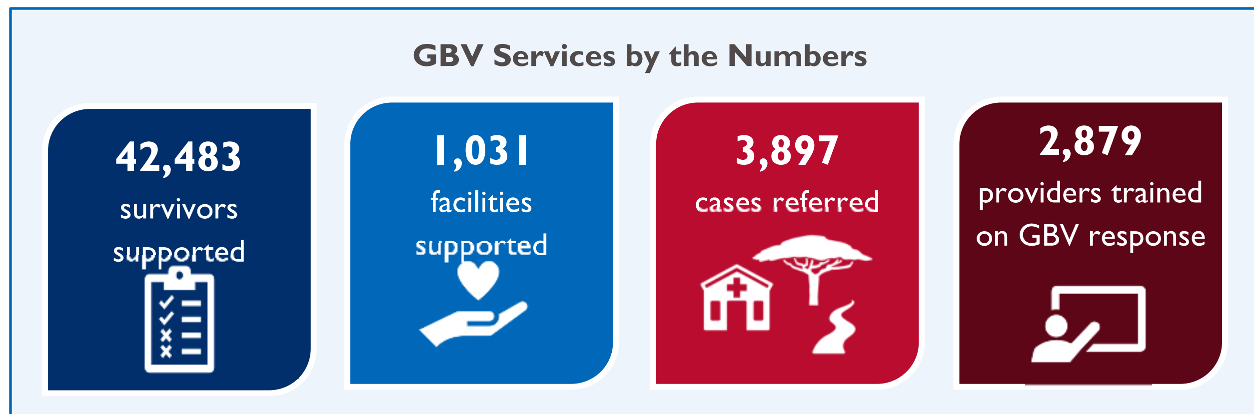
USAID Integrated Health Program Technical Series

Gender-Based Violence

INTRODUCTION

The USAID Integrated Health Program (IHP) in Nigeria aimed to reduce maternal and child mortality and morbidity and increase health systems' capacity to support quality primary health care (PHC) services across Nigeria. Over the last five years IHP has worked to improve access to and quality of PHC services across the four participating states, including Bauchi, Kebbi, Sokoto, Ebonyi, plus the Federal Capital Territory (FCT). This technical brief highlights IHP's comprehensive gender equity and social inclusion (GESI) work and gender-based violence (GBV) interventions, which aimed to address the existing gender disparities and promote social inclusion by targeting the most marginalized groups in the four participating states and the FCT.

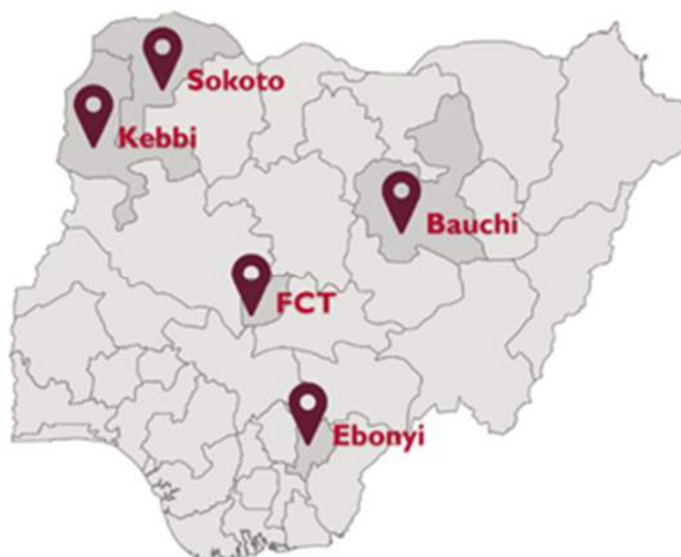
SUMMARY OF RESULTS



Over the five years of work across the four supported states and the FCT, IHP's efforts resulted in an increase in PHC service provision and the unprecedented capacity to identify, document, and respond to the needs of GBV survivors. IHP's advocacy, engagement, awareness raising, and technical assistance efforts resulted in GBV monitoring within health facilities, and the adoption of state level GESI in Health Strategies and improved coordination between health facilities, local government authorities, and state level coordinating bodies that effectuated a comprehensive survivor-centered GBV response. Additionally, State Ministries of Health accepted GESI as a health determinant, as demonstrated by the incorporation of GESI response activities in State health plans and budgets.

