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

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
BEHTFUND	Bauchi State Health Trust Fund
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women and Children
CHC	Community Health Committees
CHEW	Community Health Extension Worker
CHO	Community Health Officer
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 Response 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
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
SMOH	State Ministry of Health
SRH	Sexual and Reproductive Health
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TSHIP	Targeted States High Impact Project
UHC	Universal Health Coverage
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 3, led by Palladium International, LLC, works in Bauchi 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 Bauchi State and to identify gender and social inclusion issues affecting service quality, health programming, and health systems strengthening (HSS) outcomes. To assess this, the 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, rampant 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-east 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. Bauchi state is among Nigeria's poorest performers in terms of health and development indices, especially in child mortality, maternal health, and malaria. In Bauchi, child marriage (marriage before the age of 18) is the norm.

Despite large donor investments in the health sector in Bauchi and the prioritization of primary health care (PHC) by the state government (e.g., the Five Point Health Agenda), 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 and services persist.

Several vulnerable groups in Bauchi are particularly affected by poor RMNCH +NM outcomes: poor and marginalized populations; youth and adolescents; Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) populations; people with disabilities; ethnic and religious minorities; people on the move; and survivors of GBV. Given the poverty and limited economic opportunities across the North East and in Bauchi, these groups are more likely to be unemployed and underemployed. While it is clear that 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.

- 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 other donors and projects in Bauchi 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 strategy for integrating gender and social inclusion into 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 Bauchi State.

Introduction and background

USAID's Integrated Health Program (IHP) Task Order 3, led by Palladium International, LLC, works in Bauchi 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 3, 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 Bauchi, focusing on gender equality and equity in access to and quality of social services, and gender integration at the facility and community level, targeting integration of gender issues that impact service delivery and clinical care.

This desk review examines the health status of women, men, girls and boys in Bauchi 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. This desk review will inform the gender strategy for the project, which will address gender, social inclusion, child marriage, male engagement, and gender-based violence (GBV). 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 health systems strengthening (HSS) outcomes. The analysis examines gender and social inclusion considerations at all levels of reproductive, maternal, neonatal and child health, plus nutrition and malaria (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 assess this, the team examined elements including policies, guidelines, health worker recruitment, 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 DEC, and google search for reports from over the last five years from key global organizations (including UNICEF, CARE, Human Rights Watch, UN Women, UFPA, 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. 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
- girls' 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 Bauchi State

Nigeria

The Federal Republic of Nigeria is located on the western coast of Africa. Nigeria borders Benin, Cameroon, and the Gulf of Guinea. The country has 36 states and a Federal Capital Territory known as Abuja. 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. Nigeria is home to 350 different ethnic groups and over 250 languages.[4] 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.[5, 6] 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.[7, 8]

It is the most populous country in Africa; as of 2020, the projected population was approximately 204 million.[9] Nigeria's population is very young, with a median age of 18.1 years. There are approximately 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. [10] With an annual population growth rate of 2.6%, Nigeria is the seventh most populous country in the world.[9] The population is becoming increasingly urban with 52.0% of the population projected to be living in urban areas in 2020.[11]

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. In 2009, 53.5% of the population lived on less than $1.90 a day and the lowest quintile of the population held 5.4% of the income share.[12] Along with its slowing GDP, Nigeria has scored low in key social indices. The most recent Human Development Index (HDI) (a composite of life expectancy at birth, years of schooling, and gross national income [GNI] per capita) was 0.534 in 2018. However, the country has a Gini index[1] of 43, positioning it 157 out of 189 countries for highest levels of inequality.[12, 13] The UNDP calculates the Gender Development Index (GDI) based on the sex-disaggregated HDI and gap in achievement between genders for each of the three indicators. The 2018 GDI for females in Nigeria was 0.492, compared to 0.567 for males, giving the country an overall GDI of 0.868, slightly less than sub-Saharan Africa as a whole (0.891).[13]

As of 2019, women made up 45.6% of the national labor force.[12] Most employed Nigerian women work in informal, low-skill, low-wage jobs, if they are paid at all, and many work in subsistence farming. Women comprise 21% of the non-agricultural paid labor force nationally. Women are at particular risk to be employed in dangerous, underpaid positions, with some factories favoring hiring women because they are perceived as unlikely to complain.[14] Female-headed households (18.5% of all households as of 2018[5]) are particularly disadvantaged and vulnerable, where women are supporting families with lower incomes and often do not own the land they inhabit. As of 2014, only 4% of women in Nigeria owned agricultural land (whether alone or jointly with someone else), compared to 23% of men. When considering individual ownership, less than 2% of women owned at least one plot solely compared to almost 17% of men.[15]

In 2016-2017, 60.9% of all primary school aged children were attending classes, while 46.9% of secondary school aged children attended. In primary school, 95 girls are enrolled for every 100 boys, and this increases in secondary school to 97 girls enrolled for every 100 boys.[16] However, when looking at national lifetime school attendance, women are expected to attend school for an average of 8.6 years,

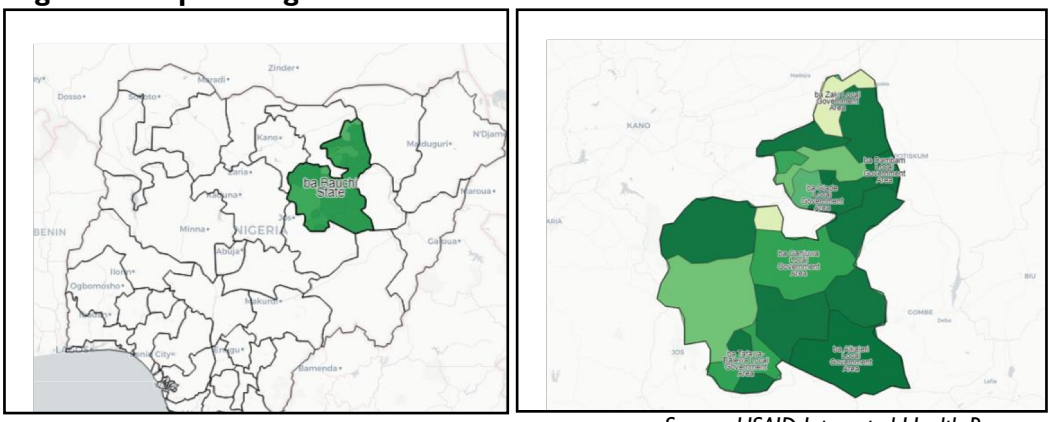
[1] The Gini coefficient measures income distribution within a population, where 0 is perfect inequality and 100 is perfect inequality.

compared to men's 10.1.[13] Women have lower rates of literacy than men: 53.1% of women are literate, compared to 75.2% of men.[5]

Nigeria has experienced periods of instability, violence, and famine over the past few decades. The north-east of Nigeria—where poverty levels are high, infrastructure and governance are weak, and education rates are lower—is marked by conflict and instability. Islamic extremist group Boko Haram is trying to establish strict Islamic law nationally, also known as Shari'a law, as well as stricter implementation of existing Shari'a law in the north-east. Boko Haram has been designated a foreign terrorist organization by the US Government and is said to be associated with the Islamic State. Its name translates to "Western education is forbidden" and the group forcefully opposes the education of girls.[17] In 2018 1,200 people were killed and 200,000 displaced due to the ongoing conflict.[18] 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.[19]

Nigeria experiences high levels of human trafficking for forced labor and sexual exploitation, as a point of origin, destination, and transit nation. The Government of Nigeria identified 1,121 potential trafficking victims in 2018: 538 victims of sexual exploitation, 203 victims of child labor, and 188 victims of forced labor. However, this number is assumed to be a very small portion of total trafficking victims.[20] Trafficking occurs both domestically and internationally, through which people are trafficked out of Nigeria to other African countries, the Middle East, and Europe. Domestic trafficking includes the forced participation of women and girls in Boko Haram and Islamic State-West Africa's (ISIS-WA) activities, including for sexual exploitation and enslavement, commercial sex, and forced marriage. Additionally, men and boys are recruited or forcibly taken as armed combatants, porters, and other support roles, and people of both genders are forced to be suicide bombers. Sexual exploitation, particularly of women and girls, by the Nigerian military or with the involvement of government officials is reported to be widespread and unchecked, with victims including local populations and residents of internally displaced persons (IDP) camps. There are also instances of young people enrolled in Quranic schools being forced to engage in street begging.[20] There have also been several reports of "baby farms" where young girls and women are kidnapped and forcibly impregnated, and the infants they bear then sold. A strong belief in witchcraft in some parts of the country 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 dark magic 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.[21] Understanding and measuring instances of such practices is incredibly difficult as they are both purposefully hidden and illegal.

Figure 1. Maps of Nigeria and Bauchi State



Source: USAID Integrated Health Program

Bauchi State

Bauchi State is one of 36 Nigerian states and is situated in the North East region of the country. It represents 5.3% of Nigeria's land mass, 3.8% of the population, and is comprised of 20 Local Government Areas (LGAs). Its capital city is also called Bauchi. With an estimated population of 7.3 million (2017),[22] Bauchi State is home to 55 tribal groups and a largely Muslim population, although the exact percent is difficult to determine as it is not tracked in the census. As of 2015, an estimated 10-15% of Bauchi State is Christian, 85-90% Muslim, and a small percentage follow traditional religions.[23] More than half of the population is under the age of 15 and 84% live in urban areas. [22, 24] The most commonly spoken and official languages are Hausa and English, but there is wide diversity in languages spoken.[25] There were 64,859 IDPs living in Bauchi in November 2019: 97% live in host communities and 3% living in camps or camp-like settings.[26] Further information on the makeup of the IDP population can be found in the Migration section.

Like the national government, the Bauchi State government is divided into executive, legislative, and judicial branches. The executive branch, headed by the State Governor, has the power to develop and execute policies in the state.[27] 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.[6] The North East is the only region where poverty increased between 2004 and 2013, from 45.6% to 47.6%; the region also saw an increase in income inequality as measured by its Gini index.[28] Bauchi state has high rates of multiple deprivation, indicating residents face challenges in accessing a wide variety of resources due to poverty. Bauchi State has the lowest HDI in Nigeria at 0.3238, significantly lower than the national average, at 0.521. [28] Women and youth are particularly affected by poverty and limited economic opportunities across the North East and in Bauchi and are more likely to be unemployed and underemployed.[28] In 2018, 32.5% of women in Bauchi State were unemployed in the twelve months preceding the NDHS, compared with 9.7% of men.[5]

Bauchi State has lower educational attainment and literacy levels compared to the national average, and women are generally less educated than men. A USAID Early Grade Reading Assessment in Bauchi and Sokoto found that 92% of students in grades 2 and 3 could not read any words in Hausa, which aligns with findings from the 2010 Nigeria Education Data Survey, which reported that even children who do attend school have some of the worst learning outcomes related to grade level in the world.[6] This is important since low education levels are correlated with low awareness of local facility health committees, which mobilize communities and promote the utilization of maternal and child health services.[29]

Boko Haram has attacked the city of Bauchi twice—in February and July 2009—killing over 60 people. In response to each attack, the Bauchi State Governor imposed a curfew for the city; after the second attack, at least 100 people were arrested. Despite this previous violence, Bauchi is considered safer and more stable than other states in the Northeast.[30] This has led to an influx of IDPs whose arrival to this already struggling state has strained local resources and infrastructure, particularly those related to health, nutrition, and social services.[30, 31]

Health overview and outcomes in Bauchi

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. With 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.[7]

Bauchi state is among Nigeria's poorest performers in terms of health indices, especially in teenage pregnancy, child mortality, and malaria.[5] Gender is intricately linked to health access and outcomes. More than two-thirds of women of reproductive age (15-49 years) in Bauchi state report facing at least one challenge to accessing healthcare; the most commonly cited of those challenges is access to funds, as Bauchi health financing is based on a fee-for-service model.[5] The distance to health centers and the attitudes of health workers were also reported as two significant barriers. Bauchi's performance on key health indicators and their relationship to gender, are summarized below.

