Interview with Gender Expert #2
Date of Interview: January 28, 2022

The gender expert interviewee was provided with the visual graphics and narrative description of the six syndromes presented in draft manuscript ahead of the interview. The interview transcript begins following affirmation of informed consent, and the interviewer verbally reviewing the six syndromes presented in draft manuscript.

INTERVIEWER: Did the system maps/syndromes resonate with you?
GENDER EXPERT: The write-ups of the syndromes were spot on. They delved into the issues of power dynamics, the inherent bias that we all have (for example, thinking a maternal health project is inherently gender focused and equitable). My question is: how can we think more about sustainability of programs? For example, USAID starts a five-year health program, working with government partners and CSOs to an extent, and then it closes out. The capacity that was built filters out too.

INTERVIEWER: What would sustainability look like vs. short-term projects?
GENDER EXPERT: That has to do with intention. If a project is about women, it needs to deal with the inherent structures that cause inequality in the first place. In Nigeria, family planning systematically is about controlling the number of children women can have. In a patriarchal system, men are in control of this. This is not a health problem, but a social-behavioral one that takes more than five years to change. Inherent biases, policies and laws also have to be addressed. Donors avoid getting at those systems, knowing that NGOs and activists have to deal with the aftermath.

INTERVIEWER: Who in the system is responsible for those kinds of things? Donors deal with gender systems as if they are politically neutral. Should we make recommendations about accountability when it comes to gender and power dynamics? Usually it is the NGOs, activist groups, women's groups who are dealing with these issues at a systems level, but they are not the ones being funded and having their capacity built.
GENDER EXPERT: Nigeria is experiencing a shrinking civil society space. Health systems strengthening is generally done by global health organizations such as Development Alternatives, Inc., an American-based global health firm that does training, builds infrastructure in health care, etc. But the smaller organizations focus on filling service gaps. During COVID for example, they focused on handwashing, making sure clinics can train enough health care workers, etc. Nigeria has allocated 1% of the budget to go towards health which took a while to get passed and still needs to be implemented. [Local] CSOs are pushing for sexual and reproductive health policy, gender equality, including in leadership in the health care system. Even though women are 70% of the health care system, they are at the lowest levels. Midwives and nurses went on mass strike recently. It is a problem that we have very few women's groups engaged in health decision-making specifically. Women are not a part of policy decisions about for example where to build a health center or how much families need to pay for health services. Their capacity is not built and often excluded from conversations in technical public health lingo.

A few years ago, I was in a meeting funded by the Gates foundation, using human-centered design to look at technical assistance [*referring to the Re-imagining Technical Assistance project by JSI/Sonder collective]*. MSH, USAID and other big orgs were there. In the room it was mostly men. Everyone was talking about technical assistance, health systems strengthening using technical lingo and not addressing gender issues. Only a handful of women were present and could speak to the technical elements.

INTERVIEWER: There are some progressive donors funding grassroots organizations to advocate at a national level about policy change. Is anyone doing that for health in your setting?
GENDER EXPERT: Government looks at civil society as the enemy. So, the narrative is that donors work closely with government, so government tells them what to do. This is to counter the fact that donors would come and dictate what needs to be focused on. Most of those decisions are made with limited contextual information or gender assessment in the first place. Maybe there was insufficient data (a DHS analysis from two years ago, for example). Donors have a fragile relationship with the government. It is part of how they decide who to work with. How do they balance the relationship between working with government and working with grassroots organizations?

INTERVIEWER: Privilege bias (syndrome two) says that people with privilege bias cannot imagine experiences of those with less privilege. They support putting systems in place to reinforce their own power without being aware of it. However, some of the mapping co-creators felt that the decision-makers *are* aware of it and reinforcing these systems intentionally. How much weight do we put on training people to examine their own privilege? Or will the systems be perpetuated regardless?
GENDER EXPERT: Intersectionality is important and not just about race, but also LGBTQ experiences. There is privilege bias from donors that is reinforced by how we treat them in terms of power dynamics. There is also privilege bias from someone like me – a middle class, educated Nigerian woman who lives in [an urban city]. Can we eliminate bias? No. But we can bring it to the fore. We are mindful of those biases. When it comes to health systems, those biases are almost bottom-line purposeful. Many of the people perpetuating those systems did not have good health care systems themselves – they are now accumulating wealth at the expense of public health centers. Avoid making a blanket statement around privilege, but instead look at it from an intersectionality lens. Make sure people have that awareness of how decisions impact different people.