IHP worked with states and at the national level to introduce new indicators for monitoring GBV via a GBV addendum to the District Health Information Management System (DHIS2), to bring visibility to GBV within the health system. IHP also supported states to develop and adopt state specific Sexual Exploitation, Abuse, and Harassment (SEAH) Codes of Conduct for frontline health workers, and to amend the federal Violence Against Persons Prevention (VAPP) Law and enact it at the state level, thereby establishing state level legal frameworks for GBV response.

BACKGROUND



According to the World Health Organization's 2018 report, Violence Against Women Prevalence Estimates, approximately 736 million women and girls (over age 15) across the world have experienced some form of gender-based violence in the forms of physical, sexual, or both at least once in their lifetime. In total, this results in a global rate of 30% of girls and women being affected by GBV.

GBV is even more prevalent in Nigeria; according to a 2018 National Demographic Health Survey (NDHS), 33% of women between 15-49 have experienced GBV. This is further complicated by the social and political landscape in the country, with a diverse population of more than 218 million people. Nigeria has the largest economy in the entire continent, and yet faces multiple development challenges, with a 30.9% poverty rate (according to the International Poverty Line). Access to services and infrastructure depends greatly on each state within Nigeria, with most of the country's population experiencing immense barriers to accessing basic services, and with high rates of insecurity and violence.

Women's experiences of GBV in Nigeria are multifaceted and contextualized by the sociocultural landscape. In addition to physical and sexual violence, Nigerian women report experiencing psychological and socioeconomic violence, often rooted in traditional practices including child marriage, female genital cutting (FGC), widowhood rites, and refusal of

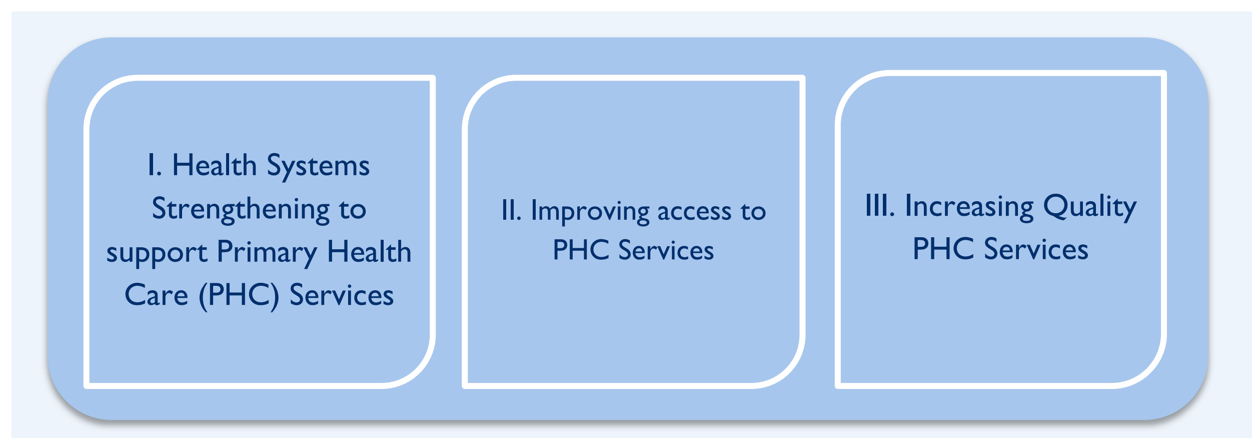
inheritance rights. Women in Nigeria generally lack access to functional legal systems to achieve justice; additionally, women's literacy rate in Nigeria is strikingly low due to marginalization and discrimination. These challenges, compounded by traditional patriarchal cultural values, deepen women's vulnerability to GBV and perpetuate violence against women.

In Nigeria, the Federal Ministry of Women Affairs (FMWA), which is responsible for efforts to prevent and respond to GBV at the national level, has partnered with State actors, civil society organizations (CSOs), international NGOs, and other stakeholders to prioritize GBV prevention and response. Organizations like UNICEF, UNFPA, the EU-UN Spotlight Initiative, and USAID have been deeply involved in this work.