Table 1. Key health indices in Bauchi State and Nigeria

Indicator	Bauchi State	National	Year	*Source*
Life expectancy at birth (years)	Not available	54.0	2017	*World Bank*
Infant mortality rate / 1,000 live births	69	67	2018	*2018 NDHS*
Under-five mortality rate / 1,000 live births	147	132	2018	*2018 NDHS*
Maternal mortality ratio / 100,000 live births	Not available	512	2018	*2018 NDHS*
Total fertility rate (births per woman)	7.2	5.3	2018	*2018 NDHS*
Percentage of teenage women (15-19) who have begun childbearing	40.7	18.7%	2018	*2018 NDHS*
HIV/AIDS prevalence-Adult population	Not available	1.5%	2018	*World Bank*
Malaria prevalence among under 5 years	48.6%	36.2%	2018	*2018 NDHS*
Diarrhea prevalence among under 5 years	34.1%	12.8%	2018	*2018 NDHS*
Prevalence of ARI among under 5 years	10.8%	2.6%	2018	*2018 NDHS*
Children <5 years stunted below-2 SD	54.7%	36.8%	2018	*2018 NDHS*

Reproductive health and family planning

Women and girls of reproductive age make up 22% of Bauchi's population.[32] In Northern Nigeria, where Bauchi is situated, men and women tend to have large families, influenced by cultural and religious beliefs.[33] Bauchi's total fertility rate is the highest in Nigeria at 7.2 births per woman of reproductive age, compared to the national average of 5.3.[5] Polygyny (the practice of one man marrying multiple wives) is correlated with high fertility rates in Bauchi; competition to bear children between wives in polygynous households has been identified as a driver of higher fertility.[34, 35] Additionally, women who want to limit or space children may be unable to due to unequal gender dynamics within relationships, including lack of decision-making power and ability to negotiate contraception use or access without a husband's approval.[33] Nationally, men said that seven was the ideal number of children to have, whereas women wanted six children; however, in Bauchi women say that between eight and nine is the ideal number of children.[5]

Contraceptive use in Bauchi state is alarmingly low. In 2018, only 6.5% of women used any contraceptive method and 5.2% used a modern method. These rates of contraceptive and modern contraceptive use were well below the national averages of 16% and 12%, respectively, and some of the lowest in the country[5], but a marked increase from rates of 2.2% and 2.1% in 2013.[36] Nationally, 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. Married women are also more likely to use modern methods of contraception. Nationally, 23% of married women with more than secondary school education use any method of modern contraception, compared with 4% of married women with no education. The unmet

need for contraception is 20.8% in Bauchi. Just over 14% of women want contraception for birth spacing and 6.7% want it to limit births.[5]

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. These rates are consistent with Bauchi, where the rates are 93.7% and 92.9%, respectively.[5] This is a significant increase over 2013 when women were less informed, with only 66.6% of women aware of any modern contraception.[36] However, despite increased knowledge of family planning in Bauchi, 81.3% of women and 75.1% 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.[5] These findings demonstrate that despite numerous sexual and reproductive health interventions taking place in the state, messaging is not reaching its target audiences.[33]

In Nigeria, 1 in 4 pregnancies is unintended; of those, 56% (1 in 7 pregnancies) end in abortion, 32% are carried to term, and 12% end in a miscarriage. There were approximately 1.25 million induced abortions in Nigeria in 2012. The North East region has one of the highest abortion rates in the country at 41 abortions per 1,000 women ages 15 to 49, or 16% of all pregnancies, compared to the national average of 33 per 1,000 women. These high abortion rates are likely linked to low contraceptive use and high unmet need for family planning.[37] In Nigeria, abortion is illegal except to save a woman's life, so the vast majority 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.[37] See Table 2 for a summary of key reproductive health indicators.

Maternal health

In Bauchi, the median age at first birth among women of reproductive age is 17.7 years, and 40.7% of women ages 15 to 19 have begun childbearing, whereas the national median age of first birth is 20.4 years and less than 20% of teenagers have begun childbearing. The median interval between births is almost 31 months, but approximately 22.1% of births still fall below the recommended interval between births of 24 months.[5] These statistics represent progress in birth spacing over the last six years—in 2013, more than 30% of births were spaces less than 24 months.[36]

Limited access to trained providers is a key factor contributing to maternal mortality and morbidity in Nigeria and in Bauchi. According to the 2018 Nigeria Demographic and Health Survey (NDHS), 39.4% of births in Nigeria take place in a health facility; in Bauchi, the percentage falls to 21.8%. Nationally, several factors were positively associated with health facility deliveries including increased educational attainment and economic status.[5] 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%, in 15 years. 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. In 2013 in Bauchi, the most commonly cited reason was that the child was born suddenly before the mother could travel to the health facility.[5, 36] Reasons for delivering at home include: the distance to the hospital; the cost of a hospital birth versus hiring a Traditional Birth Attendant (TBA); the husband's refusal to support a hospital birth, often due to financial constraints; a previous, successful home birth; or previous negative experiences with health facility staff.[36] Most married adolescents in Bauchi said they would prefer to give birth in a hospital, but the majority delivered their children at home.[34]

Over half of women in Bauchi reported receiving any antenatal care (ANC) from a skilled provider, which is lower than the national average of 67%. Of those who received ANC, 87.2% of women in Bauchi had blood samples and 81.9% had urine samples taken. Women in Bauchi are most likely to receive ANC from a nurse/midwife (46%). Nationally, a woman's level of education is strongly associated with whether she receives ANC: 97.3% of women with more than a secondary education received ANC from a skilled provider compared to 45.2% of women without an education.[5] Men and husbands were described as the gatekeepers to ANC in Bauchi. Supporting ANC attendance was considered an important way for men to support their wives during her pregnancy, either giving her permission to attend ANC or accompanying her. However, if her husband did not want her to attend—most often due to distrust of health facilities and providers or lack of money to pay for transportation and costs related to ANC—the pregnant woman could not attend ANC. Other reported barriers to ANC care were that women object to or are afraid of HIV tests, which they perceived as mandatory, and men and women mentioned the distance to health facilities and the cost and time to travel there.[34]

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.[38] Although there is not exact data on the incidence or prevalence of fistula in Bauchi, the state does host the National Obstetric Fistula Center through the USAID Fistula Care Plus initiative, and provides education, outreach, and free fistula repair.[39] The hospital has four surgeons trained in fistula repair, and carried out 187 surgical repairs in 2016.[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 (which neighbors Bauchi), women who experience fistula entered marriage at an average age of 15.5 years, tend to be now divorced or separated, have little education, have little or no access to financial resources, and come from rural areas. These patients developed fistula during a birth that lasted, on average, two days, and resulted in a stillborn fetus (91.7%). 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. This evidence highlights the pressing need for more deliveries in health facilities and for qualified care within those facilities.

Nigeria has one of the highest maternal mortality ratios (MMR) in the world at 512 maternal deaths per 100,000 live births, which accounts for 31% of all deaths of women 15-49 years old.[5] While the 2018 NDHS states that the MMR for Nigeria is 512, other estimates are much higher. According to the World Bank, Nigeria's MMR in 2017 was 917, the fourth highest in the world behind just South Sudan, Chad and Sierra Leone.[12] The main causes of maternal mortality are hemorrhage (23%), infection (17%), toxemia/eclampsia (11%), malaria (11%), obstructed labor (11%), unsafe abortion (11%), and other (11%).[42] Comprehensive, state-disaggregated data on maternal mortality is not available. However, the USAID Targeted States High Impact Project (TSHIP) collaborated with the Bauchi State Ministry of Health and Jhpiego to evaluate a project to reduce maternal and infant mortality in secondary healthcare facilities and found extremely high rates. In 2010, the MMR in these facilities was 4,113 deaths per 100,000 live births; the MMR fell to 705 deaths per 100,000 live births in 2014 after a targeted series of interventions. The intervention instituted Standards Based Management and Recognition, which supported identifying problems and gaps and their causes, setting clear, measurable, evidence-based standards (90 standards

total related to ANC, normal labor childbirth, immediate newborn care, postpartum care, complications, infection prevention, health facility management, and drug supplies management), monitoring implementation, and rewarding achievement. The rate of compliance with these standards increased from 4% in 2010, 35% in 2011, 69% in 2012, and 86% in 2013.[43] While this intervention demonstrates significant potential for reducing MMR in facilities, other approaches are needed to reduce MMR outside of facility births. See Table 2 for a summary of key maternal health indicators.

Table 2. Trends in reproductive and maternal health indicators for Bauchi State

	2013 DHS		2018 DHS	
Indicators	**Bauchi**	**Nigeria**	**Bauchi**	**Nigeria**
Contraceptive Prevalence Rate	2.1%	16%	5.2%	27.7%
Married women who had heard of any one modern method	66.6%	83.8%	93.7	93.9%
Unmet need for family planning (married women)	16.4%	16%	20.8%	18.9%
Total fertility rate	8.1	5.5	7.2	5.3
Adolescents who have begun childbearing	48.1%	22.5%	40.7%	18.7%
Any ANC care from a skilled provider	55.8%	60.6%	51.6%	67%
Delivery in health facility	16.9%	35.8%	21.8%	39.4%
Maternal mortality ratio (per 100,000 live births)	--	814	--	512
Postnatal check-up in first 2 days after birth	38.6%	40%	42%	41.8%

Source: NDHS [5, 36]

Newborn and child health

In Nigeria, one in every seven to eight children die before reaching five years old (132 deaths per 1,000 live births); in Bauchi, the rate is similar at 147 deaths per 1,000 live births. One in 15 Nigerian children die before reaching age 1, or 67 deaths per 1,000 live births. The rate in Bauchi—69 per 1,000 live births—is almost identical to the national rate.[5] Primary causes of neonatal mortality in Nigeria include asphyxia, preterm birth, infection, diarrhea, tetanus, and congenital illness.[42] In the TSHIP project, through a comprehensive quality of care improvement intervention, the neonatal mortality rate for infants born in Bauchi health facilities declined from 48 deaths per 1,000 live births in 2010 to 37 deaths per 1,000 live births in 2014.[43] 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; however, 62% of births also occur at home.[42]

Children under 5 represent 20% of the population in Bauchi state.[32] One fifth (19.6%) of children in Bauchi are fully immunized, compared to 31.3% nationally. Measles vaccine coverage stands at 35.5% in the state, compared to 54% nationally. Almost half (47.2%) of children in Bauchi have received the full series of polio vaccinations, which is the same as the national rate.[5] All of these represent improvements in immunization coverage since 2013.[36]

Over 34.1% of children under 5 in Bauchi had diarrhea in the two weeks prior to the NDHS 2018 survey, compared to 12.8% nationally.[5] In Nigeria, causes of under-5 mortality include neonatal (28%), malaria (20%), diarrhea (18%), pneumonia (15%), HIV (3%), injuries (1%) and other (15%).[42] More than half (56.6%) of women in Bauchi state do not access postnatal care for themselves, and 59.7% do not access postnatal care for their newborns.[5] 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.[44]

Nutrition

There is a high burden of undernourishment and malnourishment in Nigeria, with even higher rates in Bauchi. Nationally, 31.5% of children are moderately or severely underweight, compared to 48.5% in Bauchi; nationally 43.6% are moderately or severely stunted versus 64.9% in Bauchi; and 10.8% have moderate or severe wasting versus 7.6% in Bauchi.[16] 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.[45]

In Bauchi, 93.8% of children are breastfed, which is on par with the national rate. However, less than 1/3 of children are breastfed within an hour of birth nationally or in Bauchi. The median duration of breastfeeding in the North East region is 20.1 months, higher than the national average of 18.2, but the duration of exclusive breastfeeding is only 0.5 months, lower than the national average of 1.8. 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.[45]

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. Boko Haram activities have disrupted malaria services in northern Nigeria, increasing prevalence and decreasing service coverage. 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.[46]

In Bauchi, 84.3% of households have at least one ITN, which is higher than the national mean of 60.6% and a 14-percentage point increase since 2013. However, despite the presence of ITNs, only 48.7% of residents in Bauchi slept under an ITN the night before the 2018 NDHS was administered, compared to 43.2% of people nationally and 5.7% in 2013. This number was slightly higher for children under 5 (52.7%) and pregnant women and women of reproductive age (71%). Only 10.6% of pregnant women in Bauchi received the recommended three doses of malaria prophylaxis during their pregnancies, even though the medication is offered free of charge.[5]

HIV

Findings from the 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) indicate a lower prevalence of HIV than previously estimated.[47] The Federal Ministry of Health reported the national prevalence among 15-49 year-olds at 3.4% in 2012, however the 2018 NAIIS found a prevalence of 1.4% among this age group.[48] 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, females 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.[47]

In the North East, the overall HIV prevalence among ages 15 to 49 is 1.1%. Females have a higher prevalence than males at 1.3% compared to 0.9%. Females are also more likely to achieve VLS, 49.4% vs 47.4%. HIV prevalence was highest among females aged 40-44 and 50-54 years at 2.5%; the male age group with the highest HIV prevalence was 35-39 years at 2.2%. The gender difference in HIV prevalence was most drastic in the 55-59 years age group where 2.0% of women and 0.4% of men are HIV positive. VLS was higher among females in each age category, except among people 45-54, where males have the highest overall VLS out of any group.[49]

Knowledge of HIV prevention methods, including condom use and limiting sexual partners to one uninfected partner, were the lowest in Bauchi compared to all Nigerian states—48% of women and 46.3% of men had this knowledge. Overall, knowledge of HIV prevention methods is lowest in the North East, among uneducated men and women, among rural populations, and among lower wealth quintiles. There are also misconceptions around HIV transmission including that the virus can be transmitted by mosquitos and sharing food. Knowledge about mother to child transmission of HIV/AIDS is also low, where 62.6% of women and 42.8% of men know that the risk of mother to child transmission can be reduced with medication during pregnancy and that HIV can be transmitted by breastfeeding.[2][5]

Behaviors that put people at higher risk for HIV/AIDS are generally more prevalent among men, including total number of lifetime partners. In Bauchi, men have more sexual partners compared to women (1.9 compared to 1.4) and more frequently have multiple partners at the same time. 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 Bauchi, with only 1.6% of men reporting ever purchasing sex and 1.1% in the past 12 months. Neither women nor men were asked about whether they had been on the selling end of transactional sex.[5]

Overall, in Bauchi, as of 2013, 33.8% of women knew where to be tested for HIV, and 10.4% had been tested for HIV and had received the results. Comparatively, 59.3% of men know where to be tested and 10.2% have been tested and received the results.[3][36] Despite the fact that men are more likely than women to know where to get an HIV test, their testing rates are not higher, 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 16.2% of women in Bauchi received HIV counseling during antenatal care, which is much lower than the national average of 36%. In Bauchi, 9.7% of pregnant women received HIV counseling, an HIV test, and their HIV test results. Nationally, among women who had given birth in the past four years, 40% reported knowing their HIV status during

[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] State level data was not available in the 2018 NDHS.

