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Desk review on gender and social inclusion issues affecting the USAID Integrated Health Program in Sokoto State, Nigeria

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women and Children
CHC	Community Health Committees
CHEW	Community Health Extension Worker
CMAM	Community Management of Acute Malnutrition
CYP	Couple Years of Protection
DAPDA	Discrimination Against Persons with Disabilities (Prohibition) Act
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-based Violence
GDP	Gross Domestic Product
GII	Gender Inequality Index
GNI	Gross National Income
GPI	Gender Parity Index
GRB	Gender Responsive Budgeting
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health System Strengthening
IDP	Internally Displaced Person
IHP	Integrated Health Program
ISIS-WA	Islamic State-West Africa
ITN	Insecticide-treated Net
IUD	Intra-uterine Device
JCHEW	Junior Community Health Extension Worker
LARC	Long-acting Reversible Contraception
LGA	Local Government Area
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer
LLIN	Long-lasting Insecticide-treated Net
MDA	Ministries, Departments, and Agencies
MICS	Multiple Indicator Cluster Survey
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Ratio
MSM	Men who have sex with men
NACA	National Agency for the Control of AIDS
NAIIS	Nigeria HIV/AIDS Indicator and Impact Survey

NDHS	Nigeria Demographic and Health Survey
NGO	Non-governmental Organization
NSHDP	National Strategic Health Development Plan
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PMTCT	Prevention of Mother-to-Child Transmission
PWD	Persons with Disabilities
RMNCH+NM	Reproductive, Maternal, Neonatal, and Child Health, plus Nutrition and Malaria
SACA	State Agency for the Control of AIDS
SMC	Seasonal Malaria Chemoprophylaxis
SMBEP	Sokoto Ministry of Budget and Economic Planning
SMOH	State Ministry of Health
SOCHEMA	Sokoto State Contributory Health Care Management Agency
SRH	Sexual and Reproductive Health
SSHDP	State Strategic Health Development Plan
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TSHIP	Targeted States High Impact Project
UHC	Universal Health Care
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
VAPP	Violence Against Persons (Prohibition) Act
VLS	Viral Load Suppression
WDC	Ward Development Committees
WHO	World Health Organization
WTFR	Wanted Total Fertility Rate

Executive summary

USAID's Integrated Health Program (IHP) Task Order 5, led by Palladium International, LLC, works in Sokoto State, Nigeria to reduce child and maternal morbidity and mortality and to increase the capacity of public and private health systems to sustainably support quality primary health care services. Gender is intricately linked to health access and reproductive, maternal, neonatal and child health, plus nutrition and malaria (RMNCH+NM) outcomes. For example, imbalances in gender and power mean that many females face obstacles exercising autonomy about choice of sexual partner, contraception, number and spacing of children, and healthcare, each and all of which increases their risk for high-risk pregnancies, maternal deaths, and infectious diseases, including HIV. WI-HER conducted this desk review to examine the health status of women, men, girls and boys in Sokoto State and to identify gender and social inclusion issues affecting service quality, health programming, and health systems strengthening (HSS) outcomes. The review also looks at state policies that aim to address gender inequalities, to protect women and people with disabilities against abuse and violence, and to advance equitable services that are accessible to women, youth, and most marginalized groups. To carry out the desk review, the WI-HER team compiled available sex-disaggregated qualitative and quantitative data and examined a wide range of gender analyses/assessments, peer-reviewed publications, policies, guidelines, budgets, grey literature, and other relevant materials.

Nigeria's astounding statistics related to maternal and child mortality, HIV/AIDS, malaria, and TB burden, among many others, reflect the country's pervasive poverty, widespread inequality, lack of education, and insufficient access to services. Nigeria also experiences high levels of human trafficking for forced labor and sexual exploitation, as a point origin, destination, and transit. The North West of Nigeria—where poverty levels are high, infrastructure and governance are weak, and education rates are lower—is marked by conflict and instability. In addition, men and women are influenced by cultural and religious beliefs, resulting in large families and unequal gender dynamics. Sokoto State is among Nigeria's poorest performers in terms of health and development indices, especially in child mortality, maternal health, and malnutrition. In Sokoto, child marriage (marriage before the age of 18) is the norm.

Despite donor investments in the health sector in Sokoto and the prioritization of primary health care (PHC) and health care access by the state, preventable deaths and other harmful consequences continue to affect families and communities. Some of the underlying causes include inadequate and inequitable access to health information and services, weak health systems, inconsistent implementation of existing health and related policies, laws, and plans, inadequate funding and human resources, weak infrastructure, uneven distribution of facilities and human resources, and inadequate service quality. Additional challenges include insufficient state coverage of healthcare costs, correspondingly high out of pocket costs for patients, and challenges coordinating and tracking resources. While guidance for youth-friendly services exists, significant gaps in education, services, and access persist.

Several vulnerable groups in Sokoto are particularly affected by poor RMNCH+NM outcomes: poor, marginalized, and rural populations; youth and adolescents; lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations; people with disabilities (PWD); ethnic and religious minorities; people on the move; and survivors of gender-based violence (GBV). Given the poverty and limited economic opportunities across the North West and in Sokoto, these groups are more likely to be unemployed and underemployed. While gender and social and cultural norms heavily influence health access, some gaps in knowledge are apparent at the state level.

When considering the findings from this desk review and supported by global gender and social inclusion best practices, several recommendations to address gender and social inclusion issues in RMNCH +NM programming become clear. These broad recommendations are not for IHP to address alone, but rather are suggestions for the National and State Governments, USAID, IHP and other implementing partners in support of overall improved health outcomes.

Key recommendations:

- Conduct state-specific gender and social inclusion landscaping.
- Use sex- and age-disaggregated data and gender-sensitive indicators for more effective policies and programming.
- Develop local knowledge and capacity to integrate gender and social inclusion through innovative approaches.
- Ensure health service delivery and the health workforce meet the needs of men, women, boys, and girls.
- Prevent and treat obstetric fistula, especially for adolescents and other vulnerable groups, in collaboration with partners.
- Engage a range of visible influencers and use a positive deviance approach.
- Collaborate with donors and existing programs to change the narrative using social and behavior change communication.
- Address GBV holistically.
- Develop a strategy and related actions to combat human trafficking in the health sector.
- Leverage existing resources to achieve health and gender priorities.
- Collaborate with multi-sectoral actors.

The recommendations and findings from this broad and overarching desk review, as well as a future in-country landscaping, aim to inform more equitable, effective, and efficient RMNCH +NM strategies, activities, and sustainable change. This desk review will inform the gender and social inclusion strategy for integrating gender and social inclusion into policy enforcement, program design and implementation and mainstreaming gender into organizational culture and practices. IHP partners, led by Palladium, and a wide range of public and private actors have critical roles to play to ensure sustainable and equitable progress to reduce preventable morbidity and mortality and promote social wellbeing and development for women, men, girls, and boys in Sokoto State.

Introduction and background

USAID's Integrated Health Program (IHP) Task Order 5, led by Palladium International, LLC, works in Sokoto State, Nigeria to reduce child and maternal morbidity and mortality and to increase the capacity of public and private health systems to sustainably support quality primary health care services. WI-HER, LLC is responsible for gender integration and social inclusion within IHP and Task Order 5 addressing gender and social inequity related to primary health care and related health and social factors, including adolescent health, fistula, gender-based violence, child marriage, and human trafficking. WI-HER's work will focus on mainstreaming gender at the state level in Sokoto to advance gender equality, social integration at the facility and community level integrating of gender sensitive interventions into service delivery and clinical care so as to improve access to and quality of services and to achieve RMNCH +NM goals.

This desk review examines the health status of women, men, girls and boys in Sokoto State, and the social, economic, and political factors that influence health outcomes, including gender inequalities. It includes an analysis of existing policies, strategies, and guidelines to identify gender-related gaps and opportunities for policy development and understanding, health worker training and performance improvement, and organizational support and influence at the community level. This desk review will inform the gender strategy for the project, which will address gender, social inclusion, child marriage, male engagement, GBV, and related factors that impede sustainable capacity of systems to achieve increasingly positive RMNCH +NM outcomes. Obstetric fistula prevention and treatment will be addressed in collaboration with UNICEF and private sector actors. The gender strategy will use an innovative, results-oriented approach for integrating gender and social inclusion into program design and implementation and mainstreaming gender into organizational culture and practices, and will fulfill the tenets of USAID's Gender Equality and Female Empowerment Policy.[1]

Methodology

WI-HER LLC conducted this desk review to identify gender and social inclusion issues affecting service quality and health programming as well as HSS outcomes. The analysis examines gender and social inclusion considerations at all levels of RMNCH+NM programming within the health system (generally corresponding to the World Health Organization (WHO) HSS building blocks) to identify key challenges and opportunities for enhancing gender considerations and related impact.[2] To carry out the desk review, the team examined state policies, including gender policies, health worker recruitment and training guidelines, health system financing and budgeting, community engagement, and service delivery. The team also compiled available sex-disaggregated, qualitative, and quantitative data and background information related to gender and social inclusion to complement subsequent data collection.

Materials reviewed include peer-reviewed publications, policy papers, gender analyses, case studies, literature reviews, publicly-available data, project evaluations, government and international policies and strategy documents, state health and gender policy and strategy documents available online, donor-funded program documents, grey literature, and other relevant materials. Only data and publications from reputable journals or organizations were considered, along with policies and data produced by the countries themselves. To the extent possible, only literature from the past 10 years were considered, along with the most recent publicly available policies, strategies, and guidance documents. In addition, documents for review were identified using Google Scholar, through open access journals, the USAID Development Experience Clearinghouse (DEC), and Google searches for reports from over the last five years from key global organizations (including UNICEF, CARE, Human Rights Watch, UN Women, UNFPA, and WHO). The report also included a listing and high-level assessment of key gender policies

that have or have not been domesticated at the state level for the State. Documents were identified using the following key search words under Nigeria:

- gender
- female
- women's issues
- women's health
- women's rights
- male and female relationships
- male health
- male engagement
- girl's issues
- adolescent health
- people living with disabilities (and PWD)
- marginalized populations
- people on the move

Emergent themes were identified and used to guide the document structure and organize citations. Primary topics include:

- Reproductive health and family planning
- Maternal health
- Newborn and child health
- Nutrition
- Malaria
- HIV
- Gender norms, roles, and responsibilities
- Gender-based violence
- Marriage and divorce
- Gender norms related to sexuality
- Men and masculinities
- Governance and the health system
- Financing and budgeting
- Human Resources for Health
- Policies and guidelines about gender-sensitive care and service delivery
- Healthcare access and challenges
- Youth-friendly services
- Access to medication
- Social inclusion and vulnerable populations

The analysis was guided by USAID's Gender Policy and USAID Automated Directives System Chapter 205.[1, 3] The research team used USAID's five gender domains (laws, policies, regulations, and institutional practices; cultural norms and beliefs; gender roles, responsibilities, and time use; access to and control over assets and resources; and patterns of power and decision making) as a framework to identify key gaps, challenges, and opportunities for equity health improvements. WI-HER's research team collaborated to discuss, analyze, and triangulate information for conclusions presented.

Political, social, and economic overview of Nigeria and Sokoto State

The Federal Republic of Nigeria is located on the western coast of Africa against the Gulf of Guinea and borders the countries of Benin, Cameroon, Chad and Niger. The country has 36 states and a Federal Capital Territory (FCT) known as Abuja; and the state of Sokoto is located at the top west corner of the country, bordering Niger. It is important to understand the state of Sokoto within the broader national context, so the desk review will provide an insight into gender and social integration in Nigeria as well as an examination of Sokoto specifically.

Nigeria is a federal democratic republic composed of legislative, executive, and judicial branches whose powers are vested by the Constitution of Nigeria in the National Assembly, made up of the House of Representatives and the Senate, the President, and the federal courts, including the Supreme Court. The Sokoto State government, as in each state in Nigeria, is also divided into legislative, executive, and judicial branches. The executive branch, headed by the State Governor, currently Aminu Waziri Tambuwal, has the power to develop and execute policies in the state, which is comprised of 23 Local Government Areas (LGAs).

Nigeria is the most populous country in Africa; as of 2020, the projected population is 204 million.[4] The population is very young, with a median age of 18.1 years. There are 106 males for every 100 females in the country. However, females have a slightly longer life expectancy at 55.2 years, compared to 53.5 years for males.[5] With an annual population growth rate of 2.6%, Nigeria is the seventh most populous country in the world.[4] The population is becoming increasingly urban with 52.0% of the population projected to be living in urban areas in 2020.[6] Nigeria is home to 350 different ethnic groups and over 250 languages.[7] Although English is the official national language, children are taught in one of Nigeria's main indigenous languages—Hausa, Igbo, or Yoruba, depending on the state— in primary school.[8, 9] Most Nigerians in the South practice Christianity, while northern Nigerians are predominantly Muslim; nationally the country is approximately 50% Muslim, 40-45% Christian, and 5-10% traditionalist or indigenous religions.[10, 11]

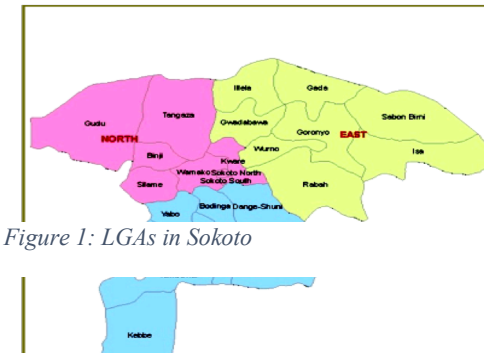

Figure 1: LGAs in Sokoto

Sokoto State, with its capital city of the same name, had an estimated population of 5.4 million in 2017 and, like the rest of Nigeria, has experienced rapid (3% per year) population growth over the past 50+ years. [12, 13] The population of Sokoto State, as with most of the northern states, is largely Muslim, although the exact percent is difficult to determine as it is not tracked in the census. The state implements Islamic, Shari'a law, which governs conduct and behavior. The Sokoto Caliphate, an Islamic Sunni caliphate, is considered the center of Islam in Nigeria.[14] Additionally, much of Nigeria's Shi'a minority resides in Sokoto.[15] The most prominent ethnic groups are Fulani and Hausa, with Zabarmawa and Taureg minority.[14] The most commonly spoken languages in Sokoto are Fulfulde and Hausa.[16] More than half of the population is under the age of 15 and 15% of the population lives in urban areas.[13, 16] The most common occupation is farming.[16]

In 2018, Nigeria had a gross domestic product (GDP) per capita of $2,028 USD, with an unstable GDP growth rate; annual GDP growth has been slowing since 2014, but saw a slight increase to 1.9% in 2018.[18] The GDP per capita in Sokoto was $1,274 USD as of 2007, which is the most recent information that could be located [19].[1] In 2018, 49.6% of women in Sokoto State were unemployed in

[1] Sourced from Knoema World Data Atlas, which does not indicate the primary source of this information.

the twelve months preceding the NDHS, compared with 13.7% of men.[8] At the national level, 62% of adults are literate.[20] Regional inequalities are evident across the country. In general, the north is much poorer and less developed compared to the south, which is wealthier, healthier, and more educated.[9] Poverty decreased in the North West between 2004 and 2013, from 61.39% to 59.08%, where the percent of people living in poverty declined, but the total number of people living in poverty increased due to population growth. The North Western region is home to 45 percent of the country's chronically poor.[12] Access to modern infrastructure is challenging in Sokoto and is not improving quickly. Between 2004 and 2013, people with access to electricity increased from 26.8% to 27.8% and the state is entirely without electricity an average of 16 days per month. More than 94% of homes had no access to improved sanitation in 2013, compared to 97% in 2004. Finally, access to improved water *decreased* from 64% in 2004 to 60% in 2013.[12]

Nigeria has experienced periods of instability, violence, and famine over the past few decades. In the Northwest of Nigeria poverty levels are high, infrastructure and governance are weak, education rates are lower, and period violence by armed groups causes significant harm in the general absence of state protection. Over the past several months over 60,000 people from Sokoto and Zamfara states were forced to flee and the United Nation High Commissioner for Refugees (UNHCR) has declared a level 2 emergency in the Maradi region of Niger, which is hosting these refugees.[20] While better known Islamic extremist group Boko Haram, designated a foreign terrorist organization by the US Government, operates in the North East, the violence in the North West is less organized and carried out by local militias as well as violence between communities and herders and farmers.[21] Additionally, Nigeria is source of significant international migration, with the net annual emigration rising from 96,000 in 2010 to 300,000 in 2017, with the majority moving the United States, UK, Cameroon, and Italy.[22]

The security situation in Sokoto has deteriorated recently according to UNHCR, forcing approximately 60,000 people to flee to Niger between early May and August of 2019.[20] Reasons for this surge in forced migration include "clashes between farmers and herders of different ethnic groups, vigilantism, as well as kidnappings for ransom in Nigeria's Sokoto and Zamfara States." Boko Haram has not been identified as connected to this violence. The migrant flow is primarily comprised of women and children who have recounted witnessing extreme violence against civilians including machete attacks, kidnappings, and sexual violence.[23] Al Jazeera reports that many of the violent attacks were carried out by gangs that reside in the surroundings forests, who enter communities to raid villages and steal livestock, killing dozens of people in the process. In response, many communities have formed armed self-defense groups, but these groups have been accused of killing bandits caught, rather than turning them over to law enforcement.[24]. Sokoto also faces threats of kidnapping, where girls are often shipped through Sokoto as a stop along the way to provide labor or other services in return for remittances sent to their families.[25] A strong belief in witchcraft in some parts of the country, including occasionally in Sokoto, can place children and young people, particularly girls, at risk. Although illegal, it is not uncommon for children to be used as human sacrifices in ceremonies intended to bring financial or political prosperity. Further, women and girls may be accused or suspected of witchcraft themselves and shunned by their communities. These communities withdraw social and community protections which makes these women and girls particularly vulnerable to trafficking and commercial sexual exploitation.[26] Understanding and measuring instances of such practices is incredibly difficult as they are both purposefully hidden and illegal. There is one shelter for victims of trafficking in Sokoto and multiple series of arrests of traffickers and rescues of trafficked persons have been made.[27] Still, Sokoto is one of eleven states, including both Bauchi and Kebbi, that have not yet signed onto the Child's Rights Act of 2003.[28, 29]

Health overview and outcomes in Sokoto

Health outcomes in Nigeria reflect the pervasive poverty and insufficient access to services faced by much of the population. For example, Nigeria is home to 13% of all global maternal mortality, 13% of child deaths, and one third of all deaths due to malaria. As one of only three countries globally with endemic

polio, the second largest population of people living with HIV/AIDS in the world, and more tuberculosis cases than any other country in Africa, Nigeria's struggle to meet the health needs of its population is apparent.[9]

The North West region is among Nigeria's poorest performers in terms of health outcomes. For example, it has the highest neonatal, infant, child, and under-five mortality rates in the country. However, Sokoto's performance on these indicators is better than the regional average, and better than the national average in all indicators except child mortality. As can be seen in Table 1 below, Sokoto's performance across health indicators varies, with particularly alarming rates of child malnutrition and stunting, a high fertility rate and infant mortality rate, and a concerning malaria prevalence.[8]

