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TECHNICAL REPORT 2022

LANDSCAPE ANALYSIS OF SEXUAL AND GENDER-BASED VIOLENCE, HARMFUL PRACTICES AND OBSTETRIC FISTULA IN NIGERIA

UNFPA

Landscape Analysis of Sexual and Gender-Based Violence, Harmful Practices & Obstetric Fistula in Nigeria

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AWWDI	Advocacy for Women With Disabilities Initiative
BHCPF	Basic Health Care Provision Fund
CBO	Community-Based Organisation
CDC	Centres for Disease Control & Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEFM	Child Early and Forced Marriage
CRPD	Convention on the Rights of Persons with Disabilities
CSOs	Civil Society Organisations
CWD	Children with Disabilities
EAs	Enumeration Areas
FBO	Faith-Based Organisation
FCT	Federal Capital Territory
FETHA	Federal Teaching Hospital Abakaliki
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FIDA	International Federation of Women Lawyers
FMOH	Federal Ministry of Health
FP	Family Planning
FRED	Foundation Resilient Empowerment and Development
GAC	Global Affairs Canada
GESI	Gender and Social Inclusion
GBV	Gender-Based Violence
GRGN	Gender Roles and Gender Norms
HIV	Human Immunodeficiency Virus
HPs	Harmful Practices
ICF	International Classification of Functioning
ICPD	International Conference on Population and Development
IDI	In-Depth Interview
IHP	Integrated Health Project
IPV	Intimate Partner Violence
KII	Key Informant Interview
LGAs	Local Government Areas
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
MCGL	Momentum Country and Global Leadership programme
MDAs	Ministries, Departments, and Agencies
MDGs	Millennium Development Goals
MSF	Medecins Sans Frontieres
NAP	National Action Plan
NAPTIP	National Agency for the Prohibition of Trafficking In Persons
NAFIC	National Association of Fraternal Insurance Counsellors
NDHS	Nigeria Demographic and Health Survey
NDLEA	National Drug Law Enforcement Agency
NGOs	Non-Governmental Organisations
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NPF	Nigeria Police Force
NPoPC	National Population Commission
NSCDC	Nigeria Security and Civil Defence Corps
NSFEOF	National Strategic Framework for the Elimination of Obstetric Fistula
NSRP	Nigerian Stability Reconciliation Programme
OF	Obstetric Fistula
OHCHR	Office of the High Commissioner for Human Rights
PHC	Primary Health Care
PPS	Probability Proportionate to Size
PWDs	Persons With Disabilities
RMNCAEH+N	Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition
RVF	Recto-Vaginal Fistula
SARC	Sexual Assault Referral Centre
SEM	Socio Ecological Model
SDGs	The Sustainable Development Goals
SGBV	Sexual and Sexual and Gender-Based Violence
SPSS	Statistical Package for Social Sciences
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
STATA	Statistical Software Package
STIs	Sexually Transmitted Infections
SWOP	State of World Population
TBAs	Traditional Birth Attendants
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSCR	United Nations Security Council Resolution
USAID	United States Agency for International Development
VAPPA	Violence Against Persons (Prohibition) Act
VAW	Violence Against Women
VVF	Vesico-Vaginal Fistula
WAVE	Women Against Violence & Exploitation
WEM	Women Empowerment Model
WGWD	Women and Girls with Disabilities
WHA	World Health Assembly
WHO	World Health Organisation
WWDs	Women with Disabilities

TABLE OF CONTENTS

ACRONYMS i
TABLE OF CONTENTS ii
LIST OF TABLES vi
LIST OF FIGURES viii
FOREWORD x
ACKNOWLEDGEMENTS xi
EXECUTIVE SUMMARY xii

CONTEXTUAL BACKGROUND TO THE STUDY 18
1.1 Introduction 18
1.2 Rationale for the Study 18
1.3 Study Objectives 19
1.4 Scope of the Study 19

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK 20
2.1 Literature Review 20
2.1.0 Introduction 20
2.1.1 Harmful Practices 21
2.1.1.1 Social Determinants of HPs 21
2.1.1.2 Knowledge, Attitude, Practices and Behaviour relating to Harmful Practices 22
2.1.1.3 Consequences of Harmful Practices 23
2.1.1.4 Policy Initiatives Curbing HPs in Nigeria 24
2.1.2 Sexual and Gender-Based Violence 25
2.1.2.1 Prevalence of SGBV 26
2.1.2.2 Determinants and Risk Factors of SGBV 27
2.1.2.3 SGBV Survivors' Help-Seeking and Acceptance Behaviours 29
2.1.2.4 Consequences of SGBV 29
2.1.2.5 Policy Initiatives Curbing SGBV in Nigeria 31
2.1.3. Obstetric Fistula 31
2.2 Conceptual Framework for the Landscape Study 34
2.2.0 Introduction 34
2.2.1 Social Ecological Model 34
2.2.2 The Intersectionality Approach 35
2.2.3 The Theory of Change 36
2.2.4 Women Empowerment Model 36
2.2.5 Synthesis of the Models 37

PROCESS AND METHODOLOGY 38
3.1 Background to the Study Location 38
3.2 The Study States 38
3.3 Study Design 39
3.3.1 Quantitative Research Design 39
3.3.2 Qualitative Research Design 41
3.4. Training of Research Team 43
3.5 Ethical Considerations 44

BACKGROUND OF SAMPLED POPULATION & HOUSEHOLD RESOURCES 45
4.0 Introduction 45
4.1: Characteristics of the Survey Respondents 45
4.1.1 Distribution of Male and Female Respondents by Geo-Political Region 45
4.1.2 Household Wealth (Assets) 46
4.1.3 Distribution of Respondents by Age, Religion, Ethnicity, & Residence 46

4.1.4 Marital Status/ Family Type 46
4.1.5 Education and Literacy 46
4.1.6 Occupational Status 46
4.2 Household Resources 49
4.2.1 Sources of Drinking Water 49
4.2.2 Sanitation Facilities 51
4.2.3 Rooms and Sleeping Facilities 52
4.2.4 Source of Energy for Cooking; Materials used for Flooring, Roofing and Walls 52
4.2.5 Household Assets and Ownership 54
4.2.6 Wealth Quintile 54
4.3 Current or Most Recent Partner Characteristics 55
4.3.1 Distribution of Male and Female Partners Characteristics 55
4.3.2 Substance use among males and Females 55
4.3.3 Percentage Distribution of Male and Female Partners' Substance Use 57

GENDER ROLES, NORMS AND PRACTICES 59
5.1 Assessment of Gender Roles, Gender Norms and Practices 59
5.2 Women's Access to wealth, and wellbeing: 63
5.3 Women's right to decision-making and participation 65
5.4 Absolute rights of men over wives' sexual and reproductive health (sexual rights) 66
5.5 Women's Tolerance to Intimate Partner Abuse 69
5.6 Male Supremacy/Male Preference 71
5.7 Composite Scores of Gender Assessment Domains and by Sex 73
5.8 Perception and Attitudes about Gender Roles and Norms 74
5.9 Access to Wealth and Wellbeing 76
5.10 Right to Decision Making and Participation 79
5.11 Women's Sexual and Reproductive Rights 82
5.12 Acceptance of Husband's Use of Violence in Marital Relationships 84
5.13 Human Rights: Male Supremacy and Male Dominance 86
5.14 Overview of Women's Status across Study Sites 88
5.1.4.1 Reasons for the male supremacy ideology: 90
5.1.4.2 Changes in Expectations of Men and Women in their Relationship 92
5.1.4.3 Rewards and Punishments for Deviations from Social and Gender Norms 92

HARMFUL PRACTICES 98
6.0. Introduction 98
6.1 Child Marriage 98
6.1.0 Prevalence of Child Marriage 99
6.1.1 Common Age of Girls at Marriage 103
6.1.2 Age Difference between Girls and Their Spouses 106
6.1.3 Reasons for Marrying Girls off at Tender Age 106
6.1.4 Commonness of the Practice of Early Marriage 108
6.1.5 Decision maker on Marrying the Girl off Early (at <18yrs Old) 110
6.1.6 Conditions Considered as Justifiable for Early Marriage 111
6.1.7 Negative Consequences for Early Girl Child Marriage 115
6.1.8 Changing the Narratives on Early Childhood Marriage in Nigeria 116
6.1.9 Policymakers and Critical Stakeholders Assessment on Child/Forced Marriage 117
6.2 Forced Marriage 118
6.2.0 Female Genital Mutilation 118
6.2.1 Knowledge of the Negative Impact of Female Genital Mutilation 118
6.2.2 Prevalence of Female Genital Mutilation 121
6.2.3 Female Genital Mutilation and the Relationship of the Survivors with the Respondents 121
6.2.4 Types of Female Mutilation (Respondents and Female Children) 122
6.2.5 Age at Mutilation 123
6.2.6 Decision Maker on Respondents' (Women Only) and Men's Daughter's Mutilation 123
6.2.7 Persons Who Performed Respondents' (Women) Mutilation 125
6.2.9 Use of Any Substance or Herb to Tighten or Narrow Vaginal Area Thereby Causing Bleeding 126

6.2.10 Daughter's Mutilation 126
6.2.11 Age of Daughter at Mutilation 128
6.2.12 Persons who performed daughter's mutilation 128
6.2.13 Decision About Daughter's Mutilation: Men's Report 131
6.2.14 Reasons for Female Mutilation 133
6.2.15 Current Practice of FGM Compared to Five Years Ago 135
6.2.16 Factors Promoting the Decline in FGM 136
6.2.17 Opinions about Stopping FGM 137
6.2.18 Agents to Stop FGM 138
6.2.19 Domesticating the Violence Against Persons Acts as an Additional Approach to Addressing FGM 139
6.2.20 Agents Likely to Oppose the End of FGM 139
6.3 Scarification 139
6.4 Virginity Test 139
6.5 Widowhood Rites (Women) 139
6.6 Witchcraft Burning and Accusation 140
6.7 Discrimination Against Vulnerable People (e.g., Persons with Disabilities) 140
6.8 Wife Inheritance Traditions 141
6.9 Surrogate Marriage 141
6.10 Child Marriage: Key Findings and Recommendations Key findings 141
6.11 Forced Marriage: Key Findings and Recommendations 142
6.12 Female Genital Mutilation: Key Findings and Recommendations 142

OBSTETRIC FISTULA 143
7.1 Awareness, Knowledge and Perception of Obstetric Fistula 143
7.2 Perceptions of the Prevalence of Obstetric Fistula 146
7.3 Availability and Access to Treatment and Rehabilitation Services 148
7.4 Prevalence of Obstetric Fistula 149
7.5 Characteristics and Management of the Reported Cases of Obstetric Fistula 150
7.6 Awareness of Interventions to Address Obstetric Fistula 150
7.7 Consequences of Obstetric Fistula 150
7.8 Capacities and Critical Stakeholders for Meaningful Interventions 151
7.9 Policy Blind Spots and Actions Needed to Address Obstetric Fistula 153

SEXUAL AND GENDER-BASED VIOLENCE 155
8.0 Introduction 156
8.1 Definition and Measurement 156
8.1.1 Measures of Economic Violence 156
8.1.2 Measures of Physical Violence 156
8.1.3 Measures of Sexual Violence 157
8.1.4 Measures of Partners' Controlling Behaviour 157
8.2 Experiences of Sexual and Gender-Based Violence 157
8.2.1 Sexual and Gender-Based Violence Cases Commonly Reported 158
8.2.2 Cases of Sexual and Gender-Based Violence Not Commonly Reported 158
8.3 Estimates of Intimate Partners Violence in Nigeria 158
8.3.1 Estimates of Women's Experience of Intimate Partner Violence and Male Partner's Controlling Behaviour 158
8.3.2 Men's Experience of Abuse and Female Partner's Controlling Behaviour 162
8.3.3 Narratives about Causes and Sustaining Factors of Intimate Partner's Violence 163
8.3.4 Network of Contexts and Situations that Support Sexual Rights Violations 164
8.3.5 Factors and Rationale Supporting IPV 166
8.3.6 Actions and Inactions in the Occurrence of Abuse/Violation 168
8.4 Non-Intimate Partners' Sexual and Gender-Based Violence 169
8.4.1 Women's Experience of Physical Violence from Non-Intimate Partners 169
8.4.2 Women's Experience of Sexual Violence from Non-Intimate Partners 170
8.4.3 Perpetrators of Violence Against Women 170
8.4.4 Men's Experience of Physical Violence from Non-Intimate Partners 170
8.4.5 Men's Experience of Sexual Violence from Non-Intimate Partners 171

8.5 Sexual and Gender-Based Violence Against Persons with Disabilities in Nigeria 171
8.5.1 Contexts and Situations that Support Sexual Rights Violations of PWD 172
8.5.2 Critical Stakeholders' Roles in Addressing Sexual and Gender-Based Violence Against PWDs 173
8.6 Covid-19 and Sexual and Gender-Based Violence 174
8.6.1 Changes in SGBV Experience During COVID-19 174
8.6.2 Changes in Women's SGBV Experience During COVID-19 by Background Characteristics 175
8.6.3 Changes in Men's Experience SGBV During COVID-19 by Background Characteristics 176
8.6.4 Partner's Controlling Behaviour During COVID-19 177

SAFETY NETS AND PROGRAMMES FOR CURBING VIOLENCE AGAINST WOMEN IN NIGERIA 179
9.0. Introduction 179
9.1 Awareness of Programmes and Activities on Violence Against Women (VAW) 180
9.2 Awareness of Programmes on VAW by the Respondents' Background Characteristics 182
9.3 Perception of Government's Policy on Rape 182
9.4 Availability of Sanctions for Perpetrators of Violence Against Women at the Community Level 183
9.5 Perceptions of Sanctions Against Perpetrators by Background characteristics 184
9.6 Types of Sanctions Meted out to Perpetrators of Different Kinds of Violence Against Women: 185
9.7 Community Support for Survivors of VAW 185
9.8 The Role of State and Non-State Actors in Curbing Violence Against Women 189
9.8.1 The Role of the Nigerian Police in Curbing Violence Against Women 189
9.8.2 Ministry of Women Affairs 190
9.8.3 Ministry of Justice (Judiciary) 191
9.8.4 Health Workers 191
9.8.5 NGOs/CSOs 191
9.9 National SGBV Strategies 192
9.9.1 Challenges of Implementing the VAPP Acts of 2015 193
9.9.2 Overcoming these Challenges 194
9.9.3 Promoting Help-Seeking Behaviour among Survivors 195
9.10 Key Findings 195
9.11 Recommendations 196

KEY FINDINGS, RECOMMENDATIONS AND CONCLUSIONS 197
10.0 Introduction 197
10.1 Background Characteristics of the Study Sample 197
10.2 Gender Roles, Norms and Practices 197
10.3 Harmful Practices 200
10.4. Obstetric Fistula 203
10.5 Sexual and Gender-Based Violence – Intimate Partner Abuse 207
10.6 Legal and the Policy Environment 208
10.7 State of Interventions/Programmes 208
10.8. Conclusion 213

REFERENCES 216
ANNEXURES 224

LIST OF TABLES

Table 1: Types of Violence Commonly Experienced by Women at Various Phases of the Life Cycle 26
Table 2: Respondents interviewed across geographical location 45
Table 3: Percentage distribution of respondents by selected background characteristics 47
Table 4: Percentage distribution of females (aged 10 - 49) and males (aged 18-64) by marital status and family type 47
Table 5: Percentage distribution of females (aged 10 – 49 years) and males (aged 18-64 years) by education/literacy 48
Table 6: Respondents' occupational status and income 48
Table 7: Source of drinking water 49
Table 8: Sanitation Facilities 51
Table 9: Rooms and sleeping facility 52
Table 10: Source of Power/Energy for Cooking & Materials used for Flooring 53
Table 11: Household Assets and Ownership 54
Table 12: Wealth Quintile 54
Table 13: Percentage Distribution of Male and Female Partners Characteristics 56
Table 14: Percentage Distribution of Respondents by Substance Abuse and by Gender 57
Table 15: Percentage Distribution of Male and Female Partners' Substance Use 58
Table 16: Distribution of Respondents by Gender Roles and Norms 61
Table 17: Distribution of Respondents by Gender Norms and Practices on Access to Wealth and Wellbeing 63
Table 18: Distribution of Respondents by Gender Norms and Practices on Rights to Decision Making and Participation 65
Table 19: Distribution of Respondents by Gender Norms and Practices on Absolute Rights of Men over their Wives' Sexual Rights 67
Table 20: Distribution of Respondents by Gender Norms and Practices on Tolerance of Intimate Partners Abuse 70
Table 21: Distribution of Respondents by Gender Norms and Practices on Male Supremacy 72
Table 22a: Assessment of Gender Norms and Roles 73
Table 22b: Logistic Regression on Gender Norms and Roles 75
Table 22c: Logistic Regression on Women's Wealth and Wellbeing 78
Table 22d: Logistic Regression of Women's Participation in Decision Making 80
Table 22e: Logistic Regression- Women's Sexual Rights 83
Table 22f: Logistics Regression - Intimate Partner's Violence/Abuse 85
Table 22g: Logistic Regression - Male Supremacy and Dominance 87
Table 23: Code-Document Showing the Perceived Prevalence of Childhood Marriage in the Six Geo-Political Zones 101
Table 24: Percentage Distribution Child Marriage and the Relationship of Survivors with the Respondents: Women's Report 102
Table 25: Common Age Girls are Married Across the surveyed Communities 105
Table 26: Reasons for marrying girls off at tender age: Women's report 107
Table 27: How common is the practice of Early Marriage 108
Table 28: Decision Makers on Marrying the Girl Off Early (<18YRS OLD): Women's Report 110
Table 29: Conditions for justifying early marriage: Women's Report 111
Table 30: Are there negative consequences for early girl child marriage 114
Table 31: Percentage Distribution of Men's and Women's Knowledge of Female Genital Mutilation by Background Characteristics 119
Table 32: Decision Maker on the Women's Mutilation 124
Table 33: Persons Who Performed Respondents' (Women) Mutilation 125
Table 34: Any mutilated female children by respondents 126
Table 35: Persons Who Performed Daughter's Mutilation 129
Table 36: Decision Maker on the Daughter's Mutilation: Men's Report 132
Table 37: Reasons for female mutilation: Women's report 134
Table 38: Awareness, Sources of Information and Knowledge of Causes

and Prevention of Obstetric Fistula Among Female and Male Respondents 144
Table 39: Perception of the Prevalence of Obstetric Fistula 147
Table 40: Awareness of Availability of Fistula Treatment/Rehabilitative Services and Barriers to Access 149
Table 41: Distribution of Fistula Repairs in Treatment Centres in Nigeria, 2014 – 2021 149
Table 42: Distribution of Female Respondents by Awareness of Programmes and Activities on Violence Against Women 181
Table 43: Distribution of Male Respondents By Awareness of Programmes and Activities on Violence Against Women 182
Table 44: Distribution of the Female Respondents By Perception of Government's Policy on Rape 183
Table 45: Distribution of Male Respondents by Perception of Government's Policy on Rape 183
Table 46: Interventions for Prevention of Obstetric Fistula in Nigeria 204

LIST OF FIGURES

Figure 1: Risk factors for SGBV 27
Figure 2: Consequences of IPV 30
Figure 3: Integrated Model for Understanding SGBV 34
Figure 4: Social Ecological Model for Explaining SGBV 35
Figure 5: Women Empowerment Model 36
Figure 6: Conceptual Framework for the assessment of Women Empowerment Model in this study 37
Figure 7: Map of States by Geo-Political Zones and Sub-Zones 38
Figure 8: Map of the Study States 38
Figure 9: Proportion of respondents interviewed by gender across the states 46
Figure 10: Percentage of households with improved sources of drinking water by State 50
Figure 11: Percentage distribution of households by sources of drinking water and by residence 50
Figure 12: Improved Toilet by State 51
Figure 13: Percentage Distribution of Men and Women by Composite Assessment of Gender Roles and Gender Norms across Region 60
Figure 14: Percentage Distribution of Men and Women by Composite Assessment of Women's Access to Wealth and Wellbeing across Regions 64
Figure 15: Percentage Distribution of Men and Women by Composite Assessment of Women's rights to decision making and participation across regions 66
Figure 16: Percentage Distribution of Men and Women by Composite Assessment of Absolute rights of men over wives sexual and reproductive health (sexual rights) 68
Figure 17: Percentage Distribution of Men and Women by Composite Assessment of Tolerance to Intimate Partner Abuse (violence) across regions 71
Figure 18: Percentage Distribution of Men and Women by Composite Assessment of Male Supremacy and Dominance by regions 73
Figure 19: Distribution of Men and Women on Perception and Attitudes about Gender Roles and Norms by Regions 74
Figure 20: Distribution of Men and Women on Access to Wealth and Wellbeing by Regions 77
Figure 21: Distribution of Men and Women - Women's Right to Decision Making and Participation by Regions 80
Figure 22: Distribution of Women and Men by Views on Women's Sexual and Reproductive Rights Across Geo-Political Zones 82
Figure 23: Distribution of Men and Women on Husband's Use of Violence in Marital Relationships by Regions 85
Figure 24: Distribution of Men and Women on Human Rights: Male supremacy and male dominance by Regions 87
Figure 25: Network showing the expectations of men and women in marital relationships 91
Figure 26: Men's Reactions to their Wives violations of Social and Gender Norms 94
Figure 27: Women's Reactions to their Husband's violations of Social and Gender Norms 97
Figure 28: Prevalence of child marriage in Nigeria and by geo-political zones 99
Figure 29: Prevalence of child marriage by state 99
Figure 30: Child marriage experience and relationship of the survivors with the respondents 100
Figure 31: Age difference between girls and their spouses 106
Figure 32: Network Showing the Rationale and Context Supporting Early Childhood Marriage 115
Figure 33: Forced marriage experience and the relationship of the survivors with the respondents 118
Figure 34: Prevalence of FGM in Nigeria 121
Figure 35: Prevalence of FGM by ethnic groups 121
Figure 36: Prevalence of FGM by ethnic groups by Zone 121
Figure 37: Prevalence of Female Genital Mutilation by State 121
Figure 38: Female genital mutilation and relationship of the Survivors with the respondents 122
Figure 39: Age at respondents' mutilation 123
Figure 40: Persons who performed daughter's mutilation 128
Figure 41: Decision maker on daughter's mutilation 131
Figure 42: Reasons for female mutilation 134

Figure 43: Current practice of FGM compared to five years ago 136
Figure 44: Factors promoting the decline in FGM 137
Figure 45: Agents to stop FGM practice 138
Figure 46: Agents likely to oppose stopping of FGM 140
Figure 47: Percentage distribution of women who have ever heard of obstetric fistula by state 144
Figure 48: Knowledge of factors contributing to the development of OF 145
Figure 49: Causes of Obstetric Fistula or Vesico-Vagina Fistula 146
Figure 50: Forms of Sexual and Gender-Based Violence prevalent in the study communities 157
Figure 51: Women's experience of economic abuse by intimate partners by zones 159
Figure 52: Women's experience of physical abuse by intimate partners by zones 159
Figure 53: Women's Experience of Sexual Abuse by Zones 160
Figure 54: Women's experience of intimate partners' controlling behaviour by zones 160
Figure 55: Women's experience of Lifetime IPV by State Compared with the National Average..... 162
Figure 56: Triggers of IPV 163
Figure 57: Network Showing Context Supporting Sexual Rights Violations 166
Figure 58: Factors providing rationale and Context for IPV 167
Figure 59: Impact of IPV Injuries among women 167
Figure 60: Reporting of IPV 168
Figure 61: Partner's reaction to violence 168
Figure 62: Women's experience of physical violence from non-intimate partners 169
Figure 63: Women's experience of sexual violence from non-intimate partners 170
Figure 64: Perpetrators of violence against women 171
Figure 65: Effect of COVID-19 on SGBV among women in Nigeria 175
Figure 66: Effect of COVID-19 on SGBV among men in Nigeria 175
Figure 67: Awareness of programmes and activities on violence against women by men and women 180
Figure 68: Percentage distribution of female and male respondents by awareness of programmes on violence against women by states 181
Figure 69: Awareness of Availability of Sanctions for Perpetrators of Violence Against Women in the Community 184
Figure 70: Distribution of Female Respondents by the Types of Sanctions Against Perpetrators of all forms of VAW in the respective Communities..... 185
Figure 71: Specific community support to survivors of IPV 185
Figure 72: Community support to survivors of FGM 186
Figure 73: Community support for survivors of early marriage 186
Figure 74: Community supports for survivors of rape 187
Figure 75: Community Supports to Survivors of Physical Violence 187
Figure 76: Community Support to Survivors of VVF 188
Figure 77: Community Supports to Survivors of Trafficking in Children & girls 188
Figure 78: Community Support to Survivors of Harmful Widowhood Practices 188
Figure 79: Guiding Principles for the Nigeria GBV Framework 192
Figure 80: Enabling frameworks for ending GBV in Nigeria 193
Figure 81: Web of support for GBV survivors 209

FOREWORD

Sexual and Gender-based violence including harmful practices are gross human rights violations under international law. Women and men, girls and boys do experience sexual and gender-based violence but majority of those affected are women and girls. Before COVID, an estimated one in three women in Nigeria have experienced physical or sexual violence over the course of their lives. Yet, it remains largely under-reported and shrouded in a culture of silence and secrecy; undermining women and girls' autonomy, health, dignity and contribution to national development.

In recognition of this, the Government of Nigeria in 2015, enacted the Violence Against Persons Prohibition (VAPP) Act, which prohibits all forms of violence against persons in private and public life, and provides maximum protection and effective remedies for victims and punishment of offenders.

Available evidence indicates that COVID-19 intensified several types of violence against women and girls globally and in Nigeria, earning the label, the "Shadow Pandemic" by the United Nations. In response, the Federal Ministry of Women Affairs in collaboration with development partners and other civil society organizations, led advocacies and awareness campaigns to the Federal and States legislatures for the domestication/passage of the VAPP Act and assent by State Governors, as well as other related Acts, such as the Child Rights Act, and the "Sexual Harassment in Tertiary Education Institution Prohibition Bill." I am glad to note that 34 out of 36 State Governments have assented and are at various stages of implementation of the VAPP laws in their respective states.

The Federal Government of Nigeria remains committed to ending all forms of gender-based violence in Nigeria. This is evidenced in the Declaration of Zero tolerance by President Muhammadu Buhari and the subsequent unanimous declaration of a "State of Emergency" by the 36 States Governors.

I want to appreciate and commend UNFPA and the Government of Canada for this initiative which provides information on the gender-based violence situation in Nigeria post-covid. This situational analysis report, the first of its kind to assess gender-based violence, harmful practices and obstetric fistula in Nigeria, provides deeper insight into the specific risks of sexual and gender-based violence that women, girls and at-risk population groups face, as well as examined effectiveness of existing GBV response and prevention mechanisms at both national and state levels.

The comprehensive analysis report also provides analytical insight into the main factors for the additional vulnerability of women and girls with disabilities, while appraising access to support services for women and girls with disabilities experiencing Gender-Based Violence. The Report further examines how well Nigeria is progressing towards zero tolerance for gender-based violence and provides specific recommendations to stakeholders for addressing gender-based violence, harmful practices and obstetric fistula by 2030.

The National Gender-based Violence, Harmful Practices, and Obstetric Fistula Landscape Analysis report aligns with the objectives of the National Gender Policy (2021-2026); and will definitely be a useful reference document in strengthening our collective efforts and accelerating the paradigm shift toward achieving gender equality and empowering all women and girls in Nigeria.

Finally, I want to reassure all stakeholders of the unrelenting commitment of the Federal Ministry of Women Affairs in fostering an enabling environment for coordination and collaboration across Government Ministries, Departments and Agencies, the Private Sector and local community structures in bringing about transformative change and ending Gender-Based Violence including harmful practices in Nigeria.

Dame Pauline Kedem Tallen, OFR, KSG
Honourable Minister,
Federal Ministry of Women Affairs.
August, 2022.

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- National Human Rights Commission: Ngozi Okore.
- State Ministries of Women Affairs: Falda Wesley (Adamawa), Habiba Ahmad (Sokoto), Esther Patrick (Bauchi), Kazeem Wonuola(Ogun), Akinpelu Funmilayo(Oyo) Olorunfemi Oluwatoyin (Lagos), Ike Jacinta (FCT), Blessing Azubuike (Imo), Joy Irenonse (Edo).
- Non-Governmental Organisations: Lola Ibrahim (WAVE Foundation), Omole Mofoyeke (CEDAW), Ene Ede (Equity Advocate), Susan Ihuoma (AWWDI).
- Academia: John Lekan Oyefara, Adedoyin Ogunyemi.

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Ulla Mueller
Resident Representative,
UNFPA Nigeria.

EXECUTIVE SUMMARY

Context and Objectives

Context:
Sexual and Gender-Based Violence is a global problem with dire consequences on health, social and economic structure and sometimes resulting in death. The scourge of SGBV in Nigeria is very alarming with daily reports in the news media and other outlets. Recognizing the contextual and situational variation of SGBV at national and sub-national levels and the associated risk factors are imperative to guide intervention design. It is in this context that UNFPA Nigeria commissioned this formative research to generate evidence that reflects the realities at national and lower administrative levels to inform the planning of integrated SGBV intervention programmes. With funding support from Global Affairs Canada (GAC), this study is therefore aimed at filling the existing data gaps in SGBV in Nigeria through an initiative that started on the 1st of March 2018 to 30th September 2022. The goal of the project is to reduce the prevalence of sexual and gender-based violence, child, early and forced marriage (CEFM), obstetric fistula, and female genital mutilation, and create enabling environment for the treatment and care of survivors. The research design and implementation plan are aimed at providing evidence-based information to guide the roadmap toward addressing SGBV in Nigeria.

Objectives:
The overall aim of this baseline study is to provide evidence-based information on sexual and gender-based violence, harmful practices and obstetric fistula at national and sub-national levels for programmatic and policy engagement in addressing SGBV in Nigeria. Specifically, the study objectives are to:

- Provide baseline data about SGBV, harmful practices (HPs), and Obstetric Fistula (OF) in Nigeria;
- Identify key drivers (including gender & social norms) and perpetrators of SGBV, HPs, and OF in Nigeria;
- Examine awareness and knowledge on how well Nigeria is progressing towards zero tolerance to SGBV, HPs, and OF by 2030;
- Document strategies and services that survivors use to cope withS GBV, HPs, and OF;
- Map the roles of stakeholders and assess the capacities of those with responsibility for SGBV, HPs, and OF (including parents, the private sector and state institutions; and
- Increase availability of disaggregated data on SGBV, HPs and OF in Nigeria

RESEARCH AND METHODOLOGICAL APPROACH

Extensive Desk Review: The desk review involved an extensive review of some official documents and statistics. Also, some related reports on sexual and gender-based violence in Nigeria were critically reviewed. Key literature and position papers were cited, and detailed bibliography was provided.

Stakeholders' Engagement and Discussions: The methodological design, instrument development, and study protocol were done through consultations and engagement of the National Population Commission, the National Bureau of Statistics, Federal Ministry of Women Affairs, and other relevant state and non-state stakeholders.

Primary Data collection: Quantitative and Qualitative. The study employed a cross-sectional descriptive method using a concurrent mixed method approach for primary data collection and analysis. For the quantitative component, a population-based household survey and a multi-stage sampling method were adopted, and data were collected from a representative sample of 6,353 women of reproductive age group (15- 49 years) and married adolescents less than 15years old, and 3,092 males aged at least 18 years with a response rate of 96.4% and 87% respectively. For the qualitative method, multiple approaches used for the data collection included focus group discussions (FGDs), key informant interviews (KII), case studies, and facility assessments, with the respondents purposively selected to represent key stakeholders and issues of interest. The study was undertaken across the six geopolitical zones of the country in the following 13 states and FCT where the GAC project is being implemented:

i. North-East Zone: Bauchi and Adamawa States
Ii. North-West Zone: Sokoto and Kaduna States
iii North Central Zone: Nasarawa and Kwara States, and the Federal Capital Territory
iv. South-West Zone: Oyo and Ogun States
v. South-East Zone: Ebonyi and Imo States
vi. South-South Zone: Akwa Ibom and Edo States

Critical stakeholders in addressing SGBV issues were interviewed at the state and national levels. Analysis of quantitative data involved nationally weighted data and sub-national disaggregates, while qualitative data were analysed thematically and used to substantiate numerical data.

KEY RESULTS

1. Background Characteristics

Approximately 40.0% of the respondents reside in urban while 60.0% resides in rural areas. About 43.2% of the households were polygamous.

Slightly more than half of the households had no radio (56.5%) and no television (55.9%). The majority of the households (77.8%) did not have a refrigerator and approximately half of the households (49.5%) belonged to the poorest and poorer wealth index.

The mean age of the females was 29 years while that of males was 42 years. About 38.4% of males have at least senior secondary education compared to females (36.8%).

While only 12.1% of the females and 9.6% of the men indicated they have had no formal education, almost half of the women said that they could not read or write (30.9%) or do so with difficulty (16.5%).

Similarly, 23.3% of men reported that they could not read or write, while 28.6% reported doing so with some difficulty.

Employment history shows that more than 9 of every ten men (94.4%) were employed, while 52.3% of the female respondents were employed. Notably, most of the women employed (71.2%) earned less than N15,000 per month, while the average earning for men was between N30,000 and N80,000 per month. Expectedly, 86.2% of the men said they are responsible for the household income, while only 8.8% of the women reported the same

2. Gender roles, norms, and practices

Gender roles, norms, and practices are key drivers of gender role relations and the context of gender violence, exploitation, and abuse.

Generally, most of the women (92.9%) and men (92.6%) expressed androcentric values on gender roles and norms. Their perspectives on other key issue are as follows: female rights to decision-making at family and community levels (73.1% females; 74.6% males); women's reproductive rights (63.5%, females; 52.7% males), tolerance of intimate partner's violence (64.0% female; 66.3% males), and access to wealth and well-being (50.6% females; 51.7% males). Only the views on male supremacy/male preference recorded very low androcentric scores (27.7% females; 37.8% males). Generally, androcentric views were more pronounced among men and women from the northern zones.

Both men and women reflected less androcentric values on women's access to wealth and wellbeing. However, male dominance in decision-making is still pervasive.

As a form of patriarchal hegemonic dominance, intimate partner abuse is entrenched and ingrained in most Nigerian cultures.

Participants believed that gender hierarchy has always existed and will continue to exist, and that like other natural laws, it cannot be altered.

Various forms of sanctions were mentioned for women that violate gender norms and practices.

3. Harmful Practices

Harmful practices consist of values, beliefs, and activities that are enshrined in the everyday life of a people. However, some of these harmful practices are considered sexual and gender-based violence. They include child marriage, forced marriage, female genital mutilation, scarification, virginity test, widowhood rites, and wife inheritance.

Child Marriage

i. Overall, the prevalence of child marriage before the age of 18 years for girls was 25.4%. The prevalence of early marriage ranged from 3.4% in the South West zone to 59.6% in the North East Zone. While Bauchi (71.8%), Sokoto (63.7%), Adamawa (42.4%), and Kaduna (34.8%) states had the highest prevalence.
ii. The majority of the women (88.2%) and men (84.6%) reported that the girls usually married men who are older than them.
iii. The need to prevent premarital sex (44.8%) was the commonest reason given for early marriage. Thus, parents take this proactive step to avert the stigma associated with pregnancy out of wedlock.
iv. Poverty and parents' desire to enjoy financial and social privileges account for most cases of child marriage in the Southern States.
v. Overall, a girl is more likely to marry early if she is from the northern zones of the country, uneducated, Moslem by religion, Hausa by ethnicity, and resides in the rural areas.
vi. Across all the states selected for this study, evidence from the qualitative phase revealed that parents, especially the fathers, are the perpetrators of early childhood marriage where and whenever it occurs.
vii. Over half (55.4%) of the women and 46.9% of the men believed that child marriage has negative consequences.

Female Genital Cutting

i. Not all the respondents were aware of the practice of female genital cutting, 56.1% of the females and 44.6% of the men indicated that they have heard of FGM. Being from the Igbo ethnic group, residing in

the urban area, and coming from the Southeast Zone increased the likelihood of being aware of the practice

ii. The overall prevalence of FGM is 39.7% with 14.6% of the women having experienced FGM, while 5.4% of them reported the same experience for their daughters, suggesting that the practice is on the decline.

iii. About 17.4% of the female and 8.3% of the male respondents had their daughter(s) mutilated, this was more pronounced among women resident in urban (21.3%) compared to rural areas (15.1%).

iv. The prevalence of FGM varied by tribe and zone. It was highest in the Southeast (50.6%), a predominantly Igbo region, followed by the Southwest (32.2%), a Yoruba region, and the North Central (30.5%), where there is a mix of many tribes, with a predominant Yoruba ethnic group in one state.

v. Of the women that reported that they have had FGM, more than half had their external genitalia removed (25.6%) or had only the clitoris removed (26.3%)

vi. Most of the mutilations (48.5%) were conducted by a traditional circumciser.

vii. Both parents participated in the decision to circumcise the girls, except among the Hausas where the father was the sole decision maker, and most of the mutilation was conducted in infancy.

viii. Control of female sexuality to reduce promiscuity and other forms of sexual immoralities due to uncontrollable sexual arousals or desires were the commonly cited reason for the practice.

ix. The general opinion is that the prevalence of this practice is declining because of government policies.

x. Views are changing; the majority of the people surveyed opined that the practice does more harm than good and should therefore be abolished.

4. Obstetric Fistula

Obstetric Fistula (OF) is the worst morbidity that could result from obstructed labour. A major underlying determinant of obstetric fistula is early marriage, which has been identified as a form of SGBV. Despite interventions to curb the menace, Nigeria continues to contribute the highest prevalence to the global OF burden. The study assessed the knowledge, prevalence, consequences of the problem, and ongoing interventions to address the problem. The key findings are:

i. Across the country, the level of awareness of OF is low; only 25.5% of the women and 24.6% of the men have heard of the condition, and the main sources of their information were traditional media (radio & television), friends, and family.

ii. More women (52.2%) exhibited better knowledge of the immediate cause of OF compared to men (33.0%). They identified prolonged obstructed labour as the cause of OF.

iii. Most of the respondents had good knowledge of underlying factors contributing to the development of OF. Early marriage and early onset of childbearing were mentioned as contributing to OF by 68.5% of the women and 63.9% of the men while 68.9% and 74.0% of the women and men respectively identified lack of access to emergency obstetric services as a factor.

Iv. The majority of the respondents did not perceive OF as present in their communities as only a fifth of both male and female respondents mentioned that they have ever heard of OF in their communities.

v. Approximately sixty percent and a quarter of the male and female respondents said that OF does not exist and is rare respectively in their communities, and more than half were not sure whether the trend is on the rise or declining.

vi. The estimated point prevalence of leaking urine among the female respondents was 0.24%. Based on this, it is estimated that there are 114,048 (CI 42, 293 - 147, 312) women with OF.

vii. From the data obtained from the FMOH on repairs conducted at OF centres across the country, at the current rate of repairs, it will take 40 years to clear the backlog of cases.

viii. There was poor knowledge of the availability of OF treatment and rehabilitation facilities as only 11.0% of both female and male respondents indicated awareness of the availability of rehabilitation centres for OF in their states.

ix. The stigma and the resultant ostracisation were the main highlighted consequences of OF.

5. Sexual/ Gender Based Violence: Intimate Partner & Non-Intimate Violence

The unequal status of men and women is the root cause of sexual and gender-based violence, which is a human rights violation. The consequences and implications of intimate and non-intimate partners' violence are damning at the individual, family, community, and national levels. The study sought to determine the prevalence and pattern of sexual and gender-based violence, the drivers and perpetrators, consequences, and responses.

The key findings are:

A. Women's experience of intimate partner's violence

i. Among women aged 10-49yrs, 32.9% have experienced a male partner's controlling behaviour, 12.5% physical violence, 10.1% economic, and 8.6% sexual abuse in the last 12 months preceding the survey.

Ii. Male partners' controlling behaviour was higher in Northern regions (70.3-83.1% in a lifetime and 32.2-54.8% in the last 12 months), compared to the

Southern regions (less than 50.0% in a lifetime and less than 20.0% in the last 12 months). The same pattern applies to other IPVs.

iii. All IPVs are more pronounced among adolescents aged 10-19 years compared to the women at advanced reproductive age 40-49 years.

B. Women's experience of non-intimate partner's violence

i. A higher number of women reported physical violence from non- intimate partners in their lifetime (414, 6.5%) and the last 12 months (69, 1.1%) since reaching age 15, compared to those who reported sexual violence (145, 2.3%) and (12, 0.2%) respectively.

ii. The lifetime physical violence from non-intimate partners since reaching age 15 was highest among cohabiters (12.6%) and lowest among widows (2.4%). This is higher in Nassarawa (11.2%), Edo (11.7%), FCT Abuja (10.9%) and Bauchi (10.9%), but lowest in Oyo, Kwara, and Akwa Ibom (less than 5%).

iii. Sexual violence from non-intimate partners was generally less than 4% across all individual and community groupings except in Edo State (4.4%)

C. Men's experience of intimate partner's violence

i. The most reported IPVs among men were female partners' controlling behaviour (66.9% in a lifetime and 22.3% in the last 12 months) and physical abuse (27.4% in their lifetime and 21.7% in the last 12 months). Less than 10.0% reported other IPVs.

ii. Physical abuse from women was reported most among South-eastern men (58.9%) compared to other regions (less than 26.0%). Male adolescents aged 15-19 had the least prevalence of female partners' controlling behaviour (33.4%) unlike other age groups (55.7-81.0%). However, men of advanced ages 50 years or above had the highest prevalence of physical abuse (24.8-34.7%), unlike the younger ones (below 20%).

D. Men's experience of violence from non-intimate partners

i. Men who reported physical violence (257 ≈ 8.3%) from non-intimate partners were more than those that reported sexual violence (40 ≈ 1.3%) in a lifetime. It was a similar trend and considerably lower in the last 12 months (6 ≈0.2% versus 2 ≈ 0.1%).

ii. Though the physical violence from non-intimate partners was generally low (below 10.0%), it was reported more in the Southeast (24.4%) and North Central (15.9%), with the largest in Imo (30.4%), Nasarawa (28.8%), Ebonyi (12.3%) and FCT Abuja (11.4%).

iii. The adolescents aged 15-19 (20.7%) and elderly aged 65+ years (16.2%), Christian (11.1%), Igbo (20.5%), and the unmarried including divorced/separated, never married, and widowed (10.6-16.8%) men were the most affected compared to other groups (<10%). Sexual violence also followed a similar pattern though with a much lower prevalence.

E. Triggers of IPV

i. The most reported reasons adduced to the precipitation of IPV across the states bordered on five issues ranging from money (29.7%), lack of food (22.5%), issues related to extended families of the female partners (15.3%), views around female partners' disobedience (11.4%), and refusal to have sex (9.4%).

F. Help-seeking

i. 46.4% of women never reported their experience of violence to anyone, 37.7% reported to their parents while 14.0 reported to friends.

ii. 17.4% of men are likely to react violently, 12.0% would vacate their homes while the rage lasts, and about 10.2% would report the case to their partners or their parents.

6. Safety Nets and Programmes for Curbing Violence Against Women in Nigeria

While violence against men does occur, most of the SGBV is targeted at women. . However, the root cause of the problem is the asymmetry in power relations that promote male dominance. Consequently, policies and programmes focus on women.

The key findings are:

i. Nigeria has adopted several global, regional, national, and sub-national legal instruments and policy frameworks that are meant to protect women against sexual and gender-based violence, and more importantly, to allow women and men to have equal rights and opportunities to participate in the development process. However, weak implementation frameworks have hindered the achievement of these policies.

ii. Notable legal instruments and policy frameworks within the Nigerian system include the VAPP Act (2015), which by August 2022 had been adopted by 34 of the 36 states in the country, the revised National Gender Policy 2021 (also adopted by various states and institutions since its first adoption in 2006), and the Child's Right Act (2003). The 2021- 2025 National Development Plan (NDP) stated as one of its goals, the improvement of the gender parity points of the country from 128 Gender Equality Index to 100 and to reduce sexual and gender-based violence cases from 17.4% to 10%. There are other individual state-driven legal instruments and policies on SGBV.

Iii. Despite the many policies and laws on SGBV, the level

of awareness among both men and women of programmes and activities aimed at curbing the menace is very low. Only 6.3% of the female respondents and 5.4% of the male respondents were aware of programmes and activities that addressed issues of violence against women in the country. The majority of the women (72.7%) perceived that at the community level, people are not aware of the government's policy on rape compared to 39.7% of the men. level. More than half of both the men and women said if such a policy exists, it is not working in their communities.

iv. 36.4% of females and 54.5% of males believe that husbands cannot be accused of raping their wives.

V. While the men and women were aware of the sanctions at the community level for rape (44.7% female; 58.5% male), physical violence (29.4% female; 39.6% male), and trafficking of children (23.6% female; 39.6% male), the level of awareness of the sanction for female genital cutting, early marriage, and harmful widowhood practices were abysmally low (less than 10%).

vi. There are limited support at the community level for survivors of violence against women as only 1.2% of the females and 1.9% of the men indicated the existence of such support in their communities.

KEY RECOMMENDATIONS:

The study findings demonstrated that the vulnerability of women and girls to various forms of SGBV is deeply rooted in a culture of male supremacy, which presents men and women, boys and girls, with differential access to power and resources, with men and boys disproportionately benefitting compared to women and girls. The level of awareness of SGBV is low, and interventions if any, are not reaching the primary beneficiaries: women and men. Consequently, the prevention and control of SGBV would require a multi-prong, multisectoral approach involving a diverse group of stakeholders, working at different levels, from the community to national and international levels. Some of the key recommendations to address this problem include the following:

RECOMMENDATION 1

Legislation:
Support Nigeria to domesticate CEDAW in its full form;

Support states that have domesticated the Nigeria VAPP Act of 2015 to set in motion plans/strategies that will fast-track implementation, and advocate to the few states that are yet to domesticate the VAPP Act.

Communities need to be enlightened on the existing SGBV laws and other gender-related policies which protect the interests of women, men, girls, boys, and other vulnerable groups in society, and educate them on the processes of seeking redress against perpetrators of any form of SGBV; and

The provision of legal aid services to survivors and other groups at risk of SGBV.

RECOMMENDATION 2

Develop a Comprehensive Plan for the Prevention of SGBV:
The Ministry of Women Affairs, both at the Federal and State levels should provide leadership in mobilising key MDAs and development partners, notably UNFPA, to develop a comprehensive and holistic implementation plan that combines prevention with comprehensive service delivery that addresses the root and underlying causes driving the various forms of SGBV and gender discrimination. The plan should be costed, and funds mobilised for its implementation. Some key areas for consideration in the development of the holistic plan include:

i. Targeted intervention programmes and strategies that will address some of the root causes including cultural, and religious factors sustaining SGBV across Nigeria societies.
ii. Behavioural Change Communication and literacy education around healthy social behaviour such as avoidance of alcohol and substance abuse, perpetrating IPV in front of children, and attitudes supporting violence.
iii. Improving access and utilisation of life-saving health care services for SGBV survivors including clinical management of rape/sexual violence/assault.
iv. Strengthening the capacity of frontline workers and key stakeholders facilitates lifesaving SGBV response, prevention, and risk mitigation.
v. Strengthening safety-nets and protection of vulnerable women, girls, men, and boys to prevent exposure to violence and ensure access to dignified response services.
vi. Enhancing the provision of access to justice for survivors and strengthening individuals at risk of

violence.

Vii. Improving resilience, self-reliance, and (individual and household) livelihoods for survivors and individuals vulnerable to violence.

viii. Enhancing knowledge and awareness of communities and other key stakeholders on SGBV protection policies, procedures, and accountability.

ix. Strengthening community-based protection systems to enhance accountability and respond to SGBV cases within conflict-affected communities.

x. Improving national capacity to uphold and adhere to international standards and SGBV protocols.

xi. Strengthening the framework for coordinating multi-sectoral SGBV response and prevention.

RECOMMENDATION 3

Promote Female and Gender Education:

Female education up to secondary school has the potential of empowering girls with knowledge and skills to enhance their agency and increase the horizon of their choices. It will also delay the age of marriage and contribute to reducing the incidence of OF. Strategies to promote the education of the girl-child should be strengthened nation-wide, especially in regions with higher rates of early marriage, higher prevalence of OF, and lower female school enrolment, retention, and completion rates.

The country should be supported to invest in gender education, so that children and adolescents are exposed to symmetrical gender relations both at pedagogical and instructional levels and right from schools.

Provision of vocational skills and livelihood support to women, girls, and boys at risk of SGBV

RECOMMENDATION 4

Increase Awareness and Enhance Systems for the Prevention of SGBV:

Interventions could include:

i. Facilitation of SGBV prevention and response through awareness-raising initiatives.

Ii. Facilitation of community SGBV protection mechanisms and systems.

iii. Support for gender transformative change:
- Patriarchal gender norms and unequal power dynamics between women and men which are the root causes of SGBV in society need to be addressed through deliberate actions and programmes, with men playing highly active roles in this process.
- Address social, cultural, and religious norms, and practices that perpetuate SGBV and other risk factors which increase the vulnerability of women and girls.
- Target social media messaging to address the vulnerability of women and girls, and persons with disabilities.
- Work with men and boys to end SGBV, and reject gender asymmetry behaviours and practices
- Empower women, girls, and other vulnerable groups (especially persons with disabilities) to fight SGBV.

RECOMMENDATION 5

Developing and Implementing a Comprehensive Communication Strategy:

Given the high level of ignorance about SGBV, stakeholders, under the leadership of Federal Ministry of Women Affairs, with guidance from communication experts should develop a comprehensive, segmented, targeted, and costed communication strategy that includes advocacy, social mobilization and behaviour change intervention. The strategy should be inclusive and address the different forms of SGBV.

Government and Development Partners need to invest more in SGBV research and strengthen the Data Bank on SGBV in the country, (with clear and delineated roles for key MDAs, the National Bureau of Statistics, the Police Departments, and local NGOs), and strengthen the monitoring & evaluation system for monitoring progress on ending SGBV.

RECOMMENDATION 6

Specific Interventions to Prevent and Control OF:

Strengthening the primary health care system to ensure women have increased access to safe delivery care under the supervision of a skilled birth attendant, emergency obstetric care services, and family planning services which are key to prevention of OF.

Expanding access to fistula care and rehabilitation services will help clear the backlog of untreated cases and promote their re-integration into society. This will require accelerating implementation of the National Strategic Plan for the Elimination of OF in Nigeria.

CONTEXTUAL BACKGROUND TO THE STUDY

1.1 Introduction

Sexual and Gender-Based Violence (SGBV) is one of the most pervasive and grossly underreported human rights violations, global in scale, and with no social, economic, or physical boundaries. The World Health Organisation (2014) defines GBV as violence directed against an individual based on gender, which results in psychological, physical, economic, or sexual trauma, either directly or indirectly. SGBV is violence rooted in gender inequality, harmful norms, and asymmetry in power relations (Kaitović, 2013; Oliveira, Martins, Dias, & Keygnaert, 2019). Consequently, women and girls constitute most of the survivors of this form of violence, affecting them irrespective of their race, ethnicity, age, socio-economic status, religion, education, or culture. Due to the disproportionately higher prevalence among women, sexual and sexual and gender-based violence, violence against women (VAW), violence against women and girls, and sexual and gender-based violence are used interchangeably (Bradbury-Jones, 2021).

The United Nations (1993) defines violence against women as any act of GBV that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in private or public life, including those perpetrated or condoned by the state. The various manifestations of VAW include, but are not limited to: Physical violence, such as slapping, kicking, hitting, or the use of weapons; emotional abuse, such as systematic humiliation, controlling behaviour, degrading treatment, insults, and threats; sexual violence, which includes any form of non-consensual sexual contact—female genital mutilation is an act of violence that impacts sexual organs and as such is included under this category of violence; forced and early marriage, which is the marriage of an individual against her or his will and marriage before 18 years; and denial of resources, services, and opportunities, also known as economic abuse, such as restricting access to financial, health, educational, or other resources to control or subjugate a person (Anango, 2014). In 1995, the United Nations expanded the definition of violence against women to include: violations of the rights of women in situations of armed conflict, including systematic rape, sexual slavery, and forced pregnancy; forced sterilisation, forced abortion, and coerced or forced use of contraceptives; and prenatal sex selection and female infanticide (Sklavou, 2019). This led to the further recognition of the vulnerabilities of women belonging to minority groups: the elderly and the displaced; indigenous, refugee, and migrant communities, women living in impoverished rural or remote areas, or in detention and among persons with disabilities.

The UN Women (2022a) estimates that globally, an estimated 736 million ever-partnered women aged 15 -49 years, almost one in three, have experienced physical or sexual violence, or both, intimate partner violence (IPV) at least once in their life. Of these acts of violence, current or past husbands/partners perpetrated about 87% of the incidence of violence. VAW is more prevalent in the least developed countries with an estimated prevalence of 37% among women aged 15-49 years, which is higher than the world average of 13% (Sardinha et al, 2022). In Nigeria, the lifetime prevalence of early marriage, female genital mutilation and physical and/or sexual intimate partner violence among women aged 15 - 49 years are 43.8%, 18.4% and 17.4% respectively (UN Women, 2022b). However, the lifetime prevalence of all forms of sexual and physical violence among women in the reproductive age group in Nigeria is 28% and 7% respectively (NDHS, 2018). Nigeria has one of the highest prevalence of child brides in Africa. Early marriage is a risk factor for obstetric fistula. This might be the reason for the country having the highest prevalence of OF in the world. An estimated 13,000 new cases of OF occur every year in the country (FMOH, 2018)

SGBV is a major health and developmental issue with short, long-term, and sometimes generational consequences, as it undermines the health, autonomy, dignity, and security of its survivors The resultant limitation of the full participation of women in socio-economic developmental activities has high social and economic costs for women, their families, and societies. Their children also suffer a range of behavioural and emotional challenges which sometimes result in them experiencing or perpetrating violence in adulthood. In addition to other physical consequences, survivors suffer sexual and reproductive health consequences including unwanted pregnancy, unsafe abortions, fistula, either traumatic or resulting from early commencement of childbearing, sexually transmitted infections, including HIV, and even death.

1.2 Rationale for the Study

The root causes of SGBV in cultures across the world are gender discriminatory norms that promote the subservience of women and male dominance. The latter is preserved and manifests as violence. Also, social norms shape authority as traditionally adult males encourage the use of violence as discipline to enforce authority and control. In addition, there are wider structural and contextual factors that includes weak systems, poor

governance, weak rule of law, deprivations, conflicts and other social determinants like income disparities, unemployment, and limited educational opportunities (Palermo, Bleck, & Peterman, 2014). The explosion in access to unrestricted content on social media further exposes children and other members of the society to bullying and various forms of violence. The educational environment operates within this dynamic and not only does it fail to protect children, exposes them to violence and thus reinforces the gender and social norms in the society (UN Women, 2016). Overall, structural inequalities between men and women, characterised by the misuse of physical, emotional and financial power & control by the perpetrator over the survivor, is the foundation of SGBV. However, many risk factors intersect at individual, family, community, and societal levels that influence susceptibility to SGBV. The socio-ecological model captures all these risk factors (Heise et al., 1999).

In recognition of the contextual and situational variation of the determinants and risk factors for SGBV, a comprehensive analysis at the local level is imperative to inform design of interventions that are responsive. Existing national and sub-national data do not provide detailed and disaggregated information on patterns and dynamics on sexual and gender-based violence including harmful practices, and the relationship and impact on gender equality and societal cohesion. It is in this context that UNFPA Nigeria with funding from Global Affairs Canada, commissioned this formative research to generate evidence that reflects the realities at national and lower administrative levels to inform the planning of integrated SGBV, harmful practices (HPs) and OF programmes. In order to address and end SGBV, HPs and OF in Nigeria, it is critical to understand the meaning, prevalence, the root and underlying causes of these issues as well as obtain disaggregated baseline data on the key indicators of SGBV, HPs and OF for effective programming.

UNFPA, with funding from Global Affairs Canada (GAC), is implementing a Project aimed at "Addressing Gaps in Sexual and Gender-Based Violence, Harmful Practices and Obstetric Fistula in Nigeria", which started on the 1st of March, 2018 with an end date of 30th September, 2022. The goal of the Project is to reduce the prevalence of SGBV, Child, Early and Forced Marriage (CEFM), FGM and OF, and create enabling environment for the treatment and care of survivors. The specific objectives are to: improve the legislative and policy environment for SGBV/HPs/OF according to international standards and best practices; improve utilization of quality essential services for SGBV/FGM/CEFM including Obstetric Fistula care; increase availability and utilization of disaggregated data on SGBV/FGM/CEFM in addressing violence and harmful practices against women and girls; and increase awareness and create favourable social norms, attitudes and behaviours at institutional, community and individual levels for the prevention and response to SGBV/HPs/OF against women and girls.

This study, the Landscape Survey, will contribute in generating evidence-based information for programming and advocacies in addressing SGBV/HPs/OF toward accelerating the achievement of zero sexual and gender-based violence including harmful practices and obstetric fistula in Nigeria by 2030. Previous efforts to integrate SGBV, HPs and OF activities in Nigeria had mostly been limited in scope and topic-specific projects with insufficient depth to stimulate sustainable changes across relevant sectors for health policy and planning for development.

1.3 Study Objectives

The key objectives of this landscape analysis are to:

i. Determine the prevalence of SGBV, HPs and OF in Nigeria;
ii. Identify key social and gender norms that influence the prevalence and outcomes of SGBV, HP, and OF;
iii. Identify key drivers and perpetrators of SGBV and HPs;
iv. Explore the role of boys and men as survivors and mitigators of SGBV;
v. Assess awareness and knowledge of national and global policy on the elimination of SGBV, OF and HPs; and
vi. Map the roles and assess capacities of stakeholders for the elimination of SGBV, HPs, and OF, including integration into SRHR (e.g., state institutions, parents, CSO/FBOs, and community leaders.

1.4 Scope of the Study

The landscape study was conducted in 12 States and the Federal Capital Territory (FCT). The analysis focused on generating information on the:

i. Prevalence of SGBV, OF and HPs - physical abuse, sexual abuse, child marriage, female genital mutilation;
ii. Drivers and perpetrators of SGBV and HPs, including social norms;
iii. Internal and external factors affecting the indicators of SGBV, OF and HPs (Health, Governance, Education, Culture, Religion, Residence (urban/rural), macroeconomic factors, per capita income, profession, Security, etc.);
iv. Knowledge and skills of government/CSOs/NGOs officials, social and healthcare workers in providing SGBV, FGM, CEFM and OF services and information;
v. Access to protection and treatment services for women and girls affected by SGBV to FGM, CEFM and OF;
vi. Existence (if any) of legislations against SGBV, FGM, and CEFM at federal and state levels;
vii. Availability of traditional and social media and community platforms disseminating culturally appropriate information on SGBV, FGM, and CEFM; and
viii. Existence of SGBV, OF and HPs data management and monitoring tools including data bank.

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 Literature Review

2.1.0 Introduction

Sexual and gender-based violence, harmful practices, and obstetric fistula are gender-based problems occurring across different regions of the world having diverse and dire impact on health, social and economic structure of societies (WHO, 2021). These phenomena contribute significantly to the global burden of diseases (Mokdad et al., 2016), and pose serious social, economic, sexual, and reproductive health risks to the survivor, perpetrator, and society (WHO, 2013, 2021). The consequences and impact of SGBV and its variants on the individual and the family are grievous, ranging from human rights violations to poor economic, health, and psychological outcomes. However, its socio-cultural contexts, forms, and severity varied widely across societies. The scourge of SGBV in its various forms has attracted global/regional and national/sub-national attention with landmark declarations and policies, some of which are listed in Annex 1. Notable among these declarations are Articles 1 and 2 of the United Nations.

Article 1 of the UN Declaration on the Elimination of Violence against Women, adopted by the General Assembly in 1993 defines violence against women as:

> ***"Any act of sexual and gender-based violence that results in, or is likely to result in sexual or mental harm or suffering to women, including threats of such acts as coercion or arbitrary deprivations of liberty, whether occurring in private and public life."***

According to Article 2 of the UN Declaration, GBV includes physical, sexual and psychological violence that occur within the family, general community and condoned by the State wherever it occurs. Specifically, it includes battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation, traditional practices harmful to women, rape, sexual abuse, sexual harassment, and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution (NPC & ICF Macro, 2019; Oluwole, Onwumelu & Okafor, 2020).

In addition, UNFPA strategic plan, 2022-2025, the second of three consecutive strategic plans leading to 2030, reaffirmed the Fund's commitment to prioritizing gender equality and the empowerment of women and girls, including inclusivity, women's rights, women's leadership and bodily autonomy for all. The strategic plan calls for urgent action to "achieve universal access to sexual and reproductive health, realize reproductive rights for all, and accelerate the implementation of the Programme of Action of the International Conference on Population and Development (ICPD)." With this "call to action", UNFPA contributes directly to the 2030 Agenda for Sustainable Development, in line with the Decade of Action to achieve the Sustainable Development Goals. The Strategic Plan focuses on critical pathways and the strategies necessary towards accelerating achievement of UNFPA's three transformative results: (a) ending the unmet need for family planning; (b) ending preventable maternal deaths; and (c) ending sexual and gender-based violence and harmful practices, including female genital mutilation, child, early and forced marriage. Outcome area 3 seeks to end sexual and gender-vased violence and harmful practices by 2030. This outcome responds to Sustainable Development Goal 5, target 5.2 (eliminate all forms of violence against women and girls in public and private spheres, including trafficking and sexual and other types of exploitation) and target 5.3 (eliminate all harmful practices, such as child, early and forced marriage, and female genital mutilation).

The socio-cultural context within which SGBV and other harmful traditional practices thrive across societies are embedded within the precept of traditions, religion and established norms which are retained, guided, protected, and enforced by strong prohibitions in sanctions, fines, taboos, and superstition (Longman & Bradley, 2016; Miller & McCaw, 2019; Warburton & Raniolo, 2020). Some of these traditions are exploitative and depriving with negative consequences on mental health (UN, 2016; Buttell & Ferreira, 2020), especially for those with low

social capital and economic status. Other negative consequences include poor maternal and child health outcomes (Oluwayemisi et al., 2018; Anurudran, Yared, Comrie, Harrison & Burke, 2020). These negative outcomes among others permeate societies in sub-Saharan African countries including Nigeria and constitute major social and public health concerns.

To further understand these issues within contexts, subsequent sections present a brief literature review on the three dimensions of violence against women as adopted in this landscape study which are: Harmful Practices; Sexual and Gender-Based Violence; and Obstetric Fistula.

2.1.1 Harmful Practices

Varieties of harmful practices across Nigeria's sub-ethnic groups, which are documented in extant literature, are presented in Table 1 below. Although there is a lack of national data that consistently provides estimates across sub-national and local levels, data that monitor trends and changes over time are also not available.

a. Forced/Early Marriage

There are subsisting cultural practices across Nigeria's sub-ethnic groups, which are supported by some traditional values and norms that are inimical to a healthy lifestyle. One such example is the practice of marriage by adoption, forced or early marriage of young adolescent girls (between 10-15 years) among some clans in Northern Nigeria (Omoniyi, 2020). Extant literature further shows that about a fifth of adolescent girls have begun childbearing, while national data shows that the adolescent fertility rate is 106 births per 1,000 adolescent girls aged 15-19 (Nigeria Population Commission (NPC) & ICF Macro, 2019). Half of these pregnancies are among teenage girls with no education, while about 43 per cent of these girls are from the poorest households. The consequences of early marriage and childbearing are reflected in high birth risk among adolescent mothers (Weng, Yang, & Chiu, 2014; Akinyemi et al., 2015; Akinyemi et al, 2021). Adolescents who are under 15 years are five times more likely to die during pregnancy or childbirth and to be presented with other life challenges such as obstetric fistula (Ruedinger & Cox, 2012; Omoniyi, 2020).

b. Female Genital Mutilation

Like many other African countries, the practice of FGM in Nigeria, remains an age-long practice, with health and dehumanizing effects and consequences. UNFPA considers FGM as all procedures involving partial or total removal of the external female genitalia or other injuries to the female genitals for cultural or other non-medical reasons[1].

In Nigeria, the 2018 Demographic and Health Survey (NDHS) Report shows that about one-fifth of women aged 15 - 49 years are mutilated with wide variations at sub-national levels (NPC & ICF Macro, 2019). In some cases, the mutilation is performed clandestinely, sometimes with the use of corrosive substances and other forms of unhygienic procedures (Odukoya, Afolabi, Bello, & Adeyanju, 2017). UNFPA's FGM dashboard in February 2022[2] shows that about one-quarter of women of reproductive age have undergone some form of FGM.

Women and girls that have experienced FGM are often susceptible to a series of sexual and reproductive health problems. Based on evidence, such girls and women are likely to suffer severe pain, shock, haemorrhage, tetanus or infection, urine retention, ulceration of the genital region and injury to adjacent tissue, wound infection, urinary infection, fever, and septicaemia. The haemorrhages and infections could be severe enough to cause death. Long-term consequences include complications during childbirth, anaemia, the formation of cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse), sexual dysfunction, hypersensitivity of the genital area and increased risk of HIV transmission, as well as psychological effects (UNFPA, 2022). The magnitude and frequencies of occurrence and susceptibility depend on the intersection of factors such as the type of FGM performed, the expertise of the practitioner, the hygiene conditions under which it is performed, the amount of resistance and the general health condition of the girl/woman undergoing the procedure.

2.1.1.1 Social Determinants of HPs

Social determinants consist of conditions surrounding how individuals were born, how they grow, live, work and age within social settings. Harmful practices feed on social determinants in selecting who suffers harm, the forms of harm and the degree of exposure at any material time. Women and girls with disabilities (WGWD) face double discrimination because of their gender and disability. They are subjected to multi-layered and intersecting forms of abuse because of their gender, disability, age, religious beliefs, ethnicity, cultural and social norms. Based on the evidence, women, girls, and persons with disabilities (PWDs) are more exposed to traditional harmful practices than other social categories (Amodu, 2019; Amoo et al., 2019; Oluwayemisi et al., 2018; Omoniyi, 2020). Etieyibo & Omiegbe, 2021; and Obiamaka, 2021). WGWDs, for instance, are often denied their sexual and reproductive rights to prevent unwanted pregnancies and reduce burden on caregivers, especially for those with mental disabilities (Human Rights Watch,

1. https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked- questions.
2. https://www.unfpa.org/data/fgm/NG

2018). Their vulnerabilities even worsen during conflict and war as WGWD may find it more difficult to escape violence and can be abandoned (Jerry et al 2015).

Hence, WGWD are more marginalised, violated, exploited and discriminated against (Ozemela, Ortiz, and Urban, 2019). These factors put them at more risk of different forms of HPs such as early and forced marriage, female genital mutilation and other forms of violence (Al-Bustanji et al., 2018). Liman (2016), Longman and Bradley (2016), and Madu (2020) noted that forced marriage is caused by hunger, protection of girl-child against sexual abuse, religious practices, and protection of family honour. These are latent functions as Birchall (2019) also found that early child marriage was perceived to protect family honour and the girl child from the increasing risk of GBV, abduction, sex slavery, and rape among other vices. Across many African communities where the practice persists, the craving for family honour and perceived functionality are die-hard social determinants (Amoo et al., 2019; Atim, 2017; Obiamaka, 2021).

Rigid gender norms and social practices like bride-wealth and power relations are other social determinants that have sustained the disparities between and among genders. The intersection of these factors reinforces HPs in many communities in Nigeria (Chigbu, 2015; Adebanjo-Adenugba & Ayoola, 2021; Birchall, 2019; Etieyibo & Omiegbe, 2021). The bride wealth payment among the Igbo ethnic group, for instance, promotes force-feeding, a practice that has deep hegemonic masculinity root to enhance the physical features of the bride, and FGM for the sexual satisfaction of the men.

In many African communities, boys and girls have differential access to resources and opportunities. In these settings, WGWD are worse in terms of access to education, wealth, health, and employment opportunities (Ahinkorah, Onayemi, Seidu, Awopegba, & Ajayi, 2021; Birchall, 2019). Even in rare cases, where husbandry for instance is preferred over schooling as it exists among the Jere and Gongulong communities in Borno State, Nigeria, such arrangements give boys more economic power than schooling does for the girls in these communities (Atim, 2017; Olaore & Drolet, 2017; Wodon et al., 2017). Furthermore, even when girls are provided access to education, dropout rates are higher for them than it is for boys and this pattern appears common in many communities in Nigeria and other African settings (Ahinkorah, Onayemi, Seidu, Awopegba, & Ajayi, 2021; Birchall, 2019).

Denial of access to resources and opportunities keeps sustaining HPs across many African communities and the vulnerability of WGWD. Local institutions and interests further reinforce such strategies, which benefit from the social arrangements to the detriment of the women and girls in these communities (Jaiyeola, 2020). Generally, harmful practices reinforce men's control over women/girls (Adetola, Ogunbote, Omonijo, & Odukoya, 2019; Chigbu, 2015; Joseph & Earland, 2019). Female sexual control by men, and the economic and political subordination of women, do not only perpetuate the inferior status of women but continue to inhibit structural and attitudinal changes necessary to eliminate gender inequality (Jaiyeola, 2020; Msuya, 2019). This traditional hegemonic view privileges men and position them as tough, rational, and assertive, offering them ownership of the woman's body and control of other economic resources (Longman & Bradley, 2016; Mourtada et al., 2017; Olaore & Drolet, 2017). Consequently, harmful practices tend to devalue women and girls and perpetuate the culture of male supremacy.

2.1.1.2 Knowledge, Attitude, Practices, and Behaviours Relating to Harmful Practices

Harmful practices are customs, beliefs, and ways of life that can cause death, fear, stigma, diseases, and other psychological and physical pain or damage to the community members where such practices exist. Such practices exist from generation to generation unless concrete efforts are tailored toward changing them. Sometimes, harmful practices are normalised or dismissed as dysfunctional to the collective benefit of all. Lack of knowledge of the dangers that are inherent in such practices and the rootedness of these practices in norms, beliefs and values are critical contributors (Amodu, 2019; Mberu, 2017; Umeora, 2017; Veen, Verkade, Ukwuagu, & Muthoni, 2018).

FGM, in many African communities, is a case in reference where socio-cultural beliefs and norms have fostered the practice and its normalisation across generations. These socio-cultural beliefs and norms posit female genital mutilation as a rite of passage into womanhood, promoting hygiene and cleanliness, as part of religious beliefs, family honour, and the control of female sexuality. FGM is also viewed as ensuring virginity, curbing promiscuity, and protecting female modesty and chastity (Momoh, 2017). Similarly, Mberu (2017) noted that other beliefs and justifications for FGM include preventing mother and child deaths during childbirth, and a condition for women to have entitlement to property inheritance. The uncircumcised vulva is seen as dirty and ugly, while the uncircumcised women are presumably likely to be infertile (Mberu, 2017; Oluyemi, Adejoke, & Adekeye, 2019). Although the damage to female sexual organs and their function is extensive and irreversible, the true magnitude of the problem is still underestimated due to limited information and the mystery of the practice.

The human rights aspect, together with the adverse health consequences, have been and remain the dominant arguments against FGM in Nigeria. Campaigns

have been introduced to address the practice with a focus on children's rights, right to health, security, physical integrity, freedom from torture and cruel inhuman, or degrading treatment, and the right to life (WHO, 2018; Borokini, Ige, & Folusho-Ojo, 2020).

