 rooms,” “staff accommodation provided within the premises,” and that each PHC should have at least “19 medical personnel and five non-medical personnel.” Our survey, however, shows that none of the PHCs surveyed meet this minimum standard. In relation to gaps in policy provision, it was discovered that in accessing specialized services for PWDs, the policy has little or no provision for PWDs. The only reference to PWDs in the policy is the requirement that PHCs should have wheelchairs in the facility. No particular reference was made as to how the building should be structured or the services it should provide in order to guarantee inclusive and equal access to healthcare in PHCs for PWDs. It is, therefore, important to look into reviewing and implementing the policy standard for PHC facilities and service provision in Nigeria, not only to guarantee inclusivity but also to ensure strict adherence by the PHCs.

## 5.4 Emerging Power of Communities

This gender analysis report shows clearly that primary health care facilities and services are an integral part of grassroot communities in Nigeria. In many of the communities where the survey was conducted, the only source of healthcare service delivery is the PHC facilities. The majority of the citizens in rural areas rely very strongly on PHC services. Hence, the government as well as the community need to take the PHC facilities seriously. On the part of the government, the PHC facilities can be a veritable vehicle for delivering social welfare and improving the living conditions of the citizens. It may actually be good to reconsider many of the social welfare programs to see how well they are delivering values and if a test drive can be done with the PHCs with the guarantee of free and highly subsidized access to basic health care provision. On the part of the citizens and communities, they sit at the center of the PHC facility and service delivery. There is a need to improve the knowledge of the citizens and community to take ownership of the PHC facilities and support the system to deliver optimal outcomes for them. From all indications of this gender report analysis, it is obvious that PHC service delivery will not succeed without people and community involvement and ownership.

# Gender Integration Plan

*Despite data and evidence showing how women struggle with unique and intersecting barriers to accessing healthcare services, healthcare accountability is often overlooked, especially concerning gender integration. It is, therefore, necessary to deliberately integrate gender matters into community engagement to boost healthcare accountability and ensure women's voices are heard and their unique healthcare needs are met.*

# 6

With the gaps gleaned from the above set of data, it is imperative to deliberately and strategically integrate gender in the implementation of the SCEAP project. This is crucial, considering that women's empowerment is essential for the development and progress of any society. This is also based on the principle of gender equality, which is a human right and a key factor for achieving sustainable development goals. Hence, integrating gender considerations in the quest for adequate, accessible, and equitable healthcare cannot be overemphasized. As the quality of healthcare services that women and vulnerable groups access directly impacts their ability to enjoy all their rights and freedoms and meaningfully contribute to societal growth and national development, adopting this project is a stitch in time.

Despite data and evidence showing how women struggle with unique and intersecting barriers to accessing healthcare services, healthcare accountability is often overlooked, especially concerning gender integration. It is, therefore, necessary to deliberately integrate gender matters into community engagement to boost healthcare accountability and ensure women's voices are heard and their unique healthcare needs are met.

Gender integration in healthcare accountability refers to the process of incorporating gender perspectives and ensuring that gender concerns are addressed in healthcare policies, programs, and services. It is based on the ideas that gender is a significant factor in determining health and that incorporating gender perspectives into healthcare systems can help address health inequities. Therefore, gender integration in primary healthcare accountability aims to ensure that healthcare services are accessible, acceptable, and appropriate for both women and men and that their health