Table 1. Key health indices in Sokoto State and Nigeria

Indicator	**Sokoto State**	**National**	**Year**	***Source***
Life expectancy at birth (years)	Not available	54.0	2017	*World Bank*
Infant mortality rate / 1,000 live births	102	67	2018	*2018 NDHS*
Under-five mortality rate / 1,000 live births	197	132	2018	*2018 NDHS*
Maternal mortality ratio / 100,000 live births	Not available	512	2018	*2018 NDHS*
Total fertility rate (births per woman ages 15-49)	7	5.3	2018	*2018 NDHS*
Percentage of teenage women (15-19) who have begun childbearing	32.1%	18.7%	2018	*2018 NDHS*
HIV/AIDS prevalence-Adult population	Not available	1.5%	2018	*World Bank*
Malaria prevalence among under 5 years	54.7%	36.2%	2018	*2018 NDHS*
Diarrhea prevalence among under 5 years	18.5%	12.8%	2018	*2018 NDHS*
Prevalence of ARI among under 5 years	1.5%	2.6%	2018	*2018 NDHS*
Children <5 years stunted below-2 SD	54.8%	36.8%	2018	*2018 NDHS*

Reproductive health and family planning

In 2013, there were nearly 1 million girls and women of reproductive age in Sokoto, or 18.5% of the population.[30] In Northern Nigeria, where Sokoto is situated, men and women tend to have large families, influenced by cultural and religious beliefs.[30] The North West zone of Nigeria, of which Sokoto is a part, has the third highest mean fertility in the country. On average, women in Sokoto give birth to seven children, compared to a national average of 5.3.[8] The median age at when women first give birth is Sokoto is 18.3 years, compared to 20.4 years nationally. [8] As Sokoto State is governed by Shari'a law in addition to common law, the state recognizes polygamous marriages.[31] Polygamy (a marriage between one man and multiple women) is correlated with high fertility rates in Sokoto, where 36.7% of married women and 20% of married men reported being part of such a union, according to the 2018 NDHS.[8] This is because women in polygamous relationships have been shown to have lower negotiating and decision making power, as well as lower access to resources. Women who want to limit or space children may be unable to due to unequal gender dynamics within relationships and decreased ability to negotiate contraception use or access without a husband's approval. Furthermore, competition to bear children between wives in polygynous households has been identified as a driver of higher fertility in some settings. [32, 33] Nationally, men polled say that seven was the ideal number of children to have, whereas women wanted six children; however, in Sokoto women say that eight is the ideal number of children.[8]

Contraceptive use in Sokoto State is alarmingly low. According to the 2018 NDHS, 2.3% of married and sexually active unmarried women in Sokoto use any contraceptive method, with most of those—2.1%—using a modern method.[8] While this represents an increase in contraceptive prevalence from the 2013 NDHS,[34] coverage levels are still well below the national average of 16.6% and 12%, respectively, and they are the lowest in the country (along with Yobe state). Across Nigeria, women in urban areas with higher education are more likely to use any contraception, to use a modern method, and less likely to have unplanned pregnancies. Nationally, 22.7% of married women with more than secondary school education use any method of modern contraception, compared with 4.3% of married women with no education. The unmet need for contraception among currently married women is 18.9% nationally and 13% in Sokoto, with 8.1% wanting access to contraception for child spacing and 4.9% to limit childbearing.[8]

However, a 2013 USAID program evaluation of family planning facilities explored the differences in reported use of contraceptives and found that women might mask their contraceptive use during surveys, especially if the data collectors were men. According to one respondent, women might not "want to say it probably because they are shy. Sometimes privacy is the issue and how the questions are asked."[30]

Family planning knowledge varies by gender and location. Nationally, 93.9% of married women and 97.8% of married men were aware of any modern method of contraception; in Sokoto, women are less informed, with only 60.9% of married women aware of any modern contraception, compared to 92.9% of married men. In Sokoto, 58% of women and 91.5% of men reported that they had not heard or seen messaging about family planning in the last few months, even though messages are regularly disseminated through multiple sources, including radio, posters, and brochures.[8] These findings demonstrate that despite numerous sexual and reproductive health interventions taking place in the state, messaging is not reaching its target audiences.[30]

One challenge in increasing access to and use of modern family planning methods is overcoming myths. An assessment in Sokoto and Bauchi in 2013 reported that the perception that family planning use can lead to permanent infertility was common, but a health management information system (HMIS) officer reported that people were becoming more aware of the "importance of family planning and how it can help sustain family health." All HMIS officers interviewed agreed that people had become more accepting of family planning over the course of the implementation of the program.[30]

In Nigeria, 1 in 4 pregnancies is unintended; of those, 56% end in abortion, 32% are carried to term, and 12% end in a miscarriage. There were 1.25 million induced abortions in Nigeria in 2012. In the North West region there are 31 abortions per 1,000 women ages 15 to 49, or 13% of all pregnancies end in abortion, compared to the national average of 33 per 1,000 women. These high abortion rates are linked to low contraceptive use and high unmet need for family planning. In Nigeria, abortion is illegal except to save a woman's life, so the vast majority of abortions are clandestine and therefore more likely to be unsafe, significantly contributing to maternal mortality. Nationally about 40% of women who choose to terminate their pregnancies experience complications serious enough to seek medical treatment. As a result, abortion has a significant impact on Nigeria's health system. In 2012, 212,000 women were treated for consequences of unsafe abortion and an additional 285,000 needed such treatment but did not receive the care they needed.[35] See Table 2 for a summary of key reproductive health indicators.

Maternal health

In Sokoto, the median age at first birth among women of reproductive age was 18.3 years, and 32.1% of women ages 15 to 19 (teenagers) have begun childbearing. These rates are improvements since 2013—when the median age at first birth was 17.4 years and 36.0% of teenagers had begun childbearing[34]—but worse than the national averages in 2018—where the median age of first birth is 20.4 years and 18.7% of teenagers having begun childbearing. In Sokoto, the median interval between births

is 31.4 months, but approximately 23.4% of births still fall below the recommended interval between births of 24 months.[8]

Limited access to trained providers is a key factor contributing to maternal mortality and morbidity in Nigeria and in Sokoto. According to the 2018 NDHS, nationally, 39.4% of births take place in a health facility, 43.3% with a skilled provider; in Sokoto, the percentage falls to 7.8% of deliveries occurring in health facilities, 9.2% with a skilled provider.[8] The proportion of births that occur in a health facility did not change drastically between the 2003, 2013, and 2018 NDHS, with the rate increasing from 33% to 36% to 39.4%, increasing 6.4% points in 15 years.[8] Nationally, the most common reasons for delivering at home rather than a health facility were that the child was born quickly, they felt it was not necessary, the facility was too far, or it was too expensive.[34] In Sokoto, according to the most recently available data, the most commonly cited reason for not delivering in a health facility was that it was not customary to deliver in a health facility (48.0%), the child was born suddenly before going to a health facility (20.2%), or that it was not necessary to deliver in a health facility (19.4%).[34] Nationally, several factors were positively associated with health facility deliveries including increased educational attainment and economic status.[8]

Furthermore, nationally, 67% of women receive antenatal care from a skilled provider; in Sokoto 24.3% receive this care. Just over 30% of women in Sokoto report attending four or more antenatal care (ANC) visits, and 28.6% were protected against neonatal tetanus before giving birth.[8] This indicates that, despite receiving antenatal care, some women do not receive all the recommended elements of ANC. This trend is visible in the 2018 NDHS, where 14.3% of women that attended ANC visits did not have blood samples and/or urine samples taken.[8] These findings indicate that in addition to low ANC attendance, the quality of the care received is also an issue.

Nigeria accounts for the highest total number and 40% of all obstetric fistula cases globally. Without treatment, fistula can severely impact a woman's health and wellbeing. She may be unable to control the flow of her urine or feces; suffer nerve damage in her legs; be rejected by her husband, family, and/or community; and experience shame and isolation. In addition to obstetric fistula, prolonged labor can lead to the death of the mother and/or the child.[36] There are no available fistula rates for Sokoto, but the state has been chosen as an intervention site for numerous fistula interventions.[37] The Maryam Abatcha Women and Children's Hospital, a public health facility in Sokoto, is part of the USAID Fistula Care Plus initiative, and provides education, outreach, and free fistula repair.[38, 39] On August 20, 2019 the hospital and the State Government of Sokoto launched a free fistula repair campaign with support from the Fistula Foundation Nigeria, Spotlight Initiative, the European Union, WHO, and UNFPA.[40]

The high rates of fistula are connected to low healthcare access, prolonged labor without access to surgical intervention, early maternal age, and a lack of emergency referral services. In Jos, Nigeria (also in northern Nigeria), fistula patients tended to be both short and small, with an average age of marriage of 15.5 years, but now divorced or separated, with little education or access to financial resources, from a rural area, and they developed fistula during a birth that lasted, on average, two days, and resulted in a stillborn fetus. Of these women, 23.5% delivered at home and 76.5% delivered in a health facility; 23.5% were attended by untrained traditional birth attendants, 26.6% by someone with some level of healthcare training, and 46.6% by someone with formal healthcare training (of variable quality). The average time from development of fistula to receiving care was 1-4 years (41.5% of patients), followed by 3-12 months (23%), 5-9 years (13%) and 10-19 years (13%).[41] Women who were familiar with health services (e.g., who had previously delivered in a health facility) might be more likely to seek fistula repair services, at all and sooner, however, despite this possible confounding, it does highlight the pressing need for more deliveries in health facilities and for qualified care within those facilities.

While the 2018 NDHS states that the maternal mortality ratio (MMR) for Nigeria is 512[8], other estimates are much higher. According to the World Bank, Nigeria's MMR is 917, the fourth highest in the world behind just South Sudan, Chad and Sierra Leone.[18] According to the most recent publicly

available data, the main causes of maternal mortality are hemorrhage (23%), infection (17%), toxemia/eclampsia (11%), malaria (11%), obstructed labor (11%), and unsafe abortion (11%).[42] Comprehensive, state- disaggregated data on maternal mortality is not available; however, several independent reports are available on maternal mortality in Sokoto State. One study of adolescent maternal mortality, which is an older study from 1990 - 1999, found that in Sokoto's Usmanu Danfodiyo University Teaching Hospital the facility-based maternal mortality in adolescents was 4,863 per 100,000 live births, compared to 2,151 per 100,000 live births in among non-adolescents. Risk factors included absence of pre-, intra- and post-partum care, illiteracy, and poverty. Eclampsia and prolonged obstructed labor were responsible for 76% of deaths.[43] According to a report from the International Federation of Gynecology and Obstetrics (FIGO) in 2013, maternal mortality declined from 185 per 100,000 live births in 2012 to 145 per 100,000 live births in 2013 due to interventions to improve maternal and newborn health. These interventions have included free healthcare for pregnant women and children and increasing accessibility and affordability.[44] The USAID Targeted States High Impact Project (TSHIP) program implemented two new strategies to combat maternal and infant mortality in Sokoto, and later Bauchi, starting in 2013, with the procurement of chlorhexidine gluconate gel to prevent infection and misoprostol to treat postpartum hemorrhage.[45] Sokoto is also the home to an innovative approach to reducing maternal mortality, where an emergency fund was created so as to allow any woman to be able to access emergency obstetric care, specifically in the case of a ruptured uterus, regardless of her ability to pay. The funding was a loan to the woman and her family that had to be repaid, but allowed women to receive care without paying upfront. There was a significant drop in maternal mortality among women with a ruptured uterus from 38% to 11%. Only one of 18 patients defaulted on the loan.[46]

Table 2. Reproductive and maternal health indicators for Sokoto State

	2013 DHS		2018 DHS	
Indicators	**Sokoto**	**Nigeria**	**Sokoto**	**Nigeria**
Contraceptive Prevalence Rate	1.1%	16%	2.3%	27.7%
Married women who had heard of any one modern method	75.3%	83.8%	60.9%	93.9%
Unmet need for family planning (married women)	6.6%	16%	13%	18.9%
Mean fertility rate	7	5.5	7	5.3
Adolescents who have begun childbearing	36.0%	22.5%	32.1%	18.7%
Any ANC care from a skilled provider	17.4%	60.6%	24.3%	67%
Delivery in health facility	4.7%	35.8%	7.8%	39.4%
Maternal mortality ratio (per 100,000 live births)	--	814	--	512
Postnatal check-up in first 2 days after birth	6.5%	40%	31.5%	41.8%

Source: NDHS [8, 34]

Newborn and child health

In Nigeria, approximately one in every eight children die before reaching five years old (129 deaths per 1,000 live births); in Sokoto, the rate is even higher at 197 deaths per 1,000 live births. One in 15 children in Nigeria and one in ten children in Sokoto die before reaching age one.[8] Primary causes of neonatal mortality in Nigeria include asphyxia, preterm birth, infection, diarrhea, tetanus, and congenital illness.[42] About half of neonatal mortality in Nigeria occurs on the day of birth or the first day of life. Nationally, over half of neonatal deaths occur at home[47]; it is important to note that 57.7% of births also occur at home.[8]

In Sokoto, 4.6 % of children are fully immunized, compared to 31.3% nationally. Measles vaccine coverage stands at 19% in the state, which is significantly higher than the rate of 3.6% in 2013,[34] but low compared to the national average of 54%. Just over 12% of children in Sokoto have received the full series of polio vaccinations, compared to 47.2% nationally. Over 18.5% of children under 5 in Sokoto had diarrhea in the two weeks prior to the 2018 NDHS survey, compared to 12.8% nationally.[8] Nationally in Nigeria, causes of under-5 mortality include neonatal (28%), malaria (20%), diarrhea (18%), pneumonia (15%), HIV (3%), injuries (1%) and other (15%).[42] Over two-thirds of women in Sokoto State do not access postnatal care for themselves, and 72.5% do not access postnatal care for their newborns.[8] Nationally, no formal healthcare is ever sought in more than 70% of home deliveries. One cause of not seeking postnatal care is that a woman's husband or male relative is the gatekeeper for access to such care, and she or the infant may die while awaiting such a decision or after being denied permission or access.[42] Another reason for lack of care seeking, including when infants displayed distress or danger signs, was a lack of knowledge among mothers. According to a survey in Kano and Zamfara states, also in northern Nigeria, less than half of mothers were aware of any of the most common danger signs, and knowledge was lower among rural and illiterate women.[48]

Nutrition

According to the 2017 Multiple Indicator Cluster Survey (MICS), there is a high burden of undernourishment and malnourishment in Nigeria, with even higher rates in Sokoto. Nationally, 31.5% of children are moderately or severely underweight (weight for age), compared to 48.6% in Sokoto; nationally 43.6% are moderately or severely stunted (height for age) versus 60.9% in Sokoto; and nationally 10.8% of children have moderate or severe wasting (weight for height) versus 17.2% in Sokoto.[49] In Nigeria, women are usually responsible for children's nutrition. While there is community-based management of acute malnutrition (CMAM) programming in Nigeria, mothers have identified childcare and household responsibilities, lack of decision-making power, and lack of control over resources as barriers to accessing these and other health services for their children. Furthermore, after attendance, women reported difficulty procuring appropriate food for complementary feeding due to lack of funds or the husband's refusal to buy more expensive goods.[50]

In Sokoto, 94.6% of children are ever breastfed, which is slightly below the national rate of 97.1%. However, only one in ten children are breastfed within an hour of birth in Sokoto, which is well below national levels (42.1%). Of note, over 64.3% of children in Sokoto receive a prelacteal feed, higher than the national average of 48.8%. The median duration of any breastfeeding in the North West is 21.0 months, higher than the national average of 18.5, but the duration of predominant breastfeeding is only 4.9 months, lower than the national average of 4.9 months.[8] Men and older women are often resistant to the practice of exclusive breastfeeding, and both of these groups heavily influence the practices of younger mothers.[50]

Malaria

Twenty-five percent of worldwide malaria cases and 19% of deaths occur in Nigeria, and malaria cases in Nigeria increased by more than 500,000 cases from 2017 to 2018. Nigeria is one of seven countries that did not achieve the minimum recommendation for insecticide treated net (ITN) coverage of one net per two people at risk in 2017, but ownership increased slightly from 2016 to 2017. Nigeria distributes seasonal malaria chemoprophylaxis (SMC) to children, and while Nigeria covered the lowest percentage of children needing SMC of any country implementing the intervention, reaching 45% of eligible children, the country also reached more total children than any other country. Due to its large and growing population compared to most countries implementing SMC the high number of children reached still translates in to the smallest percentage.[51]

In Sokoto, 86.6% of households have at least one ITN, which is higher than the national mean of 60.6%,[8] and twenty percentage points higher than 2013.[34] Around half (54.2%) of residents in

Sokoto slept under an ITN the night before the 2018 NDHS was administered, compared to 43.9% of people nationally, which represents progress in ownership and usage. Furthermore, this number is higher for children under 5 (57.8%) and pregnant women (80.5%). While only 22.5% of pregnant women in Sokoto received the recommended three doses of malaria prophylaxis/treatment during their pregnancies,[8] this is another major increase over the rate of 0.7% in 2013.[34] Men are much less likely to utilize mosquito nets and young men have even lower rates of utilization, which can be connected to messaging and ITNs targeted for pregnant women as well as low healthcare prevention and treatment utilization among men, as discussed in the section on masculinity.[8]

HIV

Findings from the 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) indicate a lower prevalence of HIV than previously estimated.[52] The Federal Ministry of Health reported the national prevalence among 15-49 year-olds was 3.4% in 2012, however the NAIIS found a prevalence of 1.4% among this age group.[53] The HIV epidemic in Nigeria is highly gendered, with females having a higher prevalence in every age group. Nationally, 1.9% of women and 0.9% of men are living with HIV. However, women are slightly more likely to achieve viral load suppression (VLS) than men (45.3% vs 42.3%), potentially indicating higher access to care, care uptake, or compliance with the medication regimen.[52]

In the North West, the overall HIV prevalence among ages 15 to 49 is 0.6%. Females have a higher prevalence than males at 0.7% compared to 0.4%. Unlike national trends, females in the North West are slightly less likely to achieve VLS (41.2% vs 42.1%). HIV prevalence was highest among females aged 35-49 at 1.9%, and highest among males age 40-44 at 1.2%. The gender difference in HIV prevalence was most drastic in the 35-39 years age group where females (1.9%) are more than six times more likely to be HIV positive than men (0.3%) of the same age.[54]

Levels of knowledge of HIV prevention methods, including condom use and limiting sexual partners to one uninfected partner, were lowest in the North East and highest in the South East. For both men and women, knowledge of prevention methods increase with education and wealth. For example, 60.9% of women with no education had knowledge of both prevention methods compared to 84.8% for those with higher education, and 57.2% of women from the lowest wealth quintile and 80.6% in the highest quintile knew of such methods. Knowledge about mother to child transmission of HIV/AIDS is low—77.6% of women and 64.6% of men know that HIV can be transmitted via breastfeeding and 71.5% of women and 62.7% of men know that the risk of mother to child can be reduced with medication during pregnancy.[8][2]

Behaviors that put people at higher risk for HIV/AIDS were more prevalent among men, including total number of lifetime partners. However in Sokoto, men have only slightly more sexual partners compared to women (1.9 compared to 1.3) but are more likely to have more than one sexual partner at a given time (10.2% for men compared to 0.2% for women).[8] Transactional sex is another behavior associated with contracting HIV due to the power dynamics when sex is purchased and the likelihood of one or both participants having multiple partners. However, transactional sex was reportedly uncommon in Sokoto, with 0.2% of men reporting ever purchasing sex.[8]

Overall, in Sokoto, as of 2013[3], 10.9% of women knew where to be tested for HIV, 3.7% had been tested for HIV, and 0.3% had received the results. Comparatively, 36.5% of men know where to be tested and 2.1% have been tested and 0.1% received the results.[34] Despite the fact that men are more likely

[2] Since the NAIIS focus on HIV testing and VLS, we rely on the 2018 NDHS for information about national and state trends about HIV/AIDS knowledge and behaviors.

