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ACCOUNTABILITY FOR HEALTH EQUITY: GALVANISING A MOVEMENT FOR UNIVERSAL HEALTH COVERAGE

Editors Erica Nelson,
Gerald Bloom and Alex Shankland



Notes on Article Contributors	v
Notes on Multimedia Contributors	xi
Foreword	
The International Health Partnership for UHC 2030 (UHC2030) Core Team	xiii
Introduction: Accountability for Health Equity: Galvanising a Movement for Universal Health Coverage	
Erica Nelson, Gerald Bloom and Alex Shankland	1
Introduction to Multimedia	
Sophie Marsden, Karine Gatellier and Sarah King Vaishali Zararia, Renu Khanna and Sophie Marsden Denise Namburete and Erica Nelson	17
Health Accountability for Indigenous Populations: Confronting Power through Adaptive Action Cycles	
Walter Flores and Alison Hernández	19
Inverted State and Citizens' Roles in the Mozambican Health Sector	
Jose Dias and Tassiana Tomé	35
Accountability and Generating Evidence for Global Health: Misoprostol in Nepal	
Jeevan Raj Sharma, Rekha Khatri and Ian Harper	49
The Political Construction of Accountability Keywords	
Jonathan Fox	65
Key Considerations for Accountability and Gender in Health Systems in Low- and Middle-Income Countries	
Linda Waldman, Sally Theobald and Rosemary Morgan	81
<u>Gendered Dimensions of Accountability to Address Health Workforce Shortages in Northern Nigeria</u>	
Fatima Lamishi Adamu, Zainab Abdul Moukarim and Nasiru Sa'adu Fakai	95
Reducing Health Inequalities in Brazil's Universal Health-Care System: Accountability Politics in São Paulo	
Vera Schattan Coelho	109
Making Private Health Care Accountable: Mobilising Civil Society and Ethical Doctors in India	
Abhay Shukla, Abhijit More and Shweta Marathe	129
Neglected Tropical Diseases and Equity in the Post-2015 Health Agenda	
Emma Michelle Taylor and James Smith	147
Glossary	159

Gendered Dimensions of Accountability to Address Health Workforce Shortages in Northern Nigeria

Fatima Lamishi Adamu, Zainab Abdul Moukarim and Nasiru Sa'adu Fakai

Abstract Northern Nigeria has some of the worst health indices in sub-Saharan Africa. Poor health outcomes are the result of multiple factors, including the lack of front-line health workers in rural and hard-to-reach areas. In 2012, funded by UK aid and DFID, the Women for Health programme was created to address the issue of gendered barriers of access to health education programmes and the subsequent dearth of nurses and midwives. It emerged that a different kind of 'accountability' was required to achieve improved maternal health outcomes: holding to account powerful actors within the community for their role in creating barriers of access to education for women and girls, as well as barriers to the retention of female health workers. This article, drawn directly from programme activities in Jigawa, Kano, Katsina, Yobe, and Zamfara states, documents strategies to shift gender norms that limit women's professional choices and their access to quality maternal health services.

Keywords: social accountability, maternal health, human resources for health, Northern Nigeria, health education, gender dynamics, health inequity, social determinants of health.

1 Introduction

The northern region of Nigeria has some of the worst health indices in sub-Saharan Africa (NPC and ICF International 2014; WHO 2017). In one recent review of progress across a range of health interventions in all states between 2000 and 2013, indicators show a clear stagnation and decline of health system functioning in the northwest and northeast regions when compared with other regions of the country (Wollum *et al.* 2015). These poor health outcomes are the result of multiple factors, one of which is the shortage of front-line health workers, particularly in rural and hard-to-reach areas of the region. While skilled health workers are crucial to the functioning of any health system, the

northern region of Nigeria has suffered limited financial investment and the requisite political will to ensure sufficient health worker coverage.

In light of this challenge, Women for Health (W4H), a UK aid–DFID-funded programme established in 2012, worked with communities in five states in Northern Nigeria to enable young women to access (and maintain access to) the necessary education and training to become front-line health workers. After identifying factors associated with the dearth of front-line workers, and in particular those responsible for maternal health care, W4H created community support mechanisms to both identify and support the entry of promising young women into the professional health workforce. This support carried through from identification to graduation to ensure retention, ownership, and sustainability in producing a new generation of health workers to serve the population needs of the northwestern and northeastern regions of Nigeria.