2.1.1.3 Consequences of Harmful Practices

Harmful practices have direct and indirect consequences on survivors and others community members where these practices are in vogue. Among the various harmful practices (Child marriage, FGM and window inheritance), studies have shown that survivors do suffer physical, social, and psychological consequences (Obiamaka, 2021; OHCHR, 2014; Omoniyi, 2020; UNFPA SWOP Report, 2021).

The psychological consequences of HPs on survivors can manifest in diverse forms. Across gender and social groups, HPs have enormous impacts, with women and girls as the most affected (Liman, 2016; Madu, 2020; Oluwayemisi et al., 2018; Omoniyi, 2020). From a gendered lens, HPs affect the psychological well-being of women/girls in ways that make them feel inferior to men. There is also the absence of structural and attitudinal changes necessary to eliminate gender inequality in society. Harmful practices are largely carried out without the consent of the girl or woman involved and this reflects gender inequality that includes unequal power relations, rigid gender roles, norms, and hierarchies, confining women to lower status in society (Jaiyeola, 2020; Veen et al., 2018; Yaya et al., 2019). In the study of Obianwu et al., (2018), some age long conventional social practices that reflect qualities and beliefs held by individuals across some community were identified. Some of these harmful practices are sustained to subjugate women and maintain the unequal status quo between women and men in society (Obiamaka, 2021; Olusegun & Idowu, 2016).

Notwithstanding the skewedness, women themselves continue to serve as agents of sustenance of many of these obnoxious practices (Oluwayemisi et al., 2018; Omoniyi, 2020; Umeora, 2017; UNFPA, 2022). For example, while FGM appears harmless and priced in some communities in Nigeria, there is also the erroneous assumption that the practice is beneficial to both genders. The reality is that even the men that appeared to be beneficiaries are losing in many ways. Overall, harmful practices have significant effects on the health and wellness of children and women. Existing literature has shown that the persistence of traditional practices is detrimental to the health and status of women and girls (Oluyemi et al., 2019; UNFPA, 2022).

Harmful practices have both short- and long-term effects on the health of woman and girls than it does on men. Child marriage, a common harmful practice, for instance, often leads to an increase in child mothers and child widows. Survivors of child marriage are prone to vesico-vaginal fistula - suffer an injury on the adjacent tissue of the urethra, and are likely to suffer neglect, stay unkempt with lifelong psychological as well as physical impacts (Obiamaka, 2021). Vaginal infection, haemorrhage, urine retention, rectal injury or damage to other pelvic organs during childbirth, and failure to heal have also been documented among women/girls with a history of forced marriage or early childbirth (Madu, 2020). The prevalence of these conditions also creates an additional health burden on survivors as permanent scars, physical disfiguration, and permanent disability have been documented among survivors (Omoniyi, 2020; UNFPA SWOP Report, 2021). The long-term physical effects of these conditions have also been traced to recurrent sexual dysfunction, and physiological problems, including problems during childbirth, and in extreme cases, death (Adetola et al., 2019).

Most of the survivors are plunged into mental, emotional, psychological pains and deteriorating reproductive health as well as denial of fundamental human rights such as education, freedom of choice, movement, and association (WHO, 2018). Also, OHCHR (2014) argued that harmful traditional practices violate the rights to health, life, dignity, and personal integrity. Others have found that harmful traditional practices led to survivors experiencing untold pains, bleeding, and often loss of lives or parts of the body (Momoh, 2017; Umeora, 2017; UNFPA, 2021). Furthermore, the practice of using traditional birth attendants for female mutilation has endangered a lot of women's and infants' lives, and in most cases led to death (Umeora, 2017; WHO, 2018).

Harmful practices are infringements on basic human rights. Survivors often lose their rights and freedom to make informed choices due to the possible psychological impacts of such practices (Longman & Bradley, 2016). Some survivors keep lamenting the painful impact of losing life aspirations, becoming inherited by someone they never loved, denial of financial and other forms of resources (Wodon et al., 2017). Women who challenge accepted socio- cultural norms, traditions, perceptions, and stereotypes about the status of women in society could lose their social esteem and are often labelled with psychosocial disabilities.

The rights of WGWD appear worse off when harmful practices thrive in a social setting. Persons living with disabilities with the burden of harmful practices have consequences on their social, religious, psychological, political, and economic well-being. In the light of the myriad impacts of traditional myths and cultural views of disability, combined with the negative attitudes towards women in general, women and girls with disabilities are in double jeopardy. The notion that disability is a curse and

that people with disabilities are possessed or evil, places little or no value on people living with disabilities. Likewise, the societal views of women as witches or demoniacs justify the abuse of women in African societies (Adebanjo- Adenugba & Ayoola, 2021; Olaore & Drolet, 2017). Furthermore, studies have also shown that to give birth to a child that has a disability is seen as a curse on the woman herself for some wrongdoing or breach of a societal taboo (Birchall, 2019; Etieyibo & Omiegbe, 2021; Longman & Bradley, 2016).

The consequences of HPs on PWDs are more complicated because of various attitudes and beliefs towards them from within families, ethnic groups, countries, regions, or around the world. Common beliefs about the causes of disability in Nigeria include sin (most especially an immoral act committed by the mother), a curse from the gods or ancestors, breaking laws, demonic possession, or attacks from witches and wizards (Eskay et al., 2012). The Nigerian culture and religion also stimulate some beliefs and attitudes towards PWDs that lead to HPs. PWDs are often seen as lesser humans on the grounds of their disability. Some believe that a person can become disabled by just having close contact with PWDs and that women with disabilities (WWDs) will always give birth to children with disabilities (World Bank, 2020).

PWDs are assumed to be helpless and charity-dependent who should always depend on the provision of others for survival (Thompson, 2020). Many times, children with disabilities (CWDs) are turned into investments by their parents or guardians to beg for money on the streets. Also, mental disability is often attributed to a curse, witchcraft activities or possession by evil spirits. Hence, persons with mental illness are rather taken to traditional medical homes or prayer houses where they are subjected to physical and mental pain rather than seeking proper medical care. Women and girls with disabilities (WGWDs) tend to have a sense of unattractiveness and low self-esteem because they are perceived not to conform to the traditional definition of beauty; hence, their acceptance of sexual abuse as normal (Devandas, 2017).

With a rise in ritual killings in the country, the erroneous misconceptions about people with angular kyphosis and albinism being a source of wealth, long life, good luck and success have turned this group into some sort of 'endangered' species, whereby 'money-making' ritualists hunt for their body parts (The Guardian, 2021; World Bank, 2020). In the same vein, in some rural parts of the country, it is also assumed that rituals, which involve having sexual intercourse with women with cognitive disabilities, also bring wealth and long life. Hence, women with cognitive disabilities are more vulnerable to rape and sexual violence.

It is a common practice among the Yoruba ethnic group of South West Nigeria to hide CWDs from the public view, and forbidding them from taking part in social activities, as they are perceived to bring shame to the family (Mohammed 2017; Ashi, Olayi and Ikwen 2015). Family members (most especially the mothers of PWDs) may also experience stigmatisation and marginalisation. Mothers whose children have disabilities are likely to be stigmatised by their husbands and families as they can be suspected to be the cause of their children's disabilities. Such women are at the risk of losing their marriages, and/or raising their children as single parents (Ortoleva and Frohmader, 2013). Notably, violence against WGWDs is rarely reported. Even when it is reported, survivors rarely get justice due to attitudinal, institutional, and environmental barriers. The attitudes of the police and the judiciary often add to the impunity of perpetrators of violence against WGWDs. Women and girls with disabilities might also have difficulties in accessing police stations or the services of sign language interpreters might not be available to aid better communication when making reports by WGWDs (Inguanzo, 2017).

2.1.1.4 Policy Initiatives Curbing HPs in Nigeria

Issues concerning harmful practices have gained traction and this has led to several efforts that are geared towards improving the status and human rights of women, girls, people living with disabilities, and other vulnerable groups. International agencies or organisations have taken the lead and are still dictating the pace in initiating and shaping the policy environment. An example in this direction can be observed in the efforts of the United Nations when in 1993 at the World Conference on Human Rights in Vienna, the slogan 'Women's Rights are Human Rights", was adopted (Popoola, 2020). The theme of the conference echoed the need for the disillusionment of women's rights as a reality that is and for itself, but rather a right that must be preserved because of humanity and the centrality of preserving the humanity through women's rights. The continuous violation of women's and the complexities in pushing into the subconscious and consciousness of all the idea that women's rights are human rights again informed another declaration in 2014 by the Office of the United National High Commissioner for Human Rights (OHCHR). The declaration emphasised the need for concrete efforts that will eliminate all forms of violence against women across cultural settings (OHCHR, 2014).

Before the world conference in 1994 and the 2014 declaration of the United Nations, the Forty- sixth World Health Assembly in 1993 canvassed and adopted resolution WHA 46.18 on maternal and child health and family planning for health (Sweileh, 2016). The resolution expressed concern about the continuing inequities affecting women in general and the persistence of harmful practices such as child marriages, dietary limitations during pregnancy, and FGM. Also, in 1994, the

Forty-seventh World Health Assembly adopted resolution WHA 47.10. The resolution focused specifically on harmful traditional practices, urging all member States to assess the extent to which harmful traditional practices affecting the health of women and children constitute social and public health problems in any local community or subgroup. Then, they were encouraged to promulgate laws and establish national policies and programmes that will effectively prohibit female genital mutilation, child/forced marriage, obnoxious widowhood practices and other forms of harmful traditional practices affecting the health of women and children (ICPD, 1994). After these resolutions, some levels of progress have been made among member countries; nonetheless, the progress remains far from the desired level.

The domestication of international declarations and resolutions are observable in the various laws and acts of parliaments of the Federal Republic of Nigeria. The Nigerian Constitution, for instance, contains two articles that make specific provisions for the rights of children. Article 17 (3) (f) requires the State to implement policies that ensure that children and young persons are protected against any exploitation whatsoever, including moral and material neglect (Onukogu, 2021). Article 18(3) makes provisions for free, compulsory, primary education, and free secondary and university education (Onukogu, 2021). The most relevant federal legislation includes the Children and Young Persons Act 1943 and the Child Rights Act 2003, which had been adopted in some form in 25 states by the end of 2020. Other relevant legal instruments and policies on SGBV are listed in Annex 1.

The foregoing notwithstanding, much progress is highly desired in addressing HPs, and SGBVs in Nigeria. Across communities, the culture of silence on SGBVs keeps fuelling the continuation of FGM and other forms of HPs. UNFPA's State of the World Population Report (2021) emphasised the gap between people's personal views of HPs and entrenched senses of social obligation fuelling its continuation, exacerbated by lack of open communication on this sensitive and private issue. Thus, Nigeria can achieve more and reverse the impact of HPs first by breaking the taboos around the subject through open conversation and commitment. This can be followed up with actions that can secure a future, where gender will not be a curse, but all can live freely without fear of violence nor discrimination (Mberu, 2017).

2.1.2 Sexual and Gender-Based Violence

There are variants of SGBVs, with women disproportionately affected in terms of number and the multiplier effects on society. GBV also known as violence against women, domestic/family violence, spouse/partner abuse, assault and battering may take the form of slapping, kicking, beating, biting, intimidation, humiliation, and forced intercourse. Any of these forms can be perpetrated by people known or unknown to the survivors; that is, intimate or non-intimate partners (Wirtz et al., 2018). The intersection of SGBVs with other factors and network of relations changes especially when there are disruptions in a social setting, including the recent Covid-19 crisis (Dlamini, 2021; Stark, Seff, & Reis, 2021). Women are mostly affected and vulnerable to SGBV, whereby the average woman stands a chance of experiencing any of the forms of SGBV at least once or multiple times in their lifetime (Dlamini, 2021).

The degree of exposure and vulnerability to SGBVs vary for every woman even among those in the same social setting. Structural factors and network of relations have exposed some women to violence from conception to death, while others experience it at a point in their lifetime (Heise et al., 1999). Violence among women of reproductive age is mostly by intimate partners (Krug et al., 2002). Table 2 below shows the type of violence commonly experienced at different stages of life.

SGBV is a pervasive public health problem against women globally. One in every three women has experienced at least a form of SGBV in her lifetime (Coll, Ewerling, García-Moreno, Hellwig, & Barros, 2020). Assessment of data from surveys that were conducted between 2010 and 2017 in 46 countries showed huge inequalities within countries and a high prevalence of 40% of forms of GBVs (physical, psychological, and sexual violence) in Afghanistan to an average of 27% prevalence that was estimated from some African countries like Cameroon, Congo, Central African Republic and Mozambique. Burkina-Faso and The Gambia had the lowest with a prevalence that was less than 10%. It was common among all the countries that more empowered and rich women reported lesser cases of such violence than vulnerable and poorer ones. Women in rural areas also had more experiences with SGBVs compared with those in urban areas (Coll et al., 2020). However, there have been arguments about the true prevalence of IPV in African countries because of underreporting due to the culture of silence that surrounds victimisation in these settings (Obi & Ozumba, 2007).

SGBV results in reduced productivity of the survivors and perpetrators, psychological distress and impaired quality of life experience (Cadilhac et al., 2015; Sylvia Walby, 2011). Also, survivors are unable to contribute financially to the family and consequently leading to poverty (Exner-Cortens et al., 2013; ICRW and UNFPA, 2009). It also results in direct and indirect economic loss to the government. Direct costs due to SGBV include burdens on the law enforcement, judicial costs, health-care spending, and social welfare costs. Indirect costs are due to lost wages, reduced employment and income generation, absenteeism, reduced productivity of survivor and perpetrator, mortality, and disability-adjusted life years (Duvvury et al., 2013; Sylvia Walby, 2011).

Table 1: Types of Violence Commonly Experienced by Women at Various Phases of the Life Cycle

Phase	Type of Violence
Prenatal	*Prenatal sex selection, battering during pregnancy, coerced pregnancy (rape during war)*
Infancy	*Female infanticide, emotional and physical abuse, differential access to food and medical care*
Childhood	*Genital cutting; incest and sexual abuse; differential access to food, medical care, and education; child prostitution; child labour*
Adolescence	*Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, school or places of learning, rape, sexual harassment, forced prostitution*
Reproductive	*Abuse of women by intimate partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities*
Old Age	*Abuse of widows, elder abuse (which affects mostly women)*

Source: (Heise et al., 1999)

2.1.2.1 Prevalence of SGBV

The prevalence of sexual and gender-based violence is most accurately measured through population-based surveys that count self-reports. Victimisation findings are presented below because they are more internationally available, easier to compare and less subject to low disclosure rates. In Africa, SGBV, especially intimate partner violence, is highly prevalent.

- In Sub-Saharan Africa (SSA), a survey of 84,486 women from 18 countries reported an overall prevalence of IPV as 37%. The cultural norms of African societies contribute largely to the high level of IPV experience (Ahinkorah, Dickson, & Seidu, 2018).
- Another survey in 14 SSA countries among women of reproductive age reported a prevalence of IPV of 36.5%, ranging from 10.6% in Comoros to 59.8% in Uganda (Greene et al., 2017).
- In Zimbabwe, the prevalence of domestic violence among women of reproductive age increased from 35.2% in 2005 to 42.7% in 2015 (Lasong et al., 2020).
- According to NDHS 2018, 31% of women of reproductive age in Nigeria have experienced physical violence, and 9% have experienced sexual violence. (NPC and ICF, 2019).
- In the same survey report, 36% of ever-married women have experienced physical, sexual or emotional violence from their partners.
- In Kano, northern Nigeria, an IPV prevalence of 42.0% was reported (Tanimu et al., 2016).

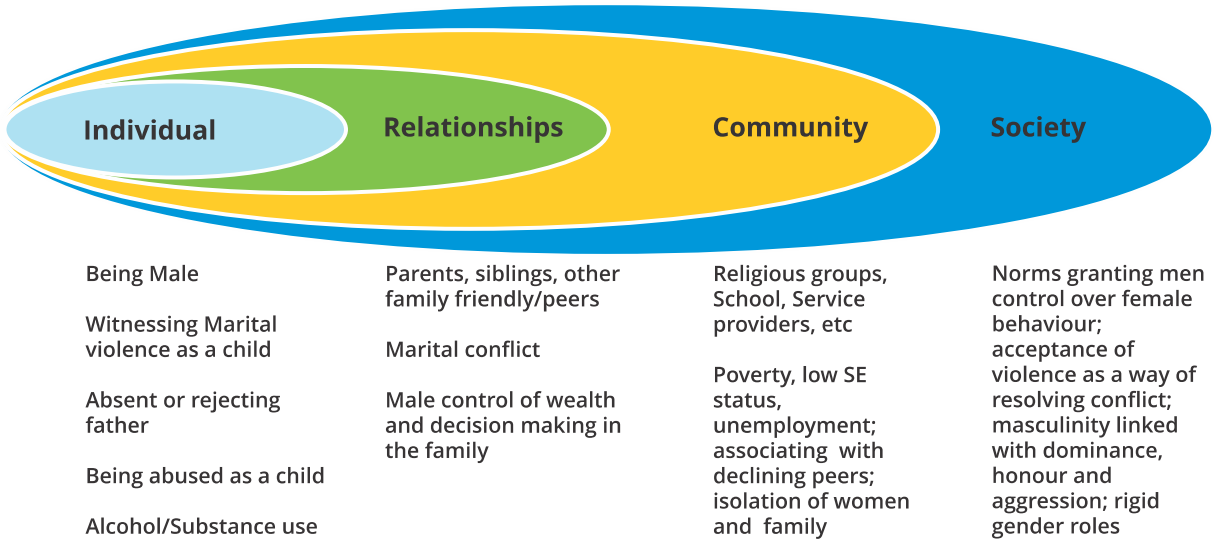
The high prevalence of IPV in Africa is associated with traditional norms, strict gender roles and wide acceptance of IPV. Women are more likely to justify IPV than men (Sardinha & Catalan, 2018). Analysis of DHS data from 19 different sub-Saharan Africa (SSA) countries showed a high level of acceptance of wife beating among women with the proportion ranging from 88% in Guinea to 20% in Sao Tome and Principe (Cools & Kotsadam, 2017).

In Africa, there is a culture of silence about violence, especially those that occur within marriage and it is often treated as a family issue. For example, in The Gambia, the Police typically consider incidents of domestic violence as a family problem that does not need legal intervention (Idoko et al., 2015). The risk factors that increase the likelihood of someone becoming a survivor and/or perpetrator of sexual and gender-based violence and their reduction should therefore be a key target of prevention efforts. Based on the ecological model proposed by Heise[3], individual, community and societal-level risk factors are associated with higher or more severe forms of sexual and gender-based violence. The ecological approach allows understanding of violence not as a single variable problem but rather as a multifaceted phenomenon grounded in the interplay of personal, situational and socio-cultural factors (Figure 1).

3. Heise et al., 1998

2.1.2.2 Determinants and Risk Factors of SGBV

Figure 1: Risk factors for SGBV



Ahinkorah et al. (2018) writing on the global impact of sexual and gender-based violence identify the following evidence-supporting factors, which are enumerated below:

Individual level Factors

In both developed and developing countries, young persons are more often involved (and affected) in violence. The overview revealed that girls were 1.5 to 3 times more likely to suffer more violence than boys. Most of the perpetrators of sexual violence are males and more likely to have a history of being abused sexually by others. More boys were more likely to conceal such violent experiences compared to girls who had similar experiences (Ahinkorah et al., 2018). Almost all studies agree that boys are more likely than girls to engage in violent behaviour (Ostrov & Perry, 2018; WHO, 2002). It is undisputed that girls and women are more at the receiving end for all forms of SGBV.

The literature holds differing opinions on the relationship of education to violence. Lower educational attainment reduces a woman's exposure and access to resources, increases the acceptance of violence, and maintains unequal gender norms. Some researchers believe that female education confers a greater risk of physical violence (because of non-acceptance of traditional norms) up to a certain level, after which it confers protection. This theory is supported by evidence from a systematic review of risks and protective factors, which found that when women's education progressed beyond secondary school their chances of suffering SGBV also reduced (Hajian, Vakilian, Najm-Abadi, Hajian & Jalalian, 2014; Ahinkorah et al., 2018). In addition, there is some evidence that religious belief is inversely related to violence perpetration. However, in Ethiopia, protestant religious affiliation was observed to be risk factor of sexual and gender-based violence (Arnold, Gelaye, Goshu, Berhane, & Williams, 2008).

The experience of negative life events, ranging from academic or business failure, job loss, to parental divorce, also appears to foster violent and other maladaptive behaviour in children and adolescents. Valois et al, 2002 found that poor grades at the age of 13 predicted violent behaviour five years later. Substance use has also been related to violent activity. Violent individuals are much more likely to be regular users of alcohol, cigarettes, or marijuana, or be poly-drug users. Other studies have also confirmed that the availability of hard drugs increases the risk of violence. At-risk drinking was associated with both IPV and other types of violence against women in a study in the United States and Canada (Thulin, Heinze, Kusunoki, Hsieh & Zimmerman, 2021; Saewyc et al., 2009).

The 2007 Minnesota Student Survey, found that multiple types of adverse childhood experiences such as experiencing physical abuse, sexual abuse or witnessing abuse were risk factors of adolescent violence perpetration during adolescence even after adjustment for demographic covariates (Duke, Pettingell, McMorris, & Borowsky, 2010). A review of studies that addressed the associations between child maltreatment and youth violence perpetration in the United States of America provided compelling evidence linking child maltreatment and later youth violence perpetration (Miller, Esposito-Smythers, Weismoore, & Renshaw, 2013). Physical abuse was the most consistent predictor of youth violence. Even

less severe forms of abuse were found to also increase the risk of later violence for some youths. Researchers have reported that exposure to inter-parental violence during childhood increases the likelihood of violence acceptance either as a survivor or perpetrator in future partnerships and high-risk situations.

Other studies have found associations between psychological distress, depressive symptoms and violent activity. A study in Minnesota showed that persons with moderate to high levels of hopelessness exhibited a statistically significant independent relationship with a range of violence-related outcomes such as the occurrence of interpersonal and intimate partner violence (Duke, Borowsky, Pettingell, & McMorris, 2011). Also, individuals with antisocial characteristics are more likely to disregard social norms and have a higher tendency to become aggressive and impulsive, resulting in the perpetration of violence (Duke et al., 2011). Women and men's acceptance of intimate partner violence; men's attitudes towards women as inferior; restrictive gender roles, and dominant patriarchal values may all perpetuate the occurrence of violence. These attitudes may be transferred across generations through learning processes, the media, schools, and witnessing and experiencing violence throughout life. There is also evidence that strong peer support may increase the risk of violence among youths.

Studies from a wide range of settings show that while SGBV cuts across all socioeconomic groups, women living in poverty are disproportionately affected (Stockman, Hayashi, & Campbell, 2015). It is not yet clear why poverty increases the risk of these forms of violence – whether it is because of low income in itself or because of other factors that accompany it, such as overcrowding, and hopelessness. For some men, living in poverty is likely to generate stress, frustration, and a sense of inadequacy for having failed to live up to their culturally expected role as providers, including the impact of Covid-19 (Cuesta & Pico, 2020; Stubbs & Szoeke, 2021). Poverty may also provide ready material for marital disagreements or make it more difficult for women to leave violent or otherwise unsatisfactory relationships. Poor women and girls may be more at risk of rape in the course of their daily tasks than those who are better off. Children of poor women may have less parental supervision when not in school, since their mothers may be at work and unable to afford childcare. Children themselves may be working and thus vulnerable to sexual exploitation. Poverty forces many women and girls into occupations that carry a relatively high risk of sexual violence, particularly sex work (Muluneh, Stulz, Francis, & Agho, 2020). It also creates enormous pressures for them to find or maintain jobs, pursue trading activities and, if studying, obtain good grades – all of which render them vulnerable to sexual coercion from those who can promise these things (Muluneh et al., 2020).

Parental and Relationship-level Factors

Men who report having multiple sexual partners are also more likely to perpetrate intimate partner violence or sexual violence (Davis, Neilson, Wegner, & Danube, 2018; Rollero, 2020). Multiple partnerships and infidelity (as perceived by female partners) were also strongly associated with both the perpetration and experiencing intimate partner violence (Davis et al., 2018). Men may seek out multiple sexual partners as a source of peer status and self-esteem, relating to their female partners impersonally and without the appropriate emotional bonding. Low parental level of education, however, isthe most consistent factor associated with both the perpetration and experiencing intimate partner violence and sexual violence across studies (Hardesty & Ogolsky, 2020).

Societies with the lowest levels of sexual and gender-based violence are those that had community sanctions against it, and where abused women had access to sanctuary – either in the form of shelters or family support (Bull, Carrington, & Vitis, 2020; Decker et al., 2015; Heise, 1998). Community sanctions, or prohibitions, could take the form either of formal legal sanctions or the moral pressure for neighbours to intervene if a woman was beaten. The “sanctions and sanctuary” framework suggests the hypothesis that sexual and gender-based violence will be highest in societies where the status of women is in a state of transition. Where women have very low status, violence is not needed to enforce male authority. On the other hand, where women have a high status, they will probably have achieved sufficient power collectively to change traditional gender roles (Heise, 1998). Sexual and gender-based violence is thus usually highest at the transition point, as is the situation in sub-Saharan Africa (Cools & Kotsadam, 2017).

Societal-Level Factors

Results of ethnographic data indicate that wife beating occurs more often in societies in which men have economic and decision-making power in the household, where women do not have easy access to divorce and where adults routinely resort to violence to resolve their conflicts (Heise, 1998). The presence of female workgroups was found to offer protection from wife beating because they provide women with a stable source of social support and economic independence from their husbands and families (Erchak & Rosenfeld, 1994).

The maintenance of patriarchy or male dominance within a society also fosters the experience of SGBV. Patriarchal and male dominance norms reflect gender inequality and inequity at a societal level and legitimise intimate partner violence and sexual violence perpetrated by men (Erchak

& Rosenfeld, 1994). While they are located at the societal level, these gender norms play out at the level of community, relationship and individual behaviours. Societal norms related to gender are believed to contribute to violence against women and gender inequality and other inequities by creating power hierarchies where men are viewed by society as economically and religiously superior, and of higher social status compared to women – who are sometimes viewed as a liability. As such, men are socialised to believe that they are superior to women, that they should dominate their partners and endorse traditional gender roles. Women's subordination and submission are then considered to be normal, expected, accepted and, in some cases, attractive to men. Women who are more competent or educated are often stigmatised or disliked by society. This gender inequality and male dominance reduce the opportunities for women to be involved in decision-making at every level, decreases the resources available to women, and increase acceptance of the use of violence against women (Heise, 1998; Tharp et al., 2013). Furthermore, it contributes to gender-based inequities in health and access to health care, opportunities for employment and promotion, levels of income, political participation and representation, and education. Examples of social and cultural norms that support violence against women include: -

- A man has a right to assert power over a woman and is considered socially superior.
- A man has a right to physically discipline a woman for "incorrect" behaviour.
- Physical violence is an acceptable way to resolve conflict in a relationship.
- Intimate partner violence is a "taboo" subject.
- Divorce is shameful and sex is a man's right in marriage.
- Sexual activity (including rape) is a marker of masculinity.
- Girls are responsible for controlling a man's sexual desire.

Thus, there is a need for more research to identify modifiable factors that can influence the perpetration or experience of sexual and gender-based violence at both community and societal levels (Tharp et al., 2013). Potential community-level factors include education, the availability and accessibility of resources, and the readiness of individuals to use available community resources. Important societal-level factors include gender norms and other structural factors supportive of gender inequality and violence.

2.1.2.3 SGBV Survivors' Help-Seeking and Acceptance Behaviours

The lack of awareness of the physical and mental health, social and economic consequences of SGBV, knowledge of types of services available, as well as limited availability and competency of services are often major barriers to the effective recovery of SGBV survivors and their families. These challenges are compounded by pervasive stigma associated with various forms of SGBV and in many cases, widespread social acceptance of different forms of violence that prevent SGBV survivors from seeking support. This section aims to highlight evidence from the literature on barriers and facilitators affecting access to services to better address the needs of SGBV survivors in Nigeria (Ministry of Gender et al., 2019). In Nigeria, 32% of women who have ever experienced physical or sexual violence have sought help to stop the violence, while 55% have never sought help or told anyone about the violence (NPC and ICF, 2019).

Attitude to SGBV dictates the help-seeking behaviour of the survivors/survivors of violence. Help-seeking is a significant step to recovery from the consequences of SGBV. It may help survivors to identify unhealthy behaviours in their relationships, leave abusive relationships, reduce the chance of further victimisation, and may also link them up to different services available. However, prevailing social norms, stigmatisation, economic dependence on male partners, and acceptance and silence about SGBV may prevent help-seeking (Parvin et al., 2016; Sardinha & Catala´n, 2018). Many survivors of SGBV do not seek help; the few who do use informal sources such as family members, in-laws, and friends (NDHS, 2013; NPC and ICF, 2019; Parvin et al., 2016; Tenkorang et al., 2017). Also, the type and severity of SGBV determine the help-seeking behaviour of survivors. In Nigeria, women who experience sexual violence (55%) are less likely to seek help (NDHS, 2013; Tenkorang et al., 2017) probably because of the shame and stigmatisation associated with rape. Likewise, women who experience severe physical and/or emotional violence are more likely (31.3%) to seek help from informal sources compared to 1.9% who would approach formal sources (Tenkorang et al., 2017). The level of education and socio-economic status of an individual predict the acceptance of IPV (Sardinha & Catala´n, 2018). When women are educated, it improves the type of job they can engage in and consequently their economic power and their overview of life.

2.1.2.4 Consequences of SGBV

The impact of SGBV resonates further than the primary survivor. The effects of SGBV on women, their children, families and communities are severe. Violence compromises the health, dignity, security and autonomy of its survivors. These adverse health outcomes may be caused by direct injuries, as well as physiological effects of stress from present or previous abuse or even cause death (WHO, 2013). Figure 2 highlights some of the health consequences of SGBV.

First, violence has hindered women's ability to achieve

economic autonomy and to ensure sustainable livelihood for themselves and their dependents. The powerlessness of survivors is also manifest in their relative lack of resources in the form of land, personal property, wages and credit, and access to support institutions. The consequence of these is deepening poverty due to diminished access of women to independent means of livelihood. Poverty, unfortunately, violates the human rights of women and girls by denying them education, food, health, housing, participation in political and public life, and freedom from violence. SGBV drains the economically productive workforce and the climate of fear and insecurity it generates reduces the productivity and development of the country. It reduces educational and developmental opportunities for women. Thus, many girls do not formally enrol in school, while others drop out to do menial work or are married off at an early age. Thus, women's educational attainment and opportunities to develop are compromised, resulting in poverty.

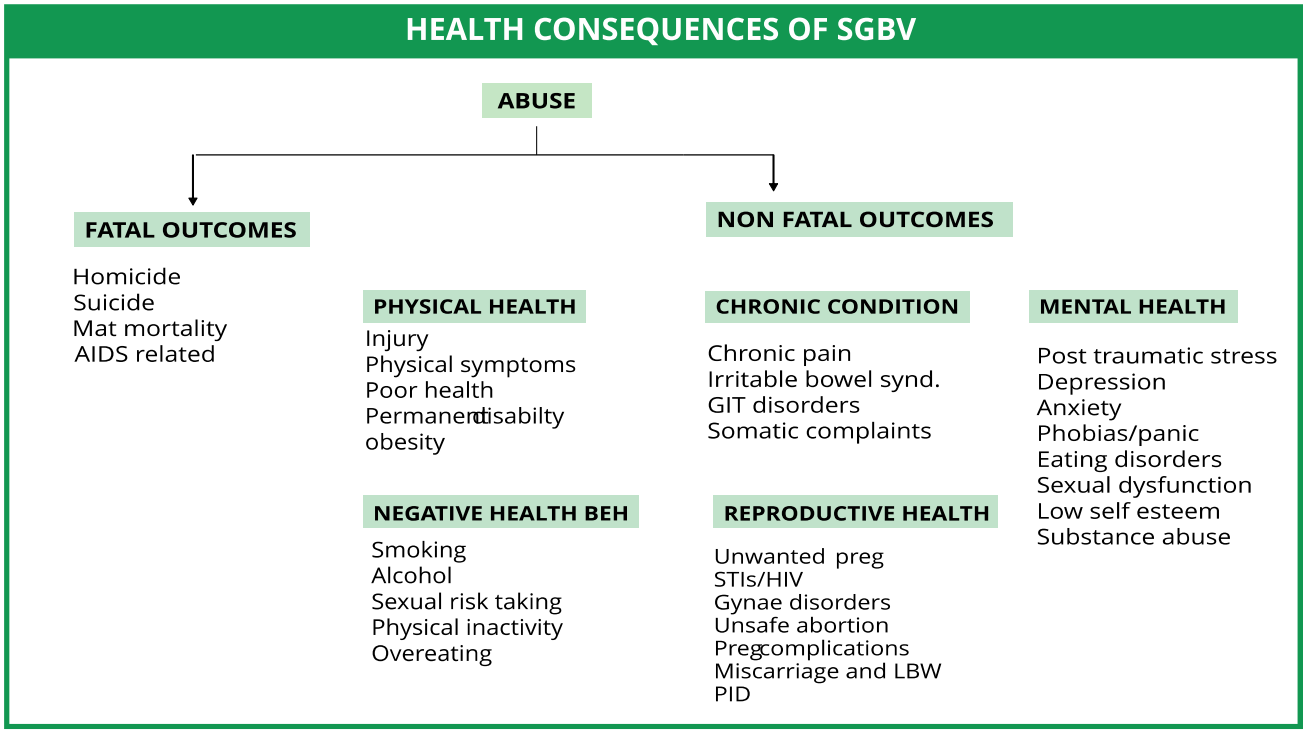


Figure 2.: Consequences of IPV

Source: Heise et al., 1999

Secondly, abuse tends to lead to an atmosphere of tension and general nervousness, which may spill over into physical violence. The beatings may even extend to children. Recent studies from India and Nigeria indicate a link between the maternal experience of violence and evidence of increased mortality and under-nutrition among children of abused mothers (Paul, 2020; Issah AN, 2022). Violence also tends to have intergenerational repercussions; children who are abused tend to become abusers themselves or passive receptors of abuse.

Thirdly, violence increases women's risk of maternal morbidity and mortality. It can also result in death through homicide, suicide or death. Abused women were six times more likely to experience depression, stress-related syndromes, chemical dependency and substance abuse and suicide than were other women[4]. Thus, SGBV affects the mental health of abused women.

Fourthly, SGBV results in social inequality and promotes sexual exploitation of girls and young women by older men. It generates high demand for commercial sex by relatively affluent men and the desire to be rich quickly by young women, which encourages them to commercialise their bodies as a means of rapid enrichment. It also promotes the international trafficking of women and girls.

Finally, VAW affects reproductive health by resulting in unwanted pregnancy, STIs/HIV, gynaecological disorders, unsafe abortion, pregnancy complications, miscarriage and low birth weight babies, including pelvic inflammatory diseases. Diverse studies have found that girls and/or young women who had previously experienced sexual coercion are significantly less likely to use condoms, and more likely to experience genital tract infection symptoms, unintended pregnancy and a higher

4. WHO, 2021 - https://www.who.int/news-room/fact- sheets/detail/violence-against-women

incidence of unsafe abortion. Lack of sexual autonomy and control stemming from actual or threatened violence, together with the fear of repercussion from the use of condoms or contraception, are direct pathways to unwanted pregnancy and increased risk of sexually transmitted infections (STIs). Moreover, intimate partner violence is independently associated with HIV infection. The association between short birth intervals and infant health and survival is well documented. There is the disintegration of reproductive autonomy amongst those who experience violence. Thus, SGBV is a significant obstacle to reducing poverty, achieving gender equality and meeting the other millennium development goals.

2.1.2.5 Policy Initiatives Curbing SGBV in Nigeria

Nigeria has policy frameworks to reduce and eliminate SGBV. The country is a signatory to a number of global and regional policies to tackle gender inequality, such as The Convention of the Elimination of All Forms of Discrimination against Women (CEDAW 1979), The Beijing Platform for Action (1995), The Millennium Development Goals (2000), The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2005), The Convention on the Rights of Persons with Disabilities (2006), The Sustainable Development Goals (2015) (Mercy & Nanji, 2014). Locally, the country also passed the Child Rights Act (2003), Nigeria's National Gender Policy (2006), and recently, the Violence Against Persons Prohibition (VAPP) law (2015).

The National Gender Policy (2006) has 16 thematic areas, including sexual and gender-based violence. The major goal of the policy for SGBV is to eradicate all forms of SGBV and discrimination, and ensure that men and women enjoy equal rights, irrespective of gender, age, ethnicity, religion and class. The policy also canvasses for the elimination of cultural and religious gender-based biases and harmful cultural and religious practices which produce gender inequalities in the Nigerian society; equal access of women, men, boys and girls to both formal and informal education; women's access to critical resources and investment in women's human capital to reduce extreme poverty in families; equality and equity in employment opportunities and elimination of all discriminatory and abusive practices against the employment of women; improved access to health services, etc. The newly revised Nigeria National Gender Policy (2021) is very emphatic on the structures for mitigating SGBV in the country, and the need to strengthen collaborative efforts across state and non-state actors working on SGBV mitigation.

The UNSCR (1325) Nigeria National Plan of Action also plays a significant role in the national SGBV response mechanism. UN Resolution 1325 recognizes that peace is inextricably linked with equality between men and women. Only women's participation on an equal basis with men in all efforts to maintain and promote peace and security is a guarantee of lasting peace. Women and girls must therefore be protected from all forms of vulnerabilities, in particular those related to SGBV. It recognizes that women and girls become more vulnerable to sexual violence with terrorism, banditry and all sorts of armed conflict, as witnessed in North-East Nigeria in recent years.

Nigeria first adopted its National Action Plan (NAP) for UNSCR (1325) in 2013, implemented for the period 2013-2017. Its most recent National Action Plan (NAP) in 2017 for the period 2017-2020, was developed by the Federal Ministry of Women Affairs with the support of the Nigerian Stability Reconciliation Programme (NSRP), the European Union, and the UN Women. The NAP's objectives present five overarching thematic pillars: prevention and disaster preparedness; participation and representation; protection and prosecution; crisis management, early recovery, and post-conflict reconstruction, and partnerships, coordination, and management. Despite, the presentation of a robust NAP, Nigerian women/girls still face violent attacks daily.

It is important to note that Nigeria is riddled with crises since its independence in 1960, starting with the politically motivated civil war (1967 - 1970) when the Eastern Region attempted to secede as the Republic of Biafra. The military era of about 29 years intermittently truncated the civilian rules, until 1999 when democracy became an orchestrated affair in the country. A new wave of conflicts in the country, especially in the North East, caused by Boko Haram since 2009, further exacerbated violence against women and girls in the country. The cases of the Chibok girls and other related insurgency experiences in the country continue to point to the vulnerability of women and girls in conflict situations.

Although Nigeria continues to take legal and policy actions to protect women and girls from SGBV and its variants (see Annex 1), many of these legal and policy documents are still like paper tigers, because of lack of implementation, often due to weak institutional frameworks. A more elaborate discussion on the legal and policy environment of SGBV in the country is presented in Chapter 9 of this report.

2.1.3. Obstetric Fistula

Obstetric Fistula is an abnormal opening between a woman's genital tract and her urinary tract and rectum that results in continuous incontinence of urine and/or faeces (Health Organisation, 2018). A hole between the urinary bladder and the vagina is regarded as a vesico-vaginal fistula (VVF), whereas a hole between the rectum and the vagina is known as a rectovaginal fistula (RVF) (Tunçalp 2015). RVF is often present concomitantly with VVF and likely represents worse or longer obstructed

labour, VVF is the most common type of Obstetric Fistula and may be used interchangeably. It is estimated that the global annual incidence of OF among women and girls is between 50,000 to 100,000 cases while more than 2 million live with untreated condition, mainly in Africa and Southeast Asia (WHO, 2018). Nigeria has the highest burden of OF in the world. According to the 2019 Federal Ministry of Health's National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria, 13,000 fresh cases occur per annum while 150,000 women and girls are living with the condition.

2.1.3.1 Determinants and Other Factors Associated with Obstetric Fistula

A review of demographic and health surveys and multiple indicator cluster surveys from countries in Sub-Saharan Africa, including Nigeria showed that most of the fistula in the region were due to complications of childbirth (90.4%), followed by pelvic operations (5.3%), and sexual assault (4.3%) (Maheu-Giroux, 2015). In addition to these causes, reports from many hospitals in northern Nigeria show that between 2.3% to 6.2% of OF cases seen are due to gishiri cut (Tahzib, 1983; Ampofo et al, 1990; Oyefara, 2015). Gishiri cut is traditional surgery carried out by local barbers where they make blind incisions into the anterior vaginal wall to manage a variety of gynaecological conditions ranging from amenorrhoea, infertility, dyspareunia, to obstructed labour (Ijaiya et al, 2010). Iatrogenic genitourinary fistula, unintentional caused by healthcare provider, is becoming an increasing source of concern with a study estimating that it accounts for 13.2% of this group of fistulas (Raassen et al, 2014).

The development of most cases of obstetric fistula is directly linked to one of the causes of maternal mortality: obstructed labour among women that lack access to emergency obstetric care. Most cases occur when labour becomes prolonged, obstructed, and is not relieved promptly by caesarean section. Prolonged pressure of the bony foetal head against the maternal pelvic bone results in the destruction (necrosis) of the soft vaginal, bladder, or rectal tissue that is sandwiched between the two opposing bone surfaces. The dead tissue disintegrates after a few days leading to tissue necrosis resulting in abnormal communications between the genital tract, the urinary tract, and the rectum.

OF is seen in all age groups affecting any woman that labours for days without recourse to emergency obstetric care to relieve the obstruction. However, teenage mothers are most vulnerable as their pelvises are immature and pelvic bones too small for easy passage of the baby during labour. Studies have demonstrated a correlation between early marriage and early onset of childbearing and OF (Tahzib, 1983; Mela et al 2007; Kabir et al, 2004; Ibrahim et al, 2000). Nigeria has the highest population of child brides in the world with 22 million girls married before the age of 18 years (UNICEF, 2019). 18% and 43% of girls marry before age 15 and 18 respectively, with much higher rates in the core northern states (National Population Commission and ICF Macro, 2019). Underpinning the practice of early marriage are gender and socioeconomic inequalities, denial of human rights, and failure of the health care system to provide accessible sexual, reproductive and maternal health services, which are the underlying causes of OF (United Nations, 2020, Wall, 1998).

While the condition is more prevalent in northern Nigeria, it has been found in all other parts of the country, and it is associated with poor, rural, and uneducated girls and women (Ampofo et al, 1990; Kabir et al, 2004; Ibrahim et al, 2000; Kirschner et al, 2010; Odusoga et al, 2011; Ijaiya et al, 2002). The typical profile of an OF patient is usually a young, poor, illiterate, rural girl who had been given out in marriage at a very young age, become pregnant soon after, had no benefit of antenatal care, and at the time of delivery, laboured at home for days without going to a hospital, ending the ordeal with the fistula and most likely, a stillbirth (Tahzib, 1983; Walls, 1988). In recent times, there has been an emergence of new OF scenarios with increasing incidence of cases among older women who had previously successfully delivered vaginally (FMOH, 2019; Bello et al, 2020). These are largely attributed to declining access to skilled obstetric care and increasing recourse to alternative health care systems, including some faith- based organisations for assistance during delivery as well as the unethical practice by some physicians and midwives who perform surgeries they have not been trained to do. The low coverage with financial risk protection schemes and the high reliance on payment at the point of service delivery are pushing more women to these alternative forms of care. The interlinkages between poverty, malnutrition, illiteracy, early and forced marriage, early childbearing, violence against women, lack or inadequate access to maternal health care services, socio- cultural barriers, and marginalisation of women, are all driven by gender and social norms that discriminate against women and girls, and are the root causes of OF.

2.1.3.2 Consequences of Obstetric Fistula

OF is the most debilitating and devastating maternal morbidity, with severe physical, social, economic, and psychological consequences that are life-shattering, if left untreated (Saifuddin et al, 2016, Walls 2012). A girl or woman suffering from OF suffers urine and/or faecal incontinence. If nerve damage to the legs occurred, she would have difficulty walking. The constant dribbling of urine may result in the excoriation of the pelvis, and if left untreated, she may die prematurely from an infection or kidney failure. Unfortunately, 90% of them deliver stillborn babies (Saifuddin. 2016). With an established fistula, her life is changed forever as she is unable to fulfil

her expected role of wife and mother. Misconceptions often result in stigmatisation and ostracization of the survivors. Most times, she is rejected by her husband and ostracised by her community and left to live a life of shame and isolation. With no education and no means of livelihood, she may end up either begging, employed in casual work, or involved in commercial sex for her livelihood, which has implications for STIs/HIV prevalence. The high burden of OF in the country is a glaring reminder of the failure to address the basic human rights and health services needs of our women and girls. Despite the realisation of its debilitation and the significant marginalisation and social exclusion it causes, it remains a largely neglected and 'hidden' disease. It is imperative to note that the Millennium Development Goal 5 and the subsequent Social Development Goal 3 have targets for the reduction of maternal mortality, the former a reduction of 75% between 1990 and not more than 70 per 100,000 live births by 2030. Since OF is caused by the same determinants, strategies put in place to reduce maternal mortality will contribute to reducing the incidence of OF.

2.1.3.3 Campaign to End Fistula

Recognizing that OF, hitherto a neglected condition that affects a large number of marginalised women is preventable and treatable, noting that addressing it provides an entry point to respond to the many developmental issues that disempower women and limit their access to reproductive health services. In 2003, UNFPA and its partners started a global Campaign to End Fistula[5]. The campaign aims to make fistula as rare in developing countries as in developed countries through support for the surgical treatment and reintegration of fistula patients, training of doctors, nurses, midwives, and community health workers with support to improve emergency obstetric services and family. Nigeria is one of 50 beneficiary countries. In 2013, the United Nations commemorated the first International Day to End Obstetric Fistula on 23rd May, to raise awareness of this issue and mobilise support around the globe. The International Day to End Obstetric Fistula is observed annually around the world by various partners committed to ending fistula. In 2016, UN Secretary-General Ban Ki-moon called upon the world to 'end fistula within a generation. UN Resolution 75/159 of 2020, called on member states to intensify efforts to eliminate OF as a deliberate effort toward attainment of the SDGs by addressing interlinkages of the determinants of OF and ensuring equitable coverage and timely access to health care services, especially skilled attendants at delivery and emergency obstetric and newborn care services. OF treatment and family planning services that are accessible, financially affordable and culturally sensitive, should be provided in rural and the most remote areas. The global agenda towards eliminating OF is premised on strengthening each country's fistula programme and supporting national ownership, sustainability, and accountability for obstetric fistula policy development and problem-solving toward 2030.

The National Strategic Framework for the Elimination of Obstetric Fistula

In 2005, the Federal Ministry of Health published its first National Strategic Framework for the Elimination of Obstetric Fistula (NSFEOF), the second framework for 2011–2015 period, and the third for 2019 – 2023 period. Reviews have shown that the goals and targets set out in the first two strategic roadmaps remain largely unmet. The third strategic framework's goal is to eliminate OF by eliminating the incidence of OF through universal access to sexual and reproductive health and maternal health services for women and girls; strengthening and expanding OF treatment centres, fostering community participation, promoting intersectoral collaboration and behaviour change communication that promotes appropriate care seeking behaviour.

OF interventions are grossly underfunded in Nigeria. Although the Federal Government makes budgetary provisions for the three federal fistula centres, National Obstetric Fistula Centre Abakaliki, Ebonyi State, National Obstetric Fistula Centre, Katsina State, and the National Obstetric Fistula Centre Ningi, Bauchi State, releasing the funds is a major challenge. The other 12 dedicated fistula centres in the country are managed by the state government with little or no specific allocations for obstetric fistula. These include: Maryam Abacha Women and Children's Hospital, Sokoto State; General Hospital, Calabar, Cross River State; Hajia Gambo Sawaba General Hospital and VVF Centre, Zaria, Kaduna State; Gesse VVF Centre, Birnin Kebbi, Kebbi State; Faridat Yakubu General Hospital, Zamfara State; Laure Fistula Centre at Murtala Mohammed Specialist Hospital, Kano State; Sobi Specialist Hospital, Ilorin, Kwara State; Jahun VVF Centre, Jigawa State; Jericho Nursing Home, Ibadan, Oyo State; ECWA Evangel VVF Centre, Jos, Plateau State; Family Life Centre/VVF Hospital, Uyo, Akwa Ibom State, and Specialist Hospital, Maiduguri, Borno State.

Development partners supporting fistula repairs in Nigeria include UNFPA, the lead partner through the Global Campaign to End Fistula, the United States Agency for International Development (USAID) through various projects dedicated to obstetric fistula, Médecins Sans Frontières (MSF), Fistula Foundation, and Rotary International.

5. https://endfistula.org/

2.2 Conceptual Framework for the Landscape Study

2.2.0 Introduction

The landscape study focuses on the specific and multidimensional effects of SGBV on women's lives and livelihoods. The study situates violence against women as part of the age- long unequal power relations between men and women which continues to explain the root causes of women's subordinate position in society, and violence against women and girls across societies. Hence, sexual and gender-based violence is seen as 'violence' perpetrated against women for the sole reason of being women, in particular, in extremely patriarchal societies, which present masculinity with power, domination, and control over women. As stated in an existing study (Dutt, 2018), violence against women is legitimised under patriarchy, as it is seen as a natural phenomenon.

At the heart of this study is the challenge of the dominant androcentric traditional knowledge considered as neutral or objective in the scientific sense, but oblivious of the specific historical, political, social, and personal conditions in which knowledge is produced. Feminists have argued that androcentric knowledge makes invisible gender differences and gendered conditions. Feminist epistemologies claimed that knowledge is dynamic, relative, variable, and at best a process. For example, violence against women has multiple and multidimensional effects, but all of these are situated within a common denominator - gender. To capture both objective and subjective realities of SGBV, it is important to balance the use of both quantitative and qualitative indicators, and in particular, give credence to the 'voices' of women who daily experience this phenomenon. Presenting the objective-subjective balance in explaining SGBV and its variants cannot be achieved using a single paradigm; hence, the use of an integrated model for this study (see Fig 3).

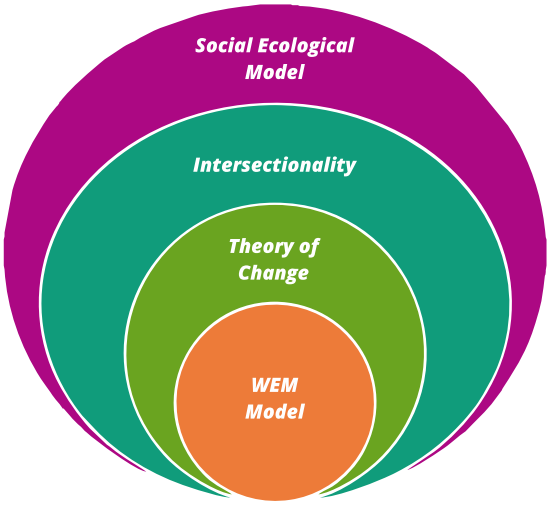


Figure 3. : Integrated Model for Understanding SGBV

The study employs an integrated model (a combination of models) in its efforts to explain, predict, and explore SGBV and its complexities. Apart from understanding the content and context of SGBV, its causes, impacts, and consequences, it is also important to explore 'what works' and 'what does not work' in terms of individual and systemic responses to SGBV and its variants. Hence, the use of the integrated conceptual model, expressed in the analytical reasoning found in the ecological model, the intersectionality approach, the theory of change, and the women empowerment model which are enumerated below:

2.2.1 Social Ecological Model

The Social Ecological Model (SEM) explains why SGBV incidences occur, and the potential prevention strategies. According to Glanz, Rimer, and Viswanath (2008), the social-ecological model identifies individual, interpersonal, community, organisational, and societal factors as important factors to consider when planning and implementing health promotion interventions in this sector. These factors are important because they directly or indirectly influence a person's lifestyle, behaviour, choices, and healthy options. The CDC, in its work on SGBV, constructed four levels of engagement with SGBV which are: individual, relationship (household/other intimate relationships), community, and society. Thus, prevention strategies in the sector, primarily generate multi-level programmes for behavioural change. At the individual level, the factors predisposing a person to the likelihood of becoming a survivor or perpetrator of SGBV are identified as age, education, income, substance use, or history of abuse. Prevention strategies at this level target change in an individual's attitudes, beliefs, and behaviour. At the relational level, the model explores an individual's experiences with peers, intimate partners, and family members that could predispose a person to the risk of SGBV. For the community level, the model explores such settings as schools, workplaces, and neighbourhoods, and the types of social relationships which can further exacerbate the SGBV experience. Here, the model also targets specific interventions. At the societal level, the model looks at broad societal factors which either aggravate and/or reduce incidences of SGBV.

These factors include gender and social norms, and other cultural norms which impede women's power and autonomy. Figure 4 presents the social-ecological model used in this study, adopted from the CDC. Notably, the social-ecological model is limited in use, as the model may not be able to explain other intersectional factors which fuel gender inequalities in society. More importantly, treating women and men as homogenous categories tends to hide the dynamic nature of gender inequalities, and the weakness of intervention programmes which treat women and men as such.

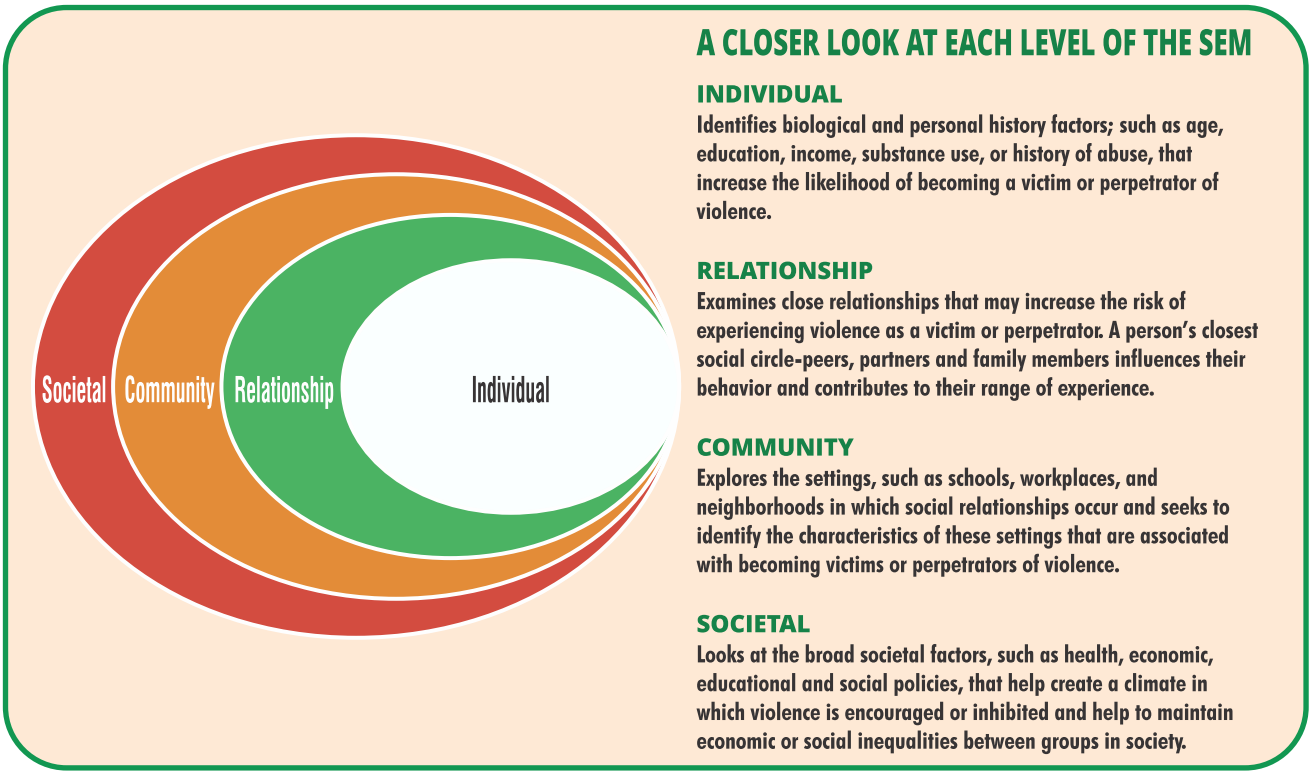


Figure 4. : Social Ecological Model for Explaining SGBV
Source: https://www.acesdv.org/wp-content/uploads/2014/06/Social-Ecological-Model-for-Prevention.pdf

2.2.2 The Intersectionality Approach

Women and men are far from being homogenous groups; rather, they are further defined by other social factors such as - age, class, religion, geographical location (rural, peri-urban, urban), and all forms of vulnerabilities/disabilities, among others. With its foundation in structural inequalities, an effective response to sexual and gender-based violence will require addressing the circumstances and causes of/and oppression that surround both the perpetrator and the victim/survivor. This is addressed within the framework of intersectionality. The concept of 'Intersectionality,' according to the Centre for Intersectional Justice (2021), describes "the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination "intersect" to create unique dynamics and effects". Intersectionality explains the interconnected nature of oppression and social categorisations such as race, class, and gender. Every form of inequality is interlinked, and thus, can be addressed simultaneously to prevent one from leading to another.

Intersectionality consists of 3 basic building blocks: social identities, systems of oppression, and how they intersect. These are generally expressed in a variety of ways, including those listed below:

i. **Social identities:** These relate to the groups or communities to which a person belongs. The group to which a person belongs often gives them a sense of who they are. For instance, social class, race/ethnicity, gender, and sexual orientation are all social identities. A person is usually a member of many different groups or communities at once; in this way, social identities are multi-dimensional. An individual's social location is defined by all the identities or groups he/she belongs to.

ii. **Systems of oppression:** These refer to the systems and structures that create inequality and social exclusion. These systems are often built around societal norms and are constructed by the dominant group(s) in society. They are maintained through the use of words ('stereotypes'), social interactions (e.g., "catcalling" women), institutions, laws, and policies. Systems of oppression include racism, colonialism, heterosexism, class stratification, gender inequality, and ableism.

iii. Social identities and systems of oppression do not exist in isolation. Instead, they can be thought of as intersecting or interacting. In other words, individuals' experiences are shaped by how their social identities intersect with each other and with interacting systems of oppression. For instance, a person can be 'poor', 'a woman', and 'elderly'. This

means she may face classism, sexism, and ageism as she navigates everyday life, including experiences of violence.

The intersectionality model may not sufficiently provide an analytical sense for the kind of transformative change provided using the Theory of Change as a model to bring about structural changes required in the types of interventions needed to bring about the desired goal concerning ending SGBV in a social environment.

2.2.3 The Theory of Change

The Theory of Change is a broad description of how and why the desired change is expected to happen, and the expected inputs that would contribute to its achievement. It is focused in particular on mapping out what can be described as the "missing link" between what the problem is and the desired goals. The Theory of Change identifies the desired goals and then uses the same to map out all the conditions that must be in place for the goals to be achieved (The Centre for Theory of Change, 2021).

To address SGBV issues using the Theory of Change, Gender and Development Network (2015) identified seven key principles to bring about the desired change, which are listed below:

i. **Context is critical:** Successful interventions on SGBV should be tailored towards factors that cause and strengthen these, in each setting and community affected. With the knowledge that SGBV is rooted in gender inequality and strengthened by cultural and traditional beliefs and practices, any intervention that will successfully tackle it must first address the inequality in power relations between both sexes.
ii. The state has primary responsibility for action on Violence against Women and Girls: Government has the ultimate responsibility for developing and implementing laws, policies, and services to reduce or eliminate sexual and gender-based violence within the society.
iii. **Holistic and multi-sectoral approaches are more likely to have an impact:** Coordinated interventions operating at multiple levels, across sectors, and over multiple timeframes are more likely to address the various aspects of, and therefore have a greater impact on, tackling Violence against Women and Girls.
iv. **Social change makes the difference:** reduction in the prevalence of SGBV will only occur through considerable social change at all levels of society.
v. **Backlash is inevitable but manageable:** resistance to tackling violence against women and girls, which may include increased risk of further violence against women and girls, is inevitable where root causes are being addressed. It is important to manage backlash carefully.
vi. **Women's rights organisations create and sustain change:** Ensuring support for women's rights organisations, working on ending violence against women and girls, making a change, and building strong and inclusive social movements are effective strategies for building sustainable change in the lives of women and girls.
vii. **Empowering women and girls:** This is seen as both the means and the end in addressing SGBV in society because it focuses on tackling gender inequality which is the core cause of violence against women and girls. The goal of engaging with SGBV both at the levels of policy and programs is to empower women and girls to stand up against SGBV with vigour and energy, and to bring perpetrators to justice. The Women Empowerment Model presents the analytical framework for understanding how this works, not just in theory, but also in practice.

2.2.4 Women Empowerment Model

Women Empowerment Model (WEM) explores the extent to which women/girls are empowered to exercise more choice and voice through the transformation of power relations, thereby having more control over their bodies and sexuality. It is also noted that women and girls experience empowerment in varying degrees and different circumstances, depending on their social placement e.g., age, education, socio-economic background, etc. A woman's or a girl's ability to make choices may influence the scope of opportunities taken, while a strengthened voice within the household could lead to greater influence and control over her time and resources. This does not happen without the transformation of unequal power relations which characterised patriarchal societies, which privileged men with power and authority over resources, including control over women and girls. Transformation of power relations occurs when women and girls exercise agency and take action through expanded access to and control over resources, and changes in institutional structures that ultimately shape their life chances and opportunities (see Figure 5).

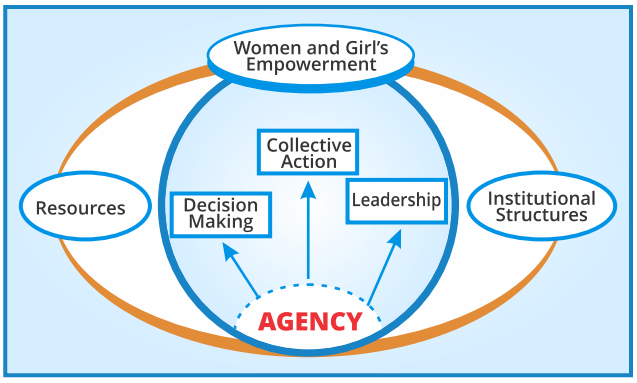


Figure 5: Women Empowerment Model

Source: Adapted from Van, A. et al (2017)

The key elements in the WEM model (agency, resources, and institutional structures) are operationalised for this study as stated below:

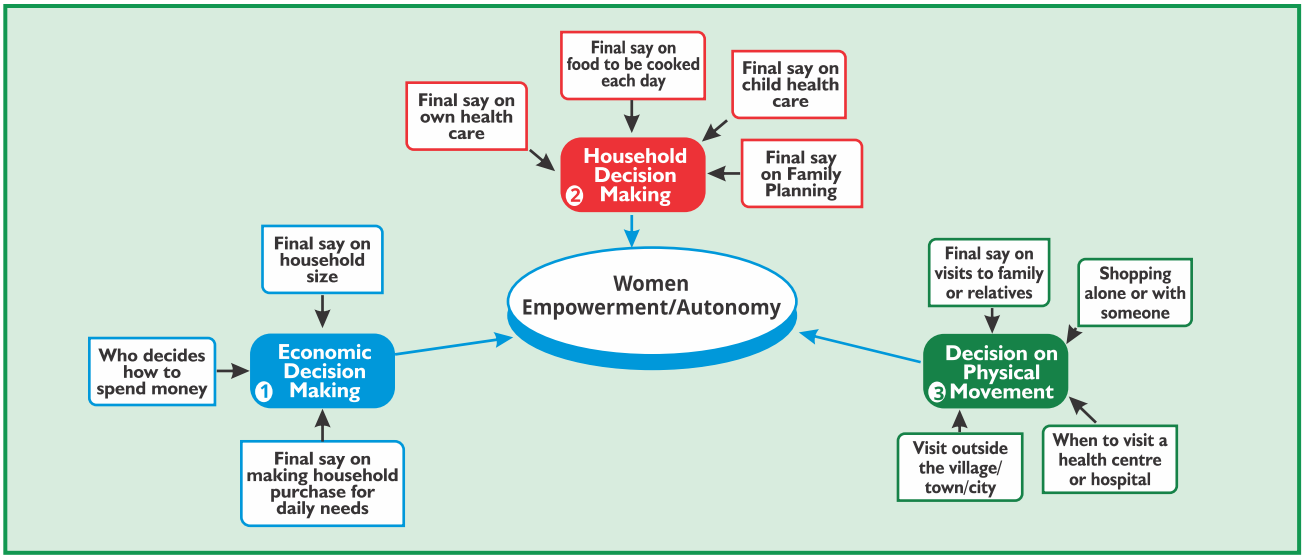
i. **Agency:** refers to women/girls' ability to take purposeful action and pursue goals, free from the threat of violence or retribution. These are expressed in the form of power to make decisions over their lives and livelihood, including their sexuality, recognition as leaders in their own right, and participating in collective action, especially those which help to change their lives' options.

ii. **Resources:** These are tangible and intangible capital and sources of power that women and girls have, own, or use individually or collectively in exercising agency. In relation to this study, the key resources in this SGBV Empowerment model include women and girls' bodily integrity (health, safety, and security), critical consciousness, and assets (financial and productive assets, knowledge and skills, time, and social capital). These are resources important for women and girls to confront conditions of sexual and gender-based violence.

iii. **Institutional structures:** These are the social arrangements, which could be both formal and informal rules and practices that shape and influence women and girls' ability to express agency and assert control over resources, especially those which could influence their ability to fight and confront sexual and gender-based violence. Institutional structures could be expressed at different levels - household, community, and the state. These are also found in formal laws and policies, as well as in the norms that shape gender role relations across social groups.

Each of these elements and their dimensions is interrelated and can be mutually reinforcing, offering entry points for interventions when addressed explicitly and intentionally. The framework for the construction of the women empowerment/autonomy model can be used to monitor gender transformative change. The study thereby explores this model to construct the women empowerment/autonomy index for an analytical framework. The Women Empowerment/Autonomy Index is used to determine the extent to which women are involved in household and economic decisions, and the level of control over their movement among others. All these elements are yardsticks for gaining autonomy, and freedom from gender- based violence.

Figure 6: Conceptual Framework for the assessment of Women Empowerment Model in this study



2.2.5 Synthesis of the Models

The adoption of an integrated model (a combination of the ecological model; the intersectionality approach; the theory of change; and the women empowerment model) helps to elucidate not only the context within which SGBV occurs in the country but also the content of programmatic actions for the elimination of SGBV. It is not enough to understand the context in which SGBV occurs (the use of social-ecological model), but also important is the ability to engage with the following: intersecting factors (intersectionality model), the quality of change (the theory of change model), and the extent to which survivors are supported through the various stages of empowerment, including welfare, access, conscientisation, participation and control (the women empowerment model). Thus, SGBV interventions and frameworks need to be sensitive to the dynamics and the complexity of the social determinants of SGBV, and their impacts and consequences for sustainable human development.

PROCESS AND METHODOLOGY

3.1 Background to the Study Location

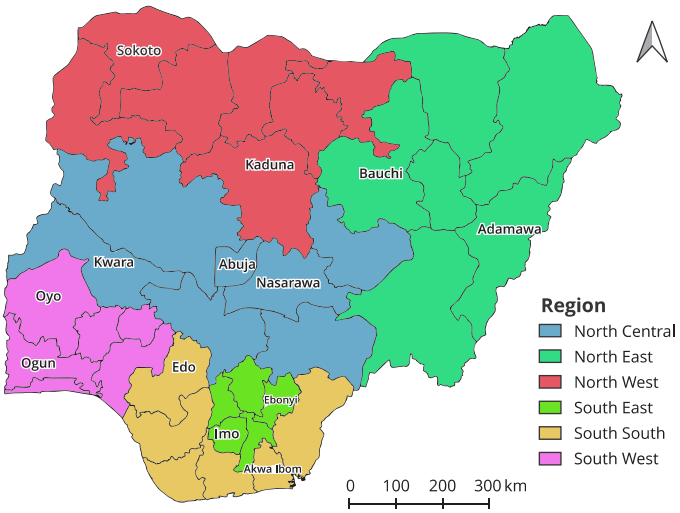
Nigeria, the most populous country in Africa, has an estimated population of 216 million people spread across 36 states and the Federal Capital Territory, and 774 Local Government Areas (LGAs). The states are grouped into six geo-political zones, based on similarity in ethnicity and/or common political history. These zones are North Central, North East, North West, South East, South-South, and South West.

There is so much diversity in culture and socio-economic development across zones in the country. While there are an estimated 400 ethnic groups and 450 languages spoken in the country, the predominant languages are Hausa, spoken in the northern states, Yoruba in the South West and Igbo in the South East. Significant cultural and gender relations differences exist across the zones of the country, with two of the northern zones, the North West and North East being more similar and more conservative.

The North West and North East zones have a high prevalence of illiteracy, the low status of women, associated high levels of early marriage of girls, and the preponderance of rural settlements within a wider context of poverty. The proportion of educated population in the southern zones is higher than the Northern zones. In the Northern zone, the proportion of educated population in the North Central zone is higher than the North West and North East zones, and the southern zones in the country. Across the zones, as the proportion of educated population increases, the population becomes more heterogeneous, with an increasing number of diverse ethnic groups, languages, and socio-cultural patterns. The Boko Haram insurgency in the North East zone has continued for more than a decade and the banditry and kidnappings in the North West zone have heightened insecurity, with implications for SGBV.

3.2 The Study States

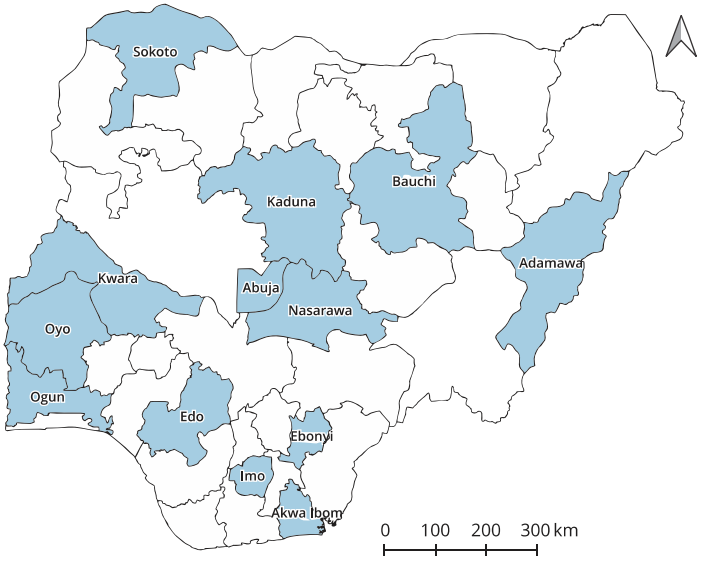
The survey was conducted in 12 states and FCT that spread across the six geo-political zones, thereby ensuring a national representation. A probability sampling technique was used to select the study sites/states. All the states in each geographical zone were listed and categorized into two (2) subgroups based on geographical congruity and cultural affinity. A total of 12 sub- groups emerged. One state was randomly selected from each subgroup using computer- generated random numbers. The three (3) Global Affairs Canada/UNFPA project states and the Federal Capital Territory were purposively selected.