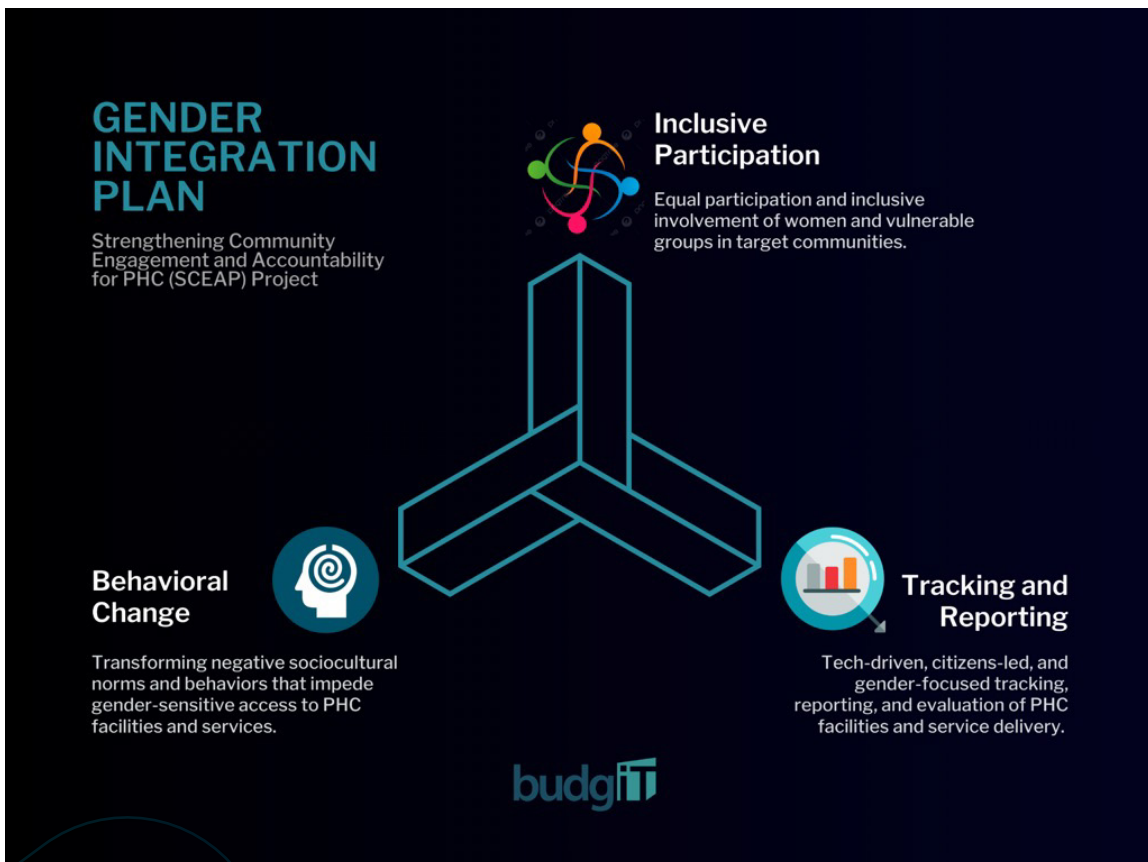
needs are recognized and addressed. It also involves ensuring gender-sensitive health policies, equally accessible healthcare services, and inclusive health systems.

In integrating gender into the Strengthening Community Engagement and Accountability for PHC (SCEAP) project, it is important to recognize three critical guiding ideas. First are gender-sensitive health policies, which recognize and address the different health needs of women and men. For example, policies that require healthcare providers to offer gender-sensitive services, such as prenatal care and family planning, can help ensure that women's maternal health needs are met.

The second is gender-responsive healthcare services, designed to meet the specific health needs of women and men. For example, breast cancer screening can help ensure women receive the necessary timely care. There are gender-sensitive health systems that recognize and address the different health needs of women and men. For example, training and support for healthcare providers to provide gender-sensitive services can help ensure women receive the special care they need.

## 6.1 Gender Integration Themes and Tactics

The strategic actions to incorporate gender in the SCEAP project will be based on three core thematic pillars: Inclusive Participation, Behavioral Change, and Tracking and Reporting.





## 6.1.1 Thematic Pillar 1: Inclusive Participation



The “Inclusive Participation” pillar seeks to ensure equitable engagement and meaningful involvement of target populations toward achieving sustainable project outcomes through inclusive decision-making processes, strengthening relationships, and deepening trust between subnational governments, communities, and key stakeholders. This will foster collaborative participation and a better understanding of the peculiar and intersectional needs of women and vulnerable populations and create a climate for informed collective advocacy to ensure access to gender-sensitive and inclusive healthcare facilities and services in local communities. Specific actions under this theme include:

- **Inclusive Project Team**

The sensitivity of this project requires that the implementing team be equipped with specific gender-related knowledge and expertise. It is advisable for the project's leadership at the coordinating and community levels to be women-led to ensure those at greatest risk of inequitable and ineffective primary healthcare delivery are at the forefront of leading the call for the needed change. The project team will also have a balanced component of both genders in implementing the project—research, tracking, community entry, project activities, monitoring and evaluation, and impact reporting. The team will also work alongside the Gender Integration Consultant, who will guide at every project stage to ensure the effective and adequate integration of unique and intersecting gender perspectives and needs.

