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

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The views expressed in this document do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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Table of Contents

Acknowledgements .... *ii*

Acronyms .... *v*

Executive Summary .... *vii*

Introduction and background *1*

Methodology *1*

Political, social, and economic overview of Nigeria and Kebbi State *3*

Health overview and outcomes in Kebbi *4*

- **Reproductive health and family planning** **5**
- **Maternal health** **6**
- **Newborn and child health** **7**
- **Nutrition** **8**
- **Malaria** **8**
- **HIV** **9**

Major gender considerations in Kebbi *10*

- **Gender norms, roles, and responsibilities** **10**
- **Gender-based violence** **11**
- **Marriage and divorce** **13**
  - **Child marriage** **13**
  - **Divorce** **14**
- **Gender norms related to sexuality** **15**
- **Men and masculinities** **15**

Governance and the health system *16*

- **Structure and decentralization** **16**
- **Lack of Public Representation** **17**

Policy analysis—Gender and health *17*

- **Existing laws, policies, guidelines** **17**

Financing and budgeting *23*

- **Commitment to gender responsive budgeting** **24**
- **Health insurance and gender** **24**

Human Resources for Health (HRH) *24*

- **Distribution** **25**
- **Education, recruitment, training, and compensation** **26**

Service delivery *26*

Main service providers **26**
Policies and guidelines about gender-sensitive care and service delivery **27**
Youth-friendly services **27**
Social inclusion and vulnerable populations ***28***
Poor and marginalized **28**
Youth and adolescents **28**
Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) Populations **28**
People with Disabilities **29**
Ethnic and religious minorities **29**
People on the move, including Internally Displaced Persons and Refugees **30**
Survivors of GBV **30**
Stakeholder analysis and review of previous gender analysis efforts ***31***
Recommendations ***33***
References ***39***
Annex 1. Gender-responsive checklists for health policies and guidelines in Kebbi, Nigeria ***49***

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women and Children
CHC	Community Health Committees
CHEW	Community Health Extension Worker
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
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MSM	Men who have sex with men
NACA	National Agency for the Control of AIDS

NAIIS Nigeria HIV/AIDS Indicator and Impact Survey
NDHS Nigeria Demographic and Health Survey
NGO Non-governmental Organization
NSHDP National Strategic Health Development Plan
OF Obstetric Fistula
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
SSHDP State Strategic Health Development Plan
TBA Traditional Birth Attendant
TFR Total Fertility Rate
TSHIP Targeted States High Impact Project
UHC Universal Health Care
UNICEF United Nations Children's Fund
USAID United States Agency for International Development
USD United States Dollar
VAPP Violence Against Persons (Prohibition) Act
VLS Viral Load Suppression
WDC Ward Development Committees
WHO World Health Organization
WTFR Wanted Total Fertility Rate

Executive Summary

USAID's Integrated Health Program (IHP) Task Order 4, led by Palladium International, LLC, works in Kebbi 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 agency that will allow them choices to protect their health and the health of their newborns. In Kebbi, women generally have little or no voice in decisions about contraception, number and spacing of children, and resources spent on 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 Kebbi State and to identify gender and social inclusion issues affecting service quality, health programming, and health systems strengthening (HSS) outcomes. The review also looks at state policies that aim to address gender inequalities, to protect women and people with disabilities against abuse and violence, and to advance equitable services that are accessible to women, youth, and most marginalized groups. To 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 northern states suffer the most. Kebbi's North West region has the highest levels of poverty, weakest infrastructure and governance, and lowest rates of education in the country. In addition, men and women of the North West are influenced by cultural and religious beliefs, resulting in large families and unequal gender dynamics. Kebbi State is among Nigeria's poorest performers in terms of health indices, especially in child mortality and maternal health, malaria, pneumonia and diarrhea. While approximately 37% of all deaths are preventable with available vaccines, malnutrition underlies about 50% of child deaths in the state.[1] In Kebbi, child marriage (marriage before the age of 18) is the norm.

Despite large donor investments in the health sector in Kebbi and the prioritization of primary health care (PHC) by the state government, 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. The extent of youth-friendly services in Kebbi is unknown, and significant gaps in education and services for youth persist.

Several vulnerable groups in Kebbi are particularly affected, which leads to poor RMNCH+NM outcomes: poor and marginalized populations, including youth and adolescents; Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) populations; people with disabilities; ethnic and religious minorities; and survivors of GBV. Given the poverty and limited economic opportunities across the North West and in Kebbi, 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, 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 to improve access to healthcare.
- Coordinate with other USAID and donor funded projects 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 aim to achieve more effective, and efficient RMNCH +NM strategies, activities, and sustainable change. It is recommended to complement these finding with additional rapid analysis to better understand gender and social issues in project focus areas. This desk review will inform the strategy for integrating gender equality and mainstreaming and social inclusion into policy development and program design at the state level, implementation and service delivery at the facility level, and organizational culture and practices at the community level. 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 well-being and development for women, men, girls, and boys in Kebbi State.

Introduction and background

USAID's Integrated Health Program (IHP) Task Order 4, led by Palladium International, LLC, works in Kebbi 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 4, 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 into policies and program designs and guidelines at the state level in Kebbi, 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 Kebbi 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. To provide context, the desk review will explore the gender landscape of Nigeria as a whole, and then highlight the particular challenges, concerns and influencing factors in the state of Kebbi. Gender related challenges are shared and often similar across the country; however, Nigeria's size and devolved political structure contributes to broad differences from state to state in cultural norms, political policies, health system management, and service delivery. Therefore, this review aims to provide a clear and thorough picture of Kebbi within the broader national context. 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 (OF) 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.[2]

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.[3] 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 Development Experience Clearinghouse (DEC), and Google searches for reports from over the last five years from key global organizations (including UNICEF, CARE, Human Rights Watch, UN Women, UNFPA, and WHO). The report also included a listing and high-level assessment of key gender policies that have or have not been domesticated at the state level. 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.[2, 4] 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 public representation) 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 Kebbi State

The Federal Republic of Nigeria is located on the western coast of Africa and borders the countries of Benin, Cameroon, Chad and Niger, as well as the Gulf of Guinea. The country has 36 states and a Federal Capital Territory known as Abuja with Kebbi State located in the far North West region of the country, bordering both Niger and Benin. It is important to understand the state of Kebbi within the broader national context.

Nigeria is a federal democratic republic composed of legislative, executive, and judicial branches whose powers are vested by the Constitution of Nigeria in the National Assembly, made up of the House of Representatives and the Senate, the President, and the federal courts, including the Supreme Court. The Kebbi State government, as in each state in Nigeria, is also divided into legislative, executive, and judicial branches. The executive branch, headed by the State Governor, has the power to develop and execute policies in the state, which is comprised of 21 Local Government Areas (LGAs).

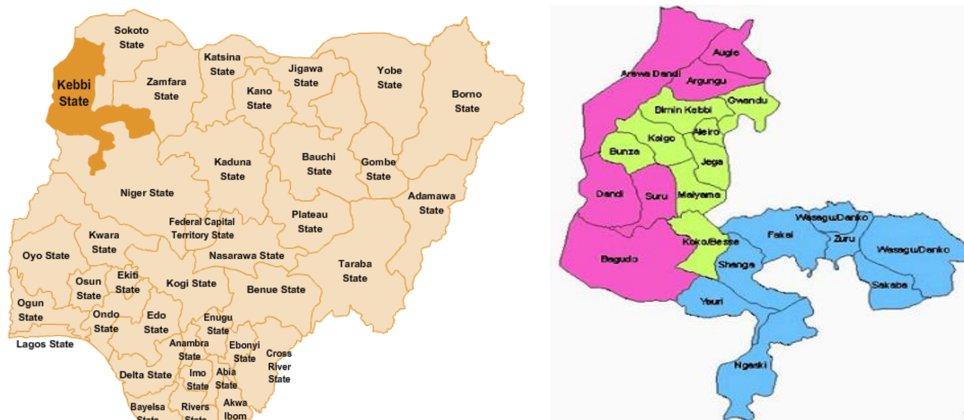
Nigeria is the most populous country in Africa and the seventh most populous country in the world; as of 2020, the projected population is approximately 204 million.[5] Kebbi, despite being 10th largest state in landmass (36,800 km^2),[6] is one of the smaller states with respect to population, ranking as the 22nd largest population with a population (as of 2018) of 4,617,431 people. [7] In line with much of sub-Saharan Africa, 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.[8] While the country's population is becoming increasingly urban with 52.0% of the population projected to live in urban areas in 2020 [9], Kebbi's population remains unevenly distributed, and there are still large numbers of small rural settlements located in hard-to-reach areas. Kebbi is mainly populated by Achifawa, Kambari, Dukkawa Fakkawa, Kambari, Katsinawa and Lelna (Dakarkari).[10] Like much of northern Nigeria, Islam is followed by a majority of the population in Kebbi.[11] Southern Nigeria is predominantly Christian; and nationally the country is approximately 50% Muslim, 40-45% Christian, and 5-10% traditionalist or indigenous religions.[12, 13] Nigeria is home to 350 different ethnic groups and over 250 languages.[14] 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.[15, 16] The most commonly spoken languages are Hausa, Zabarmanci, Dakkarci, Fakkanci, Dukkanci Achifanci, but there is wide diversity in languages spoken.[10]

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 national wealth.[17] There are regional inequalities that 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.[16] Kebbi in particular, like many states in the North, is one of the poorer states in the country; it was among five states that scored lowest in UNDP's Multidimensional Poverty Index (MPI), which looked at health, education, standard of living, and unemployment indicators. Kebbi had a Human Development Index (HDI) value of 0.3815, ranking it 28 out of 36 states in 2016, and significantly lower than the national average, at 0.521. [18] The main occupations in Kebbi are agricultural production, animal rearing, fishing, and some commerce.[10] Agriculture is key to the economy in Kebbi. Cash crop production of peanuts, cotton, and rice takes place in the floodplains, and residents also grow subsistence crops of millet, sorghum, onions, and cowpeas. Land is also used for livestock grazing.[11]

With one-third of the state desert-prone, Kebbi's economy is particularly vulnerable to drought and desertification.[19] Unemployment is also a challenge in Kebbi, with women and youth most affected by poverty and limited economic opportunities.[18] In 2018, 49.3% of women in Kebbi State were unemployed in the twelve months preceding the NDHS, compared with 4.3% of men.[15]

In addition to struggles with poverty, Nigeria has experienced periods of instability, violence, and famine over the past few decades. Poverty and famine are more endemic in the North West region of Nigeria, while Boko Haram's terrorist activity has been largely restricted to the North East region. Overall, 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] While official estimates for human trafficking cases were difficult to obtain, it is an issue in Kebbi State. It is important to understand the severity of risk to violence that all women, girls, boys, and young men face - even where there may be less documented activity – so that preventative measures can be put in place that empower and protect vulnerable groups, particularly in states like Kebbi that are located along multiple borders and often positioned along fragile areas.

Figure 1. Maps of Nigeria and Kebbi State



Sources: https://www.naijahomebased.com/kebbi-state-postal-code/, https://www.nigeriagalleria.com/Nigeria/States_Nigeria/Kebbi/Kebbi_State.html

Health overview and outcomes in Kebbi

Kebbi State is among Nigeria's poorest performers in terms of health indices, especially in child mortality and maternal health. While the national under-five mortality rate is 132/1,000 LB (live births)), Kebbi's under-five mortality rate is 252/1,000 LB. Nigeria's national maternal mortality ratio (MMR) is 512/100,000 LB which is a significant decrease from the past—in 2013, the MMR was 814.[15] Gender is intricately linked to health access and outcomes. In Kebbi, malaria, pneumonia, and diarrhea account for close to 45 per cent of under-five deaths. While approximately 37% of all deaths are preventable through the use of available vaccines, malnutrition underlies about 50% of child deaths in the state.[1] Kebbi's performance on key health indicators and their relationship to gender are summarized below.

Table 1. Key health indices in Kebbi State and Nigeria

Indicator	Kebbi State	National	Year	*Source*
Life expectancy at birth (years)	Not available	54.0	2017	*World Bank*[17]
Infant mortality rate / 1,000 live births	112	67	2018	*2018 NDHS*
Under-five mortality rate / 1,000 live births	252	132	2018	*2018 NDHS*
Maternal mortality ratio / 100,000 live births	Not available	512	2018	*2018 NDHS*
Total fertility rate (births per woman)	6.5	5.3	2018	*2018 NDHS*
Percentage of teenage women (15-19) who have begun childbearing	27.2	18.7%	2018	*2018 NDHS*
HIV/AIDS prevalence-Adult population	Not available	1.5%	2018	*World Bank*
Malaria prevalence among under 5 years	76.8%	36.2%	2018	*2018 NDHS*
Diarrhea prevalence among under 5 years	9.6%	12.8%	2018	*2018 NDHS*
Prevalence of ARI among under 5 years	1.1%	2.6%	2018	*2018 NDHS*
Children <5 years stunted below-2 SD	66.1%	36.8%	2018	*2018 NDHS*

Reproductive health and family planning

In Kebbi, as in most of Northern Nigeria, men and women tend to have large families; and the community is typically influenced by cultural and religious beliefs, which can impact decisions related to early marriage and multiple children.[21] Kebbi's total fertility rate is 6.5 births per woman of reproductive age, compared to the national average of 5.2, which is influenced by a low average age of first marriage for girls (15.8 compared to 22.2 for boys).