Through engaging and empowering communities to address this gap in health workforce coverage at the local level, it became clear that a different kind of 'accountability' was required: in this case, a holding to account of powerful (largely male) actors within the community, and a challenge of existing gender norms that created barriers to the training and retention of female health workers. The aim of this article is to document community efforts towards mobilising young women to become health workers, and how the process challenges the existing gender norms that limit women's marriage options. The content of this article is drawn from the experience of W4H, established in 2012 to support five northern states of Jigawa, Kano, Katsina, Yobe, and Zamfara to increase training of female health workers, with the aim of improving health worker coverage at primary health-care facilities in rural and hard-to-reach areas of the northwestern and northeastern regions.

2 Inequity as the root of the 'human resources for health' (HRH) crisis in Nigeria

Current understandings of health worker shortages and their impact on health were brought to global attention in the 2006 World Health Report, *Working Together for Health* (WHO 2006). The report defined the HRH crisis as the critical shortage of front-line health workers. It identified 57 countries, mostly in Africa, where the national ministry of health failed to ensure the minimal threshold of health workforce density (defined as 2.3 health service providers per 1,000 individuals).

In some respects, Nigeria is doing better than many neighbouring countries with a total of 0.39 doctors and 1.24 nurses per 1,000 people as compared to the sub-Saharan African average of 0.15 doctors and 0.72 nurses per 1,000 (*ibid.*). However, when this data is disaggregated by state and region, the stark inequity of health worker distribution is revealed. The crisis of HRH in Nigeria is a 'northern' problem. The northern regions (broken down into northwest, northeast, and north central) have fewer health workers and fewer health training institutions (HTIs) than other regions, in spite of having the greater total population

and higher levels of ill health. For example, in 2012 there were 27 accredited medical training schools in the whole country, the majority of which (78 per cent) were based in the southern region (Federal Ministry of Health Nigeria 2016).

To meet the minimum World Health Organization (WHO)-recommended HRH threshold for nurses and midwives by 2030, Keller *et al.* (2013) concluded that key states in Northern Nigeria would have to substantially increase enrolment in health training programmes. This increase would be by a factor of 20.6 for Jigawa, 19.4x for Kano, 26.5x for Katsina, 14.7x for Yobe, and 17.6x for Zamfara states. ‘Without these massive investments’, they argued, ‘millions of Nigerians will not have access to basic health services’ (*ibid.*: 4). Another characteristic of the HRH crisis in Nigeria, beyond regional disparities, is the unequal distribution of health workers across rural areas and primary health-care (PHC) facilities. In Katsina State, for example, 90 per cent of the midwives employed by the Katsina State government work in Katsina City (Katsina State HRH policy 2012). Furthermore, there is the problematic concentration of health workers (including doctors, nurses, and midwives) in the tertiary levels of care (Federal Republic of Nigeria 2007: 19).

3 Addressing interconnected challenges to health workforce shortages: Women for Health’s holistic approach

In a technical proposal, Health Partners International (2012) identified four interconnected challenges to account for the shortage of health workers in rural Northern Nigeria: first, a failure to attract and train sufficient numbers of female health workers; second, a failure to deploy female health workers to rural health facilities and retain them in rural posts; third, a failure to address a multitude of governance inadequacies that perpetuate inequity; and fourth, a failure to address women’s subordinate position in society and the socio-sexual norms of female modesty, respectability, and honour. W4H structured its programme of work in Northern Nigeria to address each of these issues in a holistic way.

3.1 Attracting and training a sufficient female health workforce in Northern Nigeria

One of the key priorities of families is to protect the moral integrity of their daughters by marrying them off early (Perlman *et al.* 2017). The average age at first marriage is 15.3 years in the north, with the lowest being in Zamfara State at 14.4 years (NCP and ICF International 2014), and the percentage of women aged 15–19 that began child-bearing was 32.1 per cent and 35.7 per cent in the northeast and northwest respectively. In addition, cultural perceptions of girls as childminders, ‘marriage material’, and a burden to the family influences their educational attainment in contemporary society (Mercy 2017). This means that many young women miss out on the educational opportunities that could facilitate progress into a career of their choice (Perlman *et al.* 2017). The anticipation of early marriage also reduces educational or training aspirations. For unmarried women who do get as far as enrolling in training courses, the primacy of marriage

leads many to withdraw before completing their training. Indeed, it is not uncommon for training courses to be treated as a 'waiting room for marriage' – a means of hiding the fact that a husband has not yet been secured; or a place to keep young unmarried women busy until a husband is found. In her doctoral research, Adamu (2000) reported several such views of mothers. Within this context, pursuing a health career is therefore a daunting task.