Figue 7: Map of states by Geo-Political Zones and sub-zones

The final study states selected from the six (6) geo-political zones and the FCT were as follows:

i. North East: Bauchi and Adamawa States
ii. North West: Sokoto and Kaduna States
iii. North Central: Nasarawa, Kwara, and FCT
iv. South West: Oyo and Ogun
v. South East: Ebonyi and Imo States
vi. South South: Akwa Ibom and Edo States



Figue 8: The map of the study states

3.3 Study Design

The study employed a cross-sectional descriptive design and used a concurrent mixed method involving the use of both quantitative and qualitative techniques for primary data collection and analysis. Mixed method designs exemplify the argument that no single methodology is self-exhaustive, thus generating evidence from multiple sources on a single reality enhances the validity and robustness of study findings. Consequently, the landscape study sought multiple perspectives in generating contextualised evidence that addresses the social realities of SGBV including HPs and OF in Nigeria. Data for the quantitative component was collected using a population-based household survey while a variety of qualitative methodologies – focus group discussions (FGD), key informant interviews (KII) case studies, and facility assessments were employed. While the quantitative data will provide information on the magnitude and distribution of the factors under study, the qualitative component will deepen our understanding of the phenomena by giving meaning to the quantitative data.

3.3.1 Quantitative Research Design

a. Study population

The study population for the quantitative component comprises:

Women in the reproductive age group: These were women aged between 15-49 years, either single, married or divorced that were residents in the sampled states and had been residing in that community for at least 12 months. Because early marriage and early childbearing are prevalent, married female adolescents aged less than 15 years were also included in the study.

Men: These comprised males that were aged 18 years and above and residents of the community.

B. Sampling Procedure

A multistage probability cluster sampling procedure was used to recruit the target populations. A probability sampling procedure was used at all stages of the selection process namely: states, LGAs, Enumeration Areas (EAs), households, and the individual female and male respondents.

Stage 1: Selection of States

All the states in each geographical zone were listed and categorized into 2 sub-groups based on geographical congruity and cultural affinity. A total of 12 sub-groups emerged. One state was selected from each subgroup using a simple random sampling method (computer-generated random numbers). The three GAC/UNFPA project States and the Federal Capital Territory were purposively selected.

Stage 2: Sampling of LGAs

A third of the LGAs in each selected state were sampled for the survey. A list of all the LGAs in each sampled state was obtained and listed in geographic order with their respective projected population. The cumulative population was computed and using probability proportionate to sample size (PPS) approach, a third of the LGAs in each selected state was sampled.

Stage 3: Sampling of Enumeration Areas

The sampling frame comprised the Population and Housing Census Enumeration Areas used during the 2006 national census, which was conducted by the National Population Commission. During the census, enumeration areas were carved out of the local governments. These census enumeration areas served as the sampling units for this stage of sampling. The EAs were referred to as clusters. For each state, all the EAs from sampled LGAs were obtained and arranged in geographic order along with their respective populations. Using probability proportionate to size, 30 clusters were sampled.

Stage 4: Sampling of respondents

Following the sampling of the EAs, Research Assistants were deployed to identify, map the EAs and carry out household listings in the clusters. After the household listing, basic demographic information was collected on each household member. All households listed in each EA (cluster) were sent to the Central Server and later retrieved from the server for the final sampling of households and individual respondents. The eligible respondent(s) in each household were females aged 15-49 and married adolescent girls aged 10-14 years, and males 18 years and above. These respondents were filtered to form frames (one for eligible females and the other for eligible males) for the final sampling of respondents.

Stage 5: Sampling of Respondents

The lists of all eligible persons from each cluster were ordered by building number and household number and eligible respondents were sampled using a computer-based systematic sampling method. A total of 17 eligible female respondents and nine (9) eligible male respondents were sampled from each cluster for interviews. This was done centrally, and the list of the final sampled eligible respondents was preloaded with their identification details into the data capturing equipment for the interview (using a structured questionnaire

schedule).

The survey interviewers interviewed only the pre-selected males and females. To prevent bias, no replacements and no changes to the pre-selected households were allowed in the implementing stages. Due to the non-proportional allocation of the sample to the different states and the possible differences in response rates, sampling weights were calculated, added to the data file, and applied for results to be represented at the national and domain levels.

c. Sample size determination

Quantitative Women: Equal sample size of women (age 15-49) was sampled in each of the 13 reporting domains and all eligible women in each domain had an equal chance of inclusion in the study.

The sample size for the quantitative data was determined using Fisher's formula given

$$n = Z^2pq/d^2$$

Where n is the sample size

P is the estimate of the proportion of interest (I.e., the prevalence of SGBV=28%).
q is the estimate of the proportion not affected by the interest (72%)
d is the level of precision
Hence, $n = 1.96^2(0.28)(0.72)/0.05^2$
n = 309.8, assuming a straight simple sample.

Thus, adjusting for the cluster effect, a Design Effect (deff) =1.5 is applied to adjust the sample size to (309.8 x 1.5) = 464.7 and taking into consideration an overall non-response rate of a maximum of 10% to bring the sample to 517 women per state.

This sample was shared equally across the 30 clusters in a reporting domain (state); this was unweighted. Thus, a sample of 17 women aged 15-49 including married females of <15 years old was included in each cluster for the survey.

Quantitative (Men): The same formula used for the computing sample size for the females was used with the following parameters:

P is the estimate of the proportion of interest (i.e., the prevalence of SGBV=28%) q is the estimate of the proportion not affected by the interest (72%)
D is the level of precision
Hence, $n = 1.96^2(0.28)(0.72)/0.10^2$
n = 154.9 assuming a straight simple sample.

Thus, adjusting for the cluster effect, a Design Effect (deff) =1.5 is applied to adjust the sample size to (154.9 x 1.5) = 232.4 and taking into consideration an overall non-response rate of a maximum of 10% to bring the sample to 258 men per state.

This sample was recruited from 30 clusters in a reporting domain (state). Thus, a sample of nine (9) men of age 18 and above were sampled in each cluster for the survey.

d. Data Tools

Questionnaire Development

Two sets of questionnaires were developed – a female questionnaire and a male questionnaire. The process of development of the questionnaires included discussions and consultations with the funding agency, government partners and a review of existing tools on the internet. Following these consultations, the national consultants developed the first draft of the data tools. This was extensively reviewed by UNFPA and Global Affairs Canada, and also by state coordinators recruited for the study. The national consultants revised the questionnaires based on the inputs received. This was again shared with the consultant analysts and UNFPA for further input before finalisation.

The questionnaires were translated by language experts into the three major Nigerian languages – Igbo, Hausa and Yoruba and back-translated by state coordinators proficient in the different languages. The translated questionnaires were pretested during the training of the state coordinators before finalisation. The final questionnaires were uploaded on ODK in tablets and given to the research assistants.

e. Data Collection

Data collection was carried out in each state by a team of six (6) female interviewers and three (3) male interviewers under the coordination of a state coordinator, a senior sociologist, or public health expert. Data collection lasted for two weeks on average. During the period of data collection, the supervisors and Coordinators carried out field supervision and monitored the outputs of the teams.

f. Data analysis - Quantitative Additional weighting for data analysis

Final sampling weights (Sw): For individual sampled.
The Final inclusion probabilities of the individuals were obtained as the product of the inclusion probabilities, that is F_{hai}:

$F_{hai} = \pi 1ha X \pi 2ha X \pi 3ha X \pi 4hai$ and the final sampling weight for the i^{th} individual in the α^{th} cluster of the h^{th} state was obtained as $W_{hai} = 1/F_{hai.}$

Adjustment for Cluster non-response:

The final sampling weights for the individuals were adjusted for non-response by target group (male or female) by cluster to obtain the final individual adjusted weights (F_{iaw}) used for data analysis.

The base weight (B_w) for each target group for each of the 390 clusters was obtained by summing the final sampling weights of all individuals sampled for each target group (male or female) for the cluster as ∑Whαi. The corresponding response weight (R_w) was also obtained by summing the final sampling weights of those that responded to the interview. The Final Weight adjustment factor was obtained by dividing the base weight by the response weight, Fiaw = B_w/ R_w.

It is the final individual adjusted weights (Fiaw) obtained that were attached to the individuals' data (case) that were used for analysis at zonal and national levels. Analysis at the state level did not require weighting since the sampling at the state level is representative.

Study Variables

The study variables included:

Explanatory (independent) Variables
- Household socio-economic status
- Socio-demographic characteristics: age, education occupation, religion, zone
- Marriage history: age at marriage, number of marriages, length of marriage

Outcome (dependent) Variables
- Awareness on types of SGBV, HPs and OFs: Aware or not aware.
- Knowledge of SGBV, HPs and OFs: adequate or inadequate.
- Perpetrators of SGBV and HPs: Partners or other men.
- Experience of SGBV, OFs and HPs: Yes or no.

KEY SECTIONS COVERED IN THE QUESTIONNAIRE
Identification
Respondents' background
Household Resources
Current/most recent partner characteristics
Gender norms, roles and practices
Harmful Traditional Practices·
Vesico-Vaginal Fistula

Possible Confounders
- Age and sex are possible confounders in the relationship between household SES/socio-demographic characteristics and knowledge/experience of SGBV, HP, and Ofs.

Data were analysed with Statistical Product and Service Solutions (SPSS) and STATA software. The open-ended questions were coded before submission to the quantitative analysis process. Descriptive statistics were used, and results were presented in frequencies, means, standard deviations, etc, using appropriate indicators and variables. Bivariate analysis, with the chi- squared (X2) test, was used to determine, for instance, the associations between socio- demographic characteristics by knowledge/experience of SGBV, HPs, and OFs. Socio-demographic characteristics of knowledgeable women were compared with those who are not, to identify determinants. Similarly, household socio-economic characteristics influencing the experience of SGBV, HPs, and OFs were identified.

3.3.2 Qualitative Research Design

For the qualitative component of the study, a phenomenological approach was employed to complement the quantitative study variant, using Focus Group Discussions, Key Informant Interviews, In-depth Interviews, observation, and facility assessment checklists.

a. Target groups

The target groups for the qualitative phase included individuals (adolescents, young adults, and older adults), and related institutions involved in curbing incidences of SGBV in the country including health institutions; the Nigeria Police Force; the Ministry of Women Affairs; Ministry of Health; Ministry of Justice; local NGOs, and Development Partners working in the sector.

b. Sampling technique and Sample size

A purposive sampling technique anchored on different strata (age, gender, and social categories) was used. FGD participants were recruited from the 30 EAs where the household survey took place. This was done through a random selection of seven (7) communities within the selected EAs, and one FGD was conducted in each of the seven (7) communities selected. The inclusion criteria for the FGDs include: being resident in the community, and age categories (females = 15 to 49 years; males = 18+; youths/adolescents age = 10 to 24 years). The purposive sampling technique was also used to select the Key informants based on their activities concerning efforts at curbing SGBV in the country while case assessments of the health and police facilities serving the selected communities were carried out. Finally, one (1) or two (2) perpetrators or survivors were also identified through the police or health facilities.

The total number of interviews from each of the 13 states are under the different categories listed below:

FGDs

i. FGD with older women 25 years and above
ii. FGD with women/girls less than 25 years (≤24 years)
iii. FGD with older men 25 years and above
iv. FGD with men/boys less than 25 years (≤24 years)
v. FGD with Community/Opinion leaders – men
vi. FGD with Community/Opinion leaders – women
vii. FGD with NGOs/SBOs/FBOs/CSOs working in the SGBV sector

Key Informant Interviews (KII) – any 4 from the list
i. Perpetrator – One
ii. Community/Opinion leader – One
iii. Gender Officers in the Ministry of Women Affairs
iv. Policy Maker (State Assembly or National Assembly)
v. Police Gender Desk officer

Case Assessment and KII (2)
i. Health Facility or NGO/CBO/FBO
ii. Police/Security Agencies (Gender officer) or Judiciary

Case Study (maximum 2)
- Survivor – 1 or 2

Community Checklist (7) – one per community where FGD took place. Thus, a maximum of 22 interviews and checklists were conducted in each state.

c. Data Collection

Each fieldworker employed had a minimum of a first degree and vast experience in qualitative data collection and transcription. The qualitative fieldwork was carried out concurrently across the selected 12 States and FCT which lasted for 10 days in each of the study sites.

In each community, a community mobiliser assisted in securing the venue and helped to identify eligible participants. A pre-FGD screening questionnaire was administered, and selection was made based on inclusion and exclusion criteria. Each session of the interviews was conducted by a moderator and a note taker and lasted for an average of one hour in the case of KIIs and IDIs or an average of 1 hour 30 minutes in the case of FGDs. Each interview session was recorded with a digital voice recorder and uploaded into a secured passworded computer with a clear label based on the standard agreed upon during the zonal training. At the end of each interview session, the moderator and the note taker debriefed to document the interview.

d. Data collection instruments

The qualitative data was generated using multiple, but connected qualitative techniques involving the use of FGDs, KIIs, Observation, Facility Case Assessment, and Case Studies (Survivors & Perpetrators). Each method focused on capturing an aspect of the realities of SGBV as conceived, explained, and experienced among individuals and social groups within and across targeted social settings in the study. Each data collection instrument was constructed with a sense of capturing an aspect of SGBV within contexts and possible programmatic actions and implications. A thematic approach guided the structuring of the issues that were probed and the sequence in which the facilitation of each interview was organised. More details on the thematic issues were next presented, with a focus on cross-cutting issues in all the instruments and additional information on where there are variations in thematic focus. The KII guide has some elements of such variations due to the need for information on perpetrators, survivors of sexual violence, child marriage, widow inheritance, and OF in the study settings.

Thematic Issues in the Focus Group and Key Informant Interview Guides

The FGD and KII guides were developed around five thematic issues and four sub-themes. Each theme had a series of questions probing issues, contexts, and explanations around SGBV (including HPs and OF). The first theme, gender, and social norms provided the foundation for interrogating the norms that position men and women differently in acting within the social frames in their communities. The questions under this theme also helped in gaining a sense of the cultural norms around gender roles within the respective communities and cultures.

The theme of sexual relations and rights focused on the notions of rights and violations of such rights within the context of heterosexual marriage. The questions under the theme helped the participants and interviewees to reflect on what marital rights entail, the circumstances under which such rights can be violated, and the possible ways for seeking justice when violated.

The theme of sexual and gender-based violence, has questions on the general sense of SGBV, the predisposing factors, perpetrators, and the measures or mechanisms available to seek redress. The remainder of the questions under this theme was structured to elicit participants' responses on who the perpetrators and the survivors are, including when, why, and what can be done to address SGBV at the household and community levels.

The fourth theme was aimed at understanding the contexts and the rationale for engaging in some harmful traditional practices. The focus was on widow inheritance, child marriage, and OF, a health consequence of early girl child marriage and childbearing at teenage age. Additional questions were asked on existing measures, if any, to address any of these practices, what has worked well and what could be done,

and by whom, to address harmful practices within the study settings.

Thematic Issues in the Facility Assessment

The facility assessment guide was designed with a focus on assessing what obtains at the targeted facilities and the responsiveness of these facilities to the growing need for gender- sensitive services and care. The first section captures information about the facility, the designated officer-in-charge of SGBV cases, services provided, and training received. The background information was complemented with a checklist that required viewing and sighting of documents, the physical condition of facilities and needed equipment for provision of care and services to survivors and the prosecution of perpetrators. The other sections of the guide were also arranged by themes and sub-themes. There were questions on existing data, availability of disaggregated data by sex, and other key indicators. The sub-section was followed by a theme on laws, guidelines, and protocols on how SGBV cases are handled at these facilities. Additional questions were directed at assessing the available facilities in ensuring compliance with regulations and guidelines of operations. The latter part of the guide captured the challenges these facilities are experiencing in providing the needed care, services, and support for survivors and prosecution of perpetrators of SGBVs.

Case Studies Guides and Observational Checklist

Two categories of cases were covered in this survey. The case study guide was structured into sections and thematic issues. The first section captures the background information on the case being assessed, whether as a survivor or perpetrator. The questions were focused on the case being studied, event(s), perpetrators, circumstances, explanations around occurrences and steps or decisions taken.

The remainder of the guide also examined the possible scenarios, explanations, and ways through which cases can be addressed. Other questions were focused on appraising existing measures, laws and other mechanisms that could be adopted to reduce vulnerabilities among social groups.

e. Analysis of Qualitative Data:

The analysis commenced with a daily debriefing of interviewers and group discussion sessions. The sessions provided the opportunity to gain a quick sense of some of the salient issues that emerged from the interviews across the study settings. Each session was handled by a team that comprised of an experienced social researcher and three team members. The analysis proceeded with verbatim transcription of all the audio-recorded interviews, group discussions, case studies and facility assessment interviews. Documentation on the communities where the interviews were conducted was also processed and added to the field notes for a deeper sense of the study settings, narratives, and views that were expressed in the interviews.
A thematic approach was adopted as suggested by Braun and Clarke (2006). First is the translation of all transcripts in languages other than English. The translated transcripts were read repeatedly by a team of qualitative experts. The reading process provided an inductive sense of the data. The codes that were developed through this initial reading were compared and discussed among the qualitative team members. Areas of conflict were discussed and resolved. The inductively developed codes were also further refined by focusing on the objectives that guided the study, the themes, and the sub-themes. The combination of inductive and deductive approaches in coding the transcripts was consistent with the overall research design that guided this study. The refined codes that emerged through this process formed the codebook. All the codes were inputted into ATLAS.ti version 9 environment where all the transcripts were filed for further analysis. Portions of the transcripts were taken as excerpts under the codes.

At the next level, codes with similarities and meanings were merged into categories and through which, themes were formed to make further sense of the data (Bryman, 2016). The names of the communities where the interviews took place are stated clearly in the transcripts. However, the names and other personal identifiers of the participants were excluded. These steps helped in maintaining a level of compliance with ethical standards around qualitative studies and the need for privacy and confidentiality (Kilburn, Nind, & Wiles, 2014). Conscious efforts were directed towards retaining the views and experiences of the participants. The words of the participants were used as excerpts that were relevant in supporting the themes and sub-themes. A complementary approach was maintained in the analysis of the qualitative data. The same strategy was adopted in the presentation of quantitative and qualitative findings in this study.

3.4. Training of Research Team

All research team members were carefully selected and were provided specialised training and support. The training included a basic introduction to SGBV and an overall orientation to the concepts of gender, and gender discrimination/inequality. There were two levels of training with a total number of 156 trainees. The first level of training which served as Training of Trainers was centrally held and lasted for three days. The training was conducted by the National Consultants and Consultant Data Analysts. The training module incorporated identification of respondents handled by experts from NPC, administration of questionnaires, use of data

capturing device (hands-on) as well as field practice.

The field workers were recruited and trained in a step-down training at the regional level in 3 locations, which was the second level of training. The South-South and South East regions had their training in Edo State. South West and North Central in Oyo State and North West, North East, and FCT were trained in Abuja. The quantitative data collectors comprised 9 males and 3 females in each state. All of them had at least post-secondary school qualifications and were experienced in surveys. A majority of the team members were drawn from the National Population Commission. The qualitative team members were graduates: either sociologists or public health specialists with experience in qualitative research. One of the qualitative team members served as the state coordinator. The training for both teams lasted five days, which included practical field sessions. The data collection exercise took place in August 2021. During the fieldwork, regular debriefing meetings were scheduled to enable the research team to discuss what they heard, how they felt about the situation, and how it affected them.

3.5 Ethical Considerations

Ethical approval was obtained from the National Health Research Ethics Committee. The World Health Organisation guidelines on researching sexual and gender-based violence were followed to ensure the study complies with all ethical standards [WHO, 2007]. Gatekeepers' permissions to access organisations and communities were obtained. The respondents gave full informed consent. Participants were also assured of their right to withdraw and that it would not affect the quality of their access to care in any way. Those who elected to participate signed an informed consent form.

Safety of the respondents and research team:
The physical safety of respondents and interviewers from potential retaliatory violence by the perpetrator or perpetrators is of paramount importance. The survey was not introduced to the household and wider community as a survey on violence, but rather as a study on women/men's health and life experiences. However, the respondent was fully informed about the nature of the questions.

- Interviews were conducted only in a private setting.
- The study was framed as a study on women/men's health, life experiences or family relations. This enabled the respondent to explain the survey to others safely.
- Only one woman/man per household was interviewed. In households with more than one eligible woman/man, a single respondent was selected randomly for interview.
- Interviewers were trained to terminate or change the subject of discussion if an interview was interrupted by anyone - including children.
- Logistics planning was taken into consideration for respondents' safety. This research team anticipated the likely need to re-schedule some interviews.
- To ensure safety, interviewers were encouraged to travel in pairs, carry mobile phones, and use designated means of transport/drivers (1,2).

Actions aimed at reducing any possible distress caused to participants by the research:
All questions about violence and its consequences were asked in a supportive and non- judgemental manner. In addition, care was taken to ensure that the language of the questionnaire could not be interpreted as being judgemental, blaming or stigmatizing. Interviewers were trained to be aware of the effects that the questions may have on the respondents and how best to respond, based on the woman's level of distress. Interviewers were trained to practice how to terminate an interview if the impact of the questions becomes too negative. All interviews ended in a positive manner reinforcing the woman's coping strategies and reminding her that the information she had shared is important.

Referral of women requesting assistance:
Fieldworkers were trained to refer women requesting assistance with available local services and sources of support. The researchers were prepared to respond appropriately to women who may need additional assistance during or following an interview (see appendix for a sample of referral form). Before conducting the study, the state teams met with potential providers of support, such as health, legal and social services and educational resources in the community, and less formal providers of support (including community representatives, religious leaders, traditional healers and women's organisations). A list of resources was developed and offered to the research team so that they could refer as appropriate.

Protecting confidentiality:
All interviewers received strict instructions about the importance of maintaining confidentiality. This was also addressed in their training. No interviewers conducted interviews in their community. Likewise, no names were written on questionnaires. Instead, unique codes were used to distinguish questionnaires. Participants were informed of confidentiality procedures as part of the consent process. Lastly, tapes of in-depth interviews with survivors of violence were kept in a locked cabinet with limited access and later erased following transcription. The permission of the respondents was sought before tape recording.

BACKGROUND OF SAMPLED POPULATION & HOUSEHOLD RESOURCES

4.0 Introduction

This chapter presents the background information of the sampled respondents in the survey component of the study. Information about the socioeconomic characteristics of the sampled population is important in understanding the contexts and nuances associated with the outcome variables of interest in this study including exposure to sexual and gender-based violence and HPs indicators. In addition, information on the socioeconomic characteristics sheds some light on the living conditions of the population.

4.1: Characteristics of the Survey Respondents

4.1.1 Distribution of Male and Female Respondents by Geo-Political Region

The percentage distribution of male and female respondents by geographical location is depicted in Table 2. (Also see Figures 9, 10 & 11). The table shows that the majority of the selected women and men live in the North West with a percentage rate of 24.9 and 23.4, respectively, followed by South West with 19.8% for women and 21.0% for men. Approximately 15% of the women and men interviewed live in the North Central, 14% in the North East, 11%, and 15% in the South East and South- South respectively.

KEY FINDINGS

Geographic coverage: The study covered all geopolitical regions in Nigeria with a sample proportion of between 11.1% and 24.9% in each zone. The ratio of female to male respondents was 21 to 10.

Household Dynamics: 43.2% of the women and 27.9% of the men were in polygamous unions while 7% of the households were female-headed.

Demographics: The mean age of the females was 29 (+ 9.9) years and that of males was 42 (+11.0) years. Forty per cent (female – 40.0%; males – 39.3%) resided in urban areas.

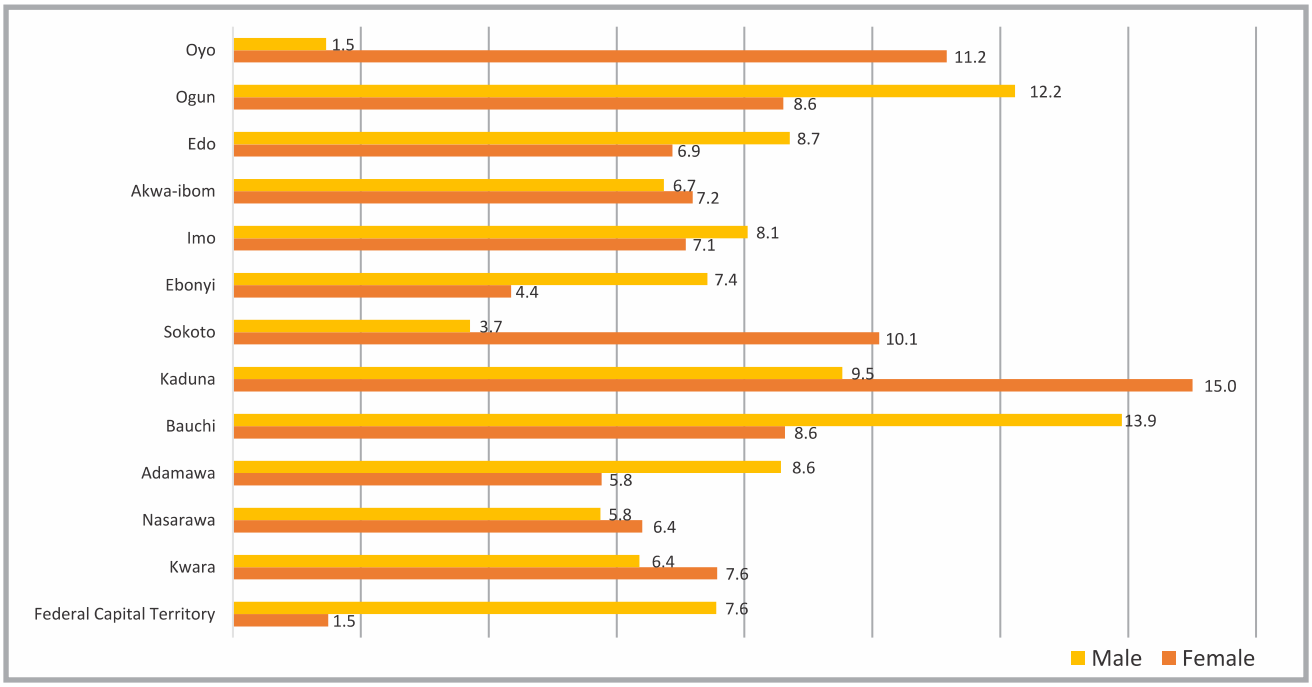
Education: More men (74.6%) had formal education compared to women (69.1%); however, more women (52.6 %) reported being able to read easily without difficulty compared to men (48.1%). It noted that 38.4% of the males have at least senior secondary education compared to females (36.8%). There was a wide regional variation in the levels of female education, with the North-East having the lowest rate.

Employment: Most of the men (94.4%) were employed compared to women (52.3%). However, most of them were working in the informal sector and earning less than the national minimum wage. The high proportion of women not currently working or earning an income (47.7%) has implications for economic dependency.

Table 2: Respondents interviewed across geographical location

Background Characteristics	Female		Male	
	Percentage	Total (N=6353)	Percentage	Total (N=3092)
Zone				
North Central	15.5	982	15.4	475
North East	14.3	915	14.3	443
North West	24.9	1,581	23.4	725
South East	11.4	726	11.1	344
South South	14.1	893	14.8	457
South West	19.8	1,256	21.0	648

Figure 9: Proportion of respondents interviewed by gender across the states



4.1.2 Household Wealth (Assets)

Scores were assigned to the households based on the number and types of consumer goods they own, ranging from a television to a bicycle or a car, and housing characteristics such as water supply, toilet facilities, and floor materials. Principal component analysis was used to calculate the scores for each household. The wealth scores for each household were categorised into five groups (quintiles) ranging from richest to poorest. In achieving this, each quintile group had one-fifth (20%) of the total number of households covered in the survey.

4.1.3 Distribution of Respondents by Age, Religion, Ethnicity, & Residence

The mean age of the women sampled was 29 (+9.9) years while that of men was 42 years (+11.0). The majority of the respondents were Christians (female - 51.8%; male – 51.2%) (see Table 3).

The survey captured ethnic diversity across the six geopolitical zones, with about 37.1% of the women and 39.9% of the men from ethnic backgrounds other than Igbo, Hausa or Yoruba. Place of residence typically determines access to services and information about health and other aspects of life. From the survey, about three-fifths of the respondents resided in rural communities.

4.1.4 Marital Status/ Family Type

Table 4 depicts the family type and marital status of the respondents. The majority of the respondents were married (Female - 64.2%; Male - 89.6%) and in monogamous marriages (Female - 56.8%; Male - 72.1%). A larger proportion of the women (43.2%) were in polygamous unions compared to 27.9% of the men.

4.1.5 Education and Literacy

Education is one of the critical factors that can influence a person's behaviour and opportunities. Table 5 shows that men (74.6%) were more likely than women (69.1%) to have attended a formal school. More men (58.5%) had had at least senior secondary school education compared to women (48.8%). However, a larger proportion of the women (52.6%) reported their ability to read with ease compared to men (48.1%).

Educational attainment was higher in urban areas compared with rural areas. About 19% and 21% of urban women and men, respectively, have no education, compared to 81% and 56% of rural women and men respectively. The proportion of women with post-secondary education was highest in the South-South (25%) and lowest in the North East (12%).

4.1.6 Occupational Status

The study found that 94.4% of the men and 52.3% of the women were employed, indicating a higher level of unemployment among women compared to men (Table 6). Sales and services were the leading occupations of the majority of the employed women (46.5%), while agriculture was the leading source of income for over one-third (38.5%) of the men. Only 22.2% of the employed women were in either professional jobs or skilled manual labour compared to men (32.7%). Information on sources of income revealed that men were the main source of income for their households (86.2%) compared to women (8.8%). More than half of the women reported that their spouses were rather their main source of income. The majority of the respondents, both men and women, earned less than the national minimum wage of N30,000 monthly (87.0% of the women and 52.2% of the men).

Table 3: Percentage distribution of respondents by selected background characteristics

Background Characteristics	Female		Male	
Age	**Percentage**	**Total (n=6353)**	**Percentage**	**Total (n=3092)**
10-14	2.1	136	-	
15-19	19.7	1,250	0.5	17
20-24	18.1	1,147	3.3	101
25-29	15.3	969	9.0	279
30-34	13.7	872	14.1	435
35-39	12.4	790	17.7	548
40-44	9.9	630	14.1	435
45-49	8.8	559	19.3	598
50-54	-	-	8.8	272
55-59	-	-	5.1	157
60-64	-	-	5.1	157
65+	-	-	3.0	93
Mean Age		29 (±9.9) years		42 (±11.0) years
Religion				
Christianity	51.8	3,292	51.2	1,582
Islam	47.9	3,045	47.3	1,463
Traditional	0.3	16	1.5	45
Others			0.1	2
Ethnic Group				
Igbo	13.2	841	13.3	410
Hausa	26.6	1,691	23.2	719
Yoruba	23.1	1,467	23.6	729
Others	37.1	2,355	39.9	1,234
Residence				
Urban	40.0	2,539	39.3	1,214
Rural	60.0	3,814	60.7	1,878

Table 4: Percentage distribution of females (aged 10 - 49) and males (aged 18-64) by marital status and family type

Background Characteristics	Female		Male	
	Percentage	**Total (n=6353)**	**Percentage**	**Total (n=3092)**
Marital Status				
Never married	29.3	1,864	8.1	250
Married	64.2	4,076	89.6	2,770
Divorced/separated	2.1	132	0.7	22
Cohabiting	0.9	57	0.5	15
Widowed	3.5	224	1.1	35
Family Type				
Monogamous	56.8	3,607	72.1	2,229
Polygamous	43.2	2,747	27.9	863

Table 5: Percentage distribution of females (aged 10 – 49 years) and males (aged 18-64 years) by education/literacy

Background Characteristics	Female		Male	
	Percentage	Total (N)	Percentage	Total (N)
Type of school attended				
None	21.3	1,355	17.5	541
Islamic	8.1	513	6.7	208
Adult Education	1.5	93	1.2	37
Formal	69.1	4,392	74.6	2,307
Literacy				
Not able to read/write	30.9	1,962	23.3	721
Read and write with difficulty	16.5	1,049	28.6	883
Read and write easily	52.6	3,341	48.1	1,488
Educational attainment				n(2,561)
No formal education	12.1	605	9.6	246
Primary not completed	5.5	274	3.0	76
Primary	19.4	968	22.3	572
Junior Secondary	14.2	710	6.5	167
Senior Secondary	36.8	1,840	38.4	984
Post-Secondary (PS)	12.0	598	20.1	516

Table 6: Respondents' occupational status and income

Background Characteristics	Female		Male	
	Percentage	Total	Percentage	Total
Employment Status (n= F:6353; M:30922)				
Yes	52.3	3,322	94.4	2,918
No	47.7	3,031	5.6	174
Occupational Status (n= F:3322; M:2918)				
Professional/Technical/Managerial	7.2	240	11.2	328
Clerical	0.7	23	1.5	43
Sale and Services	46.5	1,545	15.1	440
Skill Manual	14.1	469	20.0	583
Unskilled Manual	14.7	489	9.2	257
Agriculture	13.1	435	38.5	1,124
Domestic	1.6	53	-	-
Others	1.3	44	4.6	134
Source of Income				
Self	8.8	558	86.2	2,665
Spouse/Partner	51.6	3,275	2.8	88
Both H & W Equally	12.0	765	7.9	245
Parents	23.6	1,502	1.6	49
Children	0.7	47	-	
Others	3.2	205	1.5	45
Total	**100**	**6,353**	**100**	**3,092**
Monthly Income				
<15,000	71.2	2,348	28.8	842
15,000-29,000	15.8	521	23.4	684
30,000-80,000	12.2	401	41.2	1,204
81,000-130,000	0.3	11	3.1	92
131,000-180,000	0.0	1	0.7	21
181,000-230,000	0.1	4	1.0	28
230,000-1,000,000	0.4	13	0.8	24
Don't know			0.9	26

4.2 Household Resources

KEY FINDINGS

Drinking Water: More than a quarter of households do not have access to improved water sources..
Toilet Facilities: Almost three-fifths do not have improved toilet facilities
Basic Sanitation Service: Approximately three-fifths share toilet facilities with other households.
Bathroom Location: About three-fifths of the households have their bathroom outside separated from the house.
Sleeping Rooms: About two-fifths of the household has three or more sleeping rooms.
Sources of Energy for Cooking: Overall, 61.2% of households use wood as the main energy source for cooking.
Flooring Material: Almost all households surveyed have finished floors, with cement accounting for 59.7%.
Roofing Material: Finished roofing is present in 93% of the households surveyed, with metallic/zinc roofing accounting for 84.2% of the finished roofing.
Wall Material: More than 70% of the households polled have finished walls, with cement materials accounting for 70% of the finished walls.
Water and Residence: Seventy per cent of all households with access to improved water sources live in cities.
Wealth Status and Sanitation: A significant proportion (22%) of all households with unimproved sanitation come from the highest wealth status

Information on household resources provides a context for interpreting socio-demographic, health and cultural indicators. Furthermore, the results of such resources could shed light on household living conditions and contextual issues around sexual and gender-based violence and harmful practices.

4.2.1 Sources of Drinking Water

As shown in Table 7, a quarter of the female respondents (25.9%) got their water supply from unimproved sources. 40.8% of the households get their water from a tube well or borehole, while bottled water was the least reported source of drinking water.

Improved sources of drinking water

The options for improved sources of drinking water include piped water, public taps, standpipes, tube wells, boreholes, protected dug wells and springs, rainwater, water delivered by tanker truck or a cart with a small tank, and bottled water.

Table 7: Source of drinking water

The main source of water by HH	%	N (6353)
Pipe into dwelling/yard/pot	2.6	168
Piped to Neighbour	2.3	145
Public tap/standpipe	11.1	706
Tube well or borehole	40.8	2,592
Protected dug well	13.3	845
Protected spring	0.8	49
Rainwater	2.6	164
Tanker truck/cart small tank	0.6	39
Bottled water	0.1	5
Unimproved Source		
Unprotected dug well	11.7	744
Unprotected spring	2.2	141
Surface water	1.6	100
Sachet water	8.2	519
Others	2.2	137
Source of water located		
In own dwelling	21.1	1,340
Outside own dwelling	54.5	3,460
Public tap	16.5	1,046
Elsewhere	8.0	507
Source of water-Composite description		
Unimproved	25.8	1,641
Improved	74.2	4,712
Total	**100**	**6,353**

Figure 10: Percentage of households with improved sources of drinking water by State

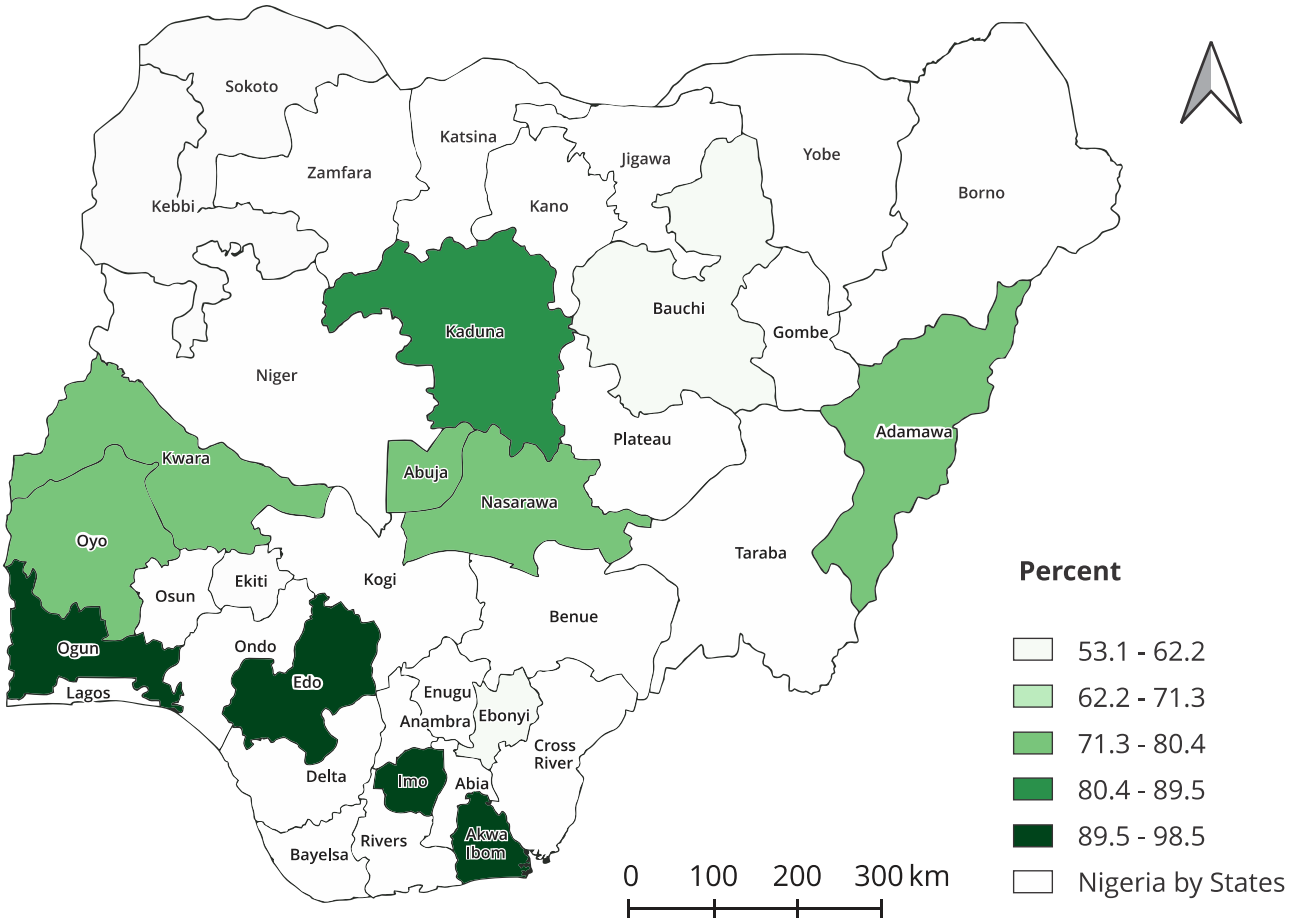
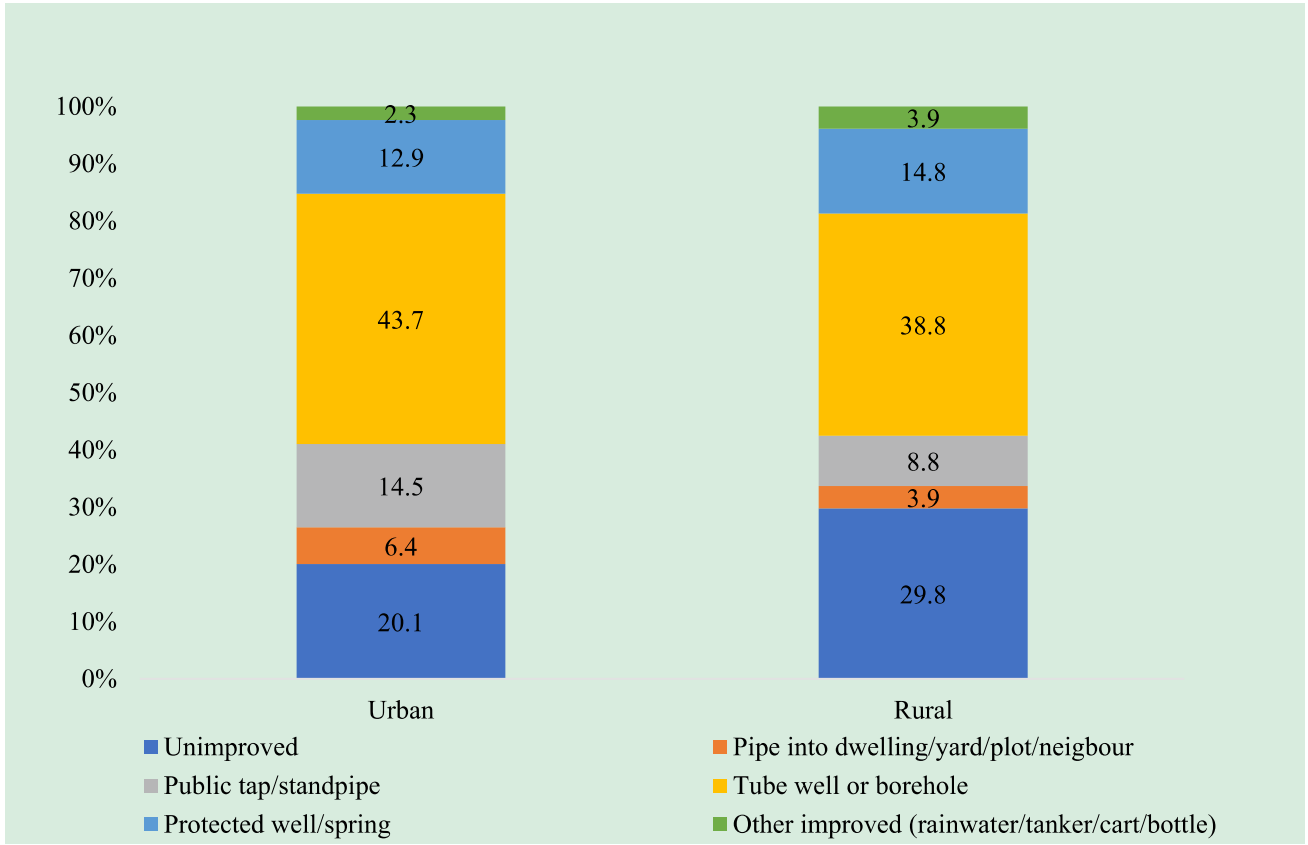


Figure 11: Percentage distribution of households by sources of drinking water and by residence



4.2.2 Sanitation Facilities

Improved Toilet Facilities
These include flush/pour flush toilets that flush water and waste to a piped sewer system, pit latrine, septic tank, or an unknown destination; ventilated improved pit (VIP) latrines; pit latrines with slabs; or composting toilets.

Basic Sanitation Service
Use of improved facilities that are not shared with other households.

Limited Sanitation Services
Use of improved facilities shared by at least two households.

Table 8 shows the sanitation facilities available to women. Overall, 43.7% of the women have access to improved sanitation facilities. Over half of the respondents (56.2%) share toilet facilities with other households and a similar proportion (57.7%) reported that their bathroom facilities were outside and separate from the house structure. Only 2.2% did not have a bathroom at all.

Figure 12: Improved Toilet by State

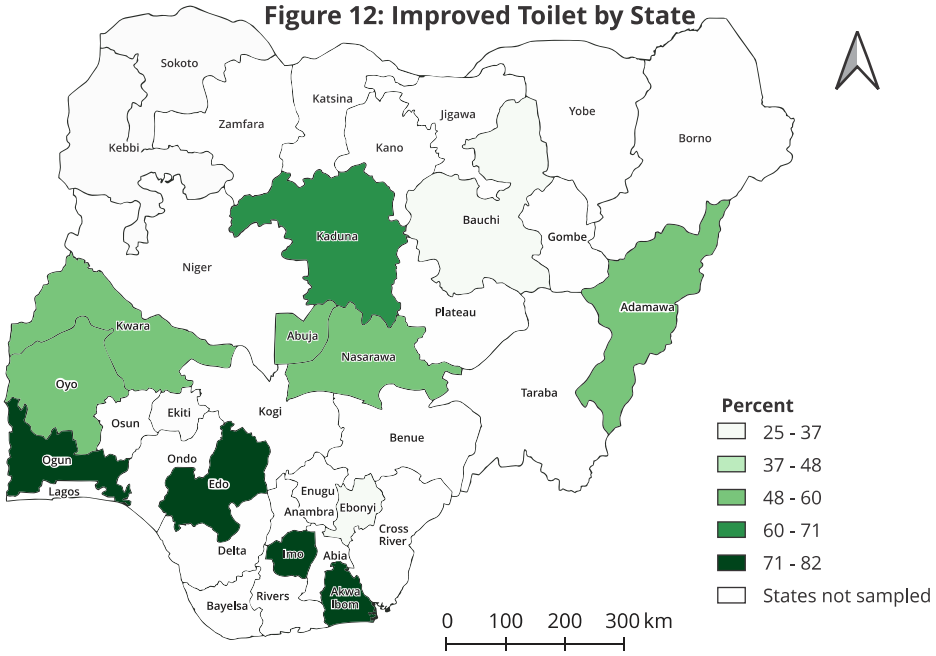


Table 8: Sanitation Facilities

Sanitation Facilities	Weighted Values	
	Percentage (%)	Total (6353)
Toilet Facilities		
Flush Toilet	25.6	1,627
Ventilated Improved Pit (VIP) latrine	4.3	271
Pit latrine with slab	26.9	1,707
Composting toilet	0.3	19
Unimproved Facility		
Pit latrine without slab/open pit	21.5	1,365
Bucket	0.0	2
Hanging toilet/hanging latrine	0.1	5
Open defecation (no facility/bush/field)	21.2	1,350
Other	0.1	7
Type of Toilet Facility		
Have own toilet	43.8	2,106
Shared toilet	56.2	2,700
Location Of Bathroom		
Inside the house	40.1	2,549
Outside separated from the house	57.7	3,667
No bathroom at all	2.2	137
Sanitation Facility		
Improved	43.7	2,779
Unimproved	56.3	3,574

4.2.3 Rooms and Sleeping Facilities

Average Household Size: Nigeria's average household size is 5.0 people, according to the 2018 Nigeria Demographic and Health Survey (NDHS 2018). In rural areas, household sizes are slightly larger than in urban areas (5.1 versus 4.7 persons).

Adequacy of Rooms and Sleeping Facilities: Taking the average Nigerian household size into account, those with three rooms or more are considered adequate sleeping space. The classification assumes that the household head and their partner will sleep in one room while others will sleep in the other rooms meant for sleeping.

Table 9 shows the percentage distribution of room and sleeping facilities. The results showed that 22.6% of the women had a room for sleeping in the household, 35.0% had two rooms, and 42.4% had three or more rooms for sleeping.

Table 9: Rooms and sleeping facility

Rooms Used for Sleeping	Percentage	Total (N)
One	22.6	1,437
Two	35.0	2,226
Three or more	42.4	2,725
Total	100	6,353

4.2.4 Source of Energy for Cooking; Materials used for Flooring, Roofing and Walls.

Clean/Healthy Sources of Energy for Cooking
These include LPG, natural gas, biogas and electricity.

Finished Floor Materials
When used, they promote a clean and healthy home environment. They include cement, ceramic tiles and carpet/rug.

Finished Roofing Materials
When used, they protect the household from adverse weather conditions like rain, heat, cold, dust, and wind. The materials include metallic/zinc, ceramic, cement and roofing shingles.

Finished Wall Materials
They also protect the house from adverse weather and ensure structural stability, ensuring that it is safe for habitation.

Table 10 describes the various energy sources for cooking as well as the materials used for the flooring, roof, and walls. Only 22.2% of the women had access to clean sources of energy forcooking. The majority (61.2%) used wood as a source of energy while one-fifth used LPG/natural gas/biogas (20.0%). About 10% used charcoal while 5.5% used kerosene stoves. Only 2.2% used electricity as a source of energy for cooking.

Regarding building materials used for the house of residence, about three-quarters of the respondents had finished floors involving the use of ceramic tiles, cement floors and asphalt strips among others. The majority (92.1%) reported using finished roofing materials with 84.2% reporting metal/zinc roofing sheets, 1.9% with ceramic roofing, 2.5% with cement roofing and 2.2% with roofing shingles.

The percentage distribution of the main wall material was described under three categories: finished wall, rudimentary wall, and natural wall. The most commonly used wall category was the “finished wall”, with 53.3% using cement, 17.1% using cement blocks, 2.6% using cement mixed with stone, and 2% using wood/shingles. About 17.9% had natural walls.

Table 10: Source of Power/Energy for Cooking & Materials used for Flooring

Variables	Percentage	Total (6,353)
Source of energy for cooking in the HH		
Electricity	2.2	137
LPG/natural gas/biogas	20.0	1,268
Kerosene	5.5	352
Coal/lignite	0.5	29
Charcoal	10.0	633
Wood	61.2	3,890
Agricultural crop/straw/shrubs/grass	0.5	34
Animal dung	0.0	1
Other	0.1	9
Flooring material		
Natural Floor		
Earth/sand	22.6	1,434
Dung	0.8	50
Rudimentary Floor		
Wood/plank	0.1	7
Bamboo/palm	0.1	5
Finished Floor		
Finished wood	0.1	7
Vinyl/asphalt strips	0.2	11
Ceramic tiles	9.4	600
Cement	59.7	3,791
Carpet/rug	4.6	294
Other	0.6	37
Unable to access/observe	1.8	117
Roofing material		
Natural Roofing		
No Roof	0.3	16
Thatched roof/palm leaves	5.8	367
Rudimentary Roofing		
Rustic mat	0.3	22
Wood/planks	1.4	89
Cardboard	0.1	6
Finished Roofing		
Metallic/zinc	84.2	5,347
Wood	0.7	45
Ceramic	1.9	121
Cement	2.5	161
Roofing shingles	2.2	138
Others	0.6	41
The main material of the wall		
Natural Wall		
No walls	0.5	33
Cane/palm/trunks	1.4	92
Dirt/mud	16.0	1,017
Rudimentary Wall		
Bamboo with mud	2.2	142
Stone with mud	6.0	384
Plywood	0.0	3
Cardboard	0.0	2
Reused wood	0.0	2
Finished Wall		
Cement	53.3	3,383
Cement with stones	2.6	166
Cement blocks	17.1	1,089
Bricks	0.3	22
Wood/planks/shingles	0.0	2
Others	0.2	14

4.2.5 Household Assets and Ownership

The percentage distribution of household assets and ownership is shown in Table 11. With regards to electronics, over half of the households (56.5%) were without a radio. About 21.7% of the respondents reported that the radio in their households was owned by their spouse while only 6.4% of the women had personal radio. Similarly, about 55.9% of the households were without a television set. For about 17.5% of the women, their spouses owned a television set in their households, while only 6.6% of the women owned one. For other household items, the majority (77.8%) of the respondents were without refrigerators, 95.9% had no computers, 79.4% had power generating sets, and 97.5% had no air conditioners. About 53.4% were without a fan in their households. Conversely, most households (82%) had at least a member that had a mobile phone among which 53.3% of the women had a personal mobile phone. Most households (94.0%) do not have land telephone lines.

The table also describes ownership of basic furniture. Only 11.4% of the households were without beds. About half of the respondents reported having tables while 66.0% indicated they had no sofas.

Table 11: Household Assets and Ownership

Items	Ownership of Asset				
	Self	Spouse	Jointly Owned	Other HH Members	None
Radio	6.4	21.7	2.8	12.6	56.5
Television	6.6	17.5	5.3	14.7	55.9
Mobile Telephone	53.3	15.7	3.6	9.4	18.0
Non-mobile Telephone	1.6	2.0	0.6	1.8	94.0
Computer	0.8	1.2	0.4	1.7	95.9
Refrigerator	5.4	5.9	3.2	7.7	77.8
Table	13.0	15.3	5.6	15.9	50.2
Chair	22.3	19.2	7.7	20.1	30.7
Bed	34.6	22.1	10	21.9	11.4
Sofa	11.4	8.0	4.1	10.5	66.0
Cupboard	19.7	7.9	4.0	13.4	55.0
Air Conditioner	0.2	0.9	0.4	1.0	97.5
Electric Iron	5.7	12.4	3.6	10.8	67.5
Generator	2.1	8.2	2.6	7.7	79.4
Fan	8.6	18.3	5.2	14.5	53.4

4.2.6 Wealth Quintile

The wealth quintile, which is a relative measure of wealth distribution in a population from quintiles was computed using principal component analysis. As shown in Table 12, almost half of the households (49.5%) belonged to the lowest 2 quintiles (poorest and poorer group) while 16.8% and 15.9% were within the richest and richer quintiles.

Table 12: Wealth Quintile

Wealth Quintile	Percentage	Total
Poorest	27.6	1,751
Poorer	21.9	1,394
Middle	17.8	1,131
Richer	15.9	1,011
Richest	16.8	1,065

4.3 Current or Most Recent Partner Characteristics

KEY FINDINGS

i. **Partners' Literacy:** About two-fifths of the female partners and one-quarter of male partners cannot read and write at all
ii. **Partners' Work Status:** 55.3% of the female partners work while 41.1% are full-time housewives.
iii. **Substance Abuse:** The most abused substance is alcohol: 27.0% among males, 8.7% among females
iv. **Ever Engaged in Substance Abuse:** Up to 31.3% of males and 11.0% of females have ever abused substances.
v. **Discontinuation of Substance Abuse:** Among those who had ever engaged in substance abuse, insignificant proportions 1.7% among males and 0.9% among females had discontinued substance abuse.

4.3.1 Distribution of Male and Female Partners Characteristics

Table 13 depicts the characteristics of the respondents' partners. About 57.2% of the women's partners were between 20 and 44 years of age while approximately 79.3% of the men's partners were within the same age range. The mean age for female partners was 34 years compared to male partners (43 years).

The table also showed the distribution of partners by their ethnicity. The partners of 13.0% of the males and 43.6% of the females were of Igbo ethnicity; 25.3% and 31.8%, respectively, were Hausas; while 22.7% and 22.5%, respectively, were of Yoruba extraction. The partners of 39.0% of the male and 2.1% of the female respondents were from other ethnic groups. The table also revealed that partners of 49.0% of the male and 43.6% of the female respondents were Christians, while the partners of 49.7% and 55.7%, respectively, were of the Islamic faith. Traditional African Religion was practised by the partners of approximately 1.3% of the males and 0.6% of the females.

In terms of partner literacy, 39.8% of males and 27.5% of females could neither read nor write at all, while 24.2% of males and 21.9% of females could read and write but with difficulty. Only about 36.0% of the males and 50.6% of the females could read and write with ease. In terms of school attendance, approximately 66.5% of the males and 77.3% of the females attended a form of school or went to school, while approximately 33.5% of the males and 22.7% of the females did not.

Approximately 13% of both male and female respondents reported that their partners attended Quranic/Islamiyah school. About 20.6% of the females and 28.5% of males had partners that attended only primary education, while 63.4% of females and 55.3% of males had secondary or higher education.

Information on the employment status of respondents' partners also revealed that 55.3% of the female respondents reported that their partners were employed, while 2.4% were unemployed but looking for a job. About 41.1% of the men reported that their partners were full-time housewives. Occupation distribution of the respondents' partners showed that those involved in sales and service were (32.6%), while those involved in clerical activities had the lowest percentage (0.4%). Only about 5% were in professional occupations and 7.4% in skilled occupations. About one in five women were into agriculture.

4.3.2 Substance use among males and Females

- **Substance Abuse**
  This refers to the use of psychoactive substances, such as alcohol and illegal drugs that are harmful or dangerous.

- **Ever Engaged in Substance Abuse**
  This refers to those who are currently abusing substances and those who have stopped abusing substances.

- **Discontinuation of Substance Abuse**
  Those who used to abuse substances, and have since stopped substance abuse.

Table 14 presents the results of the respondents' exposure to alcohol and substance abuse. More than one-quarter of men (27.0%) compared with less than one-tenth of women (8.7%) consumed alcohol. About 6.4% of men compared with only 1.1% of women in the sample had smoked cigarettes. Weed/Hemp/Marijuana use was reported among a smaller proportion of males (0.7%) and females (0.04%). The use of psychoactive drugs such as cocaine was reported among the females (0.02%); no male respondents reported cocaine use. Furthermore, none of the respondents reported the use of codeine or glue. Self-reported information on substance use may be considered unreliable; nonetheless, such information is useful to gauge the pulse of respondents on the practice.

Table 13: Percentage Distribution of Male and Female Partners Characteristics

Partner Characteristics	Male		Female	
	Percentage %	Total (N)	Percentage %	Total (N)
Age as at last Birthday				
10-14	0.3	7	0.5	19
15-19	5.0	139	0.4	16
20-24	12.7	352	1.5	60
25-29	19.3	534	9.5	373
30-34	19.0	525	12.6	495
35-39	16.5	458	15.2	597
40-44	11.8	328	18.4	720
45-49	8.6	239	17.0	666
50-54	3.8	104	13.2	519
55-59	1.9	52	7.1	279
60-64	0.8	23	4.4	173
65 and above	0.3	7	0.1	3
Total	**100**	**2,768**	**100**	**3,920**
Ethnic Group				
Igbo	13.0	360	43.6	1,710
Hausa	25.3	699	31.8	1,246
Yoruba	22.7	628	22.5	882
Others	39.0	1,080	2.1	82
Total	**100**	**2,768**	**100**	**3,920**
Religion				
Christianity	49.0	1,355	43.6	1,711
Islam	49.7	1,376	55.7	2,183
Traditional African Religion	1.3	36	0.6	23
Others	0.0	1	0.1	3
Total	**100**	**2,768**	**100**	**3,920**
Literacy				
Cannot read and write at all	39.8	1,103	27.5	1,077
Can read and write with difficulty	24.2	669	21.9	858
Can read and write easily	36.0	996	50.6	1,985
Total	**100**	**2,768**	**100**	**3,920**
Attended School				
Yes	66.5	1,842	77.3	3,031
No	33.5	926	22.7	889
Total	**100**	**2,768**	**100**	**3,920**
Highest level of Education				
Quranic/Islamiyah school	12.5	234	13.1	395
Adult classes	0.1	2	0.5	16
Primary	28.5	532	20.6	620
Secondary	42.3	789	43.2	1,303
Tertiary	13.0	242	20.2	610
Others	3.6	68	2.4	71
Total	**100**	**1,867**	**100**	**3,015**
Current work status				
Working	55.3	1,531	-	-
Unemployed/looking for a job	2.4	66	-	-
Full Housewife	41.1	1,139	-	-
Retired	0.7	19	-	-
Studying	0.5	13	-	-
Total	**100**	**2,768**	-	-
Occupation				
Professional	5.0	137	-	-
Clerical	0.4	11	-	-
Sales and Services	32.6	891	-	-
Skilled manual	7.4	203	-	-
Unskilled manual	2.0	56	-	-
Agriculture	19.4	531	-	-
Full household work	29.7	812	-	-
Others	3.5	97	-	-
Total	**100**	**2,737**	-	-

Table 14: Percentage Distribution of Respondents by Substance Abuse and by Gender

Substance Abuse	Male		Female	
	%	n=2,768	%	N=3,915
Alcohol				
Yes	27.0	746	8.7	342
No	73.0	2,022	91.3	3,573
Cigarette				
Yes	6.4	176	1.1	44
No	93.6	2,592	98.9	3,870
Weed/Hemp/Marijuana				
Yes	0.7	19	0.0	1
No	99.3	2,749	100	3,914
Cocaine				
Yes	0	0	0.0	2
No	100	2,768	99.9	3,913
Codeine				
No	100	2,768	100	3,915
Used to take some of these, but not now				
Yes	1.7	48	0.9	34
No	98.3	2,720	99.1	3,881
Never taken some of these				
Yes	68.7	1,902	89.0	3,485
No	31.3	866	11.0	430
How often do you take the identified substance				
Every day or nearly every day	28.4	256	19.8	88
Once or twice a week	50.1	452	30.2	134
Two-three times a month	12.3	111	16.9	75
Occasionally, less than once a month	9.2	83	33.1	147
Total		**902**		**444**

Overall, approximately 31.3% of males and 11.0 % of females had used some of these substances. About 0.9% of females and 1.7% of males had used some drugs and had stopped using them. In contrast, a higher proportion of males (68.7%) than females (89.0%) had never used any of these substances. Information on the frequency of use showed that 28.4% of the males and 19.8% of the females used the identified substances every/nearly every day. A higher proportion (50.1%) of the males compared to the females (30.2%) used the substance once or twice a week. About 12.3% of the men reported infrequent use between one and three times a month while about 16.9% of the females reported this same frequency of use.

4.3.3 Percentage Distribution of Male and Female Partners' Substance Use

Table 15 describes the pattern of substance abuse among the partners of the male and female respondents. About 3.1% of male respondents reported that their partners do take alcohol in contrast to 19.3% of the partners of the female respondents. Similarly, only 0.1% of the male respondents stated that their partners smoked cigarettes in contrast with 4.7% of the female respondents. Reports of the use of substances such as marijuana, cocaine and glue among partners of respondents were very low. None of the males reported marijuana, cocaine or glue use by their partners while less than 1% of the female respondents reported the use of marijuana (0.5%), cocaine (0.1%) and glue (0.1%) by their partners. However, 5.1% of males said their partner had used some of these substances, while 24.0% of females said the same. Furthermore, 0.6% of the males claimed their partner had discontinued the use of substances while 1.7 % of females claimed the same.

The frequency with which a partner consumed substance was further examined. The majority of the male

respondents (61.6%) reported that their partners had used the identified substance once or twice a week. About 35.4% of the female respondents said the same. About 32.9% of females also said their partner consumed the identified substances daily/nearly daily while only 6.2% of male respondents said the same. About 18.5% and 15.4% of the men and women, respectively, said that their partners used the substances two to three times a month. Only 13.7% of the men and 13.6% of the women reported that their partners used the identified substances occasionally or less than once a year.

Table 15: Percentage Distribution of Male and Female Partners' Substance Use

Partner Substance Use	Male		Female	
	Percentage	Total	Percentage	Total
Alcohol				
Yes	3.1	85	19.3	757
No	96.9	2,683	80.7	3,158
Cigarette				
Yes	0.1	3	4.7	183
No	99.9	2,765	95.3	3,732
Weed/Hemp/Marijuana				
Yes	0.0	0	0.5	19
No	100	2,768	99.5	3,896
Cocaine				
Yes	0.0	0	0.1	3
No	100	2,768	99.9	3,912
Codeine				
Yes	0.0	0	0.0	0
No	100	2,768	100	3,915
Glue				
Yes	0.0	0	0.1	2
No	100	2,768	99.9	3,913
Others				
Yes	1.3	37	1.0	39
No	98.7	2,731	99.0	3,876
Used to take some of these, but not now				
Yes	0.6	16	1.7	65
No	99.4	2,752	98.3	3,850
Never taken any of these				
Yes	94.9	2,628	76.0	2,974
No	5.1	140	24.0	941
Total	**100**	**2,768**	**100**	**3,915**
How often does your partner take the identified substance				
Every day or nearly every day	6.2	9	32.9	331
Once or twice a week	61.6	90	35.4	356
Two-three times in a month	18.5	27	15.4	155
Occasionally, Less than once a month	13.7	20	13.6	137
Cannot remember/Do not know	0.0	0	2.7	27
Total	**100**	**146**	**100**	**1,006**

GENDER ROLES, NORMS AND PRACTICES

This chapter presents data on gender roles, norms, and practices. These are considered important influencing factors that shape gender role relations and the contextual value ascribed to gender violence, exploitation, and abuse.

KEY FINDINGS

4.2.2.1 **Gender roles and gender norms:** Gender roles and standards were viewed from an androcentric perspective by both women and men. This domain remains generally the most resistant to change across the study sites, and often presents as the root cause of sexual and gender-based violence in homes and in society at large.

4.2.2.2 **Access to wealth, and wellbeing:** Both men and women are shifting grounds towards less androcentric views on women's access to wealth, and well-being, in particular in the face of current economic challenges; but so far, such changes do not challenge male dominance.

4.2.2.3 **Right to decision-making and participation:** Women are still less involved in decision-making in the home and the community, suggesting that androcentric beliefs are still prevalent when it comes to power-sharing between men and women at home, and the community level. It is ironic that women, themselves, lack the consciousness to challenge this age-long practice.

4.2.2.4 **Absolute rights of men over wives' sexual and reproductive rights:** Women are shifting their attention away from androcentric views of men's rights over women's sexual and reproductive rights toward gynocentric or non-androcentric views. The shift is still very slow and intangible.

4.2.2.5 **Intimate partner abuse (violence):** IPV was seen as one of the nuances in marriage and gender relations, which is sometimes unavoidable, and many cases taken as a 'given'. Pieces of evidence from qualitative data show that both men and women reject IPV in theory and not in practice.

4.2.2.6 **Male supremacy (male preference):** Although society still shows a preference for male children, women and men are increasingly moving away from cultural traditions that suffocate the rights of the girl child. Notably, change in this domain is still very sluggish.

4.2.2.6 Men are equally devoted to the advancement of female children's rights, although not to the detriment of the rights of male children.

5.1 Assessment of Gender Roles, Gender Norms and Practices

Gender roles and gender norms (GRGN)

Women and men were asked about what they consider as the general practice and attitudes to gender roles and norms in their communities, assessing specific gender domains.

Sample: women aged between 10 -49 years, either single, married or divorced and men aged 18 years and above

A quantitative assessment of gender roles, values, norms, and practices was made using 4 distinct indicators as listed below:

a. Gender roles and gender norms;
b. Access to wealth and wellbeing
c. Right to decision-making and participation
d. Men's control over wives' sexual and reproductive health rights.

For the qualitative phase, the assessment of the social and gender norms also focused on the following:

i. Roles, duties and responsibilities in contexts and relationships;
ii. Cultural norms guiding the relationship between men and women;
iii. What a man/woman looks for in a woman/man to marry; and
iv. Expectations of men and women in their marital relationship.

These contexts provide a robust description for understanding the pervasiveness of androcentric gender roles and norms and the reluctance to allow gender equality and women's empowerment principles to thrive. Results from the quantitative phase are presented in the subsequent sections.

a. Gender Roles and Gender Norms

Six indicators were used to assess gender roles and gender norms. These are listed in the box below:

I.	A woman's most important role is to take care of her home and cook for her family;
Ii.	It is a man's responsibility to provide food, shelter, and clothing for his family;
iii.	Girls are expected to help more with housework, while the boys play in this Community;
Iv.	Most key decisions in the home and community are taken by men;
v.	Fathers have the main responsibility for the discipline of children in the home; and
Vi.	Families in this community prefer having male children to female children.

The first two elements of these indicators attracted the highest mean scores, while the third element attracted the least mean value, signifying that though there are strict gender roles in terms of chores and responsibilities, parents are now re-orienting boys and girls to share housework (see Table 5.1). In general, both men and women hold androcentric views of 5 out of the 6 indicators of GRGN listed above (t, except for indicator 3 - "Girls are expected to help more with housework'). However, the level of agreement with the earlier identified 5 GRGN indicators varies across gender groups (women: these vary between 50% to 95.2%; and men: 53.1% to 93.1%). Only one of the six GRGN indicators ('girls are expected to help with housework while the boys play in this community) presents a non-androcentric view across gender groups, with women recording 39.3%, and men 39.8%. This is a great shift in androcentric values about the roles of women and men, and boys and girls. (see Table 5.1).

For both female and male respondents, the total sum of the values of the indicators used to assess GRGN was computed. The composite score for each item ranged between 6 and 18, with the score of >12 indicating people with androcentric values, while the score of < 12 is indicative of non-androcentric values, using the Likert scale of 1 to 5 for the GRGN indicators. The results indicate that 92.9% of women and 92.6% of men have androcentric values, while

7.1 % and 7.4 % of men and women, respectively, have non-androcentric values (see Table 5.1). This means that the closer the score is to the maximum score obtainable, the higher the likelihood of exhibiting androcentric values and vice versa. Across the regions, over 89% of both men and women exhibit androcentric values (see Fig. 5.1). This demonstrates that women and men alike held androcentric perspectives on gender roles and norms. The androcentric view relegates the role of women and girls to mere those of mothers, wives, and caregivers. Thus, traditional GRGN values often result in gender inequality in the distribution of roles within communities.