In Kebbi, the unmet need for contraception to space and limit births is 9.9% and 1.9%, respectively[15], and even though abortion is illegal in Nigeria, the known abortion rate in the North West region (on par with the national rate) is 31 abortions per 1,000 women ages 15 to 49. This high rate is likely linked to the low contraceptive use and high unmet need for family planning [22]. Contraceptive use in Kebbi State is low. In 2018, only 3.5% of women used any contraceptive method and 3.2.% used a modern method. This was well below the national average of 12%, and one of the lowest in the country.[15] Studies show that women in Kebbi are unaware of, or poorly informed about, their family planning choices, with only 51% of women aware of any modern contraception in 2013 (compared with the national 83.8%); while men in Kebbi show a 91.5% level of awareness (only slightly lower than the national level of 93.7%).[23] The low knowledge and use of family planning options and high rates of early and frequent childbirth have significantly compromised the health and well-being of families in Kebbi and has put strain on the health system's ability to adequately respond to need. See Table 2 for a summary of key reproductive health indicators.

Maternal health

While the Nigeria Demographic Health Survey 2018 (NDHS 2018) states that the maternal mortality ratio (MMR) for Nigeria is 512[15], 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.[17] 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%).[24] Comprehensive, state- disaggregated data on maternal mortality is not available, but the estimated MMR of 1,026 deaths/100,000 live births in Kebbi State are higher than the national average and is equally one of the highest in the world. The lifetime risk of maternal death in rural communities in Kebbi has been estimated at 1 in 16 women exposed.[25] The estimates again underscore the assertion that the highest burden of maternal mortality in Nigeria is in rural northern Nigeria communities. Maternal mortality remains consistently high due to a weak health system in the region, in terms of facilities and human resources, among other factors. The situation in Kebbi State is more worrisome where utilization of maternal health services remains very low.

In Kebbi in 2018, 27.2% of women ages 15 to 19 had begun childbearing, whereas the national median age of first birth was 20.4 years.[15] Limited access to trained providers is a key factor contributing to maternal mortality and morbidity. In Kebbi only 3.4% of births were delivered by a skilled provider, and 7.4% were delivered in a health facility.[15] In Nigeria, the most common reasons for delivering at home, rather than a health facility, are that the child was born quickly, the family felt it was not necessary, the facility was too far, or the services were too expensive. Additional reasons given that specifically apply to Kebbi are a husband's refusal to support a hospital birth, financial reasons, poor treatment from health providers, and positive experiences birthing at home with Traditional Birth Attendants (TBAs).[15]

Table 2. Reproductive and maternal health indicators for Kebbi State

	2013 DHS		2018 DHS	
Indicators	**Kebbi**	**Nigeria**	**Kebbi**	**Nigeria**
Contraceptive Prevalence Rate	1.3%	16%	3.5%	27.7%
Married women who had heard of a modern method	47.0%	83.8%	89.7%	93.9%
Unmet need for family planning (married women)	18.2%	16%	11.8%	18.9%
Mean fertility rate	6.7	5.5	6.5	5.3
Adolescents who have begun childbearing	34.4%	22.5%	27.2%	18.7%
Any ANC care from a skilled provider	24.3%	60.6%	14.7%	67%
Delivery in health facility	8.5%	35.8%	7.4%	39.4%
Maternal mortality ratio (per 100,000 live births)	N.A.	814	N.A.	512
Postnatal check-up in first 2 days after birth	7.6%	40%	17.6%	41.8%

Source: 2013 and 2018 NDHS [15, 23]

Nigeria accounts for the highest total number and 40% of all obstetric fistula (OF) cases globally. Without treatment, fistula can severely impact a woman's health and well-being; 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.[26] Kebbi State hosts the Gesse VVF Center through the USAID Fistula Care Plus initiative in Birnin-Kebbi, where it works to prevent and repair fistula and to train health professionals about fistula case management.[27] In operation since 2005, the Center is the only facility in the entire state of Kebbi providing care for women suffering from fistula.[28] The Center repaired 126 cases of obstetric fistula from January-July 2019;[29] 152 cases in 2017, and 534 since 2014.[30]

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, fistula patients tended to be both short and small, with an average age of marriage of 15.5 years, but now divorced or separated, with little education or access to financial resources, from a rural area, and they developed fistula during a birth that lasted, on average, two days, and resulted in a stillborn fetus (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%).[31] 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 highlights the pressing need for more deliveries in health facilities and for qualified care within those facilities. A 2013 assessment in Kebbi and Cross River states, supported by USAID, suggests that more thorough and consistent data collection could provide greater information at the state level and inform interventions to address obstacles to fistula care and improve services.[32]

In recognition of these alarming statistics, the Nigeria Minister of Health recently inaugurated the "Task Force on Accelerated Reduction of Maternal Mortality in Nigeria" and stated that six northern States including Kebbi were among States with the highest burden in Nigeria. Prior to this, the State Government of Kebbi and Adamawa in 2013 accessed a grant of 30 million Euros (6 billion naira) from The European Union Commission to help reduce MMR in the two states.[25] Despite these efforts, achieving a drastic reduction in MMR in Kebbi State remains a challenge.

Newborn and child health

One in 15 Nigerian children die before reaching age 1, which is 81 deaths per 1,000 live births. Primary causes of neonatal mortality in Nigeria include asphyxia, preterm birth, infection, diarrhea, tetanus, and congenital illness.[24] 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, which is not surprising given the high percentage of home births. The highest death rate of infants within the first 28 days (neonatal mortality) of life is in the North East and North West regions of the country.

The immunization coverage in Nigeria has improved over the past 10 years. The proportion of children ages 12-23 months who received all basic vaccines almost doubled from 13% in 2003 to 25% in 2013. While this improvement is appreciable, it still fell far short of the increase needed to achieve the MDG target of more than 90% by 2015. Children in the North West are less likely to receive all basic vaccinations than children in the South East (20% versus 57%). Only 6% of children Kebbi received all basic vaccinations, including BCG (25.6%), Hepatitis B (15.8%), IPV (15.9%) and measles (32.6%).[15]

The diarrheal prevalence was quite low in Kebbi State (9.6%) compared to other parts of the country, but over a third of children under age 5 (38.9%%) had a fever during the 2 weeks preceding the survey.[15]

Nutrition

There is a high burden of undernourishment and malnourishment in Nigeria, yet the burden in northern Nigeria of chronic malnutrition, particularly under-nutrition, is among the heaviest globally. Close to half of all under-fives in the North East and North West geopolitical zones were estimated to be stunted in their growth for their age in 2013, compared to 22 percent in the rest of Nigeria.[33] In Kebbi, 66% of children under five experience stunting and 12.3% experience wasting.[15]

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,[34] as well as access to sufficient knowledge so they and their children can live reliable healthy and well-nourished lives.[33]

In Nigeria, only 29% of children were exclusively breastfed up to 6 months.[15] 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.[34] In Kebbi, 97.5% of children are ever breastfed, which is on par with the national rate, however, only 25.1% of women initiate breastfeeding within 1 hour of birth and 91.5% within 1 day. Over 80% of children were found to be anemic in Kebbi.[15]

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. In Kebbi in 2016, 63.6% of children ages 6 – 59 months had malaria (microscopy positive).[35]

Nigeria is one of seven countries that did not achieve the minimum recommendation for insecticide treated net (ITN) coverage of one net per two people at risk in 2017, but ownership increased slightly from 2016 to 2017. Nigeria distributes seasonal malaria chemoprophylaxis (SMC) to children, and while Nigeria covered the lowest percentage of children needing SMC of any country implementing the intervention, reaching 45% of eligible children, the country also reached more total children than any other country. Due to its large and growing population compared to most countries implementing SMC the high number of children reached still translates in to the smallest percentage.[36]

In Kebbi, almost all (98.1%) of households have at least one ITN, which is far higher than the national mean of 60.6% and a 30-percentage point increase since 2013. On average, there are 2.6 ITNs per household. Furthermore, while usage is far lower— only 81% of 2018 NDHS respondents slept under an ITN the night before the NDHS was administered—this once again exceeds the national average of 43.2%. This rate is even higher for pregnant women (96.2%) and children under the age of five (93.5%),[15] which can be connected to messaging and ITNs targeted for pregnant women and children.

Knowledge of malaria is high amongst women in Nigeria, with 87% of women having heard of the illness in 2015. However, represents a 7 percentage point decrease from the figure reported in the 2010 National Malaria Indicator Survey (NMIS). Fewer rural women than urban woman have heard of malaria (91% and 85%, respectively). Women in the North Central and North West zones have the lowest levels of knowledge of malaria (83% each). In Kebbi, only 46.2% of women reported hearing or seeing a message about malaria in the past 6 months. Channels included radio (70%), television (32%), community worker (17%), billboard, poster, or T-shirt (8%), or relative, friend, neighbor, or school (7%).[35]

HIV

Nigeria has the second largest population of people living with HIV/AIDS in the world.[37] Findings from the 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) indicate a lower prevalence of HIV than previously estimated.[38] The Federal Ministry of Health reported the national prevalence among 15-49 year-olds at 3.4% in 2012, however the NAIIS found a prevalence of 1.4% among this age group.[39] The HIV epidemic in Nigeria is highly gendered, with females having a higher prevalence in every age group. Nationally, 1.9% of women and 0.9% of men are living with HIV. However, women are slightly more likely to achieve viral load suppression (VLS) than men (45.3% vs 42.3%), potentially indicating higher access to care, care uptake, or compliance with the medication regimen.[38] In Kebbi, 0.6% of the adult population has HIV/AIDS;[40] 3,284 men and 6,015 women were on antiretrovirals.[41] Data was not available in the 2018 NDHS at the state level, but in 2013 in Kebbi, 32.7% of women were tested for HIV and 29.6% received their results.[23]

Knowledge of HIV prevention methods, including condom use and limiting sexual partners to one uninfected partner, were slightly lower in Kebbi compared to the national average—69.3% of women and 53.8% 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.[1][23] Interestingly, in Kebbi, women aged 15-24 had much higher rates of knowledge about HIV prevention (28.9%) than men (9.0%).[15]

Across Nigeria, behaviors that put people at higher risk for HIV/AIDS were generally more prevalent among men, including total number of lifetime partners. However, in Kebbi, men only have, on average, one more sexual partner compared to women (2 compared to 1.2) but are more likely to have more than one sexual partner at a given time (19.2% compared to 0.1%). In Kebbi, only 1.6% of men reported purchasing sex compared to 4.9% nationally.[15] The low prevalence of these risky sexual behaviors likely contributes to Kebbi's lower rates of HIV compared to national averages.

Nigeria has programs in place for the prevention of mother-to-child transmission (PMTCT) of HIV, described in more detail in the ANC section.

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

Indicator	National		Kebbi		Source
	Men	Women	Men	Women	
Awareness of HIV/AIDS	95%	94.3%	91.9%	81.1%	*2018 DHS*
Know condoms and having one HIV- partner reduces risk	74.1%	70.7%	53.8%	69.3%	*2018 DHS*
Knew that HIV can be transmitted via breastfeeding	69.3%	77.6%	50.1%	76.7%	*2018 DHS*
Knew that MTCT risk can be reduced with medication	62.2%	71.5%	60.9%	42.1%	*2018 DHS*
People living with HIV (ages 15-64)	1.4%	1.9%	1.1%*		*2018 NAIIS*
People living with HIV with VLS	45.3%	42.3%	49.7%*		*2018 NAIIS*

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

[1] Since the NAIIS focuses on HIV testing and VLS, we rely on the 2013 NDHS for information about national and state trends about HIV/AIDS knowledge and behaviors.

Major gender considerations in Kebbi

Gender norms, roles, and responsibilities

The Northern region of Nigeria, including Kebbi, is mostly comprised of Muslim Hausa-Fulani societies, while the Southern region is predominantly Christian and dominated by Igbo and Yoruba ethnic groups. Both religions teach respect for women and families and provide for the rights of women. However, regional norms, particularly in rural areas where education and exposure are limited, religious teachings, as well as state and national policies protecting women, may be superseded by community practices or traditional family power structures that disempower women and even put them at risk. While the laws exist, women may not know of them or how to realize them in daily life. Women, for example, have the right to own property, work outside the home, and partake in economic activities. Muslim women also have political and legal rights, including participating in governance, voting, and expressing political opinions in public. A woman may also play a role as a decision-maker with regards to her household. In terms of land, traditionally, Muslim women could own land through inheritance, however common practices have resulted in land often being passed from fathers to sons.[42]

In terms of education, Islam promotes the education of boys, girls, men, and women. However, despite this emphasis, it may not be practiced culturally in the North. Specifically, girl children may be removed from school to sell items on the street in order to buy household goods or be expected to marry early (see section Marriage and Divorce). For some, girls may be considered "future housewives" and care workers within families which may further serve to justify keeping them out of school.[42]

One study found that differences exist in school enrollment behaviors between educated and non-educated parents.[43] The study therefore recommended efficient adult literacy programs, which should be targeted towards influencing parents, and as a result, improving girl-child enrollment, retention, and participation in education. Despite rising momentum with girl-child education in Kebbi, the state Ministry of Education experienced challenges in ensuring enrollment and retention of girl pupils. Prior to the study, researchers found evidence that 33.7% of girls in North Eastern states (Borno, Yola, Adamawa, Bauchi) had no form of education, but this number was drastically higher (87.8%) in North Western states (Kano, Kebbi, Sokoto, Jigawa). The study found that factors such as community interference, fear of immorality (engaging in premarital sex, illicit relationships, unwanted pregnancies), inadequate sensitization (some people are still conservative and do not see the relevance of girl-child education), and inadequate role models (usually teachers or health workers are mostly male and from outside the community leading some to believe that girls do not exceed secondary education) influence non-educated parents and contribute to their reluctance to enroll girl children in school.[43]

Low education, as well as lack of interpersonal skills and public speaking, limited organizing and negotiation, and financial constraints have all been cited as factors contributing to challenges women face in political participation. In some instances, regulations or resources may also pose a challenge where women may have difficulties opening a bank account (many women in the North lack bank accounts) or need permission from a man to attend activities outside of the home. In addition, political participation has also been associated with obstacles that may further limit women's participation such as fear of intimidation, physical assault, name calling, gossip, and innuendos questioning morality.[42] Information on leadership capacity, opportunities for community participation, and economic empowerment for women in Kebbi is not readily available. Further understanding of obstacles and facilitators to women's advancement – external influences as well as internal psycho-social factors – will be important to assess, including providers and educators in that process, in order to define sustainable interventions that will support and strengthen women's advancement in Kebbi.