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, over 80% reported starting ARVs prior to attending ANC.[47]

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%).[50] 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, MSM face barriers to care and difficulty accessing HIV services and treatment; this is the only population among which HIV prevalence continues to increase.[51] 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.[51] See Table 3 for a summary of key HIV/AIDS indicators.

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

	National		Bauchi		
Indicator	**Men**	**Women**	**Men**	**Women**	***Source***
Awareness of HIV/AIDS	95%	94.3%	91.8%	94.3%	*2018 NDHS*
Know condoms and having one HIV- partner reduces risk	74.1%	70.7%	46.3%	48%	*2018 NDHS*
Knew that HIV can be transmitted via breastfeeding	69.3%	77.6%	42.8%	62.6%	*2018 NDHS*
Knew that MTCT risk can be reduced with medication	62.2%	71.5%	39.9%	55.5%	*2018 NDHS*
People living with HIV	1.4%	1.9%	1.1%*	1.3%*	*2018 NAIIS*
People living with HIV with VLS	45.3%	42.3%	47.4%*	49.4%*	*2018 NAIIS*

*indicates rates for the North East, rates for Bauchi state not available

Major gender considerations in Bauchi

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 index number itself reflects the percentage of human potential lost to gender inequality. The country's 2016 GII was 0.635, which represents a 63.5% loss in human development potential due to gender inequality. In 2016, Bauchi state had a GII value of 0.698, indicating higher levels of gender inequality than the national average but lower than the majority of the surrounding states in the North East.[4][52]

Gender norms, roles, and responsibilities

There is some belief that Bauchi is characterized as a strict patriarchal society. Results from an undated mixed methods assessment conducted in Bauchi suggest that residents generally live according to a "strict

[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 Repor*t – 2016. However, the UNDP does not list GII for Nigeria for any of the most recent years. No information is available on why GII is not listed.

patriarchal hierarchy" where men are independent decision-makers and unquestioned leaders of the home and family.[34] A 2015 study came to similar conclusions, stating 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.'[53] This strict patriarchal system is supported by interpretations of Islam and Christianity, whereby there is a persistent belief that the man has been given the "mantle of leadership" by God.[53] Another 2015 national study found that religion is much of what defines the roles and responsibilities of men and women, and because the status of women in the religious texts of Islam and Christianity is generally low, and men dominate positions of power "… and this has translated to women's marginalization from positions of power and authority."[54] This belief system affects all aspects of their lives whereby the man is the decision-maker, protector, moral authority, and bread-winner, and women's role is to support, by taking care of the home, cook, and clean, and obey her husband's decisions. Marriage, bearing children, and obeying one's husband are linked with women's social status and perceived success.[34] 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.[54]

These norms give the husband authority in the family but also impose clearly defined duties and responsibilities on him. Men are responsible for taking care of the family through work outside the home, and men and women are both responsible for their children's behavior, religion, and morality. This delineation of roles trickles down to boys and girls, where they generally help their parent of the same gender. The preferential position of boy children within families is notable, whereby they are considered essential to a family; and boy children have authority over their sisters and can even punish them, even if the boy is younger.[34] These persistent power imbalances serve as a barrier to women's empowerment.[55] However, these gender roles are not universally performed, and women sometimes have more decision-making authority when they are more educated or earn an income, which are considered more "valuable" contributions than what most women contribute to a marriage.[34]

According the 2018 NDHS, men in Bauchi often display controlling behaviors towards their wives, which has been identified as a warning sign and correlates with intimate partner violence. Controlling behaviors examined in the same report included whether he: (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 knowing where she is at all times. In Bauchi, over 60% of women report that their husbands become jealous if they talk to other men and 56.5% say that their husbands must know where they are at all times. Almost a third of women in Bauchi (28.2%) say their husbands exhibit three or more controlling behaviors.[5] According to the *Because I Am a Girl* gender assessment, these are not just beliefs, but translate into women and girls' daily lives where their freedom of movement and socialization are restricted based on social and religious proscriptions, both of which are inherently intertwined with a husband's right to act in a controlling manner.[34] For example, women must have a male relative's permission to travel outside the home and may need to be accompanied when she does go outside. Women's social interaction is restricted to other women and men within their family, which makes the presence of female health workers in the community and at health facilities essential to ensuring women's access to care. Women and girls generally have little decision-making influence or authority within their communities or homes. However, within women's social groups, where women gather together to socialize and conduct activities, women reported greater freedom of association, greater influence, and social support. [34] The same report describes that some of these women's groups require fees, which the women save collectively and use for emergencies (e.g., to pay for a member's emergency transportation to a healthcare center in the case of an emergency). As inclusive as they are described to be, women can only participate if they can afford the dues.

When it comes to decision-making, only 19.3% of women in Bauchi make decisions about their own healthcare, 19.7% make decisions about household purchases, and 38.1% make decisions about visiting friends or family.[5] Men are much more likely to hold decision making power over their own health and household purchasing in Bauchi. Interviews during an evaluation in Bauchi of the Targeted States High Impact Project (TSHIP), a project to strengthen delivery of high-impact integrated MNCH, family planning, and reproductive health interventions, showed general consensus among the women interviewed that personal, family, and community norms around family planning were shifting and acceptance increasing.[33] However, decision-making authority and autonomy for women about whether to use contraception is extremely low: 4.2% of adolescents and 2.5% of women say they are the primary decision makers about whether to use family planning. Both male and female focus group discussion (FGDs) participants in Bauchi showed nearly unanimous consensus that wives could not decide to use contraception without consulting their husbands. However, despite agreeing that a wife *should* seek her husband's permission to limit or space births, some women expressed a willingness to access contraception without permission, but perceptions of how common the practice is varied amongst respondents.[34] While women do have higher healthcare access rates than men, there are still key barriers in place, as noted above, that prevent access to skilled, compassionate care. [35, 56]

Gender-based violence

According to 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 Bauchi, 63.6% of women have experienced either physical, sexual, or emotional violence by a partner or spouse, which is more than double the number in 2013 (24.5%) and almost double the national average. [5, 36] Over half of women in Bauchi say they have experienced such violence in the past year. Three-quarters of women in Bauchi agree that husbands are justified in beating their wives under at least one circumstance, the most common being if she goes out without telling him followed by if she neglects the children. A much smaller proportion of men, 32.36%, believe wife-beating is ever justified.[5] These findings were substantiated during a qualitative study in Bauchi, which showed that most participants did not approve of physical violence against one's wife, but believe that, generally, the woman had done something to antagonize her husband. Reporting a wife's misbehavior to her parents was mentioned as an alternative to physical violence.[34] In Bauchi, 3.5% of ever-pregnant women experienced intimate partner violence during their pregnancies.[5] Key figures on GBV are outlined in Table 4 below.

Table 4: State vs. National levels of violence

Description of Violence	Bauchi	National
Physical abuse from husband or partner (ever-married women between 15 and 49)	21.7%	19.2%
Sexual abuse from husband or partner (ever-married women between 15 and 49)	22.7%	7.0%
Emotional abuse from husband or partner (ever-married women between 15 and 49)	57.3%	31.7%
Controlling behavior: women whose husbands become jealous if they talk to other men	62.2%	44.2%
Controlling behavior: women whose husbands must know where they are at all times	56.5%	40.7%

Controlling behavior: women whose husbands try to limit when they see their families	26.3%	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	73.9%	28.0%
Women who never sought help or never told anyone about their experience of violence	73.8%	54.6%

Source: 2018 Nigeria DHS [5]

Women in Bauchi often do not seek help after experiencing violence. Only 16.4% of women sought any kind of help after experiencing violence[5], which is a 2-percentage point decrease sine 2013.[36] This is concerning given the increasing rates of intimate partner violence in Bauchi.[5] Women face significant barriers in seeking support after experiencing violence, including victim blaming, social and religious pressure, and distrust of law enforcement.[53] This shows that violence is normalized within the culture, especially when it occurs within the home. In one study, 3/4 of men and 2/3 of women reported being physically punished at home as children, 4/5 of men and 7/10 of women reported being beaten or physically punished at school, and 1/4 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.[53]

One national study found that 40% of men self-described as having at least at some time perpetrated physical, emotional, or economic violence against a partner, and 42% of women reported having experienced such violence. In Bauchi the rates were slightly lower, with 37% of men reporting having perpetrating violence at some time and 31% of women reporting ever experiencing violence from a partner. Men were more likely to self-report being 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 do less domestic work than women, and fathers.[53]

Female genital mutilation/cutting (FGM/C) is a form of GBV commonly practiced on women and girls in Nigeria often perpetuated due to religious or cultural beliefs. FGM/C is most often at the request of one or both of a child's parents and 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.[57] Over 60% of Nigerian women age 15-49 had undergone FGM/C as girls and young women, and it is more than common among older age groups. In Bauchi, only 10.7% of women have undergone FGM/C.[5] However, rejection of harmful traditional practices, including FGM/C, is on the rise.[53] Approximately 67.4% of Nigerian women believe that the practice should be stopped, compared to almost 80% in Bauchi (8.9% believe it should continue and 11.5% have no opinion).[5]

Marriage and divorce

The process of choosing a husband is usually controlled by the female's male relatives; their involvement reportedly includes a level of responsibility for the marriage, where they may offer financial support or intervene in cases of domestic violence or when a wife "misbehaves."[34] 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.'[53]

Polygyny (one man marrying multiple women) is common in Bauchi, where 46.6% of married women and 22.2% of married men report having one or more co-wives, compared to 30.9% of women and 14.8% of men nationally.[5] 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.[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.[34]

Child marriage

Generally, females marry younger than males in Nigeria. In 2018, the average age for marriage for females was 19, eight years earlier than the average age for males. In Bauchi, child marriage (marriage before the age of 18) is the norm: the average age of first marriage for females was 15.5, compared to 24.3 years for males.[5] Since 2013, the average age of marriage has remained the same for females but increased by two years for males.[36] Child marriage is tied to a cultural and religious veneration of female virginity, which is considered something valuable 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.[58, 59] 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.[60, 61] 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.[12] In 2013, half of females in a study had been married as children (before the age of 18). This contradicts declining levels of approval for child marriage: in 2015, only one- third of the population sampled continued to be in favor of or agree with child marriage.[53]

Nationally, age at first marriage increases with education level: on average, children with no education get married at 15 years, compared to 21 years for girls who enroll in secondary education. In Bauchi, poverty, education, and early marriage are closely linked, where families with the resources to educate their daughters before marriage may marry them later, but if those resources are not available, or were available but become scarce, marriage is seen as the other viable option by some parents.[34]

The dangers of early pregnancy are well known by Nigerians of all ages and are cited as an argument against early marriage in the national *Strategy to End Child Marriage in Nigeria 2016-2021*, as there is a general expectation that an adolescent will give birth within the first year of marriage.[34, 62] 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.[62] Child marriage has also been linked with the prevalence of obstetric fistula in the North East region, as obstructed deliveries are more likely when girls have not finished puberty.[57, 61]

When unmarried girls do get pregnant, informants in a Plan Canada gender assessment reported that they may seek an abortion, even though it is illegal except to save the life of the mother, and if that fails, will carry the fetus to term. 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 kicked out of their homes.[34] A 2004 report highlights that most births to adolescents occur in

marriages, with only 3% of women nationally and 2.4% in the north east reporting a premarital birth before age 20. This rate was higher among rural vs urban 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.[63]

Divorce

In Nigeria, marriage and divorce can be governed by customary or traditional law, which is enforceable by traditional authorities and bodies, civil law developed and enforced by the Nigerian government, and in northern Nigeria and Bauchi state, Islamic law, as developed and implemented by that state. Divorce is permitted under Nigerian law and can be granted by the state if the marriage was registered with civil authorities.[64] 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. [65, 66] 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.

Divorce is permitted under four different circumstances under Shari'a 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.[5, 56] Physical violence was mentioned as a reason to seek divorce in Bauchi state, as well as a reason for which a court would grant a wife the divorce she requested.[34]

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 Bauchi, and 1.5 for women nationally and 1.4 in Bauchi. However, in Bauchi, 19.6% of men reported having 2+ partners in the last 12 months versus 12.8% nationally, while 1.1% of women nationally had 2+ partners in the past 12 months compared to 1.5% of women in Bauchi.[5] Given the high rates of polygyny in Bauchi, this low mean number of lifetime partners are surprising and merit further investigation.

