GENDER-BASED VIOLENCE SERVICES MAPPING IN SOKOTO STATE, NIGERIA

MOMENTUM Country and Global Leadership

USAID FROM THE AMERICAN PEOPLE

MOMENTUM A Global Partnership for Health and Resilience

MAY 2022

MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

This report is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) under the terms of the Cooperative Agreement #7200AA20CA00002, led by Jhpiego and partners. The contents are the responsibility of MOMENTUM Country and Global Leadership and do not necessarily reflect the views of USAID or the United States Government.

Cover photo: Karen Kasmauski

Suggested Citation

MOMENTUM. 2022. *Gender-Based Violence Services Mapping in Sokoto State, Nigeria*. Washington, DC: USAID MOMENTUM.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

CBO	Community-based organization
CEFM	Child early and forced marriage
CMR	Clinical management of rape
CSO	Civil society organization
FGD	Focused group discussion
GBV	Gender-based violence
GII	Gender inequality index
IDI	In-depth interview
IPV	Intimate partner violence
LGA	Local government area
M&E	Monitoring and evaluation
NDHS	Nigeria Demographic and Health Surveys
NSCDC	Nigeria Security and Civil Defense Corps
ODK	Open Data Kit
PEP	Post-exposure prophylaxis
RA	Research assistant
RUWOYD	Rural Women and Youth Development
SGBV	Sexual and gender-based violence
SOP	Standard operating procedure
SRHR	Sexual and reproductive health rights
STI	Sexually transmitted infection
USAID	United States Agency for International Development
VAWG	Violence against women and girls

ACKNOWLEDGMENTS

MOMENTUM Country and Global Leadership grateful acknowledges the United States Agency for International Development for providing the funding to carry out the gender-based violence service provider mapping in Sokoto State. Special thanks go to the government and people of Ebonyi and Sokoto states for their commitment to MOMENTUM and their willingness to comply with global best practices in mitigating and preventing violence against women and girls. Of note are the local partners implementing MOMENTUM Country and Global Leadership in both states who directly led the implementation of this laudable assignment in their respective states: Excellence Community Education Welfare Scheme in Ebonyi State and Rural Women and Youth Development in Sokoto State. We also appreciate the research assistants for their tireless work in ensuring that high-quality data was collected during the mapping exercise. Finally, we are especially grateful to the numerous stakeholders and individuals across Ebonyi and Sokoto states who participated in the mapping exercise and, particularly, respondents who provided the information analyzed in the reports.

EXECUTIVE SUMMARY

Gender-based violence (GBV) is a public health and social development concern with far-reaching consequences for survivors, perpetrators, families, broader society, and economies. It primarily affects women and girls, though boys and men also experience GBV. As part of efforts to address major contributors to maternal mortality and morbidity through the prevention and mitigation of the consequences of violence against women and girls and possible drivers of child early and forced marriage, MOMENTUM Country Global Leadership, in collaboration with Rural Women and Youth Development, mapped GBV services in Sokoto State, Nigeria, to determine the availability of GBV prevention and response services; identify, enumerate, and map available formal and informal survivor-centered GBV services; and assess the readiness of facilities to provide quality services across sectors in the 11 MOMENTUM-supported local government areas of Sokoto State.

Key informant interviews

Key informant interviews were conducted with the following stakeholders and agencies:

- Officers in-charge at health facilities
- Legal aid organizations
- Courts
- Law enforcement agencies
- Temporary shelter homes
- Local government area officials
- Community leaders and survival advocates

The GBV services mapping was conducted in the following local government areas: Illela, Sokoto South, Wamakko, Gada, Binji, Dange Shuni, Bodinga, Gwadabawa, Kware, Shagari, and Kebbe. For effective and quality mapping/data collection, MOMENTUM recruited 22 research assistants, who attended a five-day training that covered topics such as gender and GBV, research ethics, study objectives and methodology, data collection procedures, and in-depth interview (see the box on the left for a list of those interviewed) and focus group discussion data collection tools, including recruitment and screening procedures for informed consent and study enrollment. The team developed a data collection schedule to support the initiation of data collection activities post-training and finalize data collection supervisory plans and overall schedules.

Included in the GBV mapping were health care services, law enforcement services, legal aid services, psychosocial support, temporary shelter, and economic empowerment.

The findings from the GBV mapping indicate that Sokoto State has a high statistical rate of GBV incidence. Rape, physical assault, intimate partner violence, and sexual violence are the most prominent forms. There are also huge gaps in the existing knowledge base and infrastructure for the prevention of and response to GBV in the state. Health care providers were found to generally lack the capacity to provide basic first-line support to GBV survivors (defined as counseling, safety planning, and referrals) and few service providers were aware of, or ever referred GBV survivors to referral services. Most health workers have never received any form of training on GBV services, and limited their care to treating physical injuries only. Essential services required to effectively provide post-GBV care at health facilities (e.g., a private room for safe counseling, post-exposure prophylaxis for HIV prevention within 72 hours of an assault, etc.) are conspicuously nonexistent.

It is important to note that although GBV prevention and response responsibilities are shared by state and local governments, police, and community-based organizations, only one (0.4 percent) of 284 mapped health facilities met all the minimum criteria for GBV service provision. Overall, there is a lack of coordination, knowledge, funding, communication, and collective action across and between sectors.

INTRODUCTION

The U.S. Agency for International Development (USAID)-funded MOMENTUM Country and Global Leadership project in Nigeria, in collaboration with Rural Women and Youth Development (RUWOYD), conducted a mapping of gender-based violence (GBV) services in 11 supported local government areas (LGAs) of Sokoto State, Nigeria, from June 14 to July 10, 2021: Sokoto South, Wamakko, Kebbe, Bodinga, Shagari, Binji, Gwadabawa, Dange Shuni, Illela, Kware, and Gada.

As part of MOMENTUM's efforts to prevent and mitigate the consequences of violence against women and girls (VAWG) and possible drivers of child early and forced marriage (CEFM), the mapping exercise aimed to identify, enumerate, and map existing survivor-centered GBV services, including formal and informal services; determine the readiness of facilities to provide quality services across sectors; and assess capacities of service providers in the 11 LGAs. The mapping project prioritized the following sectors: health care, law enforcement, legal counsel/support, psychosocial support, child protection, temporary/emergency shelter, and economic empowerment/livelihood.

The team recruited, engaged, and trained 22 research assistants (RAs), and each LGA was assigned two RAs to carry out the mapping exercise across all GBV service areas within the LGA and to conduct in-depth interviews (IDIs), focused group discussions (FGDs), and key informant interviews (KIIs) with representatives of key sectors providing GBV services.

OBJECTIVES

The objectives of the GBV mapping exercise were to:

- Identify, enumerate, and map existing survivor-centered GBV services, including formal and informal resources/services, within selected LGAs in the state.
- Assess the quality, functionality, and accessibility of mapped service delivery points using Jhpiego's GBV quality assurance standards and make recommendations for quality improvement.
- Determine and describe existing referral pathways between services, identify opportunities for improved coordination, and develop referral directories with detailed contact information.
- Identify stakeholders' perceptions of existing facilitators and barriers to survivors seeking post-GBV care (including sociocultural/attitudinal, logistical, informational, and multisectoral coordination-related facilitators and barriers).
- Identify capacity needs of first responders across sectors for effective response to GBV survivors.

PREVALENCE OF GBV IN SOKOTO STATE

According to the 2018 Nigeria Demographic and Health Survey (NDHS), the percentage of ever-married women who experienced spousal physical, sexual or emotional violence in the past 12 months was 35.4% in Sokoto State. Furthermore, 28% of Nigerian women have experienced physical violence at least once since the age of 15. The negative impacts of IPV on women's physical, sexual, and reproductive health have been broadly documented.

TABLE 1. GENDER-BASED VIOLENCE IN SOKOTO STATE AND NATIONALLY

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

Sources: NBS, 2018; NPC and ICF, 2019.

METHODS

The mapping used cross-sectional mixed methods to collect data. Qualitative methods included KIIs with key stakeholders and service providers and FGDs with men and women in the community. Quantitative methods included service provider interviews and facility surveys. Participants were identified through an iterative process involving inputs from states, LGAs, community stakeholders, and the assessment team. Several stakeholders were contacted to identify the range of available services, and additional participants were identified using a snowballing approach. For quantitative data collection, all available services were mapped; qualitative data collection involved the use of purposive sampling, with two people interviewed per service sector (health care, law enforcement, legal aid, temporary shelter, etc.). Additionally, RA teams conducted two FGDs per LGA and used a state-level tool to interview stakeholders. REDcap and Open Data Kit (ODK) software applications were used to collect quantitative data.

METHODS AND APPROACHES

The survey design was cross-sectional descriptive with both qualitative and quantitative methods used.

The qualitative methods included IDIs with identified key stakeholders at state, LGA, and community levels, and FGDs with men and women in the community (held in separate groups). The quantitative methods included surveys for facility mapping/assessment and provider capacity assessment.

Teams used an open-ended semi-structured questionnaire to collect data from health facilities, police/law enforcement agencies, legal aid services, courts, psychosocial support services, temporary shelters, community leaders, identified survivor advocates, and LGA officials.

Data was collected using mobile applications such as REDcap, ODK, and interview guides, which were transcribed into an electronic format. Two REDcap tools were used: tool A, which contained a questionnaire for GBV service mapping, and tool B, which contained a questionnaire for staff capacity assessment.

KEY FINDINGS

CROSS-CUTTING FINDINGS

- Of the 352 facilities/organizations assessed in Sokoto State, 284 (81 percent) provide health care services, 43 (12 percent) provide law enforcement, 14 (4 percent) provide psychosocial support, 10 (3 percent) provide legal aid, three provide temporary shelter, and one provides economic empowerment support.
- None of the assessed facilities provide all of the required services.
- Of the 284 health care facilities, 89 (31 percent) reported that survivors of GBV pay to receive services. Two of the 43 (5 percent) law enforcement organizations demand payment for services, one of the 14 organizations providing psychosocial support services request payment, and three of the 10 (30 percent) organizations providing legal aid services request payment.
- Based on facilities' operating hours, only 198 (56 percent) facilities operate 24/7, with 154 (44 percent) operating Monday–Friday.
- Of the 352 facilities/organizations assessed, only 84 (24 percent) reported that they have policies and protocols for providing GBV services, especially for children, whereas 154 (44 percent) have policies and protocols for data collection, management, and sharing, and 188 (53 percent) have a policy for referral and coordination.
- Of those referred to other services, 48 percent of GBV cases are referred to health care facilities, 13 percent are referred to police and other law enforcement agencies, and 8 percent are referred to legal aid services.

SECTOR-SPECIFIC FINDINGS

HEALTH FACILITIES:

- Of the 284 mapped health care facilities, 78.2 percent have pain medications, 75 percent have tetanus vaccine, 66 percent have pregnancy test kits, and 57 percent have local anesthetic for sutures.
- Only 7 percent of the mapped health care facilities have post-exposure prophylaxis (PEP) for HIV.
- Only one (0.4 percent) health care facility meets all the minimum criteria for GBV service provision.

LAW ENFORCEMENT AND LEGAL AID:

- Of the 43 law enforcement agencies mapped, 72.1 percent conduct case investigation and 60.5 percent provide safety/security planning enforcement.
- Of the 10 organizations providing legal aid services, 80 percent provide legal representation, 70 percent provide legal consultation, 40 percent offer accompaniment and support in court, and 10 percent provide mediation, basic psychosocial counseling, and security/safety planning.

PSYCHOSOCIAL SUPPORT AND TEMPORARY SHELTER:

- Of the 14 mapped facilities providing psychosocial support services, 86 percent provide counseling, 57 percent provide case management, 29 percent provide safety planning, and 14 percent provide psychotherapy for trauma cases.
- Of the three mapped temporary shelter/safe home facilities, 67 percent provide shelter/housing, case management, and basic health needs, and 33 percent provide basic psychosocial support/counseling and safety planning.

SERVICE PROVIDER CAPACITY ASSESSMENT FINDINGS

HEALTH CARE AND LAW ENFORCEMENT:

- Of the 236 health care providers interviewed, 33 percent have received training on maintaining patient privacy and confidentiality, 31 percent on effective referral and follow-up, but very few (2 percent) on how to testify in court.
- Of the 39 law enforcement officers interviewed, 54 percent have had training on communication skills, but only 13 percent have received training on medico-legal report writing.

LEGAL AID AND PSYCHOSOCIAL SUPPORT:

- Of the 10 legal aid service providers interviewed, 40 percent have received training on communication skills, maintaining patient privacy and confidentiality, testifying in court, and documentation, whereas 20 percent have received trainings on safety planning, basic GBV training, and handling of GBV cases.
- Of the 14 psychosocial support service providers interviewed, 57 percent have received training on prevention of GBV and provision of post-GBV care, 43 percent on principles of case management and prevention of sexual exploitation, and only 29 percent on referral pathways.

QUALITATIVE FINDINGS

- There is no GBV action plan in the state.
- There is no referral directory in the state.

FIELD ASSESSMENT DESIGN AND STUDY POPULATION

Before the RAs began data collection, MOMENTUM advocated with relevant ministries, departments and agencies, traditional institutions, and LGA stakeholders to seek their collaboration and ensure smooth implementation of the research in Sokoto State. The study population included (see Table 2):

- Service providers offering clinical and nonclinical services
- Law enforcement agencies, legal aid organizations, and psychosocial support organizations
- Community leaders and members
- Duty bearers/stakeholders

A four-day training was held to build the capacity of the 22 RAs in the use of the tools, advocacy skills, as well as how to properly conduct GBV research mapping. RAs field-tested the tools to familiarize themselves with them, identify gaps, and suggest ways to better implement the exercise.