- **Gender-Sensitive selection and representation**

In incorporating gender into the SCEAP project, BudgIT will work with focal state governments and the State Primary Healthcare Development Agency (SPHCDA) to identify communities and Primary Healthcare (PHC) facilities that will be direct beneficiaries of the project. In this process, the team will ensure its selection criteria prioritize women-led PHC facilities and gender-balanced Ward Development Committees (WDCs) while working with community groups and leadership to ensure change and inclusion in spaces without these criteria.

Furthermore, in selecting community representatives and Community-Based Organizations (CBOs), BudgIT will employ the reach, expertise, and proximity of 20 community-based organizations that are majorly women-led to facilitate the usage of the PHC Accountability Tracka (PAT) portal in closing the feedback loop between the government and the people. We will facilitate capacity-building, periodic town hall meetings, and engagement sessions between community leaders, government, and healthcare actors and stakeholders at the state and community levels to accelerate equal inclusion and participation of relevant community segments. Women and vulnerable groups will comprise at least 50% of the participants.

# Thematic Pillar 1

- **Community Voices for PHC Advocacy**

The hallmark of effective primary healthcare systems, infrastructure, and service delivery is the government's ability to provide essential healthcare services specific to the entire population and tailored to the needs of critical segments under its coverage. Thus, high-quality healthcare systems must include mechanisms for monitoring, evaluating, and adapting community participation. In the SCEAP project, community participation is one of the critical approaches to driving accountability and transparency in PHC service delivery. The project will, therefore, strengthen the voices of citizens and community champions through:

- identifying and collaborating with existing community structures, especially those that are women-led or women-focused
- creating accountability groups from community stakeholders and citizens that ensure equal participation and inclusive involvement of women and vulnerable groups
- equipping community-based groups with information and knowledge on women's health, children's nutrition and health, and public healthcare financing, among others
- providing technical and material mentorship to the leaders and members of the groups
- conducting regular town halls and other engagements to cascade data and information gathered and lessons learned; and
- conducting regular stakeholders' coordination meetings to collectively identify gaps and challenges and collaboratively advocate for gender-sensitive primary healthcare facilities and service delivery

## 6.1.2 Thematic Pillar 2: Behavioural Change



With the challenges and consequences of existing sociocultural norms, especially in impeding gender-sensitive and inclusive access to and enjoyment of primary healthcare facilities and services, ensuring behavioral change among community gatekeepers, religious leaders, and the custodians of traditions and customs in communities is vital to integrating gender into the SCEAP project. This is necessary because, due to limiting sociocultural factors, women and vulnerable populations, including intersectional groups, run the risk of suffering disproportionately from a lack of access to healthcare service facilities and providers.

While BudgIT recognizes the long period needed to change these mindsets and behaviors, given the project's timeline and the region's sensitivity to gender issues, gradually shifting some of these harmful norms and unfavorable behaviors will help in laying the foundation upon which other behavioral change building blocks can be subsequently laid. What is crucial, however, is to start the process of changing these norms and behaviors in the hope of moving the needle, albeit slowly, in ensuring gender-sensitive healthcare service delivery through:

### • Behavioral Change Communication

This communication targeted at community members who hold and drive social norms that affect women and vulnerable groups is crucial in achieving health outcomes for women, children, older people, PWDs, and persons with special needs. With enlightenment and education, coupled with strong relationships with health workers, these groups—male figures in the family (fathers, husbands, uncles), traditional and religious leaders, male community gatekeepers, and the custodians of traditions and cultures—can receive the necessary information, resources, and support needed to change their mindsets and support the process of equal and nondiscriminatory access to healthcare facilities and services.

Another approach, where women and vulnerable groups are targeted, is to conduct outreaches and sensitization sessions on aspects of their healthcare for which they may have relative direct control, such as personal hygiene, household and community sanitation, balanced nutrition and diet, exercising, and physical activities, and regular check-ups and screenings for early detection and treatment. This way, women and other vulnerable groups can be empowered to take personal steps to control their health and well-being, as well as that of their families.