3.2 Training and retaining female health workers in rural posts and primary health-care facilities: the impact of socio-sexual norms

Within the context of the W4H programme, one key factor in the health worker shortage crisis has been the inadequate provision of public health education that meets the needs of female students. This can mean, on the one hand, biased admissions practices in health worker training programmes that give preference to male students, and to students from urban areas. It can also mean a lack of consideration of the specific needs of female students, and female staff. At the start of the W4H programme, it was clear that there was little to no gender sensitivity or gender mainstreaming of health education institutions, and therefore no consideration of what actions and institutional reforms would be required to enable women to study and teach without compromising on their family responsibilities (per existing gender norms). Nor did these institutions make provision for the particular safety and safeguarding needs of female students and staff (SurrIDGE, Moukarim and Fakai 2016).

Once trained, there is the issue of retention, particularly within PHC facilities and rural health posts. In the predominantly Muslim northwestern and northeastern regions of Nigeria, religious and cultural norms contribute to both the difficulty in attracting and retaining female health workers who originate from other regions of the country, and to attracting and retaining women of the Muslim faith for whom living apart from their husbands is not an option. Under Islamic family law, a husband is expected to have rights and control over his wife's mobility (Adamu 2008; Imam 1993). Consequently, a 'good' wife accepts deployment away from her husband's place of residence with his permission only.

In a qualitative study of health workforce deployment in Katsina, Zamfara, and Jigawa states, 60.2 per cent of female health workers (n=24) reported their willingness to accept a rural posting; however, only 25 per cent of their husbands would permit them (Adamu 2013: 3).¹ One midwife said: 'No matter the incentive my husband will not permit me' and 'No incentive will compensate for my children's education.' (*ibid.*). In the same study, another sociocultural factor identified is the concern women have that their absence from the marital home will result in their husband taking another wife, or a loss of influence in a polygamous family because of long absences, or of being accused of abandoning a husband and children by in-laws. As noted in the technical proposal (Health Partners International 2012), a refusal to move into a rural posting is often justified on religious grounds, but the reality may

be attributed to women's limited negotiating power and the inability to balance the demands of a health career and family obligations. In this study, one husband reflected the wider view of male household heads that having women away from the home is problematic because, 'she is the only one taking care of the children and the house'. The proposal concluded that 'in the absence of support from their husbands, families or the wider community, there is too much to lose in accepting or staying in a rural post' (Health Partners International 2012: 2).

The need to support communities to produce their own health workers is imperative, considering the fact that 39 per cent and 26 per cent of women in the northwest and northeast regions respectively, stated that they had serious problems accessing care due to a lack of female providers (NPC and ICF Macro 2009). This is particularly important where social norms prohibit women from receiving care from male health workers, a common situation in rural areas of Northern Nigeria. In a W4H study, one community leader in Katsina was quoted as saying,

I visited a health facility in this community where a male health worker was attending to a woman after delivery. There was a lot of intimacy in the process which is not acceptable in our culture and in our religion. That was when I decided my wife will never give birth in these facilities. (Surridge 2017)

This remark aligns with the statistical data on births in the northwest and northeast regions, where the overwhelming majority of women report at-home births, and the indices of maternal and child mortality are ten times higher than in the southwestern region of the country (NPC and ICF 2009). In short, as stated in a Save the Children report:

if the North West region was a country, it would have a population of nearly 40 million and its rate of skilled birth attendance would be the second lowest in the world. The northeast region would have over 20 million in population and the fourth lowest birth attendance in the world (Keller *et al.* 2013: 7).

These stark geographic inequities extend beyond the circumstances of birth and the survival of mothers and infants. In the most recent Nigeria Demographic Health Survey, it is clear that women in the northeast and northwest regions report substantially lower percentages of access to antenatal care, and accessing care in general due to a lack of female providers. Further indications of inequity become apparent once the inter-regional data is taken into account. The states selected for participation in the W4H programme have, as is shown in Table 1, some of the worst maternal health indicators in the country.

