EVALUATION
Nigeria Gender Assessment

March 2016

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EVALUATION

Nigeria Gender Assessment

March 2016
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DISCLAIMER
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ACKNOWLEDGMENTS

Recognizing the critical role of gender throughout the HIV continuum of care, PEPFAR’s Gender Strategy requires all HIV programs to identify gender-related issues and take concrete steps to address them. This Gender Analysis for PEPFAR Nigeria represents one of many efforts of the PEPFAR Gender Technical Working Group (GTWG) in Nigeria to ensure that gender issues are integrated throughout its HIV prevention, care, treatment, and support programs.

In addition to the excellent documents that PEPFAR has produced, GHPro especially appreciates the cooperation of everyone in the 11 states who contributed their time and the information and insights on which this Analysis is based. These include:

- Government of Nigeria officials from state agencies, including the Ministry of Health, the Ministry of Women’s Affairs and Social Development (MOWASD), State Action Committee on AIDS (SACA), and Local Action Committee on AIDS (LACA)
- Federal officials from MOWASD and National Action Committee on AIDS (NACA)
- Staff and beneficiaries of community-based organizations
- Staff of Implementing Partners
- Caregivers of orphans and vulnerable children (OVC)
- Community volunteers
- People living with HIV
- Medical directors
- ART site coordinators and staff
- Most-at-risk populations, including men who have sex with men, sex workers, and intravenous drug users
- Community leaders

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In particular, we appreciate the ongoing assistance, encouragement, and collaboration we received from Tessie Philips-Ononye, Program Manager, OVC, and Gender Point of Contact, and from Anthonia U. Aina, from CDC.
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Definition</th>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<tr>
<td>AIDSTAR</td>
<td>AIDS Support and Technical Resources (project)</td>
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<td>ANC</td>
<td>Antenatal care</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>ARV</td>
<td>Antiretroviral drugs</td>
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
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<td>CBO</td>
<td>Community-based organization</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>COP</td>
<td>Country Operation Plan</td>
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<tr>
<td>CQI</td>
<td>Continuous quality improvement</td>
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<tr>
<td>CSO</td>
<td>Civil society organization</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DHS+</td>
<td>Demographic and Health Survey with HIV biomarkers</td>
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<tr>
<td>EMTCT</td>
<td>Elimination of Mother to Child Transmission</td>
</tr>
<tr>
<td>FGC</td>
<td>Focus group discussion</td>
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<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
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<td>FP</td>
<td>Family planning</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GON</td>
<td>Government of Nigeria</td>
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<td>GTWG</td>
<td>Gender Technical Work Group</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>IP</td>
<td>Implementing Partners</td>
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<td>KII</td>
<td>Key information interview</td>
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<td>LACA</td>
<td>Local Action Committee on AIDS</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>MTCT</td>
<td>Mother-to-child transmission of HIV</td>
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<td>MWA</td>
<td>Ministry of Women Affairs</td>
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<tr>
<td>NACA</td>
<td>National Action Committee on AIDS</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>OVCs</td>
<td>Orphans and vulnerable children</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission of HIV</td>
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<tr>
<td>PWID</td>
<td>People who inject drugs</td>
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<tr>
<td>RH</td>
<td>Reproductive health</td>
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<tr>
<td>SACA</td>
<td>State Action Committee on AIDS</td>
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<td>STD</td>
<td>Sexually transmitted disease</td>
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<tr>
<td>SW</td>
<td>Sex worker</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TPM</td>
<td>Team Planning Meeting</td>
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<td>TWG</td>
<td>Technical Working Group</td>
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<td>UNAIDS</td>
<td>United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>U.S. Agency for International Development</td>
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<td>USG</td>
<td>United States Government</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WLHIV</td>
<td>Women Living with HIV</td>
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EXECUTIVE SUMMARY

ASSESSMENT BACKGROUND
An updated gender strategy of the President’s Emergency Fund for AIDS Relief (PEPFAR) requires all PEPFAR countries to conduct a gender assessment to inform the design of projects and activities. In Nigeria, an inter-agency PEPFAR Gender Technical Work Group (GTWG) supports PEPFAR programs to integrate gender interventions into new and existing programs and to accurately report on progress. While efforts to integrate gender activities in Nigeria have begun, they have been largely project-specific and of insufficient scope and depth to stimulate lasting change. The PEPFAR-required analysis was undertaken to guide the development of a well-coordinated, systematic, and program-wide approach to gender integration in Nigeria. This report presents the results of the analysis.

METHODOLOGICAL APPROACH
A three-person team conducted site visits throughout the country to collect data on gender activities implemented in PEPFAR-supported projects. The team used a mixed-methods approach to data collection and then triangulated information from all sources to identify key findings and produce practical recommendations for integrating gender across the HIV continuum of care. The approach used the following protocols:

- Reviewing PEPFAR-recommended literature and client-approved reports the team identified prior to and after site visits;
- Developing and circulating to Implementing Partners (IPs) a pre-site visit questionnaire to gather baseline data on their understanding of gender issues and their activities to integrate gender into their projects;
- Developing data collection instruments, including key informant interview questions and focus group discussion topics, to collect information during site visits;
- Conducting interviews and focus group discussions with representatives from key stakeholders, including organizations, projects, and official agencies, as well as documenting observations at each site and discussing key issues with PEPFAR and USAID staff before, during, and after site visits; and
- Ensuring a diverse geographic range and interviews for each type of PEPFAR intervention.

ASSESSMENT QUESTIONS
The assessment reviewed key gender issues and gender-based constraints in Nigeria and assessed the institutional context and opportunities for integrating gender into the PEPFAR country program. Based on the findings, the assessment presents conclusions and proposes recommendations to strengthen the response to HIV gender issues in Nigeria. The assessment sought to answer the following three fundamental questions:

1. What is the Nigeria PEPFAR program doing to integrate gender activities into HIV prevention, treatment, and care and support?
2. What are the gaps and opportunities for gender interventions in the Nigeria PEPFAR gender program?
What are the strategies and approaches needed to improve the PEPFAR Nigeria gender program?

**ASSESSMENT FINDINGS**

**Question 1:** What is the Nigeria PEPFAR program doing to integrate gender activities into HIV prevention, treatment, and care and support?

Assessment findings indicated several areas in which the Nigeria PEPFAR program is effectively assisting its IPs to integrate gender activities into HIV projects, as follows:

**A. Supporting IPs with guidance, direction, capacity building, and leadership:** The PEPFAR Nigeria program has required IPs to disaggregate project monitoring data by sex, recommended that IPs conduct a gender analysis of their projects, and provided IPs with gender research reports and on-line and in-person training on gender, monitoring and evaluation (M&E), and other topics relevant to integrating gender into projects. Together, this combination of assistance, recommendations, and requirements has helped to build IP expertise. The initial questionnaire indicated that approximately 90 percent of IPs disaggregate reports by sex, and over 60 percent consult key PEPFAR reports for guidance. Both IPs and the community-based organizations (CBO) subs requested continued assistance on gender integration, especially in designing and conducting gender analyses.

**B. Ensuring confidentiality:** An area in which IPs and CBOs are working effectively is in recognizing the importance of ensuring confidentiality at all levels of the HIV continuum, and they have designed a variety of methods for doing so. With a scattering of exceptions, clients indicated that they trust these methods, which go a long way in attracting them to facilities for testing and treatment.

**C. Utilizing role models:** At most site visits, role models were credited with providing valuable assistance. People living with HIV (PLHIV) increase enrolment and adherence for newly detected clients, “mentor mothers” support Elimination of Mother to Child Transmission (EMTCT) for pregnant women, members from communities of men who have sex with men (MSM)/sex workers (SW) serve as peer educators and outreach staff, and men and women who are doing well on antiretroviral (ARV) treatment encourage uptake and continuation of treatment at counseling sessions. IPs and CBOs recruit role models, who are largely volunteers from the communities with whom they work. This represents an important area for expansion.

**Question 2:** What are the gaps and opportunities for gender interventions in the Nigeria PEPFAR gender program?

The baseline questionnaire, key informant interviews (KIs), focus group discussions (FGDs), and observations indicated the following gaps and opportunities for gender interventions in the Nigeria PEPFAR gender program. The Recommendations section of this assessment proposes ways for bridging the gaps and taking advantage of the opportunities identified below.

**Institutional Level**

**Gender Expertise**

Currently, the level of gender expertise within IPs and CBOs is not sufficient to effectively integrate activities addressing gender norms and disparities in program designs, objectives, activities and other inputs, M&E, and consequently the achievement of results.
**Coordination**
At the IP Exit-Brief and during site visits with IPs and CBOs, a common comment concerned better coordination among the many stakeholders working on the integration of gender into HIV-related programs in Nigeria.

**Community Level**

**Family Planning**
Family planning is an issue that will continue to grow in importance in Nigeria. We recommend developing a female condom as one response to family planning issues.

**Focus on Youth**
Seventy-five percent of Nigeria’s rapidly growing population is under age 34, and 22 percent are women of childbearing age. Therefore, a focus on youth is essential, with outreach into schools, youth clubs, sporting events, religious groups, and other places where young men and women congregate—separately or together.

**Cultural Considerations**

**Gender Norms Regarding Seeking Care**
This assessment confirmed that men were much less likely than women to visit health facilities, a tendency observed nationwide. Interviewees attributed this to women having more reasons to go to a clinic or hospital than men, in large part for reasons of pregnancy and child care. As a result, we may assume that women tend to be more familiar, knowledgeable, and comfortable with such settings. This issue is addressed in the Recommendations section of this assessment.

**Gender-based Violence**
Research confirms that GBV is closely linked with HIV. KIIIs and FGDs with health care staff, primarily nurses, as well as an extensive literature review, indicate that GBV is not viewed as a critical gender concern in local communities. This assessment’s interviews with health care providers indicated that they have not been trained on identifying or managing GBV. There are no shelters for battered women, and referrals from health care providers to the police do not take place with any regularity. The most effective way for the PEPFAR Nigeria program to contribute to solving this critical problem is by working closely with partners focused on the issue.

**Access to Communication**

**Outreach**
Interviews with CBOs stressed the importance of outreach to communities. According to interviewees, PEPFAR no longer supports community outreach programs, and state and local governments do not support them either. Volunteers warn that this will limit the potential to reach more men. As indicated in the Recommendations section, men seem to respond more readily to testing with access that comes to them, i.e., through mobile clinics, so eliminating community outreach and access programs potentially limits the testing of men, who are much less likely than women to go to a clinic or hospital.

**ASSESSMENT RECOMMENDATIONS**

**Question 3:** “What are the strategies and approaches needed to improve the PEPFAR Nigeria gender program?”
Based on the findings of this assessment, this section offers Recommendations that will ultimately help people access HIV counselling and testing, access treatment if they are found to be positive, and help them stay on treatment—the ambitious program adopted by PEPFAR known as 90-90-90. Our research has shown that cultural considerations—correcting misperceptions or feelings of stigmatization or gender-related behaviors that may prevent the seeking of and adherence to treatment—must be addressed first and foremost. Changes in gender norms and again, stigmatization, also impact the likelihood that an individual will stay in treatment. The availability of information, and understanding the options that are out there, are crucial to bringing people into treatment and having them stay there. Increasing the community’s ability to understand the issues (by conducting gender analysis, etc.) and to offer accurate and practical information, as well as collaborating with other organizations, is crucial to reaching the right people with the right information, and once they have entered the world of treatment, knowing how to keep them there. Therefore, raising awareness is a major area of intervention, one that cuts across the whole 90-90-90 gamut. Developing the capacity of stakeholders to analyze and understand the gender perspective and engage the community is also key to getting people into treatment and keeping them there. Related to these two areas of intervention are, of course, improved communications and outreach to be sure that the right information is getting to the right people.

The purpose of this assessment is not to identify new theories of change, although they would provide a rational basis for selecting approaches that are likely to achieve success. The conclusions and recommendations presented here focus on practical ways to strengthen the PEPFAR Nigeria gender response to HIV-related problems, which is based on changing social, political, and economic realities, on efforts in the PEPFAR program that are proving successful, and on activities that appear promising but have not yet been fully implemented. However, it is strongly recommended that new theories of change be identified to help guide the program along an analytical, evidence-based path. While the program will not attempt to conquer the mountain of gender norms, it will address selected issues, and employing theories of change will help ensure that the effort is systematic.

**Raising Awareness**

**Addressing Misconceptions and Superstitions**

Immediate, urgent, and bold action is needed to correct misconceptions, superstitions, and harmful practices that prevent men, women, and youth from seeking treatment. **We recommend that education begin by addressing superstitions and beliefs affecting gender relations that can be debunked using hard scientific fact, followed by other culturally ingrained beliefs.**

**Promoting the Use of Female Condoms**

According to some interviewees, female condoms are large, noisy, inconvenient to use, not readily available, and costly when compared with male condoms, which are often dispensed for no charge. Even so, suppliers quickly run out of them. **This assessment strongly recommends research and development of a female condom that meets the needs of the women who will use them; we recommend that potential users be involved in their design.**
Developing Capacity

Professional Development

Building the gender knowledge and skills of IP and CBO staff is perhaps the most important step the PEPFAR team can take to improve the quality of its program. We recommend a capacity-building program that uses local talent and takes advantage of the excellent body of existing and yet to be published research to create a cadre of capable gender specialists who could design and conduct gender analyses and integrate gender strategically throughout the HIV program. Importantly, the program could focus on the same gender issues that PEPFAR Nigeria selects as priority target areas.

The literature review undertaken for this assessment revealed a large number of recent research reports related to gender norms, GBV, and the HIV continuum of care. These materials provide accurate and comprehensive information, useful directions, practical tools, and valuable FAQs and troubleshooting advice. An entire course could be created using existing materials, which could be delivered through a participatory and interactive methodology.

Interview questions concerning staffing patterns and hiring and promotion practices revealed that aside from doctors and senior managers, most of whom are men, investments are not made in the professional development of staff. A quarterly seminar, with staff not only participating but leading the sessions—a series of “brown bags”—could be instituted, wherein staff would learn about new developments in their field, and this could contribute to a higher self-image as professionals, which nurses, program coordinators, and the few gender advisors on staff would keenly enjoy.

Some IPs are more sophisticated than others, and when asked, they expressed a willingness to share information with those who need it. We recommend mentoring and on-the-job training, which could go a long way to building practical skills. It would also enable IPs to get together more often, a recommendation they made during the IP Exit Brief.

A less immediate but intriguing way for staff to build skills is by connecting with state, national, and international associations, which could enable staff to exchange information, ideas, and experiences with people in similar positions outside their own communities. At regional and international levels, contacts with professional associations could open doors to opportunities for networking, publishing, online events, subsidized conferences, conventions, and a variety of collaborations.

Identify and Promote Talent

One result of the hierarchical and inflexible structure of systems in the HIV field is that talent often goes unrecognized, unacknowledged, and unrewarded, especially outside of major cities and particularly for women. Identifying and promoting talent within IPs and CBOs would take advantage of local expertise that could be parlayed into leading capacity-building efforts while simultaneously developing future leaders in the field.

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1 Although the Nigerian National Gender Policy was produced 10 years ago, the document provides information that is still relevant today.
In addition, efforts to professionalize IP and CBO groups by developing job descriptions and work plans and through strategic planning would increase the self-esteem of staff and improve the design and delivery of interventions.