[3] 2013 is the latest available data by state.

than women to know where to get an HIV test, their testing rates are lower, indicating that knowledge of testing facilities is only one of the barriers to overcome to increase testing rates.

Nigeria has programs in place for the prevention of mother-to-child transmission (PMTCT) of HIV, described in more detail in the ANC section. However, only 6.6% of women in Sokoto received HIV counseling during antenatal care, which is much lower than the national average of 36%. In Sokoto, 4.6% of pregnant women received HIV counseling, an HIV test, and their HIV test results, all of which is reflective of the limited interaction between pregnant women and the health system in the state.[34] Nationally, among women who had given birth in the past four years, 40% reported knowing their HIV status during pregnancy; 1.4% learned they were living with HIV prior to or during their pregnancy. Of those who self-identified as HIV-positive and who received ARVs during pregnancy, 80% reported starting antiretrovirals (ARVs) prior to attending ANC.[52]

HIV affects certain key populations in Nigeria at higher rates, particularly sex workers (14.4% prevalence), men who have sex with men (MSM) (23%), and people who inject drugs (3.4%).[55] Female sex workers who inject drugs are the population at highest risk in Nigeria, with a 43% prevalence of HIV. Additionally, due to anti-homosexuality laws, discussed in more detail in the legal framework section, men who have sex with men face barriers to care and difficulty accessing HIV services and treatment, and this is the only population among which HIV prevalence continues to increase.[56] However, members of these key populations are the most informed about HIV risk and status: 82% of MSM and 98.1% of sex workers report using a condom the last time they had sex with a male partner and 97% of MSM and 97.1% of sex workers reported being tested for HIV in the last year.[56] See Table 3 for a summary of key HIV/AIDS indicators.

Table 3. HIV prevalence and HIV/AIDS knowledge among people 15-49

	National		Sokoto		
Indicator	**Men**	**Women**	**Men**	**Women**	***Source***
Awareness of HIV/AIDS	95%	94.3%	80.4%	82.2%	*2018 NDHS*
Know condoms and having one HIV- partner reduces risk	74.1%	70.7%	65.8%	53.7%	*2018 NDHS*
Knew that HIV can be transmitted via breastfeeding	69.3%	77.6%	60.7%	57.8%	*2018 NDHS*
Knew that MTCT risk can be reduced with medication	62.2%	71.5%	45.6%	42.1%	*2018 NDHS*
People living with HIV	1.4%	1.9%	0.4%*	0.7%*	*2018 NAIIS*
People living with HIV with VLS	45.3%	42.3%	44.4%*		*2018 NAIIS*

*Data for the North West; no available data for Sokoto State.

Major gender considerations in Sokoto

Gender Inequality Index

The Gender Inequality Index (GII) is a compound metric reflecting the inequality between men and women related to reproductive health (MMR and adolescent fertility rate), empowerment (parliamentary seats by sex and educational attainment of at least secondary school by those 25+), and the labor market (labor force participation by sex). The country's 2016 GII was 0.779, which represents a 77.9% loss in human development potential due to gender inequality. In 2016, Sokoto State had a GII value of 0.698, indicating

higher levels of gender inequality than the national average, and the state with highest GII in the North West Region.[4][57]

Gender norms, roles, and responsibilities

A 2015 study found that in Nigeria 94% of men and 91% agreed that 'a woman's most important role is to take care of her home and cook for her family'.[58] This strict role definition is reflected in women's ability to access credit, land, and other inputs needed to step outside of these roles, which is 50% lower than men's. In addition to limited economic power, pervasive cultural norms often limit women's participation, power, and personal freedom.[59]

According the 2018 NDHS, men in Sokoto sometimes display controlling behaviors towards their wives, which have been identified as a warning sign of and is correlated with intimate partner violence. Controlling behaviors examined in the survey included whether a husband: (1) is jealous or angry if she talks to other men, (2) frequently accuses her of being unfaithful, (3) does not permit her to meet her female friendly, (4) tries to limit her contact with her family, or (5) insists on know where she is at all times. Across Nigeria, Sokoto has the second highest rates of such behaviors. In Sokoto, men's most frequent controlling behaviors included jealousy and steps to isolate their partner from her friends and family. In Sokoto, over 79.4% of women report that their husbands become jealous if they talk to other men and two-thirds of women in Sokoto say their husbands must know where they are at all times.[8] All of these rates have increased since 2013.[34]

Lack of economic power and decision-making are often signs of lower levels of women's empowerment and are evident in findings from the 2018 NDHS.[8] Only 1.6%, 9.9%, and 2.3% of women report that they are the primary decision maker regarding their own health, visiting friends, and household purchases, respectively. Similarly, 97.3% of men say they make final decision regarding household purchases. Across Nigeria, women with more than a secondary education and from wealthier backgrounds are less likely to report that their husbands display controlling behaviors.[8]

This strict patriarchal system is supported by local interpretations of Islam and Christianity, whereby there is a persistent belief that the man has been given the "mantle of leadership" by God.[58] Another 2015 national study found that religion is much of what defines the roles and responsibilities of men and women in Nigeria; because the status of women in the religious texts of Islam and Christianity is generally low and men dominate positions of power, "this has translated to women's marginalization from positions of power and authority."[60] Some men and religious leaders rely on religious texts to justify gender-based violence: within Christianity the Bible says that men are "preordained" and women occupy a fixed, lower station and, in the Quran, men are also portrayed as dominant and bound protectors of women.[60]

Gender-based violence

According to the narrative of the 2013 NDHS, one respondent explained "In Nigeria, generally, 'women are considered as tools to be used by men. They are regarded as objects to be used for pleasure, temptation and elimination. In Nigeria a man will beat his wife, and nothing will happen, instead [he] will expect her to go on her knees and beg him."[34]

In the 2018 NDHS, 36.2% of ever-married Nigerian women have experienced spousal violence (emotional, physical, or sexual). Among domestic relationships, emotional violence is the most common form of violence, compared to sexual and physical. In Sokoto, 35.4% of women have experienced either

[4] This information is from a report from the Nigeria Bureau of Statistics entitled *Computation of Human Development Indices for the UNDP Nigeria Human Development Report – 2016*. However, the UNDP does not list HDI for Nigeria for any of the most recent years (2000, 2005, 2010 or 2013). No information is available on why HDI is not listed.

physical, sexual, or emotional violence by a partner or spouse, which is a major increase from 3.7% in 2013 but on par with the national average.[8, 34] It is not clear whether these higher rates of violence are due to more violence or increased reporting. One-quarter of women and 34.9% of men in Sokoto agree that husbands are justified in beating their wives under at least one circumstance, the most common being if she refuses to participate in sexual intercourse. In Sokoto, 0.7% of ever-pregnant women have experienced intimate partner violence during their pregnancies.[8] Table 4 below outlines key data on GBV.

Table 4: State vs. National Levels of Violence

Description of Violence	Sokoto	National
Physical abuse from husband or partner (ever-married women between 15 and 49)	4.8%	19.2%
Sexual abuse from husband or partner (ever-married women between 15 and 49)	1.1%	7.0%
Emotional abuse from husband or partner (ever-married women between 15 and 49)	32.8%	31.7%
Controlling behavior: women whose husbands become jealous if they talk to other men	79.4%	44.2%
Controlling behavior: women whose husbands must know where they are at all times	66.3%	40.7%
Controlling behavior: women whose husbands try to limit when they see their families	16.5%	10.2%
Women who agree that a husband is justified in hitting/beating his wife for at least one specified reason—burns the food, argues with him, goes out without telling him, neglects the children, or refuses to have sex	25%	28.0%
Women who never sought help or never told anyone about their experience of violence	N/A	54.6%

Source: 2018 Nigeria DHS [8]

Nationally, women's help-seeking after experiencing violence varies greatly—while 31.6% of Nigerian women seek help; women ages 30-39, those from the South South zone (compared to the other zones), and divorced/separated/widowed women (as opposed to single or currently married women) are the most likely to have sought to stop the violence. Across Nigeria, women with any employment, whether for cash (32.9%) or not for cash (31.2%) are more likely to seek help after experiencing physical and/or sexual violence than women without work (28.7%). However, trends in who is most likely to seek help do not follow education, wealth, or residence (urban/rural) trends.[8] State-level data was not available in 2018, but in 2013 in Sokoto, 27.6% of women sought any help to stop the violence, 17.8% never sought help but told someone, and 33.5% never sought help and never told anyone (data was missing for 21% of respondents for this question). Half of women ever sought help or told anyone about their experience of violence.[34]

In Nigeria, women face significant barriers in seeking support after experiencing violence, including victim blaming, social and religious pressure, and distrust of law enforcement. This shows that violence is

normalized within the culture, especially when it occurs within the home. In one study, three-quarters of men and two-thirds of women reported being physically punished at home as children, four-fifths of men and seven out of ten women reported being beaten or physically punished at school, and one-quarter saw their mother being beaten by their father or another man when they were growing up. About 20% of participants, both male and female, reported being sexually assaulted when they were children.[58] This is significant as a major predictor of violent behavior is seeing or experiencing it as a child.

One national study found that 40% of men self-described as having, at some time, perpetrated physical, emotional, or economic violence against a partner, and 42% of women reported having experienced such violence. In Sokoto the rates were slightly lower, with 37% of men reporting having perpetrated violence at some time and 31% of women reporting ever experiencing violence from a partner. Men were more likely to be perpetrators of violence if they had work-related stress, had seen their mothers being beaten when they were children, or held gender inequitable views. On the other hand, the study found that men raised in non-violent households where their fathers participated in more household work were more likely to be non-violent, are more involved husbands, with both childcare and household chores, although still doing less domestic work than women, and fathers.[58]

Female genital mutilation/cutting (FGM/C) is a form of GBV practiced on women and girls. The practice has declined in Nigeria; although in some areas of the country, it is still perpetuated as part of religious or cultural beliefs. In those cases, FGM/C is most often at the request of one or both of a child's parents and is performed by a traditional, untrained practitioner, most often in unsanitary circumstances with rudimentary tools. Beyond psychological impact, potential health risks of FGM/C can be damaging and life-long, including severe health implications like increased rates of obstructed labor and obstetric fistula.[61] Almost 20% of Nigerian women age 15-49 had undergone FGM/C as girls and young women, and it is more common among older women.[8] FGM/C is most common in the South East of Nigeria, where approximately 35% of women have undergone the procedure. In Sokoto, only 5.4% of women have undergone FGM/C.[8] Nationally rejection of harmful traditional practices, including FGM/C, is on the rise.[58] Approximately 67.4% of Nigerian women believe that the practice should be stopped, compared to just 17% in Sokoto (27.3% believe it should continue and 55.6% have no opinion). Interestingly, women that have bene circumcised are more likely to believe that it should continue due to religious reasons.[8]

Marriage and divorce

In Nigeria, the practice of paying bride price, whereby the groom and his family pay the bride's family, enjoys broad support, with 42% of men and 38% of women in one study agreeing that paying bride price 'gives the husband the right to do whatever he wants with his wife.'[58] Polygyny (one man marrying multiple women) is common in Sokoto where 40.6% of married females and 26.4% of married males report having one or more co-wives, compared to 32.5% of women and 17% of men nationally. There is commonly a hierarchy within such unions where all wives are not treated equally, with those who are senior or more favored wielding more power to take decisions.[32, 34] However, these relationships are also described as supportive, with wives helping one another when one is pregnant or cannot perform her share of the household tasks.[32]

Child marriage

Females marry younger than males in Nigeria. In 2018, the average age for marriage for females was 19.1, eight years earlier than the average age for males (27.7 years). In Sokoto, child marriage (marriage before the age of 18) is the norm: the average age of first marriage for women is 15.9, compared to 25.8 years for men.[8] Child marriage is tied to a cultural and religious veneration of female virginity, which is considered something to be protected. Child marriage is seen as a way to prevent premarital sexual activity, pregnancy, and divorce. Marriages were reported to occur as early as 12 years old, with a family's

desire to protect a girls' chastity and reputation; girls who showed physical signs of puberty early were married earlier.

The preference of men to marry underage girls is closely linked to power and control, as marrying when they are young gives them a low sense of self-worth and is more likely to result in a controlling, violent relationship.[62, 63] In Nigeria, education and child marriage are connected in ways that perpetuate gender inequalities across generations, yet rates of child marriage have not declined with rising levels of education.[64, 65] In 1999, 40% of young women ages 20-24 had married as children. That rate fell slightly to 39% in 2008 but then rose again to 43.5% in 2017.[18] In 2018, 43% of women had been married as children (before the age of 18).[8] This contradicts declining levels of approval for child marriage: in 2015, only one-third of the population sampled continued to be in favor or agree with child marriage.[58] Nationally, age at first marriage increases with education level. On average, children with no education get married at 15 years, compared to 18 years for girls who enrolled in at least primary education.[8]

Despite the dangers of early pregnancy, which are cited as an argument against early marriage in the national *Strategy to End Child Marriage in Nigeria 2016-2021*, there is a general expectation that an adolescent will give birth within the first year of marriage.[32, 66] Such consequences of early marriage include high maternal mortality and morbidity, illiteracy, lack of skills, unemployment, low income, and wide spread misery among the women victims.[66] Child marriage has also been linked with the high prevalence of obstetric fistula in the North West region, as obstructed deliveries are more likely when girls have not finished puberty.[61, 65]

When unmarried girls do get pregnant, informants in a Plan Canada gender assessment reported that they might seek an abortion, even though it is illegal except to save the life of the mother. They may experience barriers to ANC care, including providers refusing to attend to them due to religious beliefs about sex and pregnancy out of wedlock, or not seek care at all to hide the pregnancy. The reported consequences of having a child out of wedlock included exclusion from social rituals (e.g., traditional naming ceremonies), experiencing shame, being shunned by the community, or being kicked out of their homes.[32] A 2004 report highlights that most births to adolescents occur in marriages, with only 3% of women nationally and 3.5% in the North West reporting a premarital birth before age 20. This rate was higher among rural young females (4.0% vs 1.2%) and high among those with less than 7 years of education (4.3%) compared to young women with greater than 7 years of education (1.7%). Cited reasons for these low rates include that pregnant, unwed teenagers may marry after discovering they are pregnant; 25% of unmarried, sexually active teenagers use a modern contraceptive method (25%) compared to 10% of all sexually active young women; and young, unmarried females are likely to seek out a clandestine abortion—61-75% of females treated for abortion complication were adolescents.[67]

Divorce

In Nigeria, marriage and divorce can be governed by customary or traditional law, which is enforceable by traditional authorities and bodies. Additionally, civil law applies, which is developed and enforced by the Nigerian government. In northern Nigeria and Sokoto State, Islamic law as developed and implemented by that state is upheld and enforced. Divorce is permitted under Nigerian law and can be granted by the state if the marriage was registered with civil authorities, however many marriages are only registered with religious authorities or are unregistered.[68] According to the 1970 Matrimonial Causes Act and 1983 Matrimonial Causes Rules accepted reasons to petition for divorce include: refusal to consummate, adultery, intolerability, cruelty, desertion for at least one year, separation for at least two years, lived apart for at least three years, or presumption of death. Nigerian law does not determine who should have custody of children in the case of divorce. [69, 70] Civil law, customary law, and Islamic law are not necessarily harmonized, which can result in legal conflict if a marriage is registered under more than one of these systems.

Divorce is permitted under four different circumstances under Islamic law (explained in more detail in the *Legal Framework* section below). Girls and women who are divorced, separated, or widowed are more likely to have ever experienced higher rates of physical violence and more likely to have experienced physical violence in the last 12 months.[8, 71]

Gender norms related to sexuality

Conservative gender norms are closely tied to traditional norms about sexuality in Nigeria. In Nigeria, men are more likely to engage in risky sexual activity. Among those who had ever had sex, the mean number of lifetime partners was 4.1 for men nationally and 1.9 in Sokoto, and 2.1 for women nationally and 1.3 in Sokoto. However, in Sokoto, 10.2% of men reported having 2+ partners in the last 12 months versus 12.8% nationally, while 1.3% of women nationally had 2+ partners in the past 12 months compared to 0.2% of women in Sokoto.[8]

On average across Nigeria, girls begin having sex at age 17 and men at age 22. In Sokoto, girls begin having sex earlier, around age 15 or 16 and boys around age 25. Over half of females (57%) have sex before their eighteenth birthday and a 19% of girls have sex by age 15, compared to 3% of boys. Wealthier girls have sex later in age than do girls of lower economic levels, while the reverse trend is true for boys. Girls with a secondary education begin having sex later compared to girls with no education; for men education level is not correlated with age of sexual debut.[8] This matches the trend of child marriage, where more education tends to equate to later age at first marriage. Additionally, nationally 41.2% of girls and women 15-24, and 47.4% in Sokoto, reported having a sexual partner 10 or more years older than they were in the past year, which increases risk of sexual transmitted infections (STI), including HIV, among young women, as the virus is often passed from older men to younger women.[49]

Negotiating safer sex is an essential part of sexual and reproductive health, but it is often difficult for women in relationships and cultures with inequitable gender norms. Of the women and men who reported having two or more sexual partners in the last year, 33.2% of Nigerian women and 22.7% of men reported using a male condom during the last sexual intercourse.[8]

However, the results of attitudinal questions about safer sex negotiation show an interesting trend in Sokoto, where 53.8% of women believe that a woman is justified in refusing to have sexual intercourse if she knows her husband has had sex with other women (however the question does not appear to have addressed polygyny, which might be treated differently). Less than half of men agree (45.3%). Fewer women, 46.4%, believe they are justified in asking their husband to wear a condom if he has an STI, and 62.3% of men agree, indicating openness to condom use and negotiation. Overall, agreement with these statements increases with household wealth and education levels, and is higher among urban populations.[8]

See the *Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) Populations* section below for more information about the health and wellbeing of LGBTQ people in Nigeria and Sokoto.