TABLE 2. INCLUSION CRITERIA FOR THE GENDER-BASED VIOLENCE ASSESSMENT

Population	Sampling strategy	Inclusion criteria
Service providers offering clinical and nonclinical services Law enforcement agencies, legal aid organizations, and psychosocial support organizations	A snowballing approach will be used to identify first responders, and health service providers will be identified in collaboration with the State Emergency Management Agency, State Ministry of Women Affairs, State Ministry of Health, Nigeria police force, Nigeria Security and Civil Defense Corps, National Agency for the Prohibition of Trafficking in Persons, etc.	• Staff working in health facilities • Staff working in temporary shelters and/or safe houses • Social workers • Legal aid workers • Police officers • Representatives from nongovernmental organizations, community-based organizations (CBOs), and/or faith-based organizations that provide GBV services • Other community members who provide local support to survivors, for example, teachers and religious leaders
Community leaders and members	Recruited through CBOs or other pre-existing groups in each target area	• Male and female adult (18 years and above) community members • Place of residence is in the community • Local leaders who oversee GBV-related treatment and/or prevention efforts in their communities, for example, village executive officers and ward-level leaders • Traditional rulers or their designate, e.g., emirs, sarakunas
Duty bearers/stakeholders	Relevant and influential stakeholders will be identified through LGA-level advocacy	• Ministry of Health • Ministry of Women Affairs • Ministry of Education • Ministry of Justice • Ministry of Information • United Nations Population Fund • European Union/United Nations (UN) Spotlight Initiative • State Emergency Management Agency • Integrated Health Project (IHP) • UN Women • LGA Director of Public Health (Secretary of Health) • LGA Head of Administration • LGA Director of Social Services

PREPARATORY ACTIVITIES

- A public advertisement for qualified and suitable candidates to apply for the RA positions was made through RUWOYD's Facebook page. Of the 105 applicants who submitted applications, 35 (male = 23, female = 12) fully complied with the advertisement requirements and were shortlisted for interviews. The criteria used for shortlisting applicants were compliance to mode of application (email with attachments), level of experience, qualifications with regard to the job description, and familiarity with the research location. The interview had two sections, morning and afternoon, and consisted of oral and written components. Interviews took place on May 20 and 21, 2021. Interviewers included RUWOYD staff (project coordinator, monitoring and evaluation [M&E] officer, and human resource officer) and the Sokoto State MOMENTUM Country and Global Leadership team lead.
- MOMENTUM Country and Global Leadership developed all the tools used for the mapping exercise.
- Prior to deployment of the RAs, RUWOYD, in conjunction with local partners NANA Girls & Women Empowerment Initiative and Helping Hands & Grass Root Support Foundation and state team leads, made advocacy visits to the State Ministry of Health, Sokoto State Primary Health Care Development Agency, State Ministry of Women and Children Affairs, and LGA chairs in Binji, Illela, and Sokoto South.
- Prior to data collection, the RAs paid advocacy visits to traditional leaders and LGA authorities to gain proper community entry.

SAMPLE CHARACTERISTICS

Table 3 shows the expected number of IDIs to be conducted in each LGA. In addition, two FGDs were planned to be held in each LGA—one for men and one for women.

TABLE 3. NUMBER OF IN-DEPTH INTERVIEWS CONDUCTED IN EACH LOCAL GOVERNMENT AREA

Tool #	Facility/organization type	Number of IDIs
1	Health facility	2
2	Police/law enforcement agency	2
3	Legal aid services	2
4	Courts	2
5	Social support services	2
6	Temporary shelter	2
7	Community leaders	2
8	LGA officials	3
Total		**17**

For the quantitative sampling, all facilities that can come in contact with a GBV survivor were mapped and a provided consent was given. The qualitative data sample size was fixed at two respondents each for tools 1–7 and tool 9 (FGDs with men and women) and three respondents for tool 8.

PRE-MAPPING TRAINING

MOMENTUM Country and Global Leadership coordinated training for 24 prospective RAs (of these, 22 qualified to participate in the research) on GBV services mapping at Shukura Hotel Sokoto on June 9–12, 2021. MOMENTUM and RUWOYD facilitated the training sessions, which were also attended by representatives of the Federal Ministry of Health, Federal Ministry of Women Affairs, and Sokoto State Ministry of Women and Children Affairs. Participants' knowledge was standardized on gender and GBV, research ethics, study objectives and methodology, data collection procedures and methods, such as IDI and FGD collection tools, recruitment and screening procedures for informed consent, and study enrollment. On day 3, participants were grouped and sent to different organizations to field-test the tools. The seven sectors identified for mapping were:

- Health institutions
- Law enforcement agencies (police and the Nigerian Security and Civil Defense Corps [NSCDC])

- Legal aid organizations (National Human Right Commission, Federation of Muslim Women's Association of Nigeria, International Federation of Women Lawyers, Legal Aid Commission, etc.)
- Judicial proceedings (judges, magistrates, Sharia, etc.)
- Social support services (CBOs, civil society organizations [CSOs], nongovernmental organizations, etc.)
- Temporary shelter/safe homes
- Community/LGA leaders

RAs were paired and assigned to LGAs to carry out the mapping exercise.

DATA COLLECTION

RAs collected data using mobile applications (REDcap and ODK) and questionnaires. A mixed-method (qualitative and quantitative) approach to data collection was employed to ensure comprehensive data were collected. Respondents were carefully selected and facilities were covered. All data collected were primary data as the RAs visited all respondents at their places of work.

DATA MANAGEMENT

Electronic data collected from the field were sent to a central database. RAs transcribed all IDIs and responses from the FGDs and stored these responses in an electronic system, which was also backed up to the cloud system. Hard copies of signed and dated consent forms were kept in a locked safe and digital copies were saved in the cloud.

DATA CLEANING

Data cleaning was performed on both qualitative and quantitative data. For the REDcap and ODK data collected, records were checked to ensure completeness. Duplicate, incorrect, irrelevant, or incomplete observations were removed to ensure data quality and efficiency of the data analysis. For qualitative data (e.g., IDIs, FGDs, and KIIs), data cleaning was performed to ensure answers to all relevant questions were captured and the appropriate tool was used for each facility. The team corrected typographical errors and ensured data validation and data enhancement. Data cleaning continued until the data were reported to meet data quality criteria, which included validity, accuracy, completeness, consistency, and uniformity. Upon completing data cleaning, the data were ready for analysis and presentation.

DATA ANALYSIS AND PRESENTATION

Data were analyzed by MOMENTUM Country and Global Leadership, and RUWOYD participated by reviewing the outputs and commenting on the work completed so far. Research findings have been simplified in charts and tables as seen throughout this report.

QUALITY ASSURANCE

MOMENTUM Country and Global Leadership put measures in place to ensure that the questionnaires were clear and understandable for both researchers and respondents. Part of MOMENTUM's effort was facilitating training for RAs, during which the team conducted an intensive pilot survey to finetune the questionnaires and logic. Tools were designed to be user friendly and, when necessary, clarifications were made to ascertain relevant data were collected. During the field exercise, the team maintained regular contact with the RAs so they knew they were not alone, that no fraudulent actions occurred, and that the right person(s) were interviewed. The RAs were also supported by local partners Helping Hands & Grass Root Support Foundation and NANA Girls & Women Empowerment Initiative, who were in constant contact while observing how each RA administered the survey. RUWOYD observed data collected from the field through the REDcap dashboard and followed up with researchers regarding missing data and values. Finally, MOMENTUM conducted back checks with some facilities to ascertain that the RAs actually visited and to learn how providers felt during the interview.

MAJOR FINDINGS

DESK REVIEW FINDINGS

The gender inequality index (GII) is a compound metric, ranging from 0 to 1. It reflects the inequality between men and women related to reproductive health (maternal mortality rate and adolescent fertility rate), empowerment (parliamentary seats by sex and educational attainment of at least secondary school by those age 25+), and the labor market (labor force participation by sex). Nigeria's 2016 GII was 0.779, which represents a 77.9 percent loss in human development potential due to gender inequality. In 2016, Sokoto State had a GII value of 0.698, indicating a lower level of gender inequality than the national average, with the North-West region having the highest GII.[1]

GBV is violence directed against a person because of their gender. Both women and men experience GBV, but the majority of victims are women and girls. GBV includes physical, sexual, psychological, and economic violence. GBV, or VAWG, affects one in three women in their lifetime. For example, globally[2]:

- Thirty-five percent of women have experienced physical violence and/or sexual intimate partner or nonpartner violence.
- Seven percent of women have been sexually assaulted by someone other than a partner.
- As many as 38 percent of murders of women are committed by an intimate partner.
- Two hundred million women have experienced female genital mutilation/cutting.

This issue is not only devastating for survivors of violence and their families, it also entails significant social and economic costs. In some countries, violence against women is estimated to cost countries up to 3.7 percent of their GDP—more than double what most governmental organizations spend on education.

GBV is a common social problem in Northern Nigeria, especially in the Sokoto State, as evidenced by increasing cases of domestic violence, sexual exploitation, forced early marriage, and rape of minors since the Boko Haram insurgency.[3]

GEOGRAPHIC PROFILE OF SOKOTO STATE

Sokoto State, in northwestern Nigeria, borders the Republic of the Niger to the north, Kebbi state to the west and south, and Zamfara state to the south and east. The southern part of the state is characterized by short-grass savanna vegetation, and the northern part by thorn scrub. Sokoto State experiences limited rainfall from mid-May to mid-September and a dry, dust-laden wind (the Sahara's *harmattan*) from November to March. The Sokoto (Kebbi) river, a major tributary of the Niger River, and its tributaries run through the state, serving as a source for irrigation and transportation.[†] Since 1960, Sokoto State's population has experienced a more than six-fold increase—from about 800,000 people to almost 5.4 million estimated in 2017.[4]

POLICIES AND LAWS

Violence against women is often fueled by longstanding social and cultural norms that reinforce its acceptability in society by both men and women. Worse still, some provisions of the laws in Northern Nigeria, such as Section 55 of the penal code, which allow a husband to beat his wife for the purpose of correcting her, tend to encourage violence against women in the family. Existing laws in Sokoto State are not effective in addressing GBV or protecting women and children and have not been domesticated for various reasons including religious and cultural sensitivities. Conflicting laws, such as the penal code and Islamic law, do not align with the federal constitution, making it difficult to implement any other laws. For example, the penal code states that "Sexual intercourse by a man with his own wife is not rape, if she has attained to puberty," leading to complications in adjudication in child marriage. Furthermore, the Immigration Act stipulates that any person under age 16 years is a minor, whereas the Matrimonial Causes Act puts determination of the age of maturity in the context of marriage.

As for penal responsibility, Article 50 of the Penal Code (North) states: "No act is an offence which is done by a child under seven years of age; or by a child above seven years of age but under twelve years of age who has not attained sufficient maturity of understanding to judge the nature and consequence of such act." This variance encourages different interpretations and hence gives room for the perpetuation of CEFM.

Prevailing factors that exacerbate GBV in Nigeria include[5]:

- Weak, nonexistent, and fragmented policy and legal frameworks and their implementation.
- Existing discriminatory laws and policies that repress the rights of women.
- Sociocultural and religious beliefs.

The Sokoto State House of Assembly has taken a step in addressing issues around GBV by passing a bill for a law to supplement Penal Code Law 2019 that includes punishment of GBV-related offenses.[6, 7] Sokoto State has yet to adopt the Child's Rights Act, which the majority of states in Nigeria have passed into state law.

GBV IN SOKOTO STATE

According to the 2018 NDHS, men in Sokoto State sometimes display controlling behaviors toward their wives, which has been identified as a warning sign of and is correlated with intimate partner violence (IPV).[8] Across Nigeria, Sokoto State has the second highest rate of such behaviors.[9] In Sokoto State, men's most frequent controlling behaviors include jealousy and steps to isolate their partner from her friends and family.

[†] https://www.britannica.com/place/Sokoto-state-Nigeria

Lack of economic power and decision-making are often signs of lower levels of women's empowerment and are evident in findings from the 2018 NDHS.[8] Only 1.6, 9.9, and 2.3 percent of women report that they are the primary decision-maker regarding their own health, visiting friends, and household purchases, respectively. Similarly, 97.3 percent of men say they make final decisions regarding household purchases. There is a strict patriarchal system in the state, supported by local interpretations of Islam and Christianity, and a persistent belief that men have been given the "mantle of leadership" by God.[10] In addition, religion plays a major part in defining the roles and responsibilities of men and women in Nigeria; because the status of women in Islamic and Christian religious texts is generally low and men dominate positions of power, "this has translated to women's marginalization from positions of power and authority."[11]

According to the 2018 NDHS, 36.2 percent of ever-married Nigerian women have experienced spousal violence (emotional, physical, or sexual).[8] Within domestic relationships, emotional violence is more common than sexual or physical violence.[9] In Sokoto State, 35.4 percent of women have experienced physical, sexual, or emotional violence by a partner or spouse—a major increase from 3.7 percent in 2013 but on par with the national average. It is not clear whether these higher rates of violence are due to more violence or increased reporting. One-quarter of women and 34.9 percent of men in Sokoto State agree that husbands are justified in beating their wives under at least one circumstance, the most common being if she refuses to participate in sexual intercourse. In Sokoto State, 0.7 percent of ever-pregnant women have experienced IPV during their pregnancies.[9]

Women tend to marry younger than men in Nigeria. In 2018, the average age at marriage for females was 19.1, eight years earlier than the average age for males (27.7 years). In Sokoto State, child marriage (marriage before the age of 18) is the norm: the average age of first marriage for women is 15.9, compared to 25.8 years for men.[9] Child marriage is tied to a cultural and religious veneration of female virginity, and 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 women a low sense of self-worth and is more likely to result in a controlling, violent relationship.[‡]

According to Save The Child Initiative Chief Executive Officer Abdulganiyu Abubakar, no fewer than 426 GBV cases were recorded in Sokoto State between January and November 2020.[12] Abubakar disclosed this number during the project evaluation meeting for the Spotlight Initiative, and said that although the number of cases recorded from January to April 2021 was not readily available, the number of daily violations has been on the increase.[12]

Despite awareness-creation efforts, more cases of GBV are still being recorded in Sokoto State.[§] The Spotlight Initiative report stated that 160 GBV survivors were empowered with working tools in four LGAs: Bodinga, Sokoto North, Binji, and Tangaza. They received training on environmental health and body hygiene, business skills, child spacing and family planning methods, livelihood skills, sexual and reproductive health and rights (SRHR), and special skills on how to prevent VAWG, sexual and gender-based violence (SGBV), and harmful practices.[13]

SUMMARY

The desk review showed limited research in the area of GBV in Sokoto State. The GBV mapping effort by the MOMENTUM team and RUWOYD in Sokoto State aggregated data from 11 LGAs, including staff capacity.