**Conduct Gender Analyses**
The questionnaire circulated to IPs prior to site visits as well as information obtained from those visits indicate that gender analyses have not been conducted for most PEPFAR Nigeria projects. Findings from site visits with CBOs indicated a lack of understanding of what a gender analysis is; how to design and conduct one; how to analyze, synthesize, interpret, and report on the analysis; and, perhaps most important, how to integrate the recommendations from an analysis into the design and implementation of a project. **One of the most important recommendations from this assessment is that CBOs should be enabled to conduct a gender analysis from start to finish, including its design, implementation, synthesis with other information, interpretation, deriving recommendations from its results, designing activities based on those recommendations, devising indicators to measure the results of the activities, and monitoring the results and reporting on them.**

**Engage Role Models and Celebrities**
Role models present a proven method for influencing changes in beliefs and behavior, and celebrities call attention to the cause or issue being promoted. Featuring celebrities could also contribute by demonstrating their commitment to combatting HIV and increasing the interest and appeal of the campaign. **Nurses, doctors, other medical personnel, gender advisors, successful women and men, even patients with the ability to convey information in a clear and compelling manner could be videotaped, for example, and the tapes could be used to build the knowledge and skills of staff performing technical or functional HIV-related work.**

**Communication and Community Outreach**

**Promoting Cooperation and Collaboration between Stakeholders**
This assessment revealed that many national and international agencies are working on similar issues and problems in Nigeria. Aside from a few technical working groups, however, networking between bilateral, multilateral, and national agencies, as well as with IPs, CBOs, private sector partners, and independent foundations, seems to be poor. **Establishing and invigorating cooperation—through technical working groups (TWGs) or other means—between individuals who can get things done is highly recommended.**

**Addressing Key Gender Norms**
One of the greatest problems facing all steps along the HIV continuum is the reluctance or refusal of men to visit health facilities, test for HIV status, reveal a positive status to their wives, families, or colleagues, and seek and maintain treatment. Gender norms require men to be strong, and spending time in health facilities, especially those that also cater to women and children, is anathema to the ideal of masculinity. **One recommendation would be to establish clinics for men—clinics that handle all male issues and cater only to men. While they would address ailments that affect women as well, only male patients would be seen.**

As the power of traditional beliefs and behaviors wanes, we recommend the following types of actions, which can help ensure that the cracks in those old brick walls are filled with positive messages and opportunities for both girls and boys and men and women:
• **Support the establishment, growth, and sustainability of nongovernmental agencies (NGOs) working for women’s rights, empowerment, and welfare.**

• **Reach out to, establish relationships with, and work much more closely with bilateral and multilateral entities as well as state and national agencies, civil society organizations, and national and international foundations committed to work for women’s rights, welfare, and empowerment.**

• **Help strengthen the Ministry of Women’s Affairs and Social Development,** which needs restructuring for greater efficiency and professional development for greater effectiveness.

• **Choose specific issues that are relevant to PEPFAR Nigeria as well as to other organizations and agencies and create teams to address those issues.**

• For each social, cultural, political, and economic “crack” in the status quo that keeps women down, **identify ways to fill those cracks with empowering opportunities for girls and women in education, vocational training, leadership development, advocacy and assistance for women to enter the political system, and training, mentoring, internships, and other ways for girls and women to increase their knowledge and skills in the areas where the cracks occur.**

**Gender-based Violence**

It is highly recommended that the PEPFAR Nigeria program work with national and international partners to carve out the best role for it to play in reducing and then eliminating GBV.

One way to identify effective approaches to reducing GBV is to mine the literature that USAID and PEPFAR have produced over the last decade. The research review and field work conducted during the current gender analysis revealed highly relevant similarities with PEPFAR studies worldwide, especially in Africa. From both the research and the field work, at minimum the following types of activities are recommended to reduce GBV, which evidence strongly suggests will also reduce HIV transmission among important populations in Nigeria:

• **Work with health facilities to offer GBV screening, assessment, and referrals to service providers.**

• **Develop “National Guidelines for GBV Identification and Prevention.”**

• **Organize cross-country communication with African, and other, countries that are achieving success in reducing GBV.**

• **Work with mass media to generate preventive messages for distinct populations.**

• **Work with relevant state and national ministries (education, health, youth) to design and launch a “GBV is NOT OKAY” campaign to educate and advocate.**

• **Join ongoing, or launch new, campaigns aimed at reducing and eventually eliminating FGM and child marriage, which are both aspects of GBV.**
I. INTRODUCTION

ASSESSMENT PURPOSE
An interagency PEPFAR team, which includes USAID, the State Department, the US Centers for Disease Control, and the US Department of Defense, works to implement the more than $400 million PEPFAR program in Nigeria under the oversight of the PEPFAR Coordinator's Office. The interagency PEPFAR Nigeria team manages and oversees a portfolio of activities while at the same time providing specialized technical assistance and advice to the Government of Nigeria (GON) at various levels.

As part of this system, an interagency PEPFAR Gender Technical Work Group (GTWG) supports PEPFAR programs to integrate gender interventions into new and existing programs and to accurately report on progress in this direction. However, several challenges have limited the effectiveness of gender integration, including low capacity of key stakeholders such as health care workers, GON, community-based organizations (CBOs), and United States Government (USG) staff; a dearth of uniform tools, including behavior change communication (BCC) materials for training, program implementation, and data gathering; and limited experience and expertise in Implementing Partners (IP) and CBO in designing and conducting gender analyses.

PEPFAR Nigeria's IPs have so far addressed these limitations by providing gender orientations for program staff and partner CBOs, incorporating gender into various training curricula, and developing and utilizing project-specific community dialogue guides on issues such as stigma, discrimination, gender, and GBV, and male involvement in uptake of prevention of mother-to-child transmission of HIV (PMTCT) services. IPs have identified victims gender-based violence (GBV) through chronic care screening in facilities and HIV support group meetings, and efforts have been made to strengthen referrals from HIV to GBV services, and vice versa. However, these efforts have been uncoordinated, project-specific, and insufficient in scope and depth to stimulate lasting change.

The PEPFAR interagency team seeks to pursue a comprehensive, well-coordinated gender effort that addresses the multiple dimensions (behavioral and structural) within which gender issues affect peoples' lives, including health, education, social interactions, economic opportunities, safety, legal protection, and human rights within the continuum of HIV prevention, treatment, and care. To reduce vulnerabilities and mitigate factors that put people at risk for HIV and increase access to services for men and women, the team aims to:

1. Increase gender equity in HIV/AIDS programs and services;
2. Reduce GBV and coercion within target populations;
3. Engage men and boys to address harmful norms and behaviors;
4. Increase legal protection for women and girls; and
5. Increase women and girls' access to income and productive resources, including education.

The team seeks to integrate gender into existing and new programs in an explicit and coordinated manner, with clear deliverables and benchmarks. To accomplish these goals, the

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2 From Statement of Work, Global Health Program Cycle Improvement Project -- GH Pro.
team needs an analysis of gender-related issues and gender interventions across the PEPFAR Nigeria program to develop the framework for implementation of key findings.

The updated PEPFAR gender strategy requires all PEPFAR countries to conduct a gender analysis specific to the HIV response in order to inform the design of projects and activities. The purpose of this analysis is to help the Nigeria PEPFAR country team and its implementing partners to

- Develop gender-responsive country operational plans;
- Design programs that integrate and address gender issues;
- Work to advance gender equality and female empowerment throughout the HIV continuum of prevention, care, treatment, and support; and
- Identify gender-related issues and programmatic gaps.

The PEPFAR Nigeria Country Team will use the findings to inform gender equality and GBV interventions that must be addressed in order to achieve PEPFAR Nigeria program goals.

ASSESSMENT QUESTIONS

This assessment reviews key gender issues and gender-based constraints in Nigeria, assesses the institutional context and opportunities for gender integration into the PEPFAR country program, and offers conclusions and recommendations to strengthen the PEPFAR response to HIV issues in Nigeria. The fundamental questions the analysis sought to answer are the following:

1. What is the Nigeria PEPFAR program doing to integrate gender activities into HIV prevention, treatment, and care and support?
2. What are the gaps and opportunities for gender interventions in the Nigeria PEPFAR gender program?
3. What are the strategies and approaches needed to improve the PEPFAR Nigeria gender program?
II. NIGERIA PEPFAR PROGRAM BACKGROUND

Nigeria has the second largest HIV/AIDS burden in the world, with 3.2 million people living with HIV. Women account for 57% of these individuals. Approximately 210,000 people in the country died of AIDS in 2013, and UNICEF reported that an approximate cumulative total of 2,200,000 children age 0–17 were orphaned by AIDS. The national prevalence rate is 3.6% (UNAIDS 2015). The rate varies widely among key populations and geographically.

Awareness of HIV and AIDS is high, 90%, but in-depth knowledge is much lower. Only 26% of women and 37% of men have comprehensive HIV/AIDS knowledge, e.g., that consistent use of condoms and monogamy with one uninfected partner can reduce the chances of getting HIV, and knowledge that a healthy-looking person can have the HIV/AIDS virus. Unfortunately, the two most common local misconceptions about HIV transmission or prevention are mosquitoes and supernatural transmission. Only one-third of Nigerians living in urban areas and one-quarter in rural areas are tested. In terms of treatment, only 23% of HIV-infected individuals are receiving antiretroviral therapy (ART), and just 17% of HIV-positive pregnant women receive ART to prevent mother-to-child transmission.

GENDER ANALYSIS

Nigeria ranks 106th out of 136 countries on the Global Gender Gap Index (World Economic Forum 2013). It is a very diverse society and within the differing sociocultural contexts, women, men, boys, and girls are affected differently by gender norms and expectations. Gender relations are traditionally characterized by an unequal balance of power between men and women, with women having fewer legal rights and less access to education, health services, income-generating activities, and property. Unequal power relationships based on biological sex and gender identity are codified via cultural beliefs. Societal norms are reinforced in political and economic systems. For instance, many cultures in Nigeria bar women from owning or inheriting land. According the Nigerian Constitution, civil and political rights (Chapter 4) are actionable in a court of law while social and cultural rights (Chapter 2) are not. This makes it challenging to address patriarchy and the underlying social structures that perpetuate the subjugation of, and violence against, women. The majority of women are concentrated in casual, low-skilled, low-paid, informal employment. The feminization of poverty means that women and girls exchange sex for money, food, shelter, or other needs and are also vulnerable to being trafficked into sexual slavery.

Gender-based power inequalities mean that women face barriers in deciding

- Sexual partner selection
- Use of contraception
- Number and spacing of children
- Seeking health care behavior
- Access to productive resources

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Independent life decision making.

The percentage of women whose children are delivered by a skilled provider is 38%. Only 15% of all bank accounts are owned by women, and only 7.2% of land is owned by women. In Northern Nigeria, which is a predominantly Islamic and conservative society, cultural and religious norms such as purdah often impede women’s access to quality health services. Women’s involvement in family and community decision making is limited, which contributes to household vulnerability. Women account for 57% of the 2.8 million adults living with HIV in the country. Heterosexual transmission of HIV accounts for 95% of HIV infections. Nigeria contributes approximately 29% to the global burden of mother-to-child transmission (MTCT) of HIV, and only 9% of pregnant HIV-positive women receive the most effective drug regimen for MTCT.

There are a range of gender issues that contribute to these HIV/AIDS results. Husbands make the majority of decisions regarding healthcare and limit women’s ability to access services. Women are plagued by abuse, with 25% of husbands agreeing that wife-beating is justified for certain things, including not having sex with the husband. Twenty-five percent of ever-married women indicate that they have experienced emotional, physical, or sexual abuse from their spouses. Social norms, traditional cultural practices, and legal constraints relegate women to second-class status in Nigerian society, inhibiting their access to HIV/AIDS prevention and treatment options.

Gender-based violence has implications for almost every aspect of health and development, from access to and use of health services to educational attainment, economic empowerment and full enjoyment of human rights. Thirty percent of women and girls aged 15–49 in Nigeria have experienced some form of physical or sexual violence. Over 52% of the women in the south-south zone report experiencing violence. Divorced, separated, or widowed women experience especially high rates of physical violence, 44%, across all zones (DHS 2008). Spousal violence is a major form of violence against women and cuts across all six zones, education levels, and rural and urban areas. Most sexual violence in Nigeria is perpetrated by family members, intimate partners, and former husbands or boyfriends. The prevalence of female genital mutilation (FGM) is 30% across Nigeria, with the south-east and south-west having the highest prevalence rates at 53% each.

Although women and girls are most at risk and most affected by GBV, boys and men can also experience GBV, as can sexual and gender minorities, such as men who have sex with men (MSM) and transgender persons. Regardless of the target, GBV is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control. Traditional gender norms in Nigeria support male superiority and entitlement. Violence against women is often tolerated or even justified in some instances and community sanctions against perpetrators are weak.

Women, men, boys, and girls are affected differently by gender norms and expectations. This affects their sexuality and HIV vulnerability. Women have limited access to information about HIV/AIDS, sexuality, and reproductive health because of social pressures and cultural norms. Cultural definitions of masculinity also prevent men and boys from communicating their sexual and reproductive health needs and adopting safer sexual behaviors. Men are generally expected to be more knowledgeable than women about sex and have more sexual partners, including more extramarital partners—a tendency reinforced by male migration and mobility. Such beliefs
and practices are an obstacle to HIV prevention because they absolve men from taking responsibility for their sexual behavior. They also mean that women are more likely to be infected by their steady male partner.

The PEPFAR team aims to reduce HIV risk, mitigate its impact, and increase access to services for men and women with a focus on:

- Increasing gender equity in HIV/AIDS programs and services;
- Reducing violence and coercion;
- Engaging men and boys to address harmful norms and behaviors;
- Increasing legal protection for women and girls;
- Increasing women and girls’ access to income and productive resources; and
- Implementing outreach programs that empower women to seek health services for themselves and their children.
III. ASSESSMENT METHODS AND LIMITATIONS

The assessment team consisted of one expatriate Team Lead, one Nigerian Gender Specialist, and one Nigerian Logistics Coordinator. Due to unavoidable time constraints, the team had to travel in two separate groups, with the team lead and logistics coordinator covering the south and west of the country and the national gender specialist covering the north and east. Altogether, the two groups conducted 24 site visits in 12 days.

METHODS

The assessment team employed a mixed-methods approach to collecting data and then triangulated information from all sources to identify key findings and produce practical recommendations for integrating gender activities across the HIV continuum of care. The approach used the following protocols:

1. Reviewing PEPFAR-recommended literature and client-approved reports the team identified prior to and after site visits⁴;
2. Developing and circulating to IPs a pre-site visit questionnaire to gather baseline data on their understanding of gender issues and activities undertaken to integrate gender into their projects⁵;
3. Developing and using key informant interview (KII) questions and focus group discussion (FGD) topics to collect information during site visits⁶;
4. Conducting KIIs and FGDs with representatives from a variety of IPs, CBOs, beneficiary groups, patients, and official state and federal agencies, including
   - State Governments—MoH, Ministry of Women Affairs (MWA), State Action Committee on AIDS (SACA), Local Action Committee on AIDS (LACA)
   - Federal Government (MWA, National Action Committee on AIDS or NACA)
   - CBOs
   - Caregivers for orphans and vulnerable children (OVCs)
   - Community volunteers (male and female)
   - People living with HIV (male and female; PLHIV)
   - Antiretroviral therapy (ART) site coordinators and staff
   - Medical directors
   - Most at-risk populations (MARPs): men who have sex with men (MSM), commercial sex workers, and intravenous [check] drug users

⁴ See Annex IV for a list of documents reviewed.
⁵ See Annex V for the pre-site visit questionnaire results from IPs.
⁶ See Annex VI for data collection instruments developed and used.
5. Noting observations not included in data collection instruments when encountered and deemed potentially important;

6. Discussing key issues with PEPFAR and USAID staff before, during, and after site visits; and

7. Ensuring a diverse geographic range and site visits to each type of PEPFAR intervention, as follows:
   - Akwa Ibom State—2 site visits Health systems—1 site visit
   - Anambra State—1 site visit Care & treatment—13 site visits
   - Benue State—4 site visits OVC—7 site visits
   - Cross River—1 site visit MARP—3 site visits
   - Enugu—2 site visits
   - FCT—3 site visits
   - Kaduna State—2 site visits
   - Lagos State—5 site visits
   - Niger—1 site visit
   - Ogun—1 site visit
   - Plateau—2 site visits

LIMITATIONS

Compressed Time Schedule
Due to unavoidable delays in international travel, the time available for the Team Planning Meeting (TPM) was cut short, leaving just one day for the team to work together in person to develop data collection methods and instruments and establish protocols for the assessment. While waiting for the resolution of international travel logistics, the team worked remotely to start creating the analytical approach and materials, which were refined when the team lead arrived and while on the road.

Internal travel also proved problematic, with weather conditions causing flight delays and cancellations. To compensate, the team used ground transportation when poor visibility prevented air travel. Team members experienced Internet connectivity and cell phone problems throughout their time in the field, which made coordination and communication inconsistent and difficult not only with each other but also with PEPFAR team members, interviewees, and the GH Pro headquarters.