On average across Nigeria, females begin having sex at age 17 and males at age 22. Over half of females have sex before their eighteenth birthday. In Bauchi state, females begin having sex at a younger age (15.4 years), while male's sexual debut tends to be later (23.4 years). Girls with a secondary education and greater wealth begin having sex later compared to girls with no education, and for boys the reverse is true.[5] This matches the trend of child marriage. Additionally, nationally 41.2% of females 15-24 reported having a sexual partner 10 or more years older than they in the past year, which increases risk of sexual transmitted infections (STI), including HIV, among females, as the virus is often passed from older men to younger women.[16]

Negotiating safer sex is an essential part of HIV/AIDS prevention and sexual and reproductive health, however, 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, 29% of women and 20% of men reported using a male condom during the last sexual intercourse. However, the results of attitudinal questions about safer sex negotiation show an interesting trend in Bauchi, where 85.8% of

women believe that a woman is justified in asking her husband to wear a condom if she knows he has sex with other women, and 53.9% of men agree (however the question does not appear to have addressed polygyny, which might be treated differently). Similarly, 76.3% of women believe that a woman is justified in asking her husband to wear a condom if she knows he has an STI, and 52.9% of men agree.[5] Overall, agreement with these statements increases with household wealth and education levels. 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 Bauchi.

Men and masculinities

There is a growing concern that harmful gender norms and toxic views of masculinity can result in 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.[45] According to the Nigeria Men and Gender Equality Survey (NiMAGES) survey, "toughness, sexual performance, and income were central to notions of masculinity in study sites."[53] Additionally, men's healthcare 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.[53]

Men reported significant rates of mental health issues: in Bauchi, 55% felt regularly stressed, 31% felt regularly depressed, and 13% had suicidal thoughts. While men did not generally seek professional mental health support, they did report reaching out to personal, informal sources. Additionally, men reported drinking much more alcohol more often than women, with 50% of male respondents in Bauchi having five or more drinks in a sitting at least once a month, compared to 0% of women, and many also recognized the negative consequences it had for them and those around them.[53]

When describing men's roles during pregnancy and birth, 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.[34]

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.[34]

Governance and the health system

The Government of Bauchi State developed The Five-Point Health Agenda to identify priorities to improve healthcare in the state from 2016 – 2020. It aims to:

1. Strengthen primary healthcare including routine immunization and reproductive, maternal, newborn, and child health services
2. Improve access to quality and cost-effective essential and life-saving drugs, including consumables and laboratory services
3. Motivate, retain, and retrain frontline health workers for effective and quality service delivery
4. Improve funding of the health sector through innovative financing mechanisms, accountability, and transparency
5. Create demand via health education, awareness creation, and strategic communication.[67]

Bauchi must overcome a number of challenges to reach these goals, which will be addressed throughout the forthcoming sections of the report, including inadequate health sector funding, inadequate number and distribution of health workers, low private sector engagement in health care delivery, lack of state health coverage, high out of pocket expenses for patients, and challenges in budget coordinating and tracking.[67]

Structure and decentralization

The Bauchi 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, generally divided between primary, secondary, and tertiary care facilities.[68] The SMOH was decentralized into various ministries, departments, and agencies (MDA) between 2010 and 2015:

1. The Ministry of Health Headquarters
2. State Primary Healthcare Development Agency
3. The Bauchi State Agency for the Control of HIV/AIDS, Tuberculosis and Malaria
4. The Hospitals Management Board
5. The Specialist Hospital Bauchi
6. The Drug Management and Medical Consumables Agency
7. School of Nursing and Midwifery
8. School of Health Technology

Primary health care (PHC) centers are owned, funded, and managed by Local Government Authorities (LGA) through their Departments of Health. Secondary and some tertiary health facilities are the responsibility of the SMOH. Specialized tertiary facilities, such as teaching hospitals of federal universities, including the National Obstetric Fistula Hospital, are the responsibility of the Federal Ministry of Health.[32] 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.[69]

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 highlighting "other states where men were appointed to positions where one would expect a woman to be."[14]

Decision making about health in Bauchi state occurs within two bodies: the Top Management Forum, which coordinates the activities of the Ministries, Departments, and Agencies (MDAs) in Bauchi, and the Donors/Implementing Partners' Forum, which supports SMOH and MDAs through coordinated efforts to build capacity for staff and communities, financing, and in-kind donation of medical supplies and equipment. The additional engagement of civil society organizations in health sector governance is also cited as a positive development.[67]

SMOH has taken several steps to increase community participation, including the establishment of facility health committees, the original roll-out of which included training for facilities and committee members in 323 political wards. However, while continuing to increase community participation and ownership is an explicit goal of the current Bauchi State Strategic Health Development Plan (described below), the importance of the full participation of women is not mentioned, nor is the challenge of women's participation.[67]

Women are underrepresented in leadership positions within the health sector in Bauchi. As of 2015, none of Bauchi State Hospital Management Board's 17 members or of the eight-member Civil Service commission were women. Organizations managed by the state had marginally more female representation, where one in ten members of the Management Board of the Federal Medical Centre was female, while the Technical Management Committee was comprised of seven men and one woman. Of the 20 PHC Directors in Bauchi state in 2015, 17 were men. At the College of Health and Technology in Bauchi, one member of the nine-person Government Council is female. When questioned about this disparity, given that the College has a gender policy, a representative commented "we have never thought of women being on the board. With the amount of pressure that men put into lobbying for the position, it will be very difficult to remember women who have not shown any form of interest."[68]

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.[70] 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.[69, 71] 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.[69, 72]

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.[73]

- **Bauchi State Strategic Health Development Plan (2016–2020)** – Developed by the State Ministry of Health with support from USAID and RTI International, this plan is a guide to support evidence-based priority interventions, including strengthening leadership and governance, improving health service delivery, providing skilled and appropriate human resources for health, and creating a health management information system to achieve desired health targets. While the plan does utilize some sex-disaggregated data in the background, gender is not considered a determinant of health or a priority within the plan. Gender considerations are not reflected in health workforce sex distribution or training, monitoring and evaluation systems, nor in health finance and budgeting. Finally, there is nothing about prioritizing and protecting certain groups such as men, women, adolescents (of both sexes), people with disabilities and sexual minorities.
- Based on those and other findings, Bauchi State developed the **5-Point Health Agenda**, which prioritizes RMNCH, increased access to quality commodities, improved human resources for health, increased funding, and demand generation and education. This plan was costed, and strategies to garner and leverage existing and added support to fund the plan are discussed, and indicators to measure progress are presented.[67]

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."[74]

- **Bauchi State Revised Gender Policy (2017)** – Bauchi has an overall gender policy that offers guiding principles for MDAs to incorporate in their implementation plans. It considers gender equality a health determinant and seeks to give direction on how to address issues of women, boys, girls and persons with special needs in the design and implementation of government policies and programs. The guiding principles include gender mainstreaming, eliminating discrimination, sourcing human and financial capital, commitment to gender-responsive financing and budgeting, determination to address social, economic and cultural determinants, scaling up female school enrollment, community re-orientation, and empowerment schemes. It calls for the collection of sex-disaggregated data, gender-sensitive indicators and holding programs accountable for gender integration. It also proposes gender sensitivity training for decision-makers. As previously mentioned, this is a guiding document for other MDAs to establish a Gender Technical Working Group, it doesn't provide specific actionable steps for gender-responsive interventions. It also doesn't provide any strategies for male engagement, or preventing or 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.

Gender and Equal Opportunities Bill[75] – 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.[76] 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 are not entitled to any inheritance.[77]

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.[78]

- **Bauchi State Human Resources for Health Policy** – This document outlines Bauchi's policy for managing, developing, financing, monitoring and evaluating human resources for health, and integrated gender throughout the document. The policy promotes gender sensitivity training for health workers, and to reduce discrimination in the workplace. It uses sex disaggregated data of health workers, which reveals that there are more male health workers in every category from doctors (4 males to 0 females) to Community Health Extension Workers (CHEWs) (905 males to 346 females), except for midwives. While this document illustrated this large gender gap and expresses a commitment to a gender balanced workforce and equitable promotion and retention of health workers, there are no actions proposed on how to reduce this gap (e.g., no recruitment or retention strategies for female health workers). The policy also does not mention sexual harassment, violence, and security of female health workers.
- **Bauchi State Task Shifting/Sharing Policy for Essential Services (2016)**– This document outlines the protocols for RMNCH, HIV, TB and Malaria health services that can be shared among CHEWs. Gender Equality is listed as a guiding principle of the document. It also incorporates

screening techniques to identify gender-based violence, however it does little to encourage male partner involvement in any of the RMNCH activities.

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 a 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.[79]

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.[80, 81]

Discrimination Against Persons with Disabilities (Prohibition) Act (DAPDA) – This 2018 policy established a National 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.[81]

Bauchi State Costed Implementation Plan for Family Planning (2018–2020)– This document serves as a roadmap to understand the resource needs for family planning in Bauchi to harness the available resources, coordinate evidence-based advocacy, and implement family planning activities from 2018 to 2020. The State targets a contraceptive prevalence rate (CPR) of 23.54%, as suggested by the Federal Ministry of Health, which will have significant impact on its maternal and child health indicators in Bauchi. While this document touches on gender-based constraints to accessing family planning services, and really focuses on creating access for vulnerable groups like adolescents, gender is not highlighted throughout the document. There is no specific strategy for male engagement in family planning (aside from tailoring communication materials) and doesn't mention GBV at all. In their monitoring and evaluation framework there are few sex disaggregated indicators and few gender-sensitive indicators.

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[82], the National Policy on HIV/AIDS[83], the National Policy on the Health & Development of Adolescent & Young People in Nigeria[84], the Marriage Act of 1990[85]**,** Integrating Primary Health Care Governance in Nigeria (PHC Under One Roof)[86], National Policy on Sexual and Reproductive Health and Rights of Persons with Disabilities with emphasis on Women and Girls[80], National Framework for the Elimination of Obstetric Fistula[57], and the National Strategy to End Child Marriage (2016 – 2021)[62], among many others.[87]

Legal framework

Like the policy environment, Nigeria's legal environment is also 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 into the country, 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 automatically integrated into federal law within Nigeria. Once nationalized, those laws must be adopted by each state for implementation and enforcement. In many cases, national policies may not be adopted by all states if they feel the content does not align with the beliefs of their population. This right is enshrined in the Constitution.[88]

In Bauchi State, in addition to the laws of the federal government and the state, Shari'a law is enforced. Shari'a law only applies to Muslims and people who voluntarily accept it and those laws are adjudicated within Shari'a courts, a separate legal system entirely with its own system of appeals. Shari'a law as implemented in northern Nigeria is not aligned with the federal constitution.[89] There is no equivalent legal system in Bauchi for Christians. A principal element of Shari'a law enforcement is the Hisbah, or Shari'a police. They patrol the streets like civil police, specifically enforcing Shari'a law. In Northern Nigeria, there have been reports of violent attacks on women who were deemed to be dressed inappropriately by the Hisbah. While Shari'a 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.[89]

Marriage and divorce

Marriage in Nigeria can take place within one of three parallel systems: civil law, religious law (Shari'a in the case of Bauchi), and customary or tribal law. Once the marriage takes place, only the law under which a couple is married may have 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.[62] 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.[90] 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.[91] In Bauchi there are no laws against forced marriage, however there is a law prohibiting withdrawing young girls from school in order to marry.[92]

Under Shari'a law, the most common type of divorce practiced in the North East 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 request a divorce.[89] 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.[93] 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.[56] Therefore, for example, if someone is married under Shari'a law, only a Shari'a court and judge may grant them a divorce.[94]

Widows' rights

Widows in Nigeria are a very vulnerable population and face stigma and abuse. In the north east, 10.8% of widows are blamed for their husband's death by his relatives, 10.4% are physically or verbally abused by his relatives, 12.8% are maltreated by his relatives, 9.2% of their children are maltreated, and 3.0% of women's in-laws demand they carry out cultural practices to prove themselves 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.[36]

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 Shari'a law, or if the husband did not leave a will, the wife may inherit nothing.[89, 95] It is generally the woman's in-laws who deny her inheritance of resources and property. Additionally, under the Shari'a 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.[95] If she does maintain custody of her children, she may be denied child support and is also at higher risk for violence.[96]

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.[97] According to Shari'a 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.[89] In Kano (Bauchi's neighbor) the NGO Voices of Widows, Divorcees, and Orphans 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 a 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.[89]

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.[98]

As mentioned, Nigeria's government is one of the least 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.[99]

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 Shari'a 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.[89] 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 Nigerian law, 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.[100]

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 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.[79] 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).[101, 102]

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 persons 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.[20] 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.[20]

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." The law also prohibits any type of advocacy or support for LGBTQ people. [103]

According to a 2016 report, the Act 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 impunity for violence against LGBTQ people, including mobs of people attacking people based on their suspected sexual orientation.[102]

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 Bauchi 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."[101]

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.[69] 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%.[5] 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.[36]

Bauchi

The 2019 approved Bauchi State budget is available on the State's website, but it is a summary rather than detailed version. Sixty-two percent of Bauchi State's funding for its health sector comes from the Federal Government.[104] Additionally, there is significant domestic and foreign investment for development in the region in the 2019 Bauchi State Government budget. According to the Bauchi State Government budget for 2019, total domestic aid and grants, which include special funds from the central government, total nearly $39 million USD and foreign aid and grants total over $22 million USD. Both of these figures are nearly double what was received in 2018.[105]