[‡] Girls Not Brides. Nigeria - Child Marriage Around the World. Girls Not Brides; n.d. https://www.girlsnotbrides.org/child-marriage/nigeria/. Accessed June 9, 2019.
[§] https://www.youtube.com/watch?v=Ic9vyOreaZ8

MAPPING/ASSESSMENT FINDINGS

RAs visited 352 facilities—cutting across service provider types—in the 11 LGAs as part of the mapping effort. Table 4 shows the number of facilities visited by LGA, and Table 5 shows facilities visited by service type in each LGA. The findings show that the largest percentage of the facilities visited were in Illela (13.1 percent). This was followed by Sokoto South (11.4 percent), Dange Shuni and Gwadabawa (10.5 percent), and Bodinga (10.2 percent) LGAs.

TABLE 4. FACILITIES VISITED DURING THE MAPPING EFFORT, BY LOCAL GOVERNMENT AREA

LGA	Number of facilities	Percentage
Illela	46	13.1
Sokoto South	40	11.4
Dange Shuni	37	10.5
Gwadabawa	37	10.5
Bodinga	36	10.2
Shagari	33	9.4
Gada	32	8.8
Kware	27	8.2
Wamako	30	8.2
Binji	16	5.4
Kebbe	18	4.8
Total	**352**	

TABLE 5. SUMMARY OF FACILITIES ASSESSED DISAGGREGATED BY SERVICES ACROSS LGAs

LGA	Health	Law enforcement	Legal aid	Social support	Temporary shelter	Economic empowerment livelihood	Total assessed in the LGA
Binji	12	0	1	3	0	0	16
Bodinga	30	1	3	2	0	0	36
Dange Shuni	34	0	0	3	0	0	37
Gada	28	1	1	2	0	0	32
Gwadabawa	34	0	1	3	0	0	38
Illela	41	1	2	2	0	0	46
Kebbe	14	2	0	2	0	0	18
Kware	20	0	1	6	0	0	27
Shagari	23	1	0	7	0	1	32
Sokoto South	26	2	4	7	1	0	40
Wamako	22	2	0	6	0	0	30
Total	**284**	**10**	**14**	**43**	**1**	**1**	**352**

SOURCES OF FUNDING

As Table 6 shows, the Nigerian government was the primary source of funding for services across all facility types. Other funders were foreign governments, international organizations, private donors, fee for service, and other sources.

TABLE 6. FACILITY SOURCE OF FUNDING

Funding source	Number of facilities	Percentage
Nigerian government	311	88.4
Foreign governments	2	0.6
International organizations	43	12.2
Private donations	23	6.5
Fee for service	17	4.8
Other (Planned Parenthood Federation of Nigeria, Ward Development Committee, National Health Insurance Scheme, Dangote Foundation)	20	5.7

DISTRIBUTION OF AGE GROUPS SERVED BY FACILITIES

As Table 7 shows, most of the facilities visited serve both adults and children. This finding aligns with interview responses, for example,

"Children that range 6–15 and 18 above. We deal with all age" —Stakeholder IDI (Ministry of Health)

"All age ranges of survivors. Failure to address their issue entails significant cost for the future."
—Psychosocial support IDI

TABLE 7. AGE GROUPS SERVED BY FACILITIES

Age group	Number of facilities	Percentage
Only adults (18 and over)	48	13.6
Only children (under 18)	2	0.6
Adults and children	302	85.8
Total	**352**	**100**

FACILITY HOURS AND DAYS OF OPERATION

Of the 352 facilities visited, 198 (56.2 percent) operate 24 hours a day, seven days a week. Most of the 154 organizations that do not operate 24/7 are open during the week (see Table 8). Seven of every 10 facilities visited indicated that they operate only on weekdays; a much smaller number include weekends.

TABLE 8. DAYS OF OPERATION FOR FACILITIES NOT OPERATING 24/7

Days open	Number of facilities	Percentage
Monday	154	100
Tuesday	153	99.35
Wednesday	152	98.70
Thursday	148	96.10
Friday	149	96.75
Saturday	79	51.30
Sunday	41	26.62

FORMS OF GBV ADDRESSED

Table 9 shows the forms of GBV addressed in the 352 facilities visited during the mapping exercise. As the table shows, more than half of these facilities addressed IPV and physical assault, but less than 30 percent addressed violence against children or early child bearing, and only slightly more than 10 percent addressed female genital mutilation.

Interview data, which revealed the perceptions of community members and service providers on manifestations of GBV in the area, mostly aligned with the facility data. The question, "What forms of GBV do you think occur the most around here?" received the following responses:

- "Intimate partner violence" —Health worker IDI
- "Rape, child abuse, and intimate partner violence" —Stakeholder IDI
- "Ok, another form of violence that is common again in this community is rape, but not also often than the previous ones that have been mentioned by my co-participants." —Female FGD
- "Physical abuse, violence against children, and financial abuse" —Community leader IDI
- "Intimate partner violence . . . physical abuse, emotional abuse, and psychological abuse." —Psychosocial support IDI

TABLE 9. FORMS OF GBV ADDRESSED IN FACILITIES VISITED

Form of GBV	Number of facilities	Percentage
Intimate partner violence	218	61.9
Physical assault	214	60.8
Sexual violence (rape, sexual assault)	151	42.9
Early marriage	118	33.5
Violence against children (including physical or sexual abuse of children)	104	29.6
Early child bearing	99	28.1
None	37	10.5
Female genital mutilation	36	10.2
Total	**352**	

POLICIES, PROTOCOLS, AND STANDARD OPERATING PROCEDURES

Table 10 shows the number of facilities that responded that they deliver GBV services according to policies, protocols, and standard operating procedures (SOPs), as well as the number of facilities that could present the relevant documents. These findings suggest that most service providers in the visited facilities were not guided by any policies, protocols, or SOPs on the provision of GBV care; rather, staff provide services to GBV survivors based on their own experience.

TABLE 10. AVAILABILITY OF POLICIES, PROTOCOLS, OR STANDARD OPERATING PROCEDURES

	Health facilities (n = 284)	Legal aid organizations (n = 10)	Psychosocial services (n = 14)	Law enforcement agencies (n = 43)	Temporary shelters safe houses (n = 1)	Economic empowerment support (n = 1)
Availability of policies, protocols, or SOPs	91 (32.0%)	7 (70%)	10 (71.4%)	28 (65.1%)	1 (100%)	—
Relevant documents shown	11 (19.3%)	2 (28.6%)	2 (20.0%)	7 (28.0%)	—	—

Table 11 shows the different forms of GBV for which policies, protocols, or SOPs are available at the facilities visited.

TABLE 11. FORMS OF GBV FOR WHICH POLICIES, PROTOCOLS, OR STANDARD OPERATING PROCEDURES ARE AVAILABLE AT THE FACILITY

Form of GBV	Health facilities (n = 284)	Legal aid organizations (n = 10)	Psychosocial services (n = 14)	Law enforcement agencies (n = 43)	Shelters/ temporary housing (n = 1)	Economic empowerment support (n = 1)
Sexual violence (rape, sexual assault)	57 (20.1%)	8 (80%)	9 (64.3%)	28 (65.1%)	1 (100%)	—
Intimate partner violence	91 (32.0%)	9 (90%)	9 (64.3%)	24 (55.8%)	1 (100%)	—
Domestic violence by non-intimate partners	58 (20.4%)	6 (60%)	7 (50.0%)	22 (51.2%)	1 (100%)	—
Early marriage	50 (17.6%)	5 (50%)	7 (50.0%)	11 (25.6%)	1 (100%)	—
Early pregnancy	52 (18.3%)	2 (20%)	5 (35.7%)	6 (14.0%)	1 (100%)	—
Female genital mutilation	12 (4.2%)	2 (20%)	5 (35.7%)	6 (14.0%)	1 (100%)	—

Table 12 shows the reported availability of policies and protocols for prosecuting GBV cases affecting children. It also shows the reported availability of policies and protocols for data collection and management and referrals as well as the availability of forms used to collect patient information.

TABLE 12. AVAILABILITY OF POLICIES AND PROTOCOLS FOR GBV CASES AND DATA COLLECTION

Availability in facilities (N = 352)	Health facilities (n = 284)	Legal aid organizations (n = 10)	Psychosocial services (n = 14)	Law enforcement agencies (n = 43)	Shelters/ temporary housing (n = 1)
Policies and protocols for responding to GBV	43 (15.4%)	8 (80%)	11 (78.6%)	22 (51.2%)	1 (100%)
Policies and protocols for data collection and management	113 (39.8%)	9 (90%)	10 (71.4%)	25 (58.1%)	1 (100%)
Policies and protocols for referrals and coordination	142 (50.2%)	6 (60%)	12 (85.7%)	33 (76.7%)	1 (100%)
Forms for collecting patient information	199 (70.3%)	5 (50%)	14 (100%)	24 (55.8%)	1 (100%)

DATA STORAGE AND PROTECTION

Table 13 shows how GBV data are stored in the 352 facilities visited. Findings revealed that 334, or nine of every 10, service providers only store physical data while only 18 use both electronic and physical storage of data.

The mapping also revealed that although the majority of service providers across all categories (73 percent) store physical data in a secure and locked location (see Table 13), very few (5.1 percent) store electronic data on a password-protected computer.

TABLE 13. DATA STORAGE AND PROTECTION

Method of data storage	Number of facilities	Percentage
Only physical data are stored	334	94.9
Only electronic storage of data	0	0.0
Both electronic and physical storage of data	18	5.1
Physical data stored in a secure and locked location	257	73.0
All electronic files stored on a password-protected computer	18	5.1

CLIENT PRIVACY PROTECTION

As Table 14 shows, the majority of service providers reported that GBV survivors have the right to choose their treatment and/or to refuse treatment. Although approximately seven of every 10 service providers reported sufficient space to ensure GBV survivors' privacy during counseling sessions, only slightly more than 15 percent stated that they do not ask questions about GBV in the presence of another person. The findings suggest that many GBV service providers ensure client confidentiality when attending to GBV survivors.

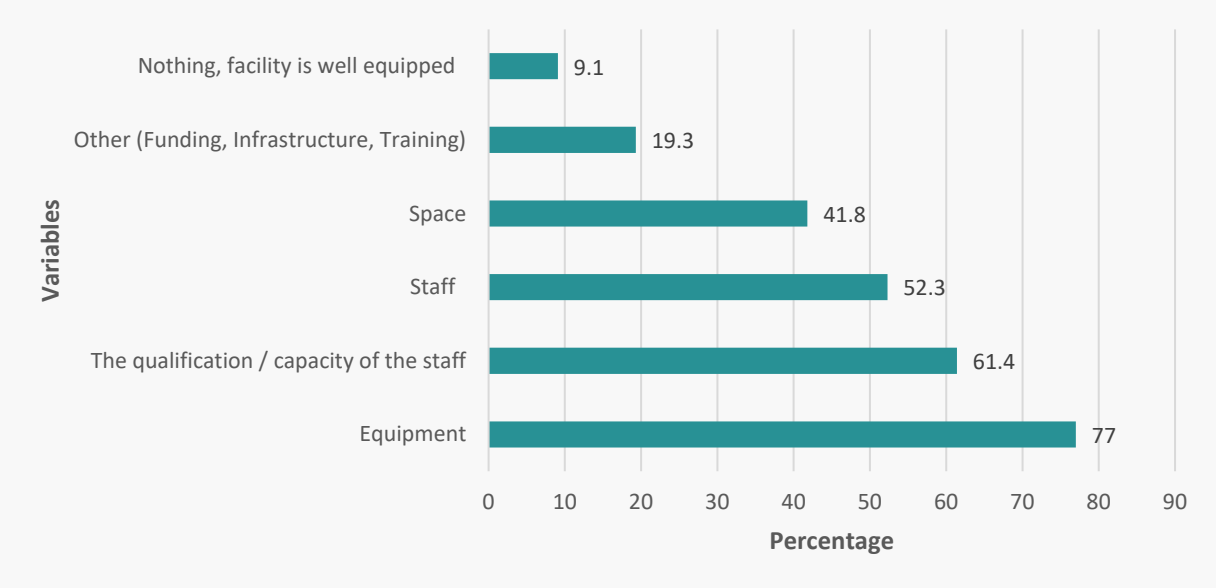
TABLE 14. MEASURES TO PROTECT CLIENT PRIVACY

Protection of clients' personal information	Number (N = 352)	Percentage
Survivors have the right to choose their treatment and/or refuse to be treated	213	60.5
Sufficient space to ensure survivor's privacy	245	69.6
Privacy of survivors during counseling sessions	246	69.9
Ever asked questions about GBV in the presence of another person	55	15.6

REPORTED GAPS IN QUALITY GBV SERVICE PROVISION

Figure 1 shows various gaps in quality care provision for GBV survivors at the facilities visited. More than half of the service providers participating in the mapping exercise cited insufficient equipment, qualifications, or staff to provide quality care for GBV survivors, with less than 10 percent reporting that their facilities are well equipped.

FIGURE 1. FACILITY READINESS TO PROVIDE QUALITY CARE TO SURVIVORS OF GBV (N = 352)



PROVISION OF SPECIALIZED SERVICES

Findings revealed that few of the service providers offer specialized service for persons with disabilities. Only 56 (15.9 percent) of the 352 facilities visited provide specialized services designed or adapted for people with disabilities. More than two two-thirds (243, or 69 percent) of the facilities reported that all staff signed code of conduct documents.

During the qualitative interviews, respondents addressed whether their facilities offered specialized services for people with disabilities:

> "*We provide support to survivors and also give special consideration to people living with disability*." —Stakeholder IDI, LGA Director of Health

> "*The existing services serve both the disabled and the non-disabled survivors in the community; both were being treated equally*." —Health care worker IDI

STAFF CODE OF CONDUCT

As Table 15 shows, although 187 facilities claimed to have a code of conduct, only 21 facilities were able to provide it. Twenty-five percent of the facilities do not have a code of conduct document.