INTERVIEWER: This syndrome expands on the idea that donors have been trained that their worldview is correct and so the way they address gender is correct. They may need to become more aware of their own privilege and be open to listening to the stories, narratives and data that tell them there is a different truth.
GENDER EXPERT: Idea of creating a privilege checklist. It's important for those with privilege to acknowledge that they are not infallible. For example, there was a health project to reach women using mobile devices. That might work in India or Kenya, but not in Nigeria. Even within different regions in Nigeria, it might not work given cell service and usage, etc. The women might not be able to power their phones, men take them away, and/or there is no funding to

collect data. There needs to be less talking and more listening. You need to learn to put yourself in another person's shoes to learn humility. This is key and must come out in the manuscript.

INTERVIEWER: Need more listening from donors, implementers *and* national health systems. Not a lot of examples of health workers being trained to become better listeners.
GENDER EXPERT: Health systems thinking about the social determinants of health is so important. Need gender integration in medical schools to teach them early on to think differently. A Nigerian artist recently drew an anatomical picture of a Black woman and a Black baby. Even as a young child, he never saw an anatomical picture of a dark-skinned baby/fetus in a medical depiction of pregnancy. That is an example of bias being implicit in the health system.

INTERVIEWER: Were there any "aha" moments reading these descriptions?
GENDER EXPERT: Reading syndrome number three really resonated. The fact that it was articulated as "assumptions do not get questioned" is so important. White privilege needs to come out. People who do not push back against funding does more harm to the development and growth of the organization in the long run. We talk about funding structures a lot. There is never enough money to do what we are supposed to do. If a clear goal of the donor is not to put a band-aid on the problem but to listen to what the people are saying. Getting them to listen and shift. Over the years, because GAVI is funding vaccines, and Gates is paying for polio, the government does not give money and are pocketing the money. Not necessarily the donor/implementing partner's problem but it's a problem and they are part of the problem.

INTERVIEWER: What else stood out for you?
GENDER EXPERT: Women's leadership and participation – having representation of women at higher levels of leadership is key – create a pipeline for women to be in decision-making positions. Funded programs for women are often about maternal mortality, i.e. women not dying, and helping women give birth, take care of children, etc. How can we accelerate putting more women in leadership positions, particularly in the health care system? Nigeria thinks it is more balanced between public and private, but in reality, I think it is 20% public, 80% private. People within the public sector still have their own private systems. Therefore, a lot of people have more faith in private facilities. At some private clinics you pay thousands of dollars to give birth. The public facilities that are supposed to be free, actually lack the resources to effectively provide care. Since we have so much private care in this country, how do we engage those private institutions in a way that a public/private partnership that is affordable for everyone? For me, I got many insights on how to engage with the government on health policy, from the workshops for re-imaging technical assistance in Nigeria. How bureaucratic our government can be, and how donors can be acting unilaterally. I appreciate the opportunity to expand insights into that intersection. It's important to recognize the role that CSOs in Nigeria are playing in this space. They are providing services, they are providing technical support. We need to recognize what they do, how they serve people. But, to be clear, they are also dealing with backlash from both government and their own beneficiaries. I'm realizing in speaking with you, I want to make a more conscious effort to engage with CSOs, organizations working on health, beyond service delivery, the organizations focusing on the policy and systems level. There are just a handful of

them, they are measuring what government is doing. They take funding from donors to do what the donor wants them to do, not what they themselves feel is important. It's the donor dictating.

INTERVIEWER: How do we broach the topic of decolonization as it relates to gender, and provide good advice to donors about what to do?
GENDER EXPERT: African feminism don't have a problem with the term 'decolonization.' I don't have a real answer except to say: the truth is the truth. The narrative coming out of Africa, is: we know what our challenges are. Though we may not have all the answers, we are learning and exploring what solutions might be in our own context. For donors, the key is collaboration, co-design and building capacity for people in the context of the program to take the lead. Recognize that although my capacity may not be up to yours, make the space to allow capacity to be built. We need to all came together to learn and build solutions.

INTERVIEWER: Thank you so much for your time and insights!