### • Behavioural change champions

Selected community members, including women and vulnerable groups, who are well-known and highly respected, will be chosen as behavioral change champions on the SCEAP project. The champions will be the voices of women and those affected by these norms and discriminatory behaviors. To ensure informed actions and engagement, the champions will be trained and their capacity continually strengthened while deepening the relationship between them and relevant healthcare stakeholders. Their proximity to and collaboration with these healthcare personnel will help shift mindsets and gradually change negative social norms that impede women's health.



- **Relationship Building and Collaboration**

Having assembled and built the capacity of relevant stakeholders, including pregnant women, mothers, healthcare personnel, and service providers, BudgIT will set in motion the process of strengthening their relationships in the hope of joint and collaborative advocacies and actions. BudgIT will also deploy a social behaviour change approach that is gender-sensitive and responsive in driving institutional transformation toward effective healthcare service delivery.

## 6.2.3 Thematic Pillar 3: Tracking and Reporting



The SCEAP project provides an opportunity to leverage digital tools for citizen-led tracking, reporting, and evaluating the effectiveness, efficiency, and gender sensitivity of PHC service delivery. This will form the basis of data-driven and evidence-based advocacy for policy, programs, and decision-making relevant to improving the quality of healthcare service and the efficiency of PHC administration, primarily as it affects maternal and infant health. For this purpose, we will focus on the following:

- **PHC Accountability Tracka (PAT)**

The PHC Accountability Tracka (PAT) portal will be used as a data hub for all PHC facilities and service delivery activities, especially those relating to resource management. It will also serve as a data reservoir for advocating improved PHC infrastructure and service delivery. Capacity-building sessions will be conducted for Ward Health Committees (WDCs), community champions, and CBOs on how to use the PAT portal for logging healthcare service delivery reports. Hence, while being used as a reporting portal, the PAT will also serve as a citizen-led social audit tool in pushing for improved PHC infrastructure and service delivery. We will pay attention to selecting individuals and CBOs to serve as community champions using the PAT portal by ensuring women and vulnerable groups constitute at least 50% of the total members.

- **BudgIT's State of States**

The State of States is BudgIT's annual comparative assessment data and analytical report on the fiscal performance and position of the 36 states in Nigeria. Concisely, the State of States report examines states' ability to finance their budgets with internally generated revenues, investment prioritisation in human capital development, and the sustainability of their borrowings. Every year, BudgIT's flagship State of States report has a sub-theme focusing on an area of development that states need to improve. Given the SCEAP project, the 2023 edition of the State of States explored the theme "Subnational Healthcare Delivery for Economic Development" using data from the latest Multiple Indicator Cluster Survey (MICS) and National Immunization Coverage Survey (NICS), the report included a spot assessment of the state of healthcare in the various states to the extent possible, with particular attention given to maternal and child health. Indicators captured in the assessments include, health insurance coverage, child immunisation, child mortality, maternal mortality, fertility rate, ANC visits, use of skilled birth attendants, contraceptive usage and health financing per capita. The report shines the spotlight on the state of healthcare delivery at state levels for improved economic development.



# Thematic Pillar 3

## • Project Tracking

The SCEAP project will mobilize relevant community actors in project monitoring and tracking toward ensuring quality, equally accessible, and gender-sensitive health infrastructure and service delivery. BudGIT will leverage the approach of its Tracka initiative and existing community champions in its 75 project locations and build their capacities to track existing and new health projects and the use of healthcare allocations in delivering maternal and neonatal healthcare through a gender-sensitive and inclusive lens. There will be a spotlight on how the actions or inactions of the government and health workers regarding infrastructure development and service delivery directly affect women and vulnerable groups to ensure that issues surrounding primary healthcare delivery are assessed and addressed through gender-sensitive perspectives and approaches.