TABLE 15. PRESENCE OF THE STAFF CODE OF CONDUCT IN THE FACILITY

Document status	Number of facilities	Percentage
No, not present	63	25.0
Yes, seen	21	8.3
Yes, did not see	168	66.7

GBV FOCAL PERSON

Findings showed that fewer than 20 percent of the facilities visited have GBV focal persons (see Table 16). The implication is that service providers in the remaining 82.4 percent of facilities are not trained and are thus providing services to the extent that they understand, which may not be in line with standard practice.

TABLE 16. AVAILABILITY OF A GBV FOCAL PERSON

Facility has a GBV focal person	Number of facilities	Percentage
Yes	62	17.6
No	290	82.4
Total	**352**	**100**

REFERRAL SERVICES

A referral directory is a document containing information on where and when services are available and provider details, including contact number and addresses of the facilities. It is a guidance document for service providers that points to the nearest location where services are, hence its importance in GBV service delivery, which usually requires the collective efforts of different services, cannot be over-emphasized. The mapping exercise found that 181 (51.4 percent) of the service providers visited have a referral directory and 171 (48.6 percent) do not.

The facilities visited use various approaches to refer GBV survivors to other services. As Figure 2 shows, verbal referral or referral through phone call dominated other methods across facilities.

FIGURE 2. EXISTING REFERRAL METHODS FOR GBV SURVIVORS (N = 325)

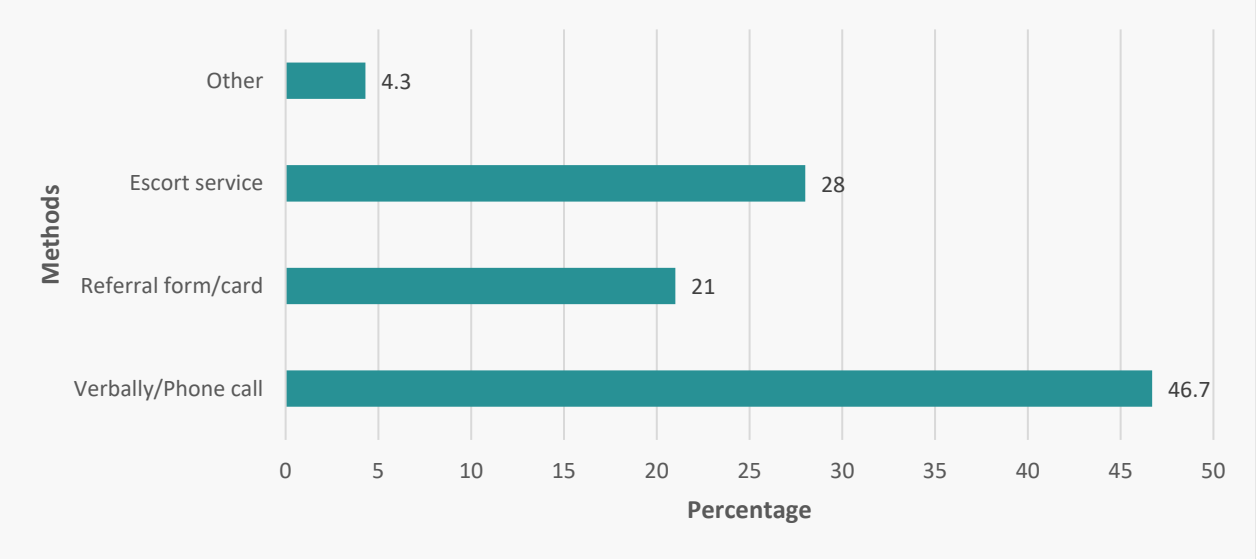


Table 17 shows referral frequency for different services. As the findings show, about 80 percent of facilities always or sometime refer GBV survivors to health facilities. However, only 30 percent always or sometimes refer GBV survivors to law enforcement, fewer than 20 percent always or sometimes refer GBV survivors to psychosocial or legal aid services, and just 6 percent always or sometimes refer GBV survivors to services that provide shelter or economic assistance.

During the interviews, respondents talked about the various referral options that they explored with their clients. Some of these options include referral to hospitals and other care centers:

"*We refer them to NANA Khadija Centre for them to be given proper care.*" —Law enforcement IDI

"*It depends on the case. If it's a rape case, we refer them to NANA Khadija Centre for medical service and if it is violence against any child or child trafficking, we refer them to NAPTIP [National Agency for the Prohibition of Trafficking in Persons], and if it is something that we feel it is the work of the security agency, we advise them to go to the security agency so they can report and do the right thing*." —Legal aid worker IDI

"*Yes, we refer to various services*" —Community leader IDI

TABLE 17. REFERRAL AMONG SERVICES

	Always		Sometimes		Never	
Type of service	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Health facility	166	48.3	112	31.8	74	21.0
Psychosocial services	20	5.7	48	13.6	284	80.7
Police or other law enforcement	44	12.5	61	17.3	247	70.2
Legal aid services	28	8.0	29	8.2	295	83.8
Temporary shelter/safe house	7	2.0	15	4.3	330	93.8
Economic empowerment services	3	0.9	18	5.1	331	94.0
Other services (social welfare, counseling, health structures)	2	0.6	10	2.8	340	96.6

Although 44.4 percent of facilities stated that they update their referral directory every six month or less and 3.3 percent update it annually, half have never updated their referral directory (see Table 18).

TABLE 18. FREQUENCY OF UPDATING REFERRAL DIRECTORY

Directory update (N=180)	**Number of facilities**	**Percentage**
Every six months or less	80	44.4
Every year	6	3.3
More than a year	4	2.2
It has never been updated	90	50.0

FINDINGS BY FACILITY TYPE

HEALTH CARE

TYPES OF HEALTH CARE FACILITIES VISITED

As Table 19 shows, primary health care facilities made up the majority of the 284 health care facilities mapped across the 11 LGAs, with far fewer secondary, tertiary, women's, and other health care facilities.

TABLE 19. TYPE OF HEALTH FACILITY MAPPED

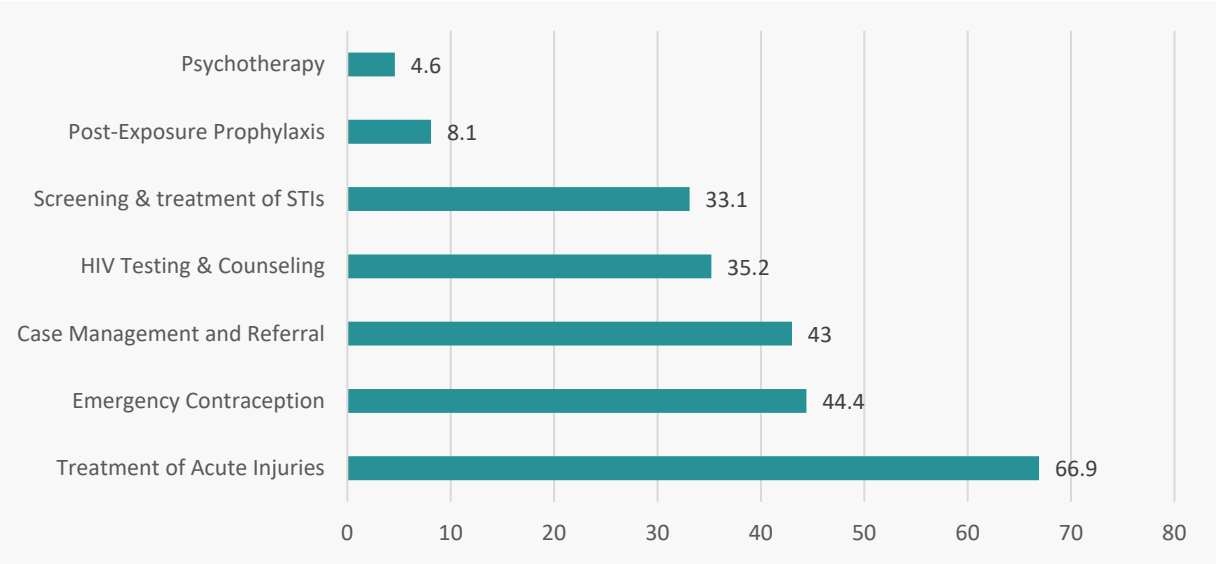
Types of facility	Number of facilities	Percentage
Primary health care facility	250	88
Secondary health care facility	13	4.6
Tertiary health care facility	2	0.7
Center for women	1	0.4
Other	18	6.3
Total	**284**	**100**

PROVISION OF MINIMUM PACKAGE OF CARE TO GBV SURVIVORS

According to the WHO GBV quality assurance tool for sexual assault, the standard minimum package of services that should be available in a typical health facility includes: HIV PEP (within 72 hours of sexual assault), emergency contraception (within 120 hours of sexual assault), HIV testing and counseling and testing and linkage to treatment, sexually transmitted infection (STI) testing and treatment, treatment of acute injuries, basic psychosocial counseling, and referrals to other services as appropriate (police, legal, shelter, economic empowerment, child protection, and community-based support organizations). Only one (0.4 percent) of the mapped health facilities met the criteria.

In terms of provision of specific subcomponents of the services, as Figure 3 shows, about two-thirds of the health facilities assess and treat injuries, fewer than half provide emergency contraception or case management and referral, and about one-third offer HIV testing and counseling services and screening and treatment of STIs (see Figure 3). Less than 10 percent provide PEP or psychotherapy.

FIGURE 3. FACILITIES PROVIDING MINIMUM CARE PACKAGE FOR GBV SURVIVORS (N = 284)

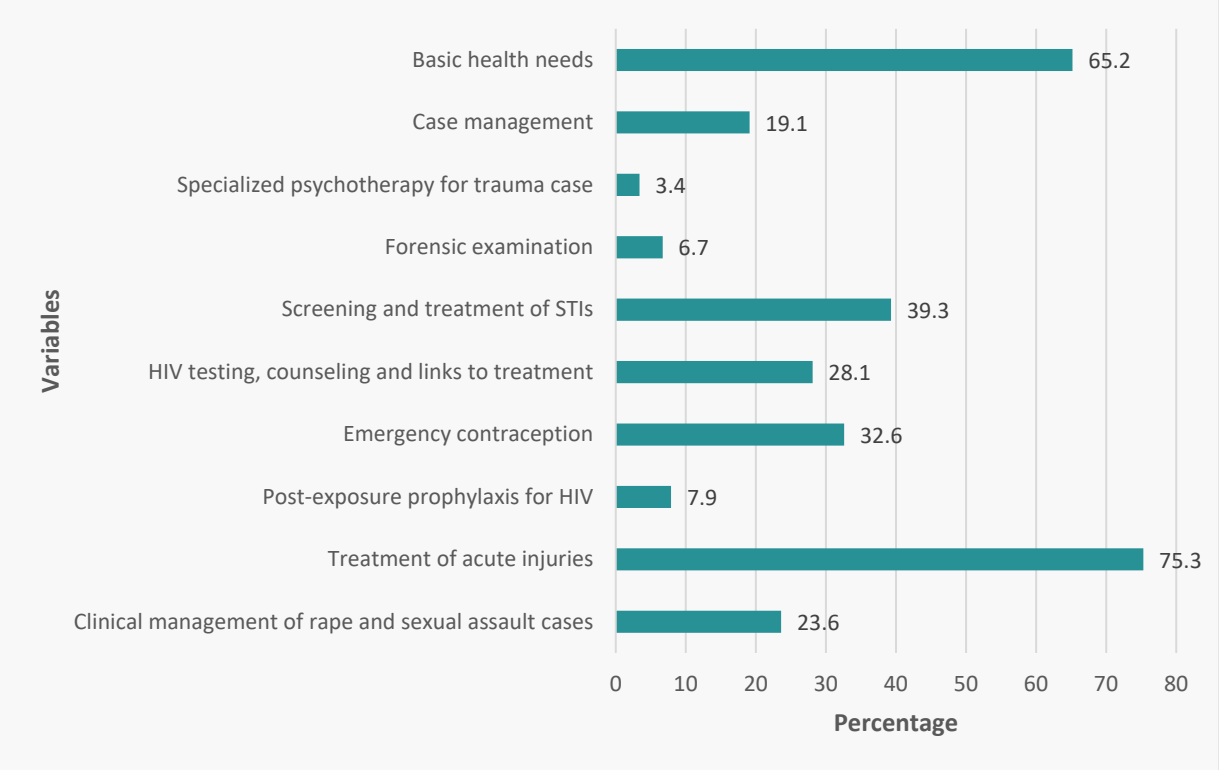


PAYMENT FOR HEALTH SERVICES

Most services provided at the health facilities are free, with fewer than one-third (89) reporting that GBV survivors pay for services received. Of the 195 facilities offering free services to survivors of GBV, 140 (71.9 percent) require clients to meet eligibility criteria, such as demonstrating that they cannot pay for health services. The remaining 55 (28.1 percent) do not require clients to meet eligibility criteria.

Among the services requiring payment by the client, treatment of acute injuries (75.3 percent) and basic health needs (65.2 percent) were the most common (see Figure 4). Few health facilities charged clients for PEP (7.9 percent), forensic examination (6.7 percent), or specialized psychotherapy for trauma (3.4 percent).