Due to the upcoming Christmas holiday, the team was unable to extend the assessment period to compensate for initial delays. The team conducted two interviews by telephone and email after the site visit end date to ensure the inclusion of all planned meetings.

Importantly, the compressed time schedule did not decrease the amount of time spent with IPs, CBOs, and beneficiaries during site visits. The meetings proved engaging for both the interviewees and the team, who on average spent two hours per site visit.
Too Few Interviews with Women’s and International Organizations

Also due to time constraints and the Christmas holiday, the team was unable to schedule meetings with Nigerian women’s rights organizations or bilateral or multilateral agencies, such as United Nations Women, United Nations Development Programme, United Nations Children’s Fund, Japan International Cooperation Agency, and others working in the country. While the analysis could have benefited from interviews with these groups, the team obtained research reports and other useful documents they had published, some of which also included information from national women’s rights CSOs.

Communication with Interviewees

It may be useful to note that, prior to assessments and analyses, instructions from PEPFAR to IPs and from IPs to CBOs should be specific, explicit, and repeated constantly and consistently both orally and in writing. Some IPs and CBOs thought the analysis was being conducted to evaluate their work, despite communications to the contrary prior to site visits, during the IP in-Brief, at the start of each site visit, and in written invitations to the IP Out-Brief. Despite all this, one representative of an IP noted at the end of the Out-Brief, “The expectation was to leave with specific feedback for [our] organization with a view to adjusting our program activities in tandem with PEPFAR gender analysis. Nevertheless, it is an eye-opener for us moving forward.”

This type of misunderstanding can affect respondents’ answers to questions and can limit the extent to which IPs describe and openly discuss problems their projects experience.

Leaders

A methodological concern is the presence and participation in interviews of high-level leaders, such as “kings,” tribal chiefs, and political officials, as well as directors of health facilities and in some instances heads of IPs and CBOs. On the one hand, their attendance reflects a positive commitment to the goals of a program and concern for its effectiveness and beneficiaries, which may very well be the case. In interviews, however, the prevailing gender and social structure could inhibit lower-level staff and beneficiaries from contradicting leaders’ statements or from identifying problems, concerns, inefficiencies, or other issues that might be construed as complaints or criticisms directed toward the leadership. During one interview, for example, with only three interviewees present, no one except the male director spoke, including the gender advisor, for the entire hour we were there. Even when questions were directed to her, the gender advisor looked at the director before speaking, seemingly requesting his permission to respond. And rather than letting her respond, the director responded. (This is an example of the kind of observation the team noted; while the supposition cannot be proven, not hearing from a gender advisor in an entire hour of discussion is noteworthy.)

This concern is nuanced, with some staff and beneficiaries remaining silent when leaders are present, others echoing what leaders have said, and still others identifying specific needs, such as leaky roofs or insufficient access to vehicles, that require additional donor inputs. While these needs may be legitimate, when several individuals repeat the same requests, using similar language, even when not responding to a particular question, it is possible that they have been coached to appeal for additional support.
IV. FINDINGS

This section synthesizes information from all data sources, including literature reviews, responses to the initial questionnaire, site visit observations, KII's, FGDs, suggestions from IPs during the Out-Brief, and materials not included in the initial literature review list but collected from IPs, CBOs, and the GON during site visits.

Detailed gender norms are nuanced between and among tribes, religious groups, and geographic regions as well as by age, urban vs. rural residence, and socioeconomic, educational, and marital status. While this assessment did not control for the variables, they have been researched and documented, the data are current and detailed, and the team lead consulted them as needed. Because this assessment focused on gender norms exclusively in the context of the HIV continuum of care, the nuanced gender variations did not significantly affect the findings, and commonalities were found to be greater than differences.

Derived from the wide range of projects the Nigeria PEPFAR program supports, our findings are grouped according to the first two Assessment Questions. As the third Assessment Question refers to recommendations for the future, it will be addressed in the following Section, Conclusions and Recommendations. Our findings for Assessment Question 2 are grouped in three main categories: institutional (policy) level, community or clinic level, and cultural- and behavior change-related.

QUESTION 1. WHAT IS THE NIGERIA PEPFAR PROGRAM DOING TO INTEGRATE GENDER ACTIVITIES INTO HIV PREVENTION, TREATMENT, AND CARE AND SUPPORT?

Supporting IPs with Guidance, Direction, Capacity Building, and Leadership

The findings indicate that the most valuable way in which PEPFAR Nigeria is integrating gender activities into its program is by recommending gender analyses, requiring disaggregation of M&E data by sex, providing IPs with gender research and reports, and supporting on-line and in-person training on gender, M&E, and other topics necessary for the successful integration of gender activities into the PEPFAR Nigeria program. Prior to this assessment’s site visits, IPs responded to a questionnaire designed to obtain information about the gender knowledge that had informed the design and implementation of their projects.7 A key finding from this questionnaire, which was subsequently confirmed by KII's, FGDs, and site visit observations, is that only 26.9% of IPs had conducted a gender analysis for their projects. When asked why so few had done so, IPs cited insufficient funding and expertise as the primary reasons. Fewer than 30% of IPs indicated they were “very familiar” with the quantitative and qualitative gender status, roles, responsibilities, problems, obstacles, constraints, opportunities, strengths, and entry points of their primary target groups. Moreover, only 42% of IPs and 13% of their subs (CBOs) have a gender advisor or specialist on staff.

Despite the low level of expertise within the IP community, and without benefit of a gender analysis or advisor, nearly 62% of questionnaire respondents said they were contractually obligated to integrate gender into their work. In addition, 88.5% of IPs indicated that gender

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7 See Annex VI for the questionnaire circulated to IPs and their full responses.
integration approaches and activities are included in their projects, 96.2% said they disaggregate their work by sex, and 64% stated they use gender-sensitive and gender equality indicators to monitor, measure, and report on their work. These are sophisticated gender tasks to be undertaken by IPs who rank their own gender expertise so low. However, they have begun the process, relying on the PEPFAR Nigeria program staff for guidance and direction.

Already, the PEPFAR Nigeria program has provided IPs and CBOs with technical gender assistance and supported gender orientations for program staff and partner CBOs, incorporating gender into various training curricula, and developing and utilizing project-specific community dialogue guides on issues such as stigma, discrimination, gender, GBV, and male involvement in uptake of prevention of mother-to-child transmission of HIV (PMTCT) services. PEPFAR has also supported IP’s identification of GBV victims through chronic care screening in facilities and HIV support group meetings, and efforts to strengthen referrals from HIV to GBV services, and vice versa.

While these early efforts have been characterized as uncoordinated, project-specific, and insufficient in scope and depth to endure, they represent the start of a process to identify the gender issues on which the PEPFAR Nigeria program should focus. Interviews with the staff demonstrated a commitment to addressing gender integration issues in a realistic, pragmatic manner, within the time and funding available. This assessment is the next step in triaging to ensure that priority issues are targeted and resources are focused where they are most likely to achieve success. When those issues are identified, the PEPFAR Nigeria program team will continue to support the capacity building of its IPs and CBOs so they are able to integrate gender activities in priority areas with an increasing level of expertise.

**Ensuring Confidentiality**

Both PLHIV and HIV practitioners confirmed that both male and female clients fear stigmatization, which can result in exclusion from social groups, family shame and embarrassment, and negative effects in the workplace, including the loss of employment. Ensuring confidentiality is key for a successful HIV program, and the Nigeria PEPFAR program staff have encouraged IPs and their CBOs to devise and share methods to ensure their clients' confidence.

For female clients, the importance of confidentiality includes—and extends beyond—stigma and its concomitant impacts. Married women who test positive face a disclosure dilemma that could require keeping a lifetime secret from their husbands, on the one hand, and the risk of replacement by other wives, expulsion from their homes, and loss of their children on the other. Single women face a dilemma of a similar nature and magnitude, with the likelihood of being rejected by potential suitors if they disclose their HIV status, if a test is required or if the church or the potential husband or his family insists on one. A single woman who has overcome those initial risks and married, faces a lifetime of fabricating excuses for absences during treatment and the constant dread of being found out. According to nurses in a busy clinic, the threat of passing the virus on to their children may be women's greatest fear. This may explain why women are more likely to seek testing, especially during prenatal care.

Site visits revealed a variety of methods that IPs and CBOs have designed and implement to ensure confidentiality, with variations for different groups of patients or beneficiaries. To protect the identities of MSM, for example, meetings include persons of other sexual
orientations who are supportive, including women. Some facilities have abolished “ART clinic days” for both men and women, and replaced them with fully integrated services to lessen the possibility of recognition or discovery. In Enugu, we encountered a woman who does not dare to disclose her positive status to her husband and travels to another state every other week for treatment; a staff member meets her half way and transports her on his motorbike to and from the clinic.

Site visits indicated that testing, treatment, care, and support providers go to great lengths to keep the HIV status of their beneficiaries’ and patients confidential, and they are open to adopting new privacy methods as needed. In one case, complaints about confidentiality resulted in a switch to using numbers instead of names to call patients in a waiting room. Still, privacy cannot be guaranteed, especially in busy facilities with too many patients, too few health workers, and a small number of examination rooms with a lack of soundproofing between them. Site visits with CBOs indicated that patients and clients—who know that nothing is foolproof—also go to great lengths to keep their status confidential, using false names and traveling to testing and treatment facilities far from their homes.

IPs and CBOs are attentive to the issue and familiar with the gender-based reasons for the importance of confidentiality for men, women, and MARPs. However, the team did not review M&E records assessing the efficacy of confidentiality methods, and it is uncertain whether or not that is an indicator that is monitored.

**Using Role Models**

According to IPs, CBOs, and beneficiaries, role models are an effective means of influencing behavior within certain stages of the HIV care continuum. While the assessment team did not encounter the use of role models to encourage testing, research reports refer to movie celebrities, sports champions, and successful businessmen and women who promote testing through mass media rather than the local role models who encourage treatment. The latter are used extensively in the PEPFAR Nigeria program, and their stories resonate with the client communities from which they come. Male and female PLHIVs who demonstrate that it is possible to live a good life on treatment provide comfort and inspiration to those who have not yet begun treatment and may be fearful.

Individuals serving as role models explained that this method of behavior change is largely based on gender norms. Aside from male doctors seen in a professional capacity, females are the most influential role models among women and men among men.

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8 In no site visits did staff or clients indicate they had encountered lesbians. The only mention of lesbians came from a group of sex workers in Lagos whose response to a question about it was that allowing female customers was forbidden. A conversation with a doctor indicated that there is no particular problem with women infecting other women, which is likely why they were not addressed in HIV-related discussions. A quick search of literature on the topic indicated that “Confirmed cases of female-to-female transmission of HIV via sexual contact are extremely rare. However, possible modes of female-to-female transmission during sex include exposure to vaginal or other body fluids, blood from menstruation, or blood from damage sustained during rougher sex.” [http://www.aidsmap.com/Rare-case-of-lesbian-transmission-of-HIV-reported-in-US/page/2837236/](http://www.aidsmap.com/Rare-case-of-lesbian-transmission-of-HIV-reported-in-US/page/2837236/).

9 The literature review refers to the use of role models such as sports champions, movie celebrities, and successful businessmen and women for encouraging testing rather than the local role models who tend to encourage treatment.
Conversations with men tend to focus largely on physical appearance, strength, and sexual ability. The concern about sexual performance was raised in conversations with male doctors, and it is noted as well in research reports. A superstition that HIV treatment negatively affects performance may limit treatment uptake. In some instances, the male role models encourage men to disclose their positive status to their wives. Men are reluctant to do so in part because they fear it will publicly reveal their infidelity. Polygamy and promiscuity are relatively widespread among those who identify as Christians and Muslims, and gender norms ascribe a strong masculine reputation to men who demonstrate a healthy sexual appetite. However, infidelity can also be considered a flaw, a negative reflection on a man’s moral character, and an admission of an HIV positive status would tarnish a man’s reputation in that regard.

Among women, treatment support specialists—“mentor mothers”—are PLHIVs who are doing well on ARV treatment and therefore used as role models to support enrolment and adherence for newly detected clients. As with men, a healthy physical appearance and physical strength are important considerations for women, and a woman who looks fit and well inspires others to begin treatment. The mentor mothers also work with pregnant women, and preventing transmission of the virus to a child is a compelling argument for treatment uptake. Following the initial session, a mentor mother stays with a pregnant woman until the baby is 18 months old—as long as the mother continues her medication. Most mentor mothers are volunteers who receive a stipend for transportation. This is largely women-focused, although some instances of male mentors were mentioned in certain communities.

The stigma against MSM populations is great and encourages them to remain underground; members from that community are recruited as peer educators and outreach staff to work at special treatment support centers that are being established.

QUESTION 2. WHAT ARE THE GAPS AND OPPORTUNITIES FOR GENDER INTERVENTIONS IN THE NIGERIA PEPFAR GENDER PROGRAM?

The baseline questionnaire, KIIs, FGDs, and observations indicated the following gaps and opportunities for gender interventions in the Nigeria PEPFAR gender program. The Recommendations section of this assessment proposes ways for bridging the gaps and taking advantage of the opportunities identified below.

Institutional Level

Gender Expertise

Currently, the level of gender expertise within IPs and CBOs is insufficient for effectively integrating activities addressing gender norms and disparities in program designs, objectives, activities and other inputs, M&E, and consequently the achievement of results. According to the baseline questionnaire, only 26.9% of IPs indicated a familiarity with quantitative and qualitative gender status, roles, responsibilities, problems, obstacles, constraints, opportunities, strengths, and entry points for primary target groups. While we cannot establish a definitive correlation between specific areas of expertise and gender analyses, it is interesting to note that, according to another response in the questionnaire, 26.9% of IPs also indicated a gender analysis had been conducted for their projects. The Recommendations section proposes capacity-building approaches to increase the gender expertise of IPs and CBOs.

10 The concern about sexual functioning was raised in conversations with male doctors, and it is noted as well in research. A superstition that HIV treatment negatively affects performance may limit treatment uptake.
Coordination
At the IP Exit-Brief and during site visits with IPs and CBOs, a common comment concerned better coordination among the many stakeholders working on the integration of gender into HIV-related programs in Nigeria. The large number of stakeholder groups and suggestions for ways in which they might coordinate are detailed in the Recommendations section.

Community Level

Family Planning
Family planning is an issue that will continue to grow in importance in Nigeria. The fertility rate is so high that the population is likely to double by 2050. This assessment found that often when men request vasectomies, male doctors tell them to go home and think about it. In polygamous households, women seem to engage in a competition to see who can give birth to the most children. Throughout the site visits, we only encountered one person—our driver—who expressed a positive opinion about family planning. In the Recommendations, we recommend developing a female condom as one response to family planning issues.

Focus on Youth
Seventy-five percent of Nigeria’s rapidly growing population is under age 34 and 22% are women of childbearing age. Therefore, a focus on youth is essential, with outreach into schools, youth clubs, sporting events, religious groups, and other places where young men and women congregate, separately or together.

Alternatives for adolescent girls to delay sexual debut and receive encouragement to practice protected sex could decrease transmission from one generation to another. In partnership with other agencies, a wide range of activities could be implemented to address this critical need. Few opportunities are available for girls, especially those in lower-income groups, and establishing arts programs, sports, scouts, or groups tied to hobbies or future vocations could serve not merely as diversions or distractions, but as preparation for a future not limited to motherhood. Experience in other countries indicates that the cost of such efforts is low, and professional women may be easily persuaded to assist. We recommend that a report on activities successfully employed elsewhere be produced, accompanied by detailed guidance on establishing and supporting them.

While more options are available for adolescent boys, because outdoor activities are more acceptable and the perceived consequences of sexual intercourse are less severe, a strategic plan with specific objectives and benchmarks could be developed to lead boys from undesirable to desirable behaviors, with explicit guidance for design, funding, sustainability and longer-term impact.

Cultural Considerations

Gender Norms
Interviews, FGDs, and observations indicated that far more women than men visit health facilities. Interviewees attributed this to women having more reasons to go to a clinic or hospital than men, in large part for reasons of pregnancy and child care. As a result, we may assume that women tend to be more familiar, knowledgeable, and comfortable with such settings. This assessment confirmed that men were much less likely than women to visit health facilities, a tendency observed nationwide. This issue is addressed in the Recommendations section.
GBV

GBV is the result of rigid gender norms, and it underlies many HIV-related efforts. While this assessment did not yield sufficient information on which to base a thorough analysis of the problem, findings indicate that it is not being adequately addressed.