# Risks and Mitigation Plan

# 7



Risk	Description and Impact	Severity	Mitigation Plan
<b>Demand side</b>			
Partisanship/ political leanings	Limited participation and engagement by the target population, including uptake of information and benefits of the project based on political leanings	High	Leverage BudgIT's proven reputation for non-partisanship. Also, limit engagement and advocacy to data and evidence.
Unfavorable and discriminatory socio-cultural norms	The prevalence of socio-cultural norms that result in partial PHC service delivery which impedes women and other vulnerable groups from accessing and enjoying primary healthcare facilities and services.	High	Continuously engage and build the capacities of community gatekeepers, religious leaders, and custodians of traditions and customs to gradually transform these unfavorable sociocultural beliefs.
Ethnocentrism	Members of other cultures frustrate project activities based on pre-existing ethnocentric evaluations and preconceptions about the gender relations of other cultures versus their cultural norms, beliefs, and standards.	Medium	Where necessary, separately engage members of different or opposing cultures while carrying out behavior change activities to limit divisiveness and reduce the chances of ethnicity-based clashes.
Geographical considerations	The project team is unable to reach the target population in rural and suburban areas with little to no access to good roads, preventing them from taking part in project activities and reaping the benefits.	Medium	Engage selected representatives, including women from inaccessible communities, by inviting them to central locations alongside others. Also, where possible, hold regular community outreaches and engagements in the more accessible communities.

Risk	Description and Impact	Severity	Mitigation Plan
<b>Supply side</b>			
Election period	Political actors' preoccupation with election activities, including during periods of election tribunals and weeks after swearing-in ceremonies, during which time engagement with public institutions for accountability is less prioritized.	Medium	Engage available political actors in anticipation of proper communication and engagement after political officeholders resume and are well settled.
Bureaucracy and weak political will	Lack of prioritization, disinterest, and the unwillingness of duty-bearers and heads of political institutions to engage, approve requests for data and information, or act on project recommendations.	High	Continuous sensitization, communication, and engagement with political actors through local political groups, individuals, and CBOs.
Limited access to duty-bearers	Limited project team's access to political actors, duty bearers, and other political stakeholders at the state and local levels.	Medium	Partner and work with individuals and CBOs with a good grounding in local politics and better access to state political officeholders.
Bias and discrimination	The unwillingness of government and community actors to engage project teams led by or populated mainly by women due to sociocultural and religious reasons	Medium	Before physical engagements, conduct due diligence on the target political actors and adjust the team formation accordingly.

# Conclusion

*These insights can inform targeted interventions and healthcare delivery strategies, recognizing that different gender groups may have distinct healthcare needs and priorities. The substantial age disparities should also underscore the importance of aligning healthcare policies and services with the demographics of the communities served by PHC facilities.*

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This Gender Analysis, which is premised on data and evidence, depicts the existing realities of women accessing PHC facilities and services across the focused SCEAP states for the Strengthening Community Engagement and Accountability for PHC (SCEAP) project, which aims to improve primary healthcare delivery in Nigeria through community-led advocacy and monitoring of service rendering, financing, and infrastructure deployment. Mainstreaming gender into the SCEAP project is imperative considering the disproportionate impact that inadequate healthcare infrastructure and services have on women, children, persons with disabilities, older people, and such groups who, from time immemorial, have been marginalized in primary healthcare delivery. The integration of gender considerations in the SCEAP project will highlight these underserved groups' peculiar and intersectional realities and needs when addressing prevalent healthcare issues such as the heightening spate of maternal and infant mortality in Nigeria. The survey showed gender disaggregation across all age groups, showing variations in healthcare utilization patterns between men and women. These insights can inform targeted interventions and healthcare delivery strategies, recognizing that different gender groups may have distinct healthcare needs and priorities. The substantial age disparities should also underscore the importance of aligning healthcare policies and services with the demographics of the communities served by PHC facilities. Most importantly, healthcare resource allocation and planning should consider the age distribution of patients. This may involve staffing, medical supplies, and infrastructure adjustments to ensure that PHC facilities can adequately meet the demands of the different age groups they serve. Policies and interventions should consider these variations to ensure that services are accessible and culturally sensitive. Adolescents' perception of the minimum age to access family planning services may also reveal potential barriers to healthcare access. Addressing these barriers, whether they are related to knowledge, stigma, or service availability, is essential to promoting reproductive health among adolescents. Education and awareness campaigns can play a crucial role in informing adolescents about their reproductive health rights and the availability of family planning services.



In the same vein, the fact that 69.8% of female respondents showed they were not subscribed to any child-spacing options shows a huge gap in reproductive health education, which should be prioritized in the implementation of this project.