4 The Foundation Year Programme: the intervention

Against this background, W4H, as funded by UK aid–DFID, created the Foundation Year Programme (FYP) in 2012. The FYP was designed to help young women from rural areas raise their level of educational achievement to meet the standards required to enter schools of nursing, midwifery, and health technology, taking into account both academic

Table 1 Health indices in Women for Health intervention sites

Indices	Jigawa	Kano	Katsina	Yobe	Zamfara
Maternal mortality rate/100,000	950	1,025	590	1,549	1,025
Delivery by health professional (%)	76	5.1	5.1	3.1	22.3
Facility base delivery (%)	6.7	6.7	23.6	7.5	5

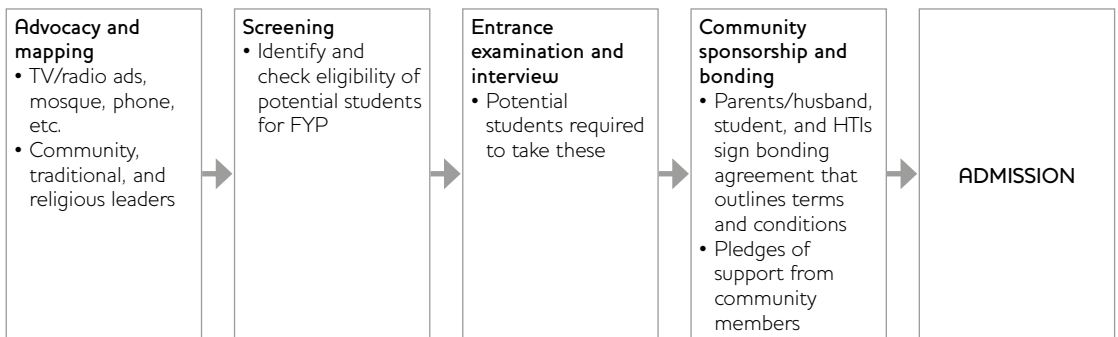
Source NPC and ICF International (2014).

challenges, gendered social norms, geographic, and cultural barriers that have hindered the creation of a female health workforce sufficient to serve the northern region. The FYP is a bridge programme intended for girls from rural communities who have studied science at senior secondary school level, but who do not have the required five credits for entry into nursing, midwifery, or community health extension worker (CHEW) training courses, or alternatively, have the credits but not the capacity to pass the required entrance exams. The FYP is designed to support the girls to gain the required credits and also to build the knowledge, skills, and attributes that will enable them to be successful as students and in their future profession as a nurse or midwife.

The FYP has two strands: a bridging strand and a preparatory strand. The bridging strand enables students to study science subjects as well as English and Maths for which they need a credit. The six months' preparatory strand is for students who already have all the required credits for entry into an HTI but who would benefit from additional support to prepare them for the entrance examination and to develop the knowledge, skills, and attitudes they will need to be successful and confident learners. By December 2016, 478 rural young women, married and unmarried, were enrolled and in training to become nurses, midwives, and CHEWs, with the expectation that 110 will be graduating as health workers in 2017. The FYP is also expecting an additional 190 graduates of the programme in 2018.

4.1 The Foundation Year Programme selection process

The selection criteria for the FYP starts with selecting a PHC facility or hospital that lacks either a female health worker, or lacks a health worker that is consistently local. Once selected, there are a range of community engagement strategies employed by W4H; for example, making an advocacy visit to the Emir, religious leaders, and imams responsible for the towns and villages around the health facilities. Once the collaboration of an Emir is achieved, the next step is to call together district heads and village heads to the Emir's palace where the FYP working group (interagency government team) introduces the programme and explains the criteria for gaining admission. Other methods of sensitisation involve working with religious leaders in mosques after prayers, communication campaigns via mobile phone, and other mediums to generate awareness of the programme, and to recruit eligible young women from the hospital or health facility

Figure 1 The Foundation Year Programme selection process

Source Authors' own.

catchment areas. The result of these efforts has been a substantial turnout of young rural women interested in joining the programme.