Figure 13: Percentage Distribution of Men and Women by Composite Assessment of Gender Roles and Gender Norms across Region

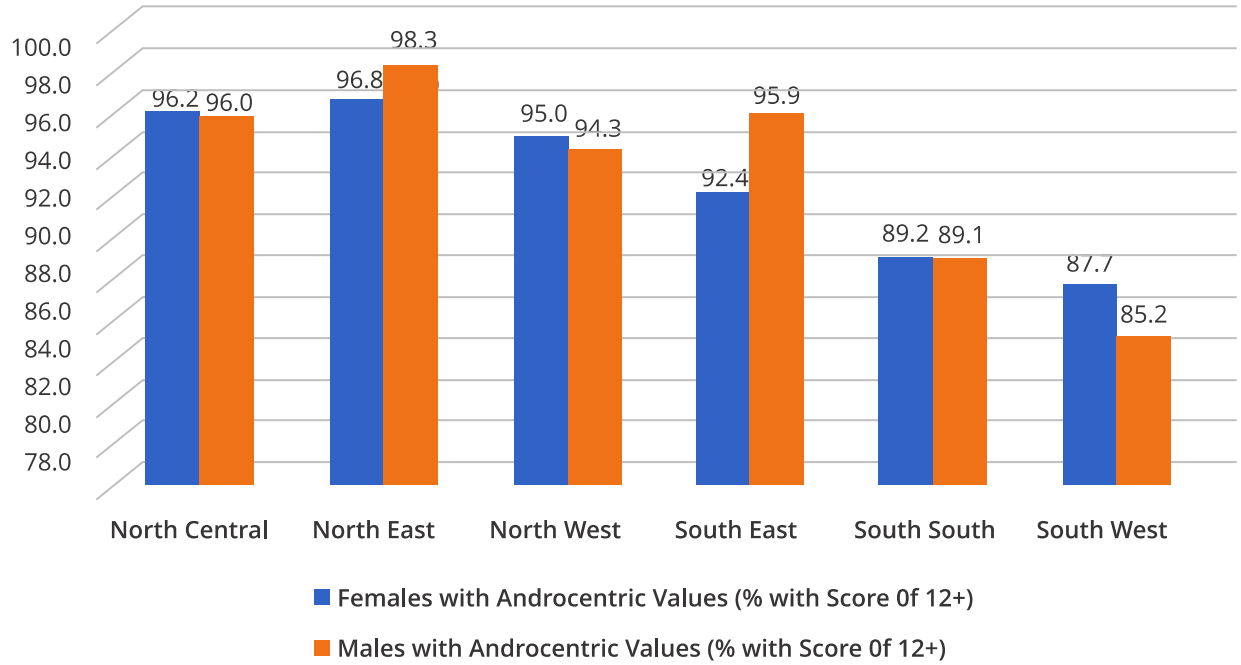


Table 16: Distribution of Respondents by Gender Roles and Norms

A. FEMALE SURVEY: GENDER ROLES AND GENDER NORMS						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	A woman's most important role is to take care of her home and cook for her family.	4.3	0.5	95.2	6,284	**2.9**
ii.	It is the man's responsibility to provide food, shelter, and clothing for their families in this community.	4.8	0.4	94.8	6,284	**2.9**
iii.	Girls are expected to help with housework while the boys play in this community.	59.6	1.1	39.3	6,284	**1.8**
iv.	Most key decisions in the home and community are taken by men.	13.9	1.2	84.9	6,284	**2.7**
v.	Fathers have the main responsibility for the discipline of children in the home	18.4	0.6	81.0	6,284	**2.6**
vi.	Families in this community prefer having male children to female children.	44.8	5.2	50.0	6,284	**2.1**
	Summary Statistics					
i.	Total Mean Score of Gender Roles and Gender Norms (i - vi)					**14.9**
ii.	Composite Score: Females with Androcentric Values (% with Score of 12+)					**92.9%**
iii.	Composite Score: Females with Non-Androcentric Values (% with score of <12)					**7.1%**
B. MALE SURVEY: GENDER ROLES AND GENDER NORMS						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	A woman's most important role is to take care of her home and cook for her family.	5.9	1.0	93.1	3,092	**1.1**
ii.	It is the man's responsibility to provide food, shelter, and clothing for their families in this community.	3.2	0.5	96.3	3,092	**1.1**
iii.	Girls are expected to help with housework while the boys play in this community.	58.0	2.2	39.8	3,092	**1.6**
iv.	Most key decisions in the home and community are taken by men.	14.7	1.0	84.3	3,092	**1.2**
v.	Fathers have the main responsibility for the discipline of children in the home	18.7	1.1	80.2	3,092	**1.2**
vi.	Families in this community prefer having male children to female children.	39.1	7.8	53.1	3,092	**1.5**
	Summary Statistics					
i	Total Mean Score of Gender Roles and Gender Norms (i - vi)					**15.1**
ii	Composite Score: Males with Androcentric Values (% with Score of 12+)					**92.6%**
iii.	Composite Score: Males with Non-Androcentric Values (% with score of <12)					**7.4%**

The qualitative assessment provided additional insights into the notions of maleness and femaleness, which represents androcentric and non-androcentric views across the communities and zones. The notion of maleness was conceived in terms of roles and responsibilities. The ability to be financially stable and earn enough income that can cater for personal needs and household members topped the list. A man must be able to take care of his wife and children by providing physical, emotional, psychological, spiritual, financial security, as well as providing moral training to the children. Such a man must be able to exercise authority and make appropriate decisions from time to time as the head of the family. The social expectation that men should be in-charge of home and public affairs cuts across the evidence from the different group discussions in most communities. In Imo State, for instance, the picture of a hardworking, hustling and burden bearer was the ideal model of maleness. Such responsibilities and expectations are also expected towards community development and roles men are expected to play (see Box 5.1 for FGD excerpts).

Beyond being socialised into what and how to fulfil such androcentric duties, age was considered a factor that could enhance the ability of any man to fit into the model. The older a man grows, the more likely the chances of imbibing and conforming to societal definitions and expectations of gender role norms. Not all men would conform as they grow older, but those seeking social acceptance and other benefits were predicted to be more likely to conform to such expectations. Citing how age promotes such conformity, findings from the FGDs in Edo State revealed that maleness requires being strong-willed, readiness to confront challenges and providing a sense of leadership within and outside the household. The chronological stage when such a sense starts was fixed at age 18 to 40 years, after which men are supposed to show more maturity in the public domain. Within this age category, men that are married would attract more acceptance as either husbands or fathers (see Box 5.2 for excerpts from FGD with Opinion Leaders in Edo State). Also, findings from Ebonyi in the Southern region revealed that unmarried males, irrespective of age, are not allowed to join men's associations where important governance issues are deliberated (also see Box 5.2 for excerpts from KII with Gender Desk Officer in Ebonyi State).

On the contrary, femaleness reflects conformity to societal expectations of submissiveness, caring, nursing and performance of supportive roles at the household and community levels. The ideal image of being female was measured by perceived satisfaction in meeting up with chores such as cooking, washing plates, clothes, dishes, cleaning the house and bathing children, among others. The picture of a homemaker, builder and supporter to the husband resonated across all the group discussions held across communities.

The excerpts in Box 5.3 are from various stakeholders in Bauchi, Adamawa and Kaduna States. Playing these roles could appear that femaleness only revolves around playing supportive roles at the home front.

A twist in this direction was introduced in the descriptions that emerged from the FGDs in the Southwestern States. The group discussions from the Southwest communities depicted women as spiritual leaders and fighters for the betterment of their homes and their loved ones. The participants equated the performance of such roles to the notions of motherhood and burden bearers in dimensions that outweigh being a breadwinner. Maturity in playing all these roles, including the ability to procreate were conceived to be possible during the reproductive years of a woman.

Box 5.1 - FGD Excerpt

You know, Nigeria is what it is today, so being a man is not just about sleeping and waking up. It has to do with a lot of hard work, what I mean by hard work is doing work that brings in good money because most of the things are expensive these days. So being a man you must probably wake up early in the morning around 4:30 or 5am and go to your work. Even when you come back in the evening and find another opportunity that will still fetch some money, you continue the hustle.
FGD with Community leaders in Ilaro, Ogun State

A man is the head of the home, the head of the family, and the head of the society. **FGD with NGOs in FCT**

Box 5.2: FGD excerpts from Edo and Ebonyi

Age also makes us differentiate between the youths and men. As from 40, you are now a matured man in the community while youths are still from 18 to 40 years. **FGD with Opinion Leaders in Edo State.**

For you to be a complete man or be regarded as a man or woman, you must have, married, and fully married, either by custom or statutorily with children. **KII with Gender Desk Officer, Ebonyi State.**

Box 5.3 - FGD Excerpts

The most important expectation is having children, then a peaceful family, but the first thing is having children. **FGD with married men in Bauchi State.**

Whatever your husband provides for you, you please thank him no matter how little it is. You should also try to manage and cook what he brought very well so that next time he will bring more of that. **FGD with Married Women in Adamawa State**

Ah, I think generally within our community the men expect that the women will be submissive to them, you know they will defer to them in areas of decision making and all that, so they will be the ones to dish out instructions on how ah you know, what should be done, what is allowed or not allowed in the family. **FGD with NGOs in Kaduna State**

5.2 Women's Access to wealth, and wellbeing:

Access to wealth (economic resources) and wellbeing

Women and men were asked if they owned land or inherited property, even if it was from their parents. Respondents were asked if they could start a business without the consent or permission of their husband and expectations of women to give their income from business to their husband in the community.

Sample: Women aged 10 to 49 years, whether single, married, or divorced, and men aged 18 years and above

The 4 indicators used to measure women's access to wealth (economic resources) and wellbeing are:

i	Women do not own land in this community;
ii	A woman cannot inherit any property even from parents in this community;
iii	A woman cannot work or start a business without the consent or permission of her husband; and
iv	A woman is expected to give her income from work or business to her husband in this community

Table 17 presents 4 different indicators for measuring women's access to wealth and wellbeing. Notably, data from the female sample presented a shift from the androcentric view that women are not entitled to property and inheritance. Rather, 3 of these indicators present non-androcentric views about women's access to wealth, and wellbeing, with a range of 58.1% to 71.5%. Only one indicator, that is, 'a woman cannot work or start a business without the consent or permission of her husband' attracted an androcentric view, which represented 71.3% of the female population.

In the same vein, men also agree that women should have access to property and inheritance, focusing on 3 of the 4 identified indicators, with a range of 58.1% to 63.9%. Just as noted by the women, men (77.9%) also frowned at women working or starting a business without the consent or permission of their husbands.

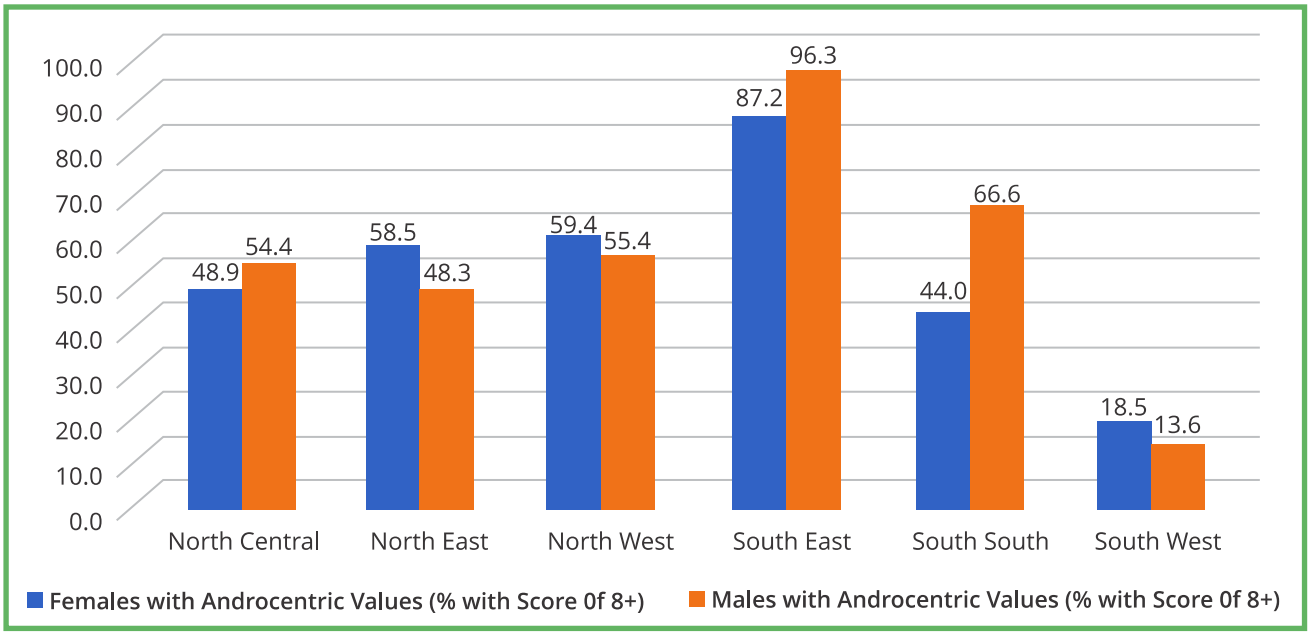
Women and men with androcentric views on the economic component of GRGN recorded a composite score of >8, while those with non-androcentric values for the same component recorded a score of <8. The percentage distribution of these composite scores across gender groups for the GRGN economic component assessment shows that more than half of the female sample (50.6%) and male sample (51.7%) still hold androcentric views about the unequal economic gender power relations (see Fig.14.). This shows that men's dominant roles continue to shape unequal economic gender power relations. Although women are now more aware of the need to have access to economic resources, they rarely challenge the root causes of the structure which continues to breed gender inequalities and women's economic dis- empowerment in homes and society (see Table 17).

Table 17: Distribution of Respondents by Gender Norms and Practices on Access to Wealth and Wellbeing

A. FEMALE SURVEY: ACCESS TO WEALTH AND WELLBEING						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	Women do not own land in this community.	58.1	7.6	34.3	6,284	**1.8**
ii.	A woman cannot inherit any property even from her parents in this community.	60.5	6.8	32.7	6,284	**1.8**
iii.	A woman cannot work or start a business without the consent or permission of her husband.	25.6	3.1	71.3	6,284	**2.4**
iv.	A woman is expected to give her income from work or business to her husband in this community.	71.5	4.9	23.6	6,284	**1.5**
	Summary Statistics					
i.	Total Mean Score of Gender Roles and Gender Norms (I - iv)					**7.5**
ii.	Composite Score: Females with Androcentric Values (% with Score of 8+)					**50.6%**
iii.	Composite Score: Females with Non-Androcentric Values (% with score of <8)					**49.5%**

B. MALE SURVEY: ACCESS TO WEALTH AND WELLBEING						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	Women do not own land in this community .	58.1	3.6	38.3	3,092	**1.6**
ii.	A woman cannot inherit any property even from her parents in this community.	63.9	3.7	32.4	3,092	**1.7**
iii.	A woman cannot work or start a business without the consent or permission of her husband.	20.8	1.3	77.9	3,092	**1.2**
iv.	A woman is expected to give her income from work or business to her husband in this community.	60.0	7.7	32.3	3,092	**1.7**
	Summary Statistics					
i.	Total Mean Score of Gender Roles and Gender Norms (I - iv)					**8.1**
ii.	Composite Score: Males with Androcentric Values (% with a score of >8)					**51.7%**
iii.	Composite Score: Males with Non-Androcentric Values (% with a score of <8)					**48.3%**

Figure 14: Percentage Distribution of Men and Women by Composite Assessment of Women's Access to Wealth and Wellbeing across Regions



There are, however, regional variations in GRGN economic component assessment. In the Southwest, both women (81.5%) and men (86.4%) approved women's access to wealth, and wellbeing, contrary to other regions (Southeast: women (12.8), men (3.7%); South-south: women (56.0%), men (33.4%); Northwest: women (40.6%), men (44.6%); Northcentral: women

(51.1%), men (45.6%); Northeast: women (41.5%), men (51.7%) (see Appendix 5.10). This continues to show gender disparities in access to wealth and well-being across the regions.

Evidence from the qualitative component mirrors how women are relegated in terms of inheritance and transfer of wealth from parents to their female children. With improved access to education, employment opportunities and opportunities to engage in productive economic activities, women that are educated, and can earn reasonable incomes are better valued and preferred by men of marriageable age. Men with similar traits are equally treated and appreciated by women, especially for marriage purposes.

5.3 Women's right to decision-making and participation

Right to Decision Making and Participation

Respondents were asked if women are involved in decision-making about where a wife seeks treatment when she is sick, including where she gives birth, decisions concerning children, and other wellbeing issues in the community.

Sample: Women aged 10 to 49 years, whether single, married, or divorced, and men aged 18 years and above

Data from the quantitative assessment of GRGN used the 4 under-listed indicators to measure women's right to decision-making and participation.

i	The husband or family decides where a wife goes for treatment when sick, including where she delivers;
ii	Women are rarely involved in decisions concerning their children;
iii	Women rarely go out of their houses without the permission of their husbands; and
iv	Women rarely join men to make decisions about issues in the community.

In general, both women and men held 3 of the 4 androcentric indicators used to assess women's right to participate in decision-making, with responses ranging between 62.9% to 66.2% for the female respondents; and for men, 60.4% to 67.1%. Both women and men are less androcentric when it comes to taking decisions that relate to their children. Hence, fewer women (41.3%) and men (38.5%) reported that 'women are rarely involved in decisions concerning their children'. When the composite score for these indicators was computed using a Likert Scale of 1 to 3 for each indicator, the majority of the female respondents (73.1 %) and men (74.6%) continued to hold androcentric values regarding women's right to decision- making and participation (see Table 18).

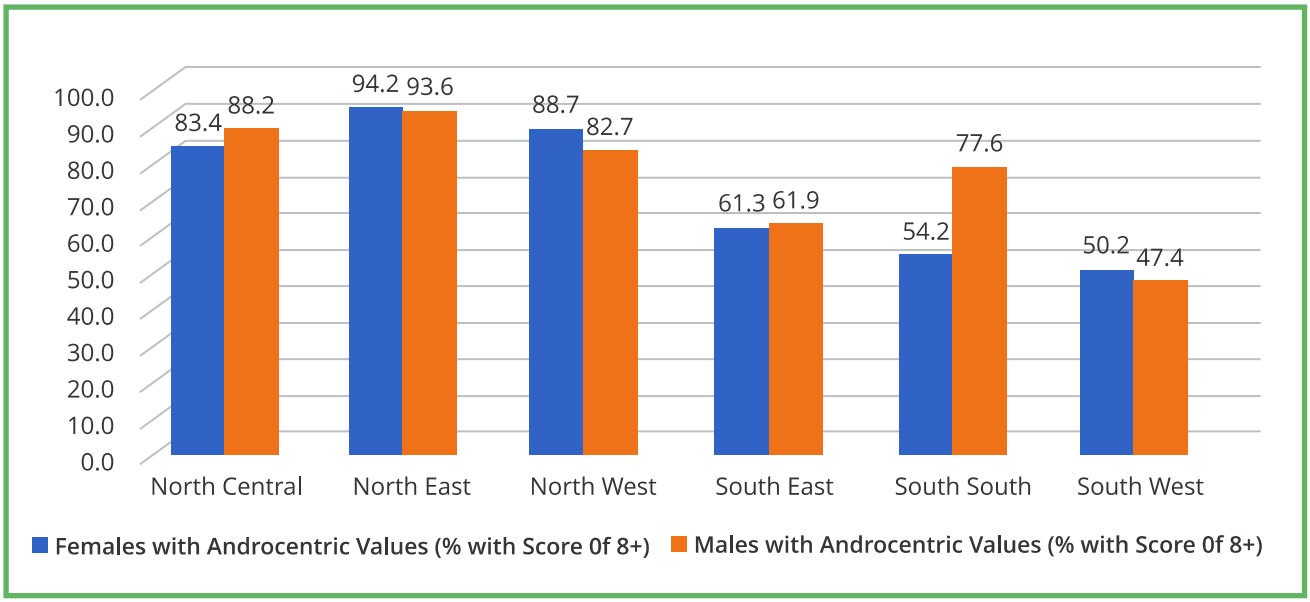
Regional data presented in Figure 15 shows that fewer women and men hold androcentric values in the Southern regions (Southwest: 50.2% women compared to 47.4% men; South- south: 54.2% women compared to 77.6% men; and Southeast: 61.3% women compared to 61.9% men) compared to the Northern Regions. Results show an average that is much over 80% across zones and across gender groups, who believe that it is not the prerogative of women to contribute to decision making whether in the private and/or in the public spheres of life. Data on women's role in decision-making continues to point to the central role gender values and norms play in understanding sexual and gender-based violence. The cultural dimensions of gender role relations need deeper understanding, engagement, and advocacy for re-orientation if marital relations are to experience peace and harmony. Figure 15, for example, presents the intensity of androcentrism across zones, but much more pronounced in all the Northern zones, followed by South South, South East and South West.

Table 18: Distribution of Respondents by Gender Norms and Practices on Rights to Decision Making and Participation

A. FEMALE SURVEY: RIGHT TO DECISION MAKING AND PARTICIPATION						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	The husband or family decides where a wife goes for treatment when sick, including where she delivers.	32.8	4.3	62.9	6,284	**2.3**
ii.	Women are rarely involved in decisions concerning their children.	55.1	3.6	41.3	6,284	**1.8**
iii.	Women rarely go out of their houses without the permission of their husbands.	30.7	3.1	66.2	6,284	**2.3**
iv.	Women rarely join men to make decisions about issues in the community.	28.9	5.6	65.5	6,284	**2.4**
	Summary Statistics					
i.	Total Mean Score of right to decision making and participation (i - iv)					**8.8**
ii	Composite Score: Females with Androcentric Values (% with Score of 8+)					**73.1%**
iii	Composite Score: Females with Non-Androcentric Values (% with a score of <8.)					**26.9%**

B. MALE SURVEY: RIGHT TO DECISION MAKING AND PARTICIPATION						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	The husband or family decides where a wife goes for treatment when sick, including where she delivers.	28.8	4.1	67.1	3,092	**1.3**
ii.	Women are rarely involved in decisions concerning their children.	58.4	3.1	38.5	3,092	**1.6**
iii.	Women rarely go out of their houses without the permission of their husbands.	32.1	2.5	65.4	3,092	**1.4**
iv.	Women rarely join men to make decisions about issues in the community.	36.4	3.2	60.4	3,092	**1.4**
Summary Statistics						
i.	Total Mean Score of right to decision making and participation (i - iv)					**8.9**
ii	Composite Score: Males with Androcentric Values (% with Score of 8+)					**74.6%**
iii	Composite Score: Males with Non-Androcentric Values (% with a score of <8.)					**25.4%**

Figure 15: Percentage Distribution of Men and Women by Composite Assessment of Women's rights to decision making and participation across regions



5.4 Absolute rights of men over wives' sexual and reproductive health (sexual rights)

Absolute rights of men over wives Sexual and Reproductive Rights (Sexual Rights)

Women and men were asked whether a woman can refuse sex with her husband, who makes the decision about how many children a woman should have, who makes the decision about contraceptive use, whether a woman can discuss using family planning to space her children with her husband or not, and about the woman's status as her husband's property.

Sample: Women aged 10 to 49 years, whether single, married, or divorced, and men aged 18 years and above

The assessment of women's sexual rights was quantified using the five indicators listed below:

I	Women cannot refuse to have sex with their husbands under any condition;
ii	The decision on how many children women should have is taken by their husbands;
iii	A husband decides on whether his wife should use contraceptives;
iv	Women are not expected to discuss the option of using family planning to space children with their husbands; and
v.	When women marry, they become the property of their husbands.

Data presented in Table 19 shows that over half of the female sample (56.4%) compared to 47.0% of the male sample, reported that men make decisions on contraceptive use for their wives. Also, men disagreed with the statement that women could 'ever refuse sex with their husbands'. Overall, 83.6% of women aged 10–49 years and 83.9% of men aged 18 and older agreed that "when women marry, they become their husband's property." For this component assessment, women recorded a mean composite score of 10.7, while men recorded a mean score of 10.3, indicating that both women and men shared a similar androcentric value regarding men's absolute rights over women's sexual and reproductive rights.

The composite score of the sexual rights component revealed that the majority of the female sample (63.5%) favour absolute rights of husbands over their wives' sexual and reproductive rights (androcentric value), while slightly more than half of men (52.7%) also have rigid androcentric values of men's rights over women's sexual and reproductive rights (see Table 19). That both men and women promote androcentric values, including the view of women as 'mere property owned by men', is a pointer to the strength of normative gender values, which may require tenacious programmatic action(s) to achieve a gender transformative change and the adoption of more liberal gender relations.

Notably, the composite score of measures of the sexual rights component indicates that both women and men hold on to androcentric views of men's rights over women's sexual and reproductive rights, rather than a move toward gynocentric or non-androcentric views of women's sexual and reproductive health rights (Table 19). Field data, however, presents variations across zones, especially concerning men's absolute right over wives' sexual rights.

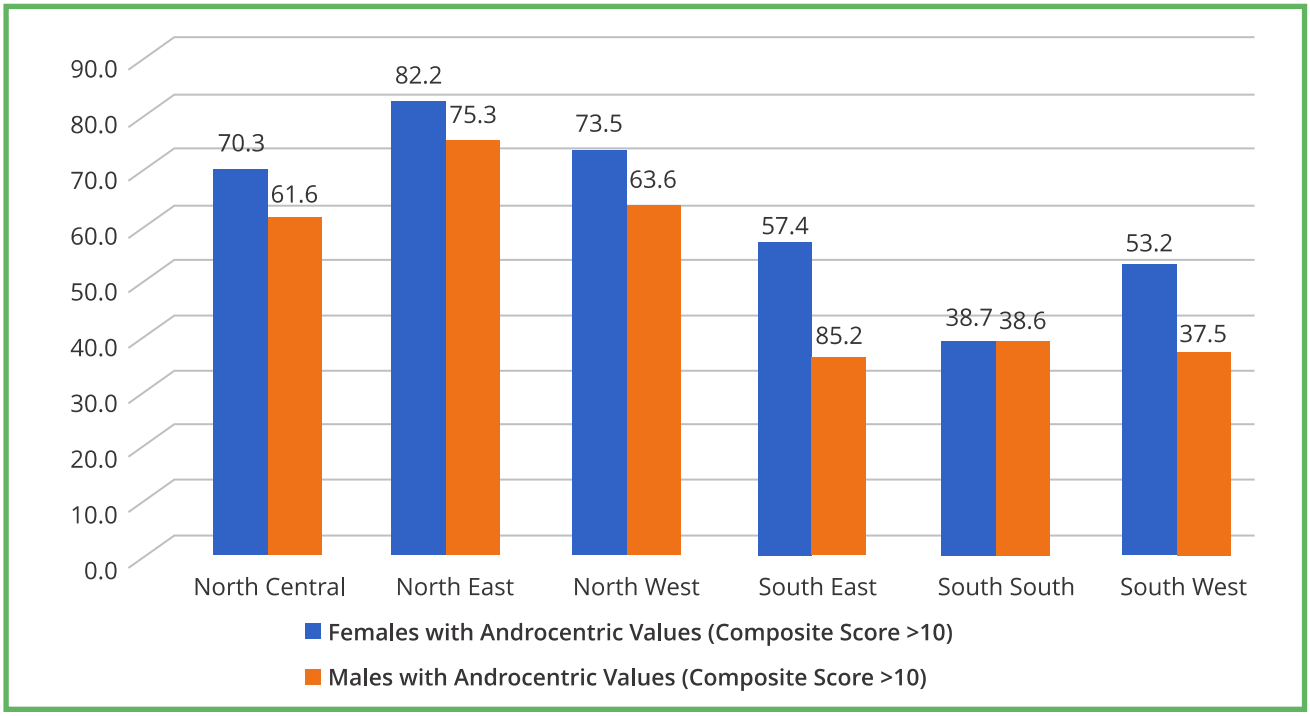
Men in the Southern Regions (SE 35.2%, SW 37.5%, SS 38.6%) are less androcentric in this respect compared to those in the North (NE 75.3%, NW 63.6%, NC 61.6%,) (see Figure 16, and Appendix 5:4). Ironically, women (compared to men) are more tenacious about men's absolute rights over wives' sexual and reproductive rights (see Figure 16). Women remain the custodian of gender tradition and may need more impactful gender transformative engagements to interrogate the underlying causes of gender inequalities and implications for sexual and gender-based violence.

Table 19: Distribution of Respondents by Gender Norms and Practices on Absolute Rights of Men over their Wives' Sexual Rights

A. FEMALE SURVEY: ABSOLUTE RIGHTS OF MEN OVER WIVES SEXUAL AND REPRODUCTIVE HEALTH (SEXUAL RIGHTS)						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	Women cannot refuse to have sex with their husbands under any condition.	44.7	8.6	46.7	6,284	**2.0**
ii.	The decision on how many children women should have is taken by their husbands.	43.4	7.5	49.1	6,284	**2.1**
iii.	A husband decides on whether his wife should use contraceptives.	34.3	9.3	56.4	6,284	**2.2**
iv.	Women are not expected to discuss the option of using family planning to space children with their husbands.	57.3	9.7	33.0	6,284	**1.7**
v.	When women marry, they become the property of their husband	14.2	2.2	83.6	6,284	**2.7**
	Summary Statistics					
i.	Total Mean Score of sexual rights (i - v)					**10.7**
ii	Composite Score: Females with Androcentric Values (% with Score of 10+)					**63.5%**
iii	Composite Score: Females with Non-Androcentric Values (% wi th score of <10)					**36.5%**
B. MALE SURVEY: ABSOLUTE RIGHTS OF MEN OVER WIVES' SEXUAL AND REPRODUCTIVE HEALTH (SEXUAL RIGHTS)						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	Women cannot refuse to have sex with their husbands under any condition.	53.2	5.8	41.0	3,092	**1.7**
ii.	The decision on how many children women should have is taken by their husbands.	48.7	7.7	43.6	3,092	**1.6**

iii.	A husband decides on whether his wife should use contraceptives.	43.5	9.5	47.0	3,092	**1.6**
iv.	Women are not expected to discuss the option of using family planning to space children with their husbands.	62.6	8.1	29.3	3,092	**1.7**
v.	When women marry, they become the property of their husband	14.9	1.2	83.9	3,092	**1.2**
	Summary Statistics					
i.	Total Mean Score of sexual rights (i - v)					**10.3**
ii	Composite Score: Males with Androcentric Values (% with Score of 10+)					**52.7%**
iii	Composite Score: Males with Non-Androcentric Values (% with a score of <10)					**47.4%**

Figure 16: Percentage Distribution of Men and Women by Composite Assessment of Absolute rights of men over wives sexual and reproductive health (sexual rights)



Evidence from the qualitative component provided further insights into how rights to resources, well-being, and sexual and reproductive health issues are governed by gender norms, values and practices within intimate relationships and social frames. Women are specifically expected to respect and be submissive to their husbands.

She is expected to take instruction from the husband and do whatever she does including sexual and reproductive health issues with the permission of the husband while a man can do anything he wants without taking permission from the wife. It is also the man that is expected to make a marriage proposal to the woman and not otherwise. The man pays the woman's bride price, provides for the family, and has the liberty to marry as many wives as he could take care of. However, women are expected to remain with a man at any point in time. In the case of the demise of the husband, the wife is entitled to a portion of the husband's property if she already has at least a child for him (see Box 5.4 for excerpts on gender norms relating to the rights of men over women across different states in the Northern and Southern parts of the country).

Box 5.4

There are norms guiding relationship between a man and a woman. We define marriage as a union between a man and woman to become husband and wife. If you marry a man and you don't totally submit to him, that marriage will not stand. **FGD with Married Women in FCT.**

Humility and respect from both partners. Both partners being faithful and committed to the marriage. A man provides a larger part of the financial needs for the two partners. **KII with a Perpetrator of SGBV in Akwa Ibom State**

A woman takes a man as a pillar in her life, who whatever she wishes to do, she must inform him, seek his advice and his permission, when a man wants to do something, he doesn't give his woman this priority, he does his thing without seeking her counsel or permission. **KII with a perpetrator of SGBV in Kaduna State**

I can say that the norms that guides man and woman relationship is that, a man is the one responsible to approach a woman for marriage, and when a man approaches a woman, it is the right of the woman to accept or to reject. **FGD with Married women in Ebonyi State**

5.5 Women's Tolerance to Intimate Partner Abuse

Tolerance to Intimate Partner Abuse (Violence)

This section explored the forms of punishments that are culturally permitted to husbands in punishing a wife for wrongdoing, including:

I. Beating a wife;
ii. Marital rape;
iii. Husband denial of wife sexual relations as a form of punishment etc.

Sample: Women aged 10 to 49 years, whether single, married, or divorced, and men aged 18 years and above

The following measures were used to determine the extent to which intimate partner violence is tolerated across study sites:

i	In this community, if wives do something wrong, their husbands have the right to punish them;
ii	There are times when women deserve to be beaten;
iii	In this community, women cannot claim being raped by their husbands/partners; and
iv	Men may decide to withhold having sexual relations with their wives as a form of punishment.

Data presented in Table 20 shows that both men (70.5%) and women (59.3%) agreed with the statement that a 'husband, has a right to punish a wife that erred. About 17.8% of the male sample, and 15.2% of the female sample agreed to the statement that allows 'a husband to beat his wife irrespective of the kind of offence'. Also, while the claim of being raped by a husband attracts 2.3 mean score amongst women, it was just 1.5 mean score among men. The 'use of denial of sex by husband as a punishment' attracted 2.2 mean score among women, and 1.5 mean score among men. The percentage distributions present very similar views across the gender groups (both women (57.6%) and men (58%) saw nothing wrong in marital rape, as men could have a sexual relationship with a wife just on demand, while 54.6% of the female sample and 49.6% of the male sample said men could use denial of sex as a form of punishment in marriage. The composite scores for both women and men in this domain ranged over '8', meaning that both women and men shared some level of androcentric values regarding tolerance for intimate partner abuse. The composite score for this component revealed that more than half (64.0%) of the female sample and more than half (66.3%) of the male sample tend to be permissive of tolerance for intimate partner abuse (an expression of androcentric gender values about marital relationship) (see Table 20.).

Table 20: Distribution of Respondents by Gender Norms and Practices on Tolerance of Intimate Partners' Abuse

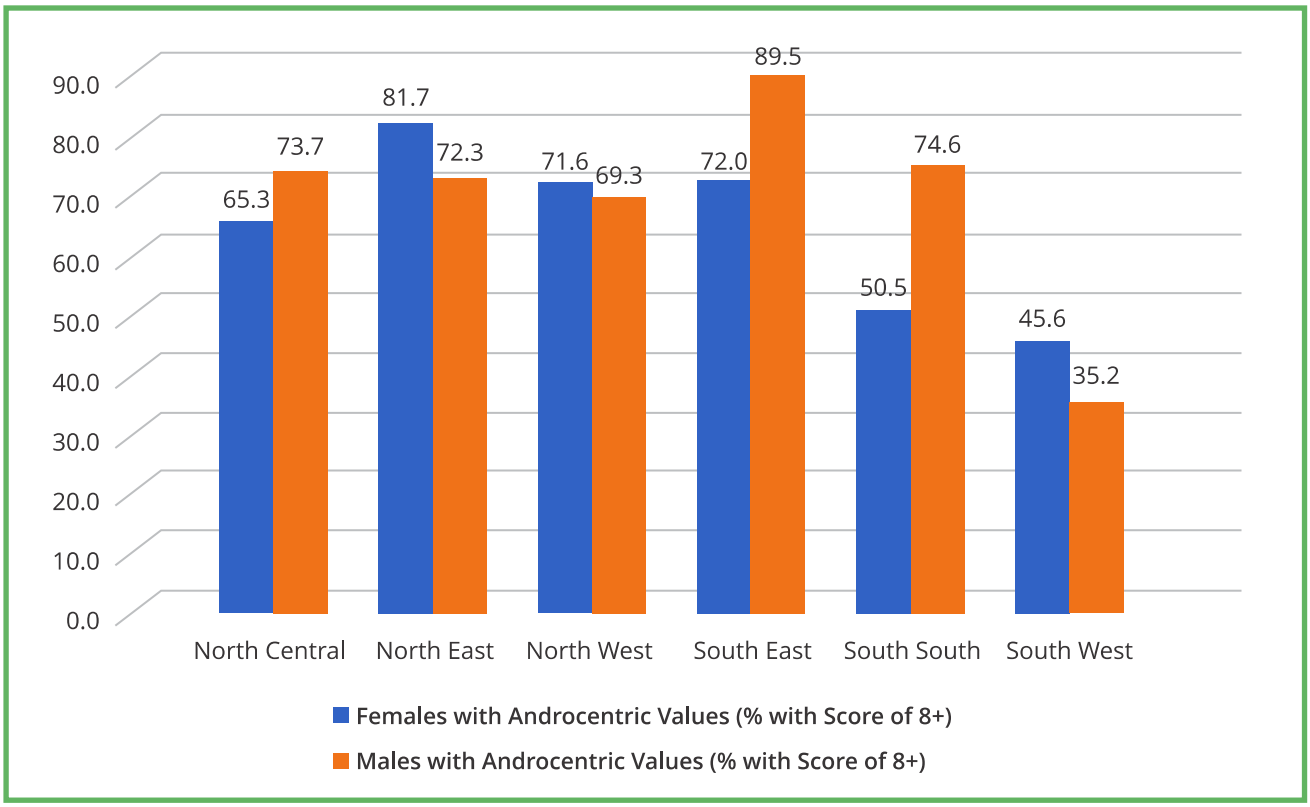
A. FEMALE SURVEY: TOLERANCE TO INTIMATE PARTNER ABUSE (VIOLENCE)						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	In this community, if wives do something wrong, their husbands have the right to punish them.	36.8	3.9	59.3	6,284	**2.3**
ii.	There are times when women deserve to be beaten.	80.9	3.9	15.2	6,284	**1.3**
iii.	In this community, women cannot claim being raped by their husbands/partners	32.5	9.9	57.6	6,284	**2.3**
iv.	Men may decide to withhold having sexual relations with their wives as a form of punishment.	35.1	10.4	54.5	6,284	**2.2**
Summary Statistics						
i.	Total Mean Score of violence (i - iv)					**8.1**
ii.	Composite Score: Females with Androcentric Values (% with Score of 8+)					**64.0%**
iii.	Composite Score: Females with Non-Androcentric Values (% with score of <8)					**36.0%**
B. MALE SURVEY: TOLERANCE TO INTIMATE PARTNER ABUSE (VIOLENCE)						
	Statements	**Disagree (%)**	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	In this community, if wives do something wrong, their husbands have the right to punish them.	27.0	2.5	70.5	3,092	**1.3**
ii.	There are times when women deserve to be beaten.	76.7	5.5	17.8	3,092	**1.9**
iii.	In this community, women cannot claim being raped by their husbands/partners	32.2	9.8	58.0	3,092	**1.5**
iv.	Men may decide to withhold having sexual relations with their wives as a form of punishment.	43.2	7.2	49.6	3,092	**1.5**
Summary Statistics						
i.	Total Mean Score of violence (i - iv)					**8.4**
ii	Composite Score: Males with Androcentric Values (% with Score of 8+)					**66.3%**
iii	Composite Score: Males with Non-Androcentric Values (% with score of <8)					**33.7%**

Regional data presented in Figure 17 shows some levels of variations in how men and women tolerate intimate partner violence. On the whole, a higher expression of androcentric value in this domain was expressed more in the Northern zones compared to the Southern zones. Androcentric views expressed in this domain recorded across the zones are: Southeast: Women (72%), Men (89.5%); Northeast: women (81.7%), Men (73.3%); Northwest: Women (71.6%),

Men 69.3%); North-central: Women (65.3%), Men (73.7%); South-south: Women (50.5%), Men (74.6%); Southwest: Women (45.6%), Men (35.2%). These data show that men with the strongest androcentric view in this domain are mainly from the Southeast (89.5%), South-south (74.6%); and the three Northern regions. Women with the most pronounced androcentric view in the domain are from the Northeast (81.7%); Southeast (72%); Northwest (71.6%) and Northcentral (65.3%) (See Figure 17 and Appendix 5.5.).

The findings in this domain reinforce cultural norms governing gender power relations in marital relationships, which may foster unhealthy attitudes, promote and normalise intimate partner abuse/violence.

Figure 17: Percentage Distribution of Men and Women by Composite Assessment of Tolerance to Intimate Partner Abuse (violence) across regions



In most cases, women and their children bear the negative impact of intimate partner abuse, ranging from physical, psychological, health and emotional traumas among others. Shreds of evidence from the qualitative data collected during this field study elucidated on this. Participants across all the geopolitical zones noted that men may refuse to support their wives and her children as they used to do before through physical, emotional, and financial deprivation. A man can also punish his wife with sexual deprivation, abuse her physically and separate or divorce her while the wife is expected to endure her husband's chastisement/abuse as an attribute of "a virtuous woman". Her negative reactions/rejection of the husband's corrections/abuse may be interpreted as a lack of maturity and met with societal condemnations. More details of these are provided in section 5.14.4 on rewards and punishments for deviations from social and gender norms.

5.6 Male Supremacy/Male Preference

Male Supremacy (Male Preference)

This section measures indicators of male supremacy and male dominance values, including: a preference for male children; boys deserving more education than girls, and the acceptability of a brother inheriting his brother's wife upon his death.

Sample: Women aged 10 to 49 years, whether single, married, or divorced, and men aged 18 years and above.

The male supremacy/male preference component of the GRGN model was measured by the under-listed indicators:

I	There is a general preference for male children;
Ii	Boys deserve education more than girls; and
iii	It is acceptable for a brother to inherit his brother's wife if the brother dies

Over half of the women aged 10–49 years (54.3%) and men aged 18 and older (52.5%) agreed that there is a widespread preference for male children. However, the

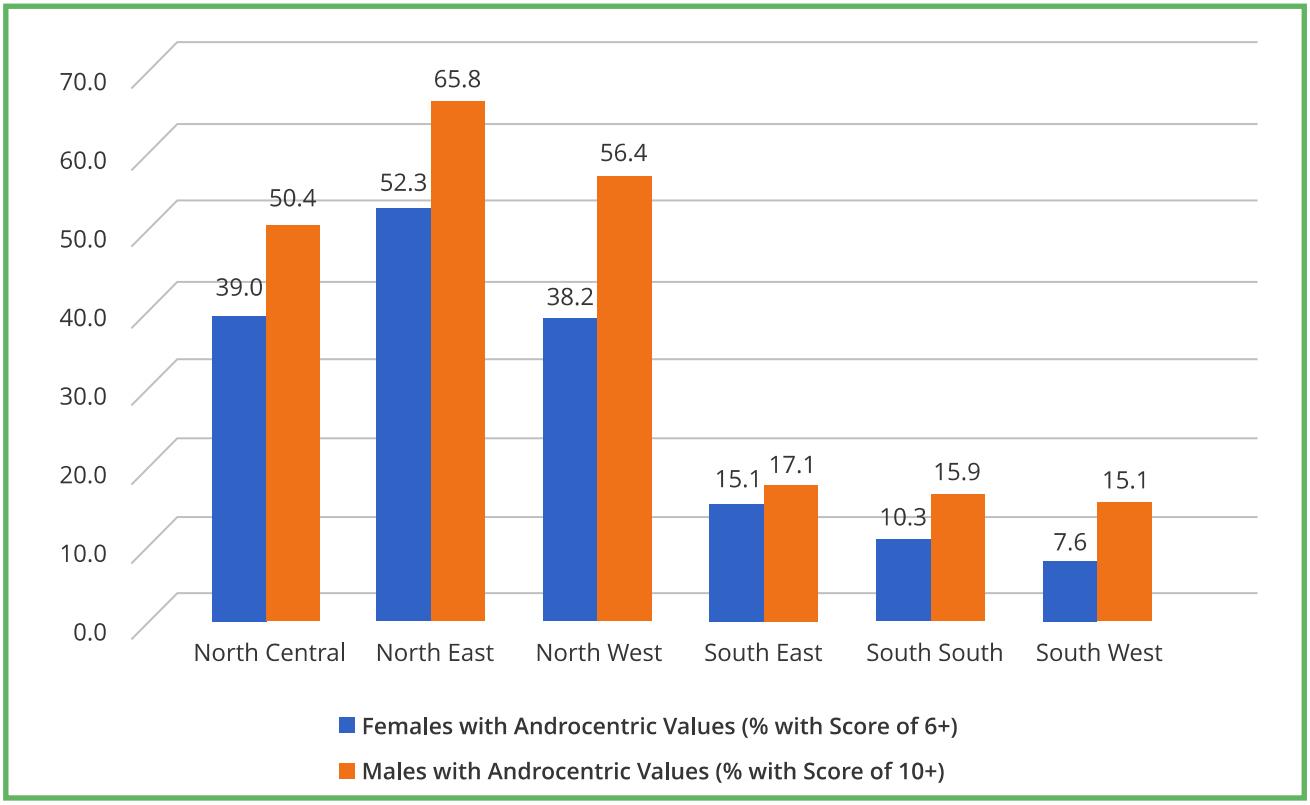
tides are changing against offering "only" male children the opportunities for formal education. The majority of the sample (77.4% of females and 65.8% of males) are opposed to prioritising boys' education over girls' education.

Also, widowhood inheritance is now treated with disdain (reported by 73.3% of women and 63.8% of men). The mean scores of 4.9 for women and 5.5 for men show a tendency towards non-androcentric values for this component for both women and men. Notably, the composite score for this component shows that 72.2% of the female sample and 62.2% of the male sample embraced non-androcentric values for this component (Table 21). This means that both men and women are currently reversing their androcentric tendencies by advocating for girl-child education and the abolition of widow inheritance (Table 21). Across the regions, more than 80% of women and men in the southern states hold non-androcentric values about extending the vision of 'male supremacy' to the future generation. Although in the North, less than half of the men were non-androcentric in this respect (NC 49.6%, NE 34.2%, NW 43.6%), while 47.7%, 60.9% and 61.8% of women in North Central, North East and North West respectively held non-androcentric views (Appendix 5.6). In general, women and men are gradually moving away from cultural practices that stifle the rights of girls as children. Men are gradually becoming more committed to advancing the rights of female children, although still very quick at giving them out in 'child marriage' (thereby negating recent investments in girls).

Table 21: Distribution of Respondents by Gender Norms and Practices on Male Supremacy

A. FEMALE SURVEY: MALE SUPREMACY (MALE PREFERENCE)						
		Disagree (%)	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	There is a general preference for male children	41.3	4.4	54.3	6,284	**2.1**
ii.	Boys deserve education more than girls	77.4	2.0	20.6	6'284	**1.4**
iii.	It is acceptable for a brother to inherit his brother's wife if the brother dies	73.3	6.4	20.3	6'284	**1.4**
	Summary Statistics					
i.	Total Mean Score of human rights (i - iii)					**4.9**
ii	Composite Score: Females with Androcentric Values (% with Score of 6+)					**27.7%**
iii	Composite Score: Females with Non-Androcentric Values (% with a score of <6)					**72.2%**
B. MALE SURVEY: MALE SUPREMACY (MALE PREFERENCE)						
		Disagree (%)	**Not Sure (%)**	**Agree (%)**	**Total No**	**Mean Score**
i.	There is a general preference for male children	41.7	5.8	52.5	3,092	**1.5**
ii.	Boys deserve education more than girls	65.8	4.0	30.2	3,092	**1.7**
iii.	It is acceptable for a brother to inherit his brother's wife if the brother dies	63.8	6.7	29.5	3,092	**1.8**
	Summary Statistics					
i.	Total Mean Score of human rights (i - iii)					**5.5**
ii	Composite Score: Males with Androcentric Values (% with Score of 6+)					**37.8%**
iii	Composite ScoreMales with Non-Androcentric Values (% with a score of <6)					**62.2%**

Figure 18: Percentage Distribution of Men and Women by Composite Assessment of Male Supremacy and Dominance by regions



5.7 Composite Scores of Gender Assessment Domains and by Sex

This section reviews 'sex' as an explanatory variable for the six gender assessment domains used in this landscape analysis. Both women (92.9%) and men (92.6%) expressed androcentric values on gender roles and norms, followed by the right to decision-making (73.1% F; 74.6% M), access to wealth, and well-being (50.6% F; 51.7% M), absolute right of men over wives sexual and reproductive health (63.5% F, 52.7% M), and tolerance to intimate partners' abuse (64.0% F, 66.3% M) . Androcentric views are more pronounced across gender groups for these five domains, compared to the remaining domain used in this assessment i.e., male supremacy (male preference). The sharp difference in androcentric view was recorded across gender groups on issues relating to men's supremacy, they both shared non-androcentric views on 'male supremacy', especially those affecting children (72.2% F; 62.2% M) (see Table 22a).

Table 22a: Assessment of Gender Norms and Roles

		FEMALE (N=6353)			MALE (N=3092)		
	Gender Assessment Domains	***Androcentric Values %***	***Non-Androcentric Values %***	**Mean Scores**	***Androcentric Values %***	***Non-Androcentric Values %***	**Mean Scores**
i.	Gender roles and gender norms	*92.9*	*7.1*	*14.9*	*92.6*	*7.4*	*15.1*
ii.	Access to wealth and well being	*50.6*	*49.4*	*7.5*	*51.7*	*48.3*	*8.1*
iii.	Right to decision making and participation	*73.1*	*26.9*	*8.8*	*74.6*	*25.4*	*8.9*
iv.	Absolute rights of men over wives sexual and reproductive health (sexual rights)	*63.5*	*36.5*	*10.7*	*52.7*	*47.4*	*10.3*
v.	Tolerance to intimate partner abuse (violence)	*64.0*	*36.0*	*8.1*	*66.3*	*33.7*	*8.4*
vi.	Male supremacy (male preference)	*27.8*	*72.2*	*4.9*	*37.8*	*62.2*	*5.5*

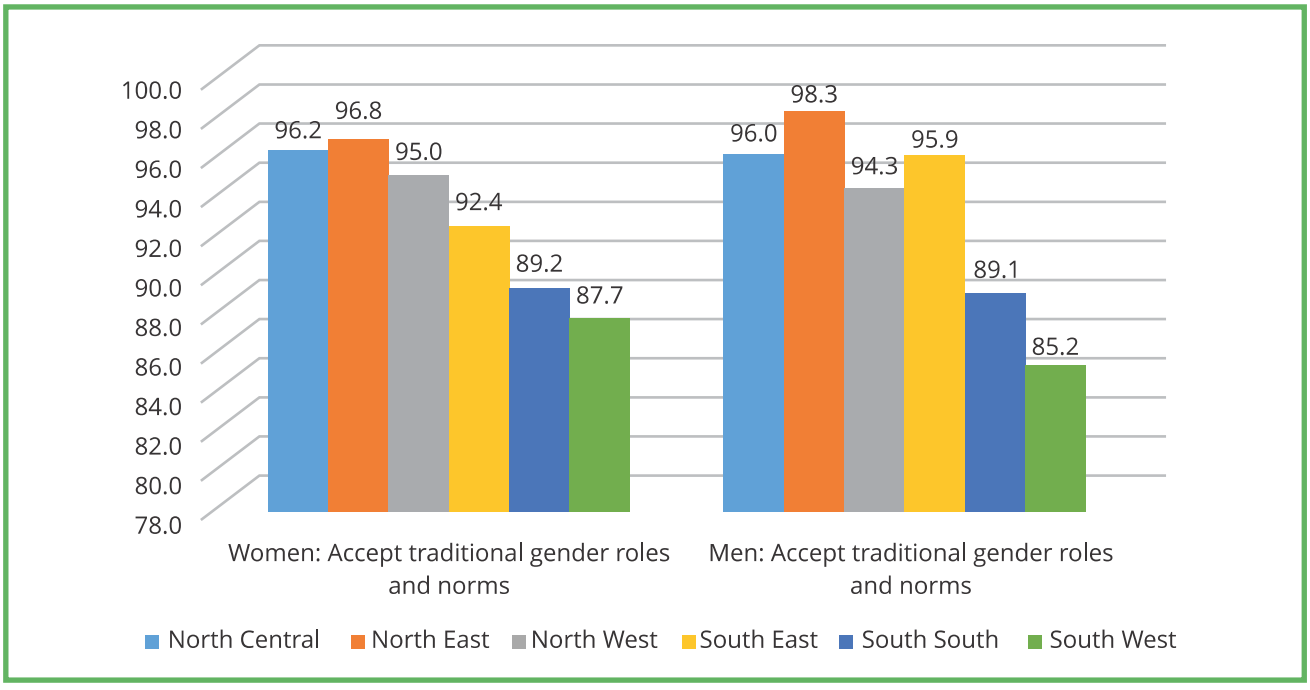
5.8 Perception and Attitudes about Gender Roles and Norms

Data presented in Appendix 5.1 compares women aged 10–49 years with men aged 18–65 years in terms of their acceptance and rejection of gender roles, norms, and practices in society. The table presents a cross-tabulation of socio-demographic variables (age, religion, ethnicity, residence, marital status, level of literacy, education, occupational status, geopolitical zones, states, and quintile by wealth) and the acceptance or rejection of traditional gender roles, norms, and practices. Overall, women and men of all ages, religions, ethnicities, residences, marital status, literacy, education, educational levels, employment/occupational categories, geographical zones, states, and wealth quintiles still largely subscribe to androcentric beliefs. This demonstrates that their perceptions and attitudes regarding gender roles and gender norms are androcentric, regardless of their socio-demographic background (see Appendix 5.1).

The geographic spread shows that women accepted gender roles and norms in all zones, with a predominance in the North East (96.8 %), North central (96.2%), North West (95.0%), and Southeast (92.4%) zones, respectively. Traditional gender roles, norms and practices were accepted with 89.2% in the south-south and 87.7% in the south-west. Men in the same zones, on the other hand, showed similar support for traditional gender roles and norms. The South South and South West recorded 89.1% and 85.2% acceptance of traditional gender roles, norms and practices (see Fig. 5.7) among menfolk. These explain the pervasiveness and influence of traditional gender roles, norms, and practices throughout all socio-demographic categories.

The GRGN domain presents interesting scenarios across the selected states. Notably, all the 13 sampled States present very high level of androcentric values across gender groups for this domain: Nasarawa (W:98.2%, M:97.9%); Sokoto (W:98.2%, M:98.2%); Adamawa (W:97.6%, M:98.9%); Bauchi (W:96.2%, M:97.9%); Imo (W:95.9%, M:96.5%); Kwara (W:95.3, M:97.2% %); Edo (W:94.1%, M:92.8%); Kaduna (W:92.7%, M:91.6%); the Federal Capital Territory (W:92%, M: 81.9%); Oyo (W:88%, M:89.1%); Ogun (W:87.2%, M:79.8%); Ebonyi (W:86.6%, M:94.5%); Akwa Ibom (W:84.6%, M:85.9%) (See Appendix 5.1).

Figure 19: Distribution of Men and Women on Perception and Attitudes about Gender Roles and Norms by Regional Spread



Predictors of Gender Norms and Roles

As the age of women increases, they are less likely to be androcentric. Muslims are more likely to be androcentric towards gender norms and roles compared to Christians. Concerning ethnicity, Igbos, and Hausas tend to exhibit more traditional gender norms and roles compared to the Yorubas. Those in marital relationships, living in rural with no form of education are more likely to exhibit traditional gender norms and values. As women increase on the wealth spectrum, the probability of being androcentric reduces.

Table 22b: Logistic Regression on Gender Norms and Roles

Gender Norms and Roles	Odds ratio	Std. err.	z	P>z	[95% conf.	interval]
Age						
15-19	1.128935	0.471665	0.29	0.772	0.497784	2.56034
20-24	0.7904683	0.328702	-0.57	0.572	0.349887	1.785834
25-29	0.71541	0.302324	-0.79	0.428	0.312498	1.637808
30-34	0.6416254	0.274514	-1.04	0.3	0.277397	1.484094
35-39	0.53828	0.232246	-1.44	0.151	0.231073	1.253913
40-44	0.6676304	0.295447	-0.91	0.361	0.280448	1.589349
45-49	0.5755094	0.254672	-1.25	0.212	0.241759	1.370006
Religion						
Islam	1.162159	0.175913	0.99	0.321	0.863817	1.563541
Traditional Religion	1	-				
Ethnicity						
Hausa	1.437665	0.481007	1.09	0.278	0.74622	2.7698
Yoruba	2.372596	0.714047	2.87	0.004	1.315375	4.279548
Others	2.268817	0.633263	2.94	0.003	1.312852	3.920878
Residence						
Rural	1.070807	0.127627	0.57	0.566	0.847732	1.352583
Marital Status						
Married	1.769438	0.253137	3.99	0	1.336787	2.342117
Divorced/separated	0.8636011	0.261161	-0.48	0.628	0.477421	1.562157
Cohabiting	0.6982251	0.260488	-0.96	0.336	0.336075	1.450623
Widowed	0.7816439	0.194026	-0.99	0.321	0.480526	1.271456
Education						
Islamic	0.6897341	0.252632	-1.01	0.311	0.33644	1.41402
Adult Education	0.4861194	0.249228	-1.41	0.159	0.177968	1.327835
Formal	0.4690641	0.086057	-4.13	0	0.327391	0.672045
Employed						
No	1.629811	0.209396	3.8	0	1.266998	2.096519
Zone						
North East	0.6293819	0.266678	-1.09	0.274	0.274314	1.444043

North West	0.9364462	0.48379	-0.13	0.899	0.340199	2.577705
South East	2.027696	0.956475	1.5	0.134	0.804427	5.111158
South South	0.5337634	0.202261	-1.66	0.098	0.25398	1.121754
South West	0.1753867	0.071308	-4.28	0	0.079053	0.389112
States						
Akwa Ibom	0.3861496	0.095315	-3.85	0	0.23804	0.626415
Bauchi	0.5689276	0.19926	-1.61	0.107	0.286375	1.130263
Ebonyi	0.1654266	0.044008	-6.76	0	0.098211	0.278644
Edo	1	-				
FCT Abuja	0.4462283	0.167785	-2.15	0.032	0.21355	0.932428
Imo	1	-				
Kaduna	0.4015449	0.167406	-2.19	0.029	0.177364	0.909084
Kwara	0.4439773	0.191385	-1.88	0.06	0.190737	1.033446
Nasarawa	1	-				
Ogun	1.20574	0.241731	0.93	0.351	0.813958	1.7861
Oyo	1	-				
Sokoto	1	-				
Wealth Index						
Second	0.9994427	0.167419	0	0.997	0.719733	1.387856
Middle	0.8087469	0.137405	-1.25	0.212	0.579689	1.128315
Fourth	0.6525109	0.111951	-2.49	0.013	0.466174	0.91333
Highest	0.5678209	0.095705	-3.36	0.001	0.408079	0.790094
_cons	32.93735	19.98283	5.76	0	10.02932	108.1697

5.9 Access to Wealth and Wellbeing

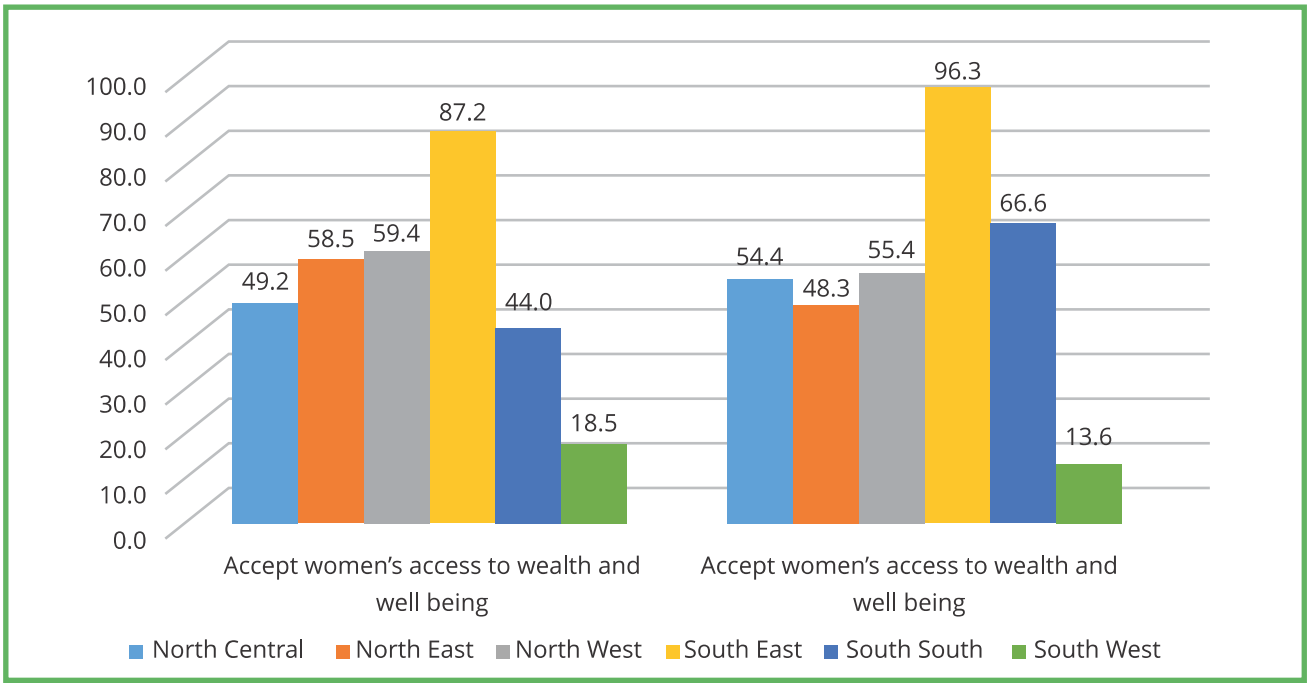
Data presented in Appendix 5.2 enumerates both androcentric and non-androcentric views about women's access to wealth, and wellbeing using socio-demographic characteristics as explanatory variables. Appendix 5.2 indicates a mix of acceptance and rejection of women's access to wealth and well-being across gender groups. Only three socio-demographic factors (ethnicity, zones, and states) reveal a definite acceptance or rejection of women's access to wealth and well-being. Ethnic consideration shows that Igbo (79.4%) and mildly, Hausa (55.6%) groups supported women's access to wealth, and well-being, while only Yorubas (78.5%) disapproved of women's access to wealth, and well-being within the female population. Men from the Igbo ethnic group (86.3%) and 62.7% from other ethnic groups favoured women's access to wealth, and well-being, while a majority of men from the Yoruba extraction (82.6%), and about half of Hausa (52.2%) would rather prefer economically disempowered women. It is however ironic that only Southwest zone recorded the majority of both men (86.4%) and women (81.5%) rejecting women who are economically empowered.

Women and men in the FCT (78.1%) are united in their opinion that women should have equal access to wealth and well-being. FCT being the seat of government, is a

melting point, for the fusion of all cultures, and where abridged cultures emerged. FCT houses a lot of educated elites, and more importantly civil servants, and those employed in various corporations and agencies. However, more androcentric views were expressed in the rural territories of FCT, which are places far from the city centres where indigenous people reside.

A non-androcentric view of women's right to participate in the economy (reported by over 50% of the total sample - men and women), is an indicator of a shared understanding of the role of women in economic development, both at the household level and for national development. Ironically, some states still have a somewhat distaste for women's access to wealth, and well-being: Adamawa: men (78.9%), women (98.7%); Ebonyi: men (78.9%), women (98.7%); Edo state (71.6%); Akwa Ibom (58.9%); Kwara (55.9%). This means that ethnicity, geographical zones, and states all have an impact on the extent to which women are granted access to wealth, and well-being. This is a domain where gender transformative development is currently taking place compared with other domains earlier discussed. Across the geo-political zones, there are similar patterns between women and men in the acceptance of women's access to wealth and wellbeing (see Fig. 20).

Figure 20: Distribution of Men and Women on Access to Wealth and Wellbeing by Regions



Predictors of Wealth and Wellbeing

Examining the predictors of androcentrism in relation to women's access to wealth, and wellbeing, rural dwellers, Hausas and those in marital relationships are more likely to support androcentric views of women's access to wealth, and wellbeing. Having formal education, living in the south-south or southwest reduces the probability of being androcentric towards women's access to wealth, and wellbeing.

Table 22c: Logistic Regression on Women's Wealth and Wellbeing

Wealth and Wellbeing	Odds ratio	Std. err.	Z	P>z	[95% conf.	interval]
Age						
15-19	1.41114	0.263983	1.84	0.066	0.977991	2.036129
20-24	1.098121	0.206191	0.5	0.618	0.760015	1.586638
25-29	1.088349	0.208943	0.44	0.659	0.747057	1.585561
30-34	1.171727	0.229936	0.81	0.419	0.797608	1.721326
35-39	1.028231	0.206467	0.14	0.89	0.693698	1.52409
40-44	1.207655	0.249116	0.91	0.36	0.80604	1.809377
45-49	0.954012	0.201259	-0.22	0.823	0.630934	1.442527
Religion						
Islam	0.907257	0.076618	-1.15	0.249	0.768857	1.070569
Traditional religion	1.211908	0.717046	0.32	0.745	0.380051	3.864539
Ethnicity						
Hausa	1.012733	0.242663	0.05	0.958	0.633195	1.619769
Yoruba	0.850254	0.203666	-0.68	0.498	0.531686	1.359695
Others	1.465508	0.326346	1.72	0.086	0.947194	2.267449
Residence						
Rural	1.402327	0.095742	4.95	0	1.22669	1.603113
Marital Status						
Married	1.283423	0.10578	3.03	0.002	1.091976	1.508434
Divorced/separated	0.904862	0.191321	-0.47	0.636	0.59787	1.369486
Cohabiting	0.747014	0.224582	-0.97	0.332	0.414404	1.346584
Widowed	0.940639	0.161658	-0.36	0.722	0.671638	1.317378
Education						
Islamic	0.918786	0.115932	-0.67	0.502	0.717481	1.176572
Adult Education	1.013853	0.276432	0.05	0.96	0.594142	1.730054
Formal	0.743728	0.061751	-3.57	0	0.632034	0.875161
Employed						
No	1.36493	0.090261	4.7	0	1.199007	1.553814
Zone						
North East	1.129231	0.16407	0.84	0.403	0.849394	1.501262

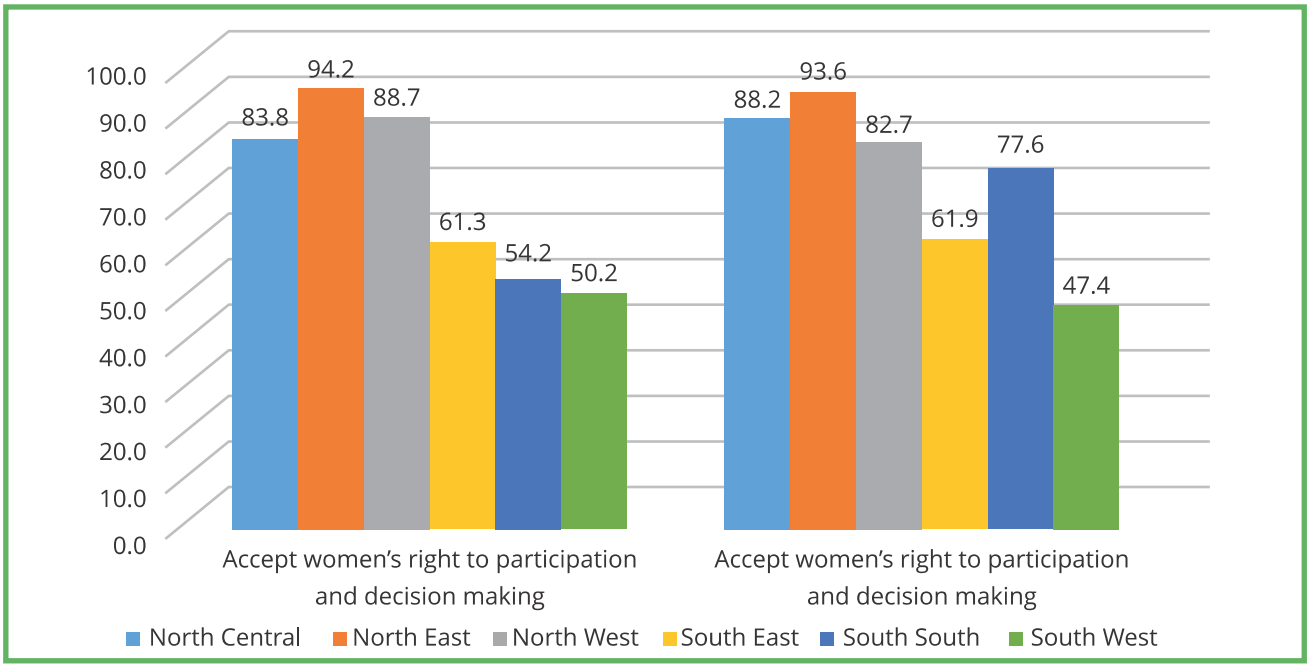
North West	0.566939	0.095132	-3.38	0.001	0.408042	0.787713
South East	12.00006	3.422294	8.71	0	6.861665	20.98637
South South	0.372102	0.052635	-6.99	0	0.282005	0.490984
South West	0.211719	0.040563	-8.1	0	0.145439	0.308205
States						
Akwa Ibom	2.729782	0.388534	7.06	0	2.065261	3.608118
Bauchi	0.558169	0.077091	-4.22	0	0.425797	0.731691
Ebonyi	0.318741	0.062715	-5.81	0	0.21675	0.468726
Edo	1	-				
FCT Abuja	0.222645	0.033997	-9.84	0	0.165059	0.300322
Imo	1	-				
Kaduna	3.10742	0.483219	7.29	0	2.291046	4.214693
Kwara	0.913906	0.154169	-0.53	0.594	0.656614	1.272017
Nasarawa	1	-				
Ogun	1.53515	0.264522	2.49	0.013	1.095166	2.151898
Oyo	1	-				
Sokoto	1	-				
Wealth Index						
Second	0.89465	0.071349	-1.4	0.163	0.76519	1.046013
Middle	0.873153	0.078661	-1.51	0.132	0.731825	1.041775
Fourth	0.801737	0.079578	-2.23	0.026	0.660001	0.973913
Highest	0.852514	0.086764	-1.57	0.117	0.698348	1.040715
_cons	0.815468	0.251037	-0.66	0.508	0.446035	1.490886

5.10. Right to Decision Making and Participation

Data presented in Appendix 5.3 enumerates women's rights to decision-making and their participation in decision-making processes' by their socio-demographic characteristics (age, religion, ethnicity, residence, marital status, level of literacy, education, occupational status, geo-political zones, states, and quintile by wealth). Overall, women and men of all ages, religions, ethnicity, residence, marital status, literacy, education, employment/occupational categories, geographical zones, states, and wealth quintiles subscribe to androcentric beliefs in this gender domain. This reveals that regardless of their socio-demographic background, their beliefs, and attitudes towards women's involvement in decision-making and participation are androcentric. This explains the insidious nature and significance of traditional norms and beliefs associated with women's right to make decisions across all socioeconomic groups (see Appendix 5.3).

The composite assessment presented in Appendix 5.11 shows that women's right to decision making and participation attracts androcentric values across gender groups and zones: Northeast: W (94.2%), M (93.6%); Northwest: W (88.7%), M (82.7%); Northcentral: W (83.4%), M (88.2%); Southeast: W (61.3%), M (61.9%); South-south: W (54.2%); M (77.6%); Southwest: W (50.2%, M (47.4%). The data presented here, however, shows that the Southwest zone is the most liberal towards women's participation in decision-making. This is also a reflection of Southwestern women's exposure to western education and urban living. More interventions are needed in other zones, not only by way of empowering women but ensuring that the structure that reproduces gender inequality is challenged and transformed.

Figure 21: Distribution of Men and Women on Women's Right to Decision Making and Participation by Regions



Predictors of Decision Making

The regression analysis data presented in Table 22d shows that support for women's participation in domestic and communal decision-making was guaranteed more as women increased in age, live in the urban centres, and had formal education. Single women, divorced, cohabiting, or widowed tend to exhibit more non-androcentric values about women's participation in decision-making, compared to women in marital union. The Southwest states exhibit more non-androcentric values concerning women's participation in decision-making. Also, an increase in wealth status strengthens a woman's participation in decision-making (see Table 22d).