IHP's approach to reducing GBV has been unique from that of other partners, utilizing a GESI lens to implement highly context-specific activities in the four participating states and the FCT (see map). Through a GESI Desk Review, Policy Analysis, and community consultations at project initiation, IHP discovered that participating states did not have any GESI integration at the state, Local Government Health Authority, and PHC structures, nor in policies, guidelines, and SOPs, and there were major gaps in capacity among healthcare workers to provide GBV clinical care and support. Furthermore, GBV data was not being reported. IHP thus focused on systems strengthening at the state and national levels, and through stakeholder engagement, capacity building, and developing referral pathways for GBV survivors, as well as capacity building for healthcare workers on data documentation and reporting.

OBJECTIVES

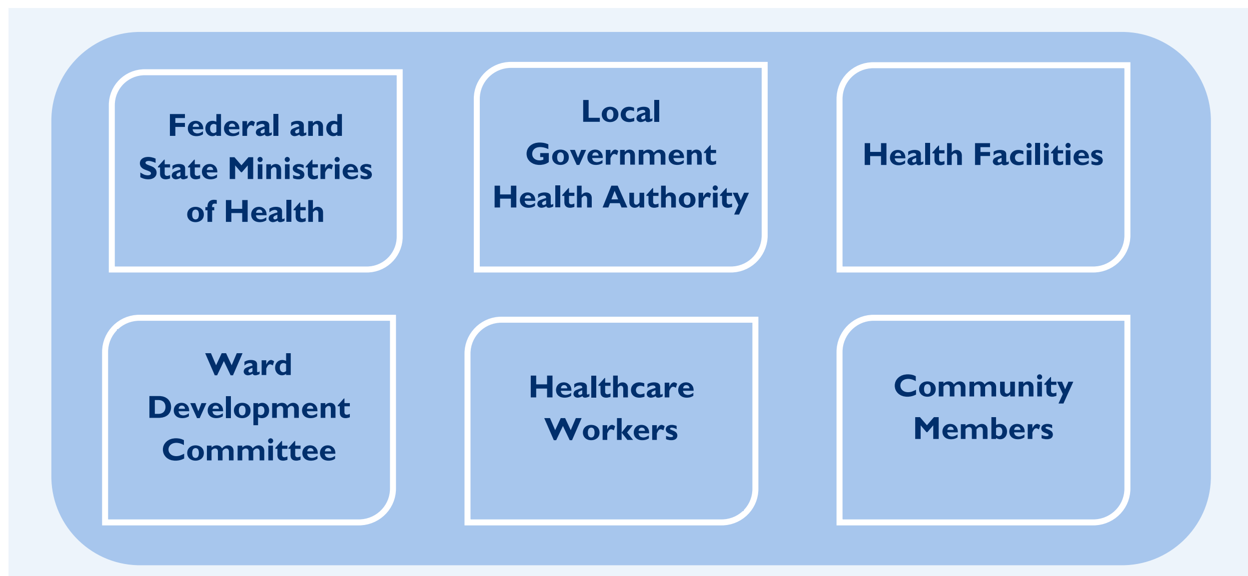
IHP's goal was to contribute to state-level reductions in child and maternal morbidity and mortality and to increase the capacity of public and private health systems to support sustainable and quality PHC services. IHP identified three main objectives to strengthen GBV service delivery, documentation, and referral:



KEY ENGAGEMENTS

In pursuit of the activity's objectives, IHP engaged with key multi-sectoral stakeholders, who were identified for their pivotal roles and profound influence within the spheres of health and community development. These stakeholders, including leaders and members of authoritative

government bodies and influential civil societal groups, harnessed their collective expertise, perspectives, and capacities to strengthen a collaborative framework and effective survivor-centered GBV response mechanisms. Stakeholders included:



APPROACH & ACTIVITIES

In partnership with WI-HER, IHP worked with local leaders and stakeholders to develop, operationalize, and institutionalize gender equity and social inclusion into the health system utilizing a GESI lens, which recognizes and addresses the root causes of violence while acknowledging the gendered power dynamics that contribute to its perpetuation. By reviewing the societal norms, cultural practices, and institutional structures through a GESI lens, IHP developed context specific interventions to transform the deeply rooted inequalities that underlie GBV, shape health-seeking behaviors, and shape the availability and quality of health services.