KIIs and FGDs with health care staff, primarily nurses, as well as an extensive literature review indicate that GBV is not viewed as a critical gender concern in local communities. Outside of gender, health, and HIV prevention, treatment, and care circles, many men and women consider GBV to be a family matter that family members and community leaders should handle quietly. Moreover, individuals interviewed explained that rape or other forms of sexual assault are considered issues of shame for the victim and the victim’s family, and so legal recourse is rarely pursued.11 The NDHS 2013 reveals that “a surprisingly high number of women think beating a wife is completely justified.” Similarly, a 2013 study that focused on male attitudes and practices reported that 82% of the males in the community were found to believe that “it is not improper to beat up a wife.”12 This assessment’s interviews with health care providers indicated that they have not been trained on identifying or managing GBV. There are no shelters for battered women, and referrals from health care providers to the police do not take place with any regularity.

The most effective way for the PEPFAR Nigeria program to contribute to solving this critical problem is by working closely with partners focused on the issue.

Access to Communication

Outreach

Interviews with CBOs stressed the importance of outreach to communities. Community volunteers stressed that many people still do not know, for example, that they can access PEP and emergency contraceptives to prevent HIV and pregnancy in the event of rape. Research confirms that girls and women have less access to information than boys and men, and the further away from home the information is, the less likely it is to reach female populations. According to interviewees, PEPFAR no longer supports community outreach programs, and state and local governments do not support them, either. Volunteers warn that this will limit the potential to reach more men. As indicated in the Recommendations section, men seem to respond more readily to testing with access that comes to them, i.e., through mobile clinics, so eliminating community outreach and access programs potentially limits the testing of men, who are much less likely than women to go to a clinic or hospital.

11 Secular law is not the only system of jurisprudence in Nigeria. Both Islam and Christianity exert substantial influence on their practitioners, as do “customary laws of the constituent ethnic nationalities.” In addition, “[T]raditional religion continues to be furtively patronized by a great many adherents of both Islam and Christianity and has therefore maintained its relevance.” “Religion and the Nigerian State,” Oxford Journal of Law and Religion, http://ojlr.oxfordjournals.org/content/3/2/311.full. All religious systems have gender norms that affect present-day life.
12 USAID/Nigeria Gender Analysis for Strategic Planning, July 2014
V. CONCLUSIONS AND RECOMMENDATIONS

Based on the findings of this assessment, this section offers Recommendations that will ultimately help people access HIV counselling and testing, access treatment if they are found to be positive, and help them stay on treatment, following the ambitious program adopted by PEPFAR known as 90-90-90. Our research has shown that cultural considerations—correcting misperceptions or feelings of stigmatization or gender-related behaviors that may prevent the seeking of and adherence to treatment—must be addressed first and foremost. Changing gender norms, and stigmatization again, also impact an individual’s likelihood to stay in treatment. The availability of information, and understanding the options that are out there, are crucial to bringing people into treatment and having them stay there. Increasing the community’s ability to understand the issues at hand (by conducting gender analysis, etc.) and to offer accurate and practical information and collaborating with other organizations are crucial to reaching the right people with the right information, and once they have entered the world of treatment, knowing how to keep them there. Therefore, raising awareness is a major area of intervention, one that cuts across the whole 90-90-90 gamut. Related to these two areas of intervention are, of course, improved communications and outreach to be sure that the right information is getting to the right people.

The purpose of this assessment is not to identify new theories of change, although they would provide a rational basis for selecting approaches that are likely to achieve success. The conclusions and recommendations presented here focus on practical ways to strengthen the PEPFAR Nigeria gender response to HIV-related problems, which is based on changing social, political, and economic realities, on efforts in the PEPFAR program that are proving successful, and on activities that appear promising but have not yet been fully implemented. However, it is strongly recommended that new theories of change be identified to help guide the program along an analytical, evidence-based path. While the program will not attempt to conquer the mountain of gender norms, it will address selected issues, and employing theories of change will help ensure that the effort is systematic.

RAISING AWARENESS

Addressing misconceptions and superstitions: Immediate, urgent, and bold action is needed to correct misconceptions, superstitions, and harmful practices that prevent men, women, and youth from seeking treatment. For example, women have long been blamed for not producing male offspring when the sex of a fetus is in fact determined by a Y chromosome, which comes from men. Increased understanding about how the sex of a child is determined could eliminate one justification for GBV, eviction of a wife, abandonment, and polygamy. The origin of the belief

PEPFAR’s 90–90–90: An ambitious treatment target to help end the AIDS epidemic by improving access to information, treatment, and follow-up

- By 2020, 90% of all people living with HIV will know their HIV status.
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.
in the superiority of males over females, which is the primary premise on which all gender-based discrimination is based, is less clear: “We’ve always done it this way,” “It’s our culture,” “It’s how our parents raised us,” and similar rationales for traditional beliefs and practices are no longer sufficient. **We recommend that education begin by addressing superstitions and beliefs affecting gender relations that can be disproven based on hard scientific fact, followed by other culturally ingrained beliefs.**

**Taking advantage of changing gender practices:** Rather than looking backward to the origins of the male superiority myth, it may be more productive to look forward. As life in Nigeria changes, gender practices are also changing as people adapt to new social, political, and economic realities. Cracks are appearing in gender walls, which may be changing prevailing gender norms and the systemic male control of social, political, and economic structures. **Our recommendation is to provide girls—in partnership with schools and civil society organizations (CSOs)—with information about options, possibilities, role models, professions, and vocations.**

As the power of harmful traditional beliefs and behaviors wanes, we recommend the following types of actions, which can help ensure that the cracks in those old brick walls are filled with positive messages and opportunities for both girls and boys and men and women:

- **Support the establishment, growth, and sustainability of NGOs working for women’s rights, empowerment, and welfare.** Such organizations are essential to advocate for improvements, holding government at all levels accountable, enabling women’s voices to be heard, linking women and girls with each other and with counterparts within and between states throughout the country and even internationally, and giving young women opportunities to gain experience in organizing, advocating, leading, and designing and delivering activities for specific purposes.

- **Reach out to establish relationships and work much more closely, with bilateral and multilateral entities as well as state and national agencies, CSOs, and national and international foundations committed to work for women’s rights, welfare, and empowerment.**

- **Help strengthen the Ministry of Women’s Affairs and Social Development,** which needs restructuring for greater efficiency and professional development for greater effectiveness. Engage the Ministry in PEPFAR Nigeria’s work—it will be mutually beneficial for all.

- **Choose specific issues that are relevant to PEPFAR Nigeria as well as to other organizations and agencies and create teams to address those issues.** Include bilateral partners, multinational corporations, GON agencies, CSOs, national and international foundations, members of the mass media, and others who are willing and able to contribute to common goals. Sequence the path to success logically and realistically with specific tasks assigned to each coalition member based on their strengths and mission.
• For each social, cultural, political, and economic “crack” in the status quo that keeps women down, identify ways to fill those cracks with empowering opportunities for girls and women in education, vocational training, leadership development, advocacy and assistance for women to enter the political system, and training, mentoring, internships, and other ways for girls and women to increase their knowledge and skills in the areas where the cracks occur.

DEVELOPING CAPACITY

Professional development for better understanding gender-related issues: Building the gender knowledge and skills of IP and CBO staff is perhaps the most important step the PEPFAR team can take to improve the quality of its program and its success in bringing people into treatment and having them stay in it. A synthesis of responses to the initial questionnaire, KII, and FGDs indicated that IP and CBO staff lack opportunities beyond minimal training to develop skills relevant to their work, with gender the area in which they seem to have the least expertise. A capacity-building program that uses local talent and takes advantage of the excellent body of existing and yet to be published research should be developed to create a cadre of capable gender specialists who could design and conduct gender analyses and integrate gender strategically throughout the HIV program. Importantly, the program could focus on the same gender issues that PEPFAR Nigeria selects as priority target areas.

The literature review undertaken for this assessment revealed a large number of recent research reports related to gender norms, GBV, and the HIV continuum of care. These materials provide accurate and comprehensive information, useful directions, practical tools, and valuable FAQs and troubleshooting advice. A course could be created using existing materials, which could be delivered through a participatory and interactive methodology.

Although field offices are short-staffed and extremely busy—in one case with three nurses serving 80 patients daily—carving out time for staff to participate in an occasional seminar focused on one of the many useful materials available on gender and HIV could be time well spent. A quarterly seminar, with staff not only participating but leading the sessions—a series of “brown bags”—could be instituted. Staff would learn about new developments in their field, and this could contribute to a higher self-image as professionals, which nurses, program coordinators, and the few gender advisors on staff would keenly enjoy.

Some IPs are more sophisticated than others; when asked, they expressed a willingness to share information with those who need it. Traditional training is not recommended; people are too busy, and expenses, such as catering, are costly. But mentoring and on-the-job training would go a long way to building practical skills. It would also enable IPs to get together more often, a recommendation they made during the IP Exit Brief.

Identify and promote talent: One result of the hierarchical and inflexible structure of systems in the HIV field is that talent often goes unrecognized, unacknowledged, and unrewarded, especially outside of major cities and particularly for women. During FGDs, some staff members presented sophisticated insights that described the root causes of problems, while others contributed a synthesis of daily experiences that could lead to highly innovative problem-solving. Several indicated a keen interest in developing gender skills. Identifying and promoting talent

13 Although the Nigerian National Gender Policy was produced 10 years ago, the document provides information that is still relevant today.
within IPs and CBOs would take advantage of local expertise that could be parlayed into leading capacity-building efforts while simultaneously developing future leaders in the field.

In addition, efforts to professionalize IP and CBO groups by developing job descriptions and work plans and through strategic planning would increase the self-esteem of staff and improve the design and delivery of interventions.

**Conduct gender analyses:** The questionnaire circulated to IPs prior to site visits and the information obtained from those visits indicate that gender analyses have not been conducted for most PEPFAR Nigeria projects. Although interviewees were aware of some gender norms from observation, working on a PEPFAR-funded project, and living in the community, most did not possess factual or evidence-based information. If IPs possess the level of understanding reflected in their written documents, then their CBOs could benefit greatly from opportunities to design, conduct, interpret, and implement results from gender analyses.

One of the most important recommendation from this assessment is that CBOs be enabled to conduct a gender analysis from start to finish, including its design, implementation, synthesis with other information, interpretation, deriving recommendations from its results, designing activities based on those recommendations, devising indicators to measure the results of the activities, monitoring the results, and reporting on them. The sooner the CBOs can conduct this exercise, the sooner PEPFAR Nigeria will begin seeing improvements in its gender work.

**Engage role models and celebrities:** Role models present a proven method for influencing changes in beliefs and behavior, and celebrities call attention to the cause or issue being promoted. Featuring celebrities could also contribute by demonstrating their commitment to combatting HIV and increasing the interest and appeal of the campaign. Nurses, doctors, other medical personnel, gender advisors, successful women and men, even patients with the ability to convey information in a clear and compelling manner could be videotaped, for example, and the tapes could be used to build the knowledge and skills of staff performing technical or functional HIV-related work. Recordings could be produced for a lower cost than transporting trainees to a central location, and could also control for quality from one instruction session to another. As long as presenters are selected on the basis of ability and do not favor one tribal or geographic area over another, and production is of high visual and audio quality and scripts are well-written, accurate, and informative, this could be a very effective method of building capacity and spreading knowledge.

**COMMUNICATION AND COMMUNITY OUTREACH**

**Promoting cooperation and collaboration between stakeholders:** This assessment revealed that many national and international agencies are working on similar issues and problems in Nigeria. Aside from a few technical working groups, however, networking between bilateral, multilateral, and national agencies, as well as with IPs, CBOs, private sector partners, and independent foundations, seems to be poor. Networking may be time-consuming, but sharing
information is important, and its value is increased when objectives, follow-up actions, divisions of labor, funding of activities, and leveraging are explicitly articulated, agreed upon, and documented. Gender is multifaceted, and improvements in gender equality can contribute to the achievement of numerous agency missions. No one can solve the problems in Nigeria alone. Establishing and invigorating cooperation—through TWGs or other means—between the individuals who can get things done is highly recommended.

**Addressing key gender norms:** One of the greatest problems facing all steps in the HIV continuum is the reluctance or refusal of men to visit health facilities, test for HIV status, reveal a positive status to their wives, families, or colleagues, and seek and sustain treatment. More than one doctor stated that men do not present at a clinic or hospital until they are moribund. Further, some CBO staff explained that men think of HIV as a “woman’s disease,” and they resist getting involved in what they perceive as the quagmire of female problems. Gender norms require men to be strong, and spending time in health facilities, especially those that also cater to women and children, is anathema to the ideal of masculinity. A wide range of efforts have tried to address this deeply ingrained aversion, but none has proven consistently effective. The assessment team heard about a mobile clinic operating in areas deep into villages that apparently achieved some success in attracting male clients. By bringing general health services right to their doorstep, men were able to avoid stigmatization while not being inconvenienced by travel to a hospital or waiting in a clinic. More information about this effort is needed. During the final day of site visits, a doctor at the PEPFAR office in Nigeria proposed an idea that the assessment team had not heard before: Establish clinics for men—clinics that handle all male issues and cater only to men. While they would address ailments that affect women as well, only male patients would be seen.

<table>
<thead>
<tr>
<th>The Undeniable Link between GBV and HIV</th>
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<tbody>
<tr>
<td>According to experts, it is far more difficult for a woman or a man to negotiate condom use with an abusive partner because the “victim is less likely to try to persuade the abuser to use protection,” and the “perpetrator is less likely to listen.” Studies have also found that “fear of partner violence prevented women and girls from seeking health services and from asking their partners to use condoms.” One study found that condom use was “some 20 percent lower among those who had been beaten or raped within the last year compared with those who had not faced such violence.” Moreover, because victims of GBV have less self-esteem and a lowered sense of self-worth, they often “don’t believe they have the ‘right’ to receive health services. It is much harder to coax people who face GBV or who fear violence or abandonment to seek services, test for HIV, or to successfully access or adhere to treatment.” Experts explain that GBV “cements relationships in which one partner is clearly dominant,” a feeling that can give “the abusive partner a sense of invincibility,” thereby “reducing his or her willingness to practice prevention.”</td>
</tr>
</tbody>
</table>

**Gender-based violence:** Research consistently confirms the relationship between GBV and HIV. GBV fosters the spread of HIV/AIDS by limiting (mostly) women’s ability to negotiate safe sexual practices, disclose their HIV status, and access services due to fear of GBV. Sexual violence can also directly lead to HIV infection. Country studies indicate that the risk of HIV among women who have experienced violence may be up to three times higher than among those who have not. In addition, sexual violence among adolescents and pre-adolescents is alarmingly high. One way to identify effective approaches
to reducing GBV is to mine the literature that USAID and PEPFAR have produced over the last decade. The research review and field work conducted during the current gender analysis revealed highly relevant similarities with PEPFAR studies worldwide, especially in Africa. From both the research and the field work, the following types of activities—at minimum—are recommended to reduce GBV, which evidence strongly suggests will also reduce HIV transmission among important populations in Nigeria:

1. **Work with health facilities** to offer GBV screening, assessment, and referrals to service providers.

2. **Develop “National Guidelines for GBV Identification and Prevention,”** which should provide, among other things, a framework for recognizing GBV; developing mechanisms for GBV victims, including finding shelter for victims of especially egregious incidents; alerting responsible officials to potentially life and death GBV situations; designing interventions to educate and “rehabilitate” abusers; providing current contact information for relevant referral agencies and organizations; outlining steps to address cases of child abuse; collaborating with counterpart agencies and organizations to conduct comprehensive strategic planning to reduce GBV; and ensuring the Guidelines are widely distributed.

3. **Organize cross-country communication with African and other countries that are achieving success in reducing GBV.** Tanzania, for example, has supported development of National Management Guidelines for Health Response and Prevention of GBV, which has led to training of health care providers and roll-out of a GBV register at health facilities across the country.