Men and masculinities

There is a growing concern that harmful gender norms and toxic views of masculinity can result vulnerabilities for men's health and wellbeing and negatively impact their families. In parts of Nigeria, men refuse to seek healthcare in fear of being seen as weak.[50] The Nigeria Men and Gender Equality Survey (NiMAGES), designed to investigate gender-related perceptions and behaviors, specifically among men, included two northern states but not Sokoto. The study found that both men and women believe that "toughness, sexual performance, and income were central to notions of masculinity in study sites." Furthermore, the study showed that household roles, decision-making, and authority were highly gendered, with men participating in tasks traditionally assigned to men like paying bills and household repairs, while women washed clothes, cleaned the house, and cooked, among other activities. However,

among respondents, younger men, men with more education, and men with more gender-equitable attitudes were more likely to report participating in domestic chores.[58]

Additionally, men's health seeking behavior was low, with men self-reporting that they are reluctant to seek healthcare. In all study sites, men seeking screening for HIV, prostate cancer, or routine healthcare never exceeded 35%. Women's rates of healthcare-seeking and HIV testing rates are consistently higher: 53% had ever been screened, but this likely has much to do with ANC. Additionally, the results about men's mental health showed that 60% of men are regularly stressed and one third are regularly depressed. Coupled with a reluctance to seek health care, let alone mental health support, this is cause for concern. Finally, it was found that men are much more likely to drink alcohol than women, with 32% of men and 4% of women reporting having five or more drinks in a sitting at least monthly. [58]

As mentioned above, men influence many of the decisions made about family planning and pregnancy and are gatekeepers to ANC access. However, perspectives varied widely on what a man's role is during pregnancy, although women had consistently positive reactions to increased male participation and support to attend ANC and deliver at a hospital. Interestingly, when men and women from the same communities assessed the level of support they gave or received after a birth, men scored themselves as giving significantly more support than the women said they received, demonstrating that there is room for improvement. In addition, it may imply that men want to be perceived as helpful, as seen in their overestimation of how helpful they are and might be open to providing more support. This was not the case, however, with adolescent pregnancy, where adolescent boys said they would first advise the girl to get an abortion, and if she would not or could not, they would advise her to, among other things, tell her parents, leave town, and/or not mention his name. In some instances, the adolescent boy would threaten her or the fetus.[32]

Expectations that men's only role is to provide resources, food, and permission and support for their wives to attend health facilities to give birth can act as barriers to participation. Additionally, given that a man's traditional role is to provide both permission and resources for his wife to seek care during pregnancy, if he is unable to provide those financial resources, it can limit her access to care and his ability to support her and participate. Finally, maternal health is thought of as a women's issue, and men generally have little contact with women outside their families, and therefore have very little knowledge of women's health issues, which serves to limit their ability to participate due to lack of knowledge.[32]

Governance and the health system

Sokoto State, often referred to in government documents by its nickname, "The Seat of the Caliphate," has three senatorial districts, 23 Local Government Areas (LGAs), 120 health districts, and 244 political wards. The State Governor oversees the State and is Chairman of the State Executive Council. As mentioned previously, Sokoto's governor studied Islamic and Common Law in undergraduate studies and is a lawyer with possible presidential aspirations.[14, 72] The Executive Council includes the Deputy Governor, Secretary to the State Government, Honorable Commissioners, and Head of Service. The state has 17 ministries and 46 extra-ministerial departments and parastatals.[73]

The Sokoto Ministry of Budget and Economic Planning (MBEP) is responsible for coordinating and consolidating state level plans and budgets and presenting and defending them at the State House of Assembly. Similarly, each ministry has its own planning department which coordinates its planning activities. This type of linkage also exists at LGAs, where finance and planning departments of the Local Government Councils work with the MBEP on their quarterly and annual budgets and work plans.[73]

Structure and decentralization

The Sokoto State Ministry of Health (SMOH) is responsible for public sector healthcare provision, policy setting and oversight of implementation, staff development and organization, and developing policy statements. Within the health sector, responsibility for distinct aspects of health service delivery sit with different organizations, divided between primary, secondary, and tertiary care facilities. The SMOH was decentralized into various ministries, departments, and agencies (MDA) between 2015 to date:

- The Ministry of Health Headquarters including: Administration; Medical Service; Public Health Service; Nursing Service; Pharmaceutical Service; Finance and Supply; Health Planning, Research, and Statistics
- State Primary Healthcare Development Agency
- The Hospitals Management Board

Parastatals

- Orthopedic Hospital Wamakko
- Noma Children Hospital
- Maryam Women & Children Hospital
- The Specialist Hospital Sokoto
- Hospital Sciences Management Board
- Sokoto State Management Health Care Agency
- Sokoto State Malaria Elimination Agency
- Sokoto State Primary Health Care Development Agency

Education Facilities

- Usmanu Danfodiyo University and Teach Hospital – Medical, nursing, pharmacy, laboratory, community health officers, health information management officers
- State School of Nursing
- State School of Midwifery Tambuwal
- College of Nursing and Midwifery Sokoto
- School of Health Technology – Laboratory, pharmacy technicians, community health extension workers, medical records officers, environmental health officers
- Federal Neuropsychiatry Hospital [74, 75, 76]

Local health care is provided by Primary Health Care (PHC) centers, which are owned, funded, and managed by LGAs through their Departments of Health and accompanying budgets as part of the Primary Health Care under One Roof (PHCUOR) Initiative. Secondary and some tertiary health facilities are the responsibility of the SMOH. Specialized tertiary facilities, such as teaching hospitals of federal universities, are the responsibility of the Federal Ministry of Health.[77] The supervisory institution for each health facility maintains autonomy in expenditure decision making, and no agency can compel another to change their spending priorities or patterns, despite the existence of policies and guidelines at the state or national level.[78]

Decision making

Women are poorly represented in politics at all levels, with women holding 5.5% of seats in the House of Representatives. In Nigeria's 2019 elections, 5 of 73 presidential candidates were women, 560 women and 4,139 men ran for the House of Representatives, and 232 women and 1,668 men ran for Senate. Nigeria has one of the least gender equitable governments in the world, ranking 181 out of 193 countries. This under representation means that women's concerns and opinions are not represented at the state or national levels, with men holding most elected and appointed positions. Female activists denounced the appointment of a man as the Commissioner of Women Affairs in Adamawa, insisting that the

appointment was based on cronyism. The state responded that it was a normal practices, and highlighted "other states where men were appointed to positions where one would expect a woman to be."[79] In the 2007 general election Sokoto elected zero women to the Senate, House of Representatives, Ministers, Governor, or House Assembly. A total of 6 of 360 government representatives for Northern Nigeria were women.[80] How decisions are made within the Sokoto government about health financing, or within the Sokoto Ministry of Health is unknown as this information was not available.

Policy analysis – Gender and health

Nigeria has an active role within the United Nations and the African Union, and has ratified numerous international treaties that codify the rights of women, children, and the right to health, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child, The International Covenant on Economic, Social, and Cultural Rights, which includes the right to health, the Convention on the Rights of People with Disabilities, and the African Charter on Human and Peoples' Rights, among others.[81] While these treaties are not enforceable, they underline Nigeria's commitment to health and human rights, including those of women and children, and serve as a foundation from which to build national systems that respect and promote these rights.

Existing laws, policies, guidelines

Nigeria has an extensive and complex policy environment related to gender and health, with corresponding national ministries responsible for planning, implementation, and monitoring. The health system in Nigeria is decentralized, therefore state level health authorities adopt national policies and adapt them to their local context. This varies by state; some national level policies do not exist at the state level and others are unavailable to the public for policy analysis. Below are some of the key policies related to gender and health, but it is not an exhaustive list.

Palladium International undertook a rapid gender policy review to examine the extent to which national health policies, plans and guidelines related to RMNCH+NM address gender inequities and harmful norms and identify opportunities to strengthen gender integration in health policies. To contribute to this policy analysis, we have conducted a review of state-level health policies related to RMNCH+NM. While this is not a comprehensive list of state-level policies, all available policies were reviewed to assess their sensitivity to gender. A brief overview of findings is presented below; complete checklists for each of the state-level policies can be found in Annex 1.

National Health Policy – Developed by the Federal Ministry of Health in 2016, and then revised and accepted in 2017, the policy aims to promote the health of Nigerians to accelerate socio-economic development and reflects the Sustainable Development Goals. This policy defines the national health priorities of Nigeria and is grounded in the connection between improved health and economic growth.[78, 82] A 2016 draft of the policy addressed GBV, violence against children, gender mainstreaming, positive gender culture, women's empowerment through healthcare access, and universal access to care regardless of sexual orientation. While this version was not passed, it does demonstrate broad buy-in on these topics within the Ministry of Health, which drafted the various versions of the document.[78, 83]

National Strategic Health Development Plan (NSHDP) II (2018-2022) – The recently launched plan focuses on reaching Universal Health Coverage in Nigeria, with significant support from the Bill & Melinda Gates Foundation, the Global Finance Facility, and Aliko Dangote, Africa's richest man, committed to raising 2 billion naira from the private sector. The new plan includes an amplified focus on health needs in rural areas, including reducing morbidity and mortality among children under five, women, and the elderly as well as mechanisms for accountability and transparency to avoid corruption.[84]

- **Sokoto State Strategic Health Development Plan II (2018–2022)** – Developed by the State Ministry of Health with support from USAID and RTI International, this plan aims to ensure universal access to comprehensive, appropriate, affordable, efficient, equitable and quality essential health care through a strengthened health care system. They have a defined set of essential packages of health care services, with clearly defined interventions to be provided at community, primary health care and referral levels. It includes five strategic pillars: enabled environment for sector outcomes, increased utilization of essential packages of health services, strengthened health systems for delivery of services, protection from health emergencies and risks, and predictable financing and risk protection. While the plan does utilize some sex-disaggregated data in the background, and gender equality is considered a core principle, gender is not considered a priority nor integrated throughout the plan. Gender considerations are not reflected in health workforce training, monitoring and evaluation systems, nor in health finance and budgeting. Finally, there is nothing about prioritizing and protecting certain groups such as people with disabilities and sexual minorities.[74, 75]

National Gender Policy (NGP) – Developed by the Federal Ministry of Women Affairs and Social Development and released in 2007, NGP presents an analysis of the national context, policies, and priorities for national gender mainstreaming, and gender sensitivity and responsiveness in national policy making. The policy has 16 priority areas, including attention to GBV, health and reproductive health, and HIV/AIDS. NGP recognizes the role of patriarchy in limiting women's realization of their human rights, including the rights to health and lives free from violence. GBV priorities include introducing legislation to make all forms of GBV illegal and to build individual and institutional capacity to support societal changes that reject GBV. Challenges to equitable healthcare access for women identified by the policy include "ignorance, prohibitive cost of health care, inadequate facilities and personnel, exposure to harmful traditional practices, and lack of political will to implement pro-poor health policies."[85]

- **Sokoto State Gender Policy (2017)** – Developed by the Ministry of Women and Children Affairs Sokoto State, with support from USAID and RTI International, the Sokoto State Gender Policy is a general guide on how all sectors of government, private organizations, development partners and civil society organization should integrate gender mainstreaming and social inclusion in designing and implementation of developmental programs and activities. The policy mandates that all state policies reflect gender implications and strategies and includes guidance on how to achieve that, but it does not provide specific actionable steps for gender-responsive interventions. It also doesn't provide any strategies for male engagement, or preventing and addressing GBV, early marriage, female genital mutilation, and obstetric fistula. In addition, while mentioning vulnerable populations and population with special needs, it does not specifically mention persons with disabilities or sexual minorities. It does not include anything language on gender parity in the health workforce, the importance of gender-responsive finance and budgeting, or integrating gender-sensitive indicators and sex-disaggregated data for decision-making.

Gender and Equal Opportunities Bill[86] – In 2010, the Gender and Equal Opportunities Bill was put before the national Senate for consideration. The Bill aims to eliminate gender inequality in politics, education, and employment and includes provisions about land rights and GBV. However, in 2016 the Bill was rejected for "lack of merit" and because the Senate believed it did not align with the religious and cultural values of most Nigerians.[87] The Bill continues to be resubmitted and rejected with requested changes, primarily related to inheritance rights of widows, which senior clerics have said conflicts with Islamic law that says wives and daughters and not entitled to any inheritance.[88]

National Human Resources for Health Policy and Plan – This 2007 policy and plan outlines the existing challenges to effective, high-quality human resources for health (HRH) in Nigeria, including issues of training, distribution, remuneration. The lack of capacity at the state level for planning, implementing,

and monitoring integrated HRH plans is emphasized. The policy and plan then outlines next steps to improve HRH, including its prioritization, institutionalization, and the development of national guidance, to be adopted at the state level, and continuing to increase health funding, working towards the 15% recommended by the WHO. It does not specifically mention gender considerations.[89]

Violence Against Persons Prohibition (VAPP) Act – This 2015 Act prohibits GBV, including economic, emotional, verbal, sexual, and physical abuse, incest, FGM/C, and depriving another person of their liberty, among other offenses. VAPP outlines the possible punishment for those convicted of GBV and gives victims the right to apply for orders of protection from the government. The procedure for police officers responding to GBV is also outlined: they are mandated to assist the victim in filing complaint, arrange transport to a safe location or hospital, explain the right to protection against violence and to lodge a criminal complaint, and accompany the victim to collect personal belongings if needed. The officer also has the right to remove the perpetrator and any weapons. No specifications are provided about any further obligations of the state to the victim.[90]

National Policy on the Sexual Reproductive Health of Persons with Disabilities with Emphasis on Women and Girls (SRH of PWD) – The Ministry of Health's 2018 Policy on SRH of PWD is in line with UN declarations on SRH and PWD, specifically that they have their right to make decisions about their own sexuality and reproduction. The Policy highlights that women with disabilities experience compounding barriers to accessing healthcare including lack of accessible facilities and transportation, lack of communication support, lack of skilled medical providers trained to work with PWD, and lack of financial resources. The policy is explicitly inclusive of intersecting identities of PWD including their age, sexuality, gender identity, and HIV status.[90, 92]

Discrimination Against Persons with Disabilities (Prohibition) Act (DAPDA) – This 2018 policy established a Nation Commission for Persons with Disabilities, on which someone from the Ministry of Health and Ministry of Women Affairs must sit, among others. It guarantees access to adequate healthcare without discrimination due to a person's disability. Neither gender nor healthcare are further discussed.[92]

Sokoto State Primary Health Care Development Agency: Operational Guideline (2015) - This document outlines Sokoto's policy for implementing appropriate policies, programs, and other necessary actions to strengthen primary health systems. It includes guidelines regarding schedules and job description of key decision-makers, minimum service packages offered, monitoring and evaluation processes, the role of community engagement, and patient charter of rights. Gender and social inclusion are not mentioned anywhere in the guidelines in regard to healthcare delivery, is only mentioned invitation of certain women's and youth groups within community decision making. It is important to note that this was drafted before Sokoto's latest Gender Policy was established.

As mentioned above, the national policy landscape is complex, in addition to the policies above, the following policies relate to health and gender: National Reproductive Health Policy and Strategy[93], the National Policy on HIV/AIDS[94], the National Policy on the Health & Development of Adolescent & Young People in Nigeria[95], the Marriage Act of 1990[96]**,** Integrating Primary Health Care Governance in Nigeria (PHC Under One Roof)[97], National Policy on Sexual and Reproductive Health and Rights of Persons with Disabilities with emphasis on Women and Girls[91], National Framework for the Elimination of Obstetric Fistula[61], and the National Strategy to End Child Marriage (2016 – 2021)[66], among many others.[98]

Legal framework and women's rights

Like the policy environment, Nigeria's legal environment is complex. Policies and laws developed by the national government must be adopted by states to be locally implemented and enforced. According to the

Constitution, all international treaties must be domesticated to be implemented, which is why, despite being a signatory to a range of treaties and agreements that uphold the rights of women and girls and the right to health, among others, those rights are not integrated into federal law. Once nationalized, those laws must be adopted by each state for implementation and enforcement. In many cases, states do not adopt national policies when they believe the content does not align with the beliefs of their population. This right is enshrined in the Constitution.[99] For example, in 2016 the Sultan of Sokoto, the most senior Muslim leader in the state, rejected the Gender and Equal Opportunities Bill, stating that it contradicted Shari'a law, which guarantees men a greater proportion of any estate, and that it infringed upon Muslim's right to practice their religion.[100]

In Sokoto State, in addition to the laws of the federal government and the state, Islamic law is enforced. Islamic law only applies to Muslims and people who voluntarily accept it and those laws are adjudicated within Islamic courts, a separate legal system entirely with its own system of appeals. Islamic law as implemented in northern Nigeria is not aligned with the federal constitution.[80] A principal element of Islamic law enforcement is the Hisbah, or Shari'a police. They patrol the streets like civil police, specifically enforcing Islamic law. In Northern Nigeria, there have been reports of violent attacks on women who were deemed to be dressed inappropriately by the Hisbah. While Islamic law technically only applies to Muslims and those who accept its jurisdiction, the victims of these attacks have been Christians, people from the south of Nigeria, and northern Nigerians dressed in the western style. The threat of such violence has forced non-Muslim women to dress according to Islamic law.[80] Another example of the enforcement of Islamic law is the prosecution of unmarried women for adultery (having affairs with married men), while the married men were never prosecuted.[101]

Marriage and divorce

Marriage in Nigeria can take place within one of three parallel systems: civil law, religious law (Islamic in the case of Sokoto), and customary or tribal law. Once the marriage takes place, the law under which a couple is married has jurisdiction over the marriage.