According to the 2019 Bauchi State Budget there was no apparent allocation of funds for services for GBV survivors nor did any of the projects funded by international donors explicitly address GBV, judging from the project titles. Funds were allocated for the Ministry of Women Affairs (0.26%) and the Bauchi State Commission for Youth and Women Rehab and Development (1.87%), however, more detailed budgets were not available.[106] GBV-related activities were not identified in the Bauchi State PHC 2018-2019 workplan.[107]

Bauchi State includes donors and partners in the health budgeting process to avoid duplication and ensure roles are clear. In addition to larger donors, community-based organizations and civil society organizations directly finance some health activities in the state. The participation of these organizations in the budget planning, implementation and monitoring processes was cited as one of the reasons for improved SMOH accountability and efficiency, including the release of more funds for health care facilities. However, despite the fact that these elements have improved, the participation of stakeholders, beyond senior management, in the budgeting process is still described as needing improvement.[67]

Aligning with these findings, the 2016-2021 Bauchi State Strategic Health Development Plan identifies a number of challenges related to health financing, including inadequate funding, especially for primary health care centers, insufficient state coverage of healthcare costs, correspondingly high out of pocket costs for patients, and challenges coordinating and tracking resources.[67] Table 5 expands upon the greatest

[5] The 2013 NDHS is the most recent data; this indicator was not measured in 2018.

financial challenges facing the state's health sector and their underlying causes in its Health Policy Financing Strategy.[108] To address these challenges, the Plan identifies the following objectives:

1. To develop and implement health financing strategies at state and local levels consistent with the National Health Financing Policy
2. To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services
3. To improve and secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner
4. To ensure efficiency and equity in the allocation and use of health sector resources at all levels[67]

The total cost to implement the Bauchi State Strategic Health Development Plan, which runs from 2016–2021, is 66 million naira (approximately 183 million USD); over 90% of the budget is dedicated to service delivery, including human resources.[67] Prior to this plan, the state allocated between 8 and 11% of the total budget to healthcare between 2012 and 2016, below the 15% recommended threshold under the Abuja Declaration.[104] Additionally, despite what may be budgeted on paper, the State released an average of 61% of the funds budgeted for health between 2009-2015; the highest percentage released during those years was 74% in 2010.[67, 106] The per capita spending on health averaged $6 USD between 2012 and 2016, far short of the $86 USD recommended to provide basic health services.[32] Additionally, the investment in recurring expenses versus capital investment (e.g., infrastructure) is "unacceptably low," according to a 2017 USAID assessment of Bauchi State's public expenditures.[32]

Table 5: Primary challenges in Bauchi State's health sector

		Primary challenges			
		Resource mobilization for sufficient, predictable financing	Effective pooling and fund management, esp. for universal healthcare	Strategic purchasing and efficient resource allocation	Strengthening health financing, governance and coordination
Underlying Causes	Inadequate public funding	X			
	Low release and utilization of public funds	X			
	High out of pocked expenses	X		X	
	Dependence on international donors and poor priorities alignment	X	X		X
	State and donor fund allocation not performance or results-based			X	
	Low health insurance coverage	X	X		
	Inadequate management and tracking of existing funds	X	X		X
	Lack of strategic purchasing			X	
	Over-centralized decision making			X	
	Poor provider performance due to lack of incentives			X	

Source: Health Policy Financing Strategy, SMOH [108]

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 Bauchi's State government's efforts to implement could not be found. However,

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.[109]

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 the corresponding budgets.[74] Women appear in budgets essentially as objects of health care, whose fertility rates should be lowered and whose maternal mortality rates must be addressed.[24, 27, 32, 67, 105, 106] For example, the word "gender" does not appear in the Bauchi State Health Financing Policy and Strategy.[108]

Health insurance and gender

In Nigeria less than 5% of the population has any type of health insurance.[69] As of October 2018, only two groups in Bauchi State have anything akin to health insurance. First, federal government employees are enrolled in the National Health Insurance Scheme, but less than 65,000 are enrolled thus far. Second, students in tertiary education have access to the Tertiary Institutions Social Health Insurance Programme, which covers about 45,000 people in Bauchi, a total of less than 2% of the population.[108]

As described, out of pocket expenses to access healthcare in Bauchi State are extremely high (over 70%), and if you are unable to pay, you can be refused care. This increases the vulnerability of those living in poverty, where they must face the choice of forgoing care or going into debt or becoming poorer. The Bauchi State Health Financing Policy Strategy outlines goals to move Bauchi towards universal health coverage (UHC). The objectives of the plan are grounded in international health financing guidelines and evidence and include increasing the total health expenditures per capita, reducing out of pocket expenditure, increasing the proportion of residents with a voluntary contributory prepayment scheme for vulnerable people (the Bauchi State Health Trust Fund [BEHTFUND]), adopting strategic purchasing, and improving the effectiveness of external assistance.[108] The goal of BEHTFUND is to pool funds and improve equitable access to care for people identified as vulnerable: pregnant women, children under 5, people with disabilities, the poor, and others. There is an existing scheme to support the healthcare costs of orphans and vulnerable children managed by the Ministry of Women and Social Development, which is serving as a model. Additionally, the National 2014 Health Act went into effect in 2018 and established the Basic Health Care Provision Fund, which allocates additional funding to support access to PHC and basic emergency medical services, but is not expected to cover the significant financing gap needed to reach UHC.[108]

Human Resources for Health (HRH)

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.[110] Nigeria's National Human Resources for Health Policy outlines key objectives for improving HRH including creating 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.[78]

The Bauchi State Strategic Health Development Plan identifies motivating, retaining, and retraining frontline health workers for effective and quality service delivery as one of its five priorities.[67] Current HRH challenges in Bauchi include: too few qualified health personnel that are unequally distributed between rural and urban areas; industrial disputes like strikes, inter- and intra- professional conflicts; poor education quality at available facilities; healthcare workers leaving the public sector for the private sector, NGOs, or international partners; lack of an enabling policy environment; and ineffective coordination, supervision, and organization.[67] The Plan also identifies HRH as a key thematic area for improvement through the life of the plan to improve the quality and quantity of healthcare personnel. Specific objectives include:

1. To formulate comprehensive policies and plans for HRH for health development
2. To provide a framework for objective analysis, implementation and monitoring of HRH performance
3. Strengthen the institutional framework for human resources management practice in the health sector
4. To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi-skilled, gender sensitive, and mid-level health workers
5. To improve organizational and performance-based management systems for HRH
6. To foster partnerships and networks of stakeholders and harness their contributions towards achieving [the] HRH agenda.[67]

Distribution

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. Bauchi had 688 doctors, nurses, and midwives in 2015 and 4,653,066 people, or 23 healthcare professionals per 155,553 people. The current ratio (2015) is 15 times higher than the WHO recommended ratio.[67] In 2015, women made up 33.7% of the state's health workforce. This workforce was dominated by junior staff, including Community Health Officers (CHOs), Community Health Extension Workers (CHEWs), Junior Community Health Extension Workers (JCHEWS), and Health Information Managers.[68]

In both Bauchi and Cross River States, there is currently (2019) a complete hiring freeze due to financial shortfalls, which means that as healthcare workers leave for other jobs or retire, their positions cannot be filled. To attempt to address this, Bauchi has temporarily extended the mandatory retirement age by three years for nurses. The freeze will not be lifted until the states' financial status improves. This uncertainty, combined with delayed salary payment, complicates hiring and retention of qualified staff.[111]

At the community level in Bauchi, Community Health Committees (CHCs) and other groups that focus on issues defined as affecting women provide an opportunity for women's participation, decision-making, and empowerment. Women also have a role in Ward Development Committees (WDC) for household mobilization and awareness raising, to help educate community members on key household issues, and it is crucial that these community mobilizers be female, as other women may not receive men outside their families at home if their husband or another male family member is not present.[34]

Education, recruitment, 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.[78]

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.[112]

A 2019 HRH assessment conducted in Bauchi and Cross River states found that policies and procedures for hiring and retention are in place at the state level, but awareness and adherence are low. When examining barriers to following existing policies and procedures, the two most critical factors were poor funding and political interference in hiring decisions.[111] Respondents from both Bauchi and Cross River reported corruption within the hiring process, particularly hiring based on relationships rather than competence, or employers demanding bribes from applications in order to receive a job offer.[111] They concurred that hiring was based on the needs of the health system, but that advertising, recruitment and orientation could be improved. In Bauchi state, gender was considered one of the most crucial factors for deployment of midwives, given a strong preference among clients for female service providers. Difficulties highlighted in staff deployment include delayed or withdrawal of rural posting allowances, separation from family, inadequate staff accommodation, security concerns, political interference, and the "deplorable state of some rural health facilities." When the role of gender in hiring practices was discussed by participants, only 10% believed the process discriminated based on gender, and 56% of those from Bauchi believed men were discriminated against versus 44% against women, but overall 75% of respondents believed the process was fair. Similarly, a small minority of respondents in Bauchi (8%) believed deployment was affected by pregnancy or childbirth.

In the National HRH Policy and Plan, training is referred to as the education you receive prior to beginning a health career; educational institutions are referred to as responsible for this training. There is not a perspective that training is ongoing and should be provided by the Ministry of Health or another qualified actor.[78] Examples of challenges in on-boarding include that only 57% of healthcare staff in Bauchi reported that they had received *any* orientation when they began their current post, 33% received a clear job description, 84% received any staff or institutional manual, and 72% were assigned a supervisor.[111] In the Bauchi State Ministry of Health 2018-2019 workplan, many and diverse trainings are listed, covering health education about topics including Safe Motherhood, infection prevention, and neonatal resuscitation, however the majority of training were budgeted for 30-60 people, and therefore could not reach even one staff member at each of the 106 facilities.[107] Bauchi State is home to the College of Nursing and Midwifery and the School of Health Technology; however, despite the presence of these training centers, there is still a lack of qualified health personnel, particularly women, in part because many people leave the state once they have completed their education. A policy was put in place at the national level to increase admission of women into health training institutions, which has helped increase female enrollment and may eventually increase their presence in the healthcare workforce. Additionally, organizations like Population Council have supported female enrolment by providing scholarships and training materials to female students.[67]

Staff retention was described as most affected by delays in salary payments, insufficient and overworked staff, and lack of training and capacity building. Eighty-seven percent of participants from Bauchi reported delays in salary payments in the past 12 months, compared to 13% of Cross River staff. Similarly, workloads appeared to vary by state; 60% of staff from Bauchi reported that their clinic attended to over 150 patients a week, compared to 5.3% from Cross River; 89.1% of Cross River health workers reported personally attending to 20 patients or less in the last week, while 60% of Bauchi personnel reported seeing at least 41 patients in the last week. Additionally, 47% of Bauchi staff believe opportunities for promotion are insufficient, whereas 78% of Cross River staff believe opportunities are sufficient.[111]

To increase the health workforce in Bauchi, a scheme was put in place that incentivizes students in health-related tracks to stay in Bauchi after graduation, including providing them with a salary while they study,

and providing incentives for those assigned to rural posts.[67] Similarly, the State has adopted the national midwives service scheme and community midwifery program.[67] However, despite the implementation of bonding agreements, where trainees agree to stay in the State or work in rural posts for a specific time period after graduation, these are poorly enforced.[67, 111] Additionally, and quite likely related, Bauchi's salaries for its healthcare workers are reportedly lower than those in surrounding states, which continues to lead to an outflow of trained professionals.[67] Additionally, the Global Health Workforce Alliance highlights the need for better planning within healthcare education to ensure that enrollment in different specialties and roles matches Nigeria's healthcare workforce needs.[113]

Equal opportunity

Biased and traditional views about women's capacity as leaders and decision-makers remains pervasive and based in cultural and religious beliefs.[53] The Global Health Workforce Alliance identified a favoring of indigenous hires (i.e., people from the place where they reside) as one of the reasons for inequity, as qualified applicants who are not indigenous may be passed over.[113] However, in Bauchi, participants in the Population Council HRH assessment believed that while priority was given to indigenes, non-indigenes were given consideration, with examples of non-indigenes and non-Muslims holding leadership positions in government. Another form of discrimination described was based on political affiliation, where only members of particular parties might be given the opportunity to apply or interview for a position, or where positions that should be open calls are appointed by politicians behind the scenes, and sometimes those appointed candidates cannot be sanctioned or disciplined or may even be unqualified but cannot be dismissed due to political favoritism.[111]

Service delivery

The Bauchi SMOH Strategic Health Development Plan for 2016-2021 identifies health services delivery as a key thematic area for improvement. Specific objectives include:

1. To ensure equitable universal access to an essential package of care
2. To increase access to health care services
3. To improve the quality of health care services
4. To increase demand and access to health care services
5. To strengthen primary health care services and other public health concerns

These objectives were based on the identification of a variety of challenges to high-quality, consistent, accessible healthcare.[67]

Main service providers

Health services in Bauchi are provided by public and private providers, including non-governmental community-based organizations and faith-based organizations, religious, and traditional caregivers. Furthermore, HRH also encompasses informal health workers such as herbalists, traditional birth attendants, and volunteers, all of whom also play an important role in healthcare provision.[67] The State is currently implementing Primary Health Care Under One Roof (PHCUOR), coordinated by the Bauchi State Primary Health Care Development Agency, to coordinate at PHCs administered by the corresponding LGAs.[108] 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 services approach—rather than having different centers for different services, it has 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.[114]