4. **Work with mass media to generate preventive messages for distinct populations.** In Zambia, USAID with PEPFAR funding is collaborating with DFID and six government ministries to strengthen the response to GBV, including doubling the number of one-stop centers in several provinces, reaching 5 million adults and children with preventive messages, assisting 47,000 survivors, and training 200 police and justice sector personnel through 2018.

5. **Work with relevant state and national ministries (education, health, youth) to design and launch a “GBV is NOT OKAY” campaign to educate and advocate; include messages about the connection between GBV and HIV. Also state the harmful effects of GBV on boys and men.**

6. **Join ongoing or launch new campaigns aimed at reducing and eventually eliminating FGM and child marriage,** which are both aspects of GBV.

**Focus on educating youth:** More than 60% of Nigerians are under the age of 24 and at least two-thirds of unemployed youth are between the ages of 15 and 24; the majority of unemployed youth are females. Nigerian youth—especially females—need education, scholarships, vocational training, mentoring, internships, and every best practice we know from work in this area and around the world. Research and experience provide clear guidance on how to provide young women with alternatives to marriage and motherhood—alternatives that could even be acceptable to parents. Given the almost complete economic dependence of Nigerian women on men, not having alternatives will not change the status quo but possibly exacerbate it, perpetuate it, and enable the disparity to grow, with increasingly negative consequences for women, men, and the country as a whole as the population also grows. We recommend **improving educational access and quality so compulsory education laws can be enforced. Further, social media exerts a powerful influence on many target audiences, especially youth, and its use should be encouraged.**
ANNEX I. SCOPE OF WORK

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
September 14, 2015

TITLE: Gender Analysis for PEPFAR Nigeria (102)

Requester / Client

☐ USAID Country or Regional Mission
Mission/Division: USAID/Nigeria / Office of HIV/AIDS and TB

Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

☐ 3.1.1 HIV
☐ 3.1.2 TB
☐ 3.1.3 Malaria
☐ 3.1.4 PIOET
☐ 3.1.5 Other public health threats
☐ 3.1.6 MCH
☐ 3.1.7 FP/RH
☐ 3.1.8 WSSH
☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

Cost Estimate: Note: GH Pro will provide a final budget based on this SOW

Performance Period

Expected Start Date (on or about): October 2015
Anticipated End Date (on or about): January 2016

Location(s) of Assignment: (Indicate where work will be performed)

Abuja, Nigeria; select states/LGAs in Nigeria; home base (for desk review and writing/finalizing report)

Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

☐ Performance Evaluation (Check timing of data collection)
☐ Midterm ☐ Endline ☐ Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it
is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

☐ Impact Evaluation (Check timing(s) of data collection)
  ☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR-funded, check the box for type of evaluation

☐ Process Evaluation (Check timing of data collection)
  ☐ Midterm ☐ Endline ☐ Other (specify):

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ Outcome Evaluation

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)
**Impact Evaluation** (Check timing(s) of data collection)
- Baseline
- Midterm
- Endline
- Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

**Economic Evaluation (PEPFAR)**

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

**BACKGROUND**

Background of project/program/intervention:

The USAID/Nigeria HIV/AIDS+TB unit is a team of 30 health professionals responsible for a diverse HIV/AIDS and TB portfolio which is predominantly funded through PEPFAR. The team’s Assistance Objective is Increased Nigerian Capacity for a Sustainable HIV/AIDS and TB Response. To achieve this objective, the unit functions as part of an inter-agency PEPFAR Team which includes the State Department, the US Centers for Disease Control and the US Department of Defense to implement the over $400 million PEPFAR program in Nigeria under the oversight of the PEPFAR Coordinator’s Office. The inter-agency PEPFAR Nigeria team manages and oversees a portfolio of activities while at the same time providing specialized technical assistance and advisement to the Government of Nigeria (GON) at various levels.

An inter-agency PEPFAR Gender Technical Work Group (GTWG) exists and supports PEPFAR programs to integrate gender interventions into new and existing programs and to accurately report on progress in this direction. However, several challenges have limited the effectiveness of gender integration. Low capacity of key stakeholders such as Health Care Workers, GON, CBOs and USG staff; and a dearth of uniform tools including Behavior Change Communication (BCC) materials for training, program implementation and data gathering have limited efforts to identify and address gender issues and prevent, respond to and mitigate GBV.

PEPFAR Nigeria’s Implementing Partners have so far addressed these limitations by providing gender orientations for program staff and partner CBOs, incorporating of gender into various training curricula, and developing and utilizing project-specific community dialogue guides on issues such as stigma, discrimination, gender and GBV, and male involvement in uptake of Prevention of Mother to Child Transmission of HIV (PMTCT) services, Partners have
undertaken identification of victims of GBV through chronic care screening in facilities and HIV support group meetings. Gender analyses have been conducted and results taken into consideration in program implementation. Efforts have been made to strengthen referrals from HIV services to GBV services and vice-versa, and to strengthen referrals to other non-health services. However, these efforts are uncoordinated, project specific and insufficient in scope and depth to stimulate long lasting change.

The USAID/Nigeria HIV/AIDS+TB team in concert with the PEPFAR interagency team seeks to pursue a comprehensive, well-coordinated gender effort that addresses the multiple dimensions (behavioral and structural) within which gender issues affect peoples’ lives, including in health, education, social interactions, economic opportunities, safety, legal protection and human rights, within the continuum of HIV prevention, treatment and care. In order to reduce vulnerabilities and mitigate factors that put people at risk for HIV, and increase access to services for men and women the Team aims to:

1. Increase gender equity in HIV/AIDS programs and services
2. Reduce gender-based violence and coercion among target populations
3. Engage men and boys to address harmful norms and behaviors
4. Increase legal protection for women and girls.
5. Increase women and girls’ access to income and productive resources, including education

The team seeks to integrate gender into existing and new programs in an intentional and coordinated manner, with clear deliverables and bench marks. In order to accomplish these goals, the team needs an analysis of gender-related issues and gender interventions across the PEPFAR Nigeria program in order to develop the framework for implementation of key findings.

Describe the theory of change of the project/program/intervention.

Strategic or Results Framework for the project/program/intervention (paste framework below)

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Selected States/LGAs in Nigeria; focus will be on men and women, boys and girls, MSM and transgender

**SCOPE OF WORK**

**A. Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)?

Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The updated PEPFAR gender strategy requires all PEPFAR countries to conduct a gender analysis specific to the HIV response in order to inform the design of projects and activities. The purpose of this analysis is to help the Nigeria PEPFAR country team and its implementing partners:

a) Develop gender responsive country operational plans;
b) Design programs that integrate and address gender issues;
c) Work to advance gender equality and female empowerments throughout the HIV continuum of prevention, care, treatment and support; and
d) Identify gender-related issues and programmatic gaps.

B. Audience: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID HIV/TB team and PEPFAR Nigeria Country Team

C. Applications and use: How will the findings be used? What future decisions will be made based on these findings?

Findings will be used to inform gender equality and GBV interventions that must be addressed in order to achieve PEPFAR Nigeria program goals.

D. Evaluation questions: Evaluation questions should be: a) aligned with the evaluation purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. USAID policy suggests 3 to 5 evaluation questions.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
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<tbody>
<tr>
<td>The analysis will review key gender issues and gender-based constraints in Nigeria, assess the institutional context and opportunities for gender integration into the PEPFAR country program, and offer conclusions and recommendations to strengthen the PEPFAR response in Nigeria. In addition to other key questions, the analysis will answer the basic questions of:</td>
</tr>
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</table>

1. What is the Nigeria PEPFAR program doing to integrate gender activities into HIV prevention, treatment, and care and support? 
2. What are the gaps and opportunities for gender interventions in the Nigeria PEPFAR gender program? 
3. What are the strategies and approaches needed to improve the PEPFAR Nigeria gender program? 
4. 
5. 

Other Questions [OPTIONAL] 
(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation.)

E. Methods: Check and describe the recommended methods for this analytic activity.

Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

This analysis will follow principles and standards defined within the PEPFAR Gender Analysis

Document Review (list of documents recommended for review)

Documents include, but are not limited to:
- 2010ANC Survey findings
- 2013-12-17 PEPFAR Gender Strategy FINAL
Secondary analysis of existing data (list the data source and recommended analyses)

<table>
<thead>
<tr>
<th>Data Source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
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<tbody>
<tr>
<td>MER indicators</td>
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<td>DHS data</td>
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<tr>
<td>Other HIV surveys and surveillance data</td>
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<tr>
<td>Data on GBV</td>
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Key Informant Interviews (list categories of key informants, and purpose of inquiry)

- TBD
- USAID/Nigeria Health Office and PEPFAR staff
- Health IP in Nigeria
- GoN representatives
- Members of civil society

Focus Group Discussions (list categories of groups, and purpose of inquiry)
Some of the key informants can be interviewed in clusters for efficiency, as needed. Groupings should be mindful of power differentials, so that all participants feel comfortable in sharing their opinions.

- TBD
- USAID/Nigeria Health Office and PEPFAR staff
- Health IP in Nigeria

Client/Participant Satisfaction or Exit Interviews

Client/Participant Satisfaction or Exit Interviews (list who is to be interviewed, and purpose of inquiry)

Facility or Service Assessment/Survey

Facility or Service Assessment/Survey (list type of facility or service of interest, and purpose of inquiry)

Verbal Autopsy

Verbal Autopsy (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)

Survey

Survey (describe content of the survey and target responders, and purpose of inquiry)

Observations

Observations (list types of sites or activities to be observed, and purpose of inquiry)

Data Abstraction

Data Abstraction (list and describe files or documents that contain information of interest, and purpose of inquiry)

Case Study

Case Study (describe the case, and issue of interest to be explored)

Rapid Appraisal Methods

Rapid Appraisal Methods (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

Other

Other (list and describe other methods recommended for this evaluation, and purpose of inquiry)

If impact evaluation –
Is technical assistance needed to develop full protocol and/or IRB submission?
☐ Yes ☐ No

List or describe case and counterfactual:

<table>
<thead>
<tr>
<th>Case</th>
<th>Counterfactual</th>
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</table>

**ANALYTIC PLAN**

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

The analysis will:
1. Identify age-specific gender roles and norms that affect access to and control over resources and differences in power among and between women and men across program target communities in the north, south, east and west of Nigeria.
2. Identify the gender-based constraints to and opportunities for equitable access to and participation in PEPFAR programs and services.
3. Identify strategies and approaches for PEPFAR Nigeria programs to promote gender equality and improve the health and wellbeing of women, men, girls and boys.
4. Identify and prioritize opportunities for integration of the PEPFAR gender strategy into existing and new treatment, prevention, OVC and other care programs.
5. Identify programming and implementation gaps and opportunities for effective planning, implementation, monitoring, and evaluation of the Nigeria PEPFAR gender program and provide TA along this continuum.
6. Identify the training and technical assistance needs of Implementing Partners and provide a draft response and training plan for provision of training and TA

**ACTIVITIES**

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

**Background reading** – Several documents are available for review for this assessment. These include USAID/Nigeria CDCS and health program PADs, as well as health project agreements and contracts, workplans, PMPs, annual reports and other miscellaneous project reports. Furthermore, any USAID and PEPFAR documents dealing with gender programming and policy will also be reviewed. This desk review will provide background information for this assessment, and will also be used as data.

**Team Planning Meeting (TPM)** – A two-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:
- Review and clarify any questions on the analytic SOW;
- Clarify team members’ roles and responsibilities;
- Establish a team atmosphere, share individual working styles, and agree on procedures
for resolving differences of opinion;
- Review and finalize analytic questions;
- Review and finalize the assignment timeline and share with other USAID;
- Develop data collection methods, instruments, tools and guidelines;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a data collection plan;
- Draft the analytic work plan for USAID’s approval, including timeline, analytic questions, analytic matrix, data collection protocols, sampling and tools, etc.
- Develop a preliminary draft outline of the final report; and
- Assign drafting/writing responsibilities for the final report.

**Briefing and Debriefing Meetings** – Throughout the assessment the Consultant will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Analytic Team experts, but will be determined in consultation with the Mission. These briefings are:

- **Analytic launch**, a call/meeting among the USAID/Nigeria, GH Pro and the Team Lead to initiate the analytic activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.

- **In-brief with USAID/Nigeria**, as part of the TPM. This briefing may be broken into two meetings: a) at the beginning of the TPM, so the Analytic Team and USAID can discuss expectations and intended plans; and b) at the end of the TPM when the Analytic Team will present an outline and explanation of the design and tools of the analytic. Also discussed at the in-brief will be the format and content of the Analytic report(s). The time and place for this in-brief will be determined between the Team Lead and USAID/Nigeria prior to the TPM.

- The Team Lead (TL) will brief the USAID/Nigeria weekly to discuss progress on the analytic. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

- A **final debrief** between the Analytic Team and USAID/Nigeria will be held following data collection to present preliminary findings to USAID/Nigeria. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Analytic Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The Analytic Team shall incorporate comments received from USAID during the debrief in the Gender Analysis report. (**Note:** preliminary findings are not final and as more data sources are developed and analyzed these finding may change.)

**Fieldwork, Site Visits and Data Collection** – The Analytic Team will conduct interviews and site visits for data collection. Selection of who is to be interviewed and sites to be visited will be finalized during TPM in consultation with USAID/Nigeria. The Analytic Team will outline and schedule key meetings and site visits prior to data collection and departing to the field.

**Gender Analysis Report** – The Analytic Team under the leadership of the Team Lead will develop a report with analytic findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft **Gender Analysis Report** to GH Pro for review and
formatting

2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Gender Analysis Report, as needed, and resubmit to USAID for approval.
6. Once Gender Analysis Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

DELIVERABLES AND PRODUCTS
Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch briefing</td>
<td>October 5, 2015</td>
</tr>
<tr>
<td>Work plan with timeline</td>
<td>October 12, 2015</td>
</tr>
<tr>
<td>Analytic protocol with data collection tools</td>
<td>October 16, 2015</td>
</tr>
<tr>
<td>In-brief with Country Team</td>
<td>October 26, 2015</td>
</tr>
<tr>
<td>In-brief with target projects / programs</td>
<td>October 26, 2015</td>
</tr>
<tr>
<td>Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>Out-brief with Country Team with Power Point presentation</td>
<td>November 19, 2015</td>
</tr>
<tr>
<td>Findings review workshop with stakeholders with Power Point presentation</td>
<td>November 20, 2015</td>
</tr>
<tr>
<td>Draft report</td>
<td>December 11, 2015</td>
</tr>
<tr>
<td>Final report completed</td>
<td>January 4, 2016</td>
</tr>
<tr>
<td>Raw data submitted; report with DEC</td>
<td>January 4, 2016</td>
</tr>
</tbody>
</table>

Estimated USAID review time
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)
Evaluation team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
Additional team members can include research assistants, enumerators, translators, logisticians, etc.

Teams should include a collective mix of appropriate methodological and subject matter expertise.

Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the

Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

**Team Qualifications:** Please list technical areas of expertise required for this activities

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, or for the individual team members

**Key Staff I Title: Gender Analyst and Team Lead**

**Roles & Responsibilities:**

- The **team lead** should have significant experience conducting program analysis, evaluations and/or strategic planning. As the team lead s/he will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation team, and (5) leading briefings and presentations. S/H will be responsible for providing guidance, coordination and facilitation of all Assessment activities. The team leader, in consultation with other team members will develop tools for the gender analysis, a timeline, and a design plan to be shared with USAID/Nigeria for their feedback and comments. S/he will insure the quality of work and provide direction and coordination to the other team members. Additionally, s/he will be responsible overall for the implementation of this assignment, through the writing and timely submission of the report. The team leader is also expected to be the lead, providing oversight on overall project management and financial issues.

- As the **Gender Analyst** s/he will be responsible for providing technical expertise on gender issues related to health, and more specifically HIV, including gender-based violence (GBV), and integration of gender into USAID programming and projects.