The national Constitution establishes that entering into marriage gives both parties the legal rights of adults, this means that a child of any age who is married is no longer afforded the protections of laws and regulations that apply to children.[66] This directly contradicts the 2003 Nigeria Child's Rights Act (which is the domestication on the Convention of the Rights of the Child), which sets the age of marriage at 18 years for both men and women and explicitly prohibits the betrothal and marriage of children; However, parents can give their consent at much lower ages and it is poorly regulated and implemented.[28] Only 23 of 36 states have adopted this Act; locally the minimum marriageable age is as low as 12 in some states, and even where it has been adopted enforcement ranges from difficult to non-existent.[102]

Under Islamic law, the most common type of divorce practiced is *Talaq*, which is an informal mechanism initiated by the husband. The procedures of *Talaq* can be misused in ways that can constitute abuse and cause harm to the wife. Wives are permitted to divorce under the *Khul'*, a formal, court-based method of divorce. The *Khul'* requires wives to pay a high price to the man for the divorce, where no such payment is demanded when husbands demand a divorce.[80] Courts often have a limited conservative interpretation of martial property in divorce proceedings, often leaving women with very little at the end of a marriage.[103] There are also limited legal and protective measures in place for women who are widowed, where their deceased husband's property may be passed to a male family member rather than to his wife.[71] Therefore, for example, if someone is married under Islamic law, only a Islamic court and judge may grant them a divorce.[104]

Widows' rights

Widows in Nigeria are a very vulnerable population and face stigma and abuse. In the North West, 5.0% of widows are blamed for their husband's death by his relatives, 5.6% are physically or verbally abused by his relatives, 6.4% are maltreated by his relatives, 6.6% of her children are maltreated, and 2.4% of women's in-laws demand she carry out cultural practices to prove herself innocent of his death. Nationally, this type of treatment is significantly more common among Catholics and Christians than Muslims. For example 0.8% of Muslim women must carry out cultural practices to prove themselves innocent of their husband's death, compared to 8.3% of Christians and 5.6% of Catholics.[34]

The policy environment for widow's inheritance rights exists at the national level, where the Marriage Act of 1990 specifies that a widow is entitled to at least one-third of her deceased husband's estate. However, this law only applies if the couple was married under civil law and if the husband left a will to that effect; if it was a marriage under customary law or Islamic law, of if the husband did not leave a will, the wife may inherit nothing.[80, 105] It is generally the woman's in-laws who deny her inheritance of resources and property. Additionally, under the Islamic and customary law in many states, children are technically the property of the husband, and therefore after the husband's death they will go live with his surviving family, leaving the widow without any inheritance and without her children.[105] If she does maintain custody of her children, she may be denied child support and is also at higher risk for violence.[106]

Additional harmful traditional practices related to widowhood include 'sexual cleansing' and/or wife inheritance by a male family member, community rejection, or accusations of witchcraft and traditional rituals to disprove those accusations.[107] According to Islamic Law, a widow must maintain a period of mourning and celibacy for four months after her husbands' death to ensure she does not marry another man if she is pregnant. If she does not follow this law she can be accused of adultery, and punished with a prison sentence or flogging.[80] In Kano (also in northern Nigeria) the NGO Voices of Widows, Divorcees, and Orphan of Nigeria was prohibited from staging a rally to advocate for legislation to protect their rights after the government decreed such an event "un-Islamic", showing that rights abuses and violations are common enough to merit the formation of civil society group. Another example of enforcement of the Hisbah is the arrest and detention of one or more women living without the presence of a man, which is "frowned on" by the Hisbah, with the women often being charged with prostitution.[80]

Economic and political participation

Nigeria law does not prohibit discrimination in employment on the basis of gender, nor does it mandate that women and men be paid equally for equal work. It is against the law for women to work overnight in occupations involving manual labor. There is no civil law explicitly prohibiting sexual harassment at work.[108] As mentioned, Nigeria's government is one of the least gender equitable globally. This is despite the 2007 National Gender Policy which includes provisions to increase the number of women elected and ensure that they receive 35% of appointed positions, but this has yet to be operationalized.[109]

Gender-based violence and trafficking

The burden of proof in cases of rape is high in Nigeria, where you must present "corroborative evidence," most often making taking a case to trial and getting a conviction nearly impossible. Under Islamic law, as enforced in northern Nigeria, a woman alleging rape must produce four witnesses; if the rape allegation is not upheld, the woman can be charged and convicted of adultery, the punishment for which is prison and/or flogging.[80] Additionally, the language in the law is not gender neutral: the Criminal Code Act specifies that rape is committed by a man against a woman and only recognizes vaginal rape. Furthermore, marital rape does not exist in Nigeria, whereby upon entering into marriage a woman can no longer be

forced into sex by her husband. According to the law, all sex is consensual by definition; he can, however, be charged with assault if he forces her violently.[110]

The 2015 Violence Against Persons Prohibition (VAPP) Act prohibits all forms of violence against persons in private and public life and provides maximum protection and effective remedies for victims and punishment of offenders. The VAPP definition of rape is broad in that it is gender neutral and includes oral, anal, and vaginal rape. It also establishes a publicly accessible sex offenders' database to be maintained by the government. VAPP defines types of physical violence that are illegal and provides a framework whereby people who incite or abet the violence may also be charged. Under VAPP, FGM/C is illegal. It also makes it illegal to evict your spouse from your home or deny him/her access, abandon your spouse and leave and them without any mean of subsistence, to deprive a person of their liberty, commit economic, verbal, emotional, or psychological abuse, forcefully isolate someone from their friends and family, carry out any harmful traditional practices, including those against widows, stalk or intimidate someone, use chemical, biological or other harmful substance to injure someone, commit political violence, or expose your genitals in public.[90] However, despite being quite comprehensive in its definitions of violence, violence against women—particularly sexual violence—remains pervasive. This violence is often at the hands of state actors, including those guarding IDP camps and to extract confessions from female prisoners or those suspected of being lesbian, gay, bisexual, transgender or queer (LGBTQ).[111, 112]

Nigeria's 2015 Trafficking in Persons (Prohibition) Act aligns with international standards; however, enforcement is limited. The National Agency for the Prohibition of Trafficking in Persons received 662 cases, investigated 116, prosecuted 43, and convicted 26 (3.9%). The country is on the US Department of State's Tier 2 Watch List in the 2018 Trafficking in persons report, which means that Nigeria does not fully comply with the Trafficking Victims Protection Act, but is making effort to do so, but, despite that, either the number of victims is very significant or increasing, or the country failed to provide evidence that it is working to address severe forms of trafficking in person identified the previous year. If a country is ranked in Tier 3 the US President has the right, but not the obligation, to withhold non-trade related, non-humanitarian foreign assistance through its direct contributions and to withhold approval of funds through the International Monetary Fund and other multilateral development banks.[113] Due to "egregious reports of government employees complicit in human trafficking offenses" with the government making no effort to investigate the claims, and the military denying the allegations, the country is on the Tier 2 Watch List. If it drops to Tier 3 the US Government and allies may impose consequences, including but not limited to denying financial assistance.[113]

LGBTQ rights

Homosexuality has been entirely illegal in Nigeria since 2013 when the *Same Sex Marriage Prohibition Act* was passed, banning same sex sexual relationships, expressions of affection, and cohabitation, operation of "gay clubs, societies, organization or that supports the activities of such organizations." The Act also makes it illegal to cross-dress or present yourself as a gender other than that assigned to you at birth, called being a "vagabond." [112] The law also prohibits any type of advocacy or support for LGBTQ people. [114]

According to a 2016 report, the law has worsened an already difficult situation, leading to more physical, sexual and mob violence against LGBTQ people, increased extortion, especially by police, and made advocacy for the rights of LGBTQ people illegal. While no one had been prosecuted under the law in the three years since it's instatement, according to the report, it has increased the incidence of worsened the impunity for violence against LGBTQ people, including mobs of people attacking people based on their suspected sexual orientation.

The enforcement of the Same Sex Marriage (Prohibition) Act has been notably more active than VAPP, where the law is being enforced both by the state police and the Shari'a police, and if convicted punishments include public whipping, life imprisonment, and death by stoning, depending on the exact crime under the law. Human rights defenders in Northern Nigeria said a list of 167 people to target based on perceptions of their sexual orientation or gender identity was drawn up following the law's introduction; this was confirmed by the Assistant Commissioner of Police who described it as "profiling of criminals."[111]

Financing and Budgeting

Nigeria

Nigeria's national government allocated 4% of its national budget to health in 2013, a decrease from 6% in 2012. This was due to an increase in the total budget, where the percentage but not the total naira allocation decreased.[78] Out of pocket expenditure on health by Nigerians, as a percent of total health spending, was over 70% in 2013, considerably higher than the regional average of under 40%. This creates challenges for healthcare access among those with limited resources or women who do not have independent access to funds, and therefore may be less able to afford these costs.[34]

Sokoto

Sokoto State allocated 7.8% of its 2017 budget (N7.8 billion) to health in 2017.[16] According to the 2018 Sokoto State Health Sector Annual Operation Plan, the state is largely dependent on the federal government for health sector funding and locally generated revenue is low. Of the allocated budget, 49% goes to General and Emergency Hospital Services and Development of Health Infrastructure; 7.4% is allocated to "Reproductive, Newborn, Child, Adolescent Health Services, Nutrition, and Gender Lens" followed closely by 7.2% for "Communicable Diseases (Malaria, TB, Leprosy, HIV/AIDS) and Neglected Tropical Diseases.[74] According to Sokoto's 2011 – 2015 Strategic Health Care Plan, contributions from international donors were expected to total 7 billion naira (about 19.5 million USD) over five years, 1 billion from USAID, and 5 billion from UN agencies, NGOs; and funding mechanisms.[76]

Commitment to gender responsive budgeting

Gender responsive budgeting (GRB) is an approach to support gender mainstreaming and institutionalization and to ensure policies and programs not only consider gender as an abstract concept, but direct funds to rectify historical and structural inequalities. However, information about the national government of Nigeria or Sokoto's State government's efforts to implement could not be found. The National Agency for the Control of AIDS (NACA) and UN Women conducted a review of the NACA and Benue State Agency for the Control of AIDS (SACA) Budgets and identified only one funded gender-equality related issue within the budget, which addressed stigma. The review concluded that GRB would be useful in Nigeria at the state and national levels, but that its value is not currently recognized by political actors or institutions.[115]

Gender lens on health budgets

Beyond this draft policy, gender is present in health budgets to the extent that women need different health services than men and these must be funded. However, largely because the vast majority of health strategies and policies developed do not contain explicit integration of gender as a core priority, outside of the Gender Strategy itself, it does not appear in a meaningful way in the corresponding budgets.[85] Women appear in budgets essentially as objects of health care, whose fertility rates should be lowered and whose maternal mortality rates must be addressed.[16, 77] Yet, Nigeria's 2018 Health Strategic Development Plan is ambitious, with outputs including prevention of harmful traditional practices and GBV; scale up of prevention, counseling, and treatment for survivors; and building the capacity of service provider to offer gender-sensitive, respectful and safe services. The plan also more

broadly defines family planning as sexual and reproductive health services and encompasses family planning, post-abortion care, fistula prevention and care, and other areas.[84] However, when this is compared to the planning and costing in Sokoto, which uses an identical framework, the resources and scale of the activities is disappointing. For example, one strategic intervention is to "scale up prevention, counseling and treatment of rape and other gender-based violence such as rape, intimate partner violence, etc." The planned activities to increase access to such services, to serve a population of over 5 million, include a 3-day training for 100 health workers, establishing 3 counseling centers (for $20,000 USD total).

Health insurance and gender

In Nigeria less than 5% of the population has any type of health insurance.[78] In 1999 the National Health Insurance Scheme (NHIS) was introduced. Thereafter, several states have introduced similar state-level plans to improve quality and accessibility of care and reduce high out-of-pocket medical care costs. According to the USAID Health Finance and Governance (HFG) Project, 4.5 of Sokoto's 5.3 million people lack such coverage. This project supported the financing of a universal health care scheme, the Sokoto State Contributory Health Care Management Agency (SOCHEMA), which launched in July 2018. Funding was mobilized from a number of sources including state and LGA budgets, Zakat funds (obligatory annual payments on certain items under Islamic law), and contract funds. Such a funding scheme that relies in part on religious funding is a new direction within health care financing in Nigeria. A Health Financing Policy Framework was drafted to guide the related health financing mechanisms with HFG support. [116] Implementation of the SOCHEMA is in progress, but access to care does not yet appear to be available to Sokoto residents.[117]

Human resources for health

The makeup of the health workforce is critical to ensure quality care that meets the needs of patients; to do this, gender must be considered, particularly given cultural and religious norms about interaction between genders and in a setting as intimate as healthcare. Nigeria tends to score relatively favorably on various human resources for health (HRH) metrices; however, despite strong policies, those improvements have not yet led to improved health outcomes.[118] Nigeria's National Human Resources for Health Policy outlines key objectives for improving HRH include the creation of a monitoring and evaluation framework, applying best practices to promote equitable distribution and retention of HRH, institutionalizing performance and management incentives, promoting collaboration between health service providers including the public, private, and NGOs service providers, and strengthening human resources management.[89]

One of the objectives of Sokoto's Ministry of Health's 2018 Operational Plan is "To have in place the right number, skill mix of competent, motivated, productive and equitably distributed health work force for optimal and quality health care services provision."[119] Within this plan many key challenges are closely related to human resources for health: existing distribution of HRH is unequal and personnel insufficient, health management information and disease surveillance systems are inadequate, and existing infrastructure is poor.[74] Additionally, lack of education strongly influences the availability of human capital for the state workforce in Sokoto, where 40% of the population has no education. This lack of education is not distributed equally between genders, where 77% of men and 44% of women are literate.[12] Despite acknowledging the need to improve HRH, no plan is outlined to do so.

Health workforce

There were 7,904 people involved in public and private health care provision across 816 facilities in Sokoto State as of 2018.[75] There is limited detailed, up-to-date health workforce information for Sokoto State. The recent Sokoto State Strategic Health Development Plan II (SSHDP II) does not provide detailed information about personnel by cadre, and Sokoto has not yet localized the National Human Resources for Health Policy. However, the Sokoto SSHDP II does indicate a widespread shortfall

of health providers across cadres. The plan proposes baseline, moderate, and aggressive policy approaches to achieve essential service coverage in the state. While the baseline plan sustains essential service coverage at current levels, the moderate and aggressive plans increase coverage to varying extents. For the moderate plan, coverage is increased with the goal of reducing mortality, and 344 additional medical doctors and 2,635 additional nurses will be required to increase service. Under the aggressive plan, which works toward Universal Health Coverage, an additional 446 medical doctors and 3,343 nurses are needed. Despite providing these recommendations, the plan does not provide the current baseline estimates of the health personnel in the state. Notably, the plan does indicate there is not any current baseline information about the number of midwives in the state.[75]

The WHO recommends a ratio of 23 doctors, nurses, and midwives per 10,000 people as necessary to deliver essential maternal and child health services. While it is not possible to analyze Sokoto State's current health workforce shortfall based on these recommendations, available evidence indicates an inadequate supply of health personnel. The USAID-funded Health Financing and Governance Project identified inadequate manpower supplies in PHC centers as an obstacle to improving health in Sokoto [16]. The Sokoto SSHDP II estimates that there are only one or two midwives or nurses per healthcare facility in the state.[75] Significantly older health workforce information is available from 2005 in the Sokoto State Strategic Health Development Plan I (2010-2015). This data has not been included in this review due to its age. This older data in combination with recent assessments confirm a widespread and ongoing shortage of health personnel in the state. Further, the data from 2005 indicate that the limited health workforce is concentrated in urban areas where a small proportion of the state's population resides, highlighting the need to assess the current distribution of the limited health personnel in the state.[76]

Human resources for health – education, training, and compensation

According to the 2008-2012 National HRH Policy and Plan, recruitment of health professionals tends to be onerous in many states, and remuneration varies significantly between federal and state levels and among states, which leads many employees to change employers or locations based on salary.[89] Turnover is a critical problem and can be as high as 40% annually. According to experienced family planning providers, lack of continuing education and capacity building is one reason staff in their field choose to leave, with some saying they had not seen large-scale family planning capacity building efforts since the 1980s.[120]

There is insufficient information available to draw conclusions about education, training, and compensation in Sokoto. The educational facilities mentioned earlier appear sufficient to train a health workforce, but the quality and accessibility of that education is unknown. The literature search did not uncover any in-depth report on human resources for health in Sokoto. Some information is available in relation to HRH interventions in the state. For instance, according to an assessment at the conclusion of the five-year TSHIP/DELIVER projects in Sokoto and Bauchi, which primarily examined contraceptive use and commodities, 10 out of 15 providers interviewed reported receiving any training in the provision of family planning services, known as Child Birth Spacing (child-spacing) in Sokoto. Most trainings focusing on the

provision of LARCs, such as IUDs and implants, which some providers reported being unfamiliar with before the training. Others reported that while stock of LARCs was available, there were no providers available with the knowledge to insert them. "A few" also reported receiving training on patient counseling and education about family planning. [30] Management Sciences for Health (MSH), with funding from USAID and PEPFAR, carried out HIV-related HRH strengthening in Sokoto and 4 other states to improve provider performance, including developing a Centers for Health Professional Continuing Education Program. No detailed project descriptions or evaluations were identified.[121]

Equal opportunity

No information about equal opportunity for education, training, hiring, and retention in Sokoto were identified. Given stigma and discrimination surrounding identities such as gender, sexual orientation and gender identity, people with disabilities, people living with HIV/AIDS, and clashes between communities, states, religious sects, and other groups, it is feasible that such issues exist, but no direct evidence was identified. Nationally, biased and traditional views about women's capacity as leaders and decision-makers remains pervasive and based in cultural and religious beliefs.[58] Additionally, discrimination against non-indigenes is reportedly common at the national level, and discussed further in *Ethnic and Religious Minorities*.[122]

Service Delivery

The National and Sokoto State Ministry of Health Strategic Health Development Plans for 2018-2022 identify various aspects of health service delivery:

1. Strategic Pillar: Enables environment for attainment of sector outcomes
    a. Leadership and governance,
    b. Community partnership and ownership
    c. Partnerships for health
2. Strategic Pillar: Increased utilization of essential package of health care services
    a. Reproductive, maternal, newborn, child, adolescent health services and nutrition
    b. Communicable diseases (malaria, tuberculosis, leprosy, HIV/AIDS) and neglected tropical diseases
    c. Non-communicable disease, care of the elderly, mental health, oral health, eye healthcare
    d. General and emergency hospital services
    e. Health promotion and social determinants of health (environmental health)
3. Strategic Pillar: Strengthened health system for delivery of package of essential health care services
    a. Human resources for health
    b. Health infrastructure
    c. Medicines, vaccines, and other health technologies and supplies
    d. Health information system
    e. Research for health
4. Strategic Pillar: Protection from health emergencies and risks
    a. Public health emergencies: Preparedness and response
5. Strategic Pillar: Predictable financing and risk protection
    a. Health financing

Through these strategic plans the National and State MOH are prioritizing both the provision of care and its uptake, both of which are essential to improve the health of Sokoto residents.[74]

Main service providers

Public and private providers, including non-governmental and community-based organizations and faith-based organizations, as well as religious and traditional caregivers provide health services in Sokoto. Furthermore, HRH in Nigeria encompasses informal health workers such as herbalists, traditional birth attendants, and volunteers, all of whom play an important role in healthcare provision.[76] The State is currently implementing Primary Health Care Under One Roof (PHCUOR), coordinated by the Sokoto State Primary Health Care Development Agency, to coordinate at PHC centers administered by the corresponding LGAs.[76] The goal of PHCUOR is to improve implementation of PHC by bringing a minimum package of standardized, high-quality services as close as possible to where people are. It is an integrated approach where available services are integrated, rather than having different centers for different services, with one management body, the State Primary Health Care Board/Agency, overseeing implementation, and decentralized authority, responsibility, and accountability, one universal implementation plan, and one monitoring and evaluation system.[123]

In Northern Nigeria, including in Sokoto, community health extension workers (CHEWs) are often the primary service providers. They generally have at least two years of post-secondary school education and are the only staff at some PHC centers, sometimes providing levels of care for which they are not trained. CHEWs are assigned to health care facilities from where they provide on-site care and education as well as community-based outreach. The National Task-shifting/Task-sharing Policy (2018) gave CHEWs who had received LARC training permission to provide injectable contraceptives, insert intrauterine devices (IUDs) and sub-dermal implants. This means that injectables, implants, and IUDs will be more accessible, even in health facilities that are only staff by CHEWs following training.[120]

Policies and guidelines about gender-sensitive care and service delivery

The Nigeria National Gender Policy outlines objectives for moving forward gender mainstreaming in education, health, communications, and law, among others. One objective is the integration of gender-sensitivity into guidelines on HIV/AIDS, people with disabilities, and access to care, as well as setting up a Gender and Human Rights Unit within the National AIDS Coordination Agency. However, there are no objectives related to gender and health outside of HIV/AIDS within this document.[85]

Gender-sensitive care specifications can also be found within the *National Policy on Sexual and Reproductive Health of People with Disabilities with emphasis on Women and Girls*. The policy highlights the lack of mainstreaming of either people with disabilities or gender within Nigeria's policy framework. Additionally, the policy specifies the right of all people, including those of diverse sexual and gender identities to make their own choices about the sexuality and reproduction. It also discusses the compounded challenges faced by women and girls with disabilities, and the need for trained providers and accessible health facilities to guarantee access and demands a specific focus on sexual and gender-based violence against all people with disabilities, especially women and girls.[91]

Healthcare access and challenges

The North East and North West regions of Nigeria have the lowest concentration of health facilities per population. The North West region has 14 primary, 0.46 secondary, and 0.028 tertiary health facilities per 100,000 residents. Sokoto State has 14.1 primary, 0.907 secondary, and 0.042 tertiary facilities per 100,000 residents. Most health facilities in Sokoto are publicly owned and the remaining facilities are private (owned by private providers or NGOs).[124] According to a situational analysis of primary health care centers in Sokoto State conducted in 2018, there are significant gaps in access to quality care on demand. While nearly two-thirds of the PHC centers provide service 24 hours a day for maternal and child

care, few had appropriate staff to provide quality care: 16% had medical officers, 12.5% had the required number of nurses/midwives, and 27% had no nurses/midwives. Furthermore, even when staff were present, there were gaps in training that could affect the quality of care and morbidity and mortality rates. For example, two-thirds of facilities had no staff trained in medium and extended lifesaving skills, 80% had no staff trained in emergency obstetrics and newborn care, and 61% had no staff trained on integrated management of childhood illness. In addition to the facility and well trained personnel, appropriate equipment is critical, but two-thirds of facilities lacked misoprostol and magnesium sulfate.[125] This study demonstrates the need for a broad interpretation of health care access, where it must include appropriate, accessible facilities, sufficient and well trained staff, and appropriate supplies.