CHALLENGES

Prior to developing activities, IHP conducted GESI Desk Reviews and policy analyses for each participating state, during which several challenges were identified in the context of GBV and healthcare:

I. Healthcare workers' insufficient knowledge on GBV
II. Long-standing cultural norms and beliefs (for example, causing survivors to experience shame in accessing care)
III. A lack of relevant guidelines, policies, and tools in facilities
IV. Lack of male engagement
V. Absence of GBV-related data capture mechanisms within health facilities

ACTIVITIES

From 2019-2024, IHP engaged federal, state, and local government authorities, and civil society organizations to inform and lead a GBV response in four states and the FCT using evidence-

informed and survivor-centered approaches. With technical assistance from IHP, local organizations facilitated GBV training, established GBV coordination mechanisms, developed and operationalized GBV referral pathways, and strengthened GBV documentation and GBV-related policies and plans.

The **Grants Under Contract (GUC) cascading initiative** empowered healthcare providers with the knowledge and skills necessary for providing care to survivors of GBV, ranging from employment opportunities to housing solutions, facilitated through the adept utilization of the **Referral Pathway Tool/Job Aid**. This initiative was used also to train healthcare workers in documenting GBV cases.

IHP **engaged men as clients, partners, and agents of change through GESI Learning Labs**. These labs were opportunities to consult local leaders and healthcare providers, thereby co-creating locally owned solutions to four areas of health: maternal, child, and adolescent health, as well as gender-based violence. The labs also included capacity building of healthcare providers to integrate GESI into service delivery and to establish metrics to monitor improvements in RMNCAH+NM services as they directly relate to GESI interventions. The primary aim of the Learning Labs was to synthesize and document learning to produce measurable change outcomes.

After community members and healthcare providers identified men's lack of access to healthcare services as a major challenge, IHP collaborated with health providers, men- and boys-led local civil society organizations, and community structures to develop each state's specific **Male Engagement Action Plans**. These included co-identified problems, objectives, and strategies for addressing the problems, activities, measurement plans, monitoring schedules, the timeline for activities, the person(s) responsible, and resources needed. IHP also worked with male champions and service providers to address cultural gender-related barriers related to GBV in the communities.

IHP conducted **Mentoring and Monitoring Activities,** involving the meticulous review of GBV documentation by GUC-trained personnel monthly to ensure ongoing refinement of skills and practices. Follow-up mentoring focused on topics covered under the initial Capacity Building Workshops conducted at the facility level. At the facility, providers and trainers reviewed the follow-up mentoring checklist to identify gaps in identification, care, referral, and documentation of GBV cases. During the mentoring sessions, trainers coached health providers based on gaps identified. Action plans were co-developed, with the facility Gender Focal Point assigned to hold responsibility.

The **Peer-to-Peer Learning Activity** facilitated visits by healthcare workers from less high-performing facilities to higher-performing facilities to be exposed to successful GBV data documentation and survivor care, and bring lessons learned back to their communities.

The creation of diverse **Job Aids** stands as a testament to the commitment to mentoring and supporting healthcare workers beyond initial training and to address the lack of gender sensitive health promotion materials in the health facilities. IHP reviewed existing job aids across IHP-supported health facilities and developed GESI-responsive job aids to facilitate learning and serve as guides for health care providers and the community. These job aids include the GBV Referral Pathway and GBV pocket guide as well as posters on male engagement in nutrition and family planning, adolescent and youth health, and mental health, among others.

IHP facilitated the adoption of **the Violence Against Persons (Prohibition) (VAPP) and Child Rights Laws,** fostering their integration within the legal framework as endorsed by State Governors. This has opened the door for equitable treatment and recognition of GBV survivors in the justice system in Kebbi, Sokoto, Bauchi, and Ebonyi states. This was achieved in collaboration with local organizations; traditional and religious leaders; legal experts; ministries, departments, and agencies; security agencies; and the media.

Based on the gaps identified in the gender desk review, IHP addressed the lack of multisectoral coordination by establishing and strengthening **a GBV Technical Working Group (TWG)/Response Team** across the four IHP-supported states and the FCT. The TWGs are coordinating bodies in each IHP-supported state, which strengthen gender-based violence prevention and response, and consist of key representatives of state level ministries, departments, and agencies, such as health, security, social welfare, legal, education, implementing partners (IPs), and civil society organizations.