  **Qualifications:**
  - Minimum of 10 years of experience in international development and gender
  - Experience working internationally on gender and health programs/projects, including HIV projects/programs
  - Experience in conducting gender analysis within the health and/or HIV sector
  - Familiarity with Nigerian socio-cultural norms and structures
  - Ability to lead an analysis and work as part of a team
  - Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with USAID, implementing partners, host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Knowledge of USAID and PEPFAR gender policies and strategies
  - US Strategy to Prevent and Respond to Gender-Based Violence Globally
  - Gender Equality and Female Empowerment Policy
  - PEPFAR Gender Strategy
  - Compendium of Gender Equality and HIV Indicators

7. Familiarity with USAID programming and planning policies and practices
   - Program Cycle
   - Programming Policy (ADS 200)
   - Planning (ADS 201)

Number of consultants with this expertise needed: 1

Key Staff 2 Title: Logistics Specialist and Translator (local hire)

Roles & Responsibilities: This person will be responsible for setting up and confirming all meetings and logistics needed for the analysis, including meetings with GoN representatives, implementing and civil society partners, and USG staff

Qualifications: Ability to manage schedules and arrange all logistical details in a timely manner; ability to communicate in English as well as one other local language.

Number of consultants with this expertise needed: 1

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

<table>
<thead>
<tr>
<th>Role / Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Evaluation Logistics / Program Assistant</td>
<td>Support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.</td>
</tr>
<tr>
<td>Other Translators as required, depending on the part of Nigeria visited.</td>
<td></td>
</tr>
</tbody>
</table>

NIGERIA GENDER ANALYSIS
Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

- Yes – If yes, specify who: Tessie Philips-Ononye
- No

**Staffing Level of Effort (LOE) Matrix (Optional):**

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.

b) Immediately below each staff title enter the anticipated number of people for each titled position.

c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.

d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.

e) At the bottom of the table total the LOE days for each consultant title in the ‘Sub-Total’ cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

**Level of Effort in days for each Evaluation/Analytic Team member**

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Evaluation/Analytic Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender Specialist / Team Lead</td>
</tr>
<tr>
<td>1 Launch Briefing</td>
<td>0.5</td>
</tr>
<tr>
<td>2 Desk review &amp; Data Synthesis</td>
<td>5</td>
</tr>
<tr>
<td>3 Travel to country</td>
<td>2</td>
</tr>
<tr>
<td>4 Team Planning Meeting</td>
<td>3</td>
</tr>
<tr>
<td>5 In-brief with Mission</td>
<td>1</td>
</tr>
<tr>
<td>6 In-brief with PEPFAR IPs, with prep</td>
<td>1</td>
</tr>
<tr>
<td>7 Data Collection DQ Assurance Workshop (protocol orientation for all involved in data collection)</td>
<td>1</td>
</tr>
<tr>
<td>8 Prep / Logistics for Site Visits</td>
<td></td>
</tr>
<tr>
<td>Activity / Deliverable</td>
<td>Gender Specialist / Team Lead</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Data collection / Site Visits</td>
<td>10</td>
</tr>
<tr>
<td>Data analysis</td>
<td>5.5</td>
</tr>
<tr>
<td>Debrief with Mission including prep</td>
<td>1</td>
</tr>
<tr>
<td>Stakeholder debrief workshop with prep</td>
<td>1</td>
</tr>
<tr>
<td>Depart country</td>
<td></td>
</tr>
<tr>
<td>Draft report(s)</td>
<td>5</td>
</tr>
<tr>
<td>GH Pro Report QC Review &amp; Formatting</td>
<td></td>
</tr>
<tr>
<td>Submission of draft report(s) to Mission</td>
<td></td>
</tr>
<tr>
<td>USAID Report Review</td>
<td></td>
</tr>
<tr>
<td>Revise report(s) per USAID comments</td>
<td></td>
</tr>
<tr>
<td>Finalization and submission of report(s)</td>
<td></td>
</tr>
<tr>
<td>508 Compliance Review</td>
<td></td>
</tr>
<tr>
<td>Upload Eval Report(s) to the DEC</td>
<td></td>
</tr>
<tr>
<td><strong>Total LOE</strong></td>
<td><strong>41</strong></td>
</tr>
</tbody>
</table>

If overseas, is a 6-day workweek permitted: [ ] Yes [ ] No

**Travel anticipated:** List international and local travel anticipated by what team members.

It is expected that the Gender Analysis Team Lead will spend at least three weeks in Nigeria. The Team Lead will be based in Abuja but may travel out to specific States/LGAs as needed to meet with partners, GoN representatives, and members of civil society.

**LOGISTICS**

**Note:** Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

[ ] USAID Facility Access
Specify who will require Facility Access: Team Leader is a TCN. Facility access must be processed by the Mission.

☐ Electronic County Clearance (ECC) (International travelers only)
☐ GH Pro workspace

Specify who will require workspace at GH Pro:
☐ Travel - other than posting (specify):
☐ Other (specify):

**GH PRO ROLES AND RESPONSIBILITIES**

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

**USAID ROLES AND RESPONSIBILITIES**

Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>USAID</strong> will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</td>
</tr>
</tbody>
</table>

**Before Field Work**

- **SOW.**
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- **Consultant Conflict of Interest (COI).** To avoid conflicts of interest or the appearance
of a COI, review previous employers listed on the CV’s for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.

- **Documents.** Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- **Local Consultants.** Assist with identification of potential local consultants, including contact information.
- **Site Visit Preparations.** Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- **Lodgings and Travel.** Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

**During Field Work**

- **Mission Point of Contact.** Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team’s work.
- **Meeting Space.** Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- **Meeting Arrangements.** Assist the team in arranging and coordinating meetings with stakeholders.
- **Facilitate Contact with Implementing Partners.** Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.

**After Field Work**

- **Timely Reviews.** Provide timely review of draft/final reports and approval of deliverables.

**ANALYTIC REPORT**

Provide any desired guidance or specifications for Final Report. (See *How-To Note: Preparing Evaluation Reports*).

Although this is not an evaluation, it is recommended that the **Gender Analysis Report** follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

- a. The report must not exceed 25 pages (excluding executive summary, table of contents, acronym list and annexes).
- b. The structure of the report should follow the Evaluation Report template, including branding found [here](##) or [here](##).
- c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](##).

**Reporting Guidelines:** The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and
lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. The report will be edited(formatter and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.

The preliminary findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID/GH/OHS and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 2 pages);
- Table of Contents (1 page);
- Acronyms
- Purpose of Gender Analysis and Analytic Questions (1-2 pages)
- Program Background (1-3 pages)
- Analytic Methods and Limitations (1-3 pages)
- Findings
- Conclusions
- Recommendations
- Annexes
  - Annex I: Analytic Statement of Work
  - Annex II: Analytic Methods and Limitations (if more details than presented in the body of the report)
  - Annex III: Data Collection Instruments
  - Annex IV: Sources of Information
    - List of Persons Interviews
    - Bibliography of Documents Reviewed
    - Databases
    - [etc.]
  - Annex V: Disclosure of Any Conflicts of Interest
  - Annex VI: Statement of Differences [if applicable]

Although this is not an evaluation, the assessment methodology and report should closely follow the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

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All data instruments, data sets (if appropriate), presentations, meeting notes and report for this analysis will be provided to GH Pro and presented to USAID electronically to the Program Manager. All data will be in an unlocked, editable format.

**USAID CONTACTS**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Primary Contact</th>
<th>Alternate Contact 1</th>
<th>Alternate Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Program Manager, OVC</td>
<td>Division Chief: Community Programs</td>
<td>Program Assistant</td>
</tr>
<tr>
<td>Email:</td>
<td>tphilips-</td>
<td><a href="mailto:jnwosu@usaid.gov">jnwosu@usaid.gov</a></td>
<td><a href="mailto:bpius@usaid.gov">bpius@usaid.gov</a></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:ononye@usaid.gov">ononye@usaid.gov</a></td>
<td>+234 9 461 9394</td>
<td>+234 9 461 9426</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td>+234 803 450 7819</td>
<td>+234 803 960 6380</td>
<td>+234803 788 2292</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List other contacts [OPTIONAL]

**REFERENCE MATERIALS**
Documents and materials needed and/or useful for consultant assignment, that are not listed above
ANNEX II. EVALUATION METHODS AND LIMITATIONS

METHODS
Using a mixed methods approach to data collection, the Team undertook the following:

- Reviewing PEPFAR-recommended literature and client-approved reports the Team identified prior to and after site visits\textsuperscript{14};
- Developing and circulating to IPs a pre-site visit questionnaire to gather baseline data on IPs’ understanding of gender issues and activities undertaken to integrate gender into their projects\textsuperscript{15};
- Developing and using surveys, key informant interview questions, and focus group discussion topics to collect information during site visits\textsuperscript{16};
- Conducting interviews and focus group discussions with representatives from a variety of organizations, projects, and official agencies, as well as documenting observations at each site, and discussing key issues with PEPFAR and USAID staff before, during, and after site visits; and
- Ensuring a diverse geographic range and interviews with each type of PEPFAR intervention.

Limitations

\textit{Compressed time schedule}

- Due to unavoidable delays in international travel, the time available for the Team Planning Meeting (TPM) was cut short, leaving just one day for the Team to work together, in person, to develop data collection methods and instruments and establish protocols for the assessment. While waiting for the resolution of international travel logistics, the Team worked remotely to start creating the analytical approach and materials, which were refined when the Team Lead arrived and while on the road.

- Internal travel also proved problematic, with weather conditions causing flight delays and cancellations. To compensate, the Team used ground transportation when poor visibility prevented air travel. Team members experienced internet connectivity and cell phone problems throughout their time in the field, which made coordination and communication inconsistent and difficult not only with each other but also with PEPFAR Team members, interviewees, and the GH Pro headquarters.

- Due to the upcoming Christmas holiday, the Team was unable to extend the assessment period to compensate for initial delays. The Team conducted two interviews by telephone and email after the site visit end date to ensure the inclusion of all planned meetings.

\textsuperscript{14} See Annex IV for a list of documents reviewed.
\textsuperscript{15} See Annex V for the pre-site visit questionnaire results from IPs.
\textsuperscript{16} See Annex VI for data collection instruments developed and used.
Importantly, the compressed time schedule did not decrease the amount of time spent with IPs, CBOs, and beneficiaries during site visits. The meetings proved engaging for both the interviewees and the Team, who, on average, spent 2 hours/site visit.

**Limited interviews with women's organizations and international organizations**

- Also due to time constraints and the Christmas holiday, the Team was unable to schedule meetings with Nigerian women's rights organizations or bi-lateral or multi-lateral agencies, such as UN Women, UNDP, UNICEF, JICA, and others working in the country. While the analysis could have benefited from interviews with these groups, the Team obtained research reports and other useful documents that IOs had published, some of which also included information from national women's rights CSOs.

**Communication with interviewees**

- It may be useful to note that, prior to assessments and analyses, instructions from PEPFAR to IPs and from IPs to CBOs should be specific, explicit, and repeated constantly and consistently both verbally and in writing. Some IPs and CBOs thought the analysis was being conducted to evaluate their work despite communications to the contrary prior to site visits, during the IP in-Brief, at the start of each site visit, and in written invitations to the IP Out-Brief. Despite all this, one representative of an IP noted at the end of the Out-Brief, “The expectation was to leave with specific feedback for [our] organization with a view to adjusting our program activities in tandem with PEPFAR gender analysis. Nevertheless, it is an eye-opener for us moving forward.”

- This type of misunderstanding can affect respondents’ answers to questions and can limit the extent to which IPs describe and openly discuss problems their projects’ experience.

**Leaders**

- A methodological concern is the presence and participation in interviews of high level leaders, such as “kings,” tribal chiefs, and political officials, as well as directors of health facilities and in some instances heads of IPs and CBOs. On the one hand, their attendance reflects a positive commitment to the goals of a program and concern for its effectiveness and beneficiaries, which may very well be the case. In interviews, however, the prevailing gender and social structure could intimidate lower level staff and beneficiaries from contradicting leaders' statements or from identifying problems, concerns, inefficiencies, or other issues that might be construed as complaints or criticisms directed toward the leadership. During one interview, for example, with only three interviewees present, no one except the male director spoke, including the gender advisor, for the entire hour we were there. Even when questions were directed to the gender advisor, she looked at the director before speaking, seemingly requesting his permission to respond. Instead, he responded. (This is an example of the kind of “observation” the Team noted; while the suppositions cannot be proven, not hearing from a gender advisor in an entire hour of discussion is noteworthy.)

- This concern is nuanced, with some staff and beneficiaries remaining silent when leaders are present, others echoing what leaders have said, and still others identifying specific needs, such as leaky roofs or insufficient access to vehicles, that require additional donor inputs. While the needs may be legitimate, when several individuals repeat the same requests, even when they are not responsive to a particular question, using similar language, it is possible that individuals have been coached to appeal for additional support.
## ANNEX III. PERSONS INTERVIEWED

**CLASSIFICATION OF SITES VISITED FOR PEPFAR—USG NIGERIA GENDER EVALUATION, 2015**

<table>
<thead>
<tr>
<th>S/N</th>
<th>Name of Site</th>
<th>State</th>
<th>Name of Implementing Partner</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HEALTH SYSTEMS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Community Partners for Development, Uyo</td>
<td>Akwa Ibom</td>
<td>Management Sciences for Health (MSH) PLAN-Health Project</td>
<td>Dr. Nsekpong Udoh</td>
</tr>
<tr>
<td>2.</td>
<td>Health Finance Governance Project, Calabar</td>
<td>Cross River</td>
<td>ABT Associates</td>
<td>Mr. Azu Ibiam</td>
</tr>
<tr>
<td></td>
<td>CARE &amp; TREATMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Federal Medical Centre, Makurdi</td>
<td>Benue</td>
<td>Institute of Human Virology Nigeria (IHVN)</td>
<td>Cyrina</td>
</tr>
<tr>
<td>2.</td>
<td>General Hospital, Vandeikya</td>
<td>Benue</td>
<td>Centre for Integrated Health Programs (CIHP)</td>
<td>Dr. Samuel Ngishe</td>
</tr>
<tr>
<td>3.</td>
<td>St. Anthony’s Hospital, Zaki Biam</td>
<td>Benue</td>
<td>Catholic Caritas Foundation of Nigeria (CCFN)</td>
<td>Sr. Grace Abakpa</td>
</tr>
<tr>
<td>4.</td>
<td>44 Nigeria Army Reference Hospital (NARH)</td>
<td>Kaduna</td>
<td>DOD</td>
<td>Dooshima</td>
</tr>
<tr>
<td>5.</td>
<td>Ahmadu Bello University Teaching Hospital, Shika</td>
<td>Kaduna</td>
<td>Friends for Global Health Initiative in Nigeria (FGHN)</td>
<td>Dr. John Chama</td>
</tr>
<tr>
<td>6.</td>
<td>General Hospital, Suleja</td>
<td>Niger</td>
<td>Management Sciences for Health (MSH) ProACT Project</td>
<td>Dr. Adedokun Adebayo</td>
</tr>
<tr>
<td>7.</td>
<td>Dengi General Hospital, Kanam</td>
<td>Plateau</td>
<td>Pro-Health International</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>DHQ Mogadishu Barracks</td>
<td>Abuja</td>
<td>DOD</td>
<td>Dooshima</td>
</tr>
<tr>
<td>9.</td>
<td>Parklane Hospital, Enugu State University Teaching Hospital (ESUTH)</td>
<td>Enugu</td>
<td>Centre for Clinical Care and Clinical Research of Nigeria (CCCRN)</td>
<td>Dr. Emeka Okekeze</td>
</tr>
<tr>
<td>10.</td>
<td>Oji River District Hospital</td>
<td>Enugu</td>
<td>Excellence Community Education Welfare Scheme (ECEWS)</td>
<td>Grace Jimbo</td>
</tr>
<tr>
<td>11.</td>
<td>Ifako-Ijaiye General Hospital</td>
<td>Lagos</td>
<td>AIDS Prevention Initiative Nigeria (APIN)</td>
<td>Dr. Ime Okon</td>
</tr>
<tr>
<td>12.</td>
<td>Mayfair Medical Center</td>
<td>Lagos</td>
<td>Pathfinder International (E2A PMTCT Project)</td>
<td>Dr. Akinlembola</td>
</tr>
<tr>
<td>S/N</td>
<td>Name of Site</td>
<td>State</td>
<td>Name of Implementing Partner</td>
<td>Contact Person</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>1.</td>
<td>Centre for Gospel Health and Development,</td>
<td>Plateau</td>
<td>Save the Children International</td>
<td>Nansik Onu</td>
</tr>
<tr>
<td></td>
<td>Sabon Bariki, Jos)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Society for Community Development, Kuje</td>
<td>Abuja</td>
<td>Catholic Relief Services (CRS) Nigeria</td>
<td>Maryam Muhammed</td>
</tr>
<tr>
<td></td>
<td>(OVC LOPIN 2 Project)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Ugbenu Community (OVC LOPIN 2 Project)</td>
<td>Anambra</td>
<td>Widows and Orphans Empowerment Organization (WEWE)</td>
<td>Ngozi Orame</td>
</tr>
<tr>
<td></td>
<td></td>
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**Attendance List for PEPFAR/USAID Nigeria Gender Assessment 2015**