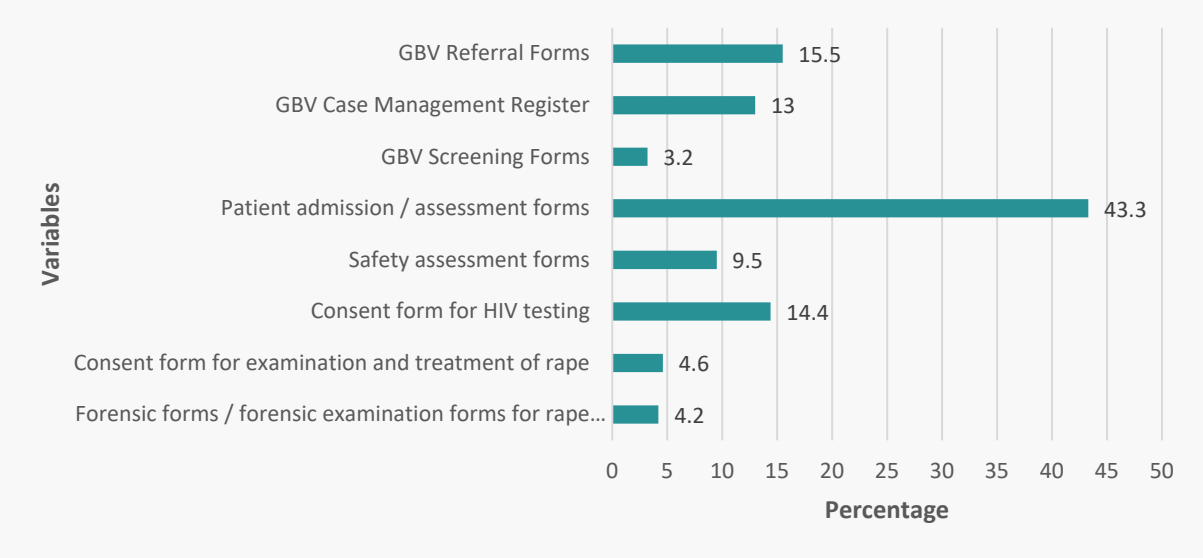
FIGURE 4. TYPES OF SERVICES REQUIRING PAYMENT IN FACILITIES THAT INDICATED THAT PAYMENT MUST BE MADE



AVAILABILITY OF DOCUMENTATION

Although more than half (53.5 percent) of the health facilities visited reported availability of health forms, findings revealed that few had the full range of health forms related to treatment of GBV survivors, such as GBV referral and screening forms (15.5 and 3.2 percent, respectively) and consent forms for HIV testing (14.4 percent) and examination and treatment of rape (4.6 percent) (see Figure 5).

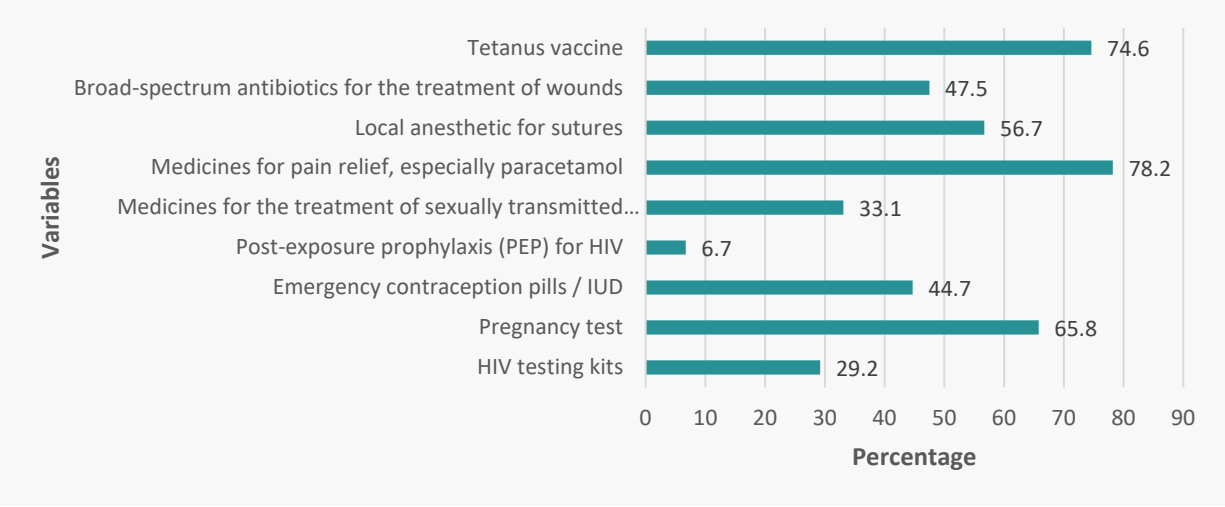
FIGURE 5. AVAILABILITY OF FORMS RELATED TO GBV AT HEALTH FACILITIES (N = 284)



AVAILABILITY OF MEDICINES AND ESSENTIAL HEALTH SUPPLIES

Most health care facilities reported having medicines and essential supplies available. Figure 6 shows the percentage of health facilities reporting availability of certain medicines and essential supplies. More than half reported having medicines for pain relief (paracetamol), tetanus vaccine, pregnancy tests, and local anesthetic for sutures, while fewer than half of the facilities reported supplies of broad-spectrum antibiotics, emergency contraception pills, drugs for treating STIs, HIV testing kits, and PEP.

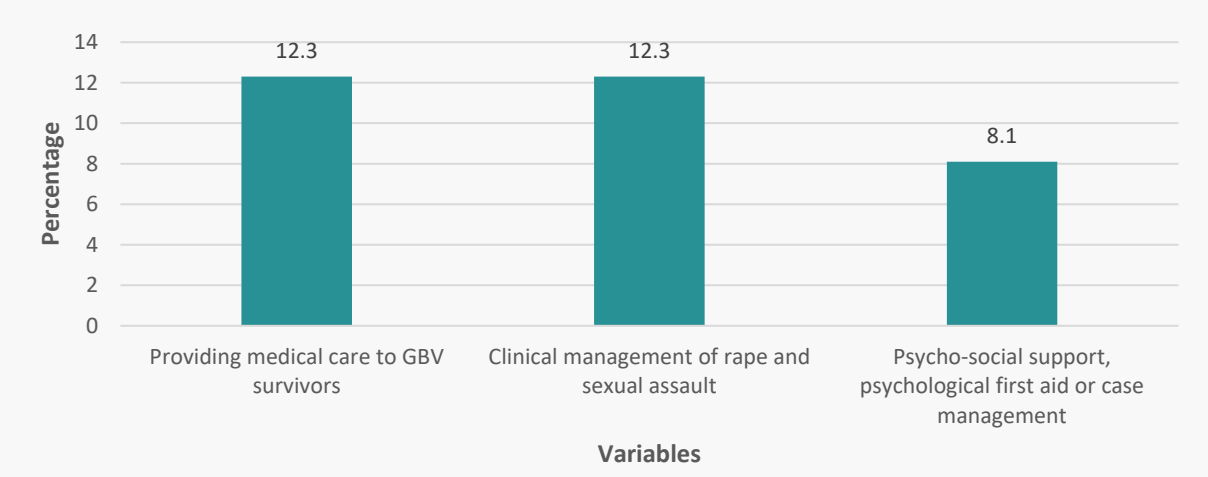
FIGURE 6. COMMODITIES AND SUPPLIES READILY AVAILABLE IN HEALTH FACILITIES (N = 284)



AVAILABILITY OF TRAINED HEALTH CARE PROVIDERS

Findings showed a low proportion of GBV-trained providers in the health care facilities visited, with only 12.3 percent of facilities having staff trained to provide medical care to GBV survivors or clinical management of rape and sexual assault, and just 8.1 percent with staff trained to provide psychosocial support or case management (see Figure 7).

FIGURE 7. AVAILABILITY OF TRAINED HEALTH CARE PROVIDERS (N = 284)



LAW ENFORCEMENT

SERVICES PROVIDED

Law enforcement agencies, such as police and the NSCDC, provide a range of services to GBV survivors. As Figure 8 shows, of the 43 law enforcement agencies visited, the majority provide both case investigation and safety/security planning and enforcement to survivors of GBV.

FIGURE 8. SERVICES PROVIDED TO GBV SURVIVORS BY LAW ENFORCEMENT AGENCIES

Only two (4.7 percent) of the 43 law enforcement/security formations visited reported that GBV survivors pay for the services received, with the other 41 (95.3 percent) provide these services at no charge.

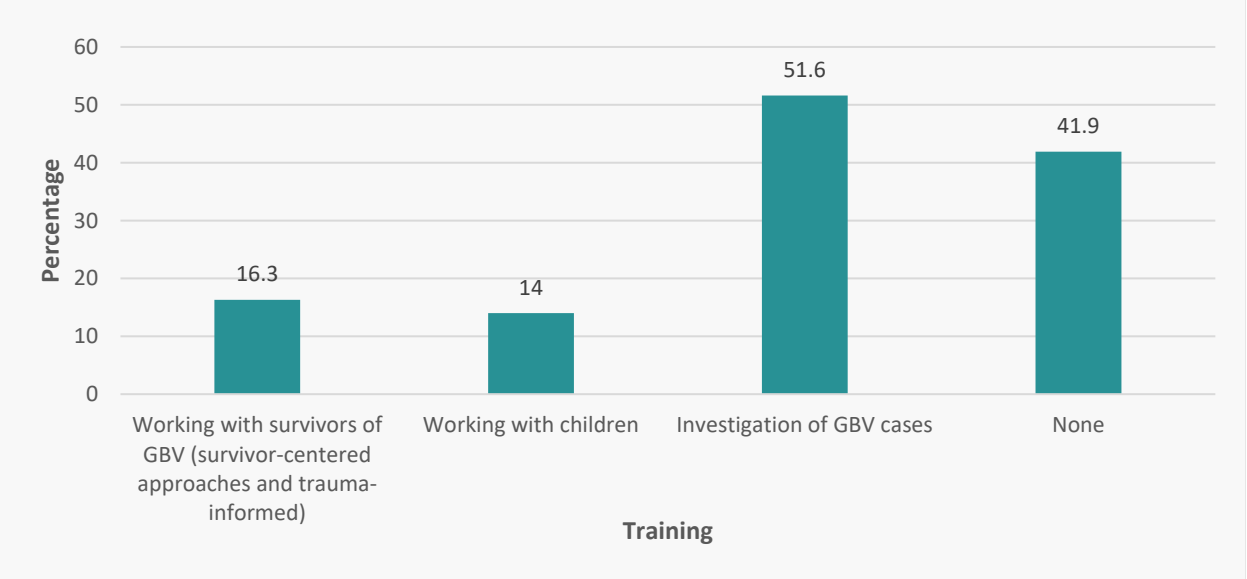
REFERRAL

Of the 43 law enforcement agencies visited, 30 (69.8 percent) refer GBV survivors to other police/NSCDC locations.

AVAILABILITY OF TRAINED LAW ENFORCEMENT OFFICERS

The mapping exercise found that about half of the 43 law enforcement agencies visited have staff trained to investigate GBV cases (see Figure 9). However, far fewer reported having staff trained to work with GBV survivors (16.3 percent) or children (14 percent). More than 40 percent have no staff trained to provide GBV-related services.

FIGURE 9. AVAILABILITY OF STAFF TRAINED TO PROVIDE GBV-RELATED SERVICES



AVAILABLE RESOURCES FOR INVESTIGATION

Table 20 shows the resources available at different law enforcement/security facilities. Less than half reported that vehicles are available, and about a quarter reported having motorbikes available for use in investigations.

TABLE 20. RESOURCES AVAILABLE AT LAW ENFORCEMENT/SECURITY AGENCIES

Resources available	Number of facilities	Percentage
Vehicles	20	46.5
Motorbikes	10	23.3
Fuel	1	2.3
Other	12	27.9
Total	**43**	**100**

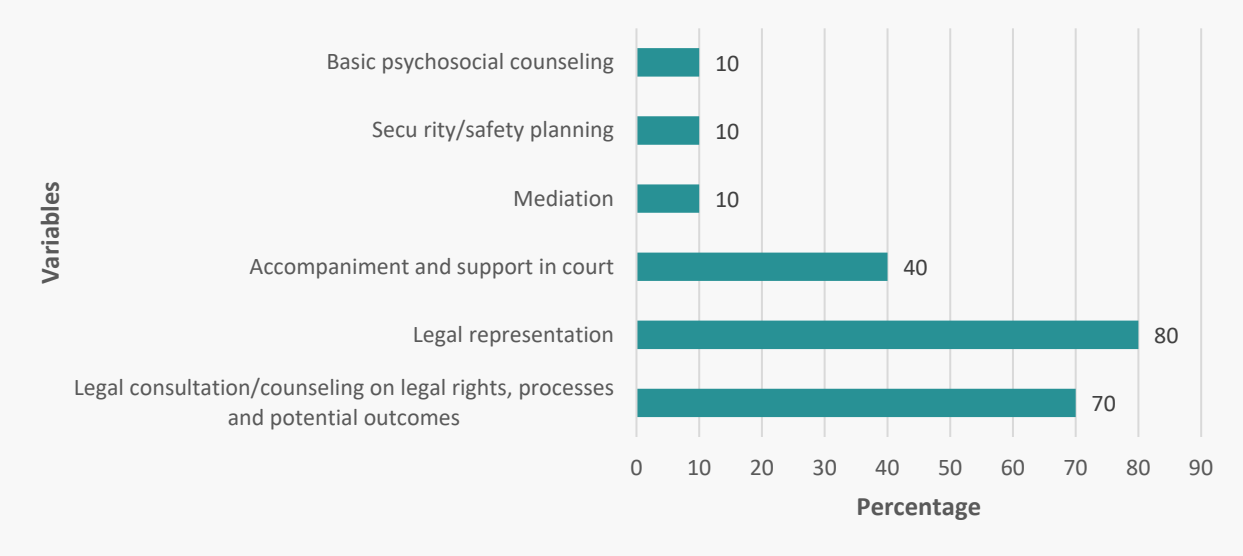
FOLLOW-UP WITH SURVIVORS

There was an almost even split between law enforcement agencies/security providers that do and do not contact GBV survivors for follow-up and to ensure their well-being, with 22 stating that they do follow up with survivors of GBV and 21 stating they do not.

LEGAL AID SERVICES

Figure 10 shows that the majority of the 10 legal aid organizations visited provide legal representation and consultation/counseling on legal rights and processes to survivors of GBV. Other legal aid services provided are security/safety planning, accompaniment and support in court, mediation, and basic psychosocial counseling.

FIGURE 10. AVAILABLE SERVICES AT LEGAL AID ORGANIZATIONS



Three of the 10 legal aid organizations require survivors of GBV to pay for services; the remaining seven do not require payment. All three of the organizations that charge for services require survivors of GBV to pay for legal consultation or counseling on legal rights, processes, and potential outcomes; two require payment for legal representation, accompaniment, and representation in court; and two for security/safety planning.

If the legal aid organization does not have enough resources to investigate a case, they may close the case, transfer the case to another organization, or ask the GBV survivor to pay (see Table 21).