The selection criteria for FYP participation began with requisite documentation of educational credentials, an identification letter from their village or local government leader, and a statement of interest. Community and religious leaders interviewed potential candidates, and those who met all the requisite criteria were then asked to sit an entrance qualification exam. An oral interview was held immediately after the examination for those successful in the written exams. Collated examination results (written and oral) were forwarded to the Health Training Institution hosting the FYP who would use the predetermined cut-off grades to produce the final list. An additional consideration was to ensure a representative proportion of students from every selected local government area (LGA), based on LGA populations. All students that reached the cut-off grade were accommodated. The selection process is presented in Figure 1.

It is important to reiterate that supporting young women from rural areas to gain admission to HTIs is only a first step to addressing the health worker shortages in northeast and northwest Nigeria. It is also crucial to create a supporting and enabling environment for the education of girls and young women at the community and school level. This can only be achieved through significant changes to both the community-level and institutional cultures, including student welfare mechanisms, guidelines on the professional conduct of staff, and ensuring the safety and security of the learning environment.

4.2 Community action

Any strategy aimed at promoting gender and health equity in Northern Nigeria must first address potential areas of cultural and religious conflict in the minds of husbands, families, and the wider community. Failure to do so will result in doing more harm to women than good. The FYP's guiding ethos in negotiating these gender dynamics was one of 'do no harm', taking great care to create an enabling environment

for the training, recruitment, and retention of female health workers without alienating potential male allies.

One way the FYP operated in respect of existing cultural norms, was to make clear to participating communities that solving their localised health worker crisis – given the limits on married women's freedom of movement – was to support the creation of a local female health workforce. If communities continued their reliance on female health workers from urban or distant areas, they would run the risk of losing the health worker if her husband demanded her to return, or denied her permission to travel. In this sense, the community is ultimately accountable for the production of a reliable workforce capable of meeting the needs of local women. Through this process of raising awareness, it became possible to make the financial and social costs associated with the health training a social and communal responsibility (note: where a candidate was not able to secure the needed financial support, the programme provided funding through its grants and incentives scheme).

Within this context of a social contract, the FYP working group would meet with individual FYP programme candidates, together with her parents or husband and with other key community gatekeepers. The objective of these initial meetings with candidates and their extended social and familial networks was to create awareness – at the community level – of FYP expectations of family, extended family, and broader community support of the programme participants. This involved signing collective bond forms and consent forms, not just for the young female participants, but also for her family members and community leaders. This commitment includes financial and logistical support, as well as emotional and social support to the FYP participants, from the beginning of their educational programme through to their placement at a health post, clinic, or hospital.

Recent data on the FYP shows that 57 per cent of participants report receiving financial support from their communities, over 90 per cent report receiving advice and prayers, 23 per cent were visited in school by their communities, and 46 per cent have received phone calls (W4H 2017). In order to ensure the successful transition of FYP students into HTIs, and subsequently into full-time employment, a bonding agreement has been devised in consultation between stakeholders. The bonding agreement sets out the responsibilities of each partner as follows: (1) State Ministry of Health (SMoH) to accept all FYP students who pass the entrance examination into nursing, midwifery, or CHEW training at an HTI upon completion of the FYP; (2) SMoH and Ministry of Local Government to offer a full-time, pensionable appointment to the student upon completion of training; and (3) student to commit to returning to work within her community/LGA upon completion of training.

Across 912 communities and 1,617 married and unmarried young women and mothers, this bond-pledging has largely been successful.

Box 1 A case of community sponsorship

Fatima Lami is from the Iggi community in Jigawa. It has a population of 26,700 and is made up of 14 community wards. It has a PHC facility but does not have a health worker. The nearest referral facility for women is in Birnin Kudu about 45km from Iggi or Dutse (40km). The community had set up a small committee to collect the pledges made by community members every quarter. The committee treasurer Malam Umar is responsible for documenting the pledges from both family members and community pledges, collecting them when due and making sure that these pledges are redeemed by the FYP students. These are documented in a notebook for each student. Pledges redeemed for Fatima include two plates of Garri,² 12 bars of bathing soap, cream, 18 bars of washing soap, seven packets of detergent, NGN600 [about US\$1.67], one packet of cabin biscuits, six packets of detergent, 12 notebooks, and visits to her in the school by the community.

My interest is in my daughter's education. A lot of suitors have come to ask for her hand in marriage and I have told them that she has to finish school first. She currently has a suitor who is also a graduate of NCE [National Certificate of Education]. I have made my stand, she will marry after school.³ (Fatima's father)

Source: Community dialogue meeting, Jigawa State, W4H.