Persistent power imbalances can serve as a barrier to women's empowerment.[44] 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.[45] In Kebbi, women making decisions related to healthcare (4.4%), household purchases (54.3%), and visits to families (12.9%) is low compared to other regions. Interestingly, 96.7% of men say they make the final decisions regarding household purchases.[15]

According to one paper, one factor that could influence both health and earnings is women's seclusion. Where seclusion is practiced, it can limit a women's mobility in public and private spaces particularly with regards to economic activities and accessing health care. Many women, especially those from poor rural areas, may delay seeking antenatal or hospital care, potentially impacting maternal mortality (such as babies delivered at home without skilled birth attendants). However, in some rural areas, seclusion may be limited as there is a need for laborers particularly in agriculture where women often work.[42] One source estimated that almost 70% of Nigeria's women live and work in rural areas where they provide over two-thirds of the rural labor force and make a living from the land. However, less than one-fifth of all households are characterized as female-headed.[42]

These norms exemplify the strong influence men have in women's lives. In many instances, 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.[45] According to the 2018 NDHS, controlling behaviors towards wives have been identified as warning signs that correlate with intimate partner violence. Controlling behaviors examined in the NDHS include whether a husband (or partner): (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 Kebbi, almost half (46.3%) of women say their husbands display at least one of the specific behaviors associated with warning signs and 16.5% say they display three or more. The most common behavior (42.1%), according to women, is husbands insisting on knowing where their wives are at all times. This behavior of controlling movements was reported at a higher frequency in 2018 compared to 2013.[15]

Gender-based violence

According to the 2018 NDHS, 36.2% of ever-married Nigerian women have experienced spousal violence (emotional, physical, or sexual). In Kebbi, 15.6% of women have experienced physical, sexual, or emotional violence by a partner or spouse, with 14.9% of women experiencing violence in the last 12 months. This was a four-percentage point increase since 2013.[15] In Northern Nigeria, the most common forms of GBV include intimate partner violence, sexual violence, verbal abuse, and financial deprivation, food deprivation, child/forced marriage, torture and stigmatization on alleged involvement in witchcraft, and some application of Shar'ia law.[46]. Additionally, at the national level, 4% of women said that their husband or partner had forced them to have sex against their will, and 2% reported that they had been forced to perform sexual acts they did not want to do. The most common form of emotional spousal violence is a spouse insulting or making his wife feel bad about herself (28%), followed by humiliating her in front of others (19%) and threatening to harm her or someone she cares about (6%). Furthermore, in Kebbi, 87.4% of women and 62% of men agree that husbands are justified in beating their wives under at least one circumstance, the most common being if she refuses to have sex with him followed by if she goes out without telling him.[15] These numbers are summarized in the table below.

Table 4: State vs. National Levels of Violence

Description of Violence	Kebbi	National
Physical abuse from husband or partner (ever-married women between 15 and 49)	7.4%	19.2%
Sexual abuse from husband or partner (ever-married women between 15 and 49)	0.5%	7.0%
Emotional abuse from husband or partner (ever-married women between 15 and 49)	14.2%	31.7%
Controlling behavior: women whose husbands become jealous if they talk to other men	32.0%	44.2%
Controlling behavior: women whose husbands must know where they are at all times	42.1%	40.7%
Controlling behavior: women whose husbands try to limit when they see their families	19.8%	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	87.4%	28.0%
Women who never sought help or never told anyone about their experience of violence	78.8%	54.6%

Source: 2018 NDHS [15]

Nationally, seeking help after experiencing violence varies greatly—while 31.6% of Nigerian women seek help; women ages 30-39, those from the South zone (compared to the other zones), and divorced/separated/widowed women (as opposed to single or currently married women) are the most likely to seek help to stop the violence. Across Nigeria, women with any employment, whether for cash (32.9%) or not for cash (31.2%) are more likely to seek help after experiencing physical and/or sexual violence than women without work (28.7%). However, trends in who is most likely to seek help do not follow education, wealth, or residence (urban/rural) trends.[15]

Women in Kebbi often do not seek help after experiencing violence. Together, underreporting, infrequent prosecution and conviction, minimal sentences, and shame and stigma continue to discourage victims of GBV from speaking out.[47] In Kebbi, only 11.8% of women sought any kind of help after experiencing sexual/physical violence, which was a decrease from 16% in 2013.[15] Women face significant barriers in seeking support after experiencing violence, including victim blaming, social and religious pressure, and distrust of law enforcement.[48] For Muslim women whose communities practice Shari'a law in particular, one paper indicated that women who have been raped may face challenges in seeking justice due to legal obligations such as having multiple witnesses which makes successful prosecution more difficult.[42] This shows that violence is normalized within the culture, especially when it occurs within the home. In one study, three-quarters of men and two-thirds of women reported being physically punished at home as children. Four out of five of men and seven out of then of women reported being beaten or physically punished at school, and one-quarter saw their mother being beaten by their father or another man when they were growing up. About 20% of participants, both male and female, reported being sexually assaulted when they were children.[48]

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 their 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, including increased rates of obstructed labor and obstetric fistula.[30] Almost 20% of Nigerian women ages 15-49 had undergone FGM/C as girls and young women, with higher rates among older age groups. Kebbi has significantly lower rates of FGM/C where only 1.6% of women have undergone the procedure.[15] Rejection of harmful traditional practices, including FGM/C, is on the rise nationally.[48] Approximately 67.4% of Nigerian women believe that the practice should be stopped, compared to just 31% in Kebbi (67% believe it should continue and 1% have no opinion). Interestingly, women that have bene circumcised are more likely to believe that it should continue due to religious reasons.[15]

More information about survivors of GBV is presented below in the section on social inclusion and vulnerable populations.

Marriage and divorce

Polygyny (the practice of one man marrying multiple women) is common in Nigeria. In Kebbi specifically, 39.2% of women report having one co-wife and 5.1% of women report having two or more. This is compared to 24% and 6.5% at the national level. On the other hand, 27.3% of men in Kebbi report having more than one wife.[15] In such unions, there is commonly a hierarchy where all wives are not treated equally, with those who are senior or more favored wielding more power to make decisions.[15, 45] 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.[45]

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."[45] 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.'[48]

Child marriage

Generally, women marry younger than men in Nigeria. In 2018, the average age of marriage for women was 19, eight years earlier than the average age for men. Nationally, among women age 20-49, 17.9% were married before the age of 15 and 43.1% before the age of 18. In Kebbi, child marriage (marriage before the age of 18) is the norm: the average age of first marriage for women was 15.8, compared to 22.2 years for men.[15] 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.[49, 50] 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.[51, 52] 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.[17] In 2013, half of women 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.[48]

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.[15] In Kebbi, poverty, education, and early marriage are closely linked. The National Bureau of Statistics determined that 62.6% of the population was living in poverty in 2010; Kebbi experienced higher levels of poverty, with 72.5% of the population living under the poverty line.[53] Child marriage is sometimes considered advantageous, especially for parents who are poor of living in rural areas. Parents may marry their daughters to alleviate the cost and responsibilities of raising their daughters.[54]

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.[45, 55] 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.[55] Child marriage has also been linked with the prevalence of obstetric fistula, as obstructed deliveries are more likely when girls have not finished puberty.[30, 52] Further, one paper linked fistula to prostitution stating, that some women who have permanent internal damage after childbirth (such as fistula) may be seen or feel undesirable to husbands and men who may cast them out or divorce them, resulting in turning to prostitution.[42]

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.[45] 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.[56]

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 Kebbi 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.[57] 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. [58, 59] 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.[15, 60] Physical violence has been mentioned as a reason to seek divorce, as well as a reason for which a court would grant a wife the divorce she requested.[45]

Gender norms related to sexuality

Conservative gender norms are closely tied to traditional norms about sexuality in Nigeria. While age at first marriage could be used as a proxy for reproductive risks, because some women and men are sexually active prior to marriage, it is also important to look at when they initiate sexual intercourse. At the national level, 18.5% of females aged 20-49 (23.7%) had sex by age 15 and over half (57.1%) before their eighteenth birthday, compared to males of whom 3% had sex by 15 and 14.1% by 18. Wealthier girls have sex later than girls from lower economic levels while the reverse trend is true for boys. Girls with a secondary education begin having sex later compared to girls with no education; male education level is not correlated with age of sexual debut. In Kebbi, the average age for sexual debut is 16 years for females and 21.5 years for males.[15]

Recent sexual activity can be an indicator for several factors including trying to get pregnant or engaging in risky sexual behaviors. Men are more likely to engage in risky sexual activity. Men in Kebbi had on average 2.1 partners in the 12 months prior to the 2018 NDHS survey and 2 lifetime sexual partners compared to 1.1 lifetime sexual partners for women. For men, this is lower than the national average of 4.4. Over 3% of men reported ever paying for sex (transactional sex) and 74% of those men reported using a condom at the last time they paid for sex.[15]

Negotiating safer sex is an essential part of HIV/AIDS prevention and sexual and reproductive health, however, it is often difficult for women in relationships and cultures with inequitable gender norms. Nationally 41.2% of girls and women 15-24 reported having a sexual partner 10 or more years older than they were in the past year, which increases risk of sexually transmitted infections (STI), including HIV, among young women, as the virus is often passed from older men to younger women.[61] Of the women and men nationally who reported having two or more sexual partners in the last year, 36% of women and 65% of men reported using a male condom during the last sexual intercourse (0% of men in Kebbi reported condom use with last sexual intercourse but no data for women is available). Of these men that had more than one sexual partner, 16% reported having sex with someone who was not their wife or lived with them. [15]

Results of attitudinal questions about safer sex negotiation show an interesting trend in Kebbi, where 49% of women believe that a woman is justified in asking her husband to wear a condom if she knows he has an STI, whereas 61.3% of men believe she would be justified in doing so.[15] Interestingly, this represents an increase for men and a decrease for women since 2013.[23] Further, 60.4% of women and 70.2% of men believe a woman is justified in refusing to have sex with her husband if she knows he has sex with other women (however the question does not appear to have addressed polygyny, which might be treated differently). Overall, agreement with the statements related to condom use increases with household wealth and education levels.[15] 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 Kebbi.

Men and masculinities

There is a growing concern that harmful gender norms and toxic views of masculinity can result vulnerabilities for men's health and wellbeing and negatively impact their families. In parts of Nigeria, men's access to health care is affected in fear of being seen as weak.[34] According to the Nigeria Men and Gender Equality Survey (NiMAGES), "toughness, sexual performance, and income were central to notions of masculinity in study sites."[48] Additionally, men's healthcare seeking behavior was low, with men self-reporting that they are reluctant to seek healthcare. While Kebbi was not one of the states included in the study, all study sites, which represented diverse regions of the country, found that 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.[48]

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.[45]

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.[45]

Governance and the health system

Structure and decentralization

The Kebbi 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 sits with different organizations, generally divided between primary, secondary, and tertiary care facilities.

Local government facilitates the provision of primary health care, which provides primarily preventive services such as community mobilization, health education, personal hygiene, environmental sanitation, immunization, and immediate disease outbreak notification. Health personnel include community health officers (CHO) and other community health extension workers, such as lab technicians and pharmacy technicians. Secondary care facilities include state-run hospitals, including the VVF Center to repair fistula cases. Personnel include doctors, pharmacists, nurses, midwives, laboratory scientists, dental officers, and physiotherapists. Tertiary care facilities provide specialized health care services and include all teaching hospitals, federal medical centers and specialist hospitals; they are the responsibility of the federal government.[62] In Kebbi, there are 94 primary health care (PHC) centers, 374 health clinics, and 331 health posts; 32 secondary health facilities; and1tertiary hospital.[41]

PHC centers are owned, funded, and managed by Local Government Authorities (LGAs) 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. 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.[63]

Lack of Public Representation

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.[64]

As of 2017, neither Kebbi State, nor Sokoto and Zamfara States, had produced a female presidential or vice-presidential candidate. In addition, Kebbi has never produced a female senatorial candidate, although it did produce a female representative in 2007. Finally, the state has never produced a female gubernatorial candidate or chairperson.[65] Since its creation, only one Christian from Kebbi has ever been promoted to the State Cabinet.[66]

Women's lack of participation both at the state and national level has negatively impacted promotion and enforcement of their rights. An example is the Gender and Equal Opportunity Bill, which was presented at the Nigerian Senate for a second reading on March 15, 2016 and was rejected. One could argue that one of the reasons why the Bill was not passed is because only seven of the 109 senators are women. Men's efforts, if any, to promote these rights are not sufficient, because they are not direct beneficiaries.[67] Kebbi has some state laws in place to curb the negative impacts of cultural practices on the realization of women's rights, such as the Prohibition of Early Marriage Law.