TABLE 21. ORGANIZATION RESPONSE TO HAVING INSUFFICIENT RESOURCES TO INVESTIGATE OR FOLLOW UP ON A CASE

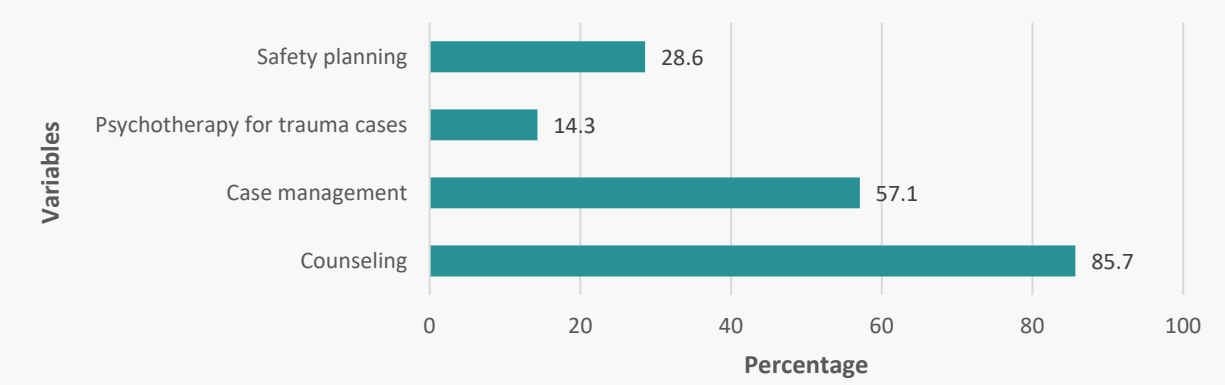
Response	Frequency (n=10)	Percentage
Close the case	1	10
Transfer the case to another organization	4	40
Ask the survivor to pay	3	30

PSYCHOSOCIAL SUPPORT

SERVICES PROVIDED

Fourteen of the 352 facilities assessed provide psychosocial support services for GBV survivors. The majority provide counseling to GBV survivors (85.7 percent), and more than half (57.1 percent) offer case management. Other services provided to survivors of GBV include safety planning (28.6 percent) and psychotherapy (14.3 percent) for trauma cases (see Figure 11).

FIGURE 11. SERVICES AVAILABLE FOR GBV SURVIVORS AT PSYCHOSOCIAL SUPPORT ORGANIZATIONS



NUMBER OF SURVIVORS BENEFITING FROM PSYCHOSOCIAL SERVICES

Findings showed that 594 GBV survivors have benefited from services at the 14 psychosocial support organizations. However, the number of GBV survivors benefiting per facility varied widely, from zero at four facilities to more than 200 at two facilities (see Table 22).

TABLE 22. NUMBER OF SURVIVORS WHO HAVE BENEFITED FROM PSYCHOSOCIAL SERVICES AT THE 14 VISITED ORGANIZATIONS IN THE PAST SIX MONTHS

Number of survivors per organization	Number of organizations	Percentage	Total number of GBV survivors benefiting
0	4	28.6	0
1	1	7.1	1
3	1	7.1	3
10	1	7.1	10
11	1	7.1	11
12	1	7.1	12
13	1	7.1	13
36	1	7.1	36
50	1	7.1	50
229	2	14.3	458
Total	**14**		**594**

COST AND CRITERIA FOR PROVISION OF SERVICES

The assessment found that 13 (92.9 percent) psychosocial support organizations provide services to survivors of GBV for free; with only one provider (7.1 percent) reporting that survivors of GBV paid.

As Table 23 shows, some psychosocial support organizations require GBV survivors to meet special conditions before accessing services.

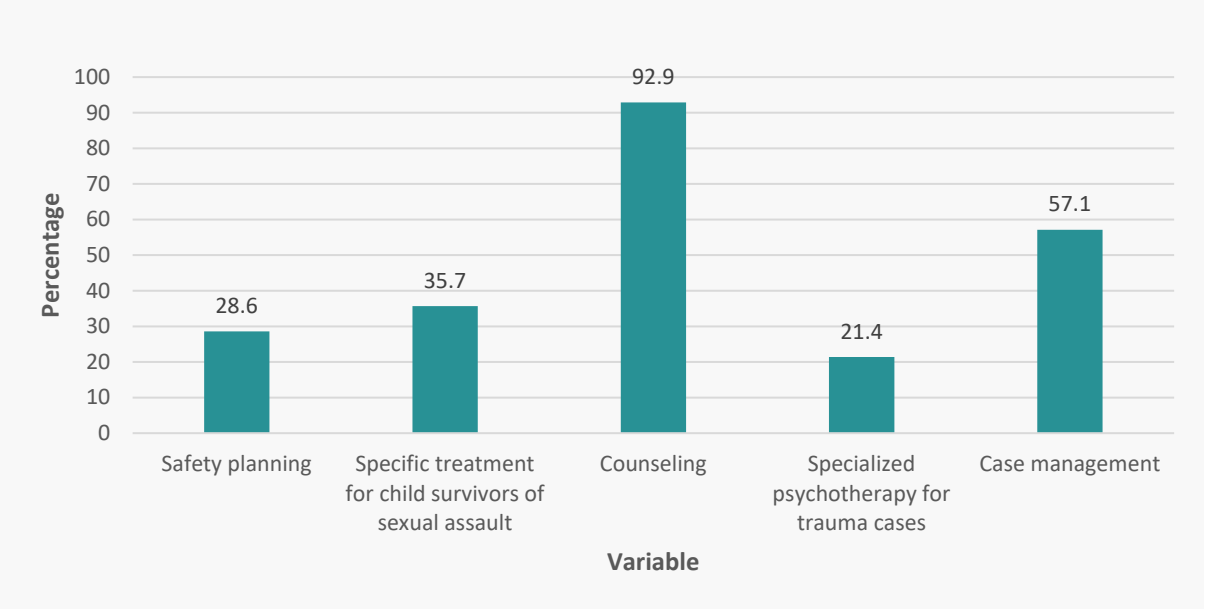
TABLE 23. SPECIAL CONDITIONS TO BE MET TO ACCESS PSYCHOSOCIAL SERVICES

Condition	Number of facilities	Percentage
The client must be assessed and sign terms and conditions.	1	7.1
Depending on the case, a police or law enforcement officer might be required to be present.	1	7.1
Funds are available for filing and investigation.	1	7.1
In most cases, the police or community head must be involved.	1	7.1

AVAILABILITY OF TRAINED STAFF

Psychosocial organizations in Sokoto State have staff trained to provide various services. As Figure 12 shows, the assessment found that most psychosocial organizations (92.9 percent) have staff trained to provide counseling, yet far fewer have staff with training in safety planning (28.6 percent), specialized therapy for trauma cases (21.4 percent), or treatment specific to child survivors of sexual assault (35.7 percent).

FIGURE 12. SPECIALIZED TRAINING RECEIVED BY PROVIDERS IN THE 14 PSYCHOSOCIAL SUPPORT ORGANIZATIONS VISITED

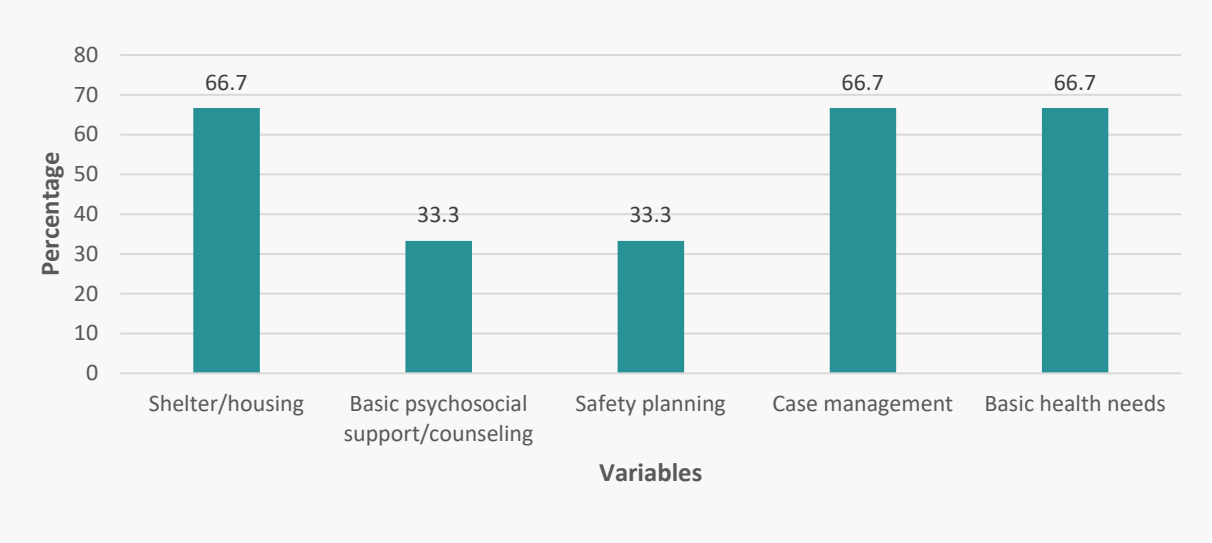


TEMPORARY SHELTER

SERVICES PROVIDED BY TEMPORARY SHELTER FACILITIES

As Figure 13 shows, two of the three temporary shelter providers visited provide shelter/housing, case management, and basic health needs while only one facility provides basic psychosocial/counseling and safety planning to survivors of GBV. Two of the three facilities allow GBV survivors to bring family members to the temporary housing.

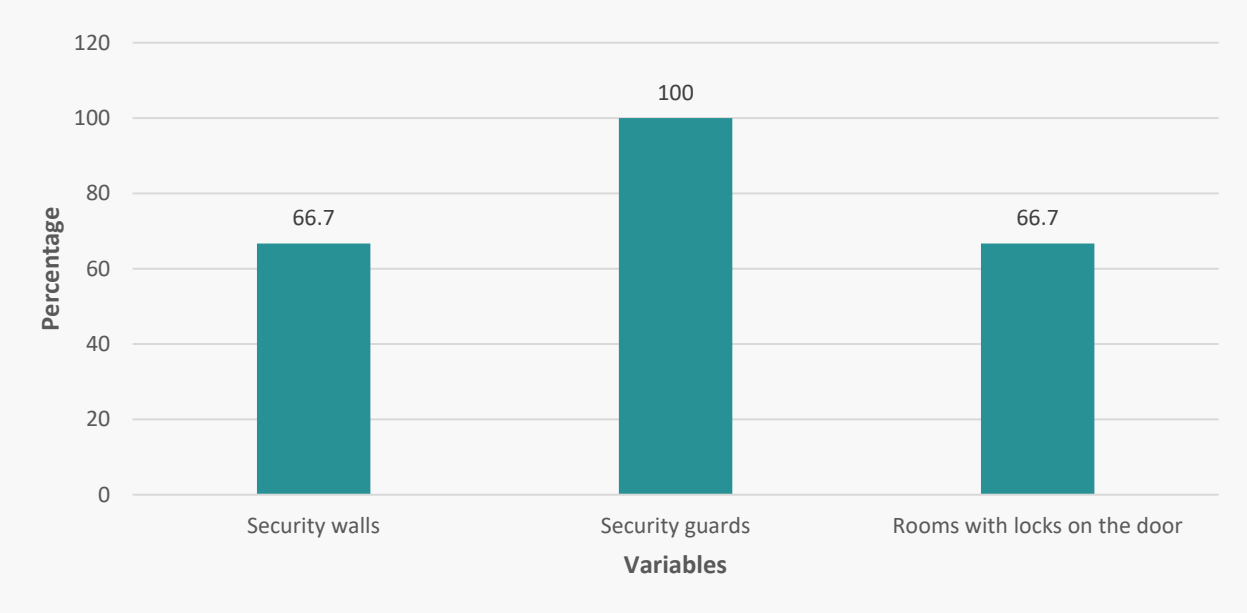
FIGURE 13. SERVICES PROVIDED TO GBV SURVIVORS AT THE THREE TEMPORARY SHELTER FACILITIES VISITED



SPECIALIZED SERVICES FOR CHILDREN

Findings from the mapping revealed that temporary shelter providers take some precautions for children. For instance, two of the three have security walls and rooms with locks on the door, and all the three use security guards (see Figure 14).

FIGURE 14. SECURITY SITUATION OF THE THREE TEMPORARY SHELTER/SAFE HOUSES



AVAILABILITY OF BASIC AMENITIES

Table 24 shows the various amenities offered by the temporary shelter facilities visited. Two offer sanitary/showers, one each offers clothing and electricity, and two facilities offer both electricity and water.

TABLE 24. AMENITIES OFFERED BY THE FACILITY

Amenities	Number of facilities	Percentage
Clothing	1	33.3
Sanitary/showers	2	66.7
Electricity	1	33.3
Both electricity and water	2	66.7

ECONOMIC EMPOWERMENT

The mapping efforts included one facility that provided economic empowerment services. The facility reported that they have the capacity to enroll more women and girls.

The facility provides various services to GBV survivors, including income-generating activities, village savings and loan associations, access to land or land ownership, and cash or in-kind assistance.

HELP-SEEKING BEHAVIOR OF SURVIVORS OF GBV

Respondents described several ways that survivors of GBV can seek help:

- Report to family members: Survivors of GBV can report incidences to a close relative such as a parent or sibling, who will in turn take appropriate action.

  "*The survivor seek help normally from their family members before bringing the case to the community for further actions*." —Community leader IDI

- Report to friends: Survivors of GBV can report their experiences to their friends.

  ". . . from family member's community leaders or friends." —Stakeholder IDI

- Report to community leaders/traditional rulers: Apart from reporting to family members, incidences of GBV are often reported to community leaders, traditional rulers, or religious leaders. These individuals will then take the appropriate steps to address the issue.
- Report to police station/security agencies: Respondents also mentioned that incidences of GBV can be reported to the police or other security agencies. These forces could help in apprehending perpetrators while also providing protection for survivors.

  "*They usually report cases of GBV or any form of violence to any law enforcement*." —Health care worker IDI

  Interviewer: Where do people most commonly seek help when they are exposed to gender-based violence? *"Court and security or law enforcement."*

- Report to health facilities: Survivors of GBV can also report to health facilities, which will provide treatment for possible injuries.

  "*They come to the hospital to make sure everything is alright.*" —Health care worker IDI

BARRIERS TO SEEKING HELP

Respondents identified barriers to seeking help, including the following:

- Acceptance of violence: A significant challenge with GBV is that it is considered a cultural norm in the community. Hence, survivors of GBV do not make efforts to report incidences of GBV or seek help.