However, in the first and second cohorts of the FYP, there were several reported cases of husbands negating on their pledge to permit their wives to attend training as health workers. Despite the FYP's efforts to achieve 'no harm' to the young, there were still substantial barriers to success. Negative pressure to drop out did not just fall on women, but also on their male partners. Some of those husbands who permitted their wives to enrol in the FYP were then called names such as *dankwali ya jawo hula* (scarf drags hat)⁴ or *mijin ungwazoma* (husband of birth attendant), and were labelled 'yes ma' husbands. This social pressure resulted in some husbands withdrawing their wives from training. There were also cases of FYP participants' husbands going polygamous or seeking divorce as a consequence of the wife's training and absence. While increased dialogue at the community level, in particular with religious and community leaders, has helped mitigate some of these challenges, they still remain. As members of the FYP working group, religious and 'traditional' leaders have played an integral role mediating and resolving these interrelationship and marital struggles. They also helped the programme to identify key messages from religious texts that emphasised the importance of women working to save lives, and to formulate the messages to reach rural communities.

Some of the backlash by FYP participants' husbands in the first two years of programme implementation helped push W4H to engage more proactively with religious and 'traditional' leaders. Four years of health worker training can be a transformative experience for rural young women, and this requires additional social, emotional, and psychological support to prepare them for their new realities. The capacity of these young women was built so that they could become local champions across the cohorts of the programme. In an assessment conducted among three cohorts to identify the level of empowerment, and how much the young women are serving as role models, the reports show that 53 per cent of 313 participants in 2015 reported feeling empowered in terms of their confidence level, their ability to negotiate for themselves, make decisions, advocate for other young girls, and in serving as role models in their communities. The figures rose to 89 per cent of 321 participants in 2016, and 82 per cent of 333 participants in 2017 (Surrridge, Moukarim and Fakai 2016, 2017). One graduate explained:

I was inspired into this profession because of difficulties my people are facing over the years when it comes to child delivery... Since I joined the programme I have become a local champion with many young girls looking up to me as their role model. They always see me as their saviour, meeting me at home, morning and night, for advices and services. (FYP midwife graduate in Kunchi)⁵

Despite the aforementioned challenges, the FYP is beginning to positively influence gender norms at the community level, and to build new relationships of accountability that help to ensure the training, recruitment, and retention of female health workers. Perlman *et al.* (2017) and Adamu (2004, 2008) have previously documented the priority that many parents in the northwest and northeast regions of Nigeria place on daughters' marriage prospects versus education. Under the current circumstances, many parents have sided and supported their daughters to sacrifice their marriages for training to become health workers. A community leader in one of the communities noted that:

I am encouraged by this initiative (FYP), especially as it relates to the issue of girl-child education. We do not take girl-child education seriously, perhaps that explains why we are facing a lot of difficulties. We don't have women to attend to our wives on our health facilities and in schools no teachers. (Ngbokai 2017: 29)

The effect of the FYP goes beyond the community to affect the running of HTIs.

5 Community and health training institutions linkages⁶

The involvement of educators *and* communities in the recruitment, selection, and support of FYP participants has contributed to the development of stronger collaborative ties and meaningful accountability relationships between health education institutions and the populations they serve. This section explores the nature and effect

of these strengthened relationships. Prior to the implementation of the FYP, there was limited communication and weak relationships between communities and HTIs. Although the HTIs would sometimes advertise educational opportunities on the radio/TV, they were not seen as institutions relevant to the community.

With the creation of the FYP and the first cohorts of successful participants, the relationship between HTIs and the communities involved began to change. The FYP students themselves become a crucial link or lever in an evolving accountability relationship between the health education sector, health services, and health users. To begin with, FYP students keep their home communities up to date on their experience and their progress. Family members relay their daughters' experiences in the health education sector to other community members. When back home from their studies, the FYP cohort representatives serve as role models and encourage other young women to follow their footsteps into health training. Current and former students frequently give advice to others on the practicalities and requirements of applying for the programme, which helps to spread the message of the FYP.