As a result of the collaborative efforts of the GBV TWG, **Gender Desk Officers (GDOs) and Gender Focal Points (GFPs)** were established. These roles are stationed in different locations. GDOs are at the local government level, whereas GFPs are at the healthcare facility level. GDOs provide the linkage between healthcare facilities and the local government authority, sharing expectations relating to GBV response. GDOs monitor GBV activities, coordinate gender-related and social inclusion activities, provide on-the-job training for healthcare workers, and supervise facilities' GBV response. GFPs record GBV-related data (encompassing indicators such as the type of GBV experienced, as well as identity factors for survivors) sourced from healthcare workers.

DATA COLLECTION

IHP enhanced the collection of GBV data in participating states, with a specific focus on improving both quality and relevance. Prior to IHP, the existing data collection process was characterized by a lack of systematic organization for collection, untrained data collectors, a lack of relevant information being collected, incorrect recording of data, and a deficiency in predefined parameters, including indicators to be collected against. GBV-related data was not collected at primary and secondary health facilities due to lack of attention as a recognized area of interest. By addressing these shortcomings, IHP fortified the overall effectiveness and precision of the data collection process in the context of GBV.

To address these challenges with data collection on a systems level, IHP worked with local government health agencies, as well as federal and state Ministries of Health and the Primary Health Care Development Agencies to revise the online platforms, Open Data Kit (ODK), and DHIS2 (an open-source health management information system) and provide users with adequate training on how to utilize both tools. With approval from the Gender, Adolescent School Health, and Elderly Care (GASHE) Division of the Federal Ministry of Health, IHP piloted the GBV addendum tools in the four IHP-supported states and the FCT by collecting and reporting data into the DHIS2.

GBV Data Collection

With IHP's intervention, ODK and DHIS2 collected the following three GBV-related data points, disaggregated by age and sex:

- Number of GBV cases seen
- Post-GBV care received
- Number of GBV cases referred

The GBV data addendum expanded on the above indicators majorly disaggregated data by type and age which the NHMIS vs 2019 tools did not provide for; the disaggregated data included the following:

- Types of GBV cases (disaggregated by age group)
- Types of post-GBV care provided (disaggregated by age group)
- Types of post-GBV care received (disaggregated by sex)

IHP also supported the review of the GBV data addendum to the National Health Management Information System (NHMIS) vs 2019 tools (used in monthly GBV data collection) in a two-day meeting of the National Gender in Health (GiH) Technical Working Group, which is a national level stakeholder coordination meeting for gender in health.

At the two-day National GiH Technical Working Group meeting, IHP introduced the new indicators and presented the data from use of the GBV addendum tools in the four supported

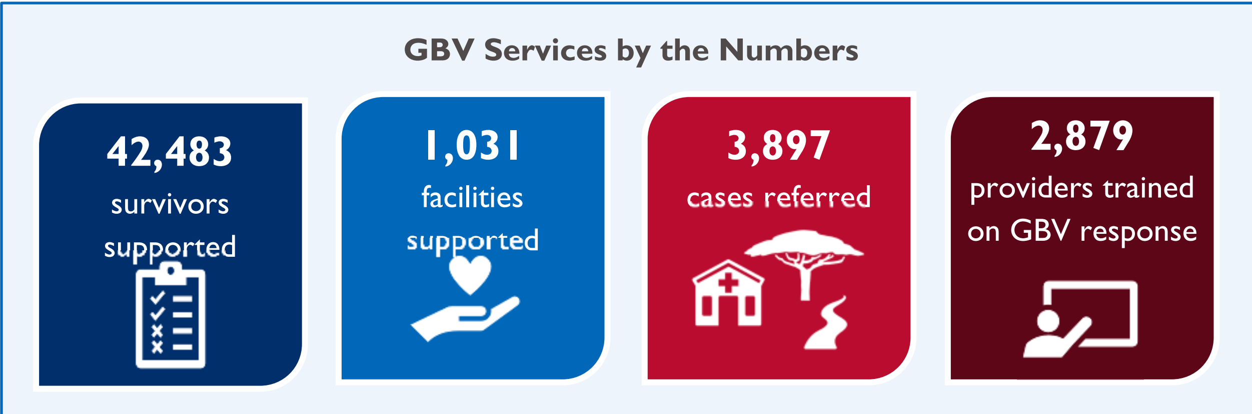
states and the FCT, and shared the process for collecting data for the new indicators. During the meeting, stakeholders at the National level, such as the Federal Ministry of Health's Department of Health Planning, Research, and Statistics (DHPRS), along with the FMWA, United Nations Population Fund (UNFPA), World Health Organization (WHO), USAID IPs, and CSOs validated and consented to using the GBV addendum tools and the testing server of DHIS2 across both primary and secondary health facilities in the 36 states in Nigeria. Following this meeting, health care workers in the four supported states and FCT were trained and mentored on GBV data documentation and reporting using the addendum tools during the GBV GUC training.