Youth-friendly services

Prioritization of youth-friendly services is included in both the national and Sokoto strategic plans for healthcare for 2018 – 2022.[119] Projects addressing young people's health are supported through external funds, such as UNFPA, according to the "Assessment Report of National Response to Young People's Sexual and reproductive Health in Nigeria." However, the assessment found that there is no coordinating body of stakeholders at the state level, although there is a focal person for adolescent health at the SMOH, and local NGOs, private sector, and young people participate in adolescent health and development. There is one youth-friendly health facility in the state, established through a partnership between ECOBANK and the National Agency for the Control of AIDS. The sex distribution of clients at the youth-friendly health facility was assessed and Sokoto saw 29% females and 71% males, which was significantly from most states where the vast majority of clients are female. Looking at capacity development to support adolescent health, there had been no trainings, attendance at meetings or conference, work to foster partnerships, technical assistance to LGAs, or promotion of adolescent participation in research.[126]

To meet the needs of young people who would like to postpone or avoid pregnancy, to provide education to those who would like it, and to provide emotional and social support, young people need youth-friendly services. Youth-friendly health services are a proven strategy to reduce barriers to care experienced by young people, including the need to access sexual and reproductive health services. Barriers experienced by young people can include costs, transportation, laws governing their right to access healthcare without parental consent, and a lack of privacy and confidentiality at the health center, as well as internal barriers, such as limited knowledge and agency, among many others.[127] In 2011, the Federal Ministry of Health released its *Clinical Protocol for the Health and Development of Adolescent and Young People in Nigeria*, which provides guidance on the specific medical concerns of young men and young women and girls, by gender, including puberty, child pregnancy (although it does not address the risk of fistula), abortion, contraception, sexually transmitted infections (STIs) and HIV, and other general challenges, including sexual violence, and harmful traditional practices. It also and emphasizes that comprehensive information about contraceptives is important for all young people to prevent STIs, HIV/AIDS, and unintended pregnancy, without mentioning marital status.[128]

The provision of sexuality education for young people, and particularly condom use education and provision can be controversial, despite positive attitudes about young people delaying child bearing, as well as their use for HIV/AIDS prevention. In Sokoto, 15.3% of women and 27.7% of men believe that children ages 12-14 should be taught about condom use for HIV/AIDS prevention.[34]

Access to medication

In 2011, the FMOH committed to providing all family planning commodities free of charge at public health facilities.[120] According to an assessment of family planning commodities availability and use in Sokoto and Bauchi in 2013, female condoms, oral contraceptives, injectables, implants, and the copper T IUD were available in nearly all facilities surveyed, without implants and/or IUDs observed in very rural facilities where no providers had the skills to insert those methods.[30]

According to the 2018 NDHS, nationally 19% of currently married females have an unmet need for family planning and 17% are currently using a contraceptive method. If the total unmet demand was met, contraceptive prevalence rate would increase to 36%, indicating that many women and girls neither use contraception nor have the desire to postpone their next birth by two or more years.[8] In Sokoto, 13% of women have an unmet need for family planning. Modern contraceptive coverage in 2018 was 2.1%, an increase from 0.7% in 2013.[8, 34]

As with ANC, husbands often act as gatekeepers to contraception access, and this arrangement was described as accepted by women, men, and healthcare providers. During an evaluation of the TSHIP program in Sokoto and Bauchi, providers interviewed universally agreed that a husband's consent for family planning was required before initiation. This consent ranged from verbal consent when husbands accompanied their wives in most facilities, to women arriving with forms signed by their husbands in more urban facilities. However, if a woman sought to access contraception without her husband's consent, some healthcare providers might facilitate that access, whereas others commented that they would refuse her care and/or call her husband to inform him of the situation and ask his permission.[30]

While detailed information about commodity availability for RMNCH in Sokoto is not available, a 2016 USAID assessment in Bauchi State in the North East examined the availability of essential commodities for RMNCH care. This evaluation found that commodity availability was low. Availability was even lower at PHC centers, where the only drugs available at 50% of facilities were iron, oxytocin, chlorhexidine and malaria treatment.[129]

Social inclusion and vulnerable populations

Poor and marginalized

In Nigeria, women and girls from poorer communities and families face additional barriers to consistent access to quality care. According to the Nigeria Bureau of Statistics, the North West has the highest regional rate of poverty in the country at 45%, and Sokoto is the state with the greatest proportion of people living in poverty in the country, with 89.9% of the population living below the poverty line. Thus, poverty must be considered in all policies and programs.[57] Poor and marginalized groups are less likely to be educated, more likely to marry young, and have worse health outcomes. In 2012, only 7% of girls from the lowest income quintile gave birth in a health facility, compared to 56% for the wealthiest quintile.[9] These trends are apparent throughout this report; it is indisputable that poverty increases marginalization and vulnerability to negative outcomes. Importantly, poverty is a cause of other vulnerabilities, such as lack of access to education and lack of funds to give birth in a health facility. Additionally, we know that poverty is not homogenous; although both men and women are poor, findings suggest that even in poor households, women have less access to and control over what resources do exist.[34] Keeping these intersecting disadvantages in mind, and how they are connected, is essential to interrupt the cycles of poverty, violence, illiteracy, maternal and infant mortality, and discrimination, among others that affect so many people in Sokoto and Nigeria.

Youth and adolescents

Approximately 62% of Nigeria's population is under the age of 24 and over 18 million girls are between the ages of 14 and 25. However, most girls do not have enough support, power, or protection, and are denied the opportunity to make decisions about their lives.[8] As mentioned earlier, girls nationally and in Sokoto tend to have earlier sexual debut than boys—in 2013[5], 32.9% of girls had sex before 15 in Sokoto compared to 0.4% of boys, and among sexually active young women, 47.3% girls under 19 had intercourse with a man more than 10 years their senior in the past 12 months.[34] Accessing health

[5] State level data is not available for the 2018 NDHS.

services is more difficult for young women who are more vulnerable to power differentials, resulting in negative sexual and reproductive health outcomes (e.g., STDs, HIV, unintended pregnancy). Unsurprisingly, low rates of contraceptive use and high rates of adolescent sexual activity, including within marriages, result in high rates of adolescent fertility. Nationally, 18.7% of girls have begun childbearing by 19 years old; in Sokoto 32.1% of girls have begun childbearing by 19.[8] There is a strong divide between rural and urban girls, where urban girls begin childbearing 3.3 years later, on average, compared to rural girls (22.3 versus 19 years). Teenagers in the North West are five times as likely to give birth by age 19 compared to their peers in the South West. Teenage pregnancy and childbearing also decrease with more education and greater wealth (3% in the highest wealth quintile compared to 32% in the lowest).[8] High rates of adolescent fertility have many negative societal and personal consequences. Adolescent childbearing is associated with higher rates of school drop-out and reduced employment and economic opportunities for women, and larger families.[34]

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations

Overall, Nigerian LGBTQ populations face challenges to the full realization of their rights, including healthcare access, social and political contexts. As stated, the 2013 *Same Sex Marriage Prohibition Act* has led to more physical, sexual and mob violence against LGBTQ people, increased extortion, and penalized LGBTQ advocacy. Even before the implementation of this law, when the Federal Penal Code did not support the rights of sexual and gender minorities, lesbian and gay Nigerians reported changing the way they presented themselves and avoiding spending time with other members of the LGBTQ community to avoid suspicion, particularly gay and bisexual women. Some even reported marrying an opposite sex partner, having children, and conforming to gender norms to be safe and avoid persecution.[130]

The reported widespread harassment, violence, and hostility toward LGBTQ individuals received from private and government actors has a profound impact on their health. For example, they may be denied health services by institutions or individual providers, fail to seek health services, including for HIV, for which they are at elevated risk, and even be reported to authorities if they reveal their sexuality or gender identity. Anti-homosexuality laws also discourage LGBTQ people from reporting when they are victims of a crime, including sexual and gender-based violence. Persons who perpetrate violence and hatred against LGBTQI people generally do so with impunity. Sexual orientation and gender identity are closely tied to health outcomes in Nigeria, and particularly in Sokoto where people can face severe punishments or death if they are convicted of being LGBTQ, they may not seek or receive the care they need, leaving them particularly vulnerable and marginalized.[130]

In Sokoto, which is among the 12 northern states that enforce Islamic law, punishment for sex between men can include death by stoning, and sex between women is punishable by caning of up to 50 lashes and up to five years in prison.[31, 114] Cross dressing and sex between men are criminalized within the Federal Penal Code that applies to northern states.[31] In July 2019, the Commissioner of Police in Sokoto reported the arrest of seven people, including two couples, for suspected sodomy and other crimes, based on a tip from a local resident. Homosexuality is presented as a crime alongside drug possession and child rape.[131]

People with disabilities

More than 25 million people are living with a disability in Nigeria (13% of the population), of whom 13 million are women and girls; however, a report from the Federal Ministry of Women Affairs places the estimate lower, at 3.2% of the national population, or 4.8 million people. Sokoto has the highest prevalence of people living with disability at 22.2%, over a million people in Sokoto alone, while the North West regional mean prevalence is 5.0%, the highest in the country.[91, 132] The difference between these estimates may due to different definitions of disability, different year or times of the year, different age groups, and different base populations, for example.

A report on the state of human rights in northern Nigeria found that the majority of disabilities in Nigeria are related to sight (45%) and hearing (15%), but this varies significantly by region depending on the risk factors and rates of infectious diseases that can cause disability; for example, Northern Nigeria has higher rates of river blindness, leprosy, and polio than the rest of the country. Other causes of disability in the North include birth defects, injuries, and injuries from labor and delivery (including obstetric fistula).[80] An important note is that there is significant discrimination against people with albinism, which, in itself, is not a disability, but can be associated with visual impairments. People with albinism and angular kyphosis face discrimination and have been violently targeted and murdered, sometimes related to ritual killings. Additionally, discrimination against people with mental illness is widespread and they are at risk for sexual assault, economic manipulation, violence, and abuse.[133]

There is a lack of knowledge and training about working with and supporting people with disabilities at the national level. Furthermore, there is limited space for people with disabilities to advocate for themselves, as there is scant policy enshrining their rights, including access to healthcare, education, and justice.[80] The National Strategic Health Development Plan 2018 – 2022 includes reducing disability due to infectious and non-communicable diseases; however, no planned activities address the needs of people living with disabilities, beyond detecting and treating cases, nor is a plan to engage with people with disabilities apparent.[119]

Ethnic and religious minorities

Sokoto State is home to two primary ethnic groups, Fulani and Hausa, and Zabarmawa and Taureg minorities. There is a strong presence of Islam, with a Sunni majority and Shi'a minority. Additionally, according to a Human Rights Watch report, discrimination against non-indigenes, or people whose family lineage is not local to the place they are applying for a job, is rampant throughout the country. Many states refuse to hire non-indigenes into government positions, deny them access to educational scholarships, charge higher fees for attendance. Additionally, non-indigene communities face systematic discrimination, such as inferior access to public works, healthcare, and education, and measures to reduce their political participation. Furthermore, those who cannot produce a "certificate of indigeneity" for a particular state will also be discriminated against where their family is from, and also making participation in positions at the federal level challenging.[122]

These three types of identity—ethnicity, religion, and place of origin—are at the root of much of the violence in Sokoto. Violence in the North West is reportedly often connected to election cycles, breaking out prior to national election, which often pit the Muslim North against the Christian South. There is a complex relationship between religion, politics, and ethnicity, exacerbated by extreme poverty, distrust of the political system and election results, and manipulation of the populace by politicians and political figures. A decline in the economy and the availability of jobs has also left many young people unemployed and vulnerable to groups offering group identity and a salary, even if it involves violence.[134] The consequences of such recent violence are discussed below in *People on the Move*.

The 2018 NDHS presents a few indicators relevant to gender and health disaggregated by religion (Table 7). The NDHS did not disaggregate indicators by religion and state, making it difficult to draw specific conclusions about Sokoto. Given Sokoto's more limited ethnic diversity, this review includes data disaggregated by ethnic group; for example, more Fulani (32.2%) and Hausa (29.6%) women believed that FGM/C should continue, higher than any other ethnic group.[8] Further, Hausa and Fulani ethnic groups have the third and fourth highest prevalence of FGM/C, at 19.7% and 12.6%, respectively.[8] Although these are just a few examples, they demonstrate that women's risk for different adverse events is strongly influenced by their religion, and likely their ethnicity too. For example, different types of FGM/C are associated with different tribes and traditional practices, and therefore interventions must be tailored to the population.

Table 7: National health outcomes among women and girls aged 15-49, by religion

	Catholic	Christian	Muslim	Traditionalist
Ever experienced emotional, physical or sexual violence by a spouse or partner	46.0%	42.4%	30.6%	44.4%
Ever experienced sexual violence	11.4%	11.1%	7.3%	2.3%
Married or unmarried women or girls who experienced sexual violence in the past 12 months	4.4%	4.4%	3.8%	1.6%
Women who experienced violence during pregnancy	7.5%	7.2%	4.0%	0%
Married women or girls whose husband/partner was ever jealous or angry if she spoke to other men	34.6%	39.8%	48.8%	32.5%
Married women or girls whose husband/partner has ever frequently accused her of being unfaithful	14.1%	13.5%	8.3%	6.3%
Married women or girls whose husband/partner ever insists or has ever insisted on knowing where she is at all times	41.8%	41.6%	40.0%	46.6%
Rates of FGM/C – Total	24.5%	19.4%	18.7%	11.9%

Source: 2018 NDHS [8]

People on the move, including internally displaced persons and refugees

As mentioned previously, recent violence in Sokoto and surrounding states has forced over 60,000 people into Niger since April, prompting UNHCR to declare a Level 2 emergency.[20] The levels of internal displacement due to this conflict are unknown. Understanding of the rise in violence appears to be limited, with various sources of violence leading to forced migration including clashes between farmers and herders of different ethnic groups, kidnappings for ransom, and vigilantism in response to the violence. According to UNHCR the majority of refugees are women and children, and reported extreme violence such as machete attacks, kidnappings, and sexual violence.[23, 135] This population of refugees is apparently spread among 40 communities along the border in Niger, and that there is no meaningful humanitarian response to the sudden rise in violence for those who have remained in Sokoto due to ongoing insecurity.[136]

Another group of people on the move in Sokoto State is the significant pastoralist population, the largest of which is the Fulani. Pastoralist populations move throughout the state throughout some parts of the year, and they are populations that traditionally experiences logistical, practical, and cultural challenges accessing healthcare. Pastoralists in Nigeria are affected by, and sometimes part of, ongoing conflict in the area over land, cattle, and between religions, and 'settlers' versus 'indigenous' residents.[137] Additionally, these groups tend to have lower levels of health knowledge and limited health seeking behavior. Concerted efforts are necessary to link them with health services. Gender relationships within pastoralist populations are often based within traditional gender roles, with work divided by gender, where women are responsible for preparing food and the home, and bearing and raising children, while men are responsible for herding animals and generally providing for the family, making decisions, and controlling assets.[138] Women pastoralists often experience many intersecting vulnerabilities, including being members of marginalized communities, poverty, lack of access and trust in government services,

all within a conservative, patriarchal society. Their specific needs and strengths should be contemplated within any program design and monitoring, and their involvement in design will be essential to understand how to best reach them.

Survivors of GBV

While it is difficult to estimate disclosure rates of sexual and gender-based violence, Nigeria and Sokoto's conservative cultures discourage victims from speaking out or reporting. According to the 2018 NDHS, 8.6% of women in Sokoto have experienced physical violence and 1% have experienced sexual violence. These rates jump to 31.0% and 9.1%, respectively, at the national level.[8]

Following physical or sexual violence, 31.6% of Nigerian women did not tell anyone or seek help, and of those that did seek help, only 1% informed the police and less than 1% told a medical professional. Women most frequently reported to their family or to their husbands' family. State-level data is not available in Sokoto due to the limited number of respondents who experienced violence.[8] In one national 2015 study, 9% of both girls and boys were raped as children, and 19% of men and 22% of women were sexually molested.[58] No estimates of the rates of sexual assault against men and boys were identified in other sources of information, however, given these findings, the rates of armed conflict, toxic masculinity, and the social stigma and severe punishment for same-sex sexual activity, regardless of age or victim status, it is likely that there is severe underreporting. This underreporting exists among girls and women as well, given the intense perceived value and scrutiny of girls and women's sexuality and virginity, and the possibly severe consequences of their husbands, families, or communities finding out.[71, 139] Additionally, according to a Nigerian human rights lawyer, reporting often does not lead to conviction—Nigeria has only recorded 18 rape convictions in its legal history.[140] Together, underreporting, infrequent prosecution and conviction, minimal sentences, and the shame and stigma continue to discourage victims of GBV from speaking out.[141]

Stakeholder analysis and review of previous gender analysis efforts

Understanding who is doing what in Sokoto State related to gender, health, and social inclusion is crucial to ensure any new interventions and activities align with what exists, build on strengths, and do not duplicate efforts. There is an extensive array of government, civil society, and UN actors implementing and funding programs in Sokoto related to reproductive, maternal, neonatal and child health, plus nutrition and malaria (RMNCH +NM) programming. This broad support translates to significant domestic and foreign investment in the region (described in more detail in the *Financing and Budgeting* section). The following tables presents a summary of organizations and recent programs or projects that may be a resource for IHP during project implementation.