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.[68] 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, this desk review includes a look at 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.[63, 69] 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.[63, 70]

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.[71]

- **Kebbi State Strategic Health Development Plan II (2018-2022)** – Developed by the State Ministry of Health, this plan identifies 15 strategic priorities within the health system as well as financial, implementation, and monitoring and evaluation plans. While the plan does list gender sensitivity as a core value and calls for all data to be disaggregated by geography, gender, age, and income, gender is not reflected in the priority areas, health workforce sex distribution or training, monitoring and evaluation systems, nor in health finance and budgeting. The plan does utilize sex-disaggregated data for demographic indicators and within the health workforce numbers, there are no commitments or activities to work towards gender balance or equity in recruitment and retention.[41] While gender or social inclusion are not outlined in detail in the Kebbi SSHDP II, proposed activities reflect understanding of the role of gender can play in health. For example, the plan calls to "ensure gender balance in the deployment of health workers, especially with regard to front-line caregivers." In addition, proposed activities strive to engage men and mothers-in-law in maternal health care.[72]

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."[73]

Gender and Equal Opportunities Bill[74] – 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.[75] 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.[67]

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 outline 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.[76]

- **Kebbi State Human Resources for Health Policy** – This document outlines priority interventions required to be strengthened in order to achieve the health Sustainable Development Goals (SDGs). It also articulates the systems and structures to be strengthened at different levels to facilitate effective planning, recruitment, deployment, retention and management of health workers at all levels in the health care delivery system. The policy utilizes uses sex-disaggregated data of health workers, which reveals that there are more male health workers in every category such as doctors (180 males to 14 females), with the exception of community health extension workers (CHEWs) (34 males to 42 females), midwives, and nurse/midwives. While this document expresses a commitment to encouraging more midwives and female CHEWS to help reduce maternal and neonatal fatalities, there are no actions proposed on how to reduce this gap (no recruitment or retention strategies for female health workers). The policy also does not mention sexual harassment, violence, or security of female health workers.[77]

- **Kebbi State Task Shifting and Sharing Policy for Essential Services (2017)** – This document promotes rational redistribution of tasks among existing health workforce cadres and allows for moving specific tasks, where appropriate, to make more efficient use of the available health workers to improve access to services. It outlines the protocols for RMNCH, HIV, TB and malaria health services that can be shared among medical officers, midwives, nurse/midwives or CHEWs to help cover the population and reduce the workload on medical professionals. "Gender equality" is listed as a guiding principle to meet health workforce needs and states that "measures will be taken to ensure gender equality to ensure positive health seeking behavior in the community" but it does not provide details on those measures. 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, or any other kind of gender integration activity.[78]

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]

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[30], and the National Strategy to End Child Marriage (2016 – 2021)[55], 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 Kebbi 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.[46] There is no equivalent legal system in Kebbi 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.[46]

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 Kebbi), 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.[55] 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.[89] 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.[90]

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.[46] 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.[91] 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.[60] Therefore, for example, if someone is married under Shari'a law, only a Shari'a court and judge may grant them a divorce.[92]

Widows' rights

Widows in Nigeria are a very vulnerable population and face stigma and abuse. In the North West, 5.0% of widows are blamed for their husband's death by his relatives, 5.6% are physically or verbally abused by his relatives, 6.4% are maltreated by his relatives, 6.6% of her children are maltreated, and 2.4% of women's in-laws demand she carry out cultural practices to prove herself innocent of his death. Nationally, this type of treatment is significantly more common among Catholics and Christians than Muslims. For example 0.8% of Muslim women must carry out cultural practices to prove themselves innocent of their husband's death, compared to 8.3% of Christians and 5.6% of Catholics.[2][23]

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.[46, 93] 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.[93] If she does maintain custody of her children, she may be denied child support and is also at higher risk for violence.[94]

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.[95] 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.[46]

Economic and political participation

As mentioned, Nigeria's government is one of the least gender equitable globally. This is despite the 2007 National Gender Policy which includes provisions to increase the number of women elected and ensure that they receive 35% of appointed positions, but this has yet to be operationalized.[96] 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.[97]

[2] Data on this indicator is not available in the 2018 NDHS.

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.[46] Additionally, the language in the law is not gender neutral: the Criminal Code Act specifies that rape is committed by a man against a woman and only recognizes vaginal rape. Furthermore, marital rape does not exist in Nigeria, whereby upon entering into marriage a woman can no longer be forced into sex by her husband. According to the law, all sex is consensual by definition; he can, however, be charged with assault if he forces her violently.[98]

The 2015 Violence Against Persons Prohibition (VAPP) Act (mentioned above) prohibits all forms of violence against persons in private and public life and provides maximum protection and effective remedies for victims and punishment of offenders. The VAPP definition of rape is broad in that it is gender neutral and includes oral, anal, and vaginal rape. It also establishes a publicly accessible sex offenders' database to be maintained by the government. VAPP defines types of physical violence that are illegal and provides a framework whereby people who incite or abet the violence may also be charged. Under VAPP, FGM/C is illegal. It also makes it illegal to evict your spouse from your home or deny him/her access; abandon your spouse and leave and them without any mean of subsistence; to deprive a person of their liberty; commit economic, verbal, emotional, or psychological abuse; forcefully isolate someone from their friends and family; carry out any harmful traditional practices, including those against widows; stalk or intimidate someone; use chemical, biological or other harmful substance to injure someone; commit political violence; or expose your genitals in public.[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).[99, 100] This policy has not yet been domesticated in Kebbi State.

Kebbi does not have well-defined domesticated laws that provide protection to GBV survivors. Kebbi State has expressed a commitment to domesticate the Child Rights Act.[101] There have been some informal projects such as the Rural Accessibility and Mobility Project in Nigeria which is mapping the GBV services in Kebbi. Further, marital rape is excluded from the legal definition of rape in penal legislation in the north and under the criminal code in the south. Also, many women and children, particularly in rural and semi-urban areas, are completely unaware of the laws and policies that exist to protect them. While a national GBV referral pathway exists, key stakeholders have not been educated or mobilized to take advantage of it.[101]

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.[102] In Kebbi, 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.[102, 103]

According to a 2016 report, the situation for LGBTQ has worsened, 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.[100]

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. Though there is little documentation in Kebbi, 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."[99]

Financing and budgeting

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.[63] Out of pocket expenditure on health by Nigerians, as a percent of total health spending, was over 70% in 2013, considerably higher than the regional average of under 40%. This creates challenges for healthcare access among those with limited resources or women who do not have independent access to funds, and therefore may be less able to afford these costs.[23]

Kebbi State receives support from a number of international development organizations, including UNICEF, WHO, British Department for International Development (DFID), Medicines Sans Frontiers, and the Netherland Relief Agency.[41] In 2018, the proposed health expenditure was N 269.34 billion (USD 2,720,000). The relative share of the budget for health fell from 8.7% in 2012 to 7.1% in 2015 and decreased 7% in 2018. Furthermore, during the same period health expenditure per capita decreased as the population increased, averaging N1291 (USD 6.8).[104]

The 2018 approved Kebbi State budget is available on the internet, but it is a summary rather than detailed version. In Kebbi, 70% of the health budget is expended on personnel costs, 30% on overhead and administration, leaving inadequate fiscal space to fund strategic HRH management and development.[77] The total cost to implement the Kebbi State Strategic Health Development Plan II (2018-2022) is 148.7 billion naira.[41]

At both state and federal levels, the government is exploring innovative ways of financing health care. In Kebbi State, an equity fund funded through voluntary contributions from various sources to provide access to health services for poor women and children was piloted; it led to an increase in health service utilization within the community. The state has also implemented state-driven conditional cash transfers (CCTs) aimed at improving demand for MNCH services.[105]

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 directs funds to rectify historical and structural inequalities. However, information about the national government of Nigeria or Kebbi'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.[106]

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.[73] Women appear in budgets essentially as objects of health care, whose fertility rates should be lowered and whose maternal mortality rates must be addressed.[10, 41]

Health insurance and gender

In Nigeria less than 5% of the population has any type of health insurance,[63] thus placing the greatest burden on those least able to pay, particularly women. Policy implications mean that the fragile health insurance schemes in the country should be strengthened through broadening of its coverage to both formal and informal sectors of the economy. As of 2018, the State Health Insurance Scheme (SHIS) was not in existence. However, the Kebbi State Health Insurance Scheme Bill was drafted and passed into law six months into the HFG/USAID intervention. NGN 150 million (USD 413,223.15) was earmarked and included in the 2018 budget for the launch of the new plan. [10]

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.[107] 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 health workers; institutionalizing performance and management incentives; promoting collaboration between health service providers including the public, private, and NGOs service providers; and strengthening human resources management.[76]

Kebbi State recognized HRH as one of 15 priority areas for the state and has prioritized addressing the state's health workforce challenges through various policy initiatives, including the *State Human Resources*

for Health Policy (2017) and a State *Human Resources for Health Strategic Plan* (2017 - 2020). However, these policies and plans have not been fully implemented due to lack of financing and a dearth of experience in strategic HRH management and development. Current HRH challenges in Kebbi include: poor staff distribution and inadequate skills mix, inadequate number of skilled health professionals, poor staff retention, and poor health care workers' attitudes.[41, 77]

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. Kebbi had 2,584 doctors, nurses, and midwives in 2017 and 4,617,431 people, or 23 healthcare professionals per 41,099 people—over four times the recommended ratio.[77] This workforce is dominated by nurses and nurse/midwives. However, according to the HRH assessment in Kebbi, the gender mix of frontline caregivers in the state is skewed in favor of men, making access to same-sex caregivers harder for females—who make up the greater number of those needing basic healthcare.[77] Table 5 presents an overview of the staffing profile of the state.

Table 5. Kebbi State current staffing profile, by cadre and gender

		STATE OWNED HEALTH FACILITIES			FEDERAL MEDICAL CENTER			
S/N	CADRE	Male	Female	Total	Male	Female	Total	GRAND TOTAL
1.	Medical Doctors	76	8	84	104	6	110	**194**
2.	Dentists	6	3	9	5	0	5	**14**
3.	Dental Technologists	1	0	1	1	1	2	**3**
4.	Dental Technicians	3	0	3	2	1	3	**6**
5.	Nurses	406	170	576	258	92	350	**926**
6	Midwives	0	102	102	0	87	87	**189**
7	Nurse /Midwives	0	159	159		179	179	**338**
8	Community Health Officers	7	2	9	0	0	0	**9**
9	CHEWs	34	42	76	0	0	0	**76**
10.	JCHEWs	7	7	14	0	0	0	**14**
11.	Pharmacists	8	0	8	7	1	8	**16**
12.	Pharmacy Technicians	64	25	89	7	2	9	**98**
13	Pharmacy Assistants	0	0	0	0	0	0	**0**
14	Laboratory Scientists	19	11	30	30	6	36	**66**
15	Laboratory Technicians	64	18	82	16	6	22	**104**
16	Laboratory Assistants	2	0	2	0	0	0	**2**
17	Records Health Officers	13	5	18	14	3	17	**35**
18	Records Health Technicians	21	8	29	14	5	19	**48**
19	Medical Records Assistant	56	27	83	1	1	2	**85**
20	Environmental Health Officers	30	5	35	0	0	0	**35**
21	Environmental Health Technicians	10	2	12	0	0	0	**12**
22	Environmental Health Assistants	11	3	14	0	0	0	**14**
23	Health Assistants	11	8	19	21	16	37	**56**
24	Cleaners	27	0	27	76	56	130	**157**
25	Guard/Security Staff	106	0	106	0	6	6	**112**
26	Gardeners	0	0	0	0	0	0	**0**
27	Others(specify)	0	0	0	169	32	201	**201**

Source: Kebbi State Human Resources for Health (HRH) Policy

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.[76] In addition, some reports suggest that job opportunities and admissions are mainly given to non-Christians. In offices, Christians are not duly promoted or paid equal salaries. In cases where they do get promoted, these promotions are often not implemented.[66] 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.[108] In Kebbi, shortages of HRH have also hampered the rollout of ART, malaria and TB.[78]

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.[76] The North has a disproportionately low distribution of health training institutions compared to the southern parts of the country; Kebbi State has only two such institutions.[77] When considering the recruitment and distribution of staff, rural areas suffer more shortages and mal-distribution of HRH compared to urban areas and State owned facilities more than Federal owned, the latter driven mostly by pay disparities.[77] Other factors include high population growth that surpasses the increase in the number of health personnel produced annually, freeze on employment and poor working environments leading to internal and external migration.[78]

Service delivery

The Kebbi SMOH Strategic Health Development Plan II for 2018-2022 identifies health service delivery as a key thematic area for improvement and was one they performed well on in the first SSHDP. The State aims to improve this by strengthening HRH; health infrastructure; medicines, vaccines, and other technologies; Health Management Information Systems; and health research.[41]

Main service providers

Health services in Kebbi 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. The State is currently implementing Primary Health Care Under One Roof (PHCUOR), coordinated by the Kebbi State Primary Health Care Development Agency, to coordinate at PHC centers administered by the corresponding LGAs. 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, responsibility, and accountability, one universal implementation plan, and one monitoring and evaluation system.[109]

In Northern Nigeria, including Kebbi, CHEWs are often the primary service providers. They generally have at least two years of post-secondary school education and are the only staff at some PHC centers, sometimes providing levels of care for which they are not trained. CHEWs are assigned to health care facilities from where they provide on-site care and education as well as community-based outreach. CHEWs recently received permission to provide injectable contraceptives and insert intrauterine devices (IUDs) and sub-dermal implants.[108]

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.[73]

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]

See **Annex 1** for further information on national and state policies.