To collect data on GBV activities, IHP produced monthly, quarterly, and annual reports, which meticulously documented the activities executed during the pertinent period by the GESI Advisors. The reports include a thorough analysis, encapsulating challenges encountered during implementation, numerical results, and a forward-looking trajectory.

IHP's GBV-related data was collected monthly and analyzed on a quarterly basis. Analysis began at the health facilities where GBV quantitative data was collected from the out-patient department (OPD) monthly register. Data was then added into the DHIS platform.

RESULTS

Over the life of the project, IHP trained 2,879 healthcare providers on both clinical and non-clinical GBV response. These healthcare providers came from 1,031 IHP-supported health facilities across the four participating states and FCT. These health facilities provided support to 42,483 GBV survivors, and of those, 19,165 survivors received post-GBV care. Additionally, there were 3,897 referrals made for services such as protection, psychosocial support, shelter, and legal services.

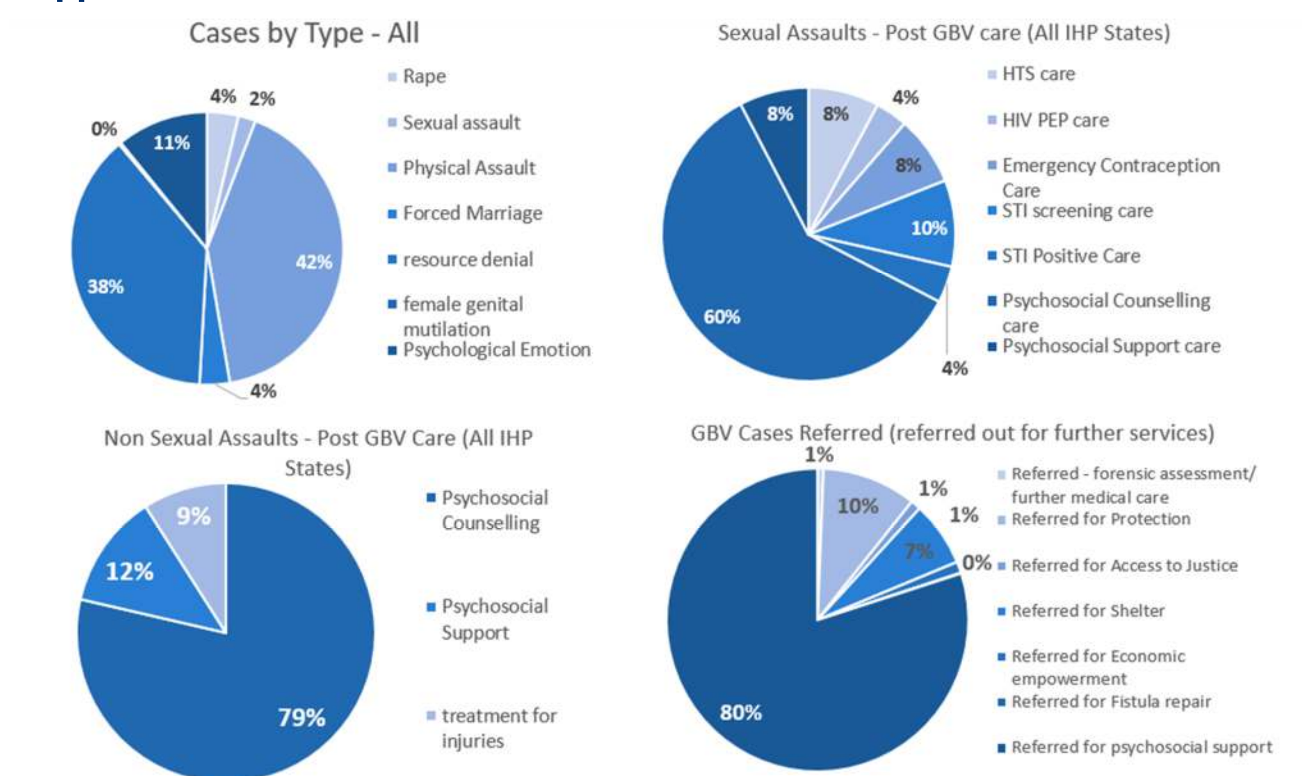


There was a remarkable increase in the number of GBV cases identified and provided with initial care across all genders and age groups from the inception of GBV activities in FY22 Q1 to FY24 Q1. This increase could be attributed to the commencement of the GBV GUC in Q4 FY22 in Bauchi, Kebbi, and Sokoto, and the GUC commencement in Ebonyi and FCT in Q4 FY23. Data on GBV cases seen in health facilities displayed a 539% increase from 1,717 in FY22 Q1 to 9,263 in FY24 Q1. Similarly, there was a 700% rise in the number of GBV survivors

provided with initial care from 963 in FY22 Q1 to 7,705 in FY24 Q1. Referrals made for other services had a 949% increase from 69 in FY 22 Q1 to 724 in FY 24 Q1.

The increase in reported cases indicates improved knowledge and skills of health care providers on GBV case management and documentation in health facilities, who are often the first point of contact for survivors of GBV in the communities.

Figure: GBV Cases, Care and Referral Disaggregation in IHP-Supported States



Reporting disaggregated GBV data on the ODK and DHIS2 staging server from the four IHP-supported states and the FCT indicates that most of the types of GBV cases seen in the health facilities were those of resource denial and physical assault. Psychosocial counseling was the highest type of post-GBV care provided for both sexual and non-sexual assault cases while referrals were made for protection and psychosocial support services in FY24 Q1.