Table 22d: Logistic Regression of Women's Participation in Decision Making

Decision Making	Odds ratio	Std. err.	z	P>z	[95% conf.	interval]
Age						
15-19	0.8630461	0.224311	-0.57	0.571	0.518563	1.43637
20-24	0.7239581	0.18931	-1.24	0.217	0.433641	1.208638
25-29	0.620706	0.164863	-1.8	0.073	0.36881	1.044647
30-34	0.6748641	0.182561	-1.45	0.146	0.397149	1.146779
35-39	0.5828796	0.159421	-1.97	0.048	0.341012	0.996295
40-44	0.6802007	0.189724	-1.38	0.167	0.393746	1.175053
45-49	0.6357865	0.177208	-1.62	0.104	0.368181	1.097895
Religion						
Islam	1.281068	0.121625	2.61	0.009	1.063552	1.543071
Traditional religion	0.7356535	0.425742	-0.53	0.596	0.236625	2.287103

Ethnicity						
Hausa	2.47223	0.615797	3.63	0	1.517283	4.0282
Yoruba	0.8346797	0.183225	-0.82	0.41	0.542835	1.283429
Others	1.786463	0.352468	2.94	0.003	1.213535	2.629878
Residence						
Rural	1.05792	0.076999	0.77	0.439	0.917275	1.22013
Marital Status						
Married	1.331942	0.123271	3.1	0.002	1.110982	1.596848
Divorced/Separated	0.5716411	0.121164	-2.64	0.008	0.377315	0.86605
Cohabiting	0.6342447	0.172311	-1.68	0.094	0.372395	1.080214
Widowed	0.7609249	0.132497	-1.57	0.117	0.540911	1.070429
Education						
Islamic	0.9972442	0.249861	-0.01	0.991	0.610284	1.629563
Adult Education	1.131409	0.44069	0.32	0.751	0.527317	2.427547
Formal	0.7497195	0.077461	-2.79	0.005	0.612284	0.918004
Employed						
No	1.252461	0.097131	2.9	0.004	1.075849	1.458065
Zone						
North East	5.087878	1.812409	4.57	0	2.531168	10.2271
North West	1.213661	0.360904	0.65	0.515	0.677607	2.173789
South East	0.6255801	0.158933	-1.85	0.065	0.380215	1.029287
South South	0.1980549	0.034083	-9.41	0	0.141352	0.277504
South West	0.2085635	0.044725	-7.31	0	0.136995	0.31752
States						
Akwa Ibom	1.67171	0.23482	3.66	0	1.26939	2.201541
Bauchi	0.1789793	0.06509	-4.73	0	0.087749	0.36506
Ebonyi	0.6921305	0.09303	-2.74	0.006	0.531835	0.900739
Edo	1	-				
FCT Abuja	0.4681226	0.084651	-4.2	0	0.328425	0.667242
Imo	1	-				
Kaduna	0.6418407	0.176585	-1.61	0.107	0.37432	1.100555
Kwara	1.275446	0.29429	1.05	0.292	0.811447	2.004767
Nasarawa	1	-				
Ogun	2.765609	0.381188	7.38	0	2.110904	3.623374
Oyo	1	-				
Sokoto	1	-				
Wealth Index						
Second	0.9341144	0.094766	-0.67	0.502	0.765677	1.139606
Middle	0.7432958	0.076687	-2.88	0.004	0.607215	0.909873
Fourth	0.7101239	0.075642	-3.21	0.001	0.576321	0.874992
Highest	0.6822568	0.07247	-3.6	0	0.55403	0.840161
_cons	5.563228	2.008583	4.75	0	2.741598	11.28886

5.11 Women's Sexual and Reproductive Rights

Sexual and reproductive rights for women present a conflicting debate between men and women, with the former (men) believing mainly that women do not have sexual rights, especially when married, while the latter (women) believe that women deserve and should have sexual rights. However, the view of women's lack of sexual rights is deeply rooted in the androcentric nature of Nigerian society. Appendix 5.4 presents data on respondents' socio- demographic characteristics and their perceptions of women's sexual rights. Both Islam and Traditional African Religion present higher levels of androcentric views of women's sexual and reproductive rights (Islam: W (71.7%), M (61.5%); Traditional Religion: W (63.7%), M (74.9%), while Christian Religion presents less emphasis on androcentric value in this domain: W: 55.9%, M: 43.8%. Also, respondents (both women (67.3%) and men (57.7%) from rural settings tend to present more androcentric values in this domain, compared to respondents from the urban centres (W: 57.8%; M: 44.8%).). Among the major Nigeria ethnic groups, the Hausas (W: 77%, M: 66%), came up as the strongest with androcentric values in this domain.

Data across the regions shows that most of the northern zones and FCT present relatively very high androcentric values in this domain: Northeast: Adamawa - W (89.2%); M (78.5%); Bauchi - W (77.5%), M (73.1%); Northwest: Kaduna: W (72%), M (64.6%); Sokoto - W (75.7%), M (62.1%); North Central: Nasarawa – W (80%), M (79.5%); Kwara: W (63.8%), M (45.7%); FCT: W(60.4%), (66.3%). However, most of the southern zones present relatively low androcentric values in this domain: Southwest: Ogun: W (54.5%), M (42.7%); Oyo: W (52.2%), M (33.8%); South-south: Edo: W (40%), M (50.8%), Akwa-Ibom: W (37.4%), M (28.4%). Overall, more women are becoming aware of their sexual and reproductive rights, and it appears that men are struggling to respect these rights in married relationships.

The qualitative data revealed specific insights from Persons with Disabilities on sexual and reproductive rights. Considering norms guiding the relationship between members of the society and PWDs, most respondents had no specific rule or norms guiding their relationship but described their relationship outside their circle (i.e., among PWDs) as unpleasant. They lamented that members of the society relate to them as outcasts. Participants in the qualitative interviews from the Federal Capital Territory (FCT) noted that Article 22 of the Disability Act safeguards the right of PWDs to have privacy and own their own families. They however believed that there are some peculiarities when it comes to marriage relationships with PWDs. For instance, unless the person without a disability understands sign language, it is always advisable for the deaf to marry other deaf people to be able to communicate with each other. They added that the visually impaired are to marry able-bodied individuals who will be able to assist them. This does not however always work out, especially when a person with disability must marry somebody without a disability. This is because of negative societal perceptions about intimate relationships between PWD and persons without disabilities. Some communities see this as a taboo and discourage such a union. An able-bodied man or woman that ventures into marrying a person with a disability can become a subject of ridicule in some communities. They noted that some men would rather have PWDs as sex partners, than venture into marriage with them. Field data reported instances of men impregnating ladies with disabilities, with the men in outright denial. Also, some parents will do everything they could to stop their children from marrying PWD because they believe they are cursed by God. Thus, societal negative attitudes were found to be more endemic in the Southern part of the county than in the Northern part.

Considering the gender differences in the experiences of male PWDs and female PWDs, it was evident that men with disabilities have better opportunities for intimate relationships than their female counterparts. It was noted that if a male PWD is rich, it becomes easier to find a marriage suitor compared to their female counterpart. A general notion is a belief that a rich man with a disability will take good care of his wife, while only a rich man can cope with the demands of marrying a woman with a disability.

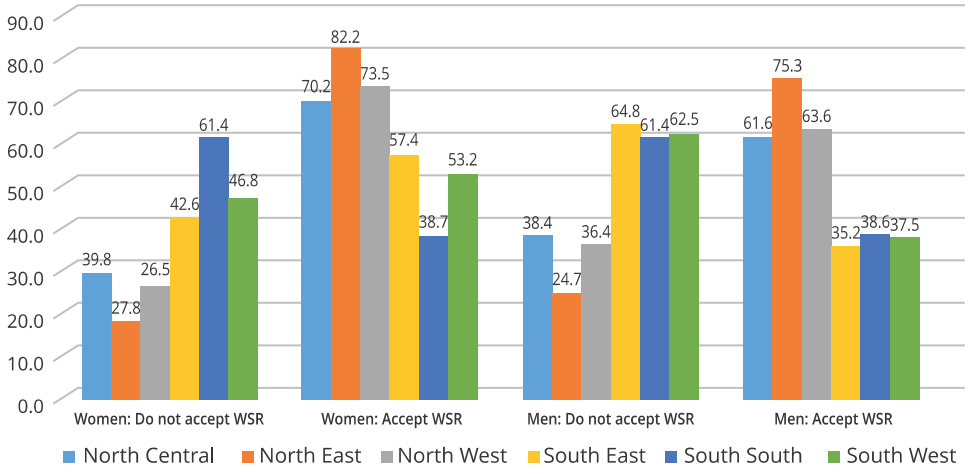


Figure 22: Distribution of Women and Men by Views on Women's Sexual and Reproductive Rights Across Geo-Political Zones

Predictors of Women's Sexual Rights

Using data from the regression analysis presented in Table 22e, rural women and those from Hausa and Yoruba ethnic backgrounds are more likely to exhibit androcentric values concerning women's sexual and reproductive health rights. Women who have ever had marital experience and with any form of education are less likely to support men's absolute rights over the sexual and health rights of their wives. Only women who are in the middle, fourth and highest wealth quintile are less likely to allow men's absolute rights over women's sexual rights (see Table 22e).

Table 22e: Logistic Regression- Women's Sexual Rights

Sexual Rights	Odds ratio	Std. err.	z	P>z	[95% conf.	interval]
Age						
15-19	1.093051	0.221832	0.44	0.661	0.73433	1.627006
20-24	0.956133	0.194764	-0.22	0.826	0.6414	1.425304
25-29	0.718438	0.148684	-1.6	0.11	0.478883	1.077828
30-34	0.858396	0.18175	-0.72	0.471	0.566841	1.299913
35-39	0.737553	0.15847	-1.42	0.157	0.484067	1.12378
40-44	0.973307	0.214616	-0.12	0.902	0.631769	1.499482
45-49	0.978546	0.217286	-0.1	0.922	0.633245	1.512136
Religion						
Islam	1.139045	0.09 4691	1.57	0.117	0.967786	1.34061
Traditional religion	0.903718	0.504386	-0.18	0.856	0.302662	2.698414
Ethnicity						
Hausa	1.280763	0.277199	1.14	0.253	0.837994	1.957476
Yoruba	1.129213	0.235301	0.58	0.56	0.750595	1.698814
Others	1.379252	0.264407	1.68	0.093	0.947253	2.008266
Residence						
Rural	1.211027	0.079049	2.93	0.003	1.065594	1.376308
Marital Status						
Married	0.838846	0.068658	-2.15	0.032	0.714518	0.984807
Divorced/separated	0.420963	0.083515	-4.36	0	0.285348	0.621031
Cohabiting	0.676 964	0.186301	-1.42	0.156	0.394743	1.160961
Widowed	0.574815	0.094267	-3.38	0.001	0.416807	0.792724
Education						
Islamic	0.746691	0.108919	-2	0.045	0.561018	0.993814
Adult Education	0.698522	0.194774	-1.29	0.198	0.40442	1.206499
Formal	0.637848	0.055 192	-5.2	0	0.538349	0.755737
Employed						
No	1.216515	0.080647	2.96	0.003	1.068288	1.38531
Zone						
North East	1.508465	0.286715	2.16	0.031	1.039314	2.189393
North West	0.530693	0.103398	-3.25	0.001	0.362242	0.777479
South East	0.949036	0.227249	-0.22	0.827	0.593554	1.517416
South South	0.214145	0.032923	-10.02	0	0.158433	0.28945
South West	0.359491	0.067798	-5.42	0	0.248403	0.520258

States						
Akwa Ibom	0.898037	0.124553	-0.78	0.438	0.684285	1.178559
Bauchi	0.39064	0.070193	-5.23	0	0.274681	0.555554
Ebonyi	0.244005	0.033243	-10.35	0	0.186824	0.318688
Edo	1	-				
FCT Abuja	0.484957	0.076546	-4.58	0	0.355917	0.660781
Imo	1	-				
Kaduna	1.369011	0.232696	1.85	0.065	0.981126	1.910245
Kwara	0.532911	0.098257	-3.41	0.001	0.37129	0.764886
Nasarawa	1	-				
Ogun	1.202029	0.160904	1.37	0.169	0.92464	1.562634
Oyo	1	-				
Sokoto	1	-				
Wealth Index						
Second	1.015003	0.085274	0.18	0.859	0.860905	1.196686
Middle	0.826354	0.073796	-2.14	0.033	0.693668	0.984421
Fourth	0.695035	0.065573	-3.86	0	0.577698	0.836205
Highest	0.720903	0.068714	-3.43	0.001	0.598057	0.868981
_cons	4.820464	1.47853	5.13	0	2.642462	8.793646

5.12 Acceptance of Husband's Use of Violence in Marital Relationships

The acceptability of a husband's use of violence in a marital relationship is further examined (see data in Appendix 5.5.). Differences of opinion are certain to arise in all types of relationships. Nevertheless, the degree to which they are resolved differs from person to person. While some individuals believe that discussing a problem is the best way to address it, others choose to express their dissatisfaction physically, which is known as domestic violence in marriages. Domestic violence is frequently perpetrated by men. This section examines the extent to which women and men perceive husbands' use of violence in marital relationships as generally acceptable or otherwise. This section explores this issue across socio-demographic characterisations. Women and men of all ages, religions, ethnicities, residences, marital status, literacy, education, educational levels, employment/occupational categories, geographical zones, states, and wealth quintiles accepted the androcentric view, which allowed men/husbands to use violence in marital relationships. This contributes to male domination and a society that marginalises women and exposes them to domestic violence.

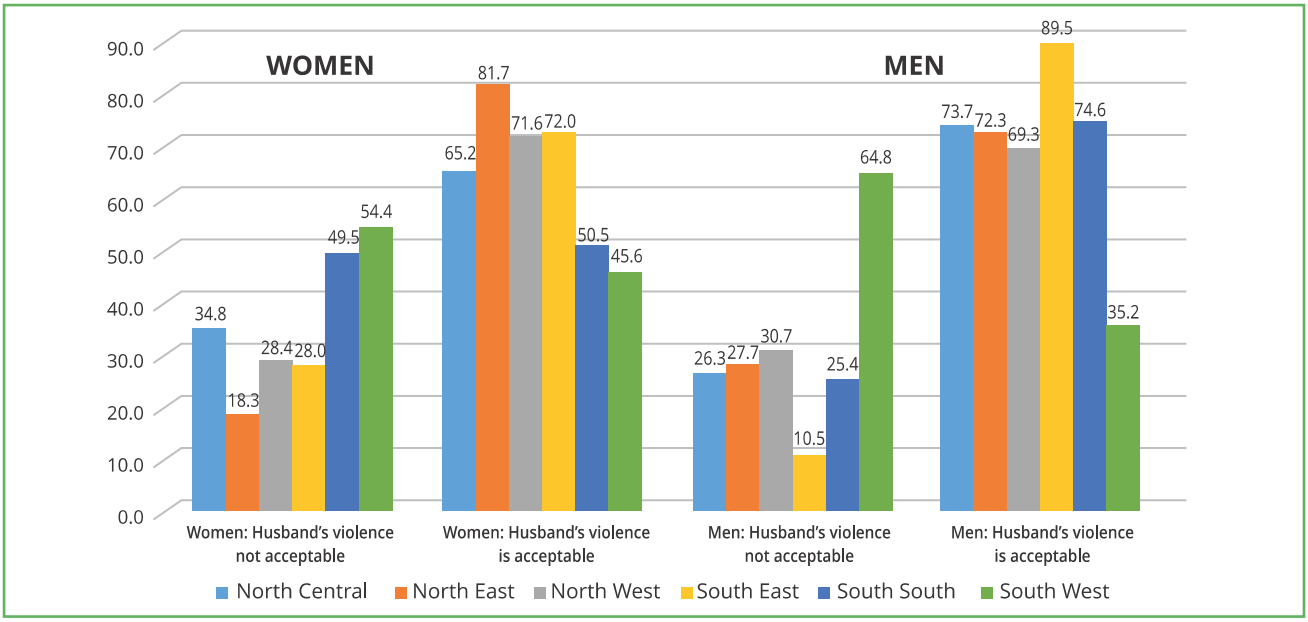
Figure 23 shows both women's and men's perspectives on husbands' use of violence in marital relationships across geopolitical zones in Nigeria. The figure showed that the use of violence by a husband in a marital relationship is supported to a varying degree across regions and states. However, it was noticed that men reported a higher percentage score in favour of using violence in marital relationship. Both genders agreed that husband violence is acceptable in marital relationships across the zones with a smaller proportion of couples from the South-west (45.6% female, 35.2% male) accepting such violence as normative. Women (81.7%) in the North East reported the highest proportion of acceptance of husbands' violence in marital relationships as compared to men (89.5%) from the South- east reporting the highest prevalence in Nigeria. At the state level, Appendix 5.5 shows that Kwara (52.6%), Akwa Ibom (58.9%), and Oyo (63.4%) were the only states where more than half of the women did not support marital violence. However, Adamawa women (94.9%) have the highest prevalence of those that accepted the use of violence in marital relationships, followed by Nassarawa State (83.8%).

Although violence in marital relationships is abhorred by both men and women, it is a daily experience in many homes. Violence experienced whether in marital or non-marital relationships tend to be more for persons with disabilities. They experience discrimination, physical abuse and sexual abuse such as rape from known and unknown assailants. These abuses are more among women/girls with disabilities, who are regularly survivors of rape and assaults. The propensity to the violence against female PWDs is higher because of other marginalised conditions such as immobility, joblessness, lack of education, and poor safety net.

In the case of sexual violence within marriage, it was noted that most women with disabilities are more at the receiving end because they are the ones that are in most need of companions. A woman with disabilities will therefore endure all sorts of ill-treatments just to keep a marriage.

Likewise, religious beliefs around sex in marriage reportedly reinforce violence against women in society. Religious beliefs that discourage denial of sex within marriage, sometimes aid the acceptance of rape within marriage.

Figure 23: Distribution of Men and Women on Husband's Use of Violence in Marital Relationships by Regions



Predictors of Intimate Partner's Violence

Regression analysis presented in Table 22f shows that Igbo women, rural women, and women who are currently in marital union or previously married are more likely to support tolerance of intimate partner's abuse. Women with any form of education are less likely to tolerate intimate partner's violence or abuse. Also, as wealth increases, women tend to reject intimate

partners' abuse. North-eastern states have the highest probability of permitting intimate partner's abuse.

Table 22f: Logistics Regression - Intimate Partner's Violence/Abuse

Violence	Odds ratio	Std. err.	z	P>z	95% conf.	interval
Age						
15-19	1.140877	0.221074	0.68	0.496	0.780363	1.667941
20-24	1.179426	0.230477	0.84	0.398	0.804144	1.729847
25-29	1.055209	0.210459	0.27	0.788	0.713787	1.559943
30-34	1.350618	0.277257	1.46	0.143	0.903227	2.019614
35-39	1.119779	0.233299	0.54	0.587	0.744372	1.684515
40-44	1.181 958	0.252764	0.78	0.434	0.777268	1.797352
45-49	1.474777	0.321599	1.78	0.075	0.961852	2.26123
Religion						
Islam	0.970565	0.083689	-0.35	0.729	0.81965	1.149267
Traditional religion	0.987827	0.566862	-0.02	0.983	0.32079	3.04187
Ethnicity						
Hausa	1.804959	0.397493	2.68	0.007	1.172232	2.779209
Yoruba	1.698332	0.360297	2.5	0.013	1.120578	2.573968
Others	1.583629	0.308903	2.36	0.018	1.080483	2.321073
Residence						
Rural	1.101366	0.073921	1.44	0.15	0.965609	1.256209

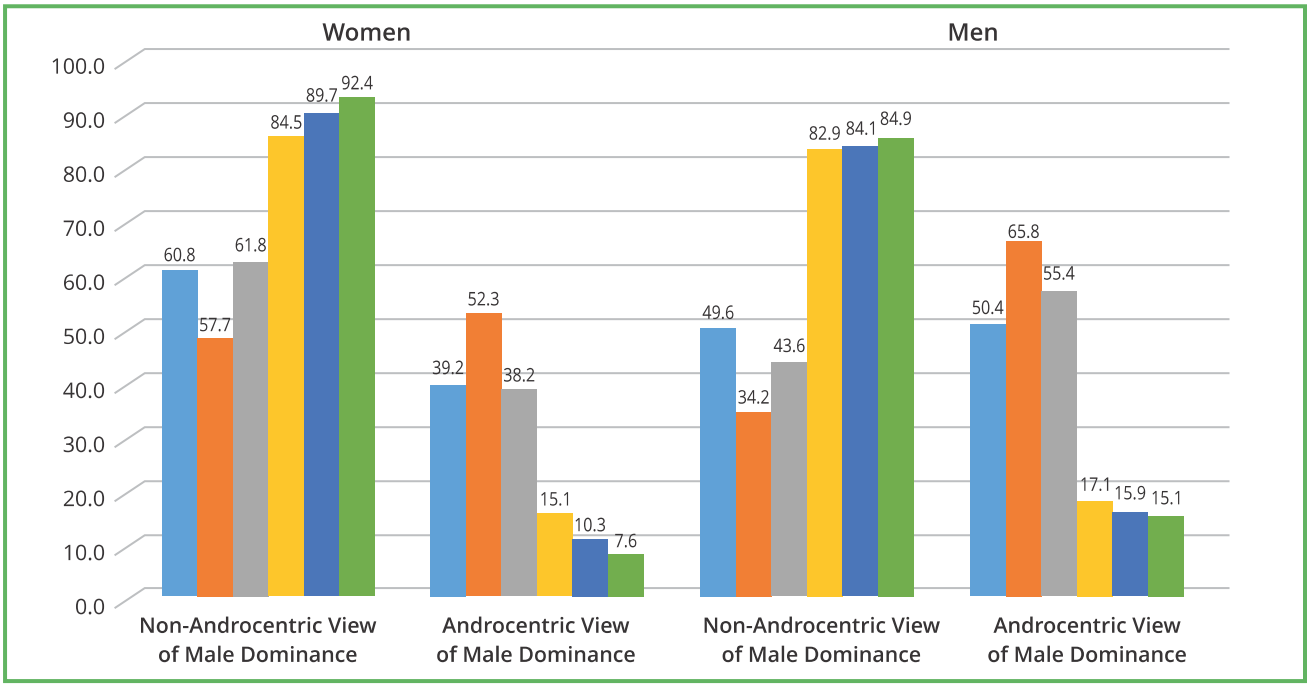
Marital Status						
Married	1.347203	0.111389	3.6	0	1.145656	1.584206
Divorced/separated	0.793942	0.15755	-1.16	0.245	0.538117	1.171389
Cohabiting	1.029756	0.282381	0.11	0.915	0.601612	1.762593
Widowed	1.36683	0.238735	1.79	0.074	0.970601	1.924811
Education						
Islamic	0.701 194	0.098581	-2.52	0.012	0.532314	0.923654
Adult Education	0.215341	0.062857	-5.26	0	0.121525	0.381583
Formal	0.854036	0.075228	-1.79	0.073	0.718617	1.014973
Employed						
No	1.154523	0.078485	2.11	0.035	1.010503	1.319069
Zone						
North East	2.250 886	0.509835	3.58	0	1.443952	3.508765
North West	0.340434	0.067752	-5.41	0	0.230478	0.502847
South East	1.293025	0.325861	1.02	0.308	0.789027	2.118955
South South	0.388872	0.063216	-5.81	0	0.28277	0.534785
South West	0.123608	0.023869	-10.83	0	0.084661	0.180474
States						
Akwa Ibom	0.482552	0.067006	-5.25	0	0.367578	0.633489
Bauchi	0.186692	0.039118	-8.01	0	0.123816	0.2815
Ebonyi	0.363091	0.052456	-7.01	0	0.273553	0.481936
Edo	1	-				
FCT Abuja	0.677887	0.116359	-2.26	0.024	0.484227	0.949
Imo	1	-				
Kaduna	1.674749	0.279894	3.09	0.002	1.206957	2.323847
Kwara	0.183761	0.033929	-9.18	0	0.127965	0.263885
Nasarawa	1	-				
Ogun	2.341736	0.316674	6.29	0	1.796509	3.052434
Oyo	1	-				
Sokoto	1	-				
Wealth Index						
Second	0.947362	0.080341	-0.64	0.524	0.802286	1.11867
Middle	0.754883	0.068325	-3.11	0.002	0.632174	0.90141
Fourth	0.708639	0.068413	-3.57	0	0.586475	0.85625
Highest	0.608195	0.059174	-5.11	0	0.502604	0.735969
_cons	2.808343	0.861578	3.37	0.001	1.539247	5.1238

5.13 Human Rights: Male Supremacy and Male Dominance

Data presented in Appendix 5.6 evaluates male dominance and supremacy from an androcentric/non-androcentric point of view, and uses a set of thirteen socio-demographic characteristics as explanatory variables. A cursory glance at the data in Appendix 5.6 shows that all the socio-demographic characteristics aligned with the rejection of male dominance for women and men, except for men with no education (56.9%), Islamic (62.3%), and adults' education (61.1%) who supported male dominance. Whereas men with formal education (69.3%) condemned male dominance. The Hausa (males, 62.4%; females, 41.1%) ethnic group are the most androcentric compared to the Igbos (males,16.3%; females, 14.6%) and Yorubas (male, 18.2%; females, 9.9%). Male dominance and supremacy is more accepted among rural (males, 45.3%; females, 33.7%) compared to urban dwellers (males 26.3%; female 18.9%).

Figure 24 also presents some zonal/regional variations across gender groups in perceptions of male dominance. Three zones present almost an overt rejection of male dominance on issues explored in this domain: Southwest: W (92.4%), M (84.9%); South-South: W (89.7%), M (84.1%); and Southeast: W (84.5%), M (82.9%). Whereas, in the Northern zones, the data spread supports androcentric views of male dominance/supremacy in the areas explored in this section: Northwest: W (61.8%), M (43.6%); Northeast: W (7.7%), M (4.2%); Northcentral: W (60.8%), M (49.6%). The data spread presents Northeast zone with the worst androcentric view in this domain.

Figure 24: Distribution of Men and Women on Human Rights: Male supremacy and male dominance by Regions



Predictors of Male Supremacy and Dominance

Using the regression analysis (see Table 22g), women tend to reject male supremacy and dominance as wealth increases. Women in the North East and North central are more likely to exhibit an androcentric view of male dominance. Southwestern women have the least probability of allowing male supremacy.

Table 22g: Logistic Regression - Male Supremacy and Dominance

Male Supremacy/Dominance	Odds ratio	Std. Err.	Z	P>z	95% Conf.	Interval
Age						
15-19	1.415373	0.305835	1.61	0.108	0.926707	2.16172
20-24	1.590919	0.344663	2.14	0.032	1.040495	2.432517
25-29	1.160468	0.257521	0.67	0.502	0.751176	1.792768
30-34	1.209458	0.274411	0.84	0.402	0.775289	1.886765
35-39	1.363392	0.315469	1.34	0.18	0.866294	2.145736
40-44	1.167363	0.278533	0.65	0.517	0.731323	1.863385
45-49	1.50528 8	0.366985	1.68	0.093	0.933467	2.427392
Religion						
Islam	1.251517	0.126082	2.23	0.026	1.027269	1.524718
Traditional religion	1.943742	1.250129	1.03	0.301	0.551041	6.856362

Ethnicity						
Hausa	1.398823	0.457575	1.03	0.305	0.736754	2.655845
Yoruba	1.083736	0.362648	0.24	0.81	0.562455	2.088137
Others	1.78864	0.560394	1.86	0.063	0.967911	3.305297
Residence						
Rural	1.34367	0.110092	3.61	0	1.144327	1.577739
Marital Status						
Married	1.071646	0.103255	0.72	0.473	0.887231	1.294392
Divorced/ Separated	0.707899	0.181799	-1.35	0.179	0.427928	1.171041
Cohabiting	2.853705	0.869053	3.44	0.001	1.571045	5.183578
Widowed	0.676539	0.144235	-1.83	0.067	0.445472	1.027461
Education						
Islamic	0.541428	0.073013	-4.55	0	0.415675	0.705226
Adult Education	0.343271	0.115301	-3.18	0.001	0.177717	0.663049
Formal	0.584539	0.055169	-5.69	0	0.485822	0.703315
Employed						
No	1.055157	0.079527	0.71	0.476	0.910253	1.223127
Zone						
North East	1.382792	0.209365	2.14	0.032	1.02773	1.860522
North West	0.238191	0.041925	-8.15	0	0.168694	0.336318
South East	0.261744	0.089047	-3.94	0	0.134367	0.50987
South South	0.09184	0.016574	-13.23	0	0.064479	0.130812
South West	0.031165	0.009446	-11.44	0	0.017206	0.05645
States						
Akwa Ibom	0.963012	0.204929	-0.18	0.859	0.634594	1.461395
Bauchi	0.163974	0.024537	-12.08	0	0.122293	0.219862
Ebonyi	0.464345	0.090339	-3.94	0	0.31713	0.679897
Edo	1	-				
FCT Abuja	0.040511	0.009405	-13.81	0	0.025702	0.063853
Imo	1	-				
Kaduna	2.375604	0.373476	5.5	0	1.745638	3.232914
Kwara	0.233727	0.043667	-7.78	0	0.162062	0.337084
Nasarawa	1	-				
Ogun	5.900667	1.73171	6.05	0	3.319655	10.4884
Oyo	1	-				
Sokoto	1	-				
Wealth Index						
Second	0.870993	0.076968	-1.56	0.118	0.73248	1.035699
Middle	0.596206	0.06319	-4.88	0	0.484373	0.733859
Fourth	0.698192	0.081683	-3.07	0.002	0.555126	0.878129
Highest	0.637513	0.079304	-3.62	0	0.499578	0.813533
_cons	0.980687	0.384504	-0.05	0.96	0.454773	2.114784

5.14 Overview of Women's Status across Study States

Field data (see Appendix 5.7) shows that the overall status of women is considered lower than that of men across study sites. Appendix 5.7 data shows that age, religion, ethnicity, residence, marital status, education, literacy, educational level, occupational position, and geographical location have little effect on how women are perceived in Nigerian society. Across the different social groups explored in this study, respondents are all in agreement on 'pervasive gender inequality and low social status for women' across the Nigerian cultural groups. Women, regardless of socio-economic status, are survivors of gender inequality. The idea that women are

Box 5.7: Excerpts on Men's expectations in marriage

The most important expectation is having children, then a peaceful family, but the first thing is having children. **FGD with married men in Bauchi State**

Whatever your husband provides for you, you please thank him no matter how little it is. You should also try to manage and cook what he brought very well so that next time he will bring more of that. **FGD with married women in Adamawa State**

Ah, I think generally within our community, the men expect that the women will be submissive to them, you know, they will defer to them in areas of decision making and all that. So, they will be the ones to dish out instructions on how, ah you know, what should be done, what is allowed or not allowed in the family. **FGD with NGOs in Kaduna State**

women as men were described as food lovers. Despite the emphasis on physical attractions and inner beauty in terms of good characters, men and women felt fertility in marriage was non-negotiable as an outcome.
In espousing further, the place of fertility in marriage, participants across the various groups also cited sexual satisfaction and fidelity in marriage as virtues that should exist and be well guarded by both men and women in a heterosexual relationship. Women's expectations and the ideal type of man or husband are similar to that of men. Generally, women cited physicalappearance and good looks as important for selecting a husband. Such a look must be backed with financial stability and independence. Some male participants in Nasarawa State emphasised good education, high intelligence, a secure source of income and the ability to engage in productive communication. A key informant in Ebonyi State hinged his/her opinion on the social expectations that men ought to be 'a true breadwinner' for the household (see Box 5.6 for the attributes men prefer in women they like to marry).

Female FGDs emphasised the need for husbands to provide secure income, and be able to provide economic security for the home. Hardly did the women touch on issues relating to: "self-respect"; and /or consideration of gender equity issues in marriage, including relations of power and prestige. Reverence for equity and gender balance was inconsequential as long as a man is ready to take care of a woman's material needs and societal acceptance of their children (also see Box 5.6 for attributes women prefer in a man they want to marry).

Men's expectations in marriage include: expectations that wives will be supportive, cooperative, responsible, home builders, submissive to the husband's authority, tolerate the husband's weaknesses, keep the house neat, appreciate the husband's roles and support, and sexually satisfy their husbands (see Box 5.7).

On the contrary, women's expectations in marital relationships include the husband's financial support and occasional special gifts from husbands. Women expect that their husbands will be religious and allow for good communication flow. They specifically stated that they want their husbands to have listening ears and communicate with them from time to time as well as have time for gist. They demand love and care from their husbands. They expect their husband to be the true "breadwinner" for the home. Also, women do not want their husbands to cheat on them while they also expect their husbands to trust them. These expectations appear similar across the study sites.The qualitative evidence captures how such cultural frames and expectations mirror what should be done, the benefits, consequences and the rules that must govern interactions between spouses across the communities where this study was conducted. At the core of marital relations within and across communities and ethnic groups in Nigeria are the gender relations of power, which gave men undue privileges over women throughout history. The extent to which this gender power relation is managed in the face of current global economic challenges and their impacts on the household economy is likely to have unprecedented impacts on domestic violence and intimate partner abuse. The ideals guiding heterosexual relations as expressed among the participants in this study are tested and fluid, looking at the experiences and positions that were expressed in different FGDs.

Expectations are becoming daunting to fulfil within the current economic climate in Nigeria and around the globe. It may be an inferred reason for the hike in domestic violence in homes, as most of these expectations become gradually illusionary and unfulfilled by both partners. Figure 25 shows the network of expectations of men and women in their marriages.

inferior to men continues to persist within modern-day Nigerian society, despite overt advancements in women's educational and professional achievements.

5.14.1 Reasons for the Male Supremacy Ideology

Appendices 5.8 and 5.9 present data on reasons for male supremacy ideology across gender groups, using socio-demographic characteristics as explanatory variables. Notably, younger women are starting to question male supremacy, but many others in the older age groups (men and women) tend to justify gender inequality using religious apologies. More women tend to believe that men are natural leaders, whereas educated men would reject gender equality principles because they appear threatened and afraid of losing control over their wives. Among the ethnic groups, community culture and tradition were identified as reasons for male supremacy mostly among the Hausas (male 48.9%; female 44.0%) and Igbos (male 56.5%; female 37.1%) compared to the Yorubas (male 30.6%; female 28.6%), while religion as rationale mostly among the Hausas indicated male 47.6% and female 35.0%, and least among the Igbos (male 13.5%; female 9.5%), while women in all the three ethnic groups (Yoruba, 30.6%; Hausa, 28.9%; Igbo, 26.0%) believe that gender equality could cause conflict in the family.

Insights from the qualitative findings revealed that cultural values, norms and practices are acquired at different levels of the socialisation processes for both males and females in any given social setting. Once acquired and imbibed, chances are high that such would be deployed in defining interactions, expectations and outcomes in intimate relationships. These qualities attract a high premium across the communities especially when describing ideal heterosexual relations, reactions to events, and decisions on critical aspects of marital relations.

Most of the participants argued that men would always prefer women that demonstrate virtues like gentleness, calmness, hardworking, peace-loving, respectful, caring, obedient, God- fearing, and humility in their interactions. Physical attraction was specifically mentioned as a gift that every woman must possess in addition to the good character earlier listed. A woman that would attract a suitor should be intelligent, good-looking, physically endowed with body shapes that are sociallyvalued, fashionable, educated or have a reasonable source of income. The family history or background of a woman was widely described as requisite in determining whether such a woman would be a suitable candidate to be married. The place of the family background was further linked to the likelihood of having good morals that are transferable to the children that will be borne by that woman.

The ability to earn a reasonable income was emphasised across all the FGDs among women in the different regions and states covered in this study. Some male participants also considered women that earn a reasonable level of income as burden sharers and with good prospects. Culinary skills are also expected to be possessed by such

Box 5.6: Excerpts on attributes men and women consider in opposite sex for marriage

So, it is good for a man intending to marry to look for a good and well- mannered wife that possesses good quality of being a married woman both religiously and culturally in addition to the type of family she is coming from. **KII with community leader in Adamawa State**

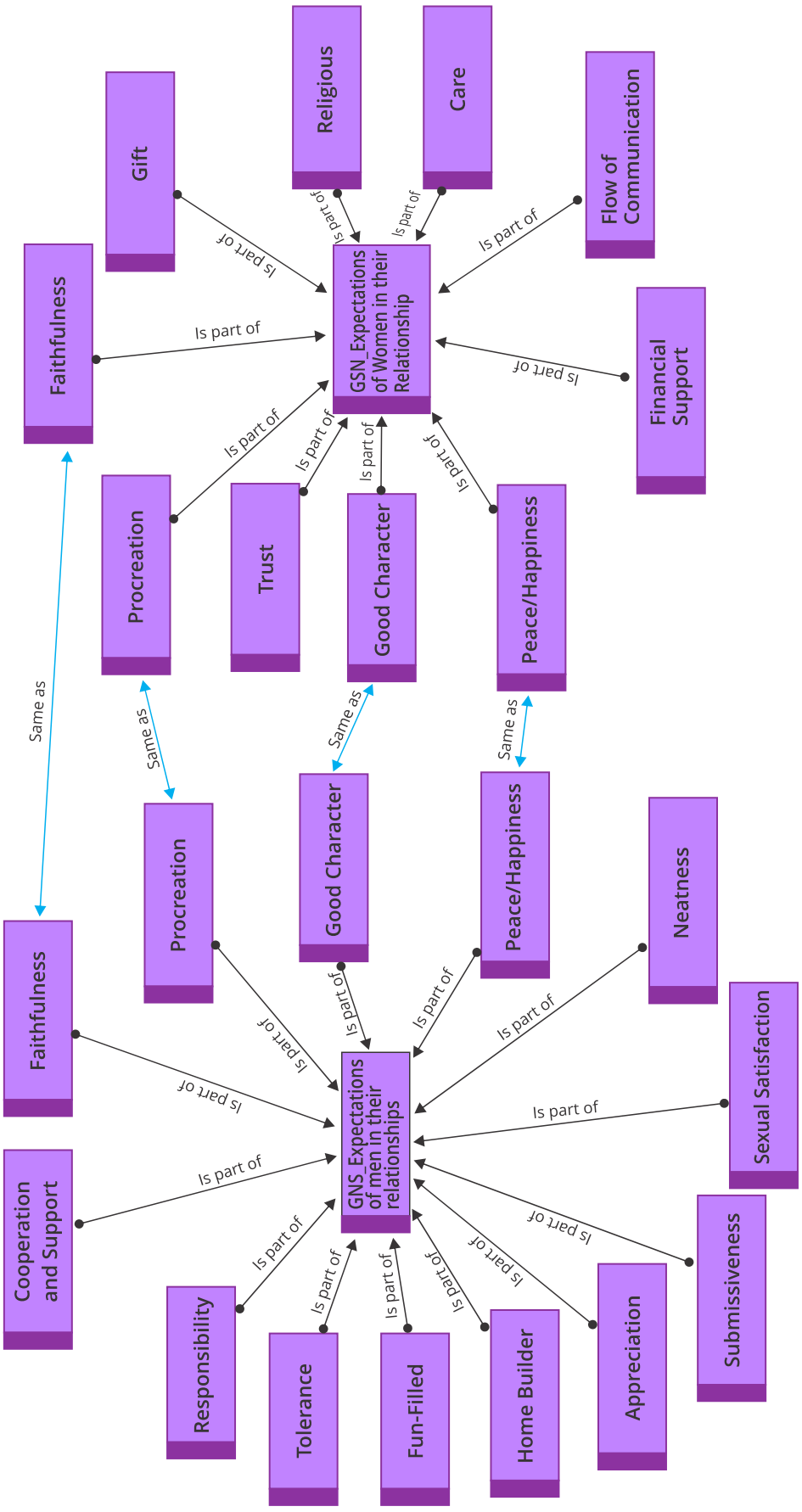
A woman that comes from a good home, a family where you will marry from and people will say you marry from a good home. I can only marry from such type of family. She must have a job, because if she is jobless after two to three years in marriage with kids the expenses will be too much for the man. A wife with job, in one way or the other, will be supporting her man. **FGD with community leaders in Ogun State**

Most women prefer men who are educated and intelligent. **FGD with male community leaders, Nasarawa State.**

They wouldn't want anybody that will be beating them. If the person is not beating them, they will be comfortable, they can take care of themselves and their children. **KII with Gender Desk Officer, Ebonyi State.**

...What women look for today in men is no longer about education, or religion, or such other thing. They look for physical structure, more especially, that attracts them to men. **FGD with married men Bauchi State**

Figure 25: Network showing the expectations of men and women in marital relationships



5.14.2 Changes in Expectations of Men and Women in their Relationship

As reported, social norms and expectations are changing across all ethnic groups. For example, men were traditionally thought to be the breadwinners of the family, but today both men and women are expected to work and contribute to the family's income. The participants in the FGD session with female adolescents in Ebonyi State noted that

"Women are now the breadwinners in some families, as though they don't want to leave the responsibility to the men alone. Sometimes women can contribute to a variety of responsibilities".

Responsibilities are now shared in the home, unlike in the past. Girls now go to school, while sex segregation in jobs is witnessing changes as gender tends not to define jobs for men and women. Hence, the traditional gender division of labour becoming blurred (see Box 5.8). Also, giving birth to many children, which was a pride in the past, is becoming unfashionable as many couples now give birth to fewer children. These changes are occurring in the face of technological innovations, western education, and sensitisation campaigns.

5.14.3 Rewards and Punishments for Deviations from Social and Gender Norms

Considering societal expectations about gender roles and gender norms, efforts were made to understand ways communities tend to reward and/or punish those who deviate from acceptable gender rules and/or practices. There are a variety of ways a man or woman reacts to their spouse's violations of the norms. The participants across all the geopolitical zones noted that men may decide to be patient with the wife, dialogue with her, demand an apology from her, refuse to carry out some domestic activities they have been assisting her to do before, report to her parents, elders in the community, or her friends, or hold a grudge against her and ignore her for some time.

The man may also decide not to eat the wife's food. In extreme cases, it can involve financial deprivation, husbands' leaving home, sexual deprivation, verbal and/or physical abuse, separation or divorce. Box 5.9 shows excerpts on husbands' reactions to wives' deviation from social norms. In justifying the physical assault of the wife, a perpetrator from one of the communities in Ebonyi stated that: "...It is bad character that causes it. If the woman is following other men outside, if the woman is stealing, and exhibiting other bad characters. She knows what she is doing is not good, but just wants to do it. Like she knows what is wrong, but still does it just to see what I will do."

Box 5.8

In the past, there are certain things that were not necessarily done by men, but women. Take for example, weaving, as we know was done mostly in the past by women. But now, weaving for children's wears is done by both males and females, this you can discover when you visit training centres for such skills. Again, with regard to sewing of women clothes which mostly in the past was the exclusive job for women. But now, men are engaged as fashion designers for women clothes.

FGD with unmarried adolescent males in Bauchi State

A departure from the view that violence among partners or spouses can be justified was recorded in one of the FGDs with married men in Akwa-Ibom. Some of the participants argued against the normativity of wife battery and the shallowness in justifying wife battery by some women. In their opinion, most married men lack patience and hardly tolerate the shortcomings of their wives when there are issues or challenging events facing their homes. The absence of patience in most homes makes wife battery a norm and as a measure of instilling discipline in some erring wives. The submission of these men was found across all the six geo-political zones of the country as various participants noted that even when men decide not to do so, some women will always push their husbands to the wall until they are physically abused. It was found that physical assault is simply a way of correcting a derailing spouse, especially the wife. The question is: "is the husband beaten when he derails?" This was jokingly expressed by another man during the FGD session.As a form of patriarchal hegemonic dominance, intimate partner abuse is entrenched and ingrained in most Nigerian cultures. Participants believed that this gender hierarchy has always existed and will continue to exist, and that, like other natural laws, it cannot be altered. It is important to note, however, that physical violence is not usually the first line of action to punish a woman for violating social and gender norms.

Figure 26 presents a network of men's reactions to their wives' violations of social and gender norms as presented by the participants across all the study sites. The figure presented the husbands' subtle reactions, the intermediate reactions, and the extreme reactions.

Box 5.9: Excepts on Men's reactions to their wife's violation of norms

...when a woman offends her husband, he normally shows his disapproval, and if it persists, he takes the step of beating. F**GD married men in Bauchi**

Most wives who receive beating from the husbands always pushed thier husband to the wall.... In most cases, the husband ends up beating her to the point of hospitalising the wife. **FGD male community leaders. Nasarawa State.**

In most cases, you will find out that the man goes to the level of beating up the woman, at some point, he might even send her back home, depending on the level of offence committed by the woman. **FGD with married women in Ebonyi State.**

Yes, there are things that if a woman does will deserve punishment from her husband. Firstly, like a married woman who leaves her house without the permission of her husband, she can be beaten if the husband is a hot-tempered person. **FGD with married women in Adamawa**

...I was called upon that my friend has beaten his wife, when I got there, I said you did not cook for him, he was buying food with his money and when his mother brought food for him you pour it away. ... why won't he get angry. **FGD with adult males in Oyo State**

The man can react with anger, calls the wife and addresses the matter, reports to wife's family, reports to women council and the woman can be fined for the offence. He can verbally abuse the wife, throws the wife's things outside, molest her, divorce, denial of sex and even denial of feeding money. **FGD female opinion leaders Akwa Ibom State**

As part of the subtle reactions to an intimate partner's abuse, participants across the study sites noted that diplomacy is often employed as a tool for settling differences. Through dialogue, couples interact, lay out their problems, and find a peaceful way to resolve them. Men will also demand an apology from their wives, but this will depend on the severity of the problems. It is when all efforts for an amicable resolution of differences at this level fail that they result in mild reactions, including reporting to her parents, friends, and community leaders, as well as psychological punishment such as ignoring her and refusing to communicate with her. Physical abuse and violence are part of the extreme reactions. In other cases, the man might decide to bring in a concubine or marry a second wife to punish the first wife. The extreme reactions can also include financial deprivation, and this may be extended to her children (see Box 5.10).

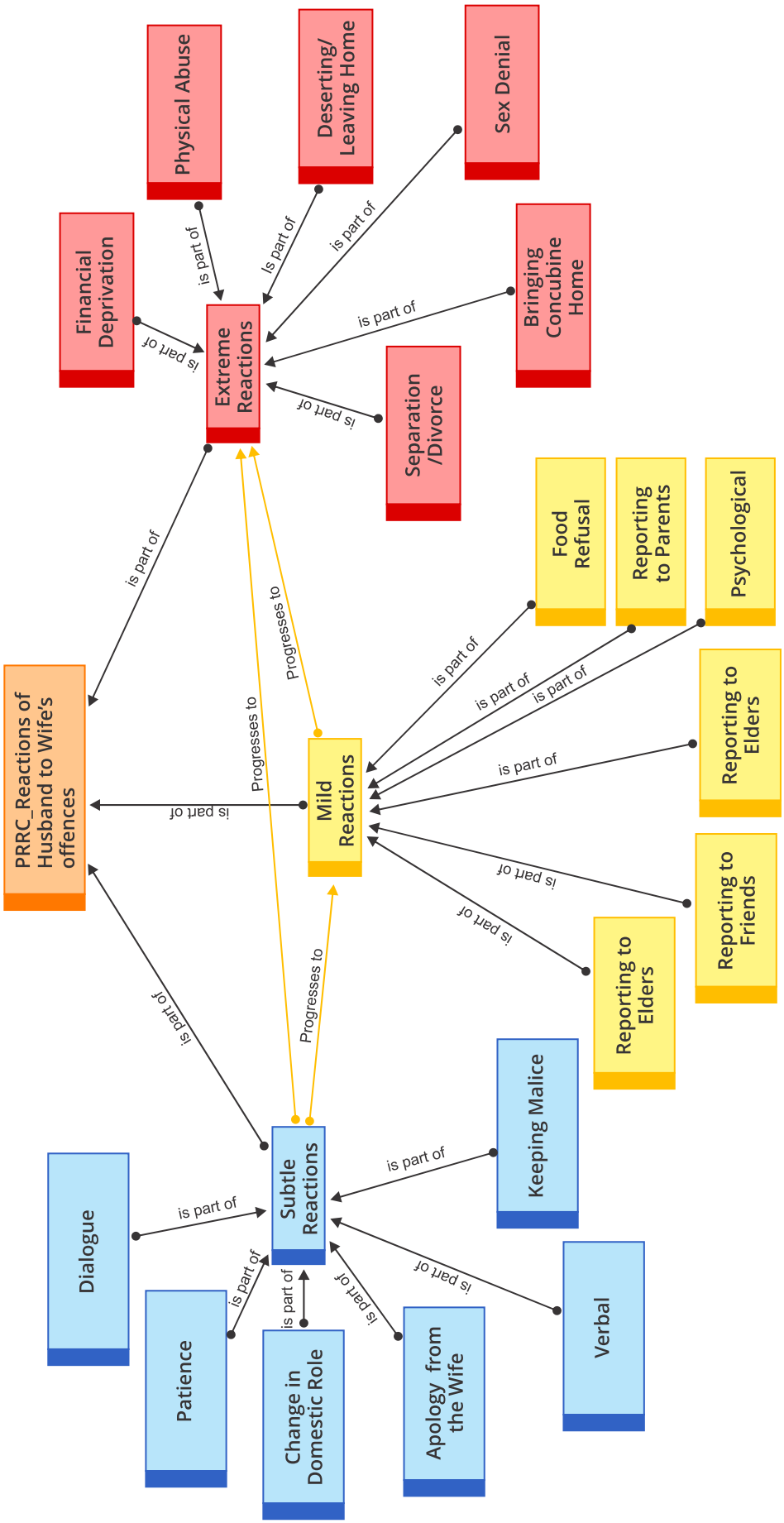
Box 5.10

And there are men, who will use the child as punishment for the wife, like refusing to give the children what they need.

Meanwhile, the mother is feeling very bad about it, so the woman will succumb and beg. So, the way we can chastise our wives in the house varies. But you that uses the child is foolish.

FGD with married men in Ogun State.

Figure 26: Men's Reactions to their Wives violations of Social and Gender Norms



A few of the respondents did not accept an intimate partner's abuse as normal or cultural, but rather they saw it as a violation of the woman's human rights and a threat to her dignity and respect. This group saw IPV as a form of sexual and gender-based violence. They also noted that some women can be nagging and troublesome. But this should not be taken as an opportunity to violate their rights. They noted that one of the major problems is that our system in Nigeria is not working well because most women who are violated do not get justice. This opinion was particularly common amongst the NGOs/CBOs participants across the different geopolitical zones (see Box 5.11 for excerpts from NGOs/CBOs on their rejection of IPV). Data from PWDs revealed that the majority of them opined that they did not report issues of abuse to anybody, either authority or individual. They added that their financial situation and lack of support silenced them and that reporting such a case exposed them to the threat from the violator such as her husband. Some kept such a secret to themselves because they did not want their husbands to divorce them.

Others opined that PWDs who are being abused by their husbands will not open up because they believed the men had done them a favour by marrying them and the society believed that the husbands are managing them. Therefore, they should endure whatever they faced in such relationships. They added that some of them did not open up because of ignorance and lack of education; they were not aware of their rights. So, they did not even know when they were being denied or their rights were violated. Some respondents opined that some families did not want to be identified with people with disability. So, they were not ready to support them in filing lawsuits against the offender.

The PWDs also noted that they did not have what it takes to pursue justice because the legal process is too cumbersome, stressful, and there is no assurance of getting justice at the end of the whole process. The police officers were also part of the reasons why the survivors kept quiet because they usually sweep such cases under the carpet. Some of them will ask them to go and settle it at home.

Women's reactions to IPV were explored. It is evident that women also had various options regarding what they could do when their husbands violated the norms. These also range from subtle to mild to extreme reactions. The wife's subtle reactions include dialogue with the husband and begging him to be patient with her, hold a grudge against him, or do nothing. She can also engage in psychological and emotional abuse, refuse to cook for him, report him to the elders in the family and community, or report him to the police as part of mild reactions. The wife's extreme reactions include denial of sex, disserting/leaving home, taking legal action against him, seeking separation/divorce, and finally, for economically independent women, ceasing to give financial support to the husband (see Box 5.12 for excerpts from Female Opinion Leaders in Akwa Ibom). While it is interesting to note that women's reactions can also be subtle, mild, or extreme, just like their husbands' reactions, it is clear that whatever the type of reaction, women continue to be at the receiving end. Even when attempting to dialogue with her husband, he retains an advantage in the negotiation because the culture empowers the man in many dimensions, which can be used as a threat for women to succumb in dialogues with their husbands. For instance, a participant in an FGD with married men in Ogun State stated, "there is no type of

Box 5.11: NGOs/CBOs Rejection of IPV

Well, some women could be nagging. ...a lady came and reported her husband for absconding...the way she was talking and the way she called the husband on the phone, insulting him on the phone, and maybe he is with another lady, (yana tare da karuwa) and he doesn't want to come back home...even if I was the one, that you spoke like this on the phone, I wouldn't come back home. However, this should not be an excuse to violate a woman.
FGD with NGOs/CBOs in Adamawa State

... if you hit me for not cooking for instance and the system works I will take you to where I am supposed to take you and then justice is done and you are dealt with as appropriate, I'm not sure tomorrow you will raise your hand and touch me... if actions are taken no matter what I do to you, you have no right to lift your hands or even touch me.
FGD with NGOs in Kaduna State.

Box 5.12: Women's Extreme Reactions to Husbands' Abuse

The woman can react with anger, denial of food, denial of sex, refusal of communication.
FGD with Female Opinion Leaders in Akwa Ibom State

punishment they (wives) can give me ooo. I am the one that provides for the house. When she is not the one that is feeding me, there is no punishment she can give me. I will beg her. If I beg her at that time, and I want to have sex with her, she may be a bit stiff, but I will tell her "don't let me go outside, and she will accept, that is the end". Another participant in the FGD with married women in Kwara State also expressed that "If our husbands offend us, we will let him know what he has done, but we will still cook because we won't want our husbands to eat outside". This is because eating outside by a husband could be a symbol of the wife losing him to other women outside, and she would be blamed for allowing that. Other similar excerpts on women's weak position in their reaction to their husbands' violations across different study locations can be seen in Box 5.13. Other subtle reactions include refusing to talk to him, begging him, or doing nothing about it.

Box 5.13: Excerpts on Women's Weak Position in Reactions to Husbands' Violations

There's nothing a woman can do because men are the superiors. Most of us, we only patiently ignore and move on, even if you go to your parent's house, nothing will be done, they'll just tell you to be patient. Also, most of the men here have between 3 and 4 wives, if he invites you to his room, some of the women even go there with pride, they'll say even if I abstain, another woman will go, so she will just patiently swallow whatever he has done even if he humiliated her and still go to him and pet him. **FGD with Community Leaders (Females) in Kaduna**

Whether the woman is wrong or not, kneel to beg the husband. **FGD with Opinion Leaders in Edo State**

As for me I will cook and eat with my children. I will not have his time again yes. **FGD with Married Women in Adamawa**

When he comes and you drive him away, you will not get solution because that thing (sex) builds stronger relationship but when he comes and you said you will not give him, automatically you are spoiling your marriage... **FGD with Married Women in FCT.**

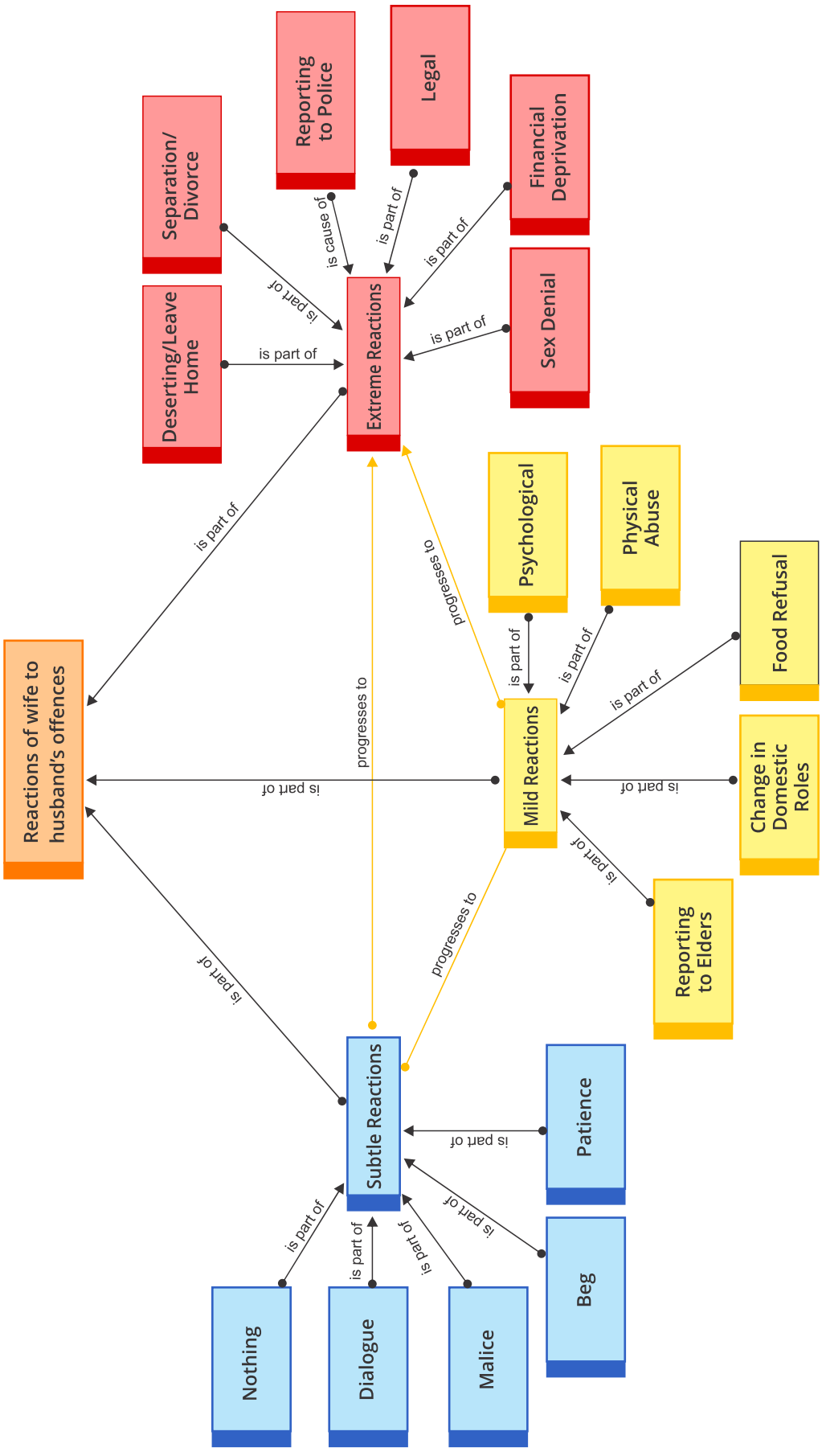
Beyond a woman's subtle reactions, her mild or extreme reactions may also be met by the husband's anger and even societal condemnation, thereby worsening the situation for her. They may not get justice even in court (see the first excerpt in Box 5.14). A participant in an FGD with community leaders in Nasarawa State stated: "Some women do not cook for their husbands as at when due, even when they are the ones that provide the food. As a gentleman, you are not expected to fight over that. You are only expected to call her attention and remind her that you are the one that provided the food and she doesn't have the moral right to refuse to give you the same food you have provided". Exceptions to this situation are some cases in which some NGOs/CBOs or NAPTIP which is a government agency on the Prohibition of Trafficking in Persons were able to intervene by supporting the women (see the second excerpt in Box 5.14). There were also cases of wives beating their husbands reported in the FCT, Nasarawa, Adamawa, and Oyo States. While this is not a common phenomenon, it is often met with wide societal condemnation while the same act may be justified for a man. Figure 27 shows the subtle, mild, and extreme reactions of women to their husbands' violations of social and gender norms. The different arrows show the direction of the reactions, from subtle to mild and extreme.

Box 5.14

Other women will go to the court of law and ask the court to provide a letter indicating they want to be out of the marriage. In all cases, the court usually call the attention of the man to hear his side of the story and advise them to go home and settle out of court. This is always the case if the husband insist that he is in love with his wife. **FGD with Male Community Leaders in Nasarawa State.**

Then NAPTIP has stood very strongly behind me, getting my kids, following up and making sure that this guy starts sending some welfare which I have it documented. I've also gone to Human Rights Radio - Brekete family. My case is with them, but all of this may not have amounted to real justice but the fact that I was given an audience. **IDI with Survivor in FCT**

Figure 27: Women's Reactions to their Husband's violations of Social and Gender Norms



HARMFUL PRACTICES

6.0 Introduction

Harmful practices consist of values, beliefs, and activities that are enshrined in the everyday lives of people within a given social setting. Across Africa, such practices are numerous. Common among them are early, child and forced marriage, female genital mutilation, scarification, virginity testing, widowhood rites, and wife inheritance. In Nigeria, each ethnic group has at least a type of harmful practice with women and girls disproportionately affected with negative consequences on their physical and mental well-being. This chapter presents evidence of harmful practices as covered in the quantitative and qualitative components of this study. The results from the survey were presented first while the qualitative findings provided complementary evidence for a deeper understanding of the contexts and the intersections deducible from the evidence across the communities and States.

6.1 Child Marriage

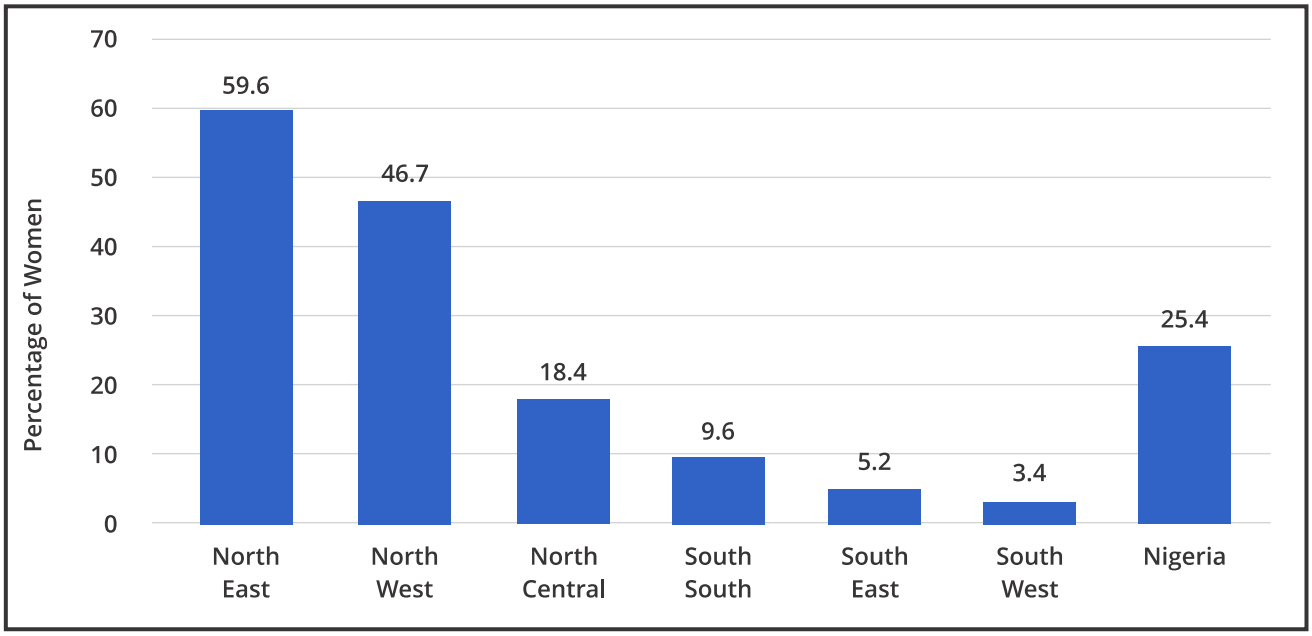
KEY FINDINGS

- Overall, about 25.4% of the women were married before the age of 18 years. Relatives that got married before 18 years of age were 16.7%. Neighbours and friends known to the female respondents that got married before age 18 were 18.3% and 12.9%, respectively.
- Women of Islamic religion (43.3%), and Hausa (55.3%) ethnic group dwelling in rural residences were more likely to experience child marriage compared to women of other groups.
- The most common age at marriage for women in Nigeria is between ages 20-26 years (54.3%), with about one-quarter reporting age 15-17 (23.5%).
- The majority of the women (88.2%) and men (84.6%) reported that the girls' partners were a few years older than the girl.
- The need to prevent pre-marital sex (44.8%) was the common reason for child marriage in States and regions where the practice was high.
- Over half (55.4%) of the women believed that child marriage has negative consequences while about 46.9% of the men believed the same.
- The religious belief that a girl child that attained puberty should be married off to prevent pre- marital sex accounted for most cases of child marriage in Northern Nigeria, with North Central (30.9%, 54.2%), North East (50.5% 59.7%), North West (44.4%, 39.3%).
- Qualitative evidence revealed that the majority of young girls had early sexual exposure thereby resulting in a high rate of unintended teenage pregnancy, with attendant social stigmatisations
- Parents in the North Central (10.9%), South East (29.4%) and South-South (13.5%) opined that giving out their girl child to marry could minimise unplanned pregnancy and the stigma such pregnancy brings upon the family.

6.1.0 Prevalence of Child Marriage

Overall, 25.4% of the women reported being married as a child (before age 18 years), see Appendix 6.1a. Figure 28 illustrates the prevalence of child marriage in Nigeria and the sub-national variations across the geo-political zones. At the sub-national level, the respondents who had child marriage experience were more prominent in Northern Nigeria compared to the Southern regions. The North East (59.6%) and North West (46.7%) had the highest child marriage prevalence across the regions

Figure 28: Prevalence of Child Marriage in Nigeria and by Geo-Political Zones



The FGD participants also shared the view that child marriage was common in their various communities. The girl child was the most affected as the participants provided an estimated age range to be between age 12 and 14 years. Such views emerged more from the participants in the Northern region and a few communities in Imo State, in the South East region. The excerpts in Box 6.1 provide more contextual insights into the views of the FGD participants.

Across the regions, Bauchi (71.8%), Sokoto (63.7%), Adamawa (42.4%) and Kaduna (34.8%) reported more experiences of child marriage (Figure 6.2). This North-South pattern of child marriage experience was similar for the respondents' sisters, mothers, relatives, cousins, friends, and neighbours. The pattern from these results revealed that the practice of child marriage was highly prevalent among communities and ethnic groups in the Northern region of Nigeria.

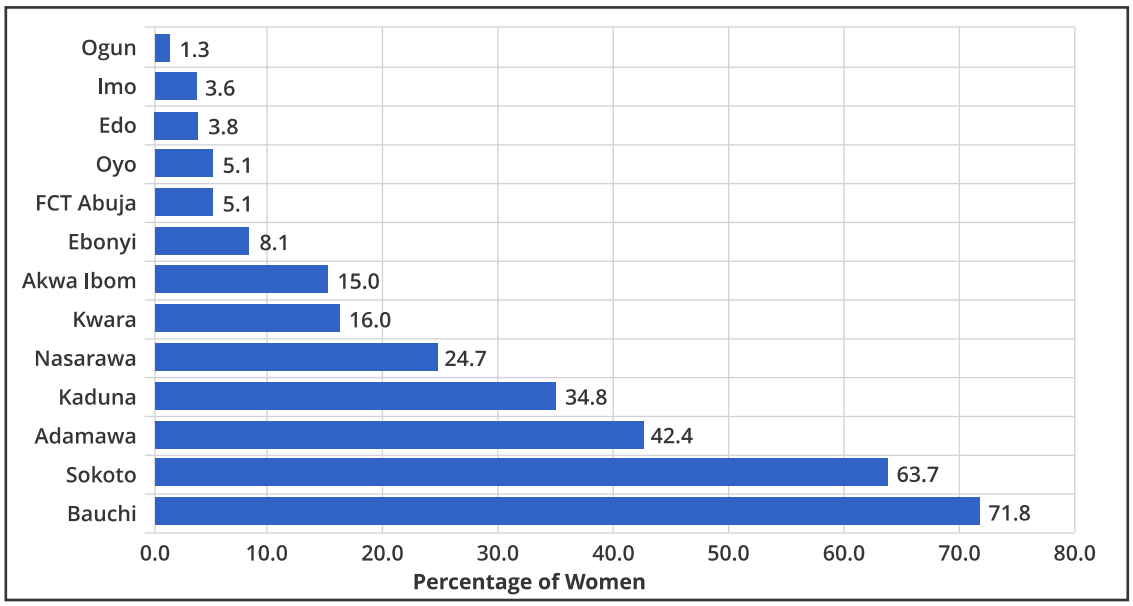
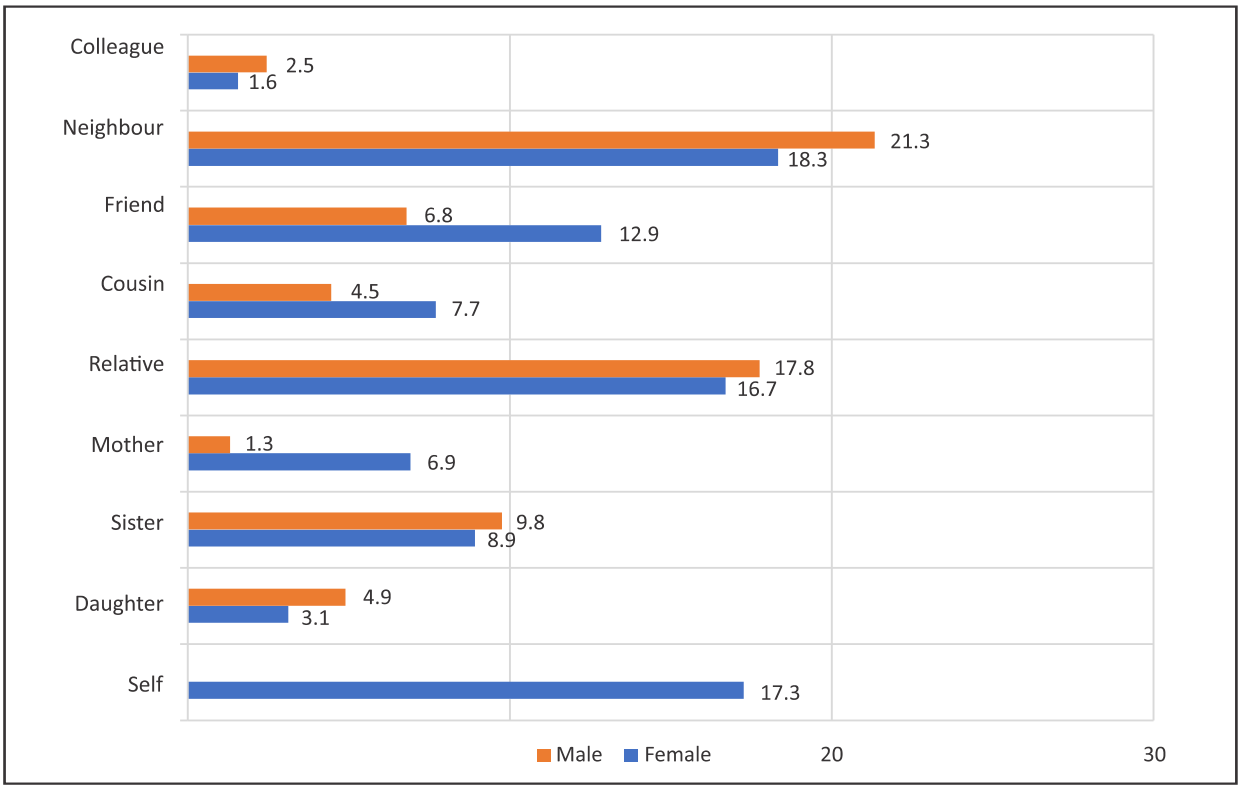


Figure 29: Prevalence of Child Marriage by State.

Figure 30 illustrates the kind of relationship that exists between the female respondents in the study and survivors of child marriage. The women reported that they knew someone with child marriage experience, while a few agreed that they were the victims. About 12.9-18.3% of the women's relatives (16.7%), neighbours (18.3%) and friends (12.9%) had such experience. There were other survivors known to the women. Those in this category included daughters, sisters, mothers, cousins and colleagues, but with fewer reported cases.

Men reported that they were not involved in or experienced child marriage, but rather they knew people (females) who had experienced child marriage. About one-fifth of the men reported that they knew a relative or neighbour that was involved in child marriage, while a few others (less than 10 per cent) also reported that their daughter, friend, mother, cousin, or colleague had the experience.

Figure 30: Child Marriage Experience and Relationship of the Survivors with the Respondents



The qualitative findings also revealed that early childhood marriage exists, but in a slightly varied manner from what was captured through the survey. Participants in some of the FGDs denied the existence of childhood marriage in their communities, while others felt it still existed at different rates. As captured in Table 23, the statements of some of the participants revealed that child marriage was increasing, while others opined that it was decreasing in their communities. Across the regions, a tabular overview of the statements in Table 23 indicates that childhood marriage was more prevalent in the North Central, North East and North West than in the Southern part of the country. Fromthe qualitative evidence, some of the participants from the South East and South-South expressed the view that childhood marriage was uncommon in their communities. Despite the view of these participants, excerpts (see Box 6.1) from the FGD with female adolescents in Imo State revealed that childhood marriage still exists in their communities and poverty was a contributing factor.