In Northern Nigeria, including Bauchi, 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 PHCs, 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. National policy recently expanded CHEWs' responsibilities to provide injectable contraceptives and insert intrauterine devices (IUDs) and sub-dermal implants.[112]

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.[74]

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 additionally 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.[80]

Healthcare access and challenges

Bauchi State has a lower concentration of health care facilities than the rest of the North East region, with 16.4 PHC facilities per 100,000 residents. Sixty-seven percent of health facilities are publicly owned.[115] A 2016 USAID assessment of Bauchi State's HRH found that less than 34% of 88 randomly sampled health facilities had at least one skilled health worker available. However, this only occurred in the public sector; all private health facilities had skilled staff. Furthermore, even though 83.5% of surveyed facilities offered labor and delivery services on paper, less than a quarter had midwives or other qualified health professionals present. While most private facilities were found to employ RMNCH life-saving practices, this was less common in public facilities, where staff were less likely to have had the necessary training or access to needed equipment.[116] This indicates that high-quality primary care cannot be received at all existing facilities. The Nigeria FMOH recently compiled a Master Facilities List for the first time in 2018 in order to better manage HRH and commodities and to move the country towards using a universal health management information system (HMIS).[117]

Bauchi residents report good access to maternal health, ANC, and delivery access , with options for both private and public healthcare centers, although most used public facilities for ANC and delivery, but access was higher in some communities and lower in others.[34] However, despite the presence of health centers, both patients and healthcare providers highlighted a number of shortcomings including staff shortages, crowding, lack of seating, long waits, and inadequate facilities.[67]

During FGDs, participants reported negative attitudes of and poor treatment by healthcare providers as a barrier to care-seeking and access. Both women and men recounted incidents of insults from healthcare workers based on gender, that could be described as sexual harassment, obstetric violence, and denial of care based on gender or judgment about a woman or girl's sexual history. This experience was compounded by a lack of female staff, which both men and women preferred as reproductive and maternal healthcare providers. Both men and women prefer that female providers attend to women, especially for

family planning, ANC, and delivery due to cultural and religious expectations around modesty, privacy, and encounters with people of a different gender outside your immediate family.[34]

Another essential element of health care access is the available infrastructure of PHCs and other health facilities. Basic service necessitates a minimum of improved sanitation facilities where at least one toilet is dedicated for staff, one is sex-separated with menstrual hygiene facilities, and one is accessible for people with limited mobility. Findings from a 2019 WHO and UNICEF review showed that in Nigeria only 50% of health facilities had basic water coverage, 12% had basic sanitation, 47% had limited sanitation, and 41% had no sanitation services. On average, rural health facilities in Nigeria had 1.1 toilets per health facility for all patients in Nigeria, and therefore by definition many do not have sex-segregated toilets, where urban facilities, which tend to be larger, had an average of 3.8 toilets for patients.[118] Another assessment found that 73% of health facilities surveyed in Bauchi had leaking roofs and less than two-thirds had electricity. Importantly, a lack of electricity was connected to a lack of 24-hour labor and delivery care.[116] Facilities also struggle with water access; 40% of primary healthcare facilities do not have access to water or source water from outside the facility.[24]

Youth-friendly services

As mentioned previously, 40.7% of girls 19 and under have begun childbearing in Bauchi, compared to 18.7% at the national level.[5] In an undated Bauchi assessment, adolescents expressed dissatisfaction with the quality of attention from healthcare staff at PHC centers, who reportedly have a particularly negative attitude towards pregnant adolescents. Pregnant adolescents mentioned shyness as a barrier to care seeking, as they are unaccustomed to discussing their health with strangers and prefer to talk to family members and may choose to give birth at home to avoid giving birth with male medical staff. Participants again also mentioned staff shortages, inadequate facilities, crowding, lack of seating, and long waits as barriers to care.[34]

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.[119] 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, STIs and HIV, and other general challenges, including sexual violence, and harmful traditional practices. It also emphasizes that comprehensive information about contraceptives is important for all young people to prevent STIs, HIV/AIDS, and unintended pregnancy, without mentioning marital status.[120]

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 2013 in Bauchi, 15.3% of women and 27.7% of men believed that children ages 12-14 should be taught about condom use for HIV/AIDS prevention.[36] Despite the presence of some youth-friendly services in Bauchi—such as youth-friendly health centers at the Abubakar Tafawa Balewa University Teaching Hospital and Azare LGA [67]—it is unlikely that youth will receive access to comprehensive healthcare if these attitudes towards condom use are as pervasive amongst health care providers.

Access to medication

In 2011, the FMOH committed to providing all family planning commodities free of charge at public health facilities.[112] However, repeated stockouts and shortages of essential commodities are widespread, due to supply chain and availability issues, according to the Bauchi SMOH.[108]

According to the 2018 NHDS, 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.[5] In Bauchi, 20.8% of married women have an unmet need for family planning. Contraceptive coverage was 6.5% in 2018, 5.2% with modern methods.[5] This is a significant increase from 2013, when 2.2% of women used a contraceptive and 2.1% used a modern method.[36]

An assessment found that availability of long-term reversible contraception (LARC) commodities (IUDs, implants, and injectables) was very low across both public and private facilities in Bauchi.[116] Additionally, due to HRH issues, where many health facilities are only staffed by CHEWs, the only LARC available is injectables, as CHEWs cannot insert IUDs or sub-dermal implants.[112] At private health facilities in Bauchi male condoms are the most frequently supplied commodity, however this is to be expected as they are single use, versus a five-year IUD, for example. The total number of public facilities reporting an increased need for family planning commodities and the total couple years of protection (CYP) rose significantly between 2009 and 2014, potentially indicating broader access and uptake. Subdermal implants and injectables were the main contributors to the increase in CYP, followed by IUDs, oral contraceptives, and male condoms. In one study in Bauchi, Health Management Information System (HMIS) Officers, healthcare providers and clients agreed that acceptance and use of family planning was increasing at the community level. [33]

As with ANC, husbands often act as gatekeepers to contraception access, and this arrangement was described as accepted by women, men, and healthcare providers. 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.[33]

In the 2016 USAID assessment mentioned previously, when examining the availability of essential commodities for RMNCH care, the 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.[116]

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, and given that 80% of the population of Bauchi state lives below the poverty line, poverty must be considered in all policies and programs.[67] They 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.[6] 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.[36] 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 Bauchi 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. As discussed, girls nationally and in Bauchi tend to have earlier sexual debut than boys.[5] Difficulties accessing health services and medications and power differentials make them more vulnerable to negative sexual and reproductive health outcomes (e.g., 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, 21.3% of girls have begun childbearing by 17 years old, 37% have begun by 19; in Bauchi 40.7% of girls have begun childbearing by 19. There is a strong divide between rural and urban girls, where 8.4% of urban girls and 27.2% of rural girls have begun childbearing by 19. Disparities are also seen by level of education, where 43.7% of girls with no education have begun childbearing by 19, compared to 8.2% of girls with a secondary school education. When considering wealth, 32% of girls in the lowest and 31% of girls in the second lowest wealth quintile have given birth or are pregnant by 19, compared to 0.8% of girls in the highest and 8.2% of girls in the second highest wealth quintile.[5] 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.[36]

Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) Populations

Overall, Nigerian LGBTQ populations face challenges to the full realization of their rights, including healthcare access. 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.[121]

In Bauchi, which is among the 12 northern states that enforce Shari'a 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.[103, 122] Cross dressing and sex between men are criminalized within the Federal Penal Code that applies to northern states.[122] In a 2014 BBC story, those interviewed generally pointed to religion as forbidding homosexuality and described it as something they "did not want here" and the Shari'a police have been targeting suspected homosexuals with the help of community members, who report them. Nine men in prison, suspected of homosexuality, reported that they were beaten while in jail and that they would not be able to stay in Bauchi, even if set free.[123] Eleven men on trial for homosexuality in Bauchi in January 2014 all signed confessions stating that they were gay, however, law enforcement has been known to engage torture to extract confessions and names of other LGBTQ people.[124, 125]

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 LGBTQ people generally do so with impunity. Sexual orientation and gender identity are closely tied to health outcomes in Nigeria, and particularly in Bauchi 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.[121]

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; in the North East zone the estimated prevalence is lower at 2.4%.[80, 126] The difference between these estimates may be due to different definitions of disability, different years or times of the year, different age groups, and different base populations, for example.

The 2006 Nigeria census reports that approximately 100,000 people with disabilities live in Bauchi state.[127] According to a separate assessment the majority of disabilities in Kano and Bauchi and related to mobility (36%) and sight (28%). Causes of disabilities in the North East include infectious diseases such as river blindness and leprosy, birth defects, injuries, and injuries from labor and delivery (including obstetric fistula). The lack of knowledge and training about working with and supporting people with disabilities described at the national level can also be observed in Bauchi, where few service providers are aware of the rights of PWDs, the support they may demand, including access to healthcare, education, and justice.[89]

While national protections for disabled persons exist in Nigeria, the literature review did not locate any laws or policies at the state level related to PWD in Bauchi. The Bauchi Strategic Health Development Plan 20116 – 2021 acknowledges that the lack of a policy to ensure inclusion of people with disabilities in health care access and decision-making is a gap that must be addressed.[67]

Ethnic and religious minorities

Bauchi state is home to 55 ethnic groups as well as a strong presence of Islam (85-90%) and Christianity (10-15%). There is also an important distinction made between 'indigenous' people (those who are originally from there area) and 'settlers' (those from other areas, even if they have now been in Bauchi for generations). These three types of identity—ethnicity, religion, and place of origin—are at the root of much of the violence in Bauchi. Due to the widespread and intense poverty and the unequal and at times unethical distribution of resources, these groups may compete and confront each other over access to support, political power, and protection.[23] This promotion of in and out groups and its relationship to access to resources can extend to healthcare. Participants in FGDs reported that discrimination and mistreatment can occur when the patient and healthcare provider come from a different tribe or religion, and specifically was a barrier to ANC care and hospital-based delivery.[34] Additionally, affiliations by ethnicity, religion, or origin can spill over into politics, where elected officials have been accused of favoring or providing more resources to members of their own group, including in healthcare.[23]

The 2018 NDHS presents a few indicators relevant to gender and health disaggregated by religion (Table 6). However, they do not disaggregate indicators by religion and state, making it difficult to draw specific assumptions about the behavior of one religion or another in Bauchi, specifically. Given Bauchi's ethnic diversity, this review does not attempt to draw conclusions about circumstances in Bauchi based on data disaggregated by ethnic group.[5] 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 6: 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 [5]

People on the move, including Internally Displaced Persons and Refugees

The ongoing conflict between Boko Haram and the Government of Nigeria has led to increased displacement across the North East of Nigeria and in Bauchi state. As of November 2019, Bauchi hosts 64,859 displaced people: 97% are living with host communities and 3% are in seven camps or camp-like settings. Overall, the IDP population in North East Nigeria is 80% women and children. The majority of IDPs living in Bauchi have fled there from other Nigerian states and were displaced from their homes before 2015. Sixty-five percent were displaced due to the insurgency and 35% were displaced due to community clashes.[6][26]

As of January 2019, IDPs living in camps and within host communities did not identify reproductive and maternal health needs as top priority needs, but general health access was high (99%). No cases of GBV were reported in camps in Bauchi since October 2018. Ninety-five percent of host-community sites did not experience any protection incidents; the most commonly reported was GBV. However, despite the absence of reports or violence or security incidents, in 96% of the camps, women said they felt unsafe, and both men and children reported they felt unsafe in 97% of sites.[128]

Bauchi state is home to pastoralist populations, the largest of which is the Fulani, during some parts of the year, a population that traditionally experiences logistical, practical, and cultural challenges accessing healthcare. Pastoralists are affected by, and sometimes part of, ongoing conflict in the area over land, cattle, and between religions, and 'settlers' versus 'indigenous' residents.[129] 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.[130] 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

[6] Violent conflict between different communities, such as groups of different religions ethnicities, political parties, or place of origin. Something like cattle theft can also lead to community clashes.