  "Because they accept violence as normal." —Community leader IDI

- Lack of funds: Finances were identified as a barrier to seeking help for GBV. Survivors are often unable to visit the appropriate providers because they do not have money to pursue the case.

  "*Stigmatization, and finance to pursue the case."* —Key stakeholder IDI

- Lack of awareness of services: Some survivors are not aware of available GBV services so do not report them.

  "*[S]tigma against [the] survivor is the most barriers they faced in reporting, followed by lack of awareness of services in the community and many other barriers.*" —Health care worker IDI

- Fear of stigmatization: Respondents further mentioned that survivors of GBV were often afraid of being stigmatized and so do not report their experiences. Stigma includes fear that no one will marry the woman or that people will look down on her.

  "*[S]tigma against survivors because when they speak, they will not get married.*" —Law enforcement IDI

- Fear of repercussions: Fear as a barrier may also manifest when survivors of GBV are concerned that the perpetrator may come back to harm them for reporting.

  "*[W]hile those facing IPV barriers include stigma by the family and community, fear of further violence from the perpetrator, feelings of helplessness and insecurity.*" —Stakeholder IDI, LGA Director of Social Welfare Services

- Feelings of shame: Feelings of shame can prevent survivors of GBV from reporting incidences. Hence, they would rather keep the issue to themselves than report it.

  "*Yes, because of shame they would not speak out so they will accept it.*" —Health provider IDI

- Family interference: Some families may prevent the survivor of GBV from reporting the incidence because they are afraid or concerned about the shame it would bring to the family.

  "*[S]ome of them are afraid of stigmatization, family interference while some of them don't know when and where to report or seek care*" —Stakeholder IDI, LGA Director of Health

RESPONDENTS' RECOMMENDATIONS

Respondents offered a number of recommendations that focused on service accessibility and service improvement:

- Create awareness: The most commonly mentioned recommendation for service improvement was to create awareness so people know their rights and what should be done in handling GBV cases.

  "*Awareness of GBV services should be in place so that the survivors will know where to seek for help when they are exposed to GBV in the community . . .*" —Female FGD

- Encourage victims to report: Respondents also recommended encouraging survivors of GBV to report incidences of abuse. Coupled with efforts to create awareness, such encouragement should help ensure that survivors of GBV receive the necessary care.

  "*Create awareness, encourage people to report their cases, . . .*" —Male FGD

- Support for victims: Some respondents mentioned providing support to survivors of GBV, such as support from the government or financial support. Some other respondents suggested that survivors of GBV be empowered through skill-acquisition programs. Counseling services for survivors were also recommended.

  "*Government should provide support to the survivors*." —Male FGD

  "*[E]nlightenment, skill acquisition program and empowering them.*" —Male FGD

- Bring services closer to people: Respondents recommended bringing support services closer to the people. One of the key services recommended was law enforcement. Another noted that well-equipped services should be situated in the community to make access easier.

  "*The law enforcement agency should bring their office here in our community.*" —Male FGD

  "*In my view, there should be at least one GBV center in the community that provides services for GBV survivors with trained or specialized staff that care for survivors of GBV. The facilities should be well equipped with modern equipment in caring for GBV survivors*." —Female FGD

- Establishment of support organizations: Some respondents asked that organizations providing support be established.

  "*We need organizations that help in providing support for survivors.*" —Male FGD

- Provision of psychosocial support: Another recommendation was to make psychosocial support services available for survivors of GBV.
- Provision of medical support: Some respondents asked that medication be made available for emergencies.

  "[P]rovision of medication in case of any emergency." —Male FGD

- Provision of legal aid services.
- Training of service providers: Some respondents recommended training for personnel who provide support services to survivors of GBV.

  "Training and enlightenment to those people who settle these cases." —Male FGD

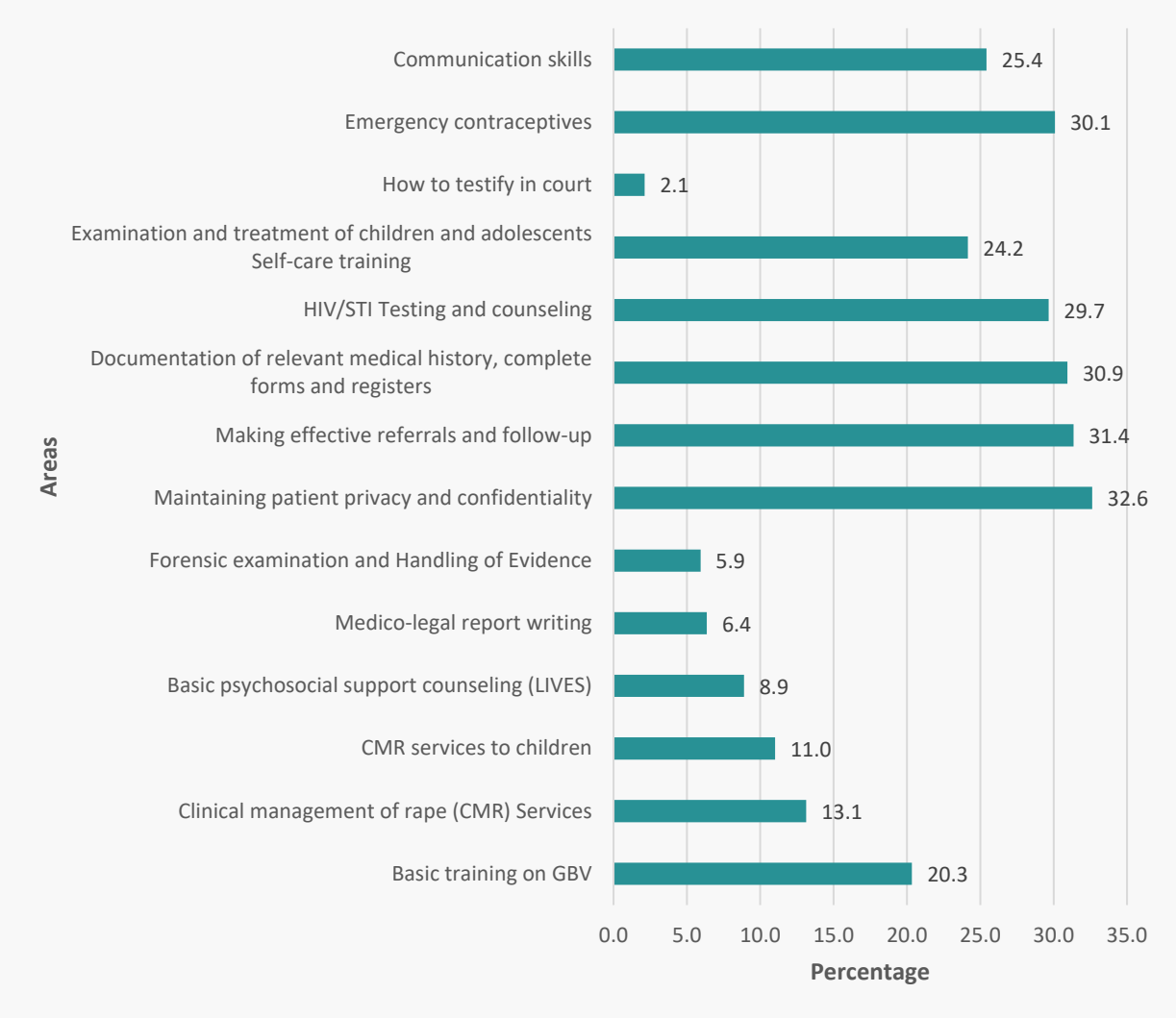
CAPACITY OF SERVICE PROVIDERS

A total of 295 facilities/organizations were visited during the period of the mapping exercise across the 11 LGAs. The health sector had the highest with 80 percent coverage (236 health facilities), law enforcement and legal aid had 13.2 and 3.4 percent, respectively, psychosocial support/economic empowerment had 2.4 percent with seven facilities visited, and temporary housing/shelter home had 1 percent coverage with three facilities visited. Highlighted below are detailed findings from each of the sectors.

HEALTH CARE

Findings from the mapping assessment showed that fewer than one-third of the health care providers have been trained on the provision of post-GBV care (see Figure 15 for the range of services with percentages of trained health care providers). Specifically, 32.6 percent of the health care providers reported having been trained on maintaining patient privacy and confidentiality. This was closely followed by training on making effective referrals and follow-up (31.4 percent), documentation of relevant medical history (30.9), emergency contraceptives (30.1 percent), and training on the provision of HIV/STI testing and counseling (29.7 percent). About one-fourth of the health care providers have received training on communication skills and examination and treatment of children and adolescents self-care; and one-fifth have received basic training on GBV. The findings suggest that a large number of health care providers have not received training on the provision of various services likely needed by survivors of GBV.

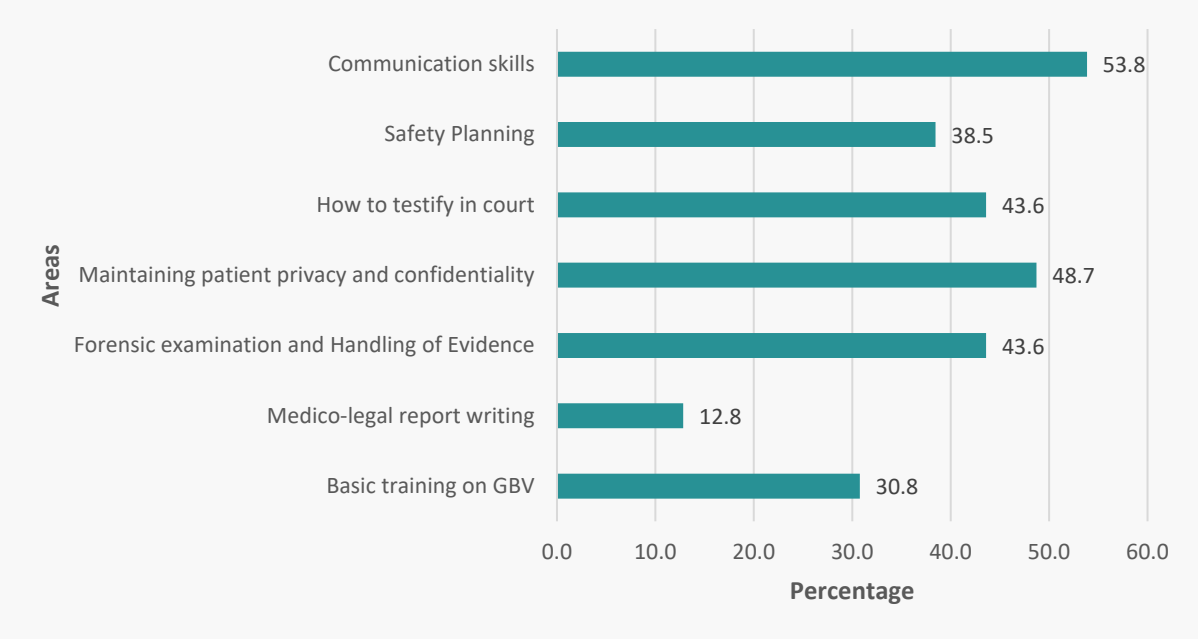
FIGURE 15. PERCENTAGE OF HEALTH CARE PROVIDERS TRAINED TO PROVIDE GBV SERVICES (N = 236)



LAW ENFORCEMENT

As Figure 16 shows, the proportion of law enforcement officers that have received training in key areas needed to prosecute GBV offenders and defend survivors of GBV in the court of law was abysmally low. Fewer than half of the law enforcement officers have received training in important areas such as maintaining patient privacy and confidentiality, forensic examination and handling of evidence, and safety planning. This lack of training makes it difficult for law enforcement officers to render services adequately. The low proportion of trained law enforcement officers reflects wide capacity gaps in the law enforcement sector.

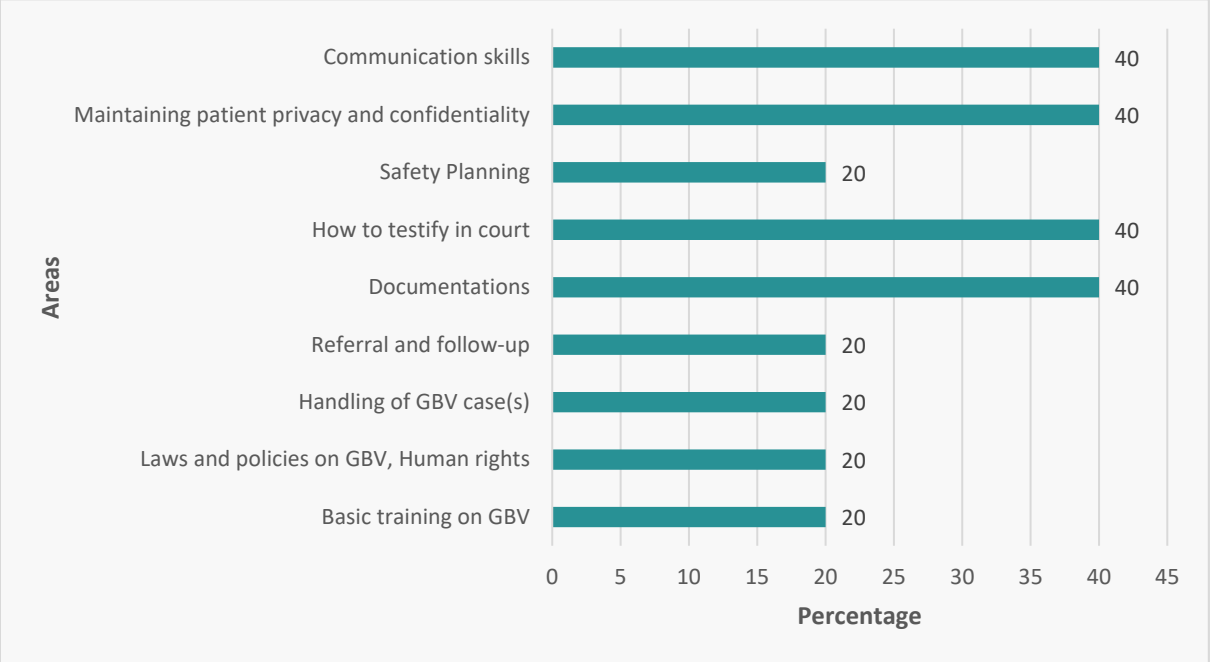
FIGURE 16. PERCENTAGE OF LAW ENFORCEMENT OFFICERS TRAINED ON PROVISION OF GBV-RELATED SERVICES (N = 39)



LEGAL AID

Findings showed that not more than two-fifths of the legal aid providers have received training in all areas (see Figure 17).