BOX 6.1: FGD EXCERPTS

Early marriage is common here, at age 12, most girls are married off. **FGD with community leaders in Kaduna State**

Yes, the practice of early marriage is common in our community. My sister too got marriage at the age of 14 and she was looking very young and small while she got marriage. **FGD with female community leaders in Nasarawa State**

Many young girls are marrying early today due to poverty... **FGD with adolescent females in Imo State**

Early marriage is still on the rise; yes, early marriage is still on the rise. **FGD with NGOs/CBOs in Adamawa State**

Table 23: Code-Document Showing Perceived Prevalence of Childhood Marriage in the Six Geo-Political Zones

Perceived Prevalence of Early Childhood Marriage	North Central	North East	North West	South East	South - South	South West	Totals
No early child marriage	0	0	0	1	1	0	2
Not common	0	5	5	1	2	1	14
Very common	5	3	3	1	0	1	13
Decreasing	4	5	4	5	4	1	23
Increasing	3	4	2	3	0	2	14
Totals	12	17	14	11	7	5	66

In the case of persons living with disability (PWDs), this study revealed that child marriage was very common among girls in many States. Some informants noted that girls with disabilities were often forced into early marriage by their parents or caregivers to relieve the parents of the burden that comes with caring for PWD. Thus, the perception of disability as an extra burden to the family predisposes disabled girls to early marriage. Notably, parents are the major perpetrators of early marriage of girls with disabilities. Similarly, some parents also resorted to marrying off their disabled daughters at early ages due to their inability to make useful contributions to the family.

Table 24 presents women's characteristics concerning the patterns of child marriage experiences in Nigeria. Considering the age distribution of child marriage experience in the country, the practice decreases with the age of the women, their mothers, relatives, friends and neighbours. The age distribution further indicates that the practice was declining over the years, as younger women reported lower prevalence compared to those older ones. Child marriage experience was more rampant at age 10-14 years for the respondents (27.0%), their relatives (22.6%), friends (20.1%) and neighbours (25.8%). In terms of associations, the results, as highlighted in Table 24 showed that child marriage experience was more pronounced among women of Islamic religion and, to a lesser degree, traditional religion. Additional results also showed that 32.1% of the respondents that were Muslims reported more prevalence than their Christian counterparts (10%). In sum, more than one-fifth of the respondents' relatives (28.1%), friends (20.5%) and neighbours (27.2%) had a child marriage experience.

Information on ethnicity also revealed that 4 in 10 respondents were of Hausa extraction (41.7%), or their relatives (38.0%), and 3 in 10 of their friends (28.7%) and neighbours (28.7%) had a child marriage experience. These results contrast sharply with respondents of the Yoruba and Igbo extractions. Respondents from these ethnic affiliations had the experience (less than 10% each). Based on the urban/rural dichotomy, experiences of child marriage were more rampant among respondents in the rural areas, where about one-fifth had personal experiences (24.5%) or their relatives (21.2%) and neighbours (19.8%). Findings from the FGD with opinion leaders in Kaduna State also revealed that early marriage could sometimes be beneficial to the girl-child even when it could cause temporary pains. In advancing the plausible benefits, a participant in the FGD argued that girls should obey and allow their parents' wishes to prevail as the benefits might not be clear in the immediate. Specifically, in Nasarawa State, the oldest person in the community has the authority to marry off a girl (See Box 6.2).

Box 6.2: FGD Excerpt

"It's the parents and oldest people. Like my father, if he gets to the age of 80 and he is the eldest in the community, he has the right to decide what will happen to every member. We call the oldest one, "Odenye". **FGD with opinion leaders in Nasarawa State**

Evidence from the qualitative data also revealed that parents, especially fathers are the perpetrators of early childhood marriage. Fathers are key decision makers and are socially protected and justified to be acting rightly and in good faith. Many participants in the FGDs from the Northern zone expressed that mothers hardly get themselves involved in making decisions concerning their daughters' marriage. The male guardians were also identified as perpetrators especially when the girl is an

orphan. Sometimes, they think they cannot waste their resources on another person's daughter and thus marry her off.

Thus, in justifying child marriage, an opinion leader in Kaduna told all young girls to always obey their parents, citing a case in which a girl (now a woman) who was married out as a child to an old rich man has become wealthy and fulfilled (See Box 6.3). The intersection of factors could sometimes cloud the judgement of individuals, including those who are community or opinion leaders in their assessments of the functionality or otherwise of child marriage. Among PWDs, the major factors responsible for early/child marriage include poverty and lack of education. The burden of care could sometimes push some parents to marry their girl child away. Such parents would sometimes force their girls with a disability out of their home so that they could be free from the burden that comes with disability. The decision, unfortunately, is insensitive to abuse and other negative consequences of childhood marriage. It was noteworthy that the level of education also influenced the age at marriage. Women without formal education, for instance, were more likely to marry early. Women with a history of child marriage were also more likely to drop out of school. The data in Table 24 further substantiated the association between the duo. As shown in the table, women who never completed primary school or had no formal education had a higher prevalence of child marriage (27.3 - 52.9%), compared to their counterparts with primary or higher education. This comparison also applies to the prevalence of child marriage experienced by the respondents' sisters, mothers, relatives, cousins, friends or neighbours. The results, here again, affirm that women with lower or no education are more likely to experience child marriage in Nigeria.

The quantitative data in the table further showed that more than half (54.1%) of the women below the middle wealth quintile were married as a child, while less than 10% of those in the fourth or fifth wealth quintile had a similar experience. A similar pattern was observed in the respondents' descriptions of the women they knew to have experienced child marriage. Such people included a relative, friend or neighbour. As a result of this finding, it can be deduced that child marriage is widespread among people in the middle wealth quintile and below.

Box 6.3: FGD Excerpt

I remember a young girl forced into early marriage. She cried for 7 days that she can't marry an old man. Finally, all her children are now in the U.S. People should understand that if you oblige to your parents' wishes, even when it is not from your own mind, you will succeed. **FGD with opinion leaders in Kaduna State.**

Table 24: Percentage distribution child marriage and relationship of survivors with the respondents: women's report

Background characteristics	Self	Daughter	Sister	Mother	Relatives	Cousin	Friend	Neighbour	Colleague	TOTAL
Religion										
Christianity	3.7	0.7	1.7	1.4	6.3	1.8	5.6	10.2	0.8	3,720
Islam	32.1	5.8	16.9	12.9	28.4	14.1	20.5	27.2	2.4	2,618
Trad Religion	16.0	9.4	1.1	19.8	28.2	6.5	40.6	19.9	5.7	15
Ethnic Group										
Igbo	2.9	0.1	0.6	0.7	3.5	0.6	4.6	5.7	0.8	1,173
Hausa	41.7	6.9	22.1	19.4	38.0	20.7	28.7	28.6	3.0	1,349
Yoruba	1.4	0.3	1.5	0.5	9.0	1.3	5.2	17.8	0.8	1,239
Others	14.5	3.3	7.0	4.1	10.9	4.8	9.1	15.7	1.3	2,592
Residence										
Urban	6.4	1.2	5.0	3.0	10.0	3.3	9.2	16.2	0.8	2,430
Rural	24.5	4.4	11.6	9.5	21.2	10.6	15.3	19.8	2.1	3,923
Education										
None	36.8	7.6	18.8	14.4	33.4	17.5	22.2	28.1	3.4	1,373
Islamic Edu	57.2	8.1	25.4	23.6	38.8	19.1	26.8	21.9	3.5	523
Adult Edu	30.3	7.9	9.2	2.5	14.6	2.2	16.9	31.9	1.1	99
Formal Edu	6.4	1.1	4.0	2.8	9.1	3.5	8.3	14.7	0.8	4,486
Zone										
North Central	6.9	2.3	6.6	1.9	12.5	4.9	9.1	27.0	0.8	1,436

North East	45.3	7.1	18.8	10.6	29.7	17.5	22.9	28.8	3.1	1,009
North West	33.8	6.1	18.8	18.1	31.9	16.5	24.9	24.3	2.8	924
South East	2.9	0.1	0.4	0.8	3.6	0.6	5.2	4.8	0.6	1,052
South-South	4.0	1.3	2.1	2.6	2.8	0.5	3.0	5.0	0.8	964
South West	2.1	0.3	0.9	0.6	8.8	0.9	4.8	13.8	0.7	968
State										
FCT-Abuja	2.7	0.2	3.7	0.9	10.8	4.5	7.6	16.9	0.9	460
Kwara	11.0	2.4	9.4	3.8	15.0	6.5	11.8	34.5	1.4	501
Nasarawa	3.2	2.7	4.1	0.1	10.1	3.3	6.5	20.9	0.0	475
Adamawa	30.1	3.3	17.2	8.9	20.6	15.6	22.2	16.7	0.6	498
Bauchi	55.4	9.5	19.9	11.7	35.8	18.9	23.4	36.9	4.7	511
Kaduna	25.7	4.2	10.5	3.9	17.4	7.2	16.6	19.1	0.3	413
Sokoto	46.1	8.9	31.5	39.9	54.2	30.7	37.6	32.1	6.6	511
Ebonyi	5.7	0.0	0.2	0.3	1.9	0.2	5.8	7.1	0.5	530
Imo	1.2	0.2	0.5	1.2	4.7	0.8	4.8	3.4	0.7	522
Akwa Ibom	5.5	2.5	2.5	3.8	1.6	0.8	2.3	2.1	0.7	461
Edo	2.5	0.0	1.7	1.2	4.1	0.3	3.8	8.1	0.9	503
Ogun	1.2	0.2	1.0	0.9	11.7	2.1	4.4	20.2	0.5	454
Oyo	2.9	0.3	0.8	0.3	6.6	0.0	5.0	8.9	0.8	514
Wealth Quintile										
Lowest	27.9	4.5	14.1	11.7	22.8	12.3	17.0	23.5	2.4	1,757
Second	26.2	4.6	12.3	9.5	23.5	10.7	18.0	21.2	2.1	1,416
Middle	13.1	2.8	6.7	3.9	12.9	4.8	10.6	15.4	0.8	1,127
Fourth	5.6	1.0	4.0	2.5	9.6	4.5	7.4	14.1	0.8	979
Highest	3.9	1.4	3.2	3.3	8.7	2.5	7.0	13.6	1.1	1,074
Total	**17.3**	**3.1**	**8.9**	**6.9**	**16.7**	**7.7**	**12.9**	**18.3**	**1.6**	**6,352**

Multiple Responses, Yes answers only are recorded in the table

Further analysis of data from the male sample also presented a similar prevalence of child marriage practices using the respective background characteristics of this male sample (Appendix 6.1b), though none of the men reported being married as a child. About one-fifth of the men, especially in the age groups 20-24 (26.3%) and 65-69 (23.6%), reported a relative being married as a child. At least one-fifth of the respondents across the age groups, except ages 40-44 (19.2%), and 50-54 years (17.0%) reported having one or more neighbours that had a child marriage experience. The men further reported child marriage experiences among relatives (28.7%), neighbours (29.3%) and sisters (16.9%). Using religion as an explanatory variable, more prevalence was reported among Muslim men compared to their Christian counterparts (1.0-13.6%) and/or men affiliated with traditional religions (1.9-15.4%).

A similar pattern was also observed among Hausa and men of other ethnic minorities compared to Yoruba and Igbo men. Similarly, more cases of child marriages were reported among men dwelling in rural areas compared to their urban counterparts: 16.3%, 9.8% and 7.1% respectively. By further disaggregation, such cases had occurred among neighbours (26.5- 33.6%), relatives (27.1-36.8%), and sisters (15.9-22.1%).

Considering the regional variations, men from Northern Nigeria reported more cases of child marriages among neighbours (21.3-46.7%), relatives (16.2-53.1%) and sisters (10.5-30.8%) compared to the evidence from men in the Southern regions where less than 10% prevalence was reported. However, the higher prevalence was reported for neighbours in the South East (15.9%) and South West (16.7%). Meanwhile, it is most pronounced among the relatives (53.1%), neighbours (46.7%) and sisters (30.8%) of the men from North Eastern Nigeria. These patterns were also consistent with findings in the component states within the Northern and Southern regions.

6.1.1 Common Age of Girls at Marriage

Table 25 presents data to show that generally, the most

common age at marriage for women in Nigeria, as reported by the respondents, is between ages 20-26 years (54.3%). However, about one-quarter of the women reported that girls get married between the ages of 15-17 (23.5%).

Examining the religious variations, the common age at marriage for women across religious groups is ages 20-24 years (24-60%). However, a higher proportion of women of Islamic religion were married between the age of 15 and 17 years (41.1%), compared to their counterparts practising traditional religion (16.1%) and Christianity (7.5%). Also, the commonly reported age at marriage among the ethnic groups, except Hausa, remains ages 20-24 years. More than half (51.1%) of Hausa women who were predominantly Muslims were married between the ages of 15-17 years compared to Yoruba (8%) and Igbo women (2.5%). The cultural disparities could explain why early child marriage was more common in the Northern region than in other regions, as well as among Muslim women. Meanwhile, there are a smaller proportion of women (2-23%) who delay marriage to older ages (25 years or over), plausibly for the pursuit of higher education or quest for good employment opportunities. This reveals a higher rate of prevalence of early marriage among the Hausa than in other ethnic groups.

Age at marriage among urban and rural dwellers varies. Women dwelling in urban areas married at a slightly different age (20-21 years) unlike those in rural areas who married between the ages of 15-17 years (31%). The quest for literacy and occupation and opportunities to earn income as a woman might be responsible for the disparity in age at marriage for women in urban versus those in rural areas. This further stressed that early marriage is more common in rural area than in urban area as another large percentage of the respondents (20.7%) are observed to get married at a later age of 25-26years. The same trend applies to the responses of the male respondents.

Opinions of the respondents about the common age at marriage for women vary by the respondents' educational level. A higher proportion of the respondents with no education and those with Islamic education supported marriage at 15-17 years, 47.5% and 58.0% respectively. Whereas a larger proportion (31.4%) of the respondents with formal education support marriage at older age of 20-21 years, and those with adult education favour marriage at age18-19years (25.9%). This suggests that a woman's educational attainment has a beneficial impact on her perceived age at marriage.

The common age at marriage varies across regions. The table revealed that while the most commonly reported age at marriage in the North East (54.2%) and North West (40.1%) was age 15- 17years, a large proportion of the women in the North Central (29.2%), South East (46.5%) and South-West (29.9%) supported marriage at age 20-21years as the most common age at marriage. A large proportion (34.9%) of the respondents from the South-South favoured age 25-26 years. Exploring the variations across the various states, a substantial proportion of the women in the Northern states, particularly in Bauchi, Adamawa and Sokoto reported girls' marriage at 15-17years (41-66%). Conversely, women from the Southern states, especially Akwa-Ibom, Edo and Oyo states opined that the most common age of women at marriage was 25-26years.

Qualitative evidence on the ideal age for a boy and a girl to marry revealed variations. FGD participants from Adamawa State opined that a girl-child could marry even when her age was below 18 years. The findings from participants in the Southern parts differ as a girl below age 18 was considered a child and too young to marry. The marriageable age for the boy child was higher and attached to the attainment of some social standards such as having an income, and being able to cater for themselves and others. In Imo State, for instance, the marriageable age for a man was pegged between 30 and 32 years, but a lower age for women (28years). See box 6.4 for more excerpts. Thus, it is evident that the opinion of community members on the acceptability of early childhood marriage varies by location (rural and urban), religious affiliation (Islam and Christianity), educational background (formally educated and persons with no western education), financial and economic status (poor and rich), even in the Northern parts of the country where it seems more acceptable than in the Southern parts.

Box 6.4: FGD Excerpts

Ideal age for marriage for the woman is 28yrs and for a man, it is either 30yrs or 32yrs. **FGD with adolescent males in Imo State**

We also see women as young as 15 and 16 coming for antenatal care in communities such as Furfure, Mubi, and other parts of Adamawa where I have been. These are not pregnancies that occur outside wedding; these are married women. **FGD with NGOs/CBOs in Adamawa State**

Yes, like a girl of 14 years old married to a person who is 60-70 years. **FGD with married women in Adamawa State.**

I have seen a situation whereby a man married off his daughter of 12 years old to his friends under the disguise they are practicing Islamic law, that the girl has seen her first menstrual period. **FGD with mixed group in Kwara State.**

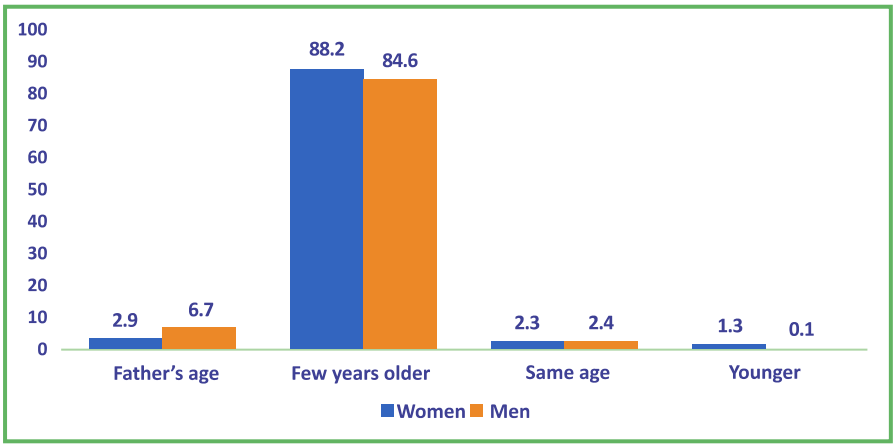
Table 25: Common age Girls are Married Across the Surveyed Communities

Background Characteristic	<15Yrs	15-17	18-19	20-21	22-24	25-26	>26	Total
Religion								
Christianity	1.5	7.5	17.3	33.6	16.4	20.6	3.1	3,364
Islam	7.8	41.1	17.7	17.8	6.6	7.4	1.6	3,094
Traditional Religion	0.0	16.1	6.8	56.7	3.5	16.9	0.0	23
Ethnic Group								
Igbo	0.1	2.5	24.3	43.6	14.5	13.0	2.0	846
Hausa	8.2	51.1	21.9	14.5	2.6	1.1	0.6	1,728
Yoruba	1.2	8.1	10.9	31.5	20.0	24.2	4.1	1,479
Others	5.3	20.6	16.0	25.4	12.0	18.0	2.7	2,428
Residence								
Urban	2.4	12.2	16.9	27.8	15.8	20.7	4.2	2,591
Rural	5.9	31.1	17.9	25.2	8.9	9.9	1.1	3,890
Education								
None	9.7	47.6	14.0	16.5	6.2	5.1	0.9	1,373
Islamic	10.4	58.0	19.6	9.7	1.5	0.8	0.0	523
Adult Education	13.3	19.4	25.9	15.8	8.3	17.3	0.0	99
Formal Education	2.0	12.2	18.1	31.4	14.6	18.6	3.1	4,486
Zone								
North Central	5.6	21.2	15.4	29.2	13.1	12.6	2.9	1,018
North East	9.1	54.2	19.5	16.0	0.8	0.3	0.1	918
North West	7.9	40.1	21.3	18.5	4.0	6.6	1.6	1,624
South East	0.1	2.1	25.1	46.5	14.5	10.6	1.1	730
South-South	0.8	1.6	10.1	25.7	23.3	34.9	3.6	932
South West	1.0	10.4	13.9	29.9	18.1	22.3	4.4	1,259
State								
FCT-Abuja	2.4	9.7	16.1	32.7	14.5	15.1	9.5	10
Kwara	4.1	18.0	9.8	28.0	18.7	19.6	1.8	485
Nasarawa	8.2	27.6	21.5	29.5	6.5	4.1	2.6	430
Adamawa	3.6	41.0	24.8	28.5	1.0	0.9	0.2	367
Bauchi	12.7	63.0	15.8	7.8	0.7	0.0	0.0	551
Kaduna	5.0	23.6	25.5	26.2	6.6	10.7	2.4	982
Sokoto	12.3	65.5	14.7	6.7	0.0	0.3	0.5	642
Ebonyi	0.2	3.9	33.3	48.7	6.1	6.5	1.3	278
Imo	0.0	0.9	20.0	45.0	19.7	13.4	1.0	452
Akwa Ibom	1.4	1.9	17.0	25.3	17.7	34.5	2.2	486
Edo	0.1	1.2	2.7	26.1	29.4	35.4	5.1	446
Ogun	1.8	9.8	21.3	41.3	8.9	16.2	0.7	548
Oyo	0.4	10.8	8.2	21.1	25.1	27.1	7.3	710
Total	**4.5**	**23.4**	**17. 5**	**26.2**	**11.7**	**14.3**	**2.4**	**6,481**

6.1.2. Age Difference between Girls and their Spouses

Figure 31 presents data on the age of men/boys to whom girls are married. The majority of the respondents reported that the boys/men are usually a few years older than the girl(s) they marry, with a higher proportion of women making the claim (88.2%) compared to men (84.6%). These patterns of reporting were consistent regardless of the respondents' religion, ethnic affiliation, place of residence, education, region, and state.

Figure 31: Age difference between girls and their spouses



6.1.3 Reasons for Marrying Girls off at Tender Age

Investigating the reasons for marrying off girls at a tender age, the most common reason reported by the women was to prevent premarital sex (44.8%) (Table 26). While about one- third believed that it was necessary once the girl attains puberty age (29.9%), this pattern was consistent across all background characteristics. However, a higher proportion of Muslim women (42.8% and 30.2%) compared to their Christian counterparts (18.2% and 7.9%) and traditional religion (9.7% and 12.5%) supported that the girls are married off once they attain puberty and for religious obligations respectively. Conversely, a higher proportion of Christian women also supported the reason for financial gain for parents (21.5%) and for bearing children early (15.6%) compared to their Muslim counterparts (5.0% and 7.3% respectively). Religious obligation and attainment of puberty as factors for early girl child marriage also received positive support among a higher proportion of Hausa women (38.4% and 49.0%) compared to Igbo and Yoruba women (less than 20% in all cases). Whereas, a higher proportion of Igbo women supported reasons such as financial gains for parents (28.9%) and early start of childbearing (26.2%), unlike the Hausa women (3.1% and 7.6% respectively).

The disparities also exist across the regions. More than half of the women from all the regions - North Central (54.2%) and North East (59.7%), South West (56.2%) with a lower proportion in the South East (41.0%) and North West (39.3%) supported the prevention of pre-marital sex as justification for early marriage. Early marriage for the reason that a girl has attained puberty was popular only in Northern Nigeria - North East (50.5%), North West (44.4%) and North Central (30.9%). Supporting child marriage for religious obligation was more prevalent only in some Northern regions, especially North West (32.5%) and North East (29.3%), unlike other regions - North Central (18.0%), South-South (16.6%), and South East and South West (less than 5% for each). However, marrying off girls for financial gains for parents was more prominent in the South Eastern (28.4%) and South Southern (37.1%) regions.

Respondents from more than half of the States, including the Federal Capital City, Abuja, stated that marrying off girls early to avoid pre-marital sex is a major factor sustaining childhood marriage. In Oyo State, more than half of the women supported this reason: 61.5 per cent of women in Adamawa, Bauchi (58.5%), Kwara (56.3%), FCT-Abuja (55.3%), Imo (52.9%) and Nasarawa State (51.4%). Another factor that also cuts across the States was the attainment of puberty age. The factor was mentioned by more than half of the women in Bauchi (55.6%) and Sokoto (61.5%) as well as more than 30% in other Northern states except FCT-Abuja (20.1%) and less than 20 per cent in the Southern states except Oyo (23.2%) and Ebonyi State (21.6%). Religious obligations emerged as a major reason in Sokoto (63.5%), with less than 30% in the other Northern states except Bauchi (33.3%), and less than 10% in the Southern states except Akwa Ibom (29.2%).

The responses from the male respondents appeared similar to that of the women, but with some variations (Appendix 6.2). Generally, marrying off girls is for the reason of religious obligation, because girls have attained

puberty, and to avoid pre-marital sex. However, a higher proportion of Muslim men (48.4%, 45.1% and 45.4%) and traditional religion (49.2%, 44.3%

And 21.1%) compared to their Christian counterparts (35.8%, 17.4% and 9.2%) reported that young girls were often married off to prevent pre-marital sex because they had attained puberty, and for religious obligations, respectively. The patterns for these three reasons were similar, with higher proportions among Hausa and to a lesser degree among Yoruba and other ethnic minorities, compared to Igbo men. Similar reasons were mentioned more by respondents from the Northern region compared to those from the Southern regions. However, some of the respondents from Ebonyi (46.8%), Imo (40.4%), Edo State (40.7%), and Akwa Ibom (30.4%) felt that the parents' desire for financial gains could be a reason. Less than 20% of respondents and 23% from Nasarawa State also felt that financial gains could be a determinant.

Table 26: Reasons for Marrying Girls off at Tender Age: Women's Report

Background Characteristics	Religious Obligations	Already at puberty	Prevent pre-marital sex	Financial gains for parents	Parents free from Educating Girls	Bearing Children early	Prevent being an Outcast	Total
Religion								
Christianity	7.9	18.2	40.9	21.5	11.6	15.6	2.9	3,720
Islam	30.2	42.8	49.0	5.0	7.6	7.3	3.04	2,618
Traditional Religion	12.5	9.7	45.1	12.6	7.3	5.1	0.0	15
Ethnic Group								
Igbo	1.5	18.2	41.1	28.9	12.7	26.2	1.7	1,173
Hausa	38.4	49.0	42.8	3.1	7.2	7.6	4.2	1,349
Yoruba	7.7	16.8	57.3	10.8	11.0	8.9	2.4	1,239
Others	17.0	28.5	39.9	17.4	9.5	11.0	2.9	2,592
Residence								
Urban	12.8	23.6	46.2	17.3	9.7	10.6	2.8	2,430
Rural	22.4	34.2	43.9	11.1	9.6	12.2	3.1	3,923
Education								
None	30.8	45.9	50.3	7.0	5.8	10.8	2.8	1,373
Islamic	46.3	49.8	32.3	3.8	6.4	5.7	3.3	523
Adult	22.5	34.3	41.7	1.0	14.8	14.4	6.9	99
Formal	11.5	22.7	44.6	17.0	11.1	12.4	2.9	4,486
Zone								
North Central	18.0	30.9	54.2	9.8	7.8	10.9	2.3	1,436
North East	29.3	50.5	59.7	1.5	4.6	7.9	4.9	1,009
North West	32.5	44.4	39.3	5.2	8.4	7.0	4.8	924
South East	1.1	19.7	41.0	28.4	13.1	29.4	1.9	1,052
South-South	16.6	11.5	17.1	37.1	14.5	13.5	0.5	964
South West	4.8	15.3	56.2	10.4	11.0	9.0	2.3	968
State								
FCT-Abuja	24.3	20.1	55.3	18.9	7.9	19.0	1.1	460
Kwara	17.0	30.1	56.3	8.8	8.0	11.7	2.4	501
Nasarawa	17.6	34.4	51.4	8.7	27.5	8.0	2.5	475
Adamawa	23.2	42.8	61.5	3.5	7.5	15.8	5.1	498

Bauchi	33.3	55.6	58.5	0.2	2.6	2.6	4.8	511
Kaduna	12.2	33.2	43.2	6.2	10.5	6.3	7.0	413
Sokoto	63.5	61.5	33.3	3.7	5.0	8.2	1.4	511
Ebonyi	1.2	21.6	21.7	34.9	15.2	25.5	0.5	530
Imo	1.0	18.5	52.9	24.4	11.9	31.8	2.7	522
Akwa Ibom	29.2	11.4	21.5	27.4	21.9	21.9	0.3	461
Edo	3.0	11.6	12.2	47.7	6.4	4.5	0.8	503
Ogun	9.3	4.9	44.4	12.3	10.1	5.1	4.1	454
Oyo	1.3	23.2	65.4	8.9	11.8	11.9	0.9	514
Wealth Quintile								
Lowest	25.1	39.3	41.6	8.6	7.6	11.1	2.4	1,757
Second	21.0	33.3	44.6	11.0	9.2	11.4	4.0	1,416
Middle	18.0	28.8	45.9	15.4	9.9	12.9	3.0	1,127
Fourth	12.1	20.6	48.3	17.3	11.0	11.4	3.5	979
Highest	11.3	20.5	45.9	19.7	12.2	11.3	2.1	1,074
Total	**18.6**	**29.9**	**44.8**	**13.6**	**9.7**	**11.6**	**3.0**	**6,352**

**Multiple Responses, Yes answers only are recorded in the table*

6.1.4 Commonness of the Practice of Early Marriage

The result in Table 27 indicates respondents' opinions on how common the practice of early marriage is in Nigeria. About 26.3% of the women claimed that the practice was very common while about 35.7% agreed that it was not very common. This response was similar to that of the men. The proportion supporting that the practice was very common was higher among Muslim women (40.8%) and men (45.9%) compared to their counterparts in other religious groups: 13.3% and 12.6% among Christians respectively and 13.7% versus 22.4% among those in traditional religion. These patterns are similar for Hausa women (48.3%) and men (51.0%) compared to other ethnic groups (5.1-15.6%), except for other ethnic minorities (23.3% for women and 32.6% for men), and in the rural areas (33.3-34.2%), compared to urban areas (16.5- 19.7%). The practice was also adjudged to be more common by the respondents with no formal education (none, Islamic and adult education) (43.6-56.2% for both genders), compared to those with formal education (16.6% for women and 20.8% for men).

It was more common among women and men in the North East (53.4% versus 62.6%), North West (38.9% versus 44.9%) and North Central (27.4% versus 34.1%) compared to their counterparts in the Southern regions (less than 15% for both men and women). These regional variations are further reflected in the component states. The child marriage practice was reportedly very common in Adamawa (52.7% versus 40.1%), Bauchi (53.9% versus 77.7%), Sokoto (54.3% versus 38.0%), Kwara (33.8% versus 32.3%), Kaduna (28.3% versus 49.6%) and Nasarawa (24.9% versus 43.9%), compared to other Northern and Southern States (less than 20%), except for women in Ebonyi (23.7%) and Ogun state (23.5%).

Table 27: How common is the practice of early marriage

	Women					Men				
Background Characteristic	**Very common**	**Not very common**	**Very rare**	**Don't Know**	**Total**	**Very common**	**Not very common**	**Very rare**	**Don't Know**	**Total**
RELIGION										
Christianity	13.3	38.5	35.5	12.7	3720	12.6	32.7	43.4	11.3	1,630
Islam	40.8	32.5	20.2	6.5	2618	45.9	25.6	22.4	6.1	1,506
Traditional	13.7	52.1	11.9	22.3	15	22.4	29.1	22.1	26.4	47
Others	0.0	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0	3

ETHNIC GROUP										
Igbo	9.9	47.4	34.2	8.5	1173	5.1	34.6	54.3	6.0	423
Hausa	48.3	27.8	20.5	3.4	1349	51.0	23.5	24.0	1.5	753
Yoruba	15.6	46.4	20.4	17.6	1239	12.5	39.0	28.1	20.4	732
Others	23.3	30.7	35.7	10.3	2592	32.6	25.2	34.5	7.7	1,278
RESIDENCE										
Urban	16.5	35.4	35.9	13.2	2,430	19.7	35.1	32.2	13.0	1,245
Rural	33.3	36.1	23.1	7.5	3,923	34.2	25.5	33.8	6.5	1,941
EDUCATION										
None	47.9	28.7	16.2	7.2	1373	49.9	27.2	16.1	6.8	561
Islamic	52.0	31.7	14.6	1.7	523	55.5	20.3	22.5	1.7	214
Adult	46.3	30.0	13.0	10.7	99	47.2	13.6	35.6	3.6	40
Formal	16.6	38.6	33.3	11.5	4486	20.8	30.9	38.1	10.2	2,371
ZONE										
North Central	27.4	36.7	21.9	14.0	1,436	34.1	25.7	35.6	4.6	490
North East	53.4	33.6	11.0	2.0	1,009	62.6	15.8	16.0	5.6	451
North West	38.9	28.7	28.8	3.6	924	44.9	25.2	23.6	6.3	776
SouthEast	10.3	50.9	32.8	6.0	1,052	3.0	32.6	60.2	4.2	353
SouthSouth	8.0	23.5	58.1	10.4	964	7.8	30.4	57.0	4.8	471
South West	13.4	45.7	19.2	21.7	968	10.9	43.1	22.7	23.3	645
STATE										
FCT-Abuja	6.5	32.4	48.0	13.1	460	1.6	41.0	54.3	3.1	52
Kwara	33.8	41.9	18.1	6.2	501	32.3	28.0	34.0	5.7	237
Nasarawa	24.9	31.7	20.0	23.4	475	43.9	19.4	33.2	3.5	201
Adamawa	52.7	33.7	11.9	1.7	498	40.1	26.1	22.9	10.9	183
Bauchi	53.9	33.5	10.4	2.2	511	77.7	8.8	11.3	2.2	269
Kaduna	28.3	26.4	40.0	5.3	413	49.6	16.0	24.3	10.1	462
Sokoto	54.3	32.2	12.4	1.1	511	38.0	38.9	22.5	0.6	314
Ebonyi	23.7	47.6	24.8	3.9	530	6.8	19.5	68.9	4.8	120
Imo	2.1	52.9	37.7	7.3	522	1.1	39.2	55.8	3.9	233
Akwa Ibom	14.5	32.3	46.0	7.2	461	2.8	23.6	72.1	1.5	256
Edo	1.2	14.4	70.8	13.6	503	13.6	38.5	39.1	8.8	214
Ogun	23.5	34.5	17.1	24.9	454	14.2	27.5	25.2	33.1	269
Oyo	5.7	54.3	20.8	19.2	514	8.5	54.2	20.9	16.4	376

6.1.5: Decision maker on Marrying the Girl off Early (at <18yrs old)

Table 28 shows the decision maker on getting a girl married early before the age of 18 years. The majority of the women (66.3%) opined that the decision was taken by the girl's father while 42.2% claimed that the decision was often made by the girls themselves. Just about 28.7% believed that the decision was made by the mother. Less than one-fifth (16.9%) of the women claimed that the decision was made by the intending husband. Also, less than 10% of the women believed that the girl's grandparents, other family members, religious leader(s) and community/traditional leaders or any other person were involved in the decision-making to get girls married before their 18th birthday. Despite these variations, this pattern of decision- making on girls' early marriage was consistent regardless of religion, ethnicity, rural-urban residence and level of education. A higher proportion of Christian women (48.1%) opined that the girls themselves were involved in the decision, unlike Muslims (35.9%) and traditional women (19.9%). Also, as reported, Hausa girls (33.6%) were the least involved in their marriage decision compared to girls of other ethnic groups (43.5-52.8%).

In comparison, states in the South East (48.9%), South-South (43.5%) and South West (51.2%). reported that girl's fathers were the key decision makers on when a girl-child could go into marriage, which were slightly fewer than the proportion that shared such view in the Northern Zones (63.2-89.4%). Consequently, while about 41.9-58.2% of the women in the Southern region believed that the girls were involved in the decision making about their marriage, a very small proportion (29.2- 31.6%), especially in the Northern regions, believed the same, except in the North Central (47.2%). Considering the disparities across states, the majority of the women (at least more than 50%) identified the father as the major decision maker except in Imo (47.4%), Akwa Ibom (28.8%) and Oyo State (48.1%), while only the Southern states – Ebonyi (52.1%), Imo (61.1%), Akwa Ibom (67.9%) – and a Northern state – Nasarawa (51.3%) – and FCT-Abuja (50.0%) gave the girls chance to decide their marriage. Men's reports in Appendix 6.3 were similar to women's, irrespective of their background characteristics.

The qualitative data also revealed that parents are the main decision-makers in early/child marriage (see Box 6.5), except in situations when a girl had an unwanted pregnancy and decided to elope with the man. In the case of PWDs, the study participants reiterated that parents were the major perpetrators of early marriage of women with disabilities. The decision to marry them off at younger ages was shaped by their perception of the condition. Parents also resort to marrying off their daughters with disabilities at early stages due to their perceived inability of the girl to make useful contributions to the family.

Box 6.5: KII Excerpt

...Male parents always show their wives that they don't have any power over the children, ...that was how I married off my daughter at 15 years of age, but she was married off without my acceptance, because I'm a mother. I don't have much stake in that, I told the father that I don't want my daughter married off at that age, he insisted and married her off. After a while, I informed him that the girl is pregnant, and he became upset and worried (she laughs). I asked him when you married her off, you thought the husband was going to be staring at her or what? You should have told him you are marrying her off to him for him to look after her like a security man. Why are you upset now? He said she's too small to give birth, and I asked, but she's not too young to get married right? **KII with survivor's mother in Kaduna State.**

Table 28: Decision makers on marrying the girl off early (<18yrs old): Women's Report

Background Characteristic	Herself	Intending Husband	Girl's Father	Girl's Mother	Girl's Grand Parent	Other family Members	Religious Leader (s)	Community/ Traditional leaders	Others	Total
Religion										
Christianity	48.1	14.6	53.9	21.7	2.1	4.5	0.2	0.7	9.8	3,720
Islam	35.9	19.4	79.7	36.4	11.2	12.4	0.4	0.3	4.4	2,618
Traditional	19.9	14.3	76.9	23.1	9.7	9.7	0.0	0.0	5.1	15
Ethnic Group										
Igbo	52.8	32.7	52.0	22.6	2.0	3.9	0.1	0.8	10.6	1,173
Hausa	33.6	24.5	89.5	39.9	14.3	15.7	0.4	0.2	1.8	1,349
Yoruba	44.0	8.5	52.8	21.4	2.5	2.9	0.4	0.4	11.2	1,239
Others	43.5	11.1	63.1	27.4	4.9	7.8	0.3	0.7	7.4	2,592
Residence										
Urban	38.8	10.3	65.7	29.2	4.8	8.9	0.2	0.5	9.3	2,430
Rural	44.5	21.3	66.7	28.5	7.6	7.9	0.4	0.5	5.8	3,923
Education										
None	39.2	25.1	76.6	32.2	13.5	11.8	0.4	0.7	5.3	1,373

Islamic	36.2	29.3	90.2	40.7	17.1	14.2	0.1	0.0	1.0	523
Adult	47.7	8.3	52.8	19.7	3.1	5.0	0.0	0.0	1.9	99
Formal	43.7	13.1	60.7	26.5	3.2	6.6	0.3	0.6	8.6	4,486
Zone										
North Central	47.2	10.0	63.2	28.1	2.2	3.3	0.8	1.1	9.2	1,436
North East	31.6	26.3	89.4	39.0	14.5	12.6	0.6	0.3	2.5	1,009
North West	29.2	18.7	87.9	41.0	13.4	19.2	0.1	0.4	3.0	924
South East	57.7	37.1	48.9	23.2	2.3	4.0	0.1	0.9	10.5	1,052
South-South	58.2	5.2	43.5	14.0	0.6	1.8	0.2	0.5	5.7	964
South West	41.9	10.3	51.2	20.2	1.9	2.4	0.1	0.2	13.6	968
State										
FCT-Abuja	50.0	16.4	71.3	31.5	0.2	4.0	0.4	0.2	5.5	460
Kwara	43.1	7.5	63.3	23.2	4.2	3.9	0.8	0.8	3.9	501
Nasarawa	51.3	11.1	61.2	33.0	0.5	2.3	0.9	1.6	16.0	475
Adamawa	27.2	17.1	93.2	24.1	2.9	3.4	0.6	0.4	0.6	498
Bauchi	34.6	32.5	86.9	48.8	22.2	18.7	0.7	0.2	3.7	511
Kaduna	19.9	4.1	85.7	30.7	6.1	19.4	0.2	0.6	4.6	413
Sokoto	43.4	41.0	91.2	56.7	24.6	19.0	0.0	0.0	0.5	511
Ebonyi	52.1	48.8	51.2	19.0	0.8	0.9	0.2	0.0	9.6	530
Imo	61.1	29.9	47.4	25.8	3.2	5.9	0.0	1.4	11.0	522
Akwa Ibom	67.9	6.9	28.8	14.7	0.7	0.6	0.2	0.2	3.5	461
Edo	47.7	3.3	59.5	13.3	0.4	3.1	0.2	0.6	8.1	503
Ogun	39.0	14.4	55.1	21.4	3.9	4.0	0.0	0.6	9.2	454
Oyo	44.1	7.1	48.1	19.2	0.3	1.3	0.2	0.0	16.9	514
Total	**42.2**	**16.9**	**66.3**	**28.7**	**6.5**	**8.3**	**0.3**	**0.5**	**7.2**	**6,352**

**Multiple Responses, Yes answers only are recorded in the table*

6.1.6 Conditions Considered as Justifiable for Early Marriage

Table 29 illustrates women's perception of the conditions considered to justify early marriage in Nigeria. While more than one-third (39.6%) of the women believe that there was no condition justifying early marriage, over one-third (37.4%) supported that early marriage was necessary for girls since they are now sexually active or to avoid promiscuity. Only a small proportion linked early marriage to parents' poverty (15.6%), girls' disobedience (13.8%), girls' poor school performance (9.5%), and many girl-children in the family (7.6%), or the girl is an orphan (5.2%). These patterns are consistent across the various background characteristics, though with some disparities. For instance, while avoiding promiscuity was a major justification among Northern women (39.5-59.5%), it was to a lesser degree in the South East (35.4%), South West (33.1%) and South-South (14.8%). This regional pattern is further reflected in the Northern states (31.9-60.0%), compared to the Southern States (7.2-19.5%), except in Imo (45.1%) and Oyo State (53.0%).

Men's report in Appendix 6.4 was similar to women's except for the disparities in some background characteristics. These disparities affected a larger proportion of men from Islamic (48.6%) and traditional religions (49.7%), compared to their Christian counterparts (24.2%). Also, a higher proportion of men of traditional religions linked the early marriage experience to the girls' disobedience (41.0%) and parents' poverty (41.6%), unlike men of other religions (10.0-21.6%). Similarly, more than half of Hausa men (56.5%) linked the practice to avoidance of promiscuity relative to men of other ethnic groups (27.1-30.5%). A higher proportion of the women in the Northern regions (32.5-53.8%) also identified avoidance of promiscuity as justification for early marriage, unlike their Southern counterparts (14.8-30.9%). The men's report in the component states further reflects this pattern.

Table 29: Conditions for Justifying Early Marriage: Women's Report

Background Characteristics	Poor performance in school	Sexually active /promiscuous	Disobe dience	Parents are poor	Family has many girls	Orphan	No condition	Total
Religion								
Christianity	10.8	30.5	10.3	19.5	7.6	6.6	42.5	3,720
Islam	8.0	45.0	17.7	11.2	7.6	3.7	36.4	2,618
Traditional	3.4	18.3	3.5	22.3	8.8	17.7	55.0	15
Ethnic Group								
Igbo	16.1	32.6	8.6	42.7	16.1	14.1	28.1	1,173
Hausa	8.4	43.1	18.0	7.6	7.3	3.4	40.5	1,349
Yoruba	5.4	36.6	8.2	16.0	5.4	4.8	45.1	1,239
Others	10.4	35.5	16.0	11.5	6.2	3.7	39.7	2,592

Residence								
Urban	9.7	36.1	13.3	14.6	6.0	4.6	43.2	2,430
Rural	9.3	38.3	14.1	16.2	8.7	5.7	37.3	3,923
Education								
None	6.8	45.5	16.0	13.9	9.1	4.9	31.7	1,373
Islamic	8.0	31.7	9.9	6.6	7.6	4.6	52.2	523
Adult	10.4	60.8	21.3	14.0	0.8	6.4	21.6	99
Formal	10.4	35.1	13.4	17.1	7.3	5.4	41.0	4,486
Zone								
North Central	12.8	39.5	21.1	15.6	6.1	4.7	33.4	1,436
North East	8.5	59.5	18.7	8.3	8.0	4.8	26.1	1,009
North West	8.1	40.9	21.9	7.7	7.2	2.7	40.3	924
South East	17.2	35.4	9.5	48.0	17.8	16.1	23.9	1,052
South-South	12.0	14.8	3.0	10.4	4.1	3.4	58.1	964
South West	2.8	33.1	4.3	16.0	5.7	4.3	49.1	968
State								
FCT-Abuja	7.9	49.0	14.3	27.5	11.3	9.3	32.3	460
Kwara	9.7	44.2	19.4	16.2	6.8	5.8	33.1	501
Nasarawa	17.4	31.9	24.7	11.9	4.1	2.4	34.1	475
Adamawa	7.1	60.0	8.1	11.2	11.4	1.4	27.4	498
Bauchi	9.4	59.2	25.8	6.3	5.7	7.0	25.1	511
Kaduna	8.7	44.5	29.4	8.1	7.0	3.8	35.4	413
Sokoto	7.3	35.3	10.6	7.1	7.6	1.1	47.9	511
Ebonyi	11.3	19.5	4.1	54.9	16.6	21.0	28.5	530
Imo	20.9	45.1	12.7	43.8	18.6	13.1	21.1	522
Akwa Ibom	8.1	15.1	1.9	6.4	2.5	4.0	59.6	461
Edo	16.3	14.5	4.2	14.7	5.7	2.8	56.5	503
Ogun	1.6	7.2	1.4	10.3	6.6	6.9	75.7	454
Oyo	3.8	53.0	6.6	20.3	5.0	2.3	28.6	514
Total	9.5	37.4	13.8	15.6	7.6	5.2	39.6	6,352

**Multiple Responses*

The benefits of early childhood marriage as perceived by some participants, especially in Bauchi and Nasarawa was that girls who married early would have a man to cater for their basic needs especially when such girls were from poor households: "Her quickest opportunity out of poverty is to marry someone who can take care of her, they applauded". Participants in Kaduna noted that marriage becomes a blessing to the family of such girls if their husbands were buoyant enough to support their family economically. It was also partly considered as a pride to her parents since they would become grandparents early in their lives.

Daily conversations on the functionality of early marriage for the girl also emerged among participants in Nasarawa State. The participants in the group discussion argued that girls in their communities would be protected from becoming "leftovers"; i.e., ladies who were unable to get suitors and are considered to have passed the age considered for "good marriage" in the community. In Bauchi State, girls that are over 24 years before they get married are described as "leftovers". The impression was that older girls become sexually active outside marital relationships, and are therefore exposed to different men, lost their virginity, exposed to sexually transmitted diseases, and might have challenges if they become pregnant. Thus, family members guard against their daughters becoming leftovers and would rather prefer to push them into early marriage. As a kind of enforcement in Adamawa State, community action is taken against any man that defiled a young girl, which is for the man to marry the girl (see Box 6.7). 6.1.7 Additional Explanations

and Context Supporting Early Childhood Marriage.

The likelihood that a girl-child would suffer rape or sexual abuse appeared as one of the emerging indirect determinants for early girl-child marriage. In Bauchi and Kaduna States, when a girl grows faster than her age, she is assumed to be ready for marriage irrespective of her age. Thus, parents would mount pressure on such girls to get married or marry them off and prevent them from being raped because they are grown up. The participants mentioned that the lack or absence of justice and fear of stigma often discouraged parents of survivors from prosecuting offenders. The shame that one's girl-child had been defiled and the chances that family members would be stigmatised appeared embedded in the perception of the FGDs participants. As captured in the excerpt in Box 6.7, some parents that have had rape cases in their families force their daughters into marriage instead of seeking justice.

The fear of being raped and the stigma that follows was advanced further in one of the FGDs with NGOs/CBOs. Participants in one of the groups cited their shocking discovery of how parents are marrying off their girl-children to avoid being raped and becoming "leftovers".

The insurgency in the northern parts of Nigeria was cited as a contributor to rape cases. Thus, some parents are further pressed in addition to religious beliefs and poverty to horridly force their daughters into marriage. Girls living with disability are also vulnerable to childhood marriage due to poverty and inadequate access to material resources. Poverty remains a critical point for girls with disability. Families sometimes abandon them, refuse to send them to school (as they cannot bear the extra burden of transportation and other special needs, and are often survivors of rape and sexual abuses (see Box 6.8).

Religious beliefs and low socio-economic background of parents and low level of education were implicated as contributory factors to child marriage. Religious beliefs emerged as a strong explanatory variable in support of early marriage. For instance, a participant in the FGD with NGOs/CBOs in Oyo cited the case of a man who converted from a brand of Islam to another brand, who withdrew one of his daughters (the most brilliant daughter) from a government science school and married her off to an Islamic teacher. The man in question argued that he was now more enlightened and therefore needed to demonstrate his new religious belief and values.

Sometimes, a young girl can also be attracted to a man, enter into a marriage with him without the consent of her parents, and even elope with him. The fear of this may lead to parents forcing their girls to marry early. Excerpt in Box 6.9 presents views of community leaders from some

Box 6.7: Excerpt from FGD with NGOs/CBOs

The fear of stigmatisation and the belief that any man that defiles a woman must marry such woman could also be a reason. I've seen a case where a girl is being raped and wants to file a complaint, but her parents say no, the man will marry you, and the girl is young, not yet 15 years old, and we're trying to intervene, but they say no, because he has defiled her, he just must marry her.
FGD with NGOs/CBOs in Adamawa State

communities in Nasarawa State, who will rather support child marriage than see their daughters elope with unknown men. The trend of girls eloping with strange men is also becoming a big problem in Nasarawa State (FGD with Men), and the trend is becoming unacceptable to families.

Box 6.8: Excerpt from FGDs

.. I remember a case of a father who forced her brilliant daughter out of school and forced her into marriage to a Quranic teacher. The man took the decision after he was converted from an Islamic group to a new one. The case affected the mother of the girl badly.... **FGD with NGOs/CBOs in Adamawa State**

Number 1 reason is poverty. Families that are not well to do in their families, to meet up with their family obligations, once they see a man that they feel is financially capable to take care of them, they easily give out their daughter to them to marry. **FGD with married women in Ebonyi State**

I have seen cases where a girl is forced to marry a rich man against her wish, by her parents. They see the girl as the only avenue to making money, and getting out of poverty.... **FGD with mixed group in Kwara State**

More insights into these alternative explanations and contexts promoting childhood marriage are further captured in Figure 32 which presents a network of the rationale and context supporting child marriage. The colours and the direction of the arrows present a multiplicity of factors relating to the prevalence of child marriage in local communities in Nigeria.

Table 30: Are there negative consequences for early girl child marriage

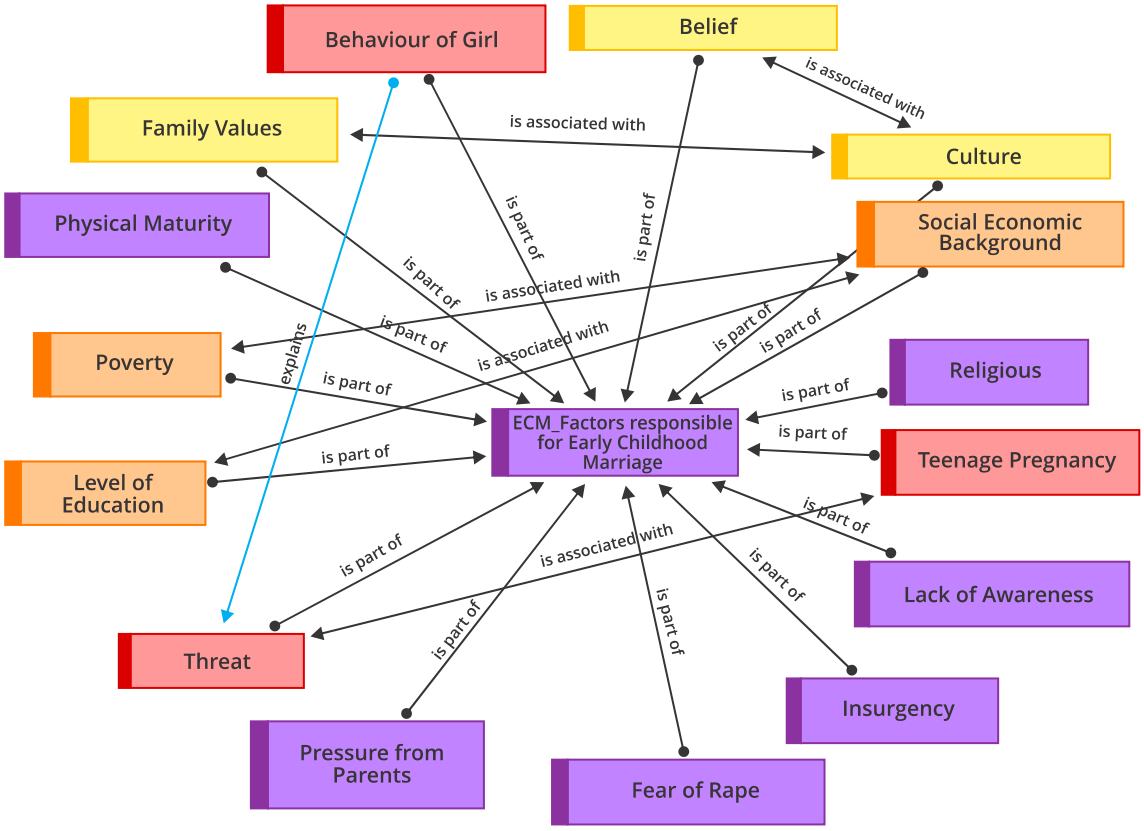
Background Caracteristics	Women				Men			
	Yes	No	Don't know	Total	Yes	No	Don't know	Total
Religion								
Christianity	66.1	18.4	15.5	3,720	66.6	18.8	14.6	1,630
Islam	43.9	44.8	11.3	2,618	25.9	52.0	22.1	1,507
Traditional	35.4	59.5	5.1	15	42.0	21.0	37.0	49
Ethnic Group								
Igbo	67.2	16.6	16.2	1,173	78.5	10.4	11.1	423
Hausa	38.1	53.0	8.9	1,349	18.4	65.7	15.9	753
Yoruba	63.0	19.0	18.0	1,239	48.6	18.4	33.0	732
Others	58.9	28.2	12.9	2,592	52.3	33.5	14.2	1,278
Residence								
Urban	67.2	20.5	12.3	2,430	52.3	26.1	21.6	1,243
Rural	47.5	38.3	14.2	3,923	43.4	40.0	16.6	1,943
Education								
None	33.0	53.3	13.7	1,373	21.2	53.9	24.9	561
Islamic	31.2	60.8	8.0	523	6.8	83.6	9.6	214
Adult	54.3	44.3	1.4	99	39.8	39.1	21.1	40
Formal	65.1	20.6	14.3	4,486	56.8	25.4	17.8	2,371
Zone								
North Central	54.4	26.0	19.6	1,436	42.7	34.5	22.8	489
North East	45.7	49.7	4.6	1,009	21.8	58.2	20.0	451
North West	42.5	49.2	8.3	924	26.6	58.5	14.9	775
South East	65.8	16.6	17.6	1,052	81.6	10.7	7.7	353
South-South	73.8	17.0	9.2	964	73.5	15.8	10.7	470
South West	60.1	17.4	22.5	968	53.5	16.1	30.4	648
State								
FCT-Abuja	77.1	9.4	13.5	460	52.2	40.7	7.1	52
Kwara	52.5	31.0	16.5	501	29.9	32.1	38.0	236
Nasarawa	51.1	24.4	24.5	475	55.3	35.6	9.1	200
Adamawa	59.3	37.1	3.6	498	23.9	49.3	26.8	183
Bauchi	36.7	58.2	5.1	511	20.3	64.3	15.4	268
Kaduna	59.7	30.3	10.0	413	43.5	38.5	18.0	462
Sokoto	16.2	78.3	5.5	511	1.8	87.8	10.4	314
Ebonyi	83.3	8.8	7.9	530	77.8	12.7	9.5	120
Imo	55.1	21.4	23.5	522	83.6	9.7	6.7	233
Akwa Ibom	57.7	27.1	15.2	461	74.7	18.1	7.2	256
Edo	91.4	5.9	2.7	503	72.2	12.9	14.9	214
Ogun	61.5	18.1	20.4	454	65.5	4.3	30.2	269
Oyo	59.0	17.0	24.0	514	45.0	24.4	30.6	379
Total	55.4	31.2	13.4	6352	46.9	34.5	18.6	3,186

Box 6.9: FGD excerpt

...we have seen cases of young girls eloping with their boyfriends. Such young girls secretly marry their boyfriends and just inform their parents later. We will rather marry out a girl early before they give us this kind of surprises. **FGD with male community leaders in Nasarawa State**

Notably, the consequences of early/child marriage on PWD also include dropping out of school, poor health conditions and premature death. Qualitative evidence shows that child marriage often results in abusing the child bride; and when this is a girl with a disability, the abuses are, even greater, giving the girl a limited way of escape.

Figure 32: Network showing the rationale and context supporting Early Childhood Marriage



6.1.7 Negative Consequences for Early Girl Child Marriage

Table 30 indicates the respondents' perception of the negative consequences of child marriage. Over half (55.4%) of the women believed that child marriage has negative consequences, while about 46.9% of the men believed the same. However, about 13.5% of the women and 18.6% of the men had no idea whether or not it had negative consequences. While about two-thirds of the Christian women (66.1%) and men (66.6%) also affirmed that there were negative consequences, less than half of respondents of Islamic religion (women - 43.9% and men - 25.9%) and traditional religion (women - 35.4% and men - 42.0%) believed the same. Similarly, the majority of the respondents from other ethnic groups also believed that child marriage attracts negative consequences, except for Hausa women (38.1%) and men (18.4%) and Yoruba men (48.6%). Less than half of rural women (47.5%) and men (43.4%) believed that child marriage had negative consequences, unlike their urban counterparts (67.2% and 52.3% respectively). A larger proportion of women and men with formal education (65.1% versus 56.8%) and adult education (54.3% versus 39.8%) felt there were consequences for marrying too early compared to their counterparts with none (33.0% versus 21.1%) or Islamic education (31.2% versus 6.8%).

Based on this survey, results by region also showed that the majority of the women (60.1- 73.8%) and men (53.5-81.6%) in the Southern regions believed that child marriage has negative consequences. A smaller proportion of respondents from the North East (45.7%) and North West (42.5%) also shared this belief, except the women from the North Central (54.4%). Examining the component states, the majority of the women from Southern states (55.1-91.4%) believed that child marriage has negative consequences compared to the lower proportions that shared such a view among Northern women (16.2-77.1%). The lowest proportions were reported among the women from Sokoto (16.2%) and Bauchi (36.7%). Men's reports also showed a similar pattern, with a much lower proportion supporting the claim across the states.

Additional evidence from the qualitative component of this study also affirmed the existence of negative consequences. Findings from FGDs, and KIIs show that for the girl pushed into child marriage, the gains are much fewer than the losses for her. Participants agreed that the problems of early marriage could result in complications during childbirth or premature death on some occasions, incomplete education, and gross inability to cope with marital duties and challenges. Susceptibility to OFs was also cited as a possible consequence as captured in the excerpt in Box 6.10.

Box 6.10: Excerpt from KII

There are so many problems in the lives of girls who are married off early. Some of them don't even know how to cook, ... Many things, to even do laundry, she used to tell the husband that she doesn't wash clothes in her house, she doesn't know how to do it (she laughs). ... her husband came complaining, but I gave him the right answer because I never supported the marriage. He felt bad and stopped complaining to me...now we know better. A doctor now talks to us on why women in our community have problem with uncontrollable urination after delivery. It is a bad experience for a woman to be in that condition. **KII with survivor's mother in Kaduna State**

Child marriage may also lead to irreconcilable differences or disputes between the husband and the child-bride, and this may result in physical abuse and sometimes the death of either of the couple. Across the different groups, participants predicted that forced marriage more often than not leads to marital rape and in some cases, other forms of abuse that could lead to mental illness.

Young girls who are survivors of OF were described as a likely source of burden for their husbands. The reason is that OF is a condition that requires much resources and care before healing and reintegration is possible. Unfortunately, some husbands have abandoned such wives for newer ones just to avoid the financial and psychological burden.

6.1.8 Changing the Narratives on Early Childhood Marriage in Nigeria

The challenge of early childhood marriage is gradually receiving attention amongdifferent stakeholders. The participants identified critical stakeholders that have been active in changing the narratives in communities where childhood marriage remains high. Among these stakeholders are religious leaders, community leaders, NGOs and relevant government Departments and Agencies. The excerpt from the FGDs & KIIs with state and non-state actors (see Box 6.11) captures how advocacy programmes on SGBV are now being championed by religious and community leaders, and local NGOs. In the judgement of the participants, these efforts have been fruitful as some of the teachings now help parents to desist from 'child marriage'. The efforts of these religious leaders are being complemented by that of the government. In this sense, participants in the FGDs with NGOs in Ogun and Kaduna States (see Box 6.11) cited how campaigns and awareness creation have increased across different communities. The Ministry of Health emerged dominant in creating awareness and the dangers of child marriages. In Ogun State, for instance, the Ministry of Health puts up jingles sensitising the public on the dangers of child marriage and other forms of abuse against children and women, and the need to bring perpetrators to justice.

In Kaduna State, the passage and domestication of the Violence Against Person Prohibitions (VAPP) alongside the GESI policy were noticeable efforts by the State

Box 6.11: FGD and KII Excerpts with Gender Desk Officers & NGOs

We have been going into the media houses to create awareness about who to report to. A lot of people don't speak out because they don't know where to go to. Once we are able to do the jingle and people hear the jingle, they will know where to run to. **KII with Gender Desk Officer in Government Ministry in Ogun State.**

In Kaduna state, we have childhood protection law, we have VAPP law that has been passed, we also have the GESI policy in Kaduna state, that is, Gender Equity and Social Inclusion. So there are legislations. **FGD with NGOs/CBOs in Kaduna State**

The law exists, but they are not enough, not strong enough. You have to make these laws and have some kind of machineries to enforce it. Specify it, this is unlawful, do this, you go to prison, or you will be penalised. Like early marriage, if a child marry at this age, the parents should be prosecuted and the prosecution should be putt in the hand of specific agencies. **FGD with NGOs/CBOs in FCT**

government in addressing the problem of child marriage and other vices against women and children in the State. The FGD with NGOs/CBOs revealed how timely these interventions are and the likelihood of making relevant impacts in reversing the tide. Similar efforts are ongoing in the FCT. NGOs within FCT said SGBV and child marriage perpetrators are now under close watch. If caught, such persons would be prosecuted and jailed if found guilty. In contrast, findings from the state level show that prosecutions of SGBV and child marriage perpetrators are not as effective. In cases where local NGOs handed culprits to the police, they are almost immediately released without prosecuting the perpetrators.

An important point raised across the FGD groups was the need to build synergy across SGBV stakeholders - government agencies, community members and leaders to successfully fight perpetrators of child/forced marriage, and child abuse. The fear was expressed that most perpetrators of child/forced marriage are community members, who are sometimes religious leaders and influential community leaders. Regular dialogues and firmness in applying existing laws were further suggested as possible approaches to changing the prevailing narratives.

6.1.9 Policymakers and Critical Stakeholders Assessment on Child/Forced Marriage

The government's efforts in addressing childhood marriage were perceived differently among government agencies and community members. The gender desk officers mentioned some awareness programmes and sensitisation that were acknowledged by some community members across the regions. In contrast, the adolescent groups felt the government is just playing lip service to the curbing of SGBV and other violence against women and children. The argument was mainly that perpetrators are within the elite class who in many instances have a way of tilting the law in their favour. They bribe the police and keep the mouths of survivors shut. In Ogun State, this group argued that the existing laws are not enforceable because political leaders are also guilty of these abusive behaviours.

The qualitative evidence showed that the NGOs/CBOs play critical roles in addressing the problem of child marriage (see Box 6.12). NGOs in Nigeria have coalition groups against SGBV across the zones. They provide shelters and safe spaces for survivors, provide legal aid, and economic empowerment to survivors. Although many State governments have the VAPP law and other laws against child marriage, it is evident that most government agencies lack the necessary facilities such as shelter and legal aid among others for addressing the problem. NGOs' facilities for survivors are also very limited because of poor funding.

Box 6.12: FGD and KII Excerpts

What kind of steps do you want the leaders to take against SGBV and child marriage when they are also culprits? A member of House of Assembly publicly married a 13-year- old girl. So, can such a person frown on others for doing the same? Many political leaders sleep with young girls, young to be their daughters. Would they ever support any punitive measures against perpetrators of SGBV? This is why laws on SGBV is difficult to enforce. Also, the police do their biddings. **FGD with adolescent Girls in Ogun State**

You mean shelter homes? Yes, we have shelters. Some NGOs have shelters, that the survivors can go and get served, at least taking them away from the abusive environment. And then there are some legal aids, like FIDA that women can approach. Some NGOs help women to seek justice in court.

NAPTIP is also active. There are government economic empowerment programme that can help such women. However, government does not have safe spaces nor is there any form of arrangement to help abused women get out of abusive relationships. **KII with service providers in Akwa Ibom State**

Similar assessments among PWDs revealed that interventions towards addressing early/child marriage were mentioned by informants in Ebonyi State and the FCT. In the FCT, such efforts were attributed to the organisation of persons with disabilities (OPD). Members of this group were praised for their efforts in kicking against child marriage. The association reports perpetrators to the law enforcement agencies and supports children with disabilities who are being threatened or forced into marriage against their desire. In Ebonyi, Rose Rehabilitation Centre for Children with Disability also emerged in the interviews as a key organisation in the fight against child marriage among PWDs. The organisation creates awareness against early/child marriage and encourages parents to protect such children.

6.2 Forced Marriage

Figure 33: Forced marriage experience and the relationship of the survivors with the respondents

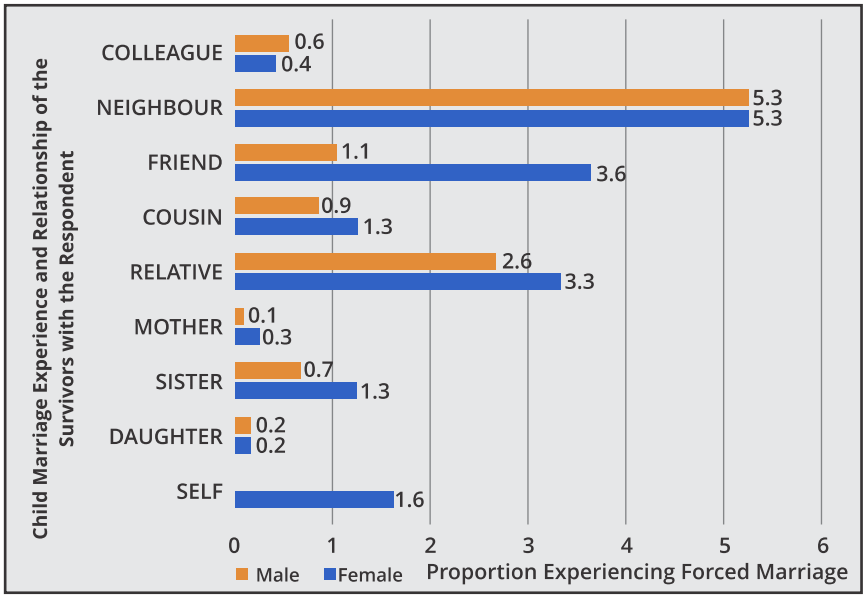


Figure 33 shows the prevalence of forced marriage in Nigeria. Overall, 1.6% of the women and none of the men experienced forced marriage. However, about 5.3% of the women and men reported that a neighbour experienced forced marriage, while less than 5% (of both men and women) reported that any other person close to them was forced into marriage.

Considering the age distribution of forced marriage, the practice decreases with the age of the respondents (Appendix 6.5). Forced marriage was not common in Nigeria compared to child marriage. Whether to the respondents themselves or someone close to them, the prevalence of forced marriage is 17.4% irrespective of age, religion, ethnic affiliation, place of residence, educational status, region of residence and wealth quintile.

A similar situation was reported by men (Appendix 6.6). However, over one-quarter of Hausa men reported forced marriage by their relatives (27.7%) and neighbour (27.6%). About one- fifth of men of other ethnic minorities also reported forced marriage by their relatives (20.3%) and neighbour (22.1%). Men's report about forced marriage by a relative and neighbour was also higher in rural areas (22.6% and 24.3% respectively) compared to urban areas (9.8% and 16.3% respectively). In the North East, a higher prevalence was also reported of a relative (53.1%), neighbour (46.7%) and sister (30.8%) compared to other regions which were all below 20% except North Central (22.1%) and North West (21.3%) for a neighbour.

6.2.0 FEMALE GENITAL MUTILATION

KEY FINDINGS

- FGM is an agelong practice and the social forces and values promoting it are changing even in communities where it still exists.
- More than half of the women in this study knew about FGM. The prevalence of FGM is 39.7% with 14.6% of the women having experienced FGM while about 5.4% of them reported the same experience for their daughters, and less than 5% reported the same for someone else close to them.
- About 17.4% of the female and 8.3% of the male respondents had their daughter(s) mutilated, this was more pronounced among women resident in urban (21.3%) compared to rural areas (15.1%).
- Parents are the major decision makers (31.6%), in some cases the mother (21.4%) or the father (16.0%) solely took the decision.
- Both men and women are coming to terms with accepting the negative impact of FGM on women's sense of sexual satisfaction with their partners/spouses.
- Social campaigns by the government, NGOs and other stakeholders about the negative effect of FGM on women (and including their partners/spouses) are yielding positive results as more people are appreciating the need to end the practice

6.2.1 Knowledge of the Negative Impact of Female Genital Mutilation

The result in Table 31 indicates that a higher proportion of women (56.1%) compared to men (44.6%) knew about the negative impact of FGM. However, more than half of women aged 25 years and above and men of ages 55 years and above knew the negative impact of FGM, while less than half of the women and men of other age groups are

knowledgeable about this. This pattern indicates that the practice is gradually becoming less common in modern days.

The knowledge of the negative impact of FGM appeared more pronounced among Christian (59.3%) and Muslim women (52.6%) alike, compared to those in the traditional religion (45.1%). Similarly, the practice was more popular among men of all religions (41.3-47.8%), except those in other religions (28.3%). The majority of the Igbo (88.8%) and Yoruba women (69.8%) knew about the practice unlike the Hausas (47.7%). Close to three-quarters of the separated/divorced (71.7%) and widowed (75.6%) women were aware of the FGM, while the prevalence of knowledge was lowest among the single women. This could be because most of the single women were in the younger age group while the majority of the separated/divorced and widows were in the older age group. The pattern was similar for men, though the prevalence was lesser among men for each marital status category.

The knowledge of the negative impact of FGM among men and women of various educational statuses was similar. However, those who had formal education had the highest prevalence of knowledge, 59.6% for women and 47.7% for men. About 44.0-50.7% of the women, and 32.8- 43.0% of the men of other educational statuses knew about FGM.

FGM is known by the majority (51.8-92.6%) of the women in all the regions except the North East (21.5%). The majority of men in the South East (83.1%) and North Central (60.9%) and a smaller proportion in the South-South also knew this harmful traditional practice. Only about 24.5-38.4% of men knew in the North-West and South West.