The disaggregated data has been helpful in decision making and planning for health providers and leadership to strengthen GBV response across multiple sectors and provides clarity for areas of increased collaboration to address issues affecting survivors of GBV such as strengthening economic empowerment interventions for women and men.

LESSONS LEARNED

Data Management: Relevant and timely documentation is more than just record-keeping; it represents a critical element of strategic planning. Disaggregated GBV indicators and relevant

data management tools are not only essential to develop effective GBV response programs but also to advocate for policies at the state and national levels.

Stakeholder Management: Crafting a comprehensive strategy for stakeholder management was paramount to IHP's success. It began with early identification of stakeholders, acknowledging their potential contributions, and aligning our efforts with their resources. Leveraging these partnerships involved a dynamic understanding of their mandates to integrate interventions into their broader objectives. A handover or sustainability document is important to provide a structured framework for continuity beyond project completion.

Adapting Activities to Context: While the activities conducted across all task orders (TOs) share similarities, IHP's approach was designed to account for diverse cultural norms and available resources. The strategic design of sub-activities took into consideration the specific characteristics of the target audience, the optimal timeframe for execution, and the requisite human and financial resources. This also required consistent communication with community members. By bringing various sessions directly to the communities, IHP created an environment where individuals could engage with the content, converse with each other, and share knowledge post-activity. This not only fostered a more inclusive and participatory learning experience but also aligned with the broader mission of making essential information on GBV easily accessible while respecting and embracing diverse cultural contexts.

Enhancing Stakeholder Understanding of GESI Improves Decision-Making: Improving the understanding of GESI among stakeholders is crucial for informed and effective decision-making. When stakeholders have a comprehensive grasp of GESI principles, they are better equipped to create inclusive policies and programs that address the needs of all community members, leading to more equitable and impactful outcomes. Therefore, investing in GESI education and stakeholder training is essential for fostering inclusive governance and ensuring that decisions benefit a diverse population.