Youth-friendly services

As mentioned previously, 27.2% of women ages 15 to 19 in Kebbi have begun childbearing, whereas the national median age is 18.7 (a four-percentage point decrease since 2013).[15] 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.[110] 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.[111]

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 childbearing, as well as their use for HIV/AIDS prevention. In Kebbi, in 2013[3], 18.4% of women and 47.2% of men believed that children ages 12-14 should be taught about condom use for HIV/AIDS prevention.[23] It is unlikely that youth will receive access to comprehensive healthcare if these attitudes towards condom use are as pervasive amongst health care providers.

[3] Data on this indicator is not available in the 2018 NDHS.

Social inclusion and vulnerable populations

Poor and marginalized

In Nigeria, poverty remains high, with 62.6% of the population living under the poverty line as of 2010.[53] As of 2017, 8.4% of the population was unemployed.[17] In Kebbi, 72.5% of the population was living under the poverty line in 2010.[53] In 2018, 49.3% of women in Kebbi State were unemployed in the twelve months preceding the NDHS, compared with 4.3% of men.[15] UNICEF also rated Kebbi as the worst in child poverty and protection in the country. Health outcomes in Kebbi reflect the pervasive poverty and insufficient access to services faced by much of the population. 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[15]. Keeping these intersecting marginalization's 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 Kebbi 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. 15% of children in Kebbi State work for more than 43 hours a week. Children who engage in informal economic activities, either on their own or to help family members, are especially at risk of sexual exploitation and abuse, especially if they are unsupervised. *Girl-child defilement*, the sexual assault of a girl under the age of 13 is particularly concerning in some project areas.[101]

As discussed, girls nationally and in Kebbi tend to have earlier sexual debut than boys.[15] 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.

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. For example, in response to the passage of this law, 25 suspected homosexuals were arrested by the Kebbi State Command of the Vigilante Group of Nigeria and were handed over to the Hisbah Commission for further action.[112] 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, particularly gay and bisexual women, reported changing the way they presented themselves and avoiding spending time with other members of the LGBTQ community to avoid suspicion. Some even reported marrying an opposite sex partner, having children, and conforming to gender norms to be safe and avoid persecution.[113]

The reported widespread harassment, violence, and hostility toward LGBTQ individuals received from private and government actors has a profound impact on their access to health services. 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. It has reduced the willingness and ability of some to access HIV/AIDS services with fewer organizations who are willing to address the needs of men who have sex with men.[16]

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 Kebbi 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.[113]

People with Disabilities

Disability is both a cause and a consequence of poverty, reducing access to education, employment, and resources. Causes of disabilities in the North West include infectious diseases such as river blindness and leprosy, birth defects, injuries, and challenges from labor and delivery (including obstetric fistula). 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 West zone the estimated rate is the highest at 5.0%.[80, 114] The difference between these estimates may be due to different definitions of disability, different year or times of the year, different age groups, and different base populations, for example. Religion and culture play a key role in the lives of Nigerians. These factors influence attitudes about PWD and can encourage discriminatory practices toward PWD. Further, some schoalrs consider the killing of PWD aspects of cultural practice because of the highly ritualized nature of these killings.[115] Furthermore, women and girls with disabilities are more likely to experience GBV and less able to escape, less likely to speak up, less likely to be believed, and less likely to find services they can access.[101]

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 Kebbi. However, in June 2016, the Association of PWD in Kebbi appealed to the state Governor to appoint PWD members as special advisors to create a sense of belonging and to enable them to contribute to the state's policy and decision making.[116] The lack of knowledge and training about working with and supporting people with disabilities described at the national level can also be observed in Kebbi, where few service providers are aware of the rights of PWDs and the support they may demand, including access to healthcare, education, and justice.[46]

Ethnic and religious minorities

Kebbi State is home to many ethnic groups and has a strong presence of Islam (84% as of the 2006 census) and Christianity (16%). Muslim Hausa and Fulani are the predominant ethnic groups in Nigeria's northern region.[117] Cities remain largely segregated along ethno-religious lines, and confrontation between ethnic groups is common. Often, ethnic clashes in one part of the country can set off a chain of reprisal riots and attacks in other parts of the country. All major ethnic groups have formed militias to protect their own interests and perpetrate violence against other groups. While illegal, these vigilante groups continue to act with impunity for lack of stringent law enforcement. As a result, Christians in some parts of the state report facing discrimination and persistent pressure to convert to Islam. Such oppression includes refusal of medical care on the basis of religion, physical violence, arrest without legal representation, churches relocated to the outskirts of cities, job discrimination and unequal pay.[66]

The 2018 NDHS presents a few indicators relevant to gender and health disaggregated by religion (Table 6).[15] However, since they do not disaggregate indicators by religion and state, it is difficult to draw specific assumptions about the behavior of one religion or another in Kebbi, specifically. Given Kebbi's ethnic diversity, this review does not attempt to draw conclusions about circumstances in Kebbi based on data disaggregated by ethnic group. 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 – Traditional type, age	24.5%	19.4%	18.7%	11.9%

Source: 2018 NDHS [15]

People on the move, including Internally Displaced Persons and Refugees

The drivers of displacement in Nigeria are multi-faceted, complex, and often overlapping. While Boko Haram remains less of a threat in Kebbi State than in the North East region, other terrorist attacks have taken place in previous years. Flooding has affected about 80% of the country in 2018 and triggered most of the 613,000 new displacements recorded.[118] In the Middle Belt region (which includes southern parts of Kebbi), competition between pastoralists and farmers has caused tensions, culminating in significant levels of violence and displacement.

Kebbi 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 are sometimes part of, ongoing conflict in the area over land, cattle, and between religions, and 'settlers' versus 'indigenous' residents.[119] 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.[120] Women pastoralists often experience many intersecting vulnerabilities, including being members of marginalized communities, poverty, lack of access to and trust in government services, all within a conservative, patriarchal society. Their specific needs and strengths should be contemplated within any program design and monitoring, and their involvement in design will be essential to understand how to best reach them.

Survivors of GBV

While it is difficult to estimate disclosure rates of sexual and GBV, Nigeria and Kebbi's conservative cultures discourage victims from speaking out or reporting. In Kebbi, only 11.8% of women sought any kind of help after experiencing sexual/physical violence, compared to 31.6% nationally. Nationally, of those that did seek help, only 1% informed the police and less than 1% told a medical professional. [15]

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.[48] 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. [60, 121] 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.[122] Together, underreporting, infrequent prosecution and conviction, minimal sentences, and the shame and stigma continue to discourage victims of GBV from speaking out.[47]

Stakeholder analysis and review of previous gender analysis efforts

Understanding who is doing what in Kebbi 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 Kebbi related to RMNCH +NM programming. This broad support translates to significant domestic and foreign investment in the region (described in more detail above in the *Financing and budgeting* section). The following tables present 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 Kebbi

Organization	Areas of focus
Action Aid	Women's Rights, GBV, access to justice, advocacy
Coalition of NGOs in Kebbi State (CONKS)	MNCH, youth and women empowerment, peace building, HIV/AIDS, education, OVC, good governance
Muslim Health Workers Union Kebbi State (MUHEWU)	Focus on HIV, family health, VVF, FP, gender, and MNCH with women, children, and youth
Development Exchange Center, Kebbi	Community empowerment and poverty reduction, with some projects focusing on women
FHI360	Integrated Humanitarian Assistance to Northeast Nigeria, Family Planning, Education, HIV, Malaria, TB, Communications
Federation of Muslim Women's Association in Nigeria (FOMWAN), Kebbi State Chapter	Focus on HIV, family health, FP, gender, and MNCH with women, children, and youth, particularly among conflict-affected populations
Kitari Community Enhancement Initiative (KiCEI)	Reproductive health, Good Governance, Nutrition, Girl-Child education, Community mobilization, community-based childbirth spacing, GBV, MNCH, vulnerable groups, peace & conflict resolution, HIV/AIDS
Marie Stopes	Family planning, reproductive health services, mobile midwives and outreach, including post abortion care, and social franchise of sexual and reproductive health providers
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

Children & Family Support Initiative (CAFSI)	Maternal & child health, education, human rights, governance, child rights including nutrition, vulnerable groups
100 Women Group	100WGs are local groups that encourage parents to send girls to school – women and youth empowerment, reproductive health, microcredit, also into massive sensitization at grassroot level
UNICEF	Education, humanitarian response, health including MNCH
Women Empowerment Initiatives (WEIN)	Women's economic empowerment, gender equity, education, HIV
Women's Rights Advancement and Protection Alternative (WRAPA)	Women's empowerment, OVC, access to justice, legal representation. Have projects in Kebbi.
National Council of Women Societies (NCWS)	Women's empowerment, women's rights, GBV, Fistula, Community mobilization, legal matters of vulnerable groups, maternal & child health
National Association of Women Journalists (NAWOJ) Kebbi State Chapter	Women empowerment, Women's rights, Fistula, Community mobilization, maternal health
Medical Women Association of Nigeria (MWAN) Kebbi State Chapter	Medical outreaches, fistula, OVC, women empowerment, nutrition, HIV/AIDS, Cancer, Community mobilization, malaria
National Association of Nigerian Nurses & Midwifery (NANNM) Kebbi State Branch	Fistula, OVC, women empowerment, nutrition, HIV/AIDS, Cancer, Community mobilization
Nigerian Medical Association (NMA)	Women 's empowerment, women's rights, GBV, Fistula, Community mobilization, maternal & child health

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

Project	Lead	Donor	Description
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
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 Kebbi (2016 – 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
Water, Sanitation and Hygiene (WASH)	UNICEF		Improving water and sanitation access to vulnerable communities including an equity and gender focus

Previous gender analyses

Previous analyses about Nigeria have addressed various aspects of gender, but none have addressed the topic so broadly as is done within this document. We were unable to find any gender analyses conducted for Kebbi State. One reason for this dearth of gender analyses is that CBOs lack an understanding of what a gender analysis is; how to design and conduct one; how to analyze, synthesize, interpret, and report on the analysis; and, perhaps most importantly, how to integrate the recommendations from an analysis into the design and implementation of a project.[123] A full list of all the documents reviewed for this project can be found in the References. However, examination of the following elements is lacking from the resources identified for this review.

- The voices of people in Kebbi – The existence of primary data is scarce, particularly qualitative data, that highlights the voices and experiences of people in Kebbi, including women, young people, people with disabilities, and members of other marginalized groups. Without an in-depth understanding of their experiences and relationship with the existing health care system it will be challenging to know what improvements are needed.

- 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 is critical to include their voices in both quantitative and qualitative analyses and to ensure that their various experiences, as young people and LGBTQ individuals, racial or ethnic minorities, heads of household, and other intersecting identities, are considered.

- Social Networks and Positive Opportunities – The research team found no reports or articles about the opportunities for leadership and socialization in Kebbi. This lack of evidence highlights the need to talk to women about these 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 analyses explored 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 chance.

As a result, critical information about how gender directly and indirectly affects the health of the Kebbi 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 Kebbi 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.** In order 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 Kebbi. 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, and the experience of the Christian minority in Kebbi. In addition, we need to better understand social networks (e.g., women's groups) and positive opportunities for populations at risk. Kebbi 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 socio-demographic 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 Kebbi. 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 Kebbi 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 Kebbi 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, hired, and retained. Possibilities to achieve such a dramatic increase include retraining CHEWs and JCHEWs and other paraprofessional health staff, increasing scholarships and financial report to ensure women enroll and graduate, and reviewing 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, GBV education, and psychosocial support. In addition, all staff in health facilities should be sensitized on 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, and fee-free consultations at PHC centers. Additionally, increasing youth-friendly services is crucial to ensure that youth receive the care they need to be healthy, as well as leadership and decision-making skills building. Specific barriers experienced by young people include 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 Kebbi, 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 Kebbi) include high maternal mortality and morbidity, among others. While we know that child marriage has been linked with the prevalence of obstetric fistula, , there is more that can be learned about fistula in the context of Kebbi, including the demographics of the disease burden, the ease of access and use of services, and the factors that impede or facilitate prevention and treatment. 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. 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.
- **Coordinate with other USAID funded projects to change the narrative using social and behavior change communication.** Data suggest that despite the presence of sexual and reproductive health interventions, messaging are 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 Kebbi related to gender more broadly.[124, 125] 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, and delivering relationship and family education for women and men, including communication skills for partners.
  - Support and coordinate with IHP partners and USAID funded projects, including Breakthrough Action to coordinate social and behavior change interventions at every level to transform destructive narratives that diminish women's and children's roles or compromise the rights and inclusion of marginalized groups. Through coordination between the State, IHP, and other partners addressing social and behavior change such as Breakthrough Action, IHP advises a multi-track intervention to transform destructive narratives that diminish women's and children's roles or compromise the rights and inclusion of marginalized groups. This means that while community outreach messages are disseminated through multiple avenues, including social media, community development committees, traditional rulers, and religious leaders, IHP, at the same time will align sensitization and training of health workers and managers at the demand side, as well as policy makers and strategic planners. IHP will recommend that school curricula at every level also include sensitization and leadership development that is incorporated in children's education and secondary school information and embedded in preservice curricula for health providers.
- **Address GBV holistically.** GBV should be addressed as a cross-cutting issue within all relevant policies and programming. 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 especially male and female health providers), 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 work to redefine masculinity as much more than physical strength, 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 Kebbi specifically, human trafficking is a major issue in northern 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. In addition, training enforcement officers and improving their performance and community responsiveness and support, as well as strengthening protective laws will protect children and individuals whose families may try to exploit opportunities.