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 GBV, Nigeria and Bauchi's conservative cultures discourage victims from speaking out or reporting. Less than a third (31.6%) of married women who were victims of physical or sexual abuse did not tell anyone or seek help, and of those that did seek help, only 1% informed the police. In Bauchi, only 16.4% of married women sought help after experiencing violence.[5]

In one 2015 study, 9% of both girls and boys were raped as children, and 19% of men and 22% of women were sexually molested.[53] 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, 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. [56, 131] 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.[132] Together, underreporting, infrequent prosecution and conviction, minimal sentences, and the shame and stigma continue to discourage victims of GBV from speaking out.[133]

Stakeholder analysis and review of previous gender analysis efforts

Understanding who is doing what in Bauchi 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 Bauchi related to 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 7. Partners working in gender, social inclusion, and community engagement in Bauchi

Organization	Areas of focus
Ablustan Women Development	Reproductive health (RH), family planning (FP), poverty alleviation, peace building
Action Aid	Women's Rights, GBV, access to justice, advocacy
Adolescent Health, Education, and Development Centre, Bauchi (AHEAD)	Adolescent health, education, capacity building, MNCH
Capacity Development Initiative for Women and Girls (CADIWOG)	Life skills, MNCH, capacity building, education support
Challenge Your Disability Initiatives, Bauchi (CYDI)	People with disabilities, HIV, FP, poverty reduction, empowerment, skills building, livelihoods
Civil Society for HIV/AIDS in Nigeria, Bauchi (CISHAN)	HIV and reproductive health included in education and healthcare access for people with disabilities
Coalition of CSOs in Health	
Community Rescue Initiative (CRI)	Community awareness building and empowerment about gender, education, and health' focused on Bauchi State Accountability Mechanism for MNCH
Development Exchange Center, Bauchi	Community empowerment and poverty reduction, with some projects focusing on women

Development Initiative for Africa Women (DIFAW)	Rural women's empowerment, MNCH, family planning, harmful traditional practices, HIV
Fahimta Women and Youth Development Initiative (FAWYODI)	Reproductive health services and poverty reduction
FHI360	Integrated Humanitarian Assistance to Northeast Nigeria, Family Planning, Education, HIV, Malaria, TB, Communications
Forward in Action for Education, Poverty, and Malnutrition, Bauchi (FacePAM)	Education, gender issues, health, poverty, peacebuilding
Federation of Muslim Women's Association in Nigeria (FOMWAN), State Chapter, Bauchi	Focus on HIV, family health, FP, gender, and MNCH with women, children, and youth, particularly among conflict-affected populations
Himma Foundation for Support of Women and Children, Bauchi	Reproductive health, family planning, gender, MNCH
Maranatha Development Rescue Center, Bauchi	Maternal, human rights, governance, environment related to women, children, vulnerable groups
Marie Stopes	Family planning, reproductive health services, mobile midwives and outreach, including post abortion care, and social franchise of sexual and reproductive health providers, but no Bauchi clinic.
National Obstetrics Fistula Centre	Provides free fistula repair and post repair livelihoods and economic support, doctor and nurse training and awareness raising
OXFAM	Livelihoods, women's rights, humanitarian response in northern Nigeria
PLAN – Nigeria	Education, reducing maternal and child mortality, nutrition, violence and protection
Planned Parenthood Federation of Nigeria	FP, RH, MNCH, HIV, working with CSOs and large volunteer and youth networks
Pioneer Reproductive Health and Youth Association, Misau (PREHYA)	Adolescent and health and education awareness raising and advocacy
Rahama Women Development Program and 100 Women Group United Religions Initiative	100WGs are local groups that encourage parents to send girls to school – women and youth empowerment, reproductive health, microcredit, advocacy for women's issues in Bauchi Parliament
Reproductive Health Initiative and Support Association (RHISA)	Capacity building, very little information online.
Save the Children	Working in Bauchi, child protection programming, perhaps other projects too
UNICEF	Education, humanitarian response, health including MNCH
Women Association for Self-Sustenance (WODASS)	RH, HIV, FP, gender, MNCH, poverty alleviation, WASH, education, orphans and vulnerable children
Women Empowerment Initiatives (WEIN)	Women's economic empowerment, gender equity, education, HIV
Women's Rights Advancement and Protection Alternative (WRAPA)	Women's empowerment, access to justice, legal representation. Have projects in Bauchi.

Table 8. Ongoing and recent RMNCH +NM projects related to gender, social inclusion, and community engagement in Bauchi, Nigeria

Project	Lead	Donor	Description
African Programme for Onchocerciasis Control (APOC)	WHO		Community-directed treatment of onchocerciasis with ivermectin
Bauchi Opportunities for Response Neonatal and Maternal Health (BORN)	Plan International	Global Affairs Canada	Associated with Because I Am a Girl – now closed
Better Education Service Delivery for All - BESDA	Government of Nigeria	World Bank	Early childhood education, primary and secondary education. 2017 - 2022

Breakthrough ACTION	Johns Hopkins	USAID	Social and behavior change programming to encourage healthy behaviors like HIV testing and bed net use
The Challenge Initiative	Johns Hopkins	Bill and Melinda Gates Foundation	Health facility upgrading, including maternal and reproductive health facilities. Includes the Community Health and Research Initiative
Education Crisis Response Program (ECRP)	Creative Associates		Psychosocial support through education for survivor of conflict and violence.
EU Support to the Health Sector	UNICEF and WHO	European Union	To strengthen the health system through improved primary health care delivery, including community-based MNCHN+ services in Bauchi. 2016 – 2020.
Fistula Care Plus	EngenderHealth	USAID	Preventing and treating obstetric fistula including training, and integrating family planning services with fistula and maternal health care
Leadership, Empowerment, Advocacy, and Development (LEAD)	RTI	USAID and Partnership Initiatives in the Niger Delta	Partnering with local CSOs to implement projects to improve governance, education access, and health services.
Northern Education Initiative Plus (NEI+)	Creative Associates	USAID	Strengthening access to basic education, especially for girls and out of school children. 2015 – 2020.
Saving One Million Lives – Program for Results	Government of Nigeria and WHO		Improve maternal and child health, reduce mother to child transmission of HIV, improve quality health access
Social Mobilization. Sanitation, Water, and Hygiene (SHAWNII)	UNICEF		Improving water and sanitation access to vulnerable communities including an equity and gender focus
States Health Investment Project (SHIP)		World Bank	To increase the delivery and use of high impact maternal and health interventions and improve quality of care
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. Ends in March 2020.
Targeted States High Impact Project	JSI	USAID	Family planning, reproductive health, health systems strengthening 2010-2015.

Previous gender analyses

Previous analyses about Nigeria, and specifically Bauchi state, have addressed various aspects of gender, but none have addressed the topic so broadly as is done within this document. 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.

- Gender and the environment/climate change – While assessments examining the relationship between gender and climate change and the environment do exist, this issue was not addressed in any general gender assessment.

- The voices of young people – The vast majority of primary data collected, including qualitative data, was collected exclusively from adults. Given the significant challenges and barriers to healthcare identified among young people, it's critical to include their voices in both quantitative and qualitative analyses and to ensure that their various experiences, as young people and LGBTQ populations, racial or ethnic minorities, heads of household, among others, are considered.

- Inclusion of migrants, IDPs, and refugees – Most assessments examined the needs and experiences of either people on the move or locals; however, no assessments were identified that included all people in Bauchi: those who have been living in urban or rural areas and those living in areas designated for refugees or IDPs. Such an analysis would help identify the elements of gender and health that are universal amongst these populations, as well as support integration by identifying interventions that could serve both populations.

- Social Networks and Positive Opportunities – One of the findings of this report is that one of the few places women find leadership and socialization opportunities in Bauchi is during participation in women's groups. This highlights the need to talk to women about their positive experiences during gender analyses, including who supports them and who is in their social network. While many analyses delve into topics like GBV, lack of educational opportunities, and early marriage, few spoke to women about what makes women feel strong, what they are passionate about, who has given them opportunities, and how they would change their homes, communities, and environment if given the opportunity.

As a result, critical information about how gender directly and indirectly affects the health of the Bauchi 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, led by Palladium, other implementing partners, 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 Bauchi 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 to recognize the constraints and opportunities related to health outcomes. Yet significant gaps exist in our knowledge of key gender and social inclusion issues in Bauchi. For example, more research is needed to better understand gender norms related to sexuality and health needs of polygynous families as well as young people in Bauchi. Significant gaps in our knowledge related to human trafficking for forced labor and sexual exploitation to, in, and from Bauchi also exist. In addition, we need to better understand social networks (e.g., women's groups) and positive opportunities for populations at risk. Bauchi State and partners should conduct a customized rapid landscaping to explore issues identified in this desk review more deeply. The landscaping should establish what programs already exist, whether from the government or partners, then identify gaps in programming 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 socialization between men and women who are not related and the lack of female healthcare providers). This landscaping could include community mappings, brief 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, and 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 should be collected and analyzed and used for decision making. In addition to health outcomes, quality sex- and age-disaggregated data on exposure to diseases, participation in and exposure to programming efforts, ability to access treatment, and composition of the health workforce, among others, are required to fully understand the scope of RMNCH +NM issues in Bauchi. 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 Bauchi 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 in Bauchi 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 capacity among the health workforce. This should include supportive supervision and regular performance assessments where demonstrating gender-sensitive approaches on the job is 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 and medications in many health facilities. IHP 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 report to ensure women enroll and graduate, and review 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 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 be 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 Bauchi, 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 Bauchi) include high maternal mortality and morbidity, among others. While we know that child marriage has been linked with the prevalence of obstetric fistula in the North East region, the prevalence and burden of fistula in Bauchi 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 members of the household, the wider community, and public messaging and expectation. Where there are influential members of these groups 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 other donors and projects in Bauchi 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 Koran teachings about child protection and caring for orphans and vulnerable children in a number of countries that observe Shari'a law, and might be of use in Bauchi related to gender more broadly.[134, 133] 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. Specific examples include:
  - 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.
  - At the community level in Bauchi, Community Health Committees (CHC) and other groups that focus on issues defined as affecting women provide an opportunity for women's participation, decision-making, and empowerment. Women also have a role in Ward Development Committees (WDC) for household mobilization and awareness raising and to help educate community members on key household issues. It is crucial that these community mobilizers be female, as other women may not receive men outside their families at home if their husband or another male family member is not present. Within women's social groups, where women gather together to socialize and conduct activities, women reported greater freedom of association, greater influence, and social support.[34] IHP can coordinate with other community development projects to harmonize efforts between these groups and state and local government initiatives. Moreover, women from these groups will be helpful advisors to government actors in intervention design, community buy-in, and information and advocacy dissemination. Women's roles in tending for their families can be strengthened through job opportunities, access to financing, and involvement in micro-businesses to enable them to contribute to the family's resources and share the burden of meeting children's health and

nutrition needs. IHP can coordinate with private sector in supporting local governments in efforts to strengthen the local economies and provide opportunities for women's participation in labor market and access to resources. Private sector and civil society partners will also help to guide the participation and buy-in of males in these efforts so they will allow females to participate and develop.

- **Address GBV holistically.** GBV should be addressed as a cross-cutting issue within all relevant policies and programming. 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 (including 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 Bauchi specifically, human trafficking is a major issue in the North East region of Nigeria. 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, particularly where police and military are complicit or IDPs are exploited. 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.** Bauchi 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 should be identified and stakeholders should advocate for their localization to Bauchi 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, women's social groups could also play a pivotal role in social mobilization, advocacy, and empowerment, where these groups could not only be social and support spaces, but also serve to learn, build capacity, network, and one community of women to another. 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 Bauchi state.

Conclusion

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.[35] 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. Bauchi state is among Nigeria's poorest performers in terms of health and development indices. Despite large donor investments in the health sector in Bauchi and the prioritization of primary health care (PHC) by the state government (e.g., the Five Point Health Agenda), 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 East and in Bauchi 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 RMNCH +NM plans and policies.

This desk review examines the health status of women, men, girls and boys in Bauchi 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 Bauchi, Nigeria

Bauchi State Strategic Health Development Plan (2016–2020)

	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	Sex disaggregated presented for some indicators (literacy rate,). Some indicators were one-sided (currently employment rate only for women, not men). Some indicators had no sex disaggregation (children's health, HIV and TB prevalence, condom use, etc). There was no sex disaggregation when presenting numbers of health workers in the Human Resources section.
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)? a. Women b. Men c. Adolescent girls d. Adolescent boys e. PWDs f. Sexual minorities	0	No.
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: a. Gender-based violence prevention and response/services b. Early/child marriage c. Obstetric fistula d. Female genital mutilation e. Male engagement	0	The plan mentions "Comprehensive emergency obstetric care (C-EOC)" in Table 2: Priority High Impact Services, but not Obstetric Fistula specifically. Does not mention GBV, 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?					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	0				No.	
16	Does the policy require health information systems collect sex and age disaggregated data?	0				No.	
17	Does the policy include equitable financing strategies that recognize gendered needs and inequitable access	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: a. acceptability b. affordability c. availability d. eligibility e. respectfulness f. physical/geographic accessibility g. unbiased and nonjudgmental and nondiscriminatory	M 0	W 0	B 0	G 0	No.	
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.