Enhancing Healthcare Providers' Capacity in GESI: There is a need for continuous capacity building among healthcare providers to sustain positive outcomes related to GESI. Consistent mentoring is essential to improve the capacity of health workers, ensuring they are well-equipped to implement GESI principles effectively. Joint Integrated Support Supervision offers a holistic view and provides an opportunity to pool resources, aligning efforts to achieve overall goals. These strategies can collectively improve the outcomes and performance of healthcare providers, leading to more inclusive and equitable healthcare services.

Male Engagement: Engaging community stakeholders in male engagement services significantly enhances the acceptability of these programs. When men accompany their wives to healthcare services, they gain a better understanding and are more prepared to support their wives on health issues. This involvement helps men respond effectively to emergencies during pregnancy. Through male engagement, men have realized that healthcare services are not solely for women and children, leading to increased male participation at primary healthcare centers. This comprehensive involvement fosters a more supportive environment for maternal and family health.

CONCLUSION & RECOMMENDATIONS

Local engagement and locally led development is the cornerstone to building sustainable initiatives that continue after funding has ended. From the inception of the project, IHP prioritized the inclusion and leadership of local partners and stakeholders to facilitate continuity of the progress from the last five years. At project closeout, IHP facilitated a sustainability workshop with stakeholders from the national level, Ebonyi, and FCT. Through the workshop, participants developed plans for the continuation of GESI interventions begun during IHP's implementation. These plans included overall recommendations for GESI and GBV activities, including:

- To further transform gendered power dynamics at the workplace, in health facilities, and at home, there is a need for ongoing state-led values clarification activities, including regular opportunities for dialogue and practical engagement of communities and stakeholders.
- There must be specific strategies for male participation and engagement to enhance acceptability and effectiveness of interventions. This requires ongoing advocacy with community institutions and leaders and at health facilities, and the identification of a male champion to advocate within their social circles.
- Continued multisectoral collaboration is essential at all levels of GBV response (TWGs, GBV response teams, facility/community, legal, and social services). Sustaining GESI efforts will require a focus on partnerships and multi-sectoral collaboration, and continued prioritization of gender equity and social inclusion. Coordination should include actors from the state, local government areas, and community levels who meet regularly and in person. To enable effective coordination among these actors, it is essential to identify and enhance their knowledge on GESI/GBV, and allow them to lead activities, which increases their buy-in and improves the effectiveness of planning and implementation (regarding policies, budgets, annual plans, etc.).
- GESI programming should be scaled to other Nigerian states across the country to ensure a wider reach and greater impact. Best practices should be established from current GESI initiatives and successful models replicated in new regions.

As a result of IHP interventions, there has been significant progress to promote gender inclusion and integrate GBV services into the health system. It is essential to sustain these efforts through strong partnerships, and a continued focus on gender equity and social inclusion in Nigeria. IHP's interventions can serve as a model for other interventions seeking to address GBV in Nigeria and beyond.

Key Definitions

Gender-based violence	Gender-based violence refers to harmful acts directed at an individual based on their gender, including physical, sexual, psychological, and economic abuse.
Sexual abuse	Sexual abuse means any unwanted sexual activity that is done based on threat and manipulation. It includes sexual assault, sexual violence, and sexual exploitation.
Sexual violence	Sexual violence means that someone has been coerced into a sexual activity without their consent.
GESI	GESI, or Gender Equity and Social Inclusion, encourages policies to be focused on groups that are marginalized based on gender, class, and race.
National Demographic Health Survey	A national sample survey that maintains records of population's demographic and health indicators.
Referrals	A referral is a written order from your primary care physician for a specific medical service or test, often for a higher level of care.
DHIS dashboard	The DHIS dashboard offers an overview of data in form of charts, tables, maps, and reports.
RMNCAH+NM	A global health strategy that is holistic in nature and focuses on "interventions aimed at reproductive, maternal, newborn, child, adolescent health, and nutrition under a broad umbrella, and focusing on the strategic lifecycle approach."[1]
Violence Against Persons (Prohibition) (VAPP)	The Act "prohibit[s] all forms of violence against persons in private and public life and provide[s] maximum protection and effective remedies for victims and punishment of offenders."[2]
WI-HER	Sub-partner specializing in gender and development work.

[1] https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=794&lid=168
[2] https://www.law.cornell.edu/women-and-justice/resource/violence_against_persons_(prohibition)_act

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