- **Leverage existing resources to achieve health and gender priorities.** Kebbi 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 Kebbi 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 Kebbi 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.[123] 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. Kebbi State is among Nigeria's poorest performers in terms of health and development indices. Despite large donor investments in the health sector in Kebbi and the prioritization of primary health care (PHC) by the state government, too many women, infants, and children continue to die from preventable and treatable causes. Some 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 and in Kebbi 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 the government 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 Kebbi 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.

References

1. UNICEF Nigeria. Accelerated action for impact: Improving maternal, newborn, and child health in Kebbi State. UNICEF Nigeria; 2019. https://www.unicef.org/nigeria/media/2431/file/AAI%20Kebbi%20State.pdf.

2. United States Agency for International Development (USAID). Gender Equality and Female Empowerment Policy. Washington, DC: USAID; 2012. https://www.usaid.gov/sites/default/files/documents/1865/GenderEqualityPolicy_0.pdf.

3. World Health Organization (WHO). Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: WHO; 2010. https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf?ua=1.

4. USAID. ADS Chapter 205 - Integrating Gender Equality and Female Empowerment in USAID's Program Cycle. Washington, DC: USAID; 2017. https://www.usaid.gov/sites/default/files/documents/1870/205.pdf.

5. World Population Review. Nigeria Population. World Population Review; 2019. http://worldpopulationreview.com/countries/nigeria-population/. Accessed 7 Feb 2020.

6. Federal Republic of Nigeria National Bureau of Statistics (NBS). Annual Abstract of Statistics, 2012. Abuja, Nigeria: NBS; 2012. https://nigerianstat.gov.ng/elibrary.

7. NBS, National Population Commission (NPC), Nigeria Federal Ministry of Health (FMOH). National Nutrition and Health Survey (NNHS) 2018. Abuja, Nigeria: NBS; 2018. https://www.unicef.org/nigeria/media/2181/file/Nigeria-NNHS-2018.pdf.

8. United Nations Development Programme (UNDP). Nigeria Human development Indicators. UNDP; 2018. http://hdr.undp.org/en/countries/profiles/NGA. Accessed 7 Feb 2020.

9. United Nations (UN) Department of Economic and Social Affairs (DESA), Population Division. World Urbanization Prospects: The 2018 Revision, custom data acquired via website. New York, NY: UN; 2019. https://population.un.org/wup/DataQuery/. Accessed 7 Feb 2020.

10. Health Finance and Governance (HFG) Project. Kebbi State Health Profile. Bethesda, MD: HFG Project, Abt Associates Inc.; n.d. https://www.hfgproject.org/kebbi-state-health-profile/.

11. The Editors of Encyclopedia Britannica. Kebbi. In Encyclopedia Britannica Online. Encyclopedia Britannica, Inc.; 2019. https://www.britannica.com/place/Kebbi-state-Nigeria.

12. Sampson IT. Religion and the Nigerian State: Situating the de facto and de jure Frontiers of State–Religion Relations and its Implications for National Security. Oxf J Law Relig. 2014; 3: 311–39. DOI: 10.1093/ojlr/rwt026

13. Religious Literacy Project. Country Profile: Nigeria. Harvard Divinity School; 2016. https://rlp.hds.harvard.edu/for-educators/country-profiles/nigeria. Accessed 17 Jun 2019.

14. Ijtemaye L. Backgrounder – Boko Haram and Political Instability in Nigeria. Centre for Security Governance; 2014. https://secgovcentre.org/2014/07/backgrounder-boko-haram-and-political-instability-in-nigeria/. Accessed 5 Jun 2019.

15. National Population Commission (NPC) [Nigeria], ICF. Nigeria Demographic and Health Survey 2018. Abuja Nigeria and Rockville Maryland, USA: NPC and ICF International; 2019. https://dhsprogram.com/publications/publication-FR359-DHS-Final-Reports.cfm.

16. USAID/Nigeria. Nigeria Country Development Cooperation Strategy 2015-2020. https://www.usaid.gov/sites/default/files/documents/1860/Nigeria_CDCS_2015-2020.pdf.

17. World Bank. World Bank Open Data - Nigeria. https://data.worldbank.org/country/nigeria. Accessed 7 Feb 2020.

18. UNDP. National Human Development Report 2018: Achieving Human Development in North East Nigeria. Abuja, Nigeria: UNDP; 2018. http://hdr.undp.org/sites/default/files/hdr_2018_nigeria_finalfinalx3.pdf.

19. About Kebbi State. Kebbi State Government; n.d. http://www.kebbistate.gov.ng/about-kebbi-state

20. US Department of State. 2018 Trafficking in Persons Report. US Department of State; 2018. https://www.state.gov/reports/2018-trafficking-in-persons-report/. Accessed 6 Jun 2019.

21. Health Communication Capacity Collaborative/HC3. Assessment of Family Planning Use in Bauchi and Sokoto States, Nigeria. Health Communication Capacity Collaborative/HC3 and Johns Hopkins University; 2015. https://healthcommcapacity.org/wp-content/uploads/2015/08/HC3-FP-Assessment-in-Nigeria-Revised-24_Jul15.pdf.

22. Guttmacher Institute, University of Ibadan. Abortion in Nigeria. New York, NY: Guttmacher Institute; 2015. https://www.guttmacher.org/fact-sheet/abortion-nigeria. Accessed 6 Jun 2019.

23. NPC, ICF. Nigeria Demographic and Health Survey 2013. DHS. Abuja Nigeria and Rockville Maryland, USA: NPC and ICF International; 2014. https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf. Accessed 5 Jun 2019.

24. Federal Republic of Nigeria. Saving Newborn Lives in Nigeria: Newborn Health in the Context of the Integrated Maternal Newborn and Child Health Strategy. 2nd Edition. Abuja, Nigeria: Federal Ministry of Health (FMOH), Save the Children, Jhpiego; 2011. https://www.healthynewbornnetwork.org/hnn-content/uploads/Nigeria-Sit-An-final-lowres_FINAL.pdf

25. Gulumbe U, Alabi O, Omisakin OA, Omoleke S. Maternal mortality ratio in selected rural communities in Kebbi State, Northwest Nigeria. BMC Pregnancy Childbirth. 2018;18:503.

26. United Nations Population Fund (UNFPA). Obstetric Fistula, Nigeria. https://nigeria.unfpa.org/en/topics/obstetric-fistula-0. Accessed 6 Jun 2019.

27. USAID. Nigeria – Fistula Care Plus. https://fistulacare.org/countries/nigeria/. Accessed 5 Jun 2019.

28. Nigeria Health Watch. Beyond Surgery: Gesse Centre's innovative approach to fistula care in Kebbi. Medium; 2019, 23 Apr. https://medium.com/@nigeriahealthwatch/beyond-surgery-gesse-centres-innovative-approach-to- fistula-care-in-kebbi-a0bb38d9e958.

29. Dakingari AB. Second quarter report of VVF Center Gesse for the Year 2019. VVF Center Gesse; 2019.

30. FMOH, UNFPA. National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria, 2019 - 2023. Abuja, Nigeria: FMOH; 2019. https://nigeria.unfpa.org/sites/default/files/pub-pdf/FMOH-NSF-2019-2023%20Fistula.pdf. Accessed 6 Jun 2019.

31. Wall LL, Karshima JA, Kirschner C, Arrowsmith SD. The obstetric vesicovaginal fistula: characteristics of 899 patients from Jos, Nigeria. Am J Obstet Gynecol. 2004; 190: 1011–9. DOI: 10.1016/j.ajog.2004.02.007

32. Tuncalp O, Isah A, Landry E, Stanton CK. Fistula Care: Community-based screening for genito-urinary fistula in Nigeria: A novel approach. New York, NY: EngenderHealth; 2013. https://fistulacare.org/archive/files/4/4.2/Nigeria-Community-Screening-Final-Report.pdf.

33. Benson T, Amare M, Oyeyemi M, Fadare O. Study of the Determinants of Chronic Malnutrition in Northern Nigeria: Qualitative Evidence from Kebbi and Bauchi States. NSSP Working Paper 44. Washington, DC: International Food Policy Research Institute Nigeria Agricultural Policy Project; 2017. http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/131440/filename/131650.pdf

34. Hansford F. ORIE Nigeria Gender Synthesis Report. Nutrition Research in Northern Nigeria. Brighton: ORIE; 2015. https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/7087.

35. National Malaria Elimination Programme (NMEP), NPC, NBS, ICF. National Malaria Indicator Program. Nigeria Malaria Indicator Survey 2015. Abuja, Nigeria, and Rockville, Maryland, USA: NMEP, NPC, and ICF; 2016. https://dhsprogram.com/pubs/pdf/MIS20/MIS20.pdf.

36. World Health Organization. World Malaria Report 2018. Geneva: WHO; 2018. http://www.who.int/malaria/publications/world-malaria-report-2018/report/en/. Accessed 6 Jun 2019.

37. AVERT. HIV and AIDS in Nigeria. AVERT; 2015. https://www.avert.org/professionals/hiv-around-world/sub- saharan-africa/nigeria. Accessed 6 Jun 2019.

38. Government of Nigeria. Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) - National Fact Sheet. NAIIS; 2019. https://www.naiis.ng/resource/factsheet/NAIIS%20PA%20NATIONAL%20FACTSHEET%20FINAL.pdf. Accessed 6 Jun 2019.

39. US President's Emergency Plan for AIDS Relief (PEPFAR). Nigeria 2019 PEPFAR Country Operational Plan (COP19): Strategic Direction Summary. PEPFAR; 2019. https://www.state.gov/wp-content/uploads/2019/09/Nigeria_COP19-Strategic-Directional-Summary_public.pdf

40. Government of Nigeria. NAIIS North West Zone Fact Sheet. NAIIS; 2019. https://naca.gov.ng/naiis-north-west-zone-factsheet/. Accessed 6 Jun 2019.

41. Kebbi State Ministry of Health. Kebbi State Strategic Health Development Plan II 2018-2022. Kebbi, Nigeria: Kebbi State Ministry of Health.

42. Koziel P. Hausa women's rights and changing perception of gender in Northern Nigeria. In Hausa and Chadic Studies. Pawlak N, Will I, Siwierska E, Eds. Warsaw: Dom Wydawniczy Elipsa; 2014: pp. 215-229.

43. Danjuma M. Influence of Parents' Educational Background on Girl-Child Education in Kebbi State, Nigeria. ATBU J Sci Technol Educ JOSTE. 2017;5.

44. Voices4Change (V4C) Nigeria, UKAID. Being a Man in Nigeria: Perceptions and Realities. V4C Nigeria and UK Department for International Development (DFID); 2015. http://www.v4c-nigeria.com/being-a-man-in-nigeria-perceptions-and-realities/.

45. Plan International. Show-Born: Gender Equality Assessment Report; Annex 6: Born Nigeria (Bauchi) Country Description/Analysis. Prepared for Global Affairs Canada. Project Number D-001999 and D-002288. Submitted by Plan International Canada. *(This report is undated and available upon request as hard copy document from the "Because I am a Girl'/ Plan International Project / (2014-2019)).*

46. Global Rights - Partners for Justice, Kano Human Rights Network, Bauchi Human Rights Network. State of Human Rights in Northern Nigeria. Global Rights; 2011.

47. Independent Advisory Group on Country Information, United Kingdom. Country Information and Guidance Nigeria: Women fearing gender-based harm or violence. UK Home Office; 2016. https://www.refworld.org/pdfid/57b70ff44.pdf. Accessed 9 Jun 2019.

48. Promundo and UK Department for International Development (DFID);. V4C Nigeria. Nigeria Men and Gender Equality Survey (NiMAGES). Promundo and UK Department for International Development (DFID); 2015. https://promundoglobal.org/wp-content/uploads/2016/03/V4C-Nigeria-Men-and-Gender-Equality-Survey-NiMAGES.pdf

49. Girls Not Brides. Nigeria - Child Marriage Around The World. Girls Not Brides; n.d. https://www.girlsnotbrides.org/child-marriage/nigeria/. Accessed 9 Jun 2019.