	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?	1	Sex disaggregated in key demographic indicators and when presenting numbers in the health workforce (pg. 3). There is a
			specific section for Gender Distribution of health workers breaking down the sex distribution of health workers by LGA (pg.
2.	Are age-disaggregated data used/presented?	.5	Age mentioned in demographic indicators (population under the age of 15).
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	4	In the foreword, mentions "…. maintaining a workforce that is responsive to the health needs of all citizens of Bauchi State in particular children, adding adolescent girls and boys, women, the poor, the vulnerable and the disadvantaged."
7.	Are specific objectives proposed to reduce gender inequalities?	1	In regards to the health workforce, under section 3.3 the Human Resources for Health Policy Principles, viii is "striving toward gender balance and equal opportunity in training and deployment" (pg. 10).
8.	Are lines of action proposed to meet the different needs of women and men?	0	There are no mention of the different needs between male and female health workers.
9.	Are lines of action proposed to reduce gender inequalities?	0	No, the sex-disaggregated data shows there are more men than women in the health workforce, but there are no actions proposed on how to reduce this gap (no recruitment strategies etc).
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	N/A	-

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	N/A	-
12	Does the policy include strategies to improve accessibility to services for PWD?	.5	Under section 3.6 HRH Planning, number 9 "There is no discrimination or stigmatization based on gender, disability or disadvantage at training schools and work places. Provision shall be made for special needs" (pg. 11). However, there are no details or actionable steps towards how this would be achieved.
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	Yes, in the Introduction, "…including the integration of gender sensitivity training as a means for creating a gender-aware and equitable work environment and workforce and as a means for building capacity for gender responsive service delivery as a key quality of care component …" (pg. 2). Under section 3. 8 Education and Training, number 3 is "Ensure that health training-school facilities take into account gender needs and requirements" (pg. 12).
14	Does the policy address risks of sexual harassment, violence, and security of female health workers?	0	No mention of the security of female workers under section 3.9 the Standards and Rights of Health Professionals and Clients (pg. 13) nor section 3.13 Health and Safety.

15	Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?	1	The Introduction mentions "to develop and promote incentive schemes for equitable promotion and retention of health workers" (pg 1). Under section 3.3 Human Resources for Health Policy Principles, viii is "striving toward gender balance and equal opportunity in training and deployment" (pg. 10). Under section 3.6 HRH Planning, number 8 is "Affirmative action is taken with relation to training and deployment of health workers from and to disadvantaged areas and vulnerable groups" and number 9 "There is no discrimination or stigmatization based on gender, disability or disadvantage at training schools and work places. Provision shall be made for special needs" (pg. 11). Under section 3.7 Information and Research for Human Resources for Health, number 7 is "Ensure that mechanisms are established and maintained for close monitoring and dissemination of information related to recruitment, attrition and retention; disaggregated to reflect equity and gender concerns" (pg. 12).				
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?	1	Under section 3.7 Information and Research for Human Resources for Health, number 7 is "Ensure that mechanisms are established and maintained for close monitoring and dissemination of information related to recruitment, attrition and retention; disaggregated to reflect equity and gender concerns" (pg. 12).			
17	Does the policy include equitable financing strategies that recognize gendered needs and inequitable access to resources for health care seeking?	0	No mention of gender in section 4 for Financing Human Resources and Development.			
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 N/A	W N/A	B N/A	G N/A	-

19	Does the policy include strategies to increase women's participation in leadership and decision-making roles in the health sector?	0	Although the sex-disaggregated data shows there are more men in the health work force, there is no mention of any actionable steps to reduce this gap.
20	Does the policy include measures for accountability in providing gender-responsive health services?	0	No mention of accountability measures.
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.

Further Questions:

- The plan mentions measuring/monitoring recruitment retention and attrition but does not cite any data mentioning who is more likely to more likely to drop-out male or female health workers? Why? (3.7 Information and Research for Human Resources for Health, pg. 12).
- The plan mentions that the Government of Bauchi will reconcile any disparities in salaries (3.14 Motivation and Rewards System, pg. 15)– where are the disparities in salaries? Is it regional? Is there a pay ap between male and female health workers?

	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	Sex disaggregated data presented for some of the demographic information (population pyramid) and some key indicators (knowledge about contraceptive methods There was no sex disaggregation when presenting numbers of health workers in the Human Resources section.
2.	Are age-disaggregated data used/presented?	.5	Age disaggregated for demographic information (population pyramid).
3.	Is gender equality considered a health determinant?	.5	Although it's not explicitly stated, throughout the introduction to Family Planning in Bauchi, gender dynamics was cited at a barrier to accessing family planning.
4.	Does the description reflect gender-based constraints in access to services?	1	Under 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." Section 2.4.1 Strategy for Demand Creation and Behavior Change Communication states "DBC 3. Improve access to FP information and services for existing and potential users, especially for those with difficulties in accessing services (e.g. rural residents, urban poor and adolescents) through the scaling up of existing ward-based, community mobilisation efforts." In addition, SD 3. Increase access to and improve Youth-Friendly Health Services (YFHS), as these are currently available only in general hospitals." Acknowledges that certain groups, like youth, have more difficulties accessing services.

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	3	Strategies for women and for youth and integrated throughout the document, but little is mentioned about strategies to deliver services to men, PWDs, and 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?	.5	Different strategies are stated for reaching men, women, and other vulnerable populations in behavior change communication (but not in other areas). Section 2.4.1 Strategy for Demand Creation and Behavior Change Communication states, "It will begin with the creation of a State-specific demand creation strategy and the development of messages for different key target groups (men, women; both married and single, adolescents, and the youth) in both English and Hausa at the beginning." In addition, "DBC 3. Improve access to FP information and services for existing and potential users, especially for those with difficulties in accessing services (e.g. rural residents, urban poor and adolescents) through the scaling up of existing ward-based, community mobilisation efforts."
9.	Are lines of action proposed to reduce gender inequalities?	0	No.
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	Mentions early childbearing but not GBV, obstetric fistula, 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: o. sexual and reproductive health	0	There is no male engagement strategy.

	p. family planning q. maternal health r. newborn health s. child health t. maternal and child nutrition u. malaria					
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				Staff and training are strategic priorities, but not gender-sensitive training.
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? c. 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: o. acceptability p. affordability q. availability r. eligibility s. respectfulness t. physical/geographic accessibility u. unbiased and nonjudgmental and nondiscriminatory	M 0	W 1	B 1	G 1	Respectful care for all is mentioned throughout the document. There are also indicators to measure acceptability of FP services (although it's not disaggregated by age or sex). Youth-friendly services are mentioned as a priority throughout the document, particularly with unbiased nonjudgmental care.
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?	.5				Annex I: Key Indicators for the Bauchi State CIP for CBS for Service Delivery, and Policy and Enabling Environments, one of their indicators is "clients, disaggregated by age, sex, gender, socioeconomic status."

			However, number of people (new/ return) clients counselled, number of trainers trained in in-service CBS/FP practices (and all other trainee, teacher, pharmacists, CHEW, peer-educator-related indicators), percentage of the population who know of at least one source of modern contraceptive services and/or supplies/had favorable views on FP, could also be disaggregated by sex.
22	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	.5	Annex I: Key Indicators for the Bauchi State CIP for CBS for Service Delivery, and Policy and Enabling Environments, one of their indicators is "clients, disaggregated by age, sex, gender, socioeconomic status."
23	Does the M&E plan include indicators to measure gender-related outcomes?	.5	Some indicators touch on perceptions and power in decision-making of men and women, but overall it is very few.
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.			

Bauchi State Revised Gender Policy (2017)

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?	1	Sex disaggregated data presented for some of the demographic information (total population of Bauchi, primary and secondary school enrollment, arable land ownership).
2.	Are age-disaggregated data used/presented?	0	No.
3.	Is gender equality considered a health determinant?	1	The Preface clearly states gender equality as a health determinant and this idea is integrated throughout the document.
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)? s. Women t. Men u. Adolescent girls v. Adolescent boys w. PWDs x. Sexual minorities	4	The Preface states "Bauchi State Gender Policy specifically focuses and seeks to give direction on how to address issues of women, boys, girls and persons with special needs in the design and implementation of government policies and programs." The documents mentions special needs or vulnerable groups but they do not specifically call out persons with disabilities or sexual minorities. Section 2.1 Guiding principles, the final principle H states "Determination to establish empowerment schemes for men, women and persons with special needs." (pg. 25)
7.	Are specific objectives proposed to reduce gender inequalities?	1	Section 2.1 Guiding Principles of the State Gender Policy Framework states, "All sectors need to apply a gender lens to the diagnosis and prescriptive interventions of their sector. They need to consider how the achievement of gender equality supports their own sectoral objectives. They need to put in place mechanisms that ensure that their interventions at the very least do not lead to greater inequality between women and men and at the most actively promotes gender equality and achieves tangible results. All Ministries and Agencies need to refer to the gender-responsive elements of the conventions, treaties, protocols conferences, and SDGs that are relevant to their sector when developing their strategies, programmes, budgets, monitoring and evaluation frameworks." (pg. 24)
8.	Are lines of action proposed to meet the different needs of women and men?	.5	No.
9.	Are lines of action proposed to reduce gender inequalities?	1	There are "guiding principles" including gender mainstreaming, eliminating discrimination, sourcing human and financial capital, commitment to gender-responsive financing and budgeting, determination to address social, economic and cultural determinants,

			scaling up female school enrollment, community re-orientation, and empowerment schemes (pg 25-26). As laid out in the purpose of the document, they are guiding principles for MDAs to follow rather than proposing specific, actionable interventions. Towards the end of the document, there are additional next steps including the creation of a State Gender Technical Working Group.
10	Does the policy include actions to address: p. Gender-based violence prevention and response/services q. Early/child marriage r. Obstetric fistula s. Female genital mutilation t. Male engagement	.5	GBV is defined in "Gender Related Concepts and Working Definitions" (pg. 16) and identified a thematic policy area of focus (pg. 23), however it is never fully discussed. There is no mention of early marriage, obstetric fistula, 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: v. sexual and reproductive health w. family planning x. maternal health y. newborn health z. child health aa. maternal and child nutrition bb. malaria	0	While there are mention of empowering men and women, there are no specific strategies that mention male engagement.
12	Does the policy include strategies to improve accessibility to services for PWD?		The policy mentions vulnerable groups, 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)?	1	Section 3.8 Capacity Building and Skills Development states, "the policy will harness from the technical expertise of professionals and collaborate with International Development Partners to build the capacity of the relevant spectrum of actors in the State through trainings, conferences and workshops and provision of institutional facilities that would enhance performance." It doesn't focus specifically on health workers, but does mention gender trainings to broader government decision-makers.
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? d. If yes, does the policy require data be used for gender analyses and evaluation to improve gender equitable service delivery?	1				In Table 2: Broad Policy Delivery Strategies and Policy Outcomes, number 6 (Research, Data and Evidence Based Planning) requires "reliable, disaggregated data available and key performance indicators" and number 7 (Monitoring, Evaluation and Review) requires "available and timely M&E Reports to inform policy evaluation and review." (pg. 29).
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 within capacity building.
18	Does the policy ensure services are equally accessible to women (W), men (M), adolescent girls (G) and adolescent boys (B) in terms of: v. acceptability w. affordability x. availability y. eligibility z. respectfulness aa. physical/geographic accessibility bb. 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?	.5	Section 3.4 Accountability for Performance relating to Outputs, with focus on Outcomes outlines their plans for accountability, but doesn't mention anything specific or actionable. The M&E section states "accountability for results also means that the allocations were actually spent and reached the intended beneficiaries and right-holders/duty bearers were satisfied and there were improvements in gender equality and well-being." (pg. 31).
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 3.10 Policy Statements states that the government shall "mandate PRS units of MDAs to submit gender disaggregated data and M& E reports to support budgetary allocations and planning" and "circulate widely data generated from M&E activities and related research studies to all stakeholders for in-depth gender disaggregated studies and future planning." (pg. 35)
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?	1	Section 3.5 Monitoring and Evaluation states that they will develop gender-sensitive indicators (pg. 30).
24	Are funding mechanisms and other resource needs and sources for the gender actions identified?	.5	It's mentioned as a guiding principle for MDAs to implement, but does not give detail or actionable steps.
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.			

Bauchi State Task Shifting/Sharing Policy for Essential Services (2016)

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?	0	No.
2.	Are age-disaggregated data used/presented?	0	No.
3.	Is gender equality considered a health determinant?	1	Gender Equality is guiding principle number 2 and states, "Women and girls seek more of the essential services and

			are disproportionately affected compared to men as a result of gender inequalities that exist. Therefore, more equal gender empowerment and health promotion of women is vital for the utilization of the essential services in the facilities. Measures will be taken to ensure gender equality to ensure positive health seeking behavior in the community."
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)? y. Women z. Men aa. Adolescent girls bb. Adolescent boys cc. PWDs dd. Sexual minorities	0	No.
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: u. Gender-based violence prevention and response/services v. Early/child marriage w. Obstetric fistula x. Female genital mutilation y. Male engagement	0	The plan mentions that "Medical officers, midwives, nurses, CHEWs and village Health Workers shall: Screen women and families for signs of domestic and sexual violence, take first-line measures in providing counseling and support, and ensure effective referral." Does not mention early marriage, obstetric fistula, FGM, and alludes to male engagement as partner notification during STI screening.
11	Does the policy include strategies to engage men as clients, as supportive partners/parents, and as agents of change in the following areas: cc. sexual and reproductive health dd. family planning ee. maternal health ff. newborn health gg. child health hh. maternal and child nutrition	0	Mention of "partner notification and examination" for management of STIs and sexual and reproductive health.

	ii. malaria					
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? e. If yes, does the policy require data be used for gender analyses and evaluation to improve gender equitable service delivery?	.5				Under ART adherence, "register client and gather additional socio-demographical data e.g. age, sex, occupation etc." is the first step for CHEWs.
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: cc. acceptability dd. affordability ee. availability ff. eligibility gg. respectfulness hh. physical/geographic accessibility ii. unbiased and nonjudgmental and nondiscriminatory	M 0	W 0	B 0	G 0	No.
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.						

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