Table 8. Partners working in gender, social inclusion, and community engagement in Sokoto

Organization	Areas of focus
Hikima Community Development Initiative	Education, Health, Good governance, Environmental Protection and Gender related Issues
Life Helpers Initiative	Education, Health, Governance, Socio Economic Development and Agriculture
Federation of Muslim Women Association of Nigeria	Education, Social Welfare and health
Health and Gender Initiative	Education, Health &Governance
Community Health and Gender Educational Empowerment	
Adolescent Girls Initiative	
Association for Better Community Health	
Save the Child Initiative	Education, Health, Good Governance, Women Empowerment, & Migration Management and Child Protection

Rural Women and Youth Development	
Society for Women and Adolescent Health Initiative	Education & Health
Women and Youth for Rural Health Development	Education, Health, Women Empowerment
Center for Community Development	
Freedom for Life Initiative	Gender Social Inclusion, Migration and Child Protection
Children and Family Support Initiative	Education, Health and Livelihood
Center for Gender Support & Community Development	
Initiative for Youth Re-Orientation	
AS Attahiru Foundation	Nutrition, OVC, Maternal Health
Association of People with Disability	
Productive Community for Sustainable Development Initiative	
Health Reform Foundation of Nigeria (HERFON)	

Table 9. Ongoing and recent RMNCH +NM projects related to gender, social inclusion, and community engagement in Sokoto, Nigeria

Project	Lead	Donor	Description	Description
Breakthrough ACTION	Johns Hopkins	USAID	Social and behavior change programming to encourage healthy behaviors like Hg and bed net use	Ongoing
Fistula Care Plus	EngenderHealth	USAID	Preventing and treating obstetric fistula including training, and integrating family planning services with fistula and maternal health care	Closed
Northern Education Initiative Plus (NEI+)	Creative Associates	USAID	Strengthening access to basic education, especially for girls and out of school children. 2015 – 2020.	Ongoing
Saving One Million Lives – Program for Results	Sokoto State Government of Nigeria	Sokoto State Government	Improve maternal and child health, reduce mother to child transmission of HIV, improve quality health access	On hold
Effective Water Sanitation & Hygiene	EWASH	USAID	Improving water and sanitation access to vulnerable communities including an equity and gender focus	Ongoing
Strengthening Health Outcomes for Women and Children (SHOW)	Plan International	Global Affairs Canada	Gender transformative project to reduce maternal and child mortality amongst vulnerable women including adolescents	Ongoing
Marie Stopes	Women Integrated Sexual Health	DFID	Family planning, reproductive health services, mobile midwives and outreach, including post abortion care, and social franchise of sexual and reproductive health providers, but no Sokoto clinic	Ongoing
Bill & Melinda Gates Foundation/ Dangote Foundation			Engaged in routine immunization but just signed a new memorandum of standing with state, USAID for five years from 2019 to 2023 to strengthen PHC services.	Ongoing

Health Finance and Governance	APT Associate	USAID	Reproductive Maternal Neonatal and Child Health	Closed
HP Plus	Palladium	USAID	Child Birth Spacing	Closed

Previous gender analyses

Previous analyses about Nigeria, and specifically Sokoto State, have addressed various aspects of gender, but none have addressed the topic so broadly as is done within this document. Additionally, after conducting gender analyses about several Nigerian states, it is apparent that less gender information is available about Sokoto than other states. A full list of all the documents reviewed for this project can be found in the References. However, examination of the following elements is lacking from the resources identified for this review.

- The voices of people in Sokoto – Very little primary data, particularly qualitative data, that highlights the voices and experiences of people in Sokoto, including women, young people, people with disabilities, and members of other marginalized groups highlighted throughout the report. Without an in depth understanding of their experiences and relationship with the existing health care system it will be challenging to know what improvements are needed. Additionally, such a study would help draw out the explanations for various anomalies in the NDHS data, for example about women having little decision-making power, but not describing their husbands as controlling.

- Experiences of current and returned IDPs and refugees – Given the current surge in violence in Sokoto, it may not be possible now, but understanding the root causes of what is happening, what appears to be the targeting of women and children, the use of rape as a weapon, and how all of this has impacted the physical and emotional health of people in and outside of Sokoto will be essential to building a health system that meets their needs.

- What is needed in Sokoto – Many of the reports reviewed for this analysis described Sokoto as "no different from other Northern states", with concerning health indices, high levels of poverty, and the like, but Sokoto is not the same. Sokoto fares somewhat or far worse than many other Northern states in many health indices, and why this is, what is different about Sokoto that has led to this, including how gender may be interrelated, and what opportunities exist for change and progress did not come out clearly in any of the available materials. It is clear that improving and expanding existing interventions could have a positive impact, but a comparison between Sokoto and another Northern state that could serve as a model for progress could be useful and productive.

Due to these gaps in information, critical information about how gender directly and indirectly affects the health of the Sokoto population is missing. This information is important for understanding and intervening in serious issues such as GBV, child marriage, human trafficking, and contraceptive use.

Recommendations

Based on findings from this desk review and supported by global gender and social inclusion best practices, we recommend the following priorities to improve gender and social inclusion issues in RMNCH +NM programming. In addition, related topics of child marriage, male engagement, GBV, and obstetric fistula prevention and treatment are addressed. These recommendations and findings from this broad and overarching synthesis/desk review, as well as a future in-country landscaping, aim to inform more equitable, effective, and efficient RMNCH+NM strategies, activities, and sustainable change. IHP partners, led by Palladium, and a wide range of public and private actors have critical roles to play to improve the health of women, men, girls, and boys in Sokoto State, including ensuring that progress in equitable and reaches the most marginalized. However, these broad recommendations are not for IHP to address alone,

but rather are suggestions for the National and State Governments, USAID, IHP and other implementing partners in support of overall improved health outcomes.

- **Conduct state-specific gender and social inclusion landscaping.** To achieve IHP goals, consortium partners and stakeholders must work with the social fabric that underpins norms and attitudes and help people recognize the constraints and opportunities related to health outcomes. Significant gaps exist in our knowledge of key gender and social inclusion issues in Sokoto. For example, more research is needed to better understand gender norms related to sexuality and health needs of pastoralist families and LGBTQ people in Sokoto. Significant gaps in our knowledge related to human trafficking for forced labor and sexual exploitation to, in, and from Sokoto, and the escalating conflict only creates more vulnerability. In addition, we need to better understand how women can be engaged in improving health outcomes, particularly when they do not leave their homes or speak to people outside their homes. The state of Sokoto, supported by partners, should conduct a customized rapid landscaping to establish what programs exist and identify gaps based on documented needs. Those findings should be used to adjust existing strategies to ensure a gender-sensitive approach for service delivery (e.g., designing health interventions that women can access, despite the constraints on social interaction and involving women in evaluations of such strategies). This landscaping could include community mappings, key informant interviews, focus group discussions with target groups, and/or observational assessment of health facilities or communities. This landscaping will provide the opportunity to understand how to best monitor and evaluate gender and inclusion, identifying critical influencing factors not captured by current systems. Participation in the landscaping will provide an opportunity to build capacity of local staff to design, implement, and analyze assessment results. Findings will provide in-depth insights into community-level gender issues, not only what they are, but why they exist, which are the systems that maintain them, and how services could be improved in response. The findings should be reviewed with community members to ensure findings reflect their experiences. This landscaping will enable programs to develop locally appropriate solutions that promote community buy-in and ownership, effectiveness, and sustainability.
- **Use sex- and age-disaggregated data and gender-sensitive indicators for more effective policies and programming.** While the collection and use of sex-disaggregated data has improved, due in large part to USAID and other donor requirements, there are crucial gaps. Data disaggregated by sex, age, and other sociodemographic variables, such as ethnic group and ability, should be collected and analyzed and used for decision-making. In addition to health outcomes, quality sex- and age-disaggregated data on disease exposure, participation in and exposure to programming efforts, ability to access treatment, and composition of the health workforce, among others, are required to fully understand RMNCH +NM issues in Sokoto. Identifying most vulnerable and at-risk groups and collecting data to identify their access and barriers is critical to ensuring equitable improvement in health outcomes. IHP and partners should build local capacity to collect, analyze, use, and report sex-disaggregated data.
- **Develop local knowledge and capacity to integrate gender and social inclusion through innovative approaches.** IHP has tremendous potential to transform human resources for health in Sokoto by building capacity and knowledge around gender issues in RMNCH +NM at all levels, from the SMOH to PHC services. IHP should conduct a values clarification about gender and health in Sokoto with key stakeholders, to better understand the reasons behind beliefs and how to approach and address them. This can include sensitization about how gender impacts health outcomes and how and why the integration of gender into programming and budgeting can promote sustainable social and economic development. For example, how supporting women's access to healthcare training could allow more women to receive healthcare from female providers, increasing coverage and improving health outcomes. Gender and social

inclusion training, coaching, and innovative adult learning approaches should be used to build and maintain health workforce capacity. This should include supportive supervision and regular performance assessments where gender-sensitive approaches are rewarded.

- **Ensure health service delivery and the health workforce meet the needs of men, women, boys, and girls.** Findings point to critical gaps in appropriate and well-trained human resources for health, key equipment, facilities, and medications in many health facilities. There are many potentially effective activities in plans, but the scale of their implementation is insufficient for large-scale change. IHP should be different; it should ensure the presence of one trained, female staff person at every health facility. To achieve this, many more women will need to be recruited, trained, and hired. Possibilities to achieve such a dramatic increase including retraining CHEWs and JCHEWs and other paraprofessional health staff, increasing scholarships and financial support to ensure women enroll and graduate, working to combat hiring discrimination to take advantage of everyone who can contribute (e.g. non-indigenes or ethnic out-groups) and ensuring human resources policies to ensure they are gender sensitive and support women's complex roles at work and at home. Hiring women for community- and home-based care could increase access to family planning, pre- and post-natal care, gender, and GBV education and psychosocial support. In addition, all staff in health facilities should be sensitized about how to treat patients, particularly women, people with disabilities, and other marginalized populations, and appropriate consequences for treating patients poorly should be enforced. To achieve increased access, services must be affordable for all target groups, including the very poor. Such efforts could include addressing cost of transportation to the health facility, especially for women in the perinatal period, access to critical prevention and treatment medications, fee-free consultations at PHC centers. Additionally, increasing youth-friendly services is crucial to ensure that youth receive the care they need to be healthy, as well as leadership and decision-making skills building. Specific barriers experienced by young people include such as cost, lack of transportation, laws restricting youth access healthcare without parental consent, and a lack of privacy and confidentiality at the health center, as well as internal barriers, such as limited knowledge and agency, among many others. In addition, options to move towards UHC should continue to explored and supported. Finally, given the high and preventable burden of unsafe abortion in the country, post-abortion care should be expanded and improved to reduce unsafe abortion-related morbidity and mortality, both long- and short-term contraception provided freely and confidentially, and comprehensive sexuality education provided to young people and adults to ensure everyone has the information and skills to decide if and when to reproduce.
- **Prevent and treat obstetric fistula, especially for adolescents and other vulnerable groups, in collaboration with partners.** Given Nigeria's large share of the global burden of fistula cases, and high rates of FGM/C (which can increase risk of obstructed labor and obstetric fistula) in Sokoto, preventing and treating fistula should be prioritized by IHP. This issue is particularly relevant for adolescents and young women since the consequences of early marriage (common in Sokoto) include high maternal mortality and morbidity, among others. While we know that child marriage has been linked with the prevalence of obstetric fistula, the prevalence and burden of fistula in Sokoto and availability and use of related services is unknown. IHP should work with local and international partners to address these gaps to better protect women and girls in State's most vulnerable to fistula and its related physical, emotional, and social consequences.
- **Engage a range of visible influencers and use a positive deviance approach.** RMNCH +NM practices are influenced by household members, the wider community, and public messaging and expectation. Where there are influential members of these groups, or such people in other Northern Nigerian states, demonstrating positive approaches for gender and health, they should be recognized, and their influence leveraged to influence decision-making and behaviors.

- For example, leveraging men's protective role and strong leadership in the family, IHP can help SMOH providers and advocates highlight how that important role translates into support of their families. This could include promoting awareness of and support for family planning, ANC, and hospital births and how household do better when household decision-making is more egalitarian, and women can engage in economic activities. The roles men play in many communities can be leveraged to organize transportation for pregnant women so they can reach health facilities safely to access antenatal services, postnatal checkups, and delivery attended by a trained health provider. In addition, since only men can intervene when other men psychologically or physically abuse women and children, community champions will be important allies with IHP in efforts toward Objective 2 by helping to address underlying factors that obstruct women's access to services and impede improvements in health outcomes for women, children, and families. Currently, no publicly available male engagement policy or guidelines exist for the state. Men as well as couples who set examples of behaviors that support women, children and other vulnerable groups will be helpful in partnering with IHP, the SMOH, and individual facilities to influence positive change.
- IHP can help state governments, CSOs, and health providers to partner with mothers-in-law and take advantage of their influence to support daughters-in-law in healthy pregnancy spacing, Activities can include promoting awareness of and support for family planning, ANC, and hospital births.
- Other key influencers (religious and traditional leaders and legal systems and institutions) should be engaged to promote positive gender norms and more egalitarian decision-making in all aspects of society.

- **Collaborate with donors and other existing programs to change the narrative using social and behavior change communication.** Data suggest that despite the presence of sexual and reproductive health interventions, messaging is not reaching its target audience or having the intended effect at the scale needed for change. Yet personal, family, and community norms around sexual and reproductive topics are slowly shifting. For example, acceptance of family planning is increasing, and acceptance of child marriage is decreasing. Social and behavior change communication that changes the narrative promoting new, rights-based social norms could have lasting impact. For example, use of traditional and new media to promote positive social norms about women working outside the home and challenge familial and workplace discrimination. Research and programming that leverages Qur'an teachings about child protection and caring for orphans and vulnerable children in a number of countries that observe Islamic law, and might be of use in Sokoto related to gender more broadly.[142, 143] Other ideas include:
  - Working with adolescent girls and women to improve decision-making and life skills, building networks of women and girls to support each other, campaigning to promote positive social norms, delivering relationship and family education for women and men, including communication skills for partners.
  - Support and coordinate with IHP partners and USAID funded projects, including Breakthrough Action to coordinate social and behavior change interventions at every level to transform destructive narratives that diminish women's and children's roles or compromise the rights and inclusion of marginalized groups. Through coordination between the State, IHP, and other partners addressing social and behavior change such as Breakthrough Action, IHP advises a multi-track intervention to transform destructive narratives that diminish women's and children's roles or compromise the rights and inclusion of marginalized groups. This means that while community outreach messages are disseminated through multiple avenues, including social media, community development committees, traditional rulers, and religious leaders, IHP, at the same time

will align sensitization and training of health workers and managers at the demand side, as well as policy makers and strategic planners. IHP will recommend that school curricula at every level also include sensitization and leadership development that is incorporated in children's education and secondary school information and embedded in preservice curricula for health providers.

- **Address GBV holistically.** GBV should be addressed as a cross-cutting issue within all relevant policies and programming, and should include physical, sexual, psychological, reproductive, and economic violence and abuse. In particular, IHP should work with stakeholders to develop and implement interventions to prevent GBV and create a culture where GBV is unacceptable to both men and women and male and female health workers, that is safe for reporting, and where support services, including legal and police actors, employ a trauma-informed approach. Positive deviance model also has potential here: efforts should demonstrate that homes with less violence do better and why and working to redefine masculinity as much more than physical strength and control and income generation.
- **Develop a strategy and related actions to combat human trafficking in the health sector.** While there are gaps in our knowledge related to human trafficking for forced labor and sexual exploitation to, in, and from Sokoto specifically, human trafficking is a major issue in the North of Nigeria, and the ongoing violence significantly increases the risk. Such efforts may include training IHP staff and stakeholders on how human trafficking impacts the health sector, developing interventions to prevent trafficking, educating people about what trafficking and traffickers look like, the potential consequences, how to report cases, improving the reporting system and passive case identification within health centers, and improving enforcement of the Trafficking in Persons Act to strengthen investigations and prosecutions, and supporting reintegration of survivors. In addition, the issues of child marriage, GBV, and trafficking should be linked closely to PHC improvement efforts. For example, these issues should be addressed in pre-service and in-service training to continually create awareness, educate providers, and improve the quality of practice and resulting impact. One innovative approach could be through creating a digital health education application to train health providers and CHEWs to recognize the symptoms of GBV and/or human trafficking, thus maximizing intervention reach and minimizing cost.
- **Leverage existing resources to achieve health and gender priorities.** Sokoto receives significant funding from the national government and from international donors, but the impact of this funding remains to be seen. Many donors have supported sexual and reproductive health programs in the State, whose outputs, successes, failures, and lessons learned should be leveraged. For example, national policies that support health and gender and have been proven effective should be identified and stakeholders should advocate for their localization to Sokoto and subsequent implementation; other states that have successfully operationalized that policy could be used as examples. In addition, existing training, social mobilization and community engagement platforms to enhance access and participation can be leveraged, expanded, and improved, incorporating gender to enhance access and participation for all people**.** For example, local NGOs could also play a pivotal role in social mobilization, advocacy, and empowerment. Innovative strategies are urgently needed to increase women's social and civil voice, opportunities and engagement.
- **Collaborate with multi-sectoral actors.** Gender and social inclusion cuts across all development and humanitarian sectors (e.g., education, protection, economic strengthening, women's empowerment) and should not be addressed as a stand-alone topic, but instead must be integrated in all interventions. This is particularly relevant for GBV and human trafficking, which require input from the legal and protection sectors. This desk review outlined some key partners working in RMNCH +NM areas related to gender and social inclusion, however additional stakeholder mapping and relationship building could identify opportunities for sectors, donors,

and projects to deliver more coordinated and effective programming. Collaboration with partners in other sectors, both public and private, could strengthen the impact and sustainability of IHP programs and improve health and social outcomes in Sokoto State.