50. Klugman J, Hanmer L, Twigg S, Hasan T, McCleary-Sills J, Santamaria J. Voice and agency: empowering women and girls for shared prosperity. Washington, D.C: World Bank Group; 2014. http://hdl.handle.net/10986/19036.

51. UNFPA. Marrying too young: end child marriage. New York, NY: UNFPA; 2012. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf. Accessed 6 Jun 2019.

52. Nguyen MC, Wodon Q. Child Marriage and Education: A Major Challenge. The World Bank; n.d. http://www.ungei.org/index_3103.html.

53. National Bureau of Statistics (NBS). National Poverty Rates for Nigeria: 2003-04 (Revised) and 2009-10 (Abridged Report). Abuja, Nigeria: NBS. http://nigerianstat.gov.ng/elibrary.

54. Braimah T. Child marriage in Northern Nigeria. Afr Hum Rights Law J. 2014; 2(8). http://www.saflii.org/za/journals/AHRLJ/2014/24.html.

55. Federal Ministry of Women Affairs and Social Development (FMWA). Strategy to End Child Marriage in Nigeria, 2016 - 2021. Government of Nigeria; 2016. https://www.girlsnotbrides.org/resource-centre/national-strategy-end-child-marriage-nigeria-2016-2021/. Accessed 9 Jun 2019.

56. Singh S, Audam S, Wulf, D. Early Childbearing in Nigeria: A continuing challenge. Research in Brief, no. 2 The Guttmacher Institute; 2004. https://www.guttmacher.org/sites/default/files/report_pdf/rib2-04.pdf. Accessed 18 Jun 2019.

57. Rahmatian A. Termination of Marriage in Nigerian Family Laws: The Need for Reform and The Relevance of the Tanzanian Experience. Int J Law Policy Fam. 1996; 10(3):281–316. DOI: 10.1093/lawfam/10.3.281

58. Supreme Court of Nigeria. Matrimonial Causes Rules. Supreme Court of Nigeria; 1983. http://www.nigeria-law.org/. Accessed 24 Jun 2019.

59. Matrimonial Causes Act, Chapter 220. In Laws of the Federation of Nigeria 1990. Government of Nigeria; 1970. http://www.nigeria-law.org. Accessed 24 Jun 2019.

60. Morel-Seytoux S, Okosun I, Olugbemi OT.. USAID/Nigeria - Gender Analysis for Strategic Planning. USAID/Nigeria Monitoring and Evaluation Management Services (MEMS) II Project, The Mitchell Group; 2014.

61. NBS, UNICEF. Multiple Indicator Cluster Survey 2016 -17, Survey Findings Report. Abuja, Nigeria: NBS and UNICEF; 2018. https://www.unicef.org/nigeria/media/1406/file/Nigeria-MICS-2016-17.pdf.pdf. Accessed 6 Jun 2019.

62. Ministry of Health: Responsibilities. Kebbi State Government; n.d. http://www.kebbistate.gov.ng/ministry-health.

63. FMOH. National Health Policy 2016 Promoting the Health of Nigerians to Accelerate Socio-economic Development. FMOH; 2016.

64. Mayah E, Mariotti C, Mere E, Odo CO. Inequality in Nigeria: Exploring the Drivers. Oxfam International; 2017. https://www-cdn.oxfam.org/s3fs-public/file_attachments/cr-inequality-in-nigeria-170517-en.pdf. Accessed 19 Jun 2019.

65. Abdulwasiu S, Gado MA. Cross-Sectional Analyses of Women Political Participation for Development in Northwestern Nigeria: A Study of Sokoto, Kebbi and Zamfara States. IOSR J Humanit Soc Sci. 2017;22:23–9. DOI: 10.9790/0837-2207082329

66. World Watch Monitor. Nigeria: Kebbi Christians face latent pressure to abandon faith. World Watch Monitor; 2016. https://www.worldwatchmonitor.org/2016/12/nigeria-kebbi-christians-face-latent-pressure-to-abandon-faith/.

67. Eniola T. Nigeria's Looming Election Puts Gender Equality Bill in Peril. News Deeply; 2018, 8 Aug. https://www.newsdeeply.com/womensadvancement/articles/2018/08/08/nigerias-looming-election-puts-gender-equality-bill-in-peril. Accessed 7 Jun 2019.

68. International Justice Resource Center (IJRC). Nigeria Country Report. IJRC; 2017. https://ijrcenter.org/wp- content/uploads/2017/11/Nigeria.pdf. Accessed 7 Jun 2019.

69. United Nations. Sustainable Development Goals. https://sustainabledevelopment.un.org/?menu=1300. Accessed 7 Jun 2019.

70. Ikeke N. What Nigerians need to know about the new health policy approved by FG. Legit Nigeria News; 2017. https://www.legit.ng/1088644-what-nigerians-health-policy-approved-by-fg.html. Accessed 10 Jun 2019.

71. Onyedika-Ugoeze N. President launches 2018-2022 National Strategic Health Development Plan. The Guardian Nigeria; 2019, 9 Jan. https://guardian.ng/news/president-launches-2018-2022-national-strategic-health-development-plan/. Accessed 11 Jun 2019.

72. Kebbi State Ministry of Health. Kebbi State Strategic Health Development Plan II Activities and Cost Inputs/Assumptions. Kebbi, Nigeria: Kebbi State Ministry of Health.

73. FMWA. National Gender Policy - Federal Republic of Nigeria - Situation Analysis/Framework. Abuja, Nigeria: FMWA; n.d http://nigerianwomentrustfund.org/wp-content/uploads/National-Gender-PolicySituation-Analysis.pdf. Accessed 7 Jun 2019.

74. Federal Government of Nigeria. Gender and Equal Opportunities Bill 2010. Government of Nigeria; 2010. http://www.aacoalition.org/images/Gender_and_Equal_Opportunities_Bill_National.pdf. Accessed 7 Jun 2019.

75. Makinde OA, Onyemelukwe C, Onigbanjo-Williams A, Oyediran KA, Odimegwu CO. Rejection of the Gender and Equal Opportunities Bill in Nigeria: A setback for sustainable development goal five. Gend Manag Int J. 2017;32(3) :234–40. DOI: 10.1108/GM-02-2017-0023

76. Federal Republic of Nigeria. Nigeria National Human Resources for Health Policy. 2007. https://drive.google.com/file/d/0B1DAmtM1BcbMQmx4a3NwWFpuYjg/view. Accessed 11 Jun 2019.

77. Kebbi State Ministry of Health. Human Resources for Health (HRH) Policy. Birnin Kebbi, Nigeria: Kebbi State Ministry of Health; 2016.

78. Kebbi State Ministry of Health. Kebbi State Task Shifting and Sharing Policy for Essential Services. Kebbi State Ministry of Health; 2017.

79. Federal Government of Nigeria. Violence Against Persons (Prohibition) Act, 2015 (VAPP). 2015. https://www.refworld.org/docid/556d5eb14.html. Accessed 7 Jun 2019.

80. FMOH. National Policy on Sexual and Reproductive Health and Rights of Persons with Disabilities with Emphasis on Women and Girls. FMOH; 2018. http://health.gov.ng/doc/NATIONAL_POLICY_ON_SRH_OF_PWD_GWD.pdf. Accessed 7 Jun 2019.

81. FMOH. Discrimintation Against Persons with Disabilities Act (Prohibition). 2018. https://drive.google.com/file/d/12459t6medwbLvSunXgk6o9x9npnXG6W4/edit. Accessed 7 Jun 2019.

82. FMOH. Nigeria National Reproductive Health Policy and Strategy. FMOH; 2001. https://cheld.org/wp-content/uploads/2012/04/Nigeria-National-Reproductive-Health-Policy-and-Strategy.pdf. Accessed 11 Jun 2019.

83. Federal Government of Nigeria. National Policy on HIV/AIDS 2009. https://drive.google.com/file/d/0B1DAmtM1BcbMVkJhLWxWLUVEdWM/view. Accessed 11 Jun 2019.

84. FMOH. National Policy on the Health and Development of Adolescents and Young People in Nigeria FMOH; 2007. https://drive.google.com/file/d/0B1DAmtM1BcbMcFpYQXNOSkRyd2s/view. Accessed 11 Jun 2019.

85. Federal Republic of Nigeria. Nigeria Marriage Act of 1990, Chapter 218. In Laws of the Federation of Nigeria 1990. Government of Nigeria; 1990. http://www.nigeria-law.org/. Accessed 7 Jun 2019.

86. National Primary Healthcare Development Agency (NPHCDA). Integrating Primary Health Care Governance in Nigeria (PHC Under One Roof) - Implementation Manual (Draft 1). NPHCDA; 2013. https://drive.google.com/file/d/0B1DAmtM1BcbMXzlsNXpIOU9tdEE/view. Accessed 11 Jun 2019.

87. Health, Food, Drug, Nutrition. Nigerian Documents. https://nigeriandocuments.blogspot.com/p/main-documents-revised-national-health.html. Accessed 11 Jun 2019.

88. Eniola BO. Gender Parity in Parliament: A Panacea for the Promotion and Protection of Women's Rights in Nigeria. Front Sociol. 2018;3. DOI: 10.3389/fsoc.2018.00034.

89. UNICEF. Information Sheet: The Nigeria Child's Right Act. UNICEF; 2007. https://www.unicef.org/wcaro/WCARO_Nigeria_Factsheets_CRA.pdf.

90. Controversy in Nigeria Over Minimum Age of Marriage. Girls Not Brides; 2013. https://www.girlsnotbrides.org/controversy-in-nigeria-over-minimum-age-of-marriage/. Accessed 9 Jun 2019.

91. Attah M. Divorcing Marriage from Marital Assets: Why Equity and Women Fail in Property Readjustment Actions in Nigeria. J Afr Law. 2018;62:427–46. DOI: 10.1017/S0021855318000207

92. Immigration and Refugee Board of Canada. Nigeria: Divorce law and practice among Muslims, including grounds, procedures, length of process, property disposition, child custody and consequences for the woman and her family. Refworld. Immigration and Refugee Board of Canada; 2006. https://www.refworld.org/docid/45f147882f.html. Accessed 11 Jun 2019.

93. Food and Agriculture Organization (FAO). Nigeria Country profile. Gender and Land Rights Database: Inheritance Legal Mechanisms. FAO; n.d. http://www.fao.org/gender-landrights-database/country-profiles/countries-list/national-legal-framework/inheritance-legal-mechanisms/en/?country_iso3=NGA. Accessed 7 Jun 2019.

94. Iruroma K. Pushing for Stronger Laws to Protect Widows' Rights in Nigeria. Women's Advancement. News Deeply; 2018, 25 Apr. https://www.newsdeeply.com/womensadvancement/articles/2018/04/25/pushing-for-stronger-laws-to-protect-widows-rights-in-nigeria. Accessed 11 Jun 2019.

95. Fraser E, Nwadinobi E. Harmful Cultural Practices towards Widows. DFID; 2018. https://assets.publishing.service.gov.uk/media/5c5966f3e5274a318116c3d0/VAWG_Helpdesk_Report_196_Widows.pdf. Accessed 15 Jun 2019.

96. It's election season in Nigeria, but where are the women? UN Women; 2019, 6 Feb. http://www.unwomen.org/en/news/stories/2019/2/feature-women-in-politics-in-nigeria. Accessed 11 Jun 2019.

97. Bro A. Nigeria's Laws Hold Women Back, and the Economy Suffers. Council on Foreign Relations; 2019, 8 Mar. https://www.cfr.org/blog/nigerias-laws-hold-women-back-and-economy-suffers. Accessed 11 Jun 2019.

98. Government of Nigeria. Nigeria Criminal Code Act Chapter 77. In Laws of the Federation of Nigeria 1990. Government of Nigeria; 1916. http://www.nigeria-law.org/. Accessed 11 Jun 2019.

99. Violence against Women Pervasive in Nigeria. Human Rights Watch; 2019, 14 Mar. https://www.hrw.org/news/2019/03/14/violence-against-women-pervasive-nigeria. Accessed 11 Jun 2019.

100. Isaack W. "Tell Me Where I Can Be Safe:" The Impact of Nigeria's Same Sex Marriage (Prohibition) Act. Human Rights Watch; 2016. https://www.hrw.org/report/2016/10/20/tell-me-where-i-can-be-safe/impact-nigerias-same-sex-marriage- prohibition-act. Accessed 19 Jun 2019.

101. World Bank. Gender-based violence: An analysis of the implications for the Nigeria For Women Project. Washington, DC: World Bank; 2019. http://hdl.handle.net/10986/31573.

102. Federal Government of Nigeria. Same Sex Marriage (Prohibition) Act, 2013. 2013. https://www.refworld.org/docid/52f4d9cc4.html. Accessed 7 Jun 2019.

103. The Centre for Islamic Studies of Ahmadu Bello University, Zaria. Chapter 4 Part III: The Centre for Islamic Legal Studies' Draft Harmonised Sharia Penal Code Annotated. In *Sharia Implementation in Northern Nigeria 1999-2006: A Sourcebook*. Ibadan: Spectrum Books, Ltd.; 2007. http://www.sharia-in-africa.net/media/publications/sharia-implementation-in-northern-nigeria/vol_4_4_chapter_4_part_III.pdf. Accessed 7 Jun 2019.