**Name of IP:** Centre for Clinical Care and Research of Nigeria, Enugu State

**Date:** Thursday, November 26, 2015

**Venue:** Parklane Hospital, Enugu State Teaching Hospital, Enugu

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## ATTENDANCE LIST FOR PEPFAR/USAID NIGERIA GENDER ASSESSMENT 2015

**Name of IP:** Widows and Orphans Empowerment Organization (WEWE)  
**Date:** Friday, November 27, 2015  
**Venue:** WEWE LOPIN Office, Mbaukwu Crescent, Agu, Awka, Anambra State

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## ATTENDANCE LIST FOR PEPFAR/USAID NIGERIA GENDER ASSESSMENT 2015

**Name of Govt. Agency:** Ministry of Gender Affairs & Social Development  
**Date:** Friday, November 27, 2015  
**Venue:** MoGA & SD Office, Enugu, Enugu State

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**ATTENDANCE LIST FOR PEPFAR/USAID NIGERIA GENDER ASSESSMENT 2015**

**Name of IP:** Excellence Community Education Welfare Scheme (ECEWS), Enugu State  
**Date:** Saturday, November 28, 2015  
**Venue:** General Hospital, Oji River, Enugu, Enugu State

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# ATTENDANCE LIST FOR PEPFAR/USAID NIGERIA GENDER ASSESSMENT 2015

**Name of IP:** The Society for Family Health (SFH)  
**Date:** Tuesday, December 1, 2015  
**Venue:** Lagos State Office, Ikeja, Lagos State

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## ATTENDANCE LIST FOR PEPFAR/USAID NIGERIA GENDER ASSESSMENT 2015

**Name of IP:** Health Initiatives for Africa Safety and Security (LOPIN 3 Project)  
**Date:** Friday, December 4, 2015  
**Venue:** HIFASS Office, Calabar, Cross River State

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## ATTENDANCE LIST FOR PEPFAR/USAID NIGERIA GENDER ASSESSMENT 2015

**Name of IP:** FHI360  
**Date:** Saturday, December 5, 2015  
**Venue:** FHI360 Office, Uyo, Akwa Ibom State

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<td>Blissful Life, Abak</td>
<td>Community Volunteer</td>
<td>08058944684</td>
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<tr>
<td>7.</td>
<td>Joseph, Theresa</td>
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<td>Nkaima</td>
<td>Community Volunteer</td>
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<td>8.</td>
<td>Effiong, Jimmy</td>
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<td>Nkaima</td>
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<td>9.</td>
<td>Umoren, Daniel</td>
<td>M</td>
<td>ARFH</td>
<td>SPO</td>
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<td>10.</td>
<td>Mshelia, Emmanuel</td>
<td>M</td>
<td>FHI360</td>
<td>TO (P &amp; M)</td>
<td>08051785904</td>
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</tbody>
</table>
## LIST OF HEAD OF HOSPITAL SERVICES/CHIEF MEDICAL DIRECTOR ACROSS CCT'S IN NIGER STATE

<table>
<thead>
<tr>
<th>S/N</th>
<th>Name</th>
<th>Name of Facility</th>
<th>Designation</th>
<th>Phone Contact</th>
<th>Email Address</th>
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<tbody>
<tr>
<td>1</td>
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</tbody>
</table>
### ATTENDANCE LIST FOR PEPFAR/USAID NIGERIA GENDER ASSESSMENT 2015

**Name:** PEPFAR, USAID HIV/AIDS+TB Team, USAID Mission, CDC, DOC  
**Date:** Wednesday, December 16, 2015  
**Venue:** USAID

<table>
<thead>
<tr>
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<tr>
<td>1.</td>
<td>Dr. Murphy Akpu</td>
<td>M</td>
<td>PEPFAR</td>
<td>Deputy PEPFAR Coordinator</td>
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<tr>
<td>2.</td>
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<td>USAID HIV/AIDS+TB Team</td>
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<td>3.</td>
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<td>4.</td>
<td>Pamela Foster</td>
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<td>Technical Lead for Prevention</td>
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<td>Senior Program Specialist, HIV</td>
</tr>
</tbody>
</table>
ANNEX IV. SOURCES OF INFORMATION

REFERENCE DOCUMENTS
1. ATHENA Network (2012). *Integrating Strategies to Address Gender-based Violence and Engage Men and Boys to advance Gender Equality through National Strategic Plans on HIV/AIDS: Case Studies Documenting Country Action*
7. Croce-Galis, M., Gay, J., and Hardee, K. (2015). “*Gender Considerations Along the HIV Treatment Cascade: An Evidence Review with Priority Actions.*” What Works Association (What Works for Women & Girls is supported by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the Open Society Foundations and is being carried out under the auspices of the USAID-supported Health Policy Project and the Public Health Institute)
12. Extract of Gender Based Violence Indicators (2013): (1.) GEND_GBV: Number of people receiving post-GBV Care (2.) GEND_NORM: Number of people completing an Intervention pertaining to gender norms, that meets minimum criteria


17. Ibid., Chapter 5: 1-57)

18. Ibid., Chapter 11: 1-91)


31. PEPFAR (2013). Updated Gender Strategy

33. PEPFAR. Gender Analysis: 10 Key Principles
PAPERS:
Community Based Health Insurance (CBHI) Documents:

1. Community Based Health Insurance in Rwanda: Overview
2. Development of Ukana West Ward II CBHI Scheme Benefits Package
3. Basic Benefits Package for CBHI Scheme (Ukana West Ward II)
4. Concept Paper for Demand Generation for Ukana West Ward II Community Based Health Insurance Scheme
5. Costing of Demand Generation Activities for UKana West Ward II Community Based Health Insurance Scheme
7. Terms of Reference (ToR) for Monitoring and Supervision Committee, PHC Ikot Ideh Drug Management System
8. Terms of Reference (ToR) for Drug Procurement Committee, PHC Ikot Ideh Drug Management System
9. Terms of Reference (ToR) for Drug Selection Committee, PHC Ikot Ideh Drug Management System
10. Akwa Ibom State Community Based Health Insurance Programme Handbook (2013)
11. Setting up CBHI BOT Governance Structure using Existing Community Decision-making process
12. Ukana West Ward II Community Based Health Insurance Scheme Model
13. Copies of Community Based Health Insurance Scheme IEC Materials
14. Community Based Health Insurance Scheme Standard Operating Procedures Manual for Ukana West Ward II
16. Ukana West Ward II Community Based Health Insurance Scheme Board Policy Guidelines
17. David Collins Reports: (1.) PLAN-Health Assessment of Akwa Ibom CBHI Pilot Scheme Summary Report (2.) PLAN-Health Sustainability Plan for Akwa Ibom CBHI

IP DOCUMENTS
- CRS-SMILE CSOs Communities and current Gender activities
- Gender Activities Summary Table_DOD Walter Reed - Draft I
- Gender Activities Summary Table_APIN Draft I
- Gender Activities Summary Table_ECEWS LOCATE Project Draft I
- Gender Activities Summary Table_SFH_SHiPS for MARPs Project
• Gender Summary Table SIDHAS project
• HAN Gender activities summary ...Draft 2
• LOPIN-3 Summary of Gender Activities - 1st draft
• PLAN-Health Gender Activities Table
• SUMMARY OF ECEWS GENDER ACTIVITIES
• WEWE Gender Summary

GON REPORTS
• Nigerian Best Practices featured at the First Commonwealth Women’s Forum Commonwealth Heads of Government Meeting, Malta, November 2015
• Gender-Based Violence in Nigeria, National Guidelines & Referral Standards, Federal Ministry of Women’s Affairs and Social Development, 2014
• National Policy and Plan of Action for the Elimination of Female Genital Mutilation in Nigeria, Federal Ministry of Health, Abuja, August 2013
• National Plan of Action: Addressing Gender-based Violence and HIV/AIDS Intersections, 2015-2017, Federal Ministry of Women’s Affairs and Social Development
• Beijing + 20 Country Report, Federal Ministry of Women’s Affairs and Social Development, June 2014
• The National Assembly Gender Strategy, National Institute for Legislative Studies (NILS), December 2014
• Compendium of Good Practices in Gender Mainstreaming: Selection of Country Good Practices, Federal Ministry of Women’s Affairs and Social Development, September 2009
• National HIV/AIDS and Reproductive Health Survey (NARHS) 2009
• 2010 HIV Sero – Prevalence Sentinel Survey Among the AnteNatal Clinic Attendees in Nigeria (Power-point Presentation)

PEPFAR RECOMMENDED DOCUMENTS:
• 2010 ANC Survey findings
• 2013-12-17 PEPFAR Gender Strategy FINAL
• Gender Analysis Infographic - final
• Gender in Nigeria 2013 OHS
• Gender in Nigeria 2013 OHS
• Gender-Nigeria2012
• HIV TB PAD 04 13 2015 final
• IBBSS 2010 layout final July 14
• Linkage btw HIV and Domestic Violence in Nigeria
• Mapping of Policies on GBV and HIV
• MARKETS II Baseline Survey Report
• NATIONAL GENDER POLICY
• Nigeria OHS 2013
• PEPFAR Gender Analysis Technical Considerations
• PEPFAR Gender Framework
• NARHS AGAIN19TH JAN 09
MER indicators
OHS data
ANNEX V. BASELINE QUESTIONNAIRE

Prior to site visits, IPs completed an online questionnaire that provided the Assessment Team with information that helped inform the design of data collection instruments and provided the Team with an overview of the nature and extent of IP’s experience and expertise in gender integration. The questionnaire follows:
1. Was a gender analysis conducted for your program/project?
   - YES
   - NO
   - DO NOT KNOW

2. Are you contractually obligated to integrate gender into your program/project?
   - YES
   - NO
   - DO NOT KNOW

3. Have gender integration approaches and activities been included in your work plans/strategic plans?
   - YES
   - NO
   - DO NOT KNOW

4. Have you received guidance about how to integrate gender into your work?
   - YES
   - NO
   - DO NOT KNOW

5. Do you have a Gender Advisor/Specialist on staff?
   - YES
   - NO
   - DO NOT KNOW

6. Do you use gender sensitive and gender equality indicators to monitor, measure, and report on your work?
   - YES
   - NO
   - DO NOT KNOW

7. Do you disaggregate work by sex within target groups (community populations)?
8. Do you disaggregate work by sex within geographic locations?
   - YES
   - NO
   - DO NOT KNOW

9. Are gender indicators included in your PMPs and Quarterly Reports?
   - YES
   - NO
   - DO NOT KNOW

10. Do data and other information from gender reports and research inform your program/activity design?
    - YES
    - NO
    - DO NOT KNOW

11. With which of the following USG, GON, PEPFAR, and UN gender policies, strategies, and mandates are you familiar? Check all that apply.
    - Gender Equality and Female Empowerment Policy (USAID, March 2012)
    - Promoting Gender Equality and Advancing the Status of Women and Girls (U.S. Department of State Policy Guidance, September 8, 2014)
    - Violence Against Women Act (US, reauthorized 2013)
    - Strategy on Preventing and Responding to Gender-based Violence Globally (US, August 2012)
    - Counter-Trafficking in Persons Policy (US, 2012)
    - The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (UN, 1979)
    - Beijing Declaration and Platform for Action and follow-on (UN, 1995)
    - Declaration on the Elimination of Violence Against Women and follow-on (UN, 1993)
    - International Conference on Population and Development (UN, 1994)
    - Women, Peace and Security Frame work and Commitments (UN Security Council Resolution 1325 and follow on resolutions, 2000-2013)
    - Nigerian National Gender Policy (GON, 2006)
    - PEPFAR Updated Gender Framework 2013-2017
12. What types of assistance would be most useful to better integrate gender into your work? Check all that apply.
- Training
- Technical Assistance
- Hiring a Gender Advisor/Specialist
- Conducting a gender analysis
- Access to relevant research and tools
- Observation of effective gender activities implemented in other projects
- Other (please specify)

13. What type of guidance would best assist your efforts to integrate gender into your work?
- Examples of evidence-based best practices and lessons learned?
- Guidance for devising gender-sensitive indicators?
- Instructions on how to conduct a gender analysis?
- Guidance on integrating gender analysis recommendations into work plans?
- Information on USG, GON, UN, and PEPFAR gender policies?
- Other (please specify)

14. How familiar are you with the quantitative and qualitative gender status, roles, responsibilities, problems, obstacles, constraints, opportunities, strengths, and entry points of your primary target groups?
- VERY FAMILIAR
- SOMewhat FAMILIAR
- UNFAMILIAR

15. How aware are your sub-contractors/sub-grantees of gender mandates?
- VERY AWARE
- SOMewhat AWARE
- NOT AWARE
16. If you have subs, do they have a Gender Advisor/Specialist on staff?
- YES
- NO
- NO, BUT OUR GENDER ADVISOR/SPECIALIST ASSISTS THEM.
- DO NOT KNOW

17. If you have subs, do they collect sex disaggregated data and report on gender sensitive indicators?
- YES
- NO
- SOMETIMES
- DO NOT HAVE SUBS
ANNEX VI. DATA COLLECTION INSTRUMENTS: KEY INFORMANT INTERVIEWS, FOCUS GROUPS, OBSERVATION

KEY INFORMANT INTERVIEWS: COMMUNITY

Demographics
- Please, can you introduce yourself: name and name of community?
- As the community leader, do you do any other work for a living?
- Please tell us about your community.
- Tell us about your work as community leader.
- Have you always lived in this community, or did you move here when you became the head of this community?
- Tell us about yourself and your background—age, academic and professional experience?
- How many hospital facilities are in your community?
- Are there any other ones close by where your community members visit? Which one(s)?

Understanding of Gender Dynamics
- What is the common occupation of people of this community?
- What are the different types of occupations for men and for women?
- If they are different, why?
- Are there any religious or cultural beliefs or practices that create the different roles for men and women?
  - Where do these beliefs or practices come from?
  - Are they beneficial in any way? If so, explain.
  - If not beneficial, what will be the role(s) of the community leader(s) in stopping them?
- Are marriages arranged?
- Age of marriage?
- Number of children?
- Decision making in the home?
- Inheritance?
- Literacy
- Level of education
- Family planning—availability, community support

- Do you think there are beliefs and practices that discriminate against men or women in this community? If yes or no, explain.
  - FGC
  - GBV

- Within the traditional council, what is the breakdown between men and women?
- How are the rights of men and women enforced?
- How are cases of rape, domestic violence, etc. handled?
- Are there beliefs/practices that make men or women access health services more or less? Explain
  - Who goes to the hospital more: Men or women? Why?
    - Accessibility? Affordability?
- Are women in positions of authority or leadership in the local government?
- What are the greatest obstacles that women and girls face?
- What actions are taken to overcome these obstacles?
- What are the social, political, and economic opportunities for women in the community?
- What role do men and women in this community play in family health? Who takes health decisions, who pays for the services and who cares for the sick?

**KNOWLEDGE & IMPACT OF PROJECT**
- Are you familiar with the program by …?
- How did you get to know about the program?
- Have you been involved in the program? If yes, How?
- Have you received any training on Gender during the program?