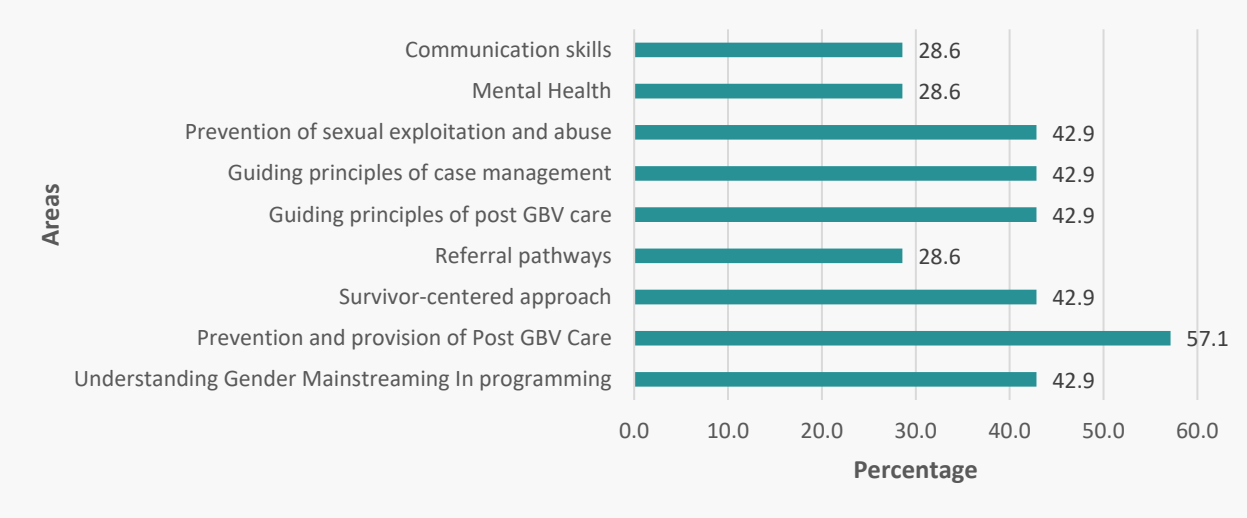
FIGURE 17. PERCENTAGE OF LEGAL AID SERVICE PROVIDERS TRAINED TO PROVIDE GBV SERVICES (N = 10)



PSYCHOSOCIAL SUPPORT

More than half of the providers in the psychosocial support sector have received training on prevention and provision of post-GBV care (see Figure 18); however, fewer than half have received training in most other critical areas for supporting survivors of GBV. The small number of service providers who have received these trainings indicates wide capacity gaps in the sectors.

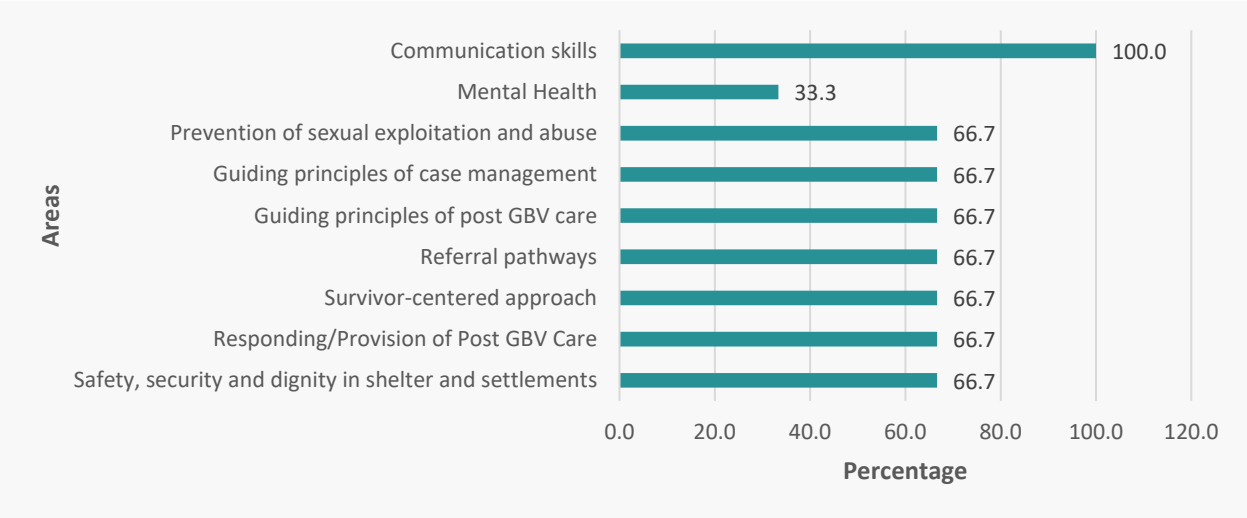
FIGURE 18. PERCENTAGE OF PSYCHOSOCIAL SUPPORT STAFF TRAINED TO PROVIDE GBV SERVICES (N = 7)



TEMPORARY SHELTER

All three temporary shelter providers interviewed received training on communication skills (see Figure 19). However, only two have received training on the provision of other critical services, and only one service provider received training on the provision of mental health care.

FIGURE 19. PERCENTAGE OF TEMPORARY SHELTER/SAFE HOME STAFF TRAINED TO PROVIDE GBV SERVICES (N = 3)



DISCUSSION

The GBV service mapping revealed that Sokoto State has never had a robust and harmonized GBV service mapping across a wide area network at a particular time, nor had a statewide referral directory been developed through primary research. The development of a GBV service referral directory from this mapping is intended to improve coordination between and among facilities within Sokoto State. Research findings show inadequate coordination among local structures that could potentially address GBV in terms of prevention and response within communities. The MOMENTUM approach builds on existing structures and stakeholder collaboration to establish a wider workforce to address GBV and improve efforts to eradicate VAWG.

Government structures, especially at the community level, show a wide gap in service provider capacity and quality service delivery. Sixty-eight percent of the facilities mapped claimed to have certain documents and policies/protocols, but could not provide evidence of such.

Community structures do not appreciate the power of collaboration in their localities, and therefore most referrals are to services within the same sector rather than across sectors. This not only prevents services from being survivor-centered, but also reveals facilities' low capacity to effect referrals and collaborate with facilities outside their sector.

Few facilities have a GBV focal person. This could lead to loss of potential GBV data within the state and impede the response required to address further spread of GBV cases within the state. Even where GBV focal persons are present, they often lack the requisite training and therefore do not function effectively.

The majority of health facilities in rural areas depend on funding from international donors and private vendors for their drug supplies. Thus, few drugs are readily available at the health facilities.

The only sectors that provide two-way referral are health care and law enforcement. Law enforcement agencies also refer survivors of GBV to the court or to legal aid organizations.

The major ministry, department, and agency stakeholders fighting to end GBV within the state include the Ministry of Health, Ministry of Justice, Ministry of Women and Children Affairs, Primary Health Care Development Agency, National Human Rights Commission, Legal Aid Commission of Nigeria, Ministry of Information, and the LGA Social Welfare Departments. Other stakeholders include the International Federation of Women Lawyers, the Spotlight Initiative, the Hisbah Commission, United Nations Population Fund, Planned Parenthood Federation of Nigeria, and CBOs/CSOs. These stakeholders all have a role to play in ending VAWG.

A significant challenge with GBV is that it is a cultural norm in many communities. Other barriers include financial challenges, stigmatization, lack of funding, inadequate awareness of how and where to access services, lack of trust in the service provider, family interference, feelings of shame, and fear of repercussion. Hence, survivors of GBV often do not make an effort to report incidents or seek help.

The most commonly mentioned recommendation for service improvement was to create awareness so that people know their rights and what to do in handling GBV cases.

IMPLEMENTATION CHALLENGES

- Security: Some communities reported security challenges, primarily kidnapping. Some other areas have been victims of banditry. Communities reporting security issues include Damba, Gidan Katta, Kalmalo, Jigawa, Sabon Birnin, Jigili, Jigawa, Shaiwashi, Maikwalpana, Arausaye, and Kunduttu.
- Topography and accessibility: Some communities were difficult to access due to heavy downpours that made the terrain difficult to traverse. Some other areas were hilly, so both difficult and expensive to reach by bike.
- Network issues: Most communities do not have network access; others had poor network coverage, making it difficult to synchronize or communicate with others.
- Multiple visits to one facility: Most RAs had to visit some of the facilities more than once for reasons beyond their control, for example, the health provider was busy or not available to see them.
- Issues with REDcap: Some RAs complained of not being able to sync their data on REDcap after capturing a facility. This made them slow down the data capture for fear of losing data already captured, allow time to rectify issues with the app, and chart the way forward.
- Bulkiness of the tool: There were reports about the bulkiness of the questionnaires. Most respondents claimed they did not have the patience to respond to so many questions since they had other tasks to perform.
- Lack of electricity: Lack of electricity supply in most LGAs and rural communities made it difficult for some researchers to recharge their devices, especially those who spent the night at the LGA due to distance and other security concerns.
- Accessibility: Some respondents were not willing to grant consent, and more time had to be spent to explain the activity and its importance to the community.

RECOMMENDATIONS

The project found that almost all primary health facilities and dispensary health clinics visited across the 11 LGAs lack adequate provisions, equipment, capacity, and experience to provide high-quality GBV services. The project therefore recommends:

- Build capacity of GBV service providers on the methods of identifying GBV cases, provision of first-line support (LIVES), and the minimum package of post-GBV care services for survivors. Capacity-building efforts should cut across sectors.
- Strengthen referral and multisectoral collaboration and coordination by ensuring first responders can meet periodically both at state and LGA levels.
- State actors should ensure that all LGAs in the state have at least one temporary shelter, psychosocial support organization, or legal aid agency.
- All key facilities providing GBV services should adopt a standard protocol or policy for providing care and promote positive social norms to prevent GBV by challenging cultural norms that support IPV, physical assault, and other forms of violence; support a culture of impunity to reduce victim blaming and the social stigma that survivors experience; and promote help-seeking behaviors.
- Explore the possibility of reducing or eliminating client fees for GBV survivors.
- Provide critical infrastructure in key GBV sectors, for example, counseling rooms, consumables in health facilities, secure safe homes, child protection, and economic empowerment support.

REFERENCES

1. U.S. Agency for International Development. 2020. *Desk Review on Gender and Social Inclusion Issues Affecting the USAID Integrated Health Program in Sokoto State, Nigeria*. http://wihersite-a116.kxcdn.com/wp-content/uploads/2021/03/SOKOTO-Full-Gender-Desk-Review.pdf.
2. World Bank. 2019. "Gender-Based Violence (Violence Against Women and Girls)." Brief. Last updated September 25, 2019. https://www.worldbank.org/en/topic/socialsustainability/brief/violence-against-women-and-girls.
3. Okolo, Ngozi Catherine, and Chukwuemeka Okolo. 2018. "PW 0246 Gender Based Violence in Nigeria: A Study of Makurdi Metropolis in Benue State, Nigeria." *Injury Prevention* 24:A99. http://dx.doi.org/10.1136/injuryprevention-2018-safety.273.
4. Nigeria Population and Development: Sokoto State. 2017. Fact sheet. http://www.healthpolicyplus.com/ns/pubs/7149-7285_SokotoRAPIDFactSheet.pdf.
5. Connected Development. 2021. *Policy Brief: Ending Gender-Based Violence in Nigeria*. https://www.connecteddevelopment.org/ending-gender-based-violence-in-nigeria/.
6. Rakiya, A. Muhammad. 2021. "New Anti-rape Law: Fresh Hope in Sokoto's Fight against GBV." *The Guardian*, August 12. https://guardian.ng/features/health/new-anti-rape-law-fresh-hope-in-sokotos-fight-against-gbv/.
7. Vanguard News Nigeria. 2021. "Sokoto Assembly Passes GBV Bill." July 7. https://www.vanguardngr.com/2021/07/sokoto-assembly-passes-gbv-bill/.
8. National Population Commission (NPC) [Nigeria], ICF. 2019. *Nigeria Demographic and Health Survey*. Abuja Nigeria and Rockville Maryland, USA: NPC and ICF International. https://dhsprogram.com/publications/publication-FR359-DHS-Final-Reports.cfm.
9. Hassan, Mairo et al. 2016. "Prevalence and Pattern of Sexual Assault in Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria." *Pan African Medical Journal* 24:332. 10.11604/pamj.2016.24.332.9462.
10. Voices 4 Change (V4C) Nigeria. 2015. *Nigeria Men and Gender Equality Survey (NiMAGES)*. Promundo and UK Department for International Development (DFID). https://promundoglobal.org/wp-content/uploads/2016/03/V4C-Nigeria-Men-and-Gender-Equality-Survey-NiMAGES.pdf.
11. Christian Aid Nigeria, V4C Nigeria, Islamic Relief Worldwide. 2015. *Masculinity and Religion in Nigeria Findings from Qualitative Research*. Abuja, Nigeria: Christian Aid. https://www.christianaid.org.uk/sites/default/files/2017-01/Masculinity-and-Religion-Nigeria-Dec-2015.pdf.
12. Vanguard News Nigeria. 2021. "Sokoto Records 426 GBV Cases, as Stakeholders Decry Delay in Prosecution." May 5. https://www.vanguardngr.com/2021/05/sokoto-records-426-gbv-cases-as-stakeholders-decry-delay-in-prosecution/.
13. Independent Newspapers. 2021. "160 GBV Survivors Benefit From EU-UN Initiative in Sokoto – Commissioner." June 28. https://independent.ng/160-gbv-survivors-benefit-from-eu-un-intuitive-in-sokoto-commissioner/.

www.usaidmomentum.org

@USAID_MOMENTUM
@USAIDMOMENTUM
@USAID MOMENTUM