In addition to the linkages created via the students themselves, the HTIs involved in the programme also reach out to parents, male partners, and community leaders, inviting them to meet with school heads and educators. This initial visit gives parents, partners, and community leaders an opportunity to see where the female student will live and to understand the set-up. Beyond the initial visit, contact is maintained throughout between the participating HTIs and district heads, representatives of community organisations, tutors, and the FYP coordinator. This contact contributes to the enabling environment for the existing FYP cohort, as well as furthering the recruitment of future cohorts.

The result of this ongoing dialogue between participating HTIs and targeted communities of the FYP, is an increased awareness of the benefits of sending more girls and young women into health education (to meet community-level health worker shortages), and of working together to ensure the educational success of each cohort. Over the course of the programme, W4H has documented not only an increase in the number of applications for the FYP, but also for nursing and midwifery training more broadly. There has also been a shift in attitudes among community members towards HTIs which, in the past, were seen as 'out of reach'. The HTIs are no longer seen as serving only those girls partnered to, or the daughters of, the richest 'big men'. In fact, some participating institutions have changed their admissions policies to allocate specific spots to young women from rural areas.

The FYP has helped engender a new-found sense of pride in participating students and their families, both for their educational achievements, and for the fact that these students would be mixing with young women perceived as being of higher social and economic status. This sense of pride and purpose is contributing to shifting

attitudes of parents and communities, and galvanising them in support of girls' education. As one community leader remarked,⁷ 'I am ready and willing to take the lead as a champion for girl-child education and specifically for their entrance into health training institutions'. In regions where early marriage is a common practice, and a common factor in the truncated education of young women, this shift in attitudes is no small feat. The possibility that health education for young women creates is both a change in social and gendered norms, as well as the practical outcome of having more female health workers available to serve women's health needs in rural and otherwise neglected areas of the northeast and northwest regions of the country. The FYP has given communities a strong argument in favour of educating girls, and through the example set by FYP graduates, has opened up new professional aspirations. One FYP student training in nursing remarked,⁸ 'I have become a role model. My friends too have developed an interest, praying that they will have a similar opportunity later in life.'

6 Conclusion

As outlined in the previous sections, social, cultural, and religious perceptions limit the ability of women, particularly those from rural areas, to train and work as health workers in Northern Nigeria. The ultimate aim of W4H, namely the sustainable deployment of female health workers to rural areas, can only be achieved if these social, cultural, and religious perceptions are taken into consideration, and a supportive environment for female health workers is created. An additional factor critical to the success of the FYP, and to ensure the programme's contribution to a more equitable distribution of health workers, is the assurance that each student will return to work in a rural area upon completion of her studies. Hence all partners, including the student, her husband and family, her community, and LGA (who are responsible for employing students after graduation) must have a common understanding of this commitment, and their respective obligations, from the outset.

While it would be artificial and probably impossible to entirely separate those links that involve W4H and those that do not, it does seem that wider links, often led by community members are now being established. Through dialogue and community engagement, the FYP initiative has helped raise awareness about HTIs and has helped to create pathways for young women to develop careers in the health sector. A new form of social accountability has been engendered by the programme. Male leaders, partners, husbands, fathers, and other powerful actors within the communities involved now understand the real health impact of keeping young girls and women from educational opportunities and health worker training. To create a sustainable health workforce, these communities now understand that they have to be part of the solution, in this case through contributing to a supporting and enabling environment for the recruitment, training, and retention of young women as nurses, midwives, and front-line health service providers. The accountability relationships in the FYP travel in multiple directions – young women are accountable to their communities for their studies and for their successful

deployment, communities are accountable (and in particular adult men) for encouraging and supporting girls' educational attainment, and health training institutions are accountable for creating environments that are supportive and nurturing. Women for Health's Foundation Year Programme exemplifies what is possible when relationships of mutual accountability are established and sustained, on the basis of a shared goal of improving health outcomes and health equity.

Notes

- 1 For further project information see: www.gov.uk/dfid-research-outputs/project-closure-report-partnership-for-reviving-routine-immunisation-in-northern-nigeria-maternal-newborn-and-child-health-initiative-prinn-mnch.
- 2 Garri is processed cassava flakes, often taken with water and sugar.
- 3 Interview, March 2016, Iggi Town.
- 4 Meaning that the husband would follow his wife wherever she goes (scarves are worn by women and hats are worn by men).
- 5 Interview, November 2017.
- 6 A substantial part of Section 5 has been paraphrased from Mitchell (2015).
- 7 Interview, November 2017.
- 8 Interview, November 2017.

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