Conclusions

Imbalances in gender and power mean that many women face obstacles exercising autonomy about choice of sexual partner, contraception, number and spacing of children, and healthcare, each and all of which increases their risk for high-risk pregnancies, maternal deaths, and infectious diseases, including HIV.[33] Nigeria's astounding statistics related to maternal and child mortality, HIV/AIDS, malaria, and TB burden, among many others, reflect the country's pervasive poverty, rampant inequality, lack of education, and insufficient access to services. Sokoto State is among Nigeria's poorest performers in terms of health and development indices. Despite national, state and donor investments in the health sector in Sokoto too many women, infants, and children continue to die from preventable and treatable causes. Some of underlying causes include inadequate and inequitable access to health information and services, weak health systems, non-implementation of existing health and related policies and plans, inadequate funding and human resources, weak infrastructure, uneven distribution of facilities and human resources, and inadequate service quality, amongst others. Women and youth and members of other vulnerable groups are particularly affected by poverty and limited economic opportunities across the North West and in Sokoto and are more likely to be unemployed and underemployed. While gender and social and cultural norms clearly heavily influence health access, some gaps in knowledge are apparent at the state level. Furthermore, although many governments and institutions are committed to both gender equality and social inclusion, there is insufficient protective and supportive policy and financial focus on implementing these goals, and even less of a focus on integrating these considerations into NTD plans and policies.

This desk review examined the health status of women, men, girls and boys in Sokoto State, and the social, economic, and political factors that influence health outcomes, including gender inequalities. By analyzing existing policies, strategies, and guidelines to identify gender-related gaps and opportunities within the health system, it offers recommendations to address gender, social inclusion, child marriage, male engagement, and GBV that have the potential to promote progress towards gender equity and improved health outcomes. The engagement of a wide range of public and private partners is critical to ensure consistent and sustainable progress to reduce preventable morbidity and mortality and promote social wellbeing and development.

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Annex 1. Gender-responsive checklists for health policies and guidelines in Sokoto, Nigeria

Sokoto State Strategic Health Development Plan II (2018–2022)

	Gender-responsive checklist – Health Policies, Guidelines, Service Protocols, and other key government documents in Nigeria	**SCORE** [NO: 0 Some what: .5 YES: 1]	**Comments**
In the description of the general state of health of the population:			
1.	Are sex-disaggregated data used/presented?	1	Some of the demographic indicators included in the Section 1.2 the State Profile include sex disaggregated data (population, unemployment, literacy rates, use of tobacco, HIV prevalence, knowledge of HIV). However, they do not include sex disaggregated for the health workers.
2.	Are age-disaggregated data used/presented?	.5	Some of the demographic indicators included in the Section 1.2 the State Profile include age disaggregated data (population, literacy rates, youth unemployment).
3.	Is gender equality considered a health determinant?	1	Gender is considered in the situational analysis of the plan. Section 2.1.6 states, "Gender and inequality issues are important elements in the State's socio-economic development discourse. While the constitution and associated State governance frameworks assure equal opportunities for women and men, traditionally embedded gender norms result in relatively high level of gender inequality in the State. The level of gender inequality is reflected, among others, in the very low share of women in governance at the State and LGA levels, in the legislature, and workforce participation rates for women in the State…." In addition, section 2.7.4. Addressing Socio-economic health determinants, mentions that "it is critical that interventions aimed at addressing socio-economic health determinants of health status such as women education, economic growth, household food security and environmental health…"
4.	Does the description reflect gender-based constraints in access to services?	.5	Section 2.1.6 continues to state, "Women have to seek approval from their husbands before seeking medical care."
5.	Does the description reflect disability-based constraints in access to services?	0	No.
In the health problems prioritized in the policy			
6.	Are the rights of the following groups protected in the policy (score one point for each)?	3	Covered in this priority area are reproductive, maternal, newborn, child and adolescent health are covered priority areas of health under the objective:

	a. Women b. Men c. Adolescent girls d. Adolescent boys e. PWDs f. Sexual minorities		Increased utilization of essential package of health care services, section 5.1. Reproductive, Maternal, Newborn, Child, Adolescent Health Services & Nutrition. The phrase "all citizens" and "all people" and integrated throughout the document, but the plan never specifically calls out PWDs and sexual minorities.
7.	Are specific objectives proposed to reduce gender inequalities?	.5	Equity and Gender Sensitivity is listed as a core value of the SSHDP II and states, "Fairness, respect and justice will be watchwords mainstreamed into the entire SSHDP II in addition to ensuring that planned interventions and activities address the health needs of all citizens across all levels and sectors of society." However it is not considered an objective.
8.	Are lines of action proposed to meet the different needs of women and men?	0	No.
9.	Are lines of action proposed to reduce gender inequalities?	0	No.
10	Does the policy include actions to address: a. Gender-based violence prevention and response/services b. Early/child marriage c. Obstetric fistula d. Female genital mutilation e. Male engagement	2	Obstetric fistula care is a priority under Reproductive, Maternal, Newborn, Child, Adolescent Health Services & Nutrition. The goal is to strengthen the prevention, treatment and rehabilitation services for fistula care in Sokoto state by: "1. Promote Obstetric Fistula preventive interventions 2.Strengthen /expand services for treatment of obstetric fistula 3.Foster community participation for the rehabilitation and re-integration of fistula patients Targets: The interventions are to target that: 4.Incidence of obstetrics fistula reduced by 50% by 2022 5.Treatment of new cases of obstetrics fistula and backlog increased by 30% 6. 75% of treated fistula cases reintegrated into their communities." Some of the activities in the workplan to address fistula include training health professional and CHEWs, sensitizing communities to destigmatize fistula, and supporting fistula patient with sewing, grinding and knitting machines to empower them. Addressing GBV is also a priority under the goal to promote demand and increase access to sexual and reproductive health services (family planning and post abortion care) by:

			5.Promote prevention of harmful traditional practices and gender-based violence 6.Scale up Prevention, counseling and treatment of rape and other gender-based violence such as Rape, intimate partner violence etc. Activities to address GBV include training of health staff prevention, treatment and counseling of rape victims; establishing counseling centers for GBV; educating the general public on gender-based violence and its prevention; and jingles on Radio and TV on gender-based violence and its prevention. The plan does not mention early marriage, FGM, or male engagement.
11	Does the policy include strategies to engage men as clients, as supportive partners/parents, and as agents of change in the following areas: a. sexual and reproductive health b. family planning c. maternal health d. newborn health e. child health f. maternal and child nutrition g. malaria	0	No mention of male engagement.
12	Does the policy include strategies to improve accessibility to services for PWD?	0	No.
Health systems strengthening			
13	Does the policy include strategies to train health workers in gender-sensitive service delivery approaches and techniques (pre-, in-service, refresher training)?	.5	No. Strategic objective and intervention for Human Resources in Health (section 6.1) is "Improve gender sensitivity in the production of health work force for all cadres at all levels." However, there are no measurable indicators or activities were mentioned.
14	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0	No.
15	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	0	No.
16	Does the policy require health information systems collect sex and age disaggregated data? a. If yes, does the policy require data be used for gender analyses and evaluation to improve gender equitable service delivery?	1	Section 11.1. Monitoring Plan states, "measures will be disaggregated by a range of factors such as demographic (i.e., age and sex), geographical (i.e., urban/rural) and socio-economic (i.e., wealth and education), to provide information on equity."
17	Does the policy include equitable financing strategies that recognize gendered needs	0	No.

	and inequitable access to resources for health care seeking?						
18	Does the policy ensure services are equally accessible to women (W), men (M), adolescent girls (G) and adolescent boys (B) in terms of: a. acceptability b. affordability c. availability d. eligibility e. respectfulness f. physical/geographic accessibility g. unbiased and nonjudgmental and nondiscriminatory	M		W	B	G	There is some language about creating youth-friendly sexual and reproductive health services.
		0		0	1	1	
19	Does the policy include strategies to increase women's participation in leadership and decision-making roles in the health sector?	0	No.				
20	Does the policy include measures for accountability in providing gender-responsive health services?	0	No.				
In the implementation and monitoring section							
21	Is the collection of sex-disaggregated data included in the monitoring and evaluation (M&E) plan?	1	Section 11.1. Monitoring Plan states, "measures will be disaggregated by a range of factors such as demographic (i.e., age and sex), geographical (i.e., urban/rural) and socio-economic (i.e., wealth and education), to provide information on equity."				
22	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	1	Section 11.1. Monitoring Plan states, "measures will be disaggregated by a range of factors such as demographic (i.e., age and sex), geographical (i.e., urban/rural) and socio-economic (i.e., wealth and education), to provide information on equity."				
23	Does the M&E plan include indicators to measure gender-related outcomes?	0	No.				
24	Are funding mechanisms and other resource needs and sources for the gender actions identified?	0	No.				
25	Does the M&E plan include what to do when M&E data reveal gender inequities?	0	No.				
* Not available.							

Sokoto State Primary Health Care Development Agency: Operational Guideline (2015)

Gender-responsive checklist – Health Policies, Guidelines, Service Protocols, and other key government documents in Nigeria	**SCORE** [NO: 0 Somewhat: .5 YES: 1]	**Comments**
In the description of the general state of health of the population:		

1.	Are sex-disaggregated data used/presented?	.5	Some of the demographic indicators in the background section are sex disaggregated (life expectancy and school enrollment).
2.	Are age-disaggregated data used/presented?	0	No.
3.	Is gender equality considered a health determinant?	0	No.
4.	Does the description reflect gender-based constraints in access to services?	0	No.
5.	Does the description reflect disability-based constraints in access to services?	0	No.
In the health problems prioritized in the policy			
6.	Are the rights of the following groups protected in the policy (score one point for each)? g. Women h. Men i. Adolescent girls j. Adolescent boys k. PWDs l. Sexual minorities	3	In the executive summary, the document states that "the goal of achieving a state of health for all citizens." However, it does not specifically mention that each of the groups are mentioned under the policy. It does specifically mention services provides for women and youth, but not men, PWDs or sexual minorities.
7.	Are specific objectives proposed to reduce gender inequalities?	0	No.
8.	Are lines of action proposed to meet the different needs of women and men?	0	No.
9.	Are lines of action proposed to reduce gender inequalities?	0	No.
10	Does the policy include actions to address: f. Gender-based violence prevention and response/services g. Early/child marriage h. Obstetric fistula i. Female genital mutilation j. Male engagement	0	The plan does not mention early GBV, obstetric fistula, early marriage, FGM, nor male engagement.
11	Does the policy include strategies to engage men as clients, as supportive partners/parents, and as agents of change in the following areas: h. sexual and reproductive health i. family planning j. maternal health k. newborn health l. child health m. maternal and child nutrition n. malaria	0	No.
12	Does the policy include strategies to improve accessibility to services for PWD?	0	No.
Health systems strengthening			

13	Does the policy include strategies to train health workers in gender-sensitive service delivery approaches and techniques (pre-, in-service, refresher training)?	0				No.
14	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0				No.
15	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	0				No.
16	Does the policy require health information systems collect sex and age disaggregated data? b. If yes, does the policy require data be used for gender analyses and evaluation to improve gender equitable service delivery?	0				No.
17	Does the policy include equitable financing strategies that recognize gendered needs and inequitable access to resources for health care seeking?	0				No.
18	Does the policy ensure services are equally accessible to women (W), men (M), adolescent girls (G) and adolescent boys (B) in terms of: h. acceptability i. affordability j. availability k. eligibility l. respectfulness m. physical/geographic accessibility n. unbiased and nonjudgmental and nondiscriminatory	M	W	B	G	No.
		0	0	0	0	
19	Does the policy include strategies to increase women's participation in leadership and decision-making roles in the health sector?	0				No.
20	Does the policy include measures for accountability in providing gender-responsive health services?	0				No.
In the implementation and monitoring section						
21	Is the collection of sex-disaggregated data included in the monitoring and evaluation (M&E) plan?	0				No.
22	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	0				No.
23	Does the M&E plan include indicators to measure gender-related outcomes?	0				No.
24	Are funding mechanisms and other resource needs and sources for the gender actions identified?	0				No.
25	Does the M&E plan include what to do when M&E data reveal gender inequities?	0				No.
* Not available.						

Sokoto State Gender Policy (2017)

Gender-responsive checklist – Health Policies, Guidelines, Service Protocols,	**SCORE**	**Comments**

and other key government documents in Nigeria		[NO: 0 Somewhat: .5 YES: 1]	
In the description of the general state of health of the population:			
1.	Are sex-disaggregated data used/presented?	1	In Appendix III, Sokoto State Disaggregated Data on Key Development Indices, there are several demographic indicators that are disaggregated by sex including population, ownership of informal sector business, attendance of primary and secondary school, unemployment rate and literacy rate.
2.	Are age-disaggregated data used/presented?	0	No data is used/presented.
3.	Is gender equality considered a health determinant?	1	Gender equality as a health determinant is integrated several times throughout the policy.
4.	Does the description reflect gender-based constraints in access to services?	1	Gender-based constraints are integrated throughout the document. For example, section 1.4.1 Behaviour Change Communication and Demand Generation mentions "studies found that women tended to want fewer children than men, but were often unable to limit or space children due to gender dynamics within relationships."
5.	Does the description reflect disability-based constraints in access to services?	0	No.
In the health problems prioritized in the policy			
6.	Are the rights of the following groups protected in the policy (score one point for each)? m. Women n. Men o. Adolescent girls p. Adolescent boys q. PWDs r. Sexual minorities	?	Although the groups are not particularly mentioned, there is a blanket statement that the policy's purpose is to "build a just society devoid of discrimination, harness the full potentials of all social groups regardless of sex or circumstance, promote the enjoyment of fundamental human rights and protect the health, social, economic and political well-being of all citizens in order to achieve equitable rapid economic growth" (pg. 11)
7.	Are specific objectives proposed to reduce gender inequalities?	1	There are seven policy objectives (in section 2.3 Policy Objectives) to reduce gender inequalities, including establishing a framework for gender-responsiveness; developing and applying gender mainstreaming approaches, tools and

			instruments; adopting gender mainstreaming as a core value and practice in social transformation, organizational cultures; incorporating principles that support gender equity and women's development in the state's legislative and state processes; encouraging women's participation and representation in governance; promoting gender-specific projects and programs; and educating and sensitizing all stakeholders on the centrality of gender equity" (pg. 13).
8.	Are lines of action proposed to meet the different needs of women and men?	0	While the policy mention that men and women need equitable access to certain resources, it does not highlight the different needs they may have.
9.	Are lines of action proposed to reduce gender inequalities?	1	Each of the aforementioned objectives have 2-5 accompanying strategies to reduce inequalities. For example, for objective 5 "encourage women's participation and representation in all aspects of governance" one of the strategies is to advocate for the adoption of special measures, quotas and mechanisms for achieving critical threshold of women and people with special needs in political offices (pg. 16).
10	Does the policy include actions to address: k. Gender-based violence prevention and response/services l. Early/child marriage m. Obstetric fistula n. Female genital mutilation o. Male engagement	0	There is no mention of GBV, early marriage, obstetric fistula, or FGM and male engagement is mentioned once with no substantial discussion.
11	Does the policy include strategies to engage men as clients, as supportive partners/parents, and as agents of change in the following areas: o. sexual and reproductive health p. family planning q. maternal health r. newborn health s. child health t. maternal and child nutrition u. malaria	0	Section 3.1.2. Information, Communication and Value-Re-orientation states, "a systematic effort to improve knowledge levels and change attitudes of all citizens on gender equity concerns through all communication mediums shall be instituted. Male involvement is critical to achieving gender equity." It mentions male engagement, but no actionable strategies.

12	Does the policy include strategies to improve accessibility to services for PWD?	.5	The policy mentions people with special needs, which would include people with disabilities, but they are not specifically called out and not about access to services.
Health systems strengthening			
13	Does the policy include strategies to train health workers in gender-sensitive service delivery approaches and techniques (pre-, in-service, refresher training)?	0	No.
14	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0	No.
15	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	1	While it's not health staff specific, section 2.4 Policy Objectives, includes the following objective "encourage equitable participation and representation of women, men, youths, boys and girls and people with special needs in all aspects of governance in order to promote equitable opportunities in all areas of political, social and economic development in the state." Table 1: Objective and Strategies includes the following steps, "a) Provide more opportunities to access and enjoy public services. (b) Advocate for the adoption of special measures, quotas and mechanisms for achieving critical threshold of women, youth and vulnerable groups in political offices, party organs and public life to bridge gender gaps in political representation in both elective and appointive posts at all levels. (c) Adopt Federal government 35% affirmative action for women to enable equitable representation of the society in both political and administrative appointment and in all sectoral programs and activities."
16	Does the policy require health information systems collect sex and age disaggregated data? c. If yes, does the policy require data be used for gender analyses and evaluation to improve gender equitable service delivery?	1	In Table 3.1 Broad Delivery Strategies and Policy Outcomes, number 6 (Research, Data and Evidence Based Planning) requires "reliable, disaggregated data available and key performance indicators" (pg. 18).
17	Does the policy include equitable financing strategies that recognize gendered needs and inequitable access to resources for health care seeking?	.5	Gender financing and budgeting is mentioned several times throughout the policy, including as a guiding principal and in capacity building. The guiding principle

			states, "Appropriate strategies and mechanisms, including financial accountability systems, for the delivery of gender equity as a cross-cutting issue" (pg. 12).			
18	Does the policy ensure services are equally accessible to women (W), men (M), adolescent girls (G) and adolescent boys (B) in terms of: o. acceptability p. affordability q. availability r. eligibility s. respectfulness t. physical/geographic accessibility u. unbiased and nonjudgmental and nondiscriminatory	M	W	B	G	No.
		0	0	0	0	
19	Does the policy include strategies to increase women's participation in leadership and decision-making roles in the health sector?	1	For objective 5 "encourage women's participation and representation in all aspects of governance" one of the strategies is to advocate for the adoption of special measures, quotas and mechanisms for achieving critical threshold of women and people with special needs in political offices (pg. 16).			
20	Does the policy include measures for accountability in providing gender-responsive health services?	0	No.			
In the implementation and monitoring section						
21	Is the collection of sex-disaggregated data included in the monitoring and evaluation (M&E) plan?	0	No.			
22	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	0	No.			
23	Does the M&E plan include indicators to measure gender-related outcomes?	0	No.			
24	Are funding mechanisms and other resource needs and sources for the gender actions identified?	0	No.			
25	Does the M&E plan include what to do when M&E data reveal gender inequities?	0	No.			
* Not available. **Notes**: They mention that there is no implementation plan, and that this would arise in MDA specific plans.						

Checklist adapted from:

- PAHO, 2009. *Guide for Analysis and Monitoring of Gender Equity in Health Policies.* Accessed June 10, 2011: http://new.paho.org/hq/dmdocuments/2009/Guide_Gender_equity_.pdf
- USAID. 2011. USAID Gender Integration Matrix: Additional Help for ADS Chapter 201: http://www.usaid.gov/sites/default/files/documents/1865/201sac.pdf
- WHO Regional Office for Europe, 2010. *Checklist for Assessing the Gender Responsiveness of Sexual and Reproductive Health Policies: Pilot Document for Adaptation to National Contexts*. Denmark. Accessed May 29, 2012: http://www.euro.who.int/ data/assets/pdf_file/0007/76525/E93584.pdf
- WHO. Gender Analysis Tool. Found in WHO Gender Mainstreaming Manual for Health Managers: a practical approach. Available at: http://www.ndi.org/files/WHO%20Gender%20Assessment%20Tool.pdf