**KEY INFORMANT INTERVIEW: ART CLINIC STAFF (ART COORDINATOR, HTC FOCAL PERSON, ADHERENCE COUNSELOR)**
- What are the common gender norms practiced in this community?
- Do you think there are beliefs that discriminate against men or women in this community? If yes or no, explain.
- Are there beliefs/practices that make men or women access health services more or less? Explain
• What do community members believe about MSM and Sex workers in this community?
• What do you believe about MSM and Sex workers?
• Have you attended to any MSM before in this centre?
• If No, what is your reaction to MSM accessing services in this facility?
• Who accesses services here the more, men or women? Why do you think so?
• Is there anything you do to encourage men to access services in this facility more?
• Can you tell us the ratio of men to women in the work force in the ART clinic. What roles do they perform?
• What are the gender issues you often come across in your work in the ART clinic?
• What gender issues related to HIV/AIDS are you familiar with?
• How have you addressed the gender issues mentioned in your work?
• What has been the impact of your gender interventions on access and utilization of HIV services?
• Do you have sex and age disaggregated data to show how men and women are accessing and utilizing services in your facility? Does the data inform how you run your services?
• Can you describe to me how your ART clinic runs? Would you say privacy and confidentiality are prioritized?
• Do you assess your clients for gender based violence? If yes, how? And what services do you provide them? Do clients get referred for services other than health management?
• How does the facility help women manage status disclosure to their partners?
• Are you familiar with National guidelines and referral standards for GBV in Nigeria?
• Have you been trained on gender and or management of GBV survivors?
• In what ways do you help women access partner support for couple counseling, testing & antenatal?
• Do you have IEC materials conspicuously displayed in the facility that address gender issues related to HIV/AIDS?
• What is the average time it takes for clients to access services when they come on appointment?
• Do clients show preferences for seeing a care provider on the basis of their sex? When they do, how do you respond?
• What do you consider to be constraints to integrating gender into your work here in the facility?
KEY INFORMANT INTERVIEW: FACILITY CHIEF MEDICAL OFFICER (HSS—HEALTH SYSTEMS STRENGTHENING)

Gender Across 6 Building Blocks
1. Good health service provision (quality, effective, safe)
2. Health work force
3. Health information system
4. Medical products
5. Health financing
6. Leadership and governance

1. Good Health Service Provision
   • Access:
     • Do women need spousal permission to access family planning services?
       – What steps has your facility taken to promote and provide reproductive health services?
       – How accessible are your services to those with limited mobility?
         a. Women
         b. People with disabilities
         c. Does the facility provide mobile health services?
       – Are medical services integrated? For example, are there linkages between reproductive health and mammography? What happens when a patient presents what could be clinical depression but visits for other reasons?
       – How are emergency services handled/provided?
       – How do you handle patients who request same sex providers?
       – In states where FGC is not illegal, do you perform this procedure if parents request it?
       – Is there a linkage with traditional medical practices, i.e. preventing mother to child transmission of HIV?

2. Health work force
   • What proportion of senior management is female? Male?
     – What proportion of mid-level management is female? Male?
     – What proportion of non-managerial staff is female? Male?
     – We assume most nurses are female and doctors male.
       • Is there recruitment of male nurses?
       • Are there professional development opportunities for women who aspire to become doctors?
• What is the nature and extent of professional development programs for medical personnel?
  - Is “gender” a topic of training that is available?
  - To what extent is the staff “gender aware”? How is that assessed?
  - Is staff trained on management of gender-based violence?

3. Health Information System

• Does your MIS disaggregate data by sex?

• Do medical professionals report evidence of gender-based violence or violence against children?
  - Are they required to do so?
  - How do they handle it?
  - Are they provided with guidance for dealing with it?

4. Medical products

• Do you have funds to procure family planning supplies?

• Under what circumstances do you provide Viagra to patients requesting it?

5. Health financing

• Are there funds for community outreach for HIV?

• Who allocates health service budgets?

• What proportion do you estimate is focused on or related to HIV?

• To what extent are donor funds used to support your operations, commodities, facilities, and staff either through the GON or directly to the hospital?
  - How can operations be sustained if there were a reduction in donor funds?

6. Leadership and governance

• What could be done to promote the advancement of women into leadership and governance into the medical field?

At conclusion of interview, ask if the interviewee would be interested in receiving material on health systems strengthening in the area of gender.

KEY INFORMANT INTERVIEW: ART CLINIC STAFF (ART COORDINATOR, HTC FOCAL PERSON, ADHERENCE COUNSELOR)

• What are the common gender norms practiced in this community?

• Do you think there are beliefs that discriminate against men or women in this community? If yes or no, explain.
- Are there beliefs/practices that make men or women access health services more or less? Explain

- What do community members believe about MSM and Sex workers in this community?

- What do you believe about MSM and Sex workers?

- Have you attended to any MSM before in this centre?

- If No, what is your reaction to MSM accessing services in this facility?

- Who accesses services here more, men or women? Why do you think so?

- Is there anything you do to encourage men to access services in this facility more?

- Can you tell us the ratio of men to women in the work force in the ART clinic? What roles do they perform?

- What are the gender issues you often come across in your work in the ART clinic?

- What gender issues related to HIV/AIDS are you familiar with?

- How have you addressed the gender issues mentioned in your work?

- What has been the impact of your gender interventions on access and utilization of HIV services?

- Do you have sex and age disaggregated data to show how men and women are accessing and utilizing services in your facility? Does the data inform how you run your services?

- Can you describe to me how your ART clinic runs? Would you say privacy and confidentiality are prioritized?

- Do you assess your clients for gender based violence? If yes, how? And what services do you provide them? Do clients get referred for services other than health management?

- How does the facility help women manage status disclosure to their partners?

- Are you familiar with National guidelines and referral standards for GBV in Nigeria?

- Have you been trained on gender and or management of GBV survivors?

- In what ways do you help women access partner support for couple counseling, testing & antenatal?

- Do you have IEC materials conspicuously displayed in the facility that address gender issues related to HIV/AIDS?

- What is the average time it takes for clients to access services when they come on appointment?

- Do clients show preferences for seeing a care provider on the basis of their sex? When they do, how do you respond?
• What do you consider to be constraints to integrating gender into your work here in the facility?

KEY INFORMANT INTERVIEW: PLHIV CLIENTS (SOME SEGREGATED, SOME INTEGRATED)

• Do you think there are beliefs that discriminate against men or women in this community? If yes or no, explain.

• Are there beliefs/practices that make men or women access health services more or less?

• When you come to this facility, how long does it take to get attended to?

• Describe the attitude of health care providers in this facility? (friendly, harsh, accommodating etc)

• Is their attitude different towards men or women?

• Have health care providers attending to you ever asked about you experiencing gender based violence? Did you receive support if you indicated need?

• Do you feel stigmatized by the actions or words of care providers? Or by anybody else?

• Do you have any reservation about being attended to by a male or female care provider?

• Have you ever been taught how to negotiate condom use in your relationships?

• Were you ever counseled on family planning options available to you?

• Do you think you have a say along with your partner on the number of children you want to have? Explain why?

• Do you feel confident to seek legal aid and pursue legal means to protect your rights if infringed upon?

• Do you have access to support group? If yes, how has the group benefited you? Have you benefitted from economic strengthening?

• Did you travel far or near to access service here?

• Is money ever a barrier to you accessing health care services? If yes, how?

• What services do you go for at the hospital? Are there differences in the services that men and women access at the facility?

• Does your partner (if any) know about your HIV status? If No, why?

• If yes, did you access couple counseling?

• Whose decision was it to access or not to access HIV services, you or your partner?

• What challenges do you think women face in accessing health care?

• What challenges do you think men face in accessing health care?

• What do you like best about the services you receive from this facility?
• What do you think can be improved in this facility to make you/women adhere to treatment more?

KEY INFORMANT INTERVIEW: GOVERNMENT

• Identify individuals—titles, functions, authorities, responsibilities, accountabilities

• What are the greatest gender challenges you face in your state? Country?

• What are the causes of these challenges?

• Policies—what policies, strategies mandates at state, national, international levels guide your work as it relates to gender?
  - Ask them to name specific documents at national, state, and international levels
  - Have you been asked to contribute to the development of specific policies/strategies?
  - Do you think the policies/strategies are clear, comprehensive, accurate, and realistic? Do they address the root causes?

• Are you able to implement the policies, strategies, etc.?
  - Why?
  - Why not?
  - Which ones?

• Are you required to report on the implementation of gender policies, strategies, etc?
  - If yes, how do you collect and verify the information?
  - If yes, to whom do you report the information?

• Who makes the policies?

• How would you recommend the policies be changed?

• Is ALL the data you collect disaggregated by sex?
  - By age?

• How are your funding levels and allocations determined?

• What% of your budget is for gender?

• Is gender funding tied to achievement of goals/objectives? If yes, which ones?

• Who collects data for you?

• Is data collection disaggregated by sex?
  - By age?

• Professional development
  - What proportion of senior and mid-level management is female? Male?
- What proportion of non-managerial staff is female? Male?
- Does the government (state or federal) have a proportion of senior level managers reserved for women?
- Is the advancement potential for men and women equitable at senior levels?
- If no, why not? What are the issues?
- Are there professional development opportunities for women who aspire to senior positions?
- Is there outreach to women/recruitment for women for senior level positions?
- To what extent are hiring, promotion decisions equitable from a gender perspective?
- Is “gender” a topic of capacity building that is available?
  - To whom is the capacity building available?
- Do you think that increasing the number of women in senior management would improve the health challenges in the country? Why or why not?
- To what extent is the staff “gender aware”? How is that assessed?
- Are you linked with counterparts in other states?
- Are you linked with international counterparts?
- Are the linkages through organizations/associations
- What are the greatest challenges YOU face overall and on a daily basis?
- If you could change the way your system is structured, how would you change it?
- What else would you do to help improve gender disparities, inequalities, and human rights abuses?

**KEY INFORMANT INTERVIEWS: MoWASD**
- Identify individuals at meeting—titles, functions, authorities, responsibilities, accountabilities
- What are the greatest gender challenges you face in your country?
  - How would you identify the most critical gender norms?
- What are the causes of these challenges/norms?
- What policies/strategies at national and international levels guide your work as it relates to gender challenges/norms in Nigeria?
  - Specific documents?
  - Who drafts the policies/strategies?
  - Do you think the policies/strategies are clear, comprehensive, accurate, and realistic? Do they address the root causes?
- To what extent is it possible to implement the policies, strategies, etc.?
- What are the primary difficulties in implementing them, and what could be done to improve the implementation?
- Are you required to report on the implementation of gender policies, strategies, etc?
  - If yes, how do you collect and verify the information?
  - If yes, to whom do you report the information?
- How are your funding levels and allocations determined?
- Is gender funding tied to achievement of goals/objectives? If yes, which ones?
- Are you linked with counterparts in other federal ministries around gender issues?
- What is your relationship with state MoWASD offices?
  - Regular, ongoing communication
  - Capacity building
  - Site Visits
  - Data collection
  - Other
- Are you linked with international counterparts?
- Are the linkages through organizations/associations?
- What are the greatest challenges you face overall and on a daily basis?
- If you could change the way your system is structured, how would you change it?
- What else do you think should be done to help improve gender disparities, inequalities, and human rights abuses?
- In what ways is MoWASD linked to NACA, the Ministry of Health, and other major agencies working to prevent, treat, and care for HIV+/at-risk HIV clients?
- Professional development
  - What proportion of senior and mid-level management is female? Male?
  - Do women who aspire to senior positions have access to professional development opportunities?
- Do you think that increasing the number of women in senior management throughout government would improve the health challenges in the country?
  - Why or why not?
- To what extent is the staff “gender aware”? How is that assessed?
FGD WITH CAREGIVERS OF OVCS (M&F)

- What is the link between OVC and HIV?
- What are your primary activities?
- When you became involved as a caregiver, did you received training?
- What are the greatest challenges you face in your work? How do you overcome them?
- What provides you with the best support and assistance?
- What role do men and women in this community play in family health? Who takes health decisions, who pays for the services and who cares for the sick?
- How far or near is the closest general hospital (providing HIV/AIDS services) to you?
- Is money ever a barrier to you accessing health care services? If yes, how?
- What services do you go for at the hospital? Are there differences in the services that men and women access at the facility?
- Have you (or your partner ever accessed HIV services including taking HIV test at the general hospital? If yes, what was your experience?
- Whose decision was it to access or not to access HIV services, you or your partner?
- If you were HIV positive, would you disclose your status to your partner or any member of your family? Give reasons.
- (If HIV positive) Have you ever been stigmatized because of your status? By who?
- (If HIV status not known) How are persons living with and affected by HIV treated in this community?
- Have you participated in any community based program that is aimed at promoting health for men, women and children? Describe the program and your participation.
- Which community based organizations running health programs are you familiar with?
- What needs to happen for men and women equally to equally enjoy good health in the advent of HIV & AIDS? Your recommendations.

FGD WITH MEN HAVING SEX WITH MEN (MSM)

- Tell us about yourself, your experience being in what is considered a sexual minority group, what do you do, age bracket and aspirations in life.
- How would you define masculinity and femininity within this group?
- Have you ever experienced violence before as a result of your sexual orientation or gender identity? By whom? (IPV, Family members, police, transactional sex partners?)
- Are there cases of sexual coercion amongst persons within the community?
• What is the frequency of condom use within this community? And do you readily access condoms?

• Do we have persons living with HIV in this community? What have been their experience accessing HIV services in the health care facilities?

• Who do you approach when in need of emotional and physical health services?

• How does this community protect itself? What is the leadership structure available?

• Are there persons in this community who have heterosexual partners?

• Are there persons in this community who engage in sex work?

• What is the impact of the anti-same sex marriage law passed in Nigeria on the community?

**FGD WITH SW (SEX WORKERS)**

• What age brackets are you?

• Are you single, married, divorced or widowed?

• What is the level of education within this community?

• Can you share with us what growing up was like? – Family life, access to resources, parental guidance etc.

• Did you ever experience any form of violence growing up? (sexual, physical, emotional)

• What was the age of sexual debut for you?

• What is the motivation for choosing sex work?

• Is the use of alcohol and or drugs common in this community?

• How aware are you about HIV infection? Share what you know.

• Do you use condom correctly and consistently?

• Which condom is mostly accessible and used – female or male condoms?

• How easy is it for you to negotiate condom use with clients?

• Do you have steady boyfriends/husbands and do you use condom with them? If No, why not?

• Does your boyfriend/husband know you are a sex worker?

• What could make you not use condom with a client?

• Have you experienced rape before in the course of your work? And by whom?

• Do you feel confident to pursue legal recourse if your rights are infringed upon? Do you have access to legal aid?

• What has been the relationship between the sex work community and police?
- Have you taken a HIV test recently? If not why?
- If positive, will you continue in the line of work?
- Do you have clients who insist on anal sex? Is such practice common in the community?
- How easy is it to access health care in health facilities? Have you ever had to disclose the nature of your work to access services? If yes, what was the reaction of the health worker(s)? (Interviewer to keep in mind the possibility of recurring sexually transmitted Infections)
- Have you or family member faced stigma and discrimination before as a result of the sex work you do? Share experience
- What is the life of a sex worker like? How many clients must you have a day to make ends meet?
- What could motivate you to stop sex work?

**FOCUS GROUP DISCUSSIONS: PLHIV CLIENTS**
Some segregated; some integrated

- Do you think there are beliefs that discriminate against men or women in this community? If yes or no, explain.
- Are there beliefs/practices that make men or women access health services more or less?
- When you come to this facility, how long does it take to get attended to?
- Describe the attitude of health care providers in this facility? (friendly, harsh, accommodating, etc.).
- Is their attitude different towards men or women?
- Have health care providers attending to you ever asked about you experiencing gender based violence? Did you receive support if you indicated need?
- Do you feel stigmatized by the actions or words of care providers? Or by anybody else?
- Do you have any reservations about being attended to by a male or female care provider?
- Have you ever been taught how to negotiate condom use in your relationships?
- Were you ever counseled on family planning options available to you?
- Do you think you have a say along with your partner on the number of children you want to have? Explain why.
- Do you feel confident to seek legal aid and pursue legal means to protect your rights if infringed upon?
- Do you have access to support group? If yes, how has the group benefited you? Have you benefitted from economic strengthening?
• Did you travel far or near to access service here?
• What services do you go for at the hospital?
• Does your partner (if any) know about your HIV status?
  – If No, why?
  – If yes, did you access couple counseling?
• Whose decision was it to access or not to access HIV services, you or your partner?
• What challenges do you think women face in accessing health care?
• What challenges do you think men face in accessing health care?
• What do you like best about the services you receive from this facility?
• What do you think can be improved in this facility to make you/women adhere to treatment more?
ANNEX VI: DISCLOSURE OF ANY CONFLICTS OF INTEREST

NONE
For more information, please visit
http://www.ghpro.dexisonline.com