Table 31: Percentage Distribution of Men's and Women's Knowledge of Female Genital Mutilation by Background Characteristics

Background Caracteristics	Women				Men		
Age	**Yes**	**No**	**Don't know**	**Total**	**Yes**	**No**	**Total**
10 - 14	32.0	61.3	6.7	136	na	na	na
15 – 19	40.1	51.3	8.6	1,249	6.0	94.0	24
20 – 24	47.1	47.6	5.3	1,151	32.1	67.9	104
25 – 29	56.4	37.9	5.7	968	37.8	62.2	286
30 – 34	62.2	34.4	3.4	872	44.3	55.7	442
35 – 39	66.8	28.2	5	789	40.7	59.3	561
40 – 44	70.7	28.2	1.1	630	41.1	58.9	451
45 – 49	74.1	23.1	2.8	558	47.7	52.3	621
50 – 54	na	na	na	na	46.0	54.0	280
55 - 59	na	na	na	na	56.2	43.8	160
60 - 64	na	na	na	na	57.9	42.1	158
65 – 69	na	na	na	na	64.7	35.3	9,793
70+	na	na	na	na	0.0	100	2
Religion							
Christianity	59.3	37.4	3.3	3,720	47.8	52.2	1,630
Islam	52.6	40.3	7.1	2,618	41.3	58.7	1,506
Traditional Religion	45.1	54.9	0.0	15	41.8	58.2	47
Others	na	na	na	na	28.3	71.7	2

Ethnic Group							
Igbo	88.8	10.4	0.8	1,173	77.1	22.9	423
Hausa	47.7	44.3	8.0	1,349	35.3	64.7	753
Yoruba	69.8	27.3	2.9	1,239	45.4	54.6	732
Others	41.8	52.2	6.0	2,592	39.0	61.0	1,277
Residence							
Urban	67.1	29.7	3.2	2,430	47.9	52.1	1,246
Rural	48.7	44.9	6.4	3,923	42.5	57.5	1,943
Marital Status							
Single (Never Married)	45.8	48.2	6.0	1,862	33.7	66.3	262
Married	59.1	36.1	4.8	4,079	45.4	54.6	2,852
Separated/Divorced	71.7	23.8	4.5	132	63.8	36.2	223
Cohabiting	61.7	38.3	0.0	57	33.2	66.8	145
Widowed	75.6	21.0	3.4	224	58.5	41.5	35
Education							
None	47.4	45.3	7.3	1,373	32.8	67.2	561
Islamic	50.7	39.0	10.3	523	43.0	57.0	214
Adult education	44.0	47.8	8.2	99	38.4	61.6	40
Formal education	59.6	36.7	3.7	4,486	47.7	52.3	2,371
Zone							
North Central	55.7	37	7.3	1,436	60.9	39.1	489
North East	21.5	70.3	8.2	1,009	36.3	63.7	451
North West	51.8	41.4	6.8	924	24.5	75.5	776
South East	92.6	6.7	0.7	1,052	83.1	16.9	353
South-South	60.7	38.3	1.0	964	48.4	51.6	471
South West	62.1	33.4	4.5	968	38.4	61.6	649
State							
FCT-Abuja	40.4	58.8	0.8	460	40.9	59.1	52
Kwara	77.7	16.8	5.5	501	64.8	35.2	237
Nasarawa	33.6	55.5	10.9	475	61.5	38.5	201
Adamawa	33.6	55.5	10.9	498	7.4	92.6	183
Bauchi	23.1	66.6	10.3	511	56.1	43.9	268
Kaduna	42.4	49.5	8.1	413	29.3	70.7	462
Sokoto	65.7	29.4	4.9	511	17.3	82.7	314
Ebonyi	88.8	11.0	0.2	530	62.4	37.6	120
Imo	95.0	3.9	1.1	522	93.7	6.3	233
Akwa Ibom	40.0	58.1	1.9	461	29.1	70.9	256
Edo	82.4	17.6	0.0	503	71.5	28.5	214
Ogun	43.5	52.1	4.4	454	17.5	82.5	269
Oyo	76.5	18.9	4.6	514	53.3	46.7	379
Total	**56.1**	**38.9**	**5.1**	**6,352**	**44.6**	**55.4**	**3,189**

6.2.2 Prevalence of Female Genital Mutilation

The prevalence of FGM is about 39.7% as shown in Appendix 6.7. About 14.6% of the cases were self-reported while the other cases had diverse relationships with the respondents. The results for men were not shown because it is an acceptable norm across religions and ethnic groups for all Nigerian men to be mutilated. However, the practice of FGM is declining and appeared less rampant in the younger generation (10-14yrs, 27.0%; 15-19yrs, 28.4%; 40-44yrs, 49.1%; 45-49yrs, 66.8%). The practice of FGM (Figure 35) is more prevalent among the Yoruba (72.2%) and Igbo women (55.6%) unlike the Hausas (28.2%) and others (22.0%). Interestingly, the practice is more prevalent among urban (52.8%) compared to rural residents (31.0%).

Additional results showed some kind of regional variations in the practice. As captured in Figure 36, the practice of FGM was highest in the South East (50.6%), the Igbo region, followed by the South West (32.2%), the Yoruba region, and the North Central (30.5%). The North East and North West of Hausas/Fulani regions had the lowest prevalence of FGM (less than 10%).

Though the regional estimates on FGM practice portrayed both the Southern and North central regions as the most affected regions, Figure 37 showed state-based estimates of the most affected states. Among these states, Kwara (56.2%) accounted for more cases of FGM, followed by Imo State (55.4%) and Oyo State (47.9%), Ebonyi (42.9%) and Edo State (35.3%). The least prevalence rate was reported in the Northern states, with less than 10% prevalence in each state.

The qualitative evidence from the FGDs and KIIs revealed FGM as an age-long tradition that is deeply rooted in the cultural interpretations of sexuality (see Box. 6.13). The embeddedness of the practice in the cultural beliefs and values of the participants is reflected in their belief about FGM. Thus, while many acclaimed FGM to be useful, others queried its usefulness. The prevalence of FGM varies across the study locations. In these locations, the practice involved the partial or complete removal of the clitoris. Many still believe that FGM was beneficial in regulating women's sexuality.

Box 6.13: FGD Excerpt

FGM (Nkukko) is an olden day's tradition, but still in practice in this community. FGM is now less common and optional/voluntary, and not done at birth, but when the female has grown to adolescence, or while she goes to put to birth, and is carried out by Traditional Birth Attendants (TBAs). **FGD with community leaders, Akwa Ibom State**

Figure 35: Prevalence of FGM by Ethnic Groups

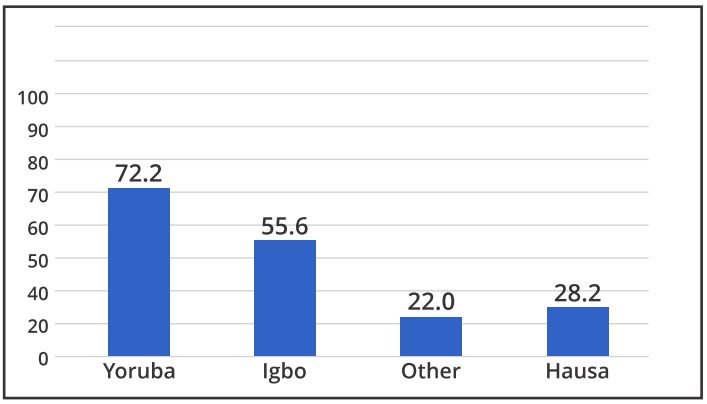


Figure 36: Prevalence of FGM by Ethnic Groups by Zone

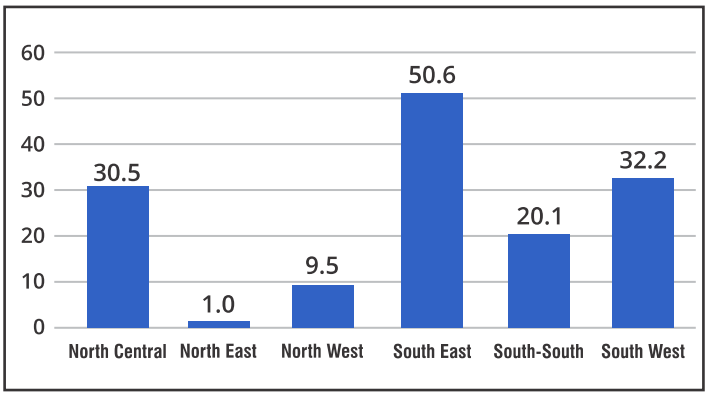
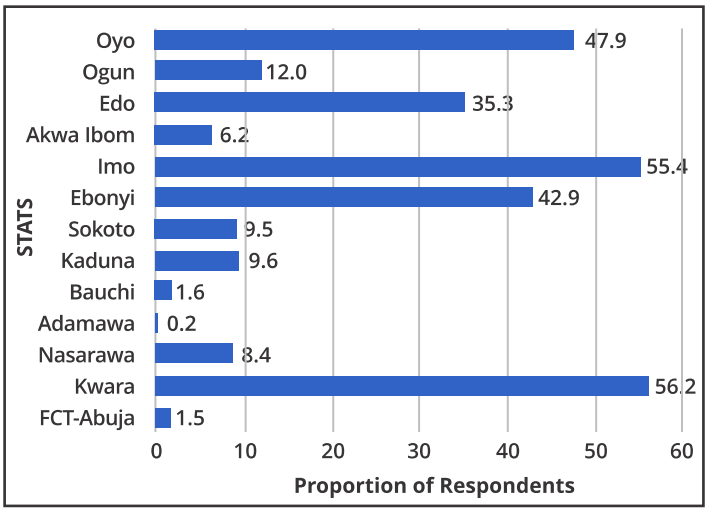


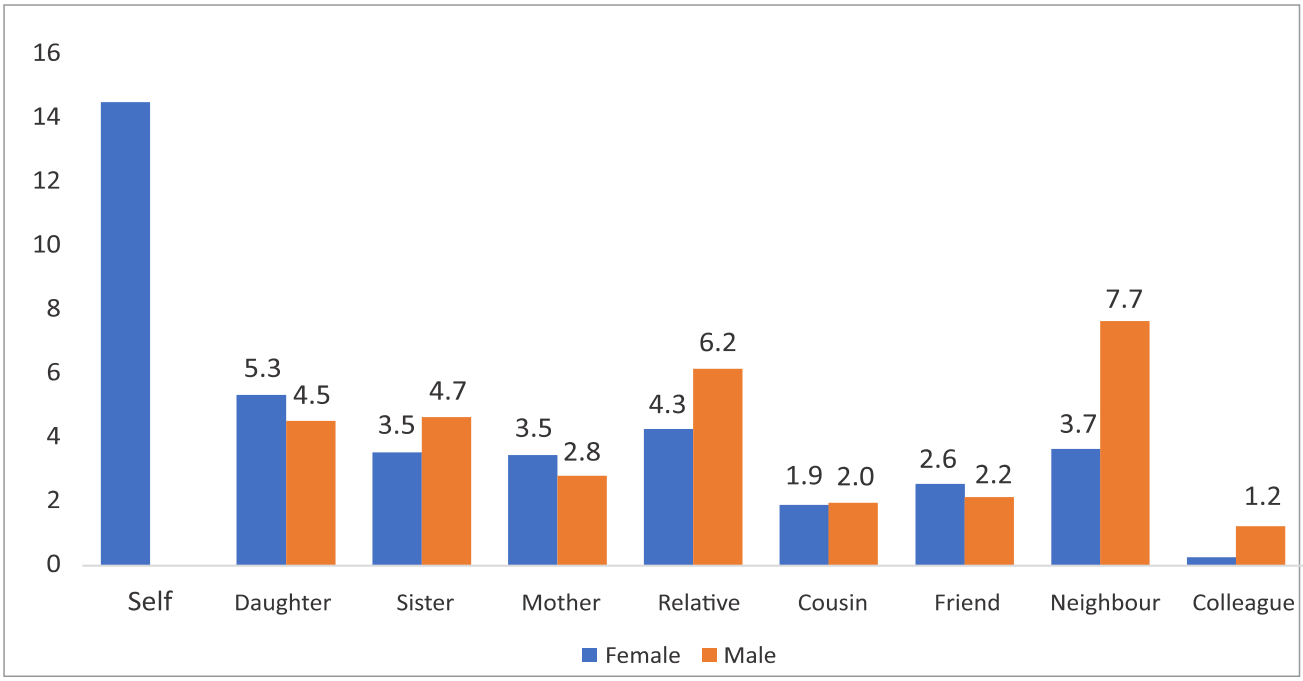
Figure 37: Prevalence of Female Genital Mutilation by State



6.2.3 Female Genital Mutilation and the Relationship of the Survivors with the Respondents

As shown in Figure 38, about 14.6% of the women had experienced FGM while about 5.4% of them reported the same experience for their daughter. Less than 5% of them reported that someone close to them also had the experience. Some men on the other hand reported that a neighbour (7.7%), a relative (6.2%), and others (less than 5%) experienced FGM.

Figure 38: Female genital mutilation and relationship of the survivors with the respondents



FGM among the respondents, their daughters, sisters, mothers, relatives, cousins, friends, neighbours and colleagues were similar regardless of religion, ethnicity, residence region and other background characteristics, except the age of the respondents (Appendix 6.7). Considering the age distribution of FGM among the respondents themselves, the practice increased with the age of the women. The age distribution indicates that the practice was declining over the years, as younger women had a lower prevalence compared to the older ones. FGM experience was more rampant at age 45-49 years for the respondents (29.0%) compared to the youngest age group of the women, 10-19 years (10.9%). The prevalence was low (less than 10%) for people close to the respondents, except for the daughters of women aged 45-49 years (14.0%) who were also mutilated.

Men's reports about FGM experienced by a daughter or someone else close to them were similar to that of the female respondents with a few exceptions (Appendix 6.7b). For instance, considering the age of the men, a larger proportion of them ages 60-64 (10.7%) and 65-69 years (15.6%) reported FGM was experienced by a daughter, unlike the younger men from ages 15 to 44 years with less than 5% of them reporting the same experience about a daughter. Less than 5% of the respondents in lower age groups (below age 55 years) reported FGM experience for some close to them, except those at older ages who reported FGM for a sister (3.4-10.4%), mother (4.7-9.7%), relative (7.7-12.0%), and neighbour (11.7-16.1%).

Men who practice traditional religion reported FGM for a sister (10.5%), mother (18.1%), relative (25.2%), cousin (15.3%), and friend (12.0 %) at a higher rate than men of other religious groups (less than 5% in most cases). Similarly, Igbo men reported a higher prevalence of FGM for a daughter (10.6%), sister (11.4%), mother (16.5%), relative (11.7%), and neighbour (19.2%), compared to men of other ethnic groups (less than 10% in most cases). This pattern is also reflected in the South Eastern region and states which are Igbo land, compared to other regions and states, except Kwara state (12.7-23.1%).

6.2.4 Types of Female Mutilation (Respondents and Female Children)

More than half of the women either had their external genitalia removed (25.6%) or had only the clitoris removed (26.3%) while about 20.5% and 61.9% of men reported the same for their daughters (Appendix 6.10). Few women (15.1%) also reported the removal of their clitoris and other nearby tissues, while 10.1% of men reported the same for their daughters.

The qualitative evidence reiterated FGM as an agelong practice; as such, it was not a surprise that some communities are still practising it. In describing the procedures, the informant mentioned that the commonest type of FGM practice is the removal of the external female genital (the clitoris and labia) during adolescence because of the belief that procedures carried out at birth may result in the growth of the labia in deformed shape after the initial cut.

Examining the religious variations, the majority (72.2%) of the women of traditional religion who had the mutilation had only the clitoris removed unlike other religions: Christianity (22.1%) and Islam (31.7%). This form of mutilation was also the most common among the Yoruba

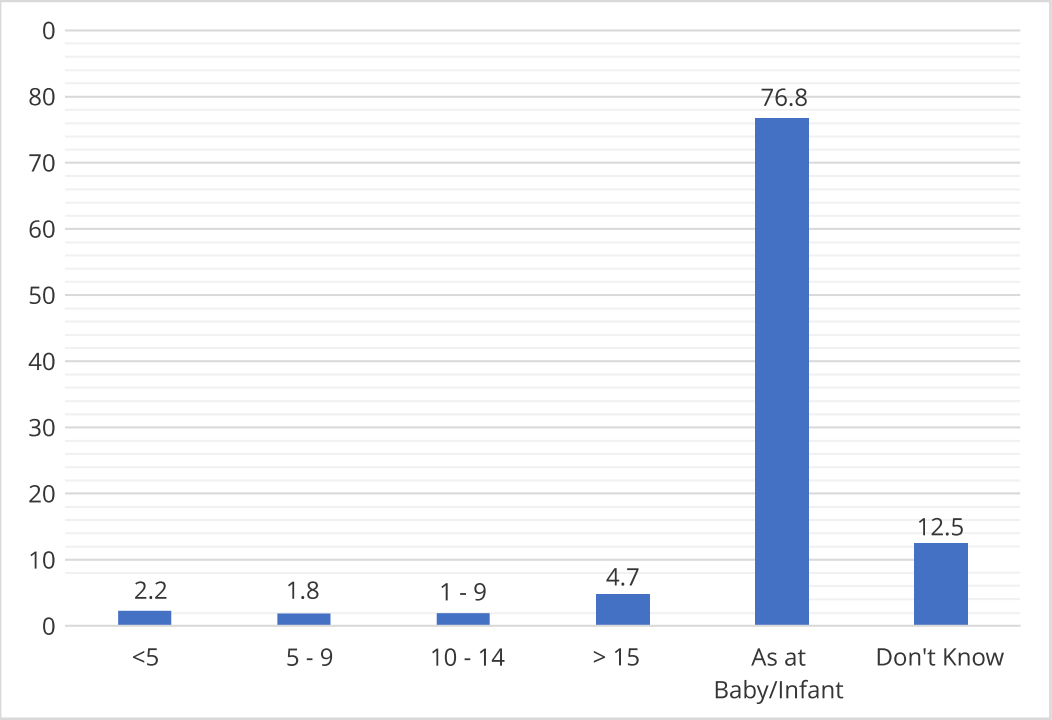
women (26.1%) and those of other ethnic groups (41.1%), with a lesser degree of other forms of mutilation: 6.5-12.3% for Yoruba and 4.6-10.8% for other ethnic groups. Removal of the clitoris with other nearby tissues was the most common practice among Igbo women (17.6%).

All the types of mutilation were evenly distributed in the Hausa ethnic group. The removal of the clitoris only was more prevalent than other types of mutilation irrespective of place of residence and marital status and education. However, a higher proportion of the women with adult education (58.4%) and those with Islamic education (38.9%) reported removal of the clitoris only, compared to their counterparts with formal education (25.4%) or no education 24.6%). In all the regions, except South East (9.5%), the prevalence of removal of the clitoris only was higher (26.0-45.5%) than in other types of mutilation.

6.2.5 Age at Mutilation

The majority of the women (76.8%) were mutilated at infancy irrespective of religion, residence, ethnicity and region (Figure 39). A few of the respondents (12.5%) did not know at what age they were mutilated. Their lack of knowledge may, however, indicate that they were also mutilated at infancy or before age 5 years. Regardless of religion, ethnicity, region and state of residence, there are no noticeable variations in age at the respondents' mutilation (Appendix 6.8).

Figure 39: Age at Respondents' Mutilation



6.2.6 Decision Maker on Respondents' (Women Only) and Men's Daughter's Mutilation

The decision about a girl's mutilation in most cases is made by both the father and mother or either of them, though sometimes might involve the grandparents. In this study, overall, about 31.6% of the women reported that the decision about their mutilation was jointly taken by their parents (Table 32). However, in some cases, their mother (21.4%) or father (16.0%) was the sole decision maker on the mutilation.

This pattern was similar across the respondents' background characteristics, though with some variations. For instance, after both parents as the decision maker of mutilation, the mother was the next most reported decision maker among Christian women (29.3%), while the father was the next most reported decision maker among Muslim women (26.0%) and those of traditional religion (24.3%). Also, the respondents' mother was the next most reported decision maker on their FGM among Igbo women (36.4%) and those of other ethnic groups (27.3%), while the father was the decision maker among the Hausa (24.8%) and Yoruba women (22.5%).

Though both parents were the most reported decision makers in some regions like North Central (39.3%), North West (57.8%) and South-South (39.1%), the father was the major decision maker in the North East (68.5%) and South West (21.6%), while the mother was the main decision maker in the South East (36.8%).

Table 32: Decision Maker on the Women's Mutilation

Background Characteristics	Self (%)	Father (%)	Mother (%)	Father and Mother (%)	Grand Parents (%)	Other Family Members (%)	Religious/ Community Leader (s) (%)	Others (%)	Don't know (%)	Total (n)
Religion										
Christianity	0.8	8.7	29.3	29.6	2.1	0.7	0.7	1.2	26.9	819
Islam	0.3	26.0	10.6	34.4	2.1	0.6	0.0	0.4	25.7	593
Traditional Religion	0.0	24.3	0.0	24.9	0.0	0.0	0.0	0.0	50.9	4
Ethnic Group										
Igbo	0.4	3.3	36.4	34.0	2.4	0.4	0.4	1.3	21.6	375
Hausa	1.2	24.8	7.1	55.5	0.8	1.1	0.0	1.1	8.5	158
Yoruba	0.1	22.5	13.1	22.7	2.2	0.2	0.2	0.0	39.1	604
Others	1.5	13.9	27.3	34.1	2.2	1.7	1.3	2.1	16.0	279
Residence										
Urban	0.3	17.6	17.8	32.6	2.3	0.2	0.7	0.2	28.3	756
Rural	0.9	14.1	25.5	30.5	1.8	1.1	0.1	1.6	24.4	660
Zone										
North Central	0.6	23.5	12.9	39.3	4.1	0.8	0.0	0.1	18.8	306
North East	0.0	68.5	10.0	0.0	0.0	13.5	0.0	0.0	8.0	9
North West	1.3	26.1	6.3	57.8	0.0	1.1	0.0	1.1	6.3	153
South East	0.4	2.7	36.8	33.6	2.4	0.4	0.4	1.3	22.1	364
South-South	1.6	6.6	31.8	39.1	1.4	0.7	1.9	2.5	14.4	185
South West	0.0	21.6	15.1	11.2	1.4	0.3	0.3	0.2	50.1	400
State										
FCT-Abuja	4.3	0.0	38.8	32.3	0.0	0.0	0.0	24.6	0.0	1
Kwara	0.2	22.6	9.5	42.9	3.9	0.0	0.0	0.0	21.0	268
Nasarawa	3.3	31.5	37.5	12.2	6.2	6.6	0.0	0.0	2.8	36
Adamawa	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100	1
Bauchi	0.0	74.5	10.9	0.0	0.0	14.7	0.0	0.0	0.0	8
Kaduna	2.1	27.0	9.1	52.4	0.0	0.0	0.0	0.0	9.5	93
Sokoto	0.0	24.8	2.1	66.2	0.0	2.8	0.0	2.8	1.4	60
Ebonyi	1.2	4.4	20.3	18.2	3.2	1.2	0.0	0.0	51.6	117
Imo	0.0	2.0	44.6	40.8	2.1	0.0	0.5	1.9	8.1	247
Akwa Ibom	0.0	6.4	43.4	16.2	0.0	0.0	6.1	8.7	19.3	30
Edo	1.9	6.6	29.6	43.5	1.7	0.8	1.1	1.3	13.5	155
Ogun	0.0	11.7	4.2	36.5	1.2	1.7	1.7	1.2	41.8	65
Oyo	0.0	23.5	17.2	6.3	1.4	0.0	0.0	0.0	51.7	335
Total	**0.6**	**16.0**	**21.4**	**31.6**	**2.1**	**0.6**	**0.4**	**0.9**	26.5	**1,416**

**Multiple Responses, Yes answers only are recorded in the table*

6.2.7 Persons Who Performed Respondents' (Women) Mutilation

For the women's mutilation (Table 33), more than half of them were mutilated by traditionalists, while a fewer proportion (21.1%) were mutilated by a health professional. However, there are some variations in some individual characteristics. A larger percentage (28.7%) of Christian women were mutilated by health professionals compared to their Muslim counterparts (10.9%). None of the women of traditional religion was mutilated by health professionals. Invariably, the majority of the women in traditional religion (72.2%) were mutilated by traditionalists, unlike the Muslim (61.9%) and Christian women (38.7%). About 93.6% of Hausas and 63.5% of women in other ethnic minorities with a smaller proportion among the Yoruba women were mutilated by one traditionalist or the other. Whereas, Igbo women had the highest prevalence of FGM done by health professionals (34.9%), compared to Yoruba (18.4%), other ethnic minorities (19.3%) and Hausas (1.7%). The ethnic variations are also reflected in the regions. For instance, mutilation by traditionalists was more prevalent in the North – North Central (67.1%), North East (86.5%) and North West (92.0%) – with about two-thirds in the South-South (62.9%) and smaller proportions in the South East (30.0%) and South West (27.0%). The Southern regions had the highest prevalence of mutilation conducted by health professionals (25.3-34.4%). The regional variations were also reflected in the statistics of the component states, the Northern states having the highest traditionally conducted mutilation (85.3-100%), except FCT Abuja (64.7%) and Kwara (64.2%), compared to the Southern States which all had below 50% except Akwa-Ibom (75.9%) and Edo states (60.3%).

Table 33: Persons who Performed Respondents' (Women) Mutilation

Background Characteristics	Traditional (%)	Health Professional (%)	Don't Know (%)	Total (n)
Religion				
Christianity	38.7	28.7	32.6	811
Islam	61.9	10.9	27.2	587
Traditional Religion	72.2	0.0	27.8	4
Ethnic Group				
Igbo	30.4	34.9	34.7	373
Hausa	93.6	1.7	4.7	157
Yoruba	41.1	18.4	40.5	596
Others	63.5	19.3	17.2	277
Residence				
Urban	47.8	20.9	31.3	746
Rural	49.3	21.4	29.3	657
Zone				
North Central	67.1	5.5	27.4	303
North East	86.5	0.0	13.5	9
North West	92.0	5.3	2.7	151
South East	30.0	34.4	35.6	361
South-South	62.9	26.1	11.0	183
South West	27.0	25.3	47.7	395

State				
FCT-Abuja	64.7	12.6	22.7	1
Kwara	64.2	6.2	29.6	266
Nasarawa	88.4	0.0	11.6	36
Adamawa	100	0.0	0.0	1
Bauchi	85.3	0.0	14.7	8
Kaduna	89.7	5.8	4.5	91
Sokoto	95.5	4.5	0.0	60
Ebonyi	46.3	2.9	50.8	116
Imo	22.3	49.2	28.5	245
Akwa Ibom	75.9	8.7	15.4	30
Edo	60.3	29.5	10.2	153
Ogun	49.0	23.6	27.4	63
Oyo	22.9	25.6	51.5	332
Total	**48.5**	**21.1**	**30.4**	**1,403**

6.2.9 Use of Any Substance or Herb to Tighten or Narrow Vaginal Area

The use of substances or herbs to tighten or narrow the vagina area is a practice among women. The results from this study showed that about 2.6% of the women reported having engaged in the practice (Appendix 6.12). The practice was low irrespective of the women's religion, ethnicity and rural-urban residence. However, it was relatively higher among the women with Islamic education (11.6%) compared to other educational groups (less than 5%), and in the North West (6.8%) compared to other regions (about2.0% or less).

6.2.10 Daughter's Mutilation

FGM was not limited to the female respondents alone; some of them had their daughters mutilated as well. For instance, about 17.4% of the women had their daughter(s) mutilated (Table 34). The prevalence of daughter mutilation increases with the mother's age. The practice was more pronounced among older women aged 45-49 years (26.7%), 40-44 years (20.1%) and 35-39 years (18.0%) compared to the younger ones (8.5% in the youngest age group to 13.9% in the age group 30-34 years). Daughter mutilation was more pronounced among Igbo women (31.3%) compared to other ethnic groups – Yoruba (23.9%), Hausa (18.5%) and others (7.2%). The practice was also more prevalent in the South East (34.9%) compared to other regions (1.1-21.7%). It was lowest in the North East (1.1%). There were appreciable variations in the daughter mutilation by religion, education, residence and other characteristics.

Table 34: Any mutilated female children by respondents

Background Caracteristics	Women				Men			
	Yes (%)	No (%)	Don't Know (%)	Total (n)	Yes (%)	No (%)	Don't Know (%)	Total (n)
Age								
10– 14	8.5	91.5	0.0	44	na	na	na	na
15– 19	9.9	89.5	0.6	180	0.0	99.4	0.6	17
20– 24	13.1	86.7	0.2	413	3.6	86.8	9.6	101
25– 29	16.7	82.6	0.7	563	3.0	92.0	5.0	279

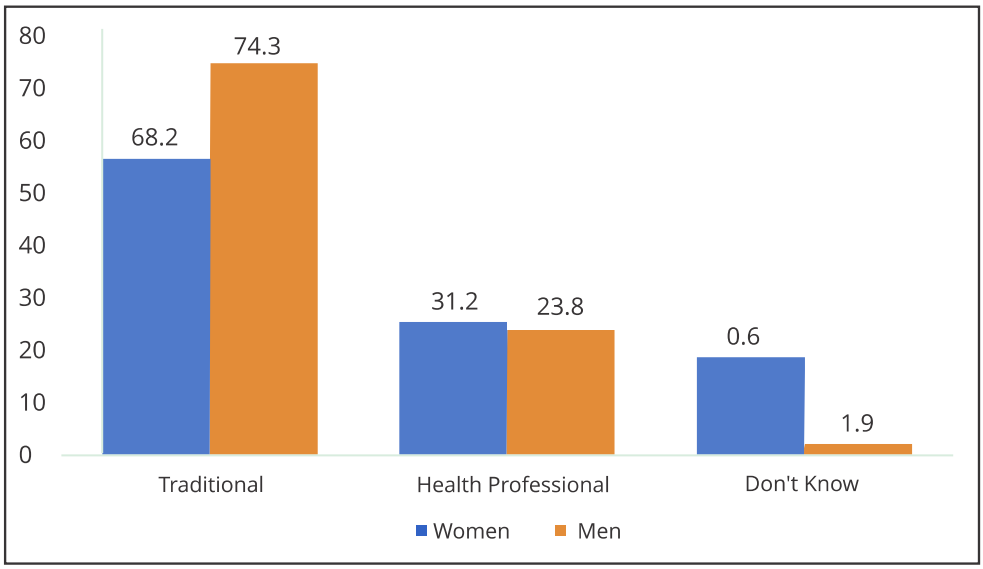
30 – 34	13.9	85.7	0.4	605	5.2	88.1	6.7	434
35 – 39	18.0	82.0	0.0	594	6.3	89.1	4.6	548
40 – 44	20.1	79.9	0.0	508	5.2	91.9	2.9	435
45 – 49	26.7	72.0	1.3	472	11.1	83.3	5.6	598
50 – 54	na	na	na	na	10.7	84.0	5.3	271
55 - 59	na	na	na	na	11.7	84.9	3.4	157
60 - 64	na	na	na	na	17.3	81.4	1.3	157
65 – 69	na	na	na	na	26.2	70.6	3.2	93
Religion								
Christianity	15.1	84.6	0.3	1,603	7.4	88.5	4.1	1,582
Islam	19.5	79.9	0.6	1,765	9.1	85.5	5.4	1,463
Traditional	20.3	79.7	0.0	11	16.8	75.3	7.9	45
Ethnic Group								
Igbo	31.3	68.4	0.3	431	16.6	82.2	1.2	410
Hausa	18.5	80.7	0.8	992	6.1	89.2	4,7	719
Yoruba	23.9	75.7	0.4	786	10.6	85.6	3.8	729
Others	7.2	92.6	0.2	1,170	5.5	87.8	6.7	1,234
Residence								
Urban	21.3	78.4	0.3	1,292	9.9	86.0	4.1	1,214
Rural	15.1	84.4	0.5	2,087	7.3	87.4	5.3	1,878
Education								
None	15.1	84.6	0.3	927	7.0	85.9	7.1	541
Islamic	20.3	78.1	1.6	332	8.5	83.1	8.4	208
Adult Education	22.6	77.4	0.0	67	2.0	93.3	4.7	37
Formal	17.9	81.8	0.3	2,054	8.7	87.3	4.0	2,307
Zone								
North Central	21.7	78.2	0.1	519	13.7	82.0	4.3	475
North East	1.1	98.6	0.3	546	5.1	85.8	9.1	443
North West	19.6	79.5	0.9	935	4.0	88.6	7.4	725
South East	34.9	64.8	0.3	381	19.5	79.7	0.8	344
South-South	15.8	84.2	0.0	322	8.8	90.1	1.1	457
South West	15.4	84.2	0.4	676	5.1	90.8	4.1	648
State								
FCT-Abuja	1.2	98.8	0.0	40	0.6	96.0	3.4	45
Kwara	38.6	61.4	0.0	255	25.2	72.5	2.3	234

Nasarawa	5.9	93.8	0.3	224	3	90.0	7.0	197
Adamawa	0.4	99.3	0.3	210	0.0	82.7	17.3	178
Bauchi	1.5	98.3	0.2	336	8.5	87.8	3.7	265
Kaduna	13.3	85.3	1.4	558	5.2	86.0	8.8	430
Sokoto	28.8	70.9	0.3	377	5.1	92.3	2.6	295
Ebonyi	13.5	86.5	0.0	140	9.9	90.1	0.0	115
Imo	47.4	52.1	0.5	241	24.2	74.6	1.2	229
Akwa Ibom	4.5	95.5	0.0	133	3.9	4.1	92.0	63
Edo	23.9	76.1	0.0	189	14.4	83.8	1.8	208
Ogun	3.3	95.7	1.0	278	0.5	97.8	1.7	269
Oyo	23.9	76.1	0.0	398	8.5	85.8	5.7	378
Total	**17.4**	**82.1**	**0.4**	**3,379**	**8.3**	**86.9**	**4.8**	**3,092**

6.2.11 Age of Daughter at Mutilation

As reported for the women respondents, among women whose daughters were mutilated, many (81.6%) were done by age 5 irrespective of religion, residence, ethnicity and region (Appendix 6.9). Men also reported the same age for the mutilation of their daughters.

Figure 40: Persons who performed daughter's mutilation



6.2.12 Persons who performed daughter's mutilation

Information on who performed the mutilation procedure showed that traditionalists topped the list. As captured in Figure 40, more than half (68.3%) of the women and about three- quarters (74.3%) of the men claimed that a traditionalist performed the procedure, while 31.2% and 23.8% respectively used health professionals. About 0.6% of the women did not know who performed the procedure.

Table 35 illustrates the women's and men's reports on their daughter's mutilation based on some selected background characteristics. The majority of the women (68.2%), regardless of age group, engaged traditionalists to perform mutilation for their daughters, except those between 35 and 49 years with a lower proportion (47.9-62.2%) circumcising their daughters' using traditionalists but highest users of health professionals 37.0-52.1%. A higher percentage of Muslim women (79.0%) compared to their Christian counterparts (52.8%) patronised traditionalists for their daughter's mutilation. The majority of the women of Hausa (98.8%) and other ethnic minorities (79.0%) patronised the traditionalists compared to their Yoruba (49.1%) and Igbo counterparts (48.3%) who reported the highest patronage of health professionals 50.3% and 51.1% respectively. Similarly, rural women patronised traditionalists (75.3%) for their daughter's mutilation more than their urban counterparts (60.1%). Though the majority of the women (63.4-89.6%), irrespective of education, patronised traditionalists, those with formal education had the lowest (55.0%) patronage for traditionalists and the highest (44.4%) for health professionals. The South West (72.3%) and South East women (51.1%) were the highest

patronisers of health professionals. The regional differences were further reflected in the component states. The Northern states including Bauchi, Nasarawa, Kaduna and Sokoto had the highest patronage for traditionalists (70.1- 100%), though some Southern states, especially Akwa Ibom (89.3%), Edo (68.8%), Ogun (58.4%) and Ebonyi (84.9%) also had high patronage. Oyo women (24.0%) had the lowest patronage of traditionalists for their daughters' mutilation.

Men's reports on their daughter's mutilation were also similar to women's mutilation statistics though with some exceptions (Table 35). The majority of the men regardless of age group engaged traditionalists to perform the mutilation for their daughters, except those in age groups 55-59 (52.3%) and 65-69 years (48.4%) with a lower proportion circumcising their daughters' using traditionalists but are highest users of health professionals: 47.7% and 51.6% respectively. A higher percentage of Muslim men (83.2%) compared to their Christian counterparts (62.6%) patronised traditionalists for their daughter's mutilation. The majority of the Hausa men (100%), other ethnic minorities (86.0%) and Yoruba ethnic background (70.4%) patronised the traditionalists compared to their Igbo counterparts (50.8%) who have the highest patronage of health professionals (44.2%). Though the majority of the men irrespective of education, patronised traditionalists, those with formal education had the lowest patronage for traditionalists (68.5%) and the highest (29.3%) for health professionals. The South East (45.1%) and South West men (42.8%) were the highest patronisers of health professionals. The regional differences are further reflected in the component states. The Northern states including Bauchi (100%), Nasarawa (100%), Kaduna (95.9%), Sokoto (100%) and FCT-Abuja (100%) had the highest patronage for traditionalists, though some Southern states, especially Akwa Ibom (91.0%), Edo (90.4%) and Ebonyi (76.5%) also had high patronage.

Table 35: Persons who performed daughter's mutilation

Background Characteristics	Women				Men			
Age	Traditional (%)	Health Professional (%)	Don't know (%)	Total (n)	Traditional (%)	Health Professional (%)	Don't know (%)	Total (n)
10 – 14	100	0.0	0.0	3	na	na	na	na
15 – 19	89.1	10.9	0.0	16	na	na	na	na
20 – 24	90.9	9.1	0.0	49	100	0.0	0.0	3
25 – 29	79.2	19.5	1.3	86	100	0.0	0.0	8
30 – 34	79.1	19.5	1.4	77	88.6	11.4	0.0	22
35 – 39	62.2	37.0	0.8	96	78.0	18.4	3.6	33
40 – 44	63.7	36.3	0.0	91	88.2	7.7	4.1	22
45 – 49	47.9	52.1	0.0	116	70.2	28.4	1.4	64
50 – 54	na	na	na	na	78.5	19.9	1.6	28
55 - 59	na	na	na	na	52.3	47.7	0.0	18
60 - 64	na	na	na	na	78.6	16.7	4.7	26
65 – 69	na	na	na	na	48.4	51.6	0.0	24
Religion								
Christianity	52.8	46.8	0.4	222	62.6	33.3	4.1	113
Islam	79.0	20.3	0.7	310	83.2	16.8	0.0	128
Traditional	100	0.0	0.0	2	100	0.0	0.0	7
Ethnic Group								

Igbo	48.3	51.1	0.6	123	50.8	44.2	5.0	66
Hausa	98.8	0.5	0.7	161	100	0.0	0.0	42
Yoruba	49.1	50.3	0.6	173	70.4	29.0	0.6	75
Others	79.0	21.0	0.0	76	86.0	12.7	1.3	66
Residence								
Urban	60.1	39.5	0.4	249	70.6	28.1	1.3	117
Rural	75.3	24.0	0.7	285	77.6	20.0	2.4	132
Marital Status								
Single (Never Married)	70.0	30.0	0.0	21	100	0.0	0.0	2
Married	67.6	31.8	0.6	457	75.0	23.0	2.0	237
Separated / Divorced	76.5	23.5	0.0	10	75.4	24.6	0.0	2
Cohabiting	100	0.0	0.0	4	0.0	0.0	0,0	0
Widowed	69.0	31.0	0.0	41	47.1	52.9	0.0	8
Education								
None	85.9	13.2	0.9	125	92.88	5.86	1.26	37
Islamic	100	0.0	0.0	60	100	0.0	0.0	17
Adult Education	88.0	12.0	0.0	14	100	0.0	0.0	1
Formal	55.0	44.4	0.6	334	68.5	29.3	2.2	195
Occupational Status								
Not Employed	87.1	12.9	0.0	130	70.4	24.0	5.6	10
Professional/Technical /Managerial	69.4	30.6	0.0	14	64.8	35.2	0.0	19
Clerical	56.7	42.5	0.8	243	0.0	100	0.0	3
Sales and Services	61.8	38.2	0.0	40	85.2	14.8	0.0	37
Skill Manual	70.7	27.4	1.9	62	68.7	27.4	3.9	48
Unskilled Manual	76.1	23.9	0.0	49	67.1	29.3	3.6	24
Agriculture	100	0.0	0.0	5	79.4	20.1	0.5	94
Domestic Work	15.6	84.4	0.0	3	0.0	0.0	0.0	0
Others	69.4	30.6	0.0	14	71.9	21.0	7.1	12
Zone								
North Central	79.9	20.1	0.0	104	80.0	20.0	0.0	63
North East	85.1	14.9	0.0	5	100	0.0	0.0	22
North West	98.8	0.5	0.7	162	96.8	0.0	3.2	28
South East	48.3	51.1	0.6	121	49.8	45.1	5.1	65
South-South	71.3	28.7	0.0	46	90.6	9.4	0.0	39
South West	26.5	72.3	1.2	95	55.8	42.8	1.4	32
State								
FCT-Abuja	67.9	32.1	0.0	0	100	0.0	0.0	1

Kwara	78.3	21.7	0.0	92	77.9	22.1	0.0	57
Nasarawa	92.0	8.0	0.0	12	100	0.0	0.0	6
Adamawa	0.0	100	0.0	1	0.0	0.0	0.0	0
Bauchi	100	0.0	0.0	5	100	0.0	0.0	22
Kaduna	100	0.0	0.0	64	95.9	0.0	4.1	22
Sokoto	98.0	0.8	1.2	98	100	0.0	0.0	7
Ebonyi	84.9	15.1	0.0	17	76.5	23.5	0.0	11
Imo	42.4	56.9	0.7	104	44.3	49.5	6.2	54
Akwa Ibom	89.3	10.7	0.0	6	91.0	9.0	0.0	10
Edo	68.8	31.2	0.0	40	90.4	9.6	0.0	29
Ogun	58.4	41.6	0.0	7	0.0	100	0.0	1
Oyo	24.0	74.8	1.2	88	58.0	40.5	1.5	31
Total	**68.2**	**31.2**	**0.6**	**534**	**74.3**	**23.8**	**1.9**	**249**

6.2.13 Decision About Daughter's Mutilation: Men's Report

Responding to the question on their daughter's mutilation, Figure 41 showed that about 30.6% of men claimed that the decision was taken by them. More than half (50.6%) reported that the decision was taken jointly with the girl's mother. Only a few of the respondents (10.7%) reported having solely taken the decision.

Irrespective of their age, a large proportion of the men (44.2-66.1%) except those in the age group 40-44 years (21.3%), reported that the decision was jointly taken with the girl's mother. About 24.2-45.8% of the men across all age groups solely took the decision (Table 36). Also, regardless of their religious background, both parents were largely involved in taking decisions on their daughter's mutilation. However, while more than half (56.3%) of Christian men reported that the decision was taken by both parents, a little above two-fifth reported the same among Muslim men (46.2%) and those of traditional religion (40.9%). Also, proportions of men reporting that the father was the sole decision maker on daughter mutilation were higher among Muslim (43.7%) and traditional men (35.5%) compared to their Christian counterparts (15.4%).

This is similar to the results based on ethnicity. By ethnic affiliations, more than half (50.1- 60.9%) of the men of Igbo, Yoruba, and other ethnic groups except the Hausas (34.0%) reported that both parents were involved in the decision-making. The father, as reported by 59.6% of the men, was the key decision maker on daughter's mutilation among the Hausas. Also, by region, more than half of the men reported both parents as the decision-makers in the North East (62.3%), South East (61.5%), South West (56.9%) and South-South (57.8%), unlike the North Central (46.1%) and North West (9.9%) where the father was the decision maker, 40.2% and 74.1% respectively.

Figure 41: Decision maker on Daughter's Mutilation

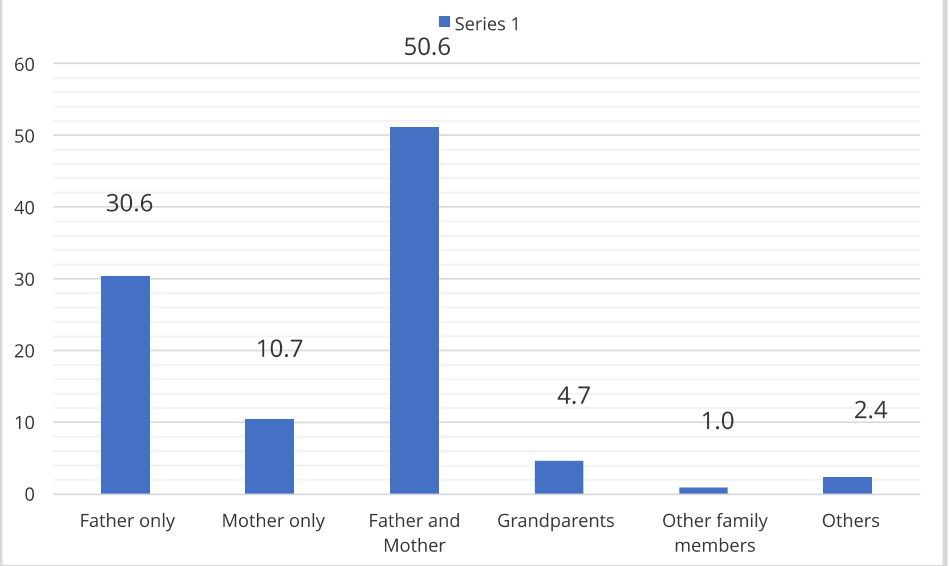


Table 36: Decision maker on the Daughter's Mutilation: Men's Report

Back ground Characteristics	Father (%)	Mother (%)	Father and Mother (%)	Grand Parents (%)	Other family members (%)	Others (%)	Total (n)
Age							
20 -24	29.0	0.0	45.4	0.0	25.6	0.0	3
25 -29	25.2	0.0	64.6	0.0	0.0	10.2	8
30 -34	45.8	10.5	43.7	0.0	0.0	0.0	22
35 -39	25.4	5.7	66.1	2.8	0.0	0.0	33
40 -44	42.0	13.1	21.3	19.5	0.0	4.1	22
45 -49	26.1	8.4	52.4	10.1	1.4	1.6	64
50 -54	37.2	8.4	50.8	0.0	0.0	3.6	28
55-59	24.2	9.0	57.6	0.0	0.0	9.2	18
60 -64	40.0	13.9	44.2	0.0	0.0	1.9	26
65 and above	14.4	27.6	55.3	0.0	2.7	0.0	24
Religion							
Christianity	15.4	19.4	56.3	4.3	0.6	4.0	113
Islam	43.7	3.0	46.2	5.4	0.7	1.0	128
Traditional Religion	35.5	11.8	40.9	0.0	11.8	0.0	7
Ethnic Group							
Igbo	14.1	24.0	60.9	0.0	0.0	1.0	66
Hausa	59.6	0.0	34.0	6.4	0.0	0.0	42
Yoruba	35.6	4.6	51.1	8.7	0.0	0.0	75
Others	22.8	11.2	50.5	3.8	3.7	8.0	66
Residence							
Urban	31.4	10.1	50.2	4.3	0.5	3.5	117
Rural	29.9	11.3	51.0	5.1	1.3	1.4	132
Zone							
North Central	40.2	7.1	46.1	3.9	1.4	1.3	63
North East	37.7	0.0	62.3	0.0	0.0	0.0	22
North West	74.1	0.0	9.9	12.9	0.0	3.1	28
South East	14.2	23.3	61.5	0.0	0.0	1.0	65
South South	9.7	15.3	57.8	4.3	3.9	9.0	39
South West	26.9	3.9	56.9	12.3	0.0	0.0	32
State							
FCT- Abuja	100	0.0	0.0	0.0	0.0	0.0	0
Kwara	42.4	3.9	50.9	2.8	0.0	0.0	57
Nasarawa	15.7	39.4	0.0	14.7	15.7	14.5	6
Adamawa	0.0	0.0	0.0	0.0	0.0	0.0	0
Bauchi	37.7	0.0	62.3	0.0	0.0	0.0	22

Kaduna	82.4	0.0	9.1	4.4	0.0	4.1	22
Sokoto	46.7	0.0	12.5	40.8	0.0	0.0	7
Ebonyi	47.5	26.7	25.8	0.0	0.0	0.0	11
Imo	7.5	22.5	68.8	0.0	0.0	1.2	54
Akwa Ibom	0.0	13.3	76.4	0.0	0.0	10.3	10
Edo	13.0	15.9	51.5	5.8	5.2	8.6	29
Ogun	0.0	100	0.0	0.0	0.0	0.0	1
Oyo	28.0	0.0	59.2	12.8	0.0	0.0	31
Total	**30.6**	**10.7**	**50.6**	**4.7**	**1.0**	**2.4**	**249**

6.2.14 Reasons for Female Mutilation

In Figure 42, about half (51.0%) of the women believed that FGM is for other reasons they choose not to mention. Whereas 36.9% of the women believed that FGM could prevent promiscuity while some others perceived that it was to remove genital impurity (10.4%). Less than 10% of the women related it to taboo (3.8%) or religious requirements (5.2%).

Results as shown in Table 37 revealed that the majority of the Muslim women (54.0%), and women of the traditional religions (71.9%) linked FGM to other reasons. For Christian women, FGM could be associated with other reasons (48.0%) and the need to prevent promiscuity (42.3%). By implication, a smaller proportion of the Muslim (31.1%) and Traditional women (23.7%) associated FGM with the prevention of promiscuity. A larger proportion of Igbo (65.4%) and Yoruba women (60.0%) believed that FGM could prevent promiscuity, unlike the Hausa women (20.3%) and other ethnic minorities (24.6%) who largely believed that FGM had some other reasons behind it. The respondents' perceived reasons for FGM were relatively similar across the rural-urban residence and educational status.

The proportion of women justifying FGM to prevent promiscuity was higher in Southern regions, especially in the South East (70.8%), South West (53.9%) and South-South (34.9%), unlike the Northern regions (8.6-22.6%), except the North Central (41.4%). In addition, ahigher proportion (23.1%) of North Western and South Eastern women (12.0%) compared to other regions (less than 10%) believed that FGM could remove genital impurity, while a higher proportion (15.5%) of South-South women associated FGM to religious requirement, unlike other regions (less than 5%) except North West – 7.8%). At the state levels, the majority of the respondents from Imo (81.0%), Oyo (74.9%), Kwara (65.7%) and Ebonyi (54.3%) with a smaller proportion in Edo (42.2%) considered FGM as a way of preventing promiscuity, unlike the women from other states (5.6-28.2%). The majority of the women in states attached lesser importance to the belief that FGM could prevent promiscuity.

Figure 42: Reasons for female mutilation

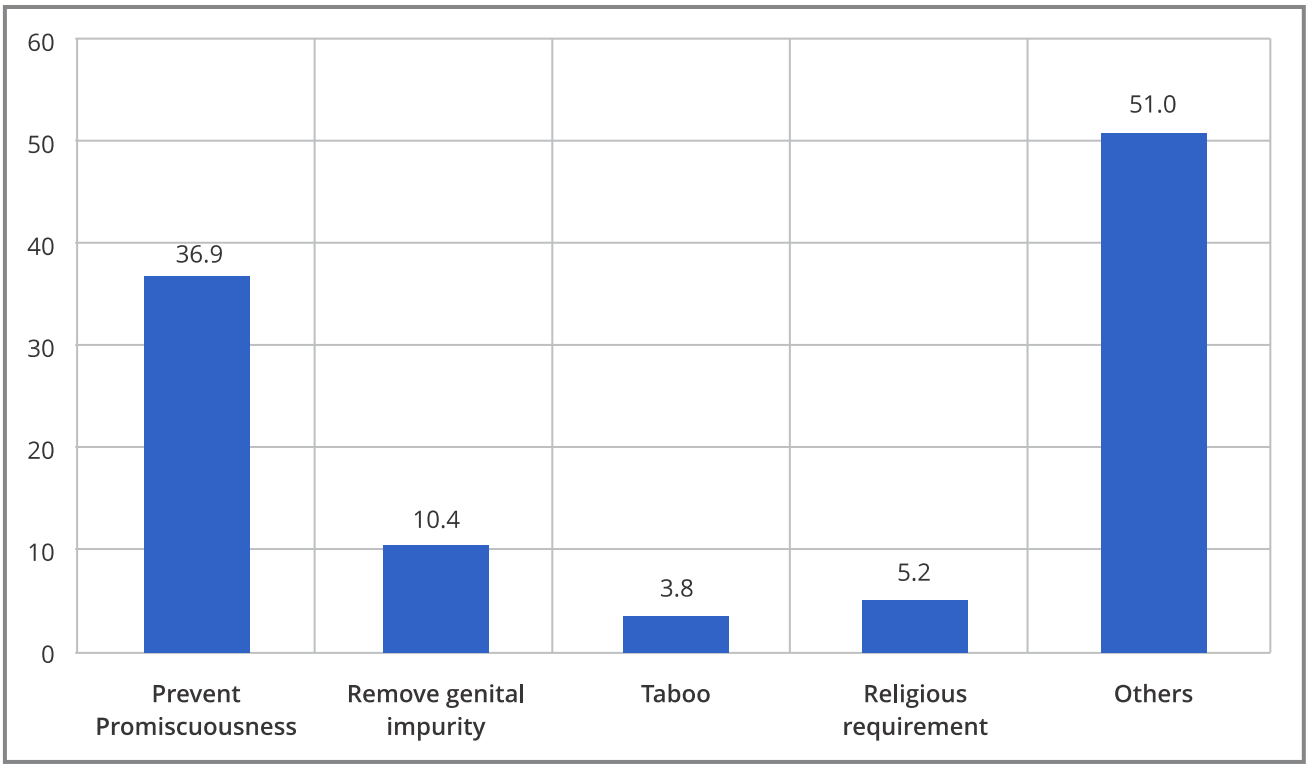


Table 37: Reasons for Female Mutilation: Women's Report

Background Characteristics	Prevent promiscuity	Remove genital impurity	Taboo	Religious requirement	Others	Total
Religion						
Christianity	42.3	7.0	4.1	5.0	48.0	3,720
Islam	31.1	14.2	3.4	5.5	54.0	2,618
Traditional Religion	23.7	4.5	0.0	4.6	71.9	15
Ethnic Group						
Igbo	65.4	10.9	4.9	0.9	30.3	1,173
Hausa	20.3	20.2	3.4	7.7	57.8	1,349
Yoruba	60.0	7.6	5.7	1.8	31.4	1,239
Others	24.6	5.0	2.4	7.1	65.2	2,592
Residence						
Urban	44.9	10.5	4.8	3.9	45.0	2,430
Rural	31.5	10.4	3.0	6.2	54.9	3,923
Education						
None	28.6	13.7	3.3	5.5	57.7	1,373
Islamic	18.5	24.4	1.1	12.1	51.9	523
Adult Education	44.2	6.9	0.8	7.2	41.0	99
Formal	41.4	7.9	4.3	4.3	49.0	4,486
Zone						
North Central	41.4	6.8	5.2	4.3	49.8	1,436

North East	8.6	0.5	4.2	0.5	86.2	1,009
North West	22.6	23.1	1.2	7.8	55.8	924
South East	70.8	12.0	4.8	1.0	25.4	1,052
South South	34.9	5.4	2.1	15.5	47.2	964
South West	53.9	6.9	6.2	0.9	37.5	968
State						
FCT-Abuja	11.4	2.9	16.1	0.0	70.3	460
Kwara	65.7	9.4	3.5	5.6	24.3	501
Nasarawa	21.2	4.9	4.4	4.0	73.7	475
Adamawa	13.2	0.3	8.8	1.4	76.5	498
Bauchi	5.6	0.7	1.1	0.0	92.6	511
Kaduna	21.8	8.9	1.3	1.4	71.3	413
Sokoto	23.9	44.9	1.1	17.6	32.0	511
Ebonyi	54.3	6.7	0.3	0.5	41.8	530
Imo	81.0	15.2	7.6	1.4	15.3	522
Akwa Ibom	28.2	7.5	0.7	22.7	45.9	461
Edo	42.2	3.1	3.6	7.6	48.6	503
Ogun	26.8	7.4	3.3	0.9	63.7	454
Oyo	74.9	6.6	8.5	1.0	17.3	514
Total	**36.9**	**10.4**	**3.8**	**5.2**	**51.0**	**6,352**

Note: Multiple Responses, Yes answers only are recorded in the table

Evidence from the qualitative findings further affirmed the ideology that uncircumcised women are prone to promiscuity and other forms of sexual immoralities due to uncontrollable sexual arousals or desires. In affirming this position, a female opinion leader in Akwa Ibom, for instance, espoused that a stop to FGM practice portends some dangers for women of reproductive age. In her opinion, the practice is beneficial for reproductive purposes and the sexuality of the girl child. Stopping the practice was regarded as wickedness on the part of society. In advancing a causal direction, a perpetrator of FGM in Akwa Ibom (see box 6.14) avowed that female genital mutilation helps in vaginal child delivery while stopping the practice is increasing the cases of caesarean section in the hospitals known to her. She further hypothesised that females without FGM could become promiscuous in their sexually active years.

In communities where FGM practice is highly rated and considered a virtue, living as an uncircumcised woman would attract neglect, labelling, and other forms of stigma. Some women would remain unmarried.

6.2.15 Current Practice of FGM Compared to Five Years Ago

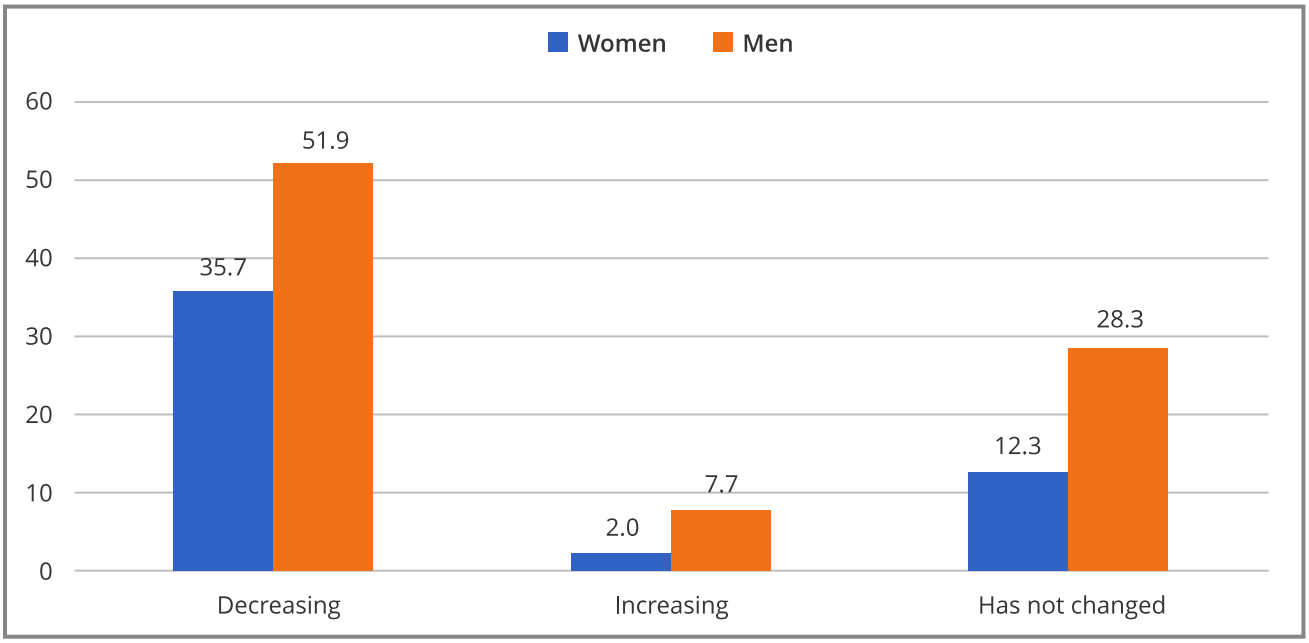
As shown in Figure 43, the majority of the respondents, men (51.9%) and women (35.7%), opined that the practice of FGM is declining while 28.3% and 12.3% respectively, believed that the practice has not changed. Overall, only about 7.7% believed that FGM practice is still on the increase.

Examining the responses of the study participants by some background characteristics in Appendix 6.13, a larger proportion of Christian respondents (women=42.8%; men=65.3%) believed that the practice is declining, compared to their Muslim counterparts (women=28.2%; men=38.6%), while those of Traditional religion had mixed opinions (13.7% versus 77.9%).

Box 6.14: FGD Excerpt

The idea of stopping FGM is wickedness to the girl child. A grown-up female that is not mutilated, anytime she sees a man, the sexual urge comes on, and this does not allow them to stay put in their husband's house, and gives them difficult childbirth, leads to Caesarean section or child death. It has also led to females sleeping with females (lesbianism). **FGD with female opinion leaders, Akwa Ibom State.**

Figure 43: Current practice of FGM compared to five years ago



Similarly, examining the ethnic variations, about three-quarters of Igbo men (74.0%) and women (70.8%) and over half of the Yoruba counterparts (Women 53.9%; Men 50.09%) opined that FGM is declining. Hausas had the lowest proportion (Women 19.4; Men 23.2%) sharing similar opinions.

A large proportion of the women (48.2-78.1%) and men (40.3-75.2%) from Southern Nigeria agree that FGM practice is decreasing unlike the Northern women (2.1-28.8%) and men (0.0- 22.3%) except the North Central men (58.4%). While a small proportion (1.9-21.9%) of women across the regions believed that nothing has changed, a larger proportion of men agreed withthe constant state of things, especially those from the North East (66.5%) and North West (61.9%). These are also reflected in the state estimates. Only the Southern states – Ebonyi (70.2%), Imo (83.0%), Oyo (65.7%), Akwa Ibom (48.0%) and Edo (45.7%) –except Ogun state (25.6%), which had a higher proportion of women believing that there has been a decline in the practice. The proportions believing that things have remained the same are highest in Sokoto (34.4%), Nasarawa (25.9%) and Adamawa (23.7%).

6.2.16 Factors Promoting the Decline in FGM

Investigating the respondents' opinions about what they think is contributing to the decline in FGM (Figure 44), about two-fifths of the women associated the decline with government policies (41.6%) and female education (37.8%) while some arrogated the decline to media advocacy and enlightenment programmes on FGM (25.5%), NGOs' advocacy and intervention (18.2%), female empowerment (12.7%) and religious intervention (10.2%). Less than 10% attributed the decline to other reasons including traditional leaders' intervention and others.

Evidence from other FGDs and KIIs across the regions affirmed that the practice has reduced drastically due to sensitisation and a growing understanding of the associated harm. The low premium placed on the marriageability of uncircumcised women is changing as revealed in other FGDs in Akwa Ibom. Narrating the changing premium on the FGM, a female participant in one of the FGDs in Akwa- Ibom (see Box 6.15) described how mutilation used to be a determinant in valuing the worthiness of a woman for marriage within the community.

Advocacy campaigns against FGM (See Box 6.15) are making positive impacts across communities. The majority of the female participants also recounted factors such as exposure to western cultural values, education, women's financial independence through breadwinning and migration from rural to urban areas. The narratives captured how the efforts of CBOs and NGOs are complementing what government agencies are doing in changing the practice across communities in the country.

From another complementing stance, excerpts from the FGDs with NGOs in Abuja (See Box 6.16) also affirmed how some married men are complaining about the negative effects of FGM on sexual pleasures. To these men, women that are mutilated are less sexually satisfying thereby making some men try other women that have not been mutilated. In espousing this view further, some of the participants claimed that such womenwhose partners were less satisfied with them sexually could be emotionally traumatised and dissatisfied as well with their sexual lives.

A common consensus among the participants was that FGM does more harm to women's sexuality than the social good of controlling their sexual desires. Some of the participants affirmed that the practice has led to the reduction of sexual urge among women and this created lot of issues in marriages. The negative impact of female genital mutilation on the response of women to sexual obligations within marriage is emphasised.

The government was not left out of the change process and campaigns around the need to stop FGM. Participants across the regions recounted efforts at addressing the challenge through legal framework and regulations of the practice. It was noted that the government have been playing active roles in the sensitisation and mobilisation of law enforcement agencies in the prevention and possible prosecution of perpetrators of FGM.

6.2.17 Opinions about Stopping FGM

As shown in Appendix 6.11, more than two-thirds of the women (67.4%) and over half of the men (54.5%) supported that FGM should be stopped. About one-quarter (24.8%) could not say whether or not it should be stopped (table not shown). Only 7.8% of the women and

Box 6.15: FGD Excerpts

For people that are out of the community, it's not happening, but, right in communities like where I come from in Cross river state, I mean it's a norm. I was mutilated. So, it's a norm that even you as a girl, if you are not mutilated, I mean, you are not supposed...you shouldn't even be married, you are not fit. There is a way they call it in my dialect, the man says, just go and cut this thing so I can have access. **FGD with service providers in Akwa Ibom State**

I think over the years now NGOs and CBOs especially gender-based NGOs have been working round the clock to enlighten families' and communities on the practice of FGM. What it means, the dangers of it and why they should abstain from such practices. So, I think they have done so much work that a lot of families are now aware of the disadvantages of doing such practices or engaging in such practices. **FGD with NGOs in Kaduna**

Figure 44: Factors promoting the decline in FGM

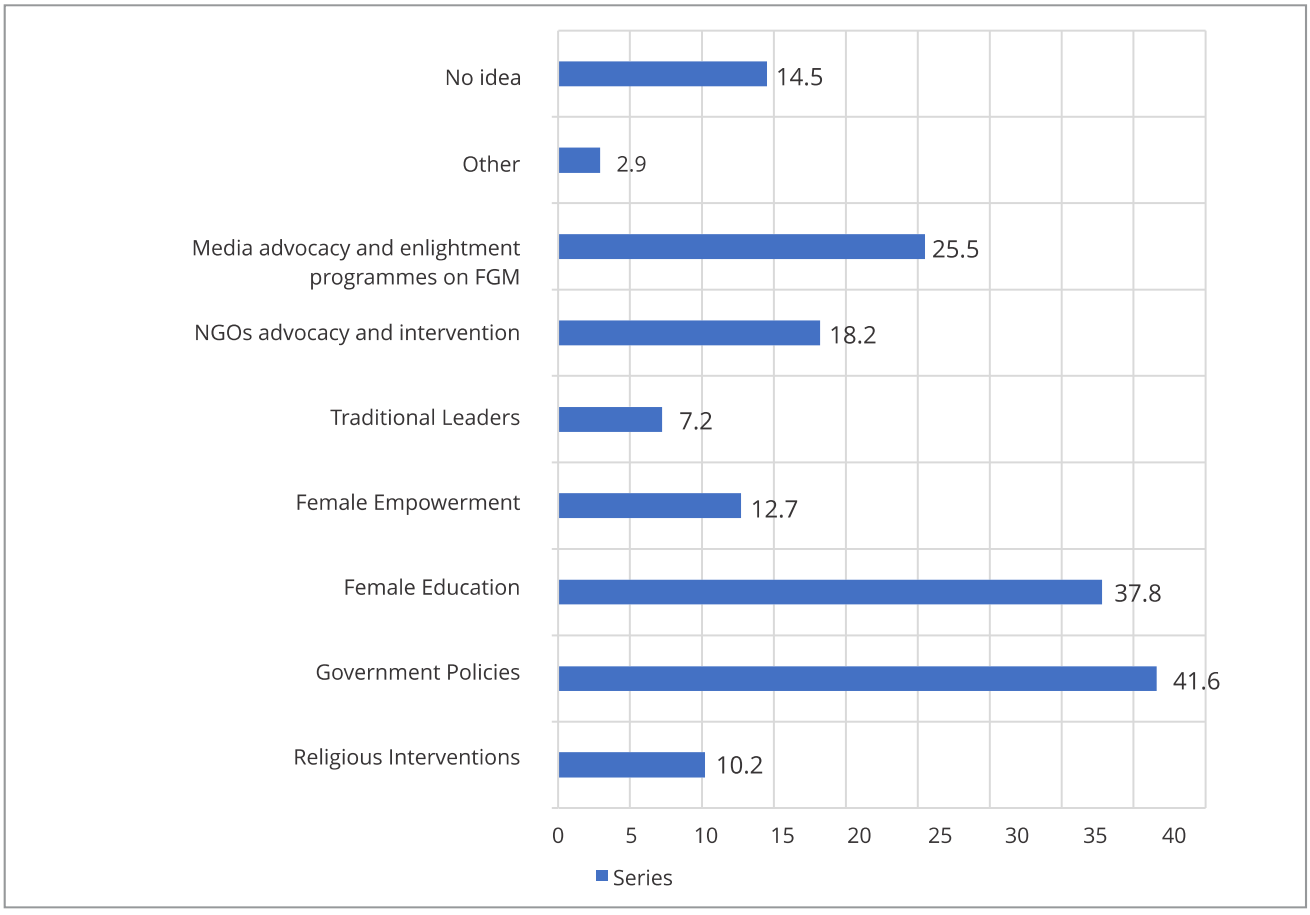
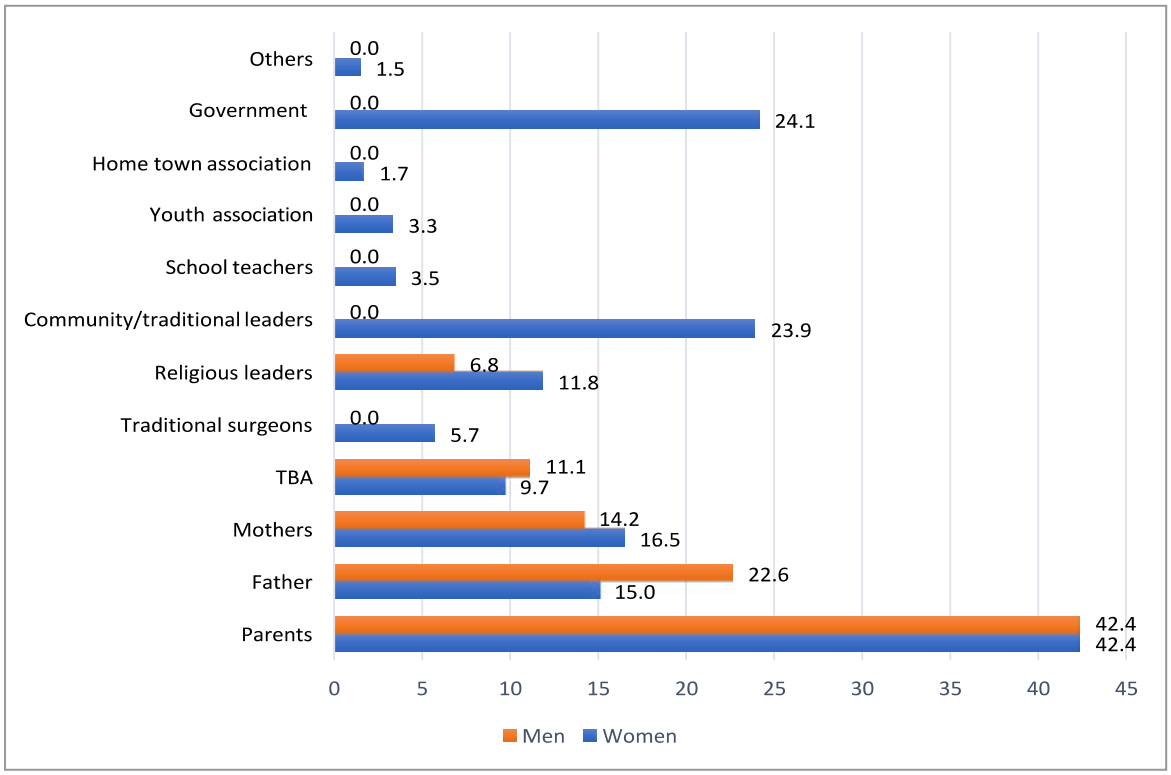


Figure 45: Agents to stop FGM practice



Box 6.16: FGD Excerpts

Majority of people that call me are men and they are not finding it funny. They don't like it, one, the wife is experiencing pain during sex and then, they themselves they feel they don't enjoy it. **FGD with NGO, FCT Abuja**

...if they remove their clitoris, it affects their sexuality when they marry. When I was in the university, I have a girlfriend, she was mutilated. I find out that any girl is mutilated, when they get to adulthood, they will always find it difficult to reach orgasm. **FGD with married men, Ogun State**

28.0% of men opined that it should continue. Irrespective of the various background characteristics, a larger proportion of the men and women were in support of ending the FGM practice.