104. HFG Project. Kebbi State Fiscal Space Analysis for Health Sector. Bethesda, MD: HFG Project, Abt Associates Inc.; 2018. https://www.slideshare.net/HFGProject/kebbi-state-nigeria-fiscal-space-analysis-for-health-sector.

105. The situation of health financing in Nigeria. 2012. http://afrolib.afro.who.int/documents/2012/en/Nigeria.pdf.

106. National Agency for the Control of AIDS (NACA), UN Women. Promoting Gender Responsive Budgeting in the National Response on HIV and AIDS in Nigeria. NACA; 2016. https://naca.gov.ng/promoting-gender-responsive-budgeting-national-response-hiv-aids-nigeria/. Accessed 10 Jun 2019.

107. WHO. Workforce Alliance Country Overview - Nigeria. WHO; n.d. https://www.who.int/workforcealliance/countries/Nigeria_En.pdf. Accessed 7 Jun 2019.

108. FMOH. Nigeria Family Planning Blueprint (Scale-Up Plan). 2014. https://www.familyplanning2020.org/sites/default/files/CIP_Nigeria.pdf. Accessed 11 Jun 2019.

109. HFG Project. Primary Health Care Under One Roof - An Overview. HFG Project, ABT Associates, Inc.; 2017. https://www.slideshare.net/HFGProject/primary-health-care-under-one-roof-an-overview. Accessed 19 Jun 2019.

110. The Challenge Initiative University. Adolescent and Youth Friendly Services. https://tciurbanhealth.org/wp-content/uploads/2018/10/NEWAYSRH-Adolescent-Youth-Friendly-Health-Services.pdf. Accessed 10 Jun 2019.

111. FMOH. Clinical Protocol for the Health and Development of Adolescent and Young People in Nigeria 2011. https://drive.google.com/file/d/0B1DAmtM1BcbMMEVGUG9SYkpWMWs/view. Accessed 19 Jun 2019.

112. Muhammad G. Nigeria: 25 Homosexuals Arrested in Kebbi. Daily Trust; 2014, 4 Nov. http://allafrica.com/stories/201411040993.html.

113. Heartland Alliance for Human Needs & Human Rights, African Men for Sexual and Human Rights, International Human Rights Clinic and Human Rights Program at Harvard Law School. The Violations of Human Rights on the Basis of Sexual Orientation and Gender Identity in the Federal Republic of Nigeria Under the African Charter of Human and People's Rights: A Shadow Report. 2011. https://www.heartlandalliance.org/gihr/wp-content/uploads/sites/12/2016/02/achpr_nigeria.pdf. Accessed 7 Jun 2019.

114. WHO, World Bank. World Report on Disability. Geneva: WHO and World Bank; 2011. 2011. https://www.who.int/disabilities/world_report/2011/en/.

115. Etieyibo E, Omiegbe O. Religion, culture, and discrimination against persons with disabilities in Nigeria. Afr J Disabil. 2016 5(1): 192. DOI: 10.4102/ajod.v5i1.192

116. DTN Correspondent. In Kebbi State, People With Disabilities Demand Political Appointment. Daily Times Nigeria; 2017, 7 Sep. https://dailytimes.ng/2017/09/07/kebbi-state-people-disabilities-demand/.

117. Okpanachi E. Ethno-religious Identity and Conflict in Northern Nigeria: Understanding the Dynamics of Sharia in Kaduna and Kebbi States. IFRA-Nigeria e-Papers, no. 07. Ibadan, Nigeria: French Institute for Research in Africa (IFRA) Nigeria; 2010. http://www.ifra-nigeria.org/IMG/pdf/Okpanachi_2010.pdf.

118. Nigeria Overview. Internal Displacement Monitoring Center; 2019. http://www.internal-displacement.org/countries/nigeria.

119. Majekodunmi AO, Fajinmi A, Dongkum C, Shaw APM, Welburn SC. Pastoral livelihoods of the Fulani on the Jos Plateau of Nigeria. Pastoralism. 2014;4:20. DOI: 10.1186/s13570-014-0020-7

120. Katushabe E. Gender and pastoralism: Why women empowerment is necessary? Pastoral and Environmental Network in the Horn of Africa; 2014. http://www.penhanetwork.org/blog/2014/05/22/gender-and-pastoralism-why-women-empowerment-necessary. Accessed 9 Jun 2019.

121. Goodly H. Ignoring Male Victims of Sexual Violence in Conflict Is Short-sighted and Wrong. Chatham House; 2019, 10 Jan. https://www.chathamhouse.org/expert/comment/ignoring-male-victims-sexual- violence-conflict-short-sighted-and-wrong. Accessed 7 Jun 2019.

122. Only 18 rape convictions recorded in Nigeria's legal history - Lawyer. Premium Times Nigeria; 2015, 9 Nov. https://www.premiumtimesng.com/news/top-news/192895-only-18-rape-convictions-recorded-in-nigerias-legal-history-lawyer.html. Accessed 7 Jun 2019.

123. Fontaine M, Ogunnubi YO, Ezekiel CA. Evaluation - Nigeria Gender Assessment. Report No. 102-16-001. Washington, DC: Global Health Performance Cycle Improvement Project; 2016. www.ghpro.dexisonline.com. Accessed 6 Jun 2019.

124. The Islamic approach to keeping children safe. Islamic Relief Worldwide; n.d.. https://www.islamic-relief.org/the-islamic-approach-to-keeping-children-safe/. Accessed 24 Jun 2019.

125. Giladi A. The Nurture and Protection of Children in Islam: Perspectives from Islamic Sources: Islamic texts command affection, care, and education. J Child Abuse & Neglect. 2014; 38(4): 585-592. DOI: 10.1016/j.chiabu.2014.03.016. Accessed 24 Jun 2019.

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

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

Gender-responsive checklist – Health Policies, Guidelines, Service Protocols, and other key government documents in Nigeria		**SCORE** [NO: 0 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	Table 2.2 Health indices data contains sex-disaggregated data for demographic indicators such as total population, literacy rate, comprehensive knowledge of HIV, number of persons on ART, and knowledge of pulmonary TB (pg. 18-19). They also disaggregated the current staffing profile by sex (pg. 20). There are more male health workers in every category except midwives.
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	0	No.
7.	Are specific objectives proposed to reduce gender inequalities?	0.5	Gender-sensitivity is listed as a core value under 3.3 The Core Values and Principles of the SSHDP II (pg. 24).
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	0	"GBV, Education, counseling and treatment of rape" is mentioned one time in the Annex for the Costing

	b. Early/child marriage c. Obstetric fistula d. Female genital mutilation e. Male engagement		Chapter (pg. 54) under programming for Sexual and Reproductive Health. Does not mention early marriage, FGM, or male engagement.
11	Does the policy include strategies to engage men as clients, as supportive partners/parents, and as agents of change in the following areas: a. sexual and reproductive health b. family planning c. maternal health d. newborn health e. child health f. maternal and child nutrition g. malaria	0	No mention of male engagement.
12	Does the policy include strategies to improve accessibility to services for PWD?	0	No.
Health systems strengthening			
13	Does the policy include strategies to train health workers in gender-sensitive service delivery approaches and techniques (pre-, in-service, refresher training)?	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? a. If yes, does the policy require data be used for gender analyses and evaluation to improve gender equitable service delivery?	1	The document states under Funding that the Kebbi State Government through the SMOH and SPHCDA should ensure that (number 7) "Data should be disaggregated by geography, gender, age and income level for targeting those in greatest need" (pg. 11).
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: 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?	1	Section 11.1 Proposed Mechanism for Monitoring and Evaluation mentions that within the M&E plan "Data should be disaggregated by geography, gender, age and income level for targeting those in greatest need" (pg. 55).
22	Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?	1	Section 11.1 Proposed Mechanism for Monitoring and Evaluation mentions that within the M&E plan "Data should be disaggregated by geography, gender, age and income level for targeting those in greatest need" (pg. 55).
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.			

Kebbi State Human Resources for Health Policy (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?	1	Table 1 is Kebbi State HRH Data Aggregated by Cadre and Gender, and breaks down the sex distribution of health workers by federal and state level facilitates (pg. 8). There are more male health providers in all categories with the exception of midwives, nurse midwifes, and CHEWs.
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)?	0	No.

	g. Women h. Men i. Adolescent girls j. Adolescent boys k. PWDs l. Sexual minorities		
7.	Are specific objectives proposed to reduce gender inequalities?	1	Under section 3.3.1. Frontline Caregivers, the policy acknowledges that there is gender imbalance in the health workforce and commits to making a change. It states, "the gender mix of frontline caregivers in the state is skewed in favour of men; means that access to same -sex caregivers is greatly reduced for the female population who make up the greater number of those needing basic healthcare. The policy shall focus on the training and equitable distribution of frontline health caregivers; including increasing the number of women healthcare givers" (pg.17). However, there are no actionable next steps laid out in how this might be implemented.
8.	Are lines of action proposed to meet the different needs of women and men?	1	The policy proposes to recruit more midwives and female CHEWs in order to reach more women and reduce maternal, neonatal and child mortality rates. Policy Statement 3.2.3.2 states, "the Kebbi State government shall prioritize and plan for an increase in the production of frontline workers, particularly midwives, and encourage production of female CHEWs to ensure rapid reduction in maternal, neonatal and child mortality rates" (pg. 16).
9.	Are lines of action proposed to reduce gender inequalities?	0	No.
10	Does the policy include actions to address: f. Gender-based violence prevention and response/services g. Early/child marriage h. Obstetric fistula i. Female genital mutilation j. Male engagement	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?	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?	1	Policy Statement 3.2.3.2 prioritizes the recruitment and retention of midwives and female CHEWs. It states, "the Kebbi State government shall prioritize and plan for an increase in the production of frontline workers, particularly midwives, and encourage production of female CHEWs to ensure rapid reduction in maternal, neonatal and child mortality rates" (pg. 16). In addition, under section 3.3.1. Frontline Caregivers acknowledges that there is gender imbalance in the health workforce and commits to making a change. states, "The gender mix of frontline caregivers in the state is skewed in favour of men; means that access to same -sex caregivers is greatly reduced for the female population who make up the greater number of those needing basic healthcare. The policy shall focus on the training and equitable distribution of frontline health caregivers; including increasing the number of women healthcare givers" (pg.17). However, there are no actionable next steps laid out in how this might be implemented.
16	Does the policy require health information systems collect sex and age disaggregated data? b. If yes, does the policy require data be used for gender analyses and evaluation to improve gender equitable service delivery?	0	No.
17	Does the policy include equitable financing strategies that recognize gendered needs and inequitable access to resources for health care seeking?	0	No 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 N/A	W: N/A; B: N/A; G: N/A; -

	m. physical/geographic accessibility n. unbiased and nonjudgmental and nondiscriminatory		
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.			

Kebbi State Task Shifting and Sharing Policy for Essential Services (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?	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" (pg. 3).
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)? m. Women n. Men o. Adolescent girls p. Adolescent boys q. PWDs r. 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: k. Gender-based violence prevention and response/services l. Early/child marriage m. Obstetric fistula n. Female genital mutilation o. 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" (pg. 11). The plan also includes measures for repair vaginal laceration (possible obstetric fistulas) (pg.8). Does not mention early marriage, FGM, and alludes to male engagement in labor preparation 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: o. sexual and reproductive health p. family planning q. maternal health r. newborn health s. child health t. maternal and child nutrition u. malaria	0	The protocol for RMNCH services includes steps to "educate pregnant women and their families" on labor preparation. However, they do not specifically mention male partner engagement or any tips or actionable steps to help facilitate this process (pg. 6).
12	Does the policy include strategies to improve accessibility to services for PWD?	0	No.

<table>
<tr><th colspan="7">Health systems strengthening</th></tr>
<tr><td>13</td><td>Does the policy include strategies to train health workers in gender-sensitive service delivery approaches and techniques (pre-, in-service, refresher training)?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td>14</td><td>Does the policy address risks of sexual harassment, violence, and security of female health workers?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td>15</td><td>Does the policy include strategies to promote equitable production, distribution, and retention of female and male health staff?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td>16</td><td>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?</td><td colspan="2">.5</td><td colspan="3">Under ART adherence, “register client and gather additional socio-demographical data e.g. age, sex, occupation etc.” is the first step for CHEWs (pg. 13).</td></tr>
<tr><td>17</td><td>Does the policy include equitable financing strategies that recognize gendered needs and inequitable access to resources for health care seeking?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td rowspan="2">18</td><td rowspan="2">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</td><td>M</td><td>W</td><td>B</td><td>G</td><td rowspan="2">No.</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>19</td><td>Does the policy include strategies to increase women’s participation in leadership and decision-making roles in the health sector?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td>20</td><td>Does the policy include measures for accountability in providing gender-responsive health services?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><th colspan="7">In the implementation and monitoring section</th></tr>
<tr><td>21</td><td>Is the collection of sex-disaggregated data included in the monitoring and evaluation (M&E) plan?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td>22</td><td>Is the collection of age-disaggregated data included in the monitoring and evaluation (M&E) plan?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td>23</td><td>Does the M&E plan include indicators to measure gender-related outcomes?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td>24</td><td>Are funding mechanisms and other resource needs and sources for the gender actions identified?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td>25</td><td>Does the M&E plan include what to do when M&E data reveal gender inequities?</td><td colspan="2">0</td><td colspan="3">No.</td></tr>
<tr><td colspan="7">* Not available.</td></tr>
</table>

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