**Regular ANC check-ups are essential for monitoring the health of both the expectant mother and the developing baby.** Monthly visits, as indicated by a significant proportion of respondents, align with the recommended guidelines for prenatal care. These underscore the need for robust health education and awareness campaigns to inform expectant mothers about the importance of regular ANC visits. Such campaigns should emphasize the benefits of early detection and intervention in addressing potential pregnancy-related complications. Healthcare providers should be prepared to offer a range of ANC services to accommodate varying visitation patterns. This includes providing comprehensive care during monthly visits and addressing urgent healthcare needs for those who visit less frequently.

**In order to address maternal deaths in the various states, it is crucial to focus on the root causes of these deaths and drastically reduce them by enhancing the quality of antenatal care services.** This entails ensuring that pregnant women receive adequate monitoring and support throughout their pregnancies. Additionally, promoting the presence of skilled birth attendants during labour and delivery is essential, as they can provide immediate medical assistance in the event of complications. It is imperative to equip PHC facilities with the necessary resources and well-trained personnel capable of offering emergency obstetric care, including procedures like caesarean sections and blood transfusions. To further enhance the situation, improving transportation accessibility to healthcare facilities, particularly in rural areas, becomes paramount. This step ensures that pregnant women can access medical facilities promptly when needed.

Moreover, conducting community awareness and educational initiatives is vital. These programs can educate communities about the significance of seeking medical care during pregnancy and childbirth. Implementing strategies to reduce teenage pregnancies is also a priority, as younger mothers are more susceptible to complications during childbirth. Furthermore, providing maternal health education to women and their families can raise awareness about recognizing signs of complications and the importance of seeking medical assistance. It is equally essential to make postpartum care readily available and accessible to address any complications that may arise after childbirth.

**Policymakers should take into account the specific healthcare needs of PWDs and work to remove barriers that hinder their access to and utilisation of quality healthcare.** The data provides valuable insights for healthcare planning and resource allocation. It can guide efforts to enhance the accessibility and utilization of PHC services by PWDs, ensuring that their unique healthcare needs are met. Overall, the data highlights variations in the provision of services for PWDs across the assessed PHC facilities in different states. While Gombe and Kaduna States demonstrate a higher commitment to addressing the needs of PWDs, there is room for improvement in Kano, Yobe, and Niger States to

ensure better accessibility and inclusivity for PWDs within their PHC facilities. It is important to make an effort to identify and remove the obstacles that PWDs face in accessing healthcare services, as well as to promote inclusivity and address their unique needs.

**A huge gender gap exists in PHC community management and engagement, despite women being the highest users of primary healthcare centers.** While 72.5% of this research respondents are women, and 82.5% of them responded that hospitals are their choice of place when it comes to giving birth, there is still a need to consider what barriers or cultural norms affect the other 17.8% from accessing healthcare facilities.

There are also pockets of other gender issues we encountered in the course of this research that require attention. For example, the WDC's across all the surveyed communities are headed by men. Although this traditional patriarchal ward development model may be accepted, it raises concerns about whether the male leaders are adequately positioned to address issues that women face at primary healthcare facilities in their communities.

Also, in the recruitment of CBOs to support this project intervention at the community level, of the 140 CBOs that applied, only 15 were from women-led community based organizations while the rest (125) were from male-led organisations. During the review process, all women-led organizations that had applied for the role were given special consideration for review as this was a requirement for engagement; 12 women-led CBOs out of the 15 applications proceeded to the interview phase as they had met most of the criteria outlined for engagement in the project. Some waivers were given to these women-led organizations with little or no prior PHC experience but had background in implementation at the grassroots level. Three female-led organisations were not shortlisted as their applications did not meet the criteria for selection (applications were suboptimal).



# Appendix

[1] Abdullahi, A., Ezenwa, S., Atobatele, S., Nzobiwu, A., & Uweja, H. (2020, 25 March 2023). Preliminary learnings from Nigeria's Basic Health Care Provision Fund. Results for Development. <https://r4d.org/blog/preliminary-learnings-from-nigerias-basic-health-care-provision-fund/>

[2] Ibid.

[3] Noncommunicable diseases country profiles 2018. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.(2018).



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