6.2.18 Agents to Stop FGM

More than two-fifths (42.4%) of the respondents (men and women) believed that parents are key in putting a stop to FGM (Figure 45). While a smaller proportion of the women opined that stopping FGM is the work of the government (24.1%), community/traditional leaders (23.9%), mothers (16.5%), fathers (15.0%) and religious leaders (11.8%), men only agreed to the role of fathers (22.6%) and mother (14.2%) in stopping the practice. Less than 10% of the respondents thought TBA, traditional surgeons, and schoolteachers should be involved in the efforts to stop the practice.

More findings around what critical stakeholders are doing in addressing FGM practices across the communities were explored further. Probes in this direction provided more insights into what has been occurring, what worked, lessons learnt and programmatic actions that could be taken in sustaining existing gains and addressing recurring challenges. The contributions and activities of health facilities, CBOs/NGOs, community leaders and members were cited and described further in terms of what roles are traceable to these stakeholders in their actions or inactions about FGM practices.

Awareness creation and campaigns against FGM were the major actions and activities that were credited to the NGOs/CBOs/CSOs/FBOs in the communities where they operate. Not all the communities have the presence of NGOs/CBOs, but nearly all mentioned the presence of a faith-based organisation. The latter was mentioned across all the communities irrespective of size and state of development.

In contrast, NGOs were found in urban communities, where they operate mainly with a spread of some of their activities to remote locations and rural areas depending on funding. Efforts of these various organisations, including those that are CBOs were noted and echoed as they have been doing a lot concerning female genital mutilation. The awareness creation efforts revolve around conversing with community leaders and

members on the disadvantages of FGM to the girl-child, homes, and the community. The central message was the urgent need to desist from the practice and embrace evidence showing the devastating consequences of FGM on womanhood and reproductive health outcomes.

The need for frameworks that could facilitate the effective enforcement of existing laws also emerged as a possible reaction to FGM. Some laws are already in place, as alluded to in one of the interviews. However, such laws must be well implemented, and the penalties carefully applied against perpetrators. Furthermore, the action of the government to reduce and eradicate female genital mutilation can never be over-emphasised. The government is mobilising resources to reach out to villages and target health workers and traditional birth attendants on the need to desist from the practice of FGM. Culprits or perpetrators of FGMs are getting to know more about the consequences of FGM and the position of the law if caught in the act.

Given the findings, governmental agencies, non-governmental organisations, and traditional and religious leaders are working collectively in putting an end to the practice of female genital mutilation. These initiatives were commended; however, inadequate feedback and lack of constant interactions with community members were reportedly non-existent. One of the interviewees argued that enforcement and implementation of laws would be more effective when timely feedback is received to modify the process and the laws.

6.2.19 Domesticating Violence Against Persons Act as an Approach to Addressing FGM

A consensus from the qualitative findings was that addressing FGM practices would require concerted efforts across all stakeholders. Such efforts cannot be overemphasised if existing gains must be sustained and expanded into other communities where the practice is still in vogue.

Domestication of VAPP acts is required across all States and regions. The government, over time, has partnered with various international and local organisations in the fight against violations of child's rights and forced labour in the society. The Nigerian government is a signatory without reservation to the convention on child rights. Also, the Child Rights Act was passed into law in 2003 by the national government, thereby giving the legal framework on which prosecution can be made against offenders of child rights, of which FGM is a part.

As such, the findings revealed that the existence of these laws at the international, national and local levels should make efforts at addressing FGM less challenging. However, sensitivity to variations in religious beliefs and ethnic diversities is required.

6.2.20 Agents Likely to Oppose the End of FGM

Male and female gatekeepers, traditional leaders, religious leaders, politicians and opinion leaders could serve both as agents of change and/or inhibitors of change. It is important to work with these groups to bring about the required gender transformative changes in local communities, and in particular, to bring an end to the practice of FGM. Hence, those listed as potential opposers to ending FGM include traditional surgeons (16.3%), community/traditional leaders (14.5%), and TBAs (15.7%).

6.3 Scarification

Scarification was not a common practice in Nigeria, and the practice has declined to some extent where it exists. As shown in Appendix 6.15, less than 10% of the women (7.4%), their relatives (6.0%) and neighbours (5.9%) experienced scarification while less than 5% of other acquaintances had the experience.

As shown in Appendix 6.15, the above pattern for women was consistent across age groups, except among those of the age group 40-44 years (11.3%). Similarly, less than 10% of the women's relatives or neighbours, and less than 5% of their daughters, sisters, mothers, cousins, friends and colleagues had the experience.

The practice of scarification was more pronounced among the respondents of traditional religion (18.2%) compared to Islam (10.8%) and Christianity (4.2%). A similar pattern was reported for their mother and relatives. The practice was higher in the North Central and North East, as high as 11.5% and 17.2%, respectively, compared to other regions with about 5% prevalence. Examining the ethnic variations, the practice was associated with Yoruba (9.3%), Hausa (7.7%) as well as other ethnic minorities (7.3%). The men's report also followed a similar pattern (Appendix 6.16).

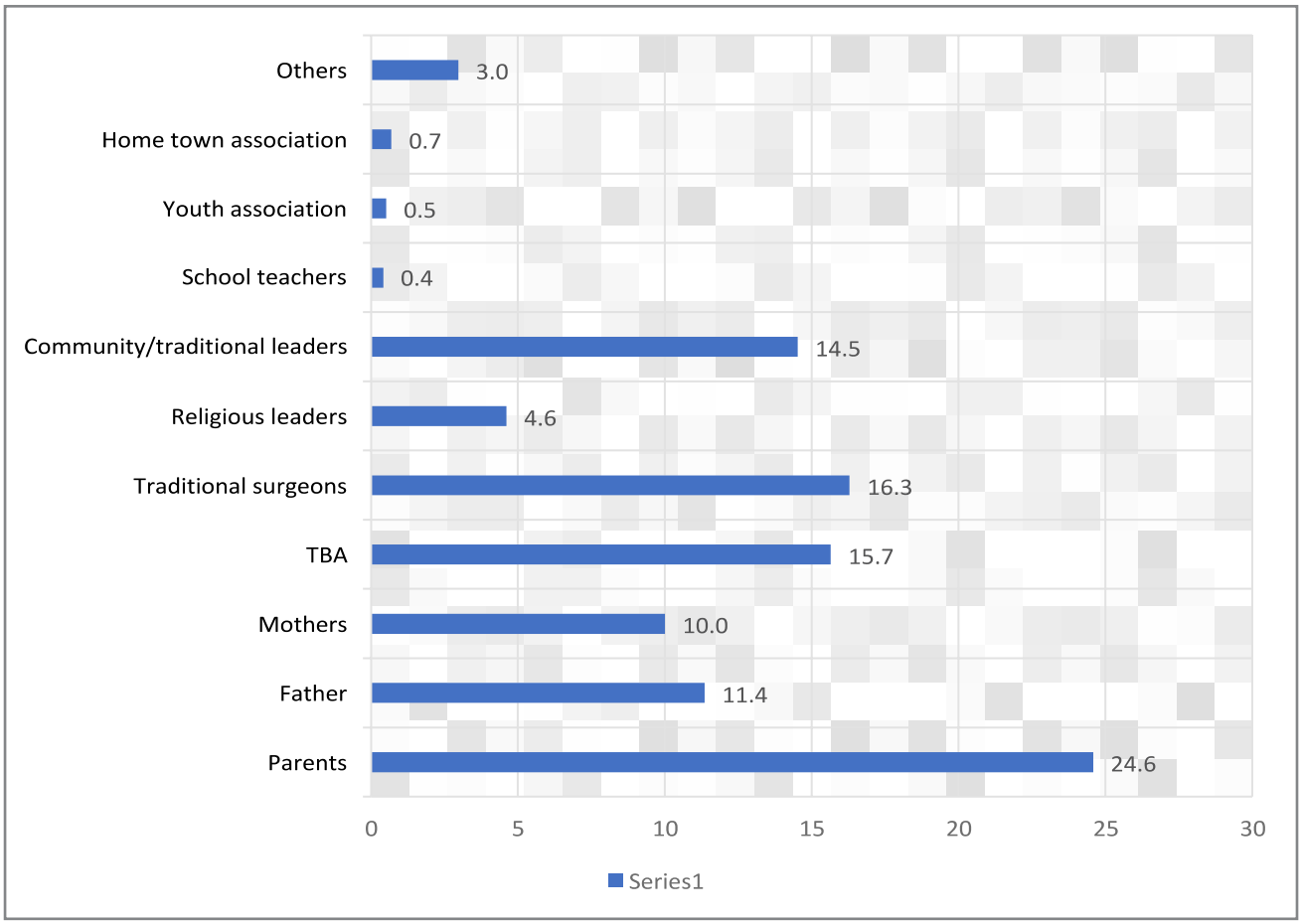
6.4 Virginity Test

The virginity test was not a common traditional practice in Nigeria, as shown in Appendix 6.13b. The results by gender showed that less than 5% of the women or any of their acquaintances had the experience. The pattern was similar, irrespective of the women's age, religion, ethnic affiliation, educational status, place of residence, region and state. Men's reports also followed a similar pattern.

6.5 Widowhood Rites (Women)

Widowhood rites are quite uncommon in Nigeria. Irrespective of their background characteristics, a very small proportion (less than 5%) of the women had

Figure 46: Agents likely to oppose stopping of FGM



experienced widowhood rites (Appendix 6.14). A similar proportion of their relatives, friends, neighbours and mothers had the experience. However, none of the respondents' daughters had ever experienced widowhood rites. Similarly, though none of the men experienced widowhood rites, about 5% of them reported that their mother, relatives, neighbours and other acquaintances had the experience. Across the regions, North Central women reported the highest (14.6%) incidence of widowhood rites, followed by the North West (11.6%), South West (8.6%), South East (5.4%) and South-South (5.7%), while North East has the lowest incidence (3.8%).

6.6 Witchcraft Burning and Accusation

The practice of witchcraft burning (burning of persons identified as witches) and accusation is extremely minimal among young and middle-aged women in Nigeria, with less than 1% of the women in this study reporting the experience (Appendix 6.14). However, though this practice seems uncommon, some of the respondents both female (3.1%) and male (3.7%), reported that their neighbours were survivors of witchcraft hunting. Across the regions, North West women reported the highest (8.1%) cases of witchcraft burning, followed by the North East (7.9%), North Central (3.8%), unlike in the South, with less than 2% in all incidence across the 3 regions.

6.7 Discrimination Against Vulnerable People (e.g., Persons with Disabilities)

Across the study sites, KIIs were conducted among PWDs to understand their specific experiences of SGBV and various strategies employed to cope. Thus, they were asked questions regarding their social interaction with members of their respective communities. Regarding social relationships, this study found that various categories of PWD described their experiences with community members as unpleasant including their experiences with the immediate members of their families. They noted that more often than not, PWDs are disrespected, neglected and regarded as inferior to others in the society. The interviewees further noted that women with disabilities are particularly disadvantaged as they are looked down upon irrespective of their academic attainment and regarded as beggars.

PWDs have untold stories of their maltreatments in their various communities, including within families. They lamented that society members relate with them as outcasts. A PWD from the Federal Capital Territory, Abuja noted that Article 22 of the Disability Act safeguards the

right of PWD to have privacy and own their own families. However, she exclaimed that the reality differs from what exists in the books, and importantly in the area of marital relationships with PWDs. For instance, unless the person without a disability understands sign language, without which a union or relationship understanding it becomes a challenge. However, due to negative societal perceptions about intimate relationships between PWDs and persons with no disability, to overcome this discrimination, persons with disability marry their peers to avoid derision and ridicule in their communities. However, at other times, some men merely impregnated ladies with disability and abandoned them. Irrespective of the pendulum, most parents would do everything they could to stop their children from marrying PWDs because they believed PWDs are cursed by the gods. This negative societal attitude could be invoked even when such disability appeared minimal (see Box 6.17).

A male interviewee from Oyo State introduced a regional dimension to this discussion. He argued that PWDs are somewhat more acceptable in the northern parts of Nigeria. Hence, it does not matter who marries them. From his experience, many deaf persons in the Northern region have entered marriage with persons without hearing problems. For him, what counts for such support includes family support and orientation on what disability entails and the support needed for PWDs to function properly.

A woman from Oyo State argued that the gender and socio-economic status of a PWD count in terms of disposition and support that is provided in establishing marital unions. From the general discussions, the PWD males tend to attract more support, and enjoy a more positive disposition from family members and the society in entering marriage, whether such union is with a PWD or otherwise. The argument was that males with disability are believed to be stronger and would be able to cope with marital roles compared to their female counterparts. The society also believes that wealthy PWDs that are males would be able to cope easily and should be encouraged to marry and procreate than those who are females. Such wealthy PWDs are rich enough to purchase supportive infrastructures, including nannies, and gadgets that would make living less challenging and life more comfortable for them. The reverse is what obtains for wealthy females living with a disability. The proportion of females in this category is rare. However, those that are rich might find suitors and willing sexual partners, but such suitors are likely to swindle them of their wealth or resources than marry them. A central point of view is that women find it more difficult to play their 'wifely' roles if they are with a disability. For example, the issue of pregnancy became a bone of contention. “How will she carry the pregnancy to term?”

Box 6.17: KII Excerpts

I wanted to marry a lady despite her hearing problems. But to my surprise, her parents refused the proposal bluntly - because they think I would abandon her along the way. The parents fought the girl seriously to the point that they cursed her. At that point, I did not have any option than to leave the girl. So, the society does not see or imagine a person with no disability, marrying a PWD. In many cases, it is unacceptable. **KII with Male PWD in Ebonyi.**

6.8 Wife Inheritance Traditions

Wife inheritance is a social and cultural practice whereby a woman who lost her husband by death is expected to marry a relative of her deceased husband. The result in Appendix 6.18 revealed that the tradition was not widely practised within the country as many of the respondents declined that they had ever experienced or seen such occurrence among their friends, family and other acquaintances. However, about 5.9% of women who were widows affirmed that they were inherited after the death of their spouse (Appendix 6.17). About 5.2% and 5.0% of the widows also reported that their relatives and neighbours respectively were inherited after the death of their spouse. More so, about 5.1% and 3.8% of older women (age 40–44 and 45–49), respectively, reported the practice of wife inheritance among neighbours.

6.9 Surrogate Marriage

The data presented in Appendix 6.13b further reveals that surrogate marriage has not been widely accepted across the country, as only 0.2% and 0.7% of the female respondents affirmed that they and their neighbours respectively are into surrogate marriage.

6.10 Child Marriage: Key Findings and Recommendations Key findings

- Women of the Islamic religion, Hausa ethnic group, and those dwelling in rural residences were more likely to experience child marriage compared to women of other religions and ethnic groups. Child marriage experiences were more pronounced among women of Islamic religion (43.3%) and Hausas (55.3%).
- The most common age at marriage for women in Nigeria is between ages 20-21 years (26.2%), with about one-quarter reporting age 15-17 (23.4%).
- Most women (88.2%) and men (84.6%) reported that the girls' partners are a few years older than the girls.
- The need to prevent pre-marital sex (44.8%) was the commonest reason for child marriage at state and regional levels where the practice is high.

- Over half (55.4%) of the women believed that child marriage has negative consequences while about 46.9% of the men believed the same
- Poverty, parents' desire to enjoy financial and social privileges account for most cases of child marriage in the Northern States of Nigeria
- Critical stakeholders who could change the narratives on girl-child marriage include religious leaders, community leaders, NGOs and relevant government departments and Agencies.
- Recommendations
- A multi-sectoral approach is needed to address the sustained practice of child marriage in Nigeria, especially in states that are in the northern part.
- The consequences of early child marriage are gradually unsettling the reasons or factors that are promoting the practice across the states in Nigeria. The findings from the quantitative and qualitative components revealed that both men and women shared the view that there are no justifications for communities and parents to continue with the practice.
- More social campaigns illustrating the long-term consequences of early girl child marriage could help influence parents and other key perpetrators of child marriage to delay the pressure to satisfy immediate needs. More social campaigns would be needed in rural communities and communities where the proportion of households with low or poor wealth quintiles are high.
- Targeted households can be supported to ensure that their adolescents are educated to complete secondary school education and entrepreneurship skills.

6.11 Forced Marriage: Key Findings and Recommendations

a. Key findings

- Overall, less than 5% of the women and none men experienced forced marriage. However, about 5.3% of the women and men reported that a neighbour experienced child marriage.
- Considering the variations across the selected background characteristics, the prevalence of forced marriage was less than 10% irrespective of age, religion, ethnic affiliation, place of residence, educational status, region of residence and wealth quintile.

b. Recommendations

- A holistic implementation of the Violence against Persons Acts across states in Nigeria will be useful in instilling fear and curbing the social pressure that motivates the practice of forced marriage.
- Using traditional and social media, more enlightenment campaigns on HPs are expected from the Ministries of Women Affairs both at the Federal and State levels, and the National Orientation Agency.

6.12 Female Genital Mutilation: Key Findings and Recommendations

a. Key Findings

- FGM practice is an age long practice, and the social forces and values promoting it are changing even in communities where it still exists.
- The prevalence of FGM is 39.7% with 14.6% of the women having experienced FGM while about 5.4% of them reported the same experience for their daughters, and less than 5% reported the same for someone else close to them.
- The most common type of female mutilation was the removal of flesh (reported by 25.6% of women and 20.5% of men) and removal of the clitoris only (26.3% and 61.9% of women and men respectively).
- Parents are the major decision makers (31.6%), in some cases the mother (21.4%) or the father (16.0%) solely took the decision
- Both men and women are coming to terms to accept that FGM affects women's and men's sense of sexual satisfaction with their partners/spouses.
- Social campaigns by the government, NGOs and other stakeholders around the harm of FGM are yielding positive results as more people are appreciating the need to end the practice.

b. Recommendations:

- More social campaigns are needed to sustain existing gains and enlighten those who still hold on to the practice of childhood marriage.
- A cohort analysis of the Nigerian National Demographic and Health Survey between 2009 and 2018 reported a drastic reduction from 40.1% prevalence among the oldest birth cohort to 3.6% among the younger cohort (Gbadebo, Salawu, Afolabi, Salawu, Fagbamigbe & Adebowale, 2021). More social campaigns by the government, NGOs and other stakeholders around the harm of FGM are yielding positive results as more people are appreciating the need to end the practice.

OBSTETRIC FISTULA

KEY FINDINGS

- **Awareness of obstetric fistula:** Only 25.5% of the women and 24.6% of the men have heard of obstetric fistula (OF) and the main sources of their information were traditional media (radio and television etc).
- **Knowledge of causes and factors contributing to obstetric fistula:** Among those aware of OF, 52.5% of the women and 33.0% of the men identified prolonged obstructed labour as the cause of OF. Early marriage and early onset of childbearing were mentioned as contributing to OF by 68.5% of the women and 63.9% of the men while 68.9% and 74.0% of the women and men respectively identified lack of access to emergency obstetric services as a factor.
- **Perception of the prevalence of obstetric fistula in their communities:** only a fifth of both male and female respondents mentioned that they have ever heard of OF in their communities. Approximately 60% of the respondents and 25% of both the male and female respondents said that OF does not exist and is very rare in their communities. More than half were not sure whether the trend is on the rise or declining.
- **Prevalence of Obstetric Fistula:** The prevalence of leaking urine among the female respondents reported, was 0.24% (CI 0.09 – 0.31)
- **Availability of rehabilitation centres:** Only 10.5% of female respondents and 11.5% of male respondents were aware of the availability of treatment and rehabilitation centres for VVF
- **Consequences of Obstetric Fistula:** Stigma and the resultant ostracisation were the main problems highlighted

One of the major underlying determinants of obstetric fistula is early marriage, which has been identified as a form of SGBV. Despite interventions to curb the menace, Nigeria continues to contribute the highest prevalence to the global OF burden[6]. The study explored the knowledge and perception of obstetric fistula among both the male and female respondents including the perceived prevalence and trend, knowledge of availability, and accessibility to fistula treatment centres. Additionally, awareness of policies and programs being implemented relating to OF and their stakeholders in addressing the problem of OF were interrogated. Also, effort was made to estimate the prevalence of OF among the women interviewed. Additional evidence on the burden of the disease was sought by triangulating with data from the treatment centres

7.1 Awareness, Knowledge and Perception of Obstetric Fistula

Community and individual knowledge of health challenges including OF is the first step toward preventive and treatment interventions.

Awareness of obstetric fistula

Overall, about a quarter of both the male and female respondents have heard of OF. There was a wide variation at the subnational level on the level of awareness of this condition. At the zonal level, Appendix 7.1 shows the level of awareness among women ranged from as low as 3.9% in the South West to 22.3% in the North East and 46.2% in the North West zone. Disaggregated to the state level (Figure 47), women in Oyo (1.1%), Imo States and the FCT (2.0%) were the least likely to have heard of OF. Awareness was highest among women resident in Sokoto (14.6%), Bauchi (16.0%) and Kaduna (31.6%) States.

Women are less likely to have heard of obstetric fistula if they were young adolescents aged 10-14 years (2.5%), have no form of education (24.1%), belonged to the highest wealth quintile (15.7%) and Igbo ethnic group (5.8%), lived in urban areas (40.4%), and traditional religion worshipper (0.2%). Appendix 7.2 shows the level of awareness of obstetric fistula among men being lowest in Imo State (0.1%) to 2.2% in the FCT, 24.5% in Bauchi State and highest in Kaduna State (30.6%).

6. National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria (2019-2023), Federal Republic of Nigeria (Federal Ministry of Health)

Figure 47: Percentage distribution of women who have ever heard of obstetric fistula by state

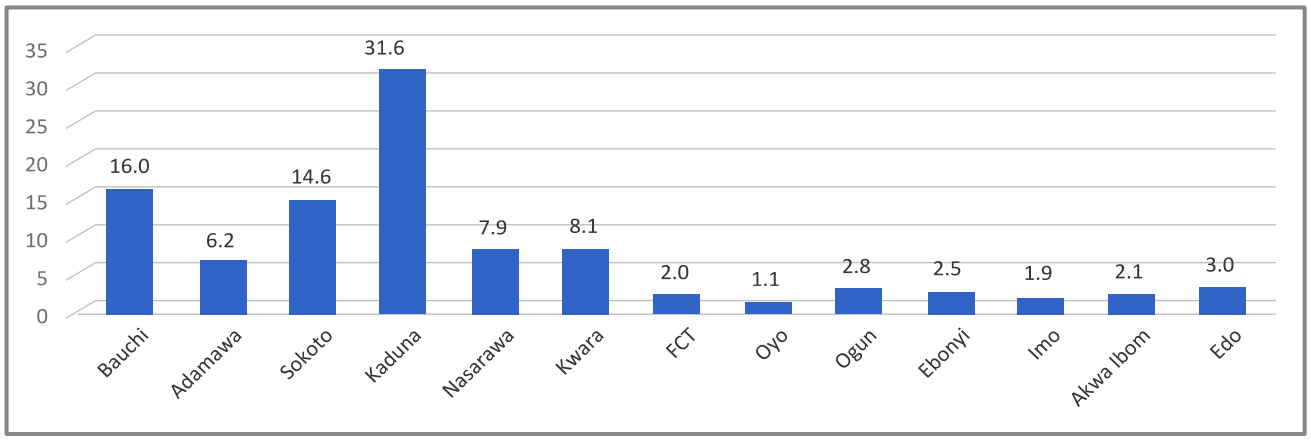


Table 38: Awareness, sources of information and knowledge of causes and prevention of obstetric fistula among female and male respondents

Variables	Female		Male	
	n	%	n	%
Have heard of VVF (n = 6352 (f) 3092 (m))	1,619	25.5	762	24.6
Source of information on VVF (n (f=1659, m= 794))				
Radio	445	26.8	506	63.7
Family/friends	811	48.9	408	51.4
Health worker	495	29.8	210	26.4
Television	270	16.3	147	18.5
Social media	79	4.8	87	11.0
Newspaper	40	2.4	47	5.9
Place of worship	34	2.0	31	3.9
Don't know	183	11.0	6	0.8
Others	81	4.9	20	2.5
Cause of obstetric fistula (n (f=1659, m= 794))				
Prolonged labour	871	52.5	262	33.0
Operation gone wrong in hospital	214	12.9	160	20.2
Local operation	163	9.8	116	14.6
Hospital delivery	140	8.4	82	10.3
Spiritual attack	55	3.3	17	2.1
Curse	25	1.5	7	0.9
Others	242	14.6	141	17.8
Don't know	497	30.0	314	39.5
Knowledge of methods of prevention of VVF (n (f=1659, m= 794))				
Allow girls to mature before marriage	885	53.3	340	42.8
Encourage women to deliver in health facilities	617	37.2	355	44.7
Delay childbearing for girls that marry early	477	28.8	147	18.5
Encourage female education	369	22.2	216	27.2
Stop harmful delivery practices	265	16.0	149	18.8
Promote child spacing	142	8.6	103	13.0
Empower women economically	97	5.8	66	8.3
Promote male participation in RH	51	3.1	101	12.7
Problems associated with VVF (n (f=1659, m= 794))				
Nobody wants to relate with them	592	35.7	270	34.0
Difficulty with hygiene	558	33.6	308	38.8
Divorce	482	29.1	158	19.9
Develop other health problems	287	17.3	150	18.9
Unable to get treatment	203	12.2	124	15.6
Can't cook for family	192	11.6	176	22.2
Can't perform religious rituals	184	11.1	161	20.3
Sent away from their community	88	5.3	28	3.5
Become beggars	47	2.8	20	2.5
Don't know	405	24.4	140	17.6

Note: Multiple Responses, Yes answers only are recorded in the table

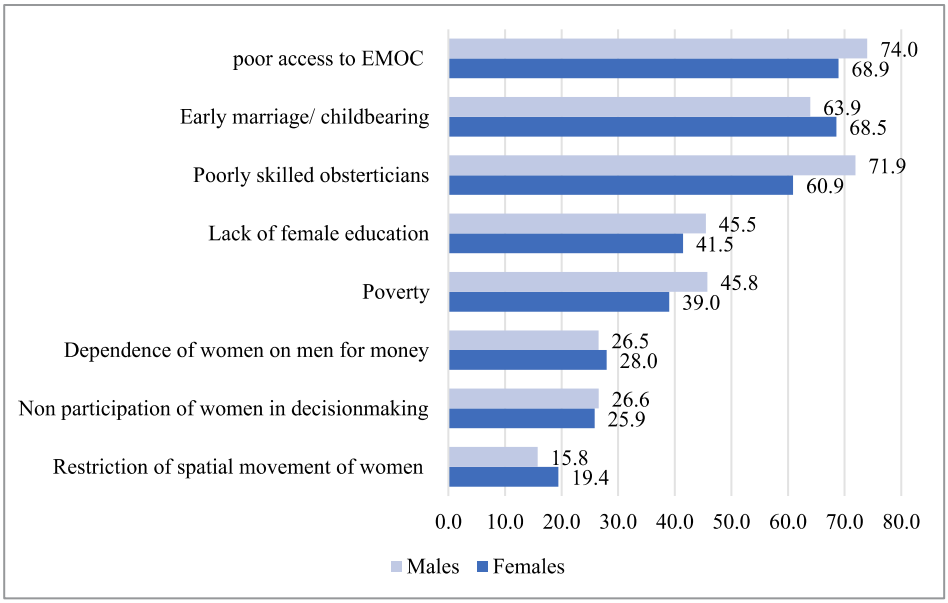
Sources of information about obstetric fistula

The leading sources of information on OF for the men that reported ever heard of the condition were radio (63.7%), friends and family (51.4%), and Health workers (26.5%). For the women, family and friends (48.9%), health workers (29.8%) and radio (26.8%) were their leading source of information, as more than a quarter of them reported hearing of the OF condition from these sources. It is noteworthy that social media is yet to become a major source of information on OF as just about a tenth of the men and 4.8% of the women heard about it through this media.

Knowledge of the causes and determinants of obstetric fistula

Generally, the female respondents were more knowledgeable about the direct cause of OF as more than half of them correctly mentioned that prolonged obstructed labour was the immediate cause of OF, followed by hospital operation during delivery that goes wrong (12.9%) and local surgeries undertaken by traditional healers (9.6%). Comparatively, men were less knowledgeable about cause of OF. Only about a third of the men attributed OF to prolonged obstructed labour, a fifth mentioned hospital operative delivery that goes wrong while one in seven perceived that surgeries undertaken by local barbers could result in the condition. It is noteworthy that almost a tenth of both female and male respondents erroneously attributed cause of OF to normal delivery in a health facility. A sizeable proportion of the men (39.5%) and 30.0% of the women indicated that they did not know the cause OF. It is noteworthy that there are still women and men thinking OF could result from curses and witchcraft.

Figure 48: Knowledge of factors contributing to the development of OF



Box 7.1: FGD with mixed groups, and married men

VVF is as a result of early marriage when the girl is not old enough to bear a child but goes through the hurdles of childbearing. **FGD with mixed Group, Kwara State**

I don't agree that early marriage is the major cause of VVF. Even in the past, girls were given into marriage at an early age but there was no this problem. Therefore, there must be something else that we don't know as the major cause, but we can't deny that there is no VVF in the community. **FGD with married men, Bauchi State**

There was good knowledge of the underlying factors contributing to the development of OF. As shown in Figure 48, poor access to emergency obstetric care services, early marriage and early commencement of childbearing, and poorly skilled doctors conducting operations were each mentioned by at least 60% of the men and women as underlying causes of the problem. Additionally, at least 40% of both the male and female respondents alluded to poverty and lack of female education as important contributory factors.

These findings were confirmed by the focus group discussants and key informants. The majority of the participants opined that early/child marriage was a dominant causal factor. The participants explained further that most girls that married too early would have most of their reproductive organs underdeveloped for commencement of childbearing. Unfortunately, procreation attracts a high premium across different communities in Nigeria and once a girl is married, childbearing becomes mandatory irrespective of the age at marriage. In espousing the implications, a young girl was likely to experience complications during delivery which results in OF. The participants elaborated further that various complications women experienced during child delivery could also result in OF if not well managed and that young girls that become mothers too early were more susceptible to OF (see Box 7.1).

However, the explanation that early marriage could cause VVF was contested in one of the FGD sessions with married men. The view expressed in this group was that something else and not marriage was the underlying cause (see Box 7.1). Nonetheless, childbearing and access to quality maternal healthcare were not disputed as part of the contributing factors to OF.

Figure 49 shows a network of possible factors or conditions that put women or girls at risk of OF, as expressed across various focus groups. On access and acceptability of modern health care services, poor health seeking behaviour during pregnancy was described as common behaviour among young married and unmarried girls who refuse to go for ANC or delivery in health facilities. Similarly, rape could sometimes be a contributing factor if such rape was violent and poorly managed (see Box 7.2).

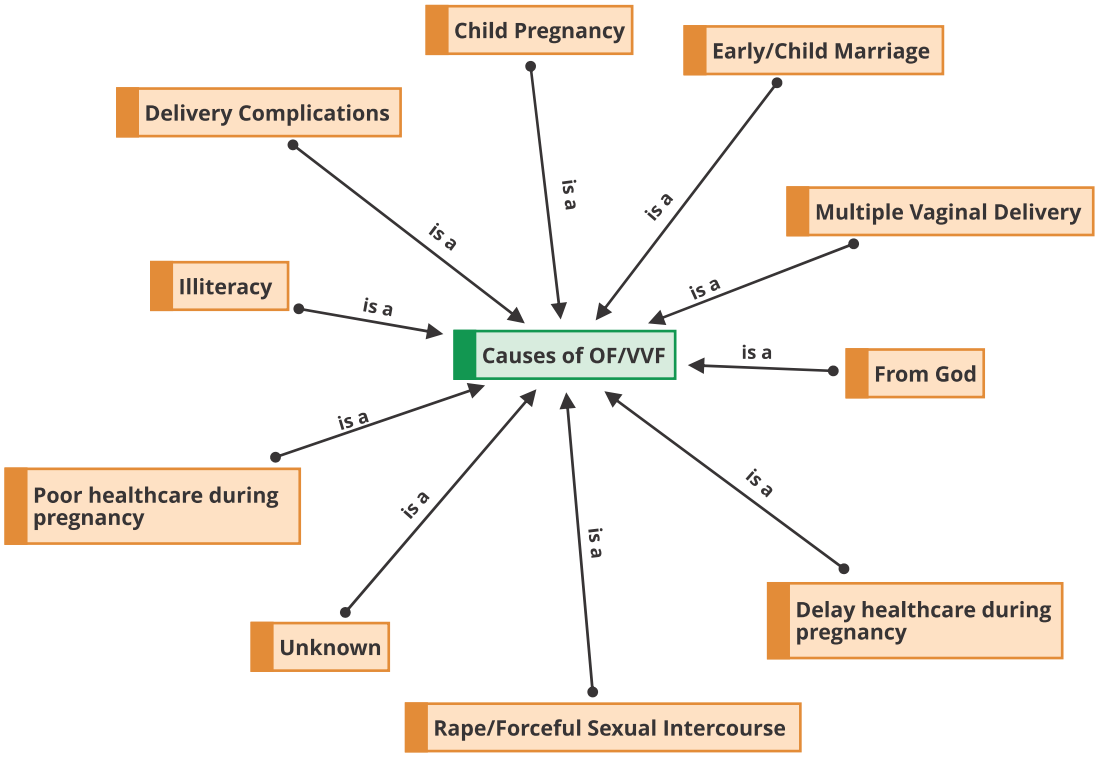
Other factors mentioned during the FGDs were illiteracy and poverty, a few attributed the cause to God. Some of the participants argued that access to quality antenatal healthcare services was still a challenge among most women which contributes to poor maternal health outcomes including OF. Some other female discussants opined that delay in registering for antenatal care or perhaps outright avoidance of the use of existing health facilities was common among uneducated women even when they are at risk of OF. Women who have had several vaginal deliveries are also at high risk of experiencing OF in the long run.

Box 7.2: Excerpts from FGDs with married men

Raping can also cause it, when you are being raped, along the line, the, the urine bladder might break and it will cause it.

FGD with married women, Ebonyi State

Figure 49: Causes of obstetric fistula or vesico-vagina fistula



7.2 Perceptions of the Prevalence of Obstetric Fistula

Perceptions of individuals influence their health behaviour. The degree to which individuals and communities perceive that they are at risk of a problem, or a problem exists, will determine the preventive or mitigating actions they will take. The general perception was that OF was not a problem in their communities. Only a fifth of both the men and women interviewed affirmed that they have ever heard of a woman leaking urine or faeces in their communities. Approximately sixty percent and a fifth of both the male and female respondents, respectively, said that OF does not exist and is very rare respectively in their communities. Only 0.7% of the men and 2.4 % of the women reported that OF is common in their communities (Table 39). This perception may be connected with the culture of silence around OF because of the associated stigma and discrimination. The conditions that lead to OF exist in all parts of Nigeria including poor access to quality emergency obstetric services which is the immediate underlying cause. Thus, it is expected that there are women with this condition in all parts of the country.

Despite the views that the OF problem is rare in many communities, about a third of the men and a quarter of the women believed that the prevalence was declining in the communities where it exists. They attributed the decline to mainly female education (female 53.1%; and male 56.0%), declining age at marriage (female 39.1% ; and male 41.9%), government policies (female 22.1% and male 21.1%) and religious interventions (female 16.3% and male 12.2%).

Table 39: Perception of the prevalence of obstetric fistula

Variables	Female		Male	
	N=1659	%	N=794	%
Ever heard of a woman that has the problem of leaking urine and or faeces in their community	337	20.3	169	21.3
Perception of the prevalence of VVF				
Very common	40	2.4	169	0.7
Rare	389	23.4	228	28.7
Not seen in this community	950	57.3	469	59.1
Don't know	281	16.9	91	11.5
VVF trend in the community				
It is decreasing	399	24.1	504	30.4
It is increasing	10	0.6	11	0.7
It has remained the same	287	17.3	262	15.8
Don't know	963	58.0	882	53.2
Reasons for the decline in VVF in the community				
Religious interventions	65	16.3	49	12.2
Government policies	88	22.1	84	21.1
Reduction in the prevalence of child marriage	156	39.1	167	41.9
Female education	212	53.1	223	56.0
Female empowerment	38	9.5	40	10.0
Traditional leaders	22	5.5	30	7.5
NGOs	23	5.8	25	6.2
Media (including social media)	24	6.0	19	4.8
Others	5	1.3	5	1.2

From the qualitative results, participants shared divergent opinions and positions on the reality of VVF in their communities (see Box 7.3). Some participants reported that cases are still being recorded in many communities in the North, but the associated stigma still remains a challenge. A participant mentioned that she came across about three cases of OF while others indicated at least one case.

Stigmatisation was identified as the major reason contributing to the culture of silence among community members and those living with OF condition. Stigma drives the condition underground leading to non-disclosure and perhaps, low perception of the magnitude of the problem in many locations at the subnational level. So, while the community members perceive the condition as a rare case, health workers and service providers affirmed that OF cases truly exist and may be more prevalent than the perceived estimates of the community members (see Box 7.4).

The availability of OF treatment and rehabilitation centres in some states in Nigeria ought to serve as a motivation for responsive health seeking behaviour. However, the reality is the opposite as reflected in narratives of the participants. Cases of OF exists across

Box 7.3: Excerpts from FGDs

Actually, very rare. In 2011 when we conducted survey, we couldn't find such cases in Azare until we went to Ningi. **FGD with married men, Bauchi State**

This kind of thing is a privacy issue. We don't know anything about it. It is only when the affected person airs it out that we will know. In short, we don't have such cases here. **FGD with men of reproductive age, Imo State**

We have not had here though we heard about one in the teaching hospital. **FGD with opinion leaders, Edo State**

Box 7.4: Excerpts from FGDs with CSOs

Yes, there are high cases and now we have a lot of patients who have been screened. **FGD with CSO, Adamawa State**

We have cases, which is why we have the VVF center. **FGD participant -Bauchi State.**

Yes, we have these cases and I have also come across 3 persons. **FGD with female community leaders, Nasarawa State**

communities and often present late for treatment in existing centres where services are accessible.

Overall, VVFs cases are prevalent and more common in some states than in others. The narratives captured across the regions showed that VVF cases do exist, but the frequencies and rates of occurrence differ due to socio-cultural, contextual, household, and biological factors. Communities in the northern region had the highest prevalence as adjudged from the number of FGDs and interview sessions where cases were reported as seen and known within their communities and health facilities.

Despite indicating that it is a non-existent or a very rare problem in their communities, a third of the respondents thought the prevalence of OF is on the decline, while about a half did not know the direction of the trend. Only about 1% thought the prevalence was on the increase. The main factors mentioned as contributing to the declining prevalence of OF includes an increase in the levels of female education and a reduction in rates of early marriage. Other contributing factors were government policies and religious interventions (Table 39). The focus groups and key informants also indicated that VVF is gradually decreasing even in communities where cases were, prior to this study, more frequent.

The postulated explanations for the decreasing prevalence were reduced early marriages, improved access to quality care at the hospital level, increased awareness of the dangers and the evitability of VVF, and improved attitudes towards responsive care-seeking.

One of the FGDs among CSOs in Adamawa revealed how the increase in screening and availability of treatment services also indicated women's access to care and mitigation of VVF consequences (see Box 7.5).

7.3 Availability and Access to Treatment and Rehabilitation Services

Awareness of the availability of OF treatment and rehabilitation services was generally very low. Only 14.5% of the women and none of the men who had heard of OF were aware that OF treatment centres are available in their states. The regional distribution of women who are aware of the availability of treatment centres is presented in Appendix 7.3. Women residing in the North East (25.6%) and North West (15.3%) are more knowledgeable about the location of VVF treatment centres with the South West (1.0%) being the least. At the state level, Bauchi (34.6%), Sokoto (26.8%), and Akwa-Ibom (23.0%) had the highest proportion of women and none in Oyo state reporting knowledge about the presence of treatment centres in those states. These findings were substantiated by the distribution of VVF treatment centres, which were more concentrated in northern Nigeria and a functional one in Akwa Ibom State (Appendix 7.4).

Only a tenth of the women and men indicated awareness of OF rehabilitation services. Most of the women who have ever heard of VVF rehabilitation centres are urban (12.5%) compared to rural residents (9.3%). Awareness of availability of rehabilitation centres is least among women of the Christian faith (5.4%), Yoruba ethnicity (3.7%), and highest among residents of Akwa Ibom (11.2%), Sokoto (13.9%) and Bauchi States (21.9%) (See Appendix 7.5). Among the men who have ever heard of VVF, only 11.5% were aware of the availability of a rehabilitation centre for VVF patients. As shown in Appendix 7.6, a larger proportion of these men were resident in urban centres (14.3%) and had a form of education (28.9%). Regional variations show that men who were aware of the rehabilitation centres were more in the North East (12.5%), South West (18.1%) and South East (37.8%) compared to other zones. The sub-national estimates reveal that men in Bauchi (15.6%), Akwa Ibom (17.3%), Sokoto (18.4%), Oyo (38.1%) and Ebonyi (38.3%) States.

Box 7.5: Excerpts from FGDs

The problem is now decreasing because early marriage has now reduced so the issue of obstetric fistula has now reduced in women. **FGD with married women, Adamawa State**

...honestly, we record the happening of this problem, but it is decreasing gradually, because we even have a Federal Government hospital for the treatment of cases of VVF, and always immediate attention for the treatment is given to the matter. **FGD with unmarried male adolescents, Bauchi State**

Yes, there are high cases and now we have a lot of patients who have been screened. **FGD with CSO, Adamawa State**

Lack of awareness of the existence of these services may be a major impediment to care- seeking. Also, this level of ignorance may explain why about 4 in 10 of the respondents did not know of any problems associated with accessing these services. For those that mentioned perceived barriers to access, lack of awareness of the location of the treatment centres (20.6% females; 23.4% males), high cost of treatment (29.5% female; 37.2% males), non-availability of treatment services in their localities (22.0% females; 42.7% males), and ignorance about the existence of the services (43.6% females; 31.1% males) were the most cited reasons (Table 40).

Table 40: Awareness of availability of fistula treatment/rehabilitative services and barriers to access

Variables	Female		Male	
	N= 1,659	%	N = 794	%
Aware of OF Treatment centre in the state	240	14.5	0	0.0
Aware of the availability of rehabilitation centres for OF	175	10.5	91	11.5
Problems accessing Hospital Treatment				
Non-availability of treatment centres in the locality	365	22.0	339	42.7
Lack of awareness of places for treatment	341	20.6	186	23.4
High cost of treatment	489	29.5	295	37.2
Treatments are usually not successful	146	8.8	116	14.6
Others	34	2.0	7	0.9
Don't know	723	43.6	247	31.1

7.4 Prevalence of Obstetric Fistula

From the study, only 14 women indicated a lifetime experience of leaked urine, out of the 6453 women interviewed. Three of these women indicated that they had been cured. The estimated prevalence of OF, that is, the proportion of women that reported leaking urine at the time of data collection was 0.24% (95% C.I.= 0.09 – 0.31). These were women in the reproductive age group (15-49 years). The prevalence is comparable to the findings from the 2018 National Demographic and Health Survey that documented an OF prevalence of less than 1%. The projected national prevalence of OF in the country, based on the estimate that 22% of the population is made up of women in the reproductive age group and a projected population of 216 million in 2022, gives 114,048 (95% C.I.= 42,293 - 147,312) women leaking urine. The 11 women currently experiencing OF were in Adamawa State (5), Kaduna State (2), Ogun State (2) and Sokoto (1) and FCT (1).

Table 41: Distribution of fistula repairs in treatment centres in Nigeria, 2014 – 2021

Zones	2014	2015	2016	2017	2018	2019	2020	2021	Total	% Repairs
North Central	315	349	383	634	311	431	690	1,040	4,153	18.0
North East	54	131	464	415	339	467	520	839	3,229	14.0
North West	681	1,252	1,098	1,198	1,655	1,002	1,196	2,738	10,820	47.0
South East	230	246	194	183	267	240	240	539	2,139	9.3
South South	103	151	164	280	125	70	256	215	1,364	5.9
South West	18	24	24	72	124	433	379	256	1,330	5.8
Total	**1,401**	**2,153**	**2,327**	**2,782**	**2,821**	**2,643**	**3,281**	**5,627**	**23,035**	**100**

Source: *FMOH Data Bank, 2021*

To have an idea of the cases seen in the treatment facilities, as a proxy for the prevalence of OF and the national effort to clear the backlog of cases, secondary data was obtained from the Federal Ministry of Health on the number of Obstetric Fistula repairs carried out across OF centres in the country from 2014 to 2021. It is important to review the interpretation of this data in the light of supply- and demand-side factors that influence service utilisation, and not just a reflection of regional distribution of prevalence of the disease. As shown in Table 41, a total of 23,035 women were treated in the designated treatment centres from the years 2014 and 2021, with average repairs of 2,879 per annum.

Over 80% of all the repairs were done in the three Northern zones, and more than half (51%) were done in the North West Zone. In 2021, the number treated in the North Central, North West and South East were more than doubled compared to previous years, which was attributed to increased reporting rates and frequency of UNFPA's fistula treatment campaigns. It is noteworthy that at the current rate of treatments (2,879 cases per annum), it would take 40 years to clear the estimated 114, 048 prevalent cases in Nigeria.

7.5 Characteristics and Management of the Reported Cases of Obstetric Fistula

From the household survey, 6 of the 14 reported cases of OF occurred within a year preceding this study. Only 3 of the survivors reported having ever sought treatment, two from the government hospitals and one from the private health facility. In addition, they also sought help from traditional healers. Those treated in health facilities reported that the problem stopped after the treatment, while those that sought help from traditional healers reported that the condition never improved after using the prescribed medicines. Ignorance of the consequences of the disease and where to go for treatment were the main reasons OF patient did not seek treatment. All the affected women reported to have stopped working and, therefore, lost their livelihood, due to their OF condition. Some reported being divorced by their husbands, the need to leave their communities and isolate from family and friends as a result of the disease.

7.6 Awareness of Interventions to Address Obstetric Fistula

Respondents were asked whether they were aware of any ongoing intervention addressing the problem of OF. Most of the respondents (96% of females and 94% of the males) were not aware of such programme or intervention, either in their communities or at state or national levels. Educated and urban women and men were more aware of VVF programmes and organisations in their state of residence. At the subnational level, the south-east had the highest proportion of men (34%) who reported knowledge of any VVF intervention program in the state. At the state level, Ebonyi (35%) and Kwara (41%) had the highest proportion. Interventions identified include an educational programme in the media (females 44%; males 51%), community sensitisation and education (females 32%; males 42%), treatment services and support for VVF victims (females 55%; males 44%), rehabilitation activity (females 10%; males 11%), promotion of female education (females 16%; males 18%) and supporting delivery and family planning services (females 14%; males 15%).

7.7 Consequences of Obstetric Fistula

OF has been referred to as the worst complication of obstructed labour, with dire enormous social, phycological, mental, economic, and physical consequences that could scar a woman for life. The leading problems mentioned by both men and women were related to stigma and the consequent rejection. About a third of the respondents mentioned that nobody would want to associate with the girls and women that develop this condition. Also, a third of the women and a fifth of the men cited divorce or separation as the associated consequences. A third of both the men and women noted that women living with OF tend to have problems with personal hygiene. Difficulties in fulfilling social and religious obligations were also cited by a fifth of the respondents. Other problem reported was the victim's experience of difficulty in accessing health care services (Table 39)

Similar findings were generated from the qualitative data where the majority of the participants across the states mentioned that survivors of VVF often suffer

Box 7.6: Excerpts from FGDs with CBOs and unmarried adolescent males

Women who have VVF face the challenge of rejection, rejection by their colleagues, and rejection by the society, if they are married, with other wives of the husband, the other wives of the husband will reject them, the husband will reject them and in the long run they can even come down with psychiatrist issue. **FGD with CBOs, Oyo State**

Also, the matrimonial life, in which it affects the relationship between the husband and his VVF patient wife once this problem manifests itself. This may lead to the dissolution of the marriage because the problem brings lots of constraints and pressure on the VVF patient. **FGD with unmarried adolescent males, Bauchi State**

psychological trauma, as a result of rejection by family, friends and the society. This leads to loss of self-esteem, inferiority complex, depression, and rejection (isolation, divorce, and stigmatisation) (see Box 7.6). Whether such stigma was perceived or actual, the consequences sometimes could be enormous, and result in delays in help-seeking, staying indoors, neglect, and patronage of traditional healers. Disclosure and responsive help-seeking are key to timely recovery and perhaps pathways to reintegration after suffering a VVF.

The perceived or actual stigma may result in non-disclosure of VVF status except when experiencing some complications and symptoms that are overtly known to neighbours and other community members. In buttressing the prevailing silence around VVF, some of the participants from the communities in the northern region narrated how parents of young girls with VVF condition would rather hide their daughters and seek help from the traditional healers instead of supporting such survivors to access care from hospitals. In this sense, some community members opined that VVF cases are often hidden and underreported (see Box 7.7).

Box 7.7: Excerpts from FGDs with NGOs

So, in our community this particular thing VVF I can say is common but to the authority its uncommon were some of the parents may hide it, whenever their daughter has this particular problem, they will just pack a room for her where they will just keep her there,. Then they will start seeking medicine traditionally, they won't take her to the hospital then when she is there nobody will even have tight relationship with her... **FGD with NGOs in Kaduna State**

The condition also has some financial implications for the survivors and her family who bear the cost of her treatment in the hospital. Such disposition has health consequences because it could lead to depression and difficulties in reintegration even when treatment and cure are possible.

The survivors of OF alluded to these problems. Stigma topped the list of the problems they face across communities. The participants explained that they were being despised, stigmatised, and isolated in the society (see Box 7.8). Many had been subjected to public shame and disgrace due to unpleasant odour resulting from the persistent urinary incontinence arising from the disease. The unpleasant odour emanating from the survivors were linked to their refusal of or delay in help-seeking and the inability to effectively correct some cases through surgeries.

The psychological and social consequences of living with VVF are curable or avoidable through prompt access to quality care, change in attitudes, orientation, and availability of support networks, according to the participants. Access to robust surgical intervention was echoed in one of the FGDs in Bauchi State (See Box 7.9). The adolescents in the FGD opined that timely and adequate treatment could restore the health of VVF survivors and perhaps change the narratives around the prevailing stigma, isolation, odours, and outright rejection. Survivors, according to the participants, would stand higher chances of being reintegrated and accepted in the society despite the condition.

Box 7.8: Excerpts from FGDs with NGOs and CSOs

They face the problem of stigma. If a woman is smelling there is nobody that want to stay beside her and some will do it openly even to hurt her, when she stand and people move away it's a lot of emotional stress for a woman. **FGD with CBOs, Oyo State**

... it happened to my childhood friend her husband divorced her; she was left to care for herself. ...she was smelling, she was isolated ...even lepers go out more than a person with VVF. Even family members ...they get tired. Unless that person has financial capability or the person has a lot of money and the person can take care of herself on her own... it is a very serious issue here **FGD NGOs, FCT, Abuja**

Here in specialist hospital, there was a time when doctors were part of the team who are conducting repairs on women with VVF and some of the women that came were even sent back because there are no spaces for them. Facilities are not adequate enough to carry out all the full surgeries at a time and you know is not only doing the surgeries but the recoveries processes. **FGD with CSOs, Adamawa State**

7.8 Capacities and Critical Stakeholders for Meaningful Interventions

This section identifies the capabilities and critical stakeholders that are making meaningful changes to OF problems. Discussants identified some stakeholders involved in curbing the VVF menace including the government agencies, community leaders and members, youths and NGOs. The findings

Box 7.9: Excerpts from FGDs with unmarried male adolescents

Actually, when the patient is well treated, she doesn't face any problem upon her return to the family fold. She was being stigmatized because of the disease, and since it is cured, she faces no problem. **FGD with unmarried male adolescents in Bauchi State**

captured the effort of the government at different levels in addressing the remote and immediate factors that are putting women at risk of VVF.

One of the government efforts mentioned by the participants was the introduction of child/early marriage prevention laws which have been implemented in some states across the regions.

Such laws target and discourage early/girl child marriage and attenuate the exposure of a biologically unprepared body to pregnancy. Implementation has been limited across the regions because of religious and cultural differences and expectations around the values in delayed marriage as against early marriage. In this sense, some of the participants suggested more collaborations between the government and thecommunity leaders in organising social campaigns and sharing details on the causes of VVF and its implication for women (see Box7.10). Husbands, family and friends, religious and community leaders and members should be encouraged to support their wives, daughters, neighbours and friends living with VVF. With more campaigns around the causes and consequences of VVF, some of the participants argued that social acceptance and support for survivors could improve the desired outcome.

Box 7.10: Excerpts from FGDs with female community leaders.

Government's effort to control this by providing laws that will govern every family in terms of early marriage and sanction be giving to any parent who violet the law **FGD with female community leaders, Nasarawa State**

Government and community should collaborate with people by providing campaign and sensitisation to people on early marriage and its implications on VVF **FGD with female community leaders, Nasarawa State**

Community leaders were credited with some supportive roles to VVF survivors. Some leaders have been involved in encouraging husbands to transport their wives to access available health services. Such efforts could be replicated in urban and rural areas. Communities in rural areas were cited as worse and therefore should be targeted in addressing the prevailing stigmas and mobilising more support for survivors to access health care services. The youth of various communities were also identified as possible agents of change. Young people could be mobilised and educated to serve as peer educators to others in addressing the stereotypes and misconceptions around VVF. As a model, young people

Box 7.11: Excerpts from FGDs with unmarried adolescent males.

The only support is for those that are still with their husbands, they get them to hospitals for medication traditionally and at the health facility **FGD with unmarried male adolescents, Kaduna State.**

Yes, the need for increased awareness campaign in the rural communities. More communities should be penetrated and take the message of enlightenment on the problem there, once it is done, greater success will have recorded in reducing the menace of VVF F**GD with unmarried male adolescents, Bauchi State**

Youth can play a role by way of giving advice any time they observe the possible occurrence of this problem in a place, or they can volunteer to team up with experts in this field so that they can go round under youth organisations creating awareness and enlightenment campaigns. **FGD with unmarried male adolescents, Bauchi State**

Box 7.12: Excerpts from FGDs with unmarried adolescent Males

Actually, there is. Non-governmental organisations come from time to time, encouraging people that one there is incidence of the nature, the woman should be rushed to the hospital. **FGD with unmarried male adolescents, Bauchi State**

There should be an NGO that'll be sensitizing people on all this, when you are enlightened, you do everything with caution and wisdom. **FGD with community leaders, Kaduna State**

could team up with experts to create awareness of VVF-related issues (see Boxes 7.11 & 7.12).

Development partners and NGOs have been sensitizing the people about VVF as well as supporting access to treatment and rehabilitation services for survivors. They need to increase their efforts to meet demand across different communities for greater impacts and mitigation of the challenges of VVF victims.

7.9 Policy Blind Spots and Actions Needed to Address Obstetric Fistula

Cultural and religious factors were the dominant constraints in addressing the complexities of OF in affected communities. The practice of early girl-child marriage is still pervasive in many communities of northern Nigeria. Some respondents in the region denied

Box 7.13: Excerpts from FGDs with NGOs

one of the challenges they have also, is the religion problem, I have seen cases where the man is still fighting the NGOs, that's even trying to treat the woman, I have seen most cases like that where you see the man fighting, I have been in a hospital, where an NGO was footing bill for the girl. And the man came out and was trying to bring down the hospital. **FGD with NGOs, FCT, Abuja**

the relationship between early marriage and OF. Addressing early/child marriage would require more sensitisation.

Beyond sensitisation and campaigns that are culturally acceptable and appealing to various religious and ethnic groups in the study settings, more concrete efforts and interventions must be driven by the government to achieve the needed impact. Wider access to free treatment

would improve the rehabilitation and reintegration of the survivors. Such access could also reduce the psychological and social consequences of isolation, neglect, divorce, and separation. This is quite important

Box 7.14: Excerpts from FGDs with female community leaders

Encouraging everyone to acquire education will help people to have the knowledge and know the implication of early marriage on causing VVF. **FGD with female community leaders, Nasarawa State**

for the financially handicapped women/girls who could not afford the high cost of accessing VVF care. The effort of NGOs in footing the bills of some survivors was commended in one of the FGDs in Abuja and perceived as making meaningful impacts. Unfortunately, as captured in the narratives, the rejection of the NGOs gesture could be hinged on education, cultural misconceptions around rights and the complexities of living with OF/VVF in some Nigerian communities (see Boxes 7.13 & 7.14).

Educating female children was considered a priority that should be explored at all levels in the regions and States. Wider access to female education, and that of the boys, would delay the age at marriage and improve the understanding of sexual and reproductive health and rights (see Box 7.14). The narratives and views around OF/VVF indicated that most of the survivors have been incapacitated by the same society that stigmatises, ostracises, and also denied them access to the needed care. The position of the participants was that an educated woman would be more empowered to make more informed decisions.

The need for access to effective, supportive, and affordable care also emerged as a policy issue that requires urgent attention. Programmes to promote free medical services for those living with OF/VVFs should be more accessible and spread across the States. Such

Box 7.15: Excerpts from FGDs with unmarried adolescent males and married women

First, let us stop early marriage practice. Secondly, increase in the awareness promotion, so that more women should be well-informed on the important of going to the hospital during pregnancy, not until when it is delivery time that they can present themselves in the hospital. Furthermore, when it is delivery time they should deliver and the hospitals, not at home. **FGD with unmarried male adolescents Bauchi State**

It is good for the government to consider them and provide professionals in that field to carry out surgery in order to correct the organ so that they will become like other women and that is our own wish and assistance the government will do to those VVF women. **FGD with married women, Adamawa State**

Box 7.16: Excerpts from FGDs with female community leaders

...Family planning should be encourage to space birth for a reasonable period, I think that would address the problem of VVF. **FGD with female community leaders, Nasarawa State**

.....authorities need to step in and help sensitize our men on the need to stop marrying our small children, because they are the problems, they make the decision, most mothers never support it, ..., men should be sensitized to stop these early marriages and allow their children to study and to strong enough. This is the only way. **FGD with community leaders, Kaduna State**

programmes would promote awareness of the availability of healthcare for VVFs. It could also motivate pregnant women to seek care early, especially those that are at risk of VVF. The majority of the participants argued further on the need for doctors that are well trained in handling the condition (see Boxes 7.15 & 7.16).

Specific laws need to target and sensitise men on the dangers of child marriage and the benefits of educating female children. Obstetric fistula was described as a common condition linked to frequent childbearing and limited spacing of births. Family planning should be encouraged to eliminate the problem.

Campaign and sensitisation on the dangers and side effects of early marriage are necessary for addressing the problem of OF/VVF. Some of the participants stated that laws addressing early marriage should be implemented and anyone who violates the law should be punished (See Box 7.17).

The need to introduce reproductive health into the school curriculum was also suggested in one of the FGDs. One of the participants mentioned that topics on OF/VVF should be included in the syllabus of students so that they can be enlightened on the dangers of early marriage to avert the problem.

Actions should be taken toward the rehabilitation and reintegration of survivors into the society. Women living with this condition should be counselled. The participants (Box 7.18) affirmed that the condition causes depression. So, patients need to be rehabilitated and reintegrated into the society after treatment.

Box 7.17: Excerpts from FGDs with female community leaders

Government should create awareness on the danger of early marriage and its implications on VVF. Government stand the better effort to control this by providing laws that will govern every family in terms of early marriage and sanction be given to any parent who violate the law. **FGD with female community leaders, Nasarawa State**

Box 7.18: Excerpts from FGDs with NGOs and CBOs

Even before the repair they need counselling and they need to be trained on how to take care of themselves because they are few things they can be doing like changing of their so called diaper or whatever so that the offensive odour will be minimized, so they need that even before the correction and after the correction may be give them vocation or trade or something just to resettle them. **FGD with NGOs/CBOs, Oyo State**

SEXUAL AND GENDER-BASED VIOLENCE

KEY FINDINGS

Women's experience of intimate partner's violence

- A third of the women age 10-49 had experienced a male partner's controlling behaviour in the last 12 months preceding this study, while 8.6-14% had experienced physical, economic and sexual abuse.
- Male partners' controlling behaviour was highest in Northern regions (70.3-83.1% in a lifetime and 32.2-54.8% in the last 12 months) compared to the Southern regions (lifetime: <50.0%; in the last 12 months: <20.0%). The same pattern applies to other IPVs. All IPVs are more pronounced among adolescents aged 10-19 years compared to women at advanced reproductive age 40-49 years.

Women's experience of non-intimate partner's violence

- A higher number of women reported physical violence from non-intimate partners in their lifetime (414) and the last 12 months (69) since reaching age 15, compared to those who reported sexual violence, 145 and 12, respectively.
- The lifetime physical violence from non-intimate partners was highest in three Nigerian states – Nasarawa, Edo, FCT Abuja and Bauchi (10.9-11.7% each) and lowest in Oyo, Kwara and Akwa Ibom (less than 5.0%). The victims are highest among cohabiters (12.5%) and lowest among widows. Sexual violence from non-intimate partners was generally less than 6.0% across all individual and community groups.

Men's experience of intimate partner's violence

- The most reported IPVs among men were female partners' controlling behaviour (lifetime: 66.9%; last 12 months: 22.3%) and physical abuse (lifetime: 27.4%; last 12 months: 21.7%). Less than 10% reported other IPVs.
- Physical abuse from women was most reported in the South East (58.9%) compared to other regions. Male adolescents aged 15-19 had the least prevalence of female partners' controlling behaviour (33.4%) unlike other age groups (55.7-81.0%). However, men of advanced ages 50 years or above had the highest prevalence of physical abuse (24.8-34.7%), unlike the younger ones (largely below 20%).

Men's experience of violence from non-intimate partners

- Men reporting physical violence (257≈27.4%) from non-intimate partners were more than those reporting sexual violence (40≈8.1%) in a lifetime. It was a similar trend and considerably low in the last 12 months (6≈21.7% versus 2≈4.2%).
- Though the physical violence from non-intimate partners was generally low (below 10%), it was accentuated in the South East (24.4%) and North Central (15.9%), with the largest shares in Imo (30.4%), Nasarawa (28.8%), Ebonyi (12.3%) and FCT Abuja (11.4%). The adolescents aged 15-19 (20.7%) and elderly aged 65+ years (16.2%), Christian (11.1%), Igbo (20.5%), and the unmarried including divorced/separated, never married and widowed (10.6- 16.8%) men were the most affected compared to other groups (<10%). Sexual violence also followed a similar pattern though with a much lower prevalence.

Triggers of IPV

- Most reported reasons adduced for precipitating IPV across the states bothered five issues ranging from money (29.7%), lack of food (22.5%), issues related to extended families of the female partners (15.3%), views around female partners' disobedience (11.4%), and, refusal to have sex (9.4%).

Reactions to IPV

- Women's reactions: 46.4% of women never reported their experience of violence to anyone and those that did largely reported to their parents (37.7%) and friends (14.0%).
- Men's reactions: At instances of violence, about 17.4% of women reported that their husband/partner reacted violently, 12.0% vacated their homes, while about 10.2% reported to friends, wife's/partner's family members or/and parents.

Persons with Disabilities

- From the qualitative evidence, the majority of persons with disabilities face discrimination, physical abuse

and sexual abuse daily. Sexual abuse is peculiar to women, unlike men.
- The major reasons for sexual abuse of women with disabilities include lack of the capacity to fight for themselves, joblessness and psychological problems of the violators.

Sexual and Gender-Based Violence during COVID-19
- Of the women who have ever experienced SGBV, 26.6% reported an increase in economic violence, 12.0% for sexual violence and 3.5% for physical violence during COVID-19.
- Of the men who have ever experienced SGBV, about 35.6% reported an increase in sexual violence, 19.3% in physical violence and 16,5% in economic violence.
- A third (32.9%) of the women and 39.4% of the men reported an increase in their partner's controlling behaviour since the onset of COVID-19.
- The increase in partner's controlling behaviour among women during COVID-19 was highest among Hausa women (38.3%) and Yoruba men (45.9%) but lowest among Igbo (14.9% and 22.3%, respectively); more reported by the women in the North Central (54.8%) and North West (43.9%) compared to the South East (13.8%) and South-South (16.0%). Men's reports were similar across the regions. It was more reported by women in FCT Abuja (81.5%), Kaduna (59.9%) and Nasarawa (57.4%) compared to the least in Ebonyi (14.2%), Akwa Ibom (15.8%) and Edo states (16.3%). For men, it was highest in Kwara (67.8%), Akwa Ibom (61.3%), Nasarawa (56.1%) and Kaduna (52.3%), and lowest in Imo (11.8%) and Adamawa (23.2%)

8.0 Introduction

The incidence of SGBV is growing astronomically, especially in the parts of the country with humanitarian crises. Nearly one in three women had an experience of SGBV in Nigeria (NHDS, 2018). Manifestations of SGBV range from forced and early marriage to mental, physical, and sexual violence from both intimate and non-intimate persons. There is an emerging dynamic in the occurrence of SGBV in Nigeria, suggesting a new typology of intimate partner abuse against men (Nwana and Kunuji, 2016; Ministry of Women Affairs and Poverty Alleviation [Lagos, Nigeria], 2021).

The COVID-19 pandemic necessitated the adoption of some mitigation measures to reduce the virus transmission, such as lockdown and restriction of movements. In Nigeria, such measures led to closure of workplaces and stay-at-home orders with little consideration for exacerbation of SGBV, especially IPV from the confinement of perpetrators and survivors in the same place. Thus, the study also explored the effect of COVID-19 pandemic on SGBV.

Disability, in any form, may also exacerbate vulnerability to SGBV. Persons with disabilities have an increased need for social and financial support which may lead to increased pressure on the support networks. This could compound the SGBV experiences of persons with disabilities. This study made a qualitative assessment of the SGBV experiences of PWDs. The study however did not cover other minority groups that may be susceptible to SGBV i.e., persons of different sexual orientations such as the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ).

This chapter is divided into five sections: women's and men's experience of intimate partner violence; sexual and gender-based violence from non-intimate partners; sexual and gender-based violence among persons with disabilities; and sexual and gender-based violence during the COVID-19 pandemic. Data used for this chapter were limited to only individuals who were currently married or cohabiting with a sexual partner (both females and males) during the data collection. However, some of the outcomes and information are to gauge both current experiences of violence within the last 12 calendar months and retrospective lifetime exposure to violence. The quantitative data provided the estimates of the indicators while qualitative data were used to provide some interpretations and narratives.

8.1 Definition and Measurement

8.1.1 Measures of Economic Violence

In this context, economic violence was construed as any act of deprivation of economic opportunities or forceful collection of money or denial of access to funds for housekeeping, and personal use. This consists of five indicators (see Appendix 8.0. for details) relating to economic issues, as it relates to relationships between women and their male partners. The indicators were carefully drafted to reflect some usual practices associated with patriarchal societies like Nigeria.

8.1.2 Measures of Physical Violence

Physical violence is an act of attempting to cause, or resulting in, pain and/or physical injury. It includes beating, burning, kicking, punching, biting, maiming, or killing, or the use of objects or weapons. In this study, nine

questions were posed to measure physical violence among intimate partners (see Appendix 8.0 for details).

8.1.3 Measures of Sexual Violence

According to the World Health Organisation (WHO), sexual violence refers to any sexual act or attempt to obtain a sexual act, or unwanted sexual comments or acts to traffic, that are directed against a person's sexuality using coercion by anyone, regardless of their relationship to the survivor, in any setting, including at home and work. The study utilised seven questions to measure the extent of sexual violence (see Appendix 8.0 for details)

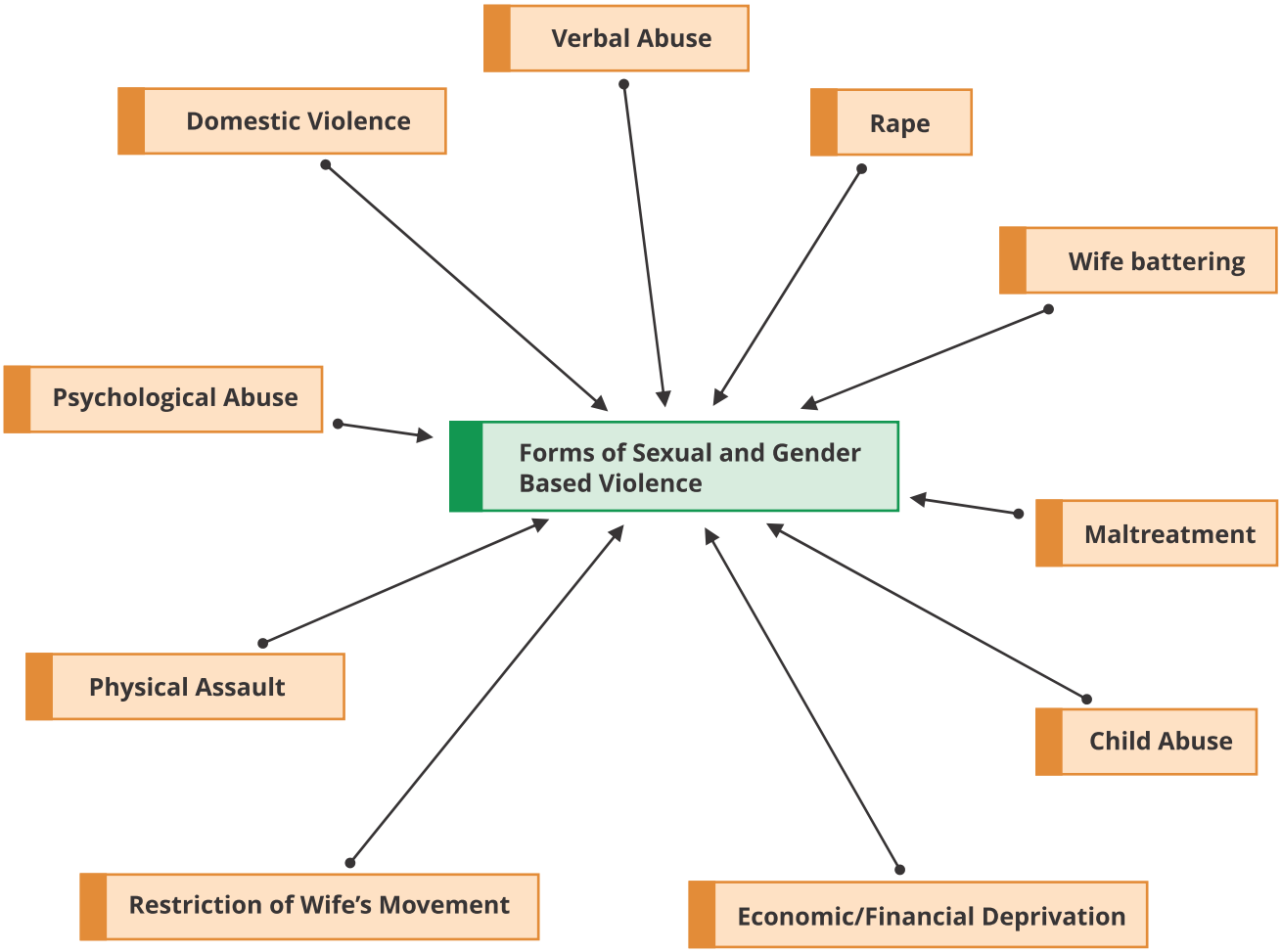
8.1.4 Measures of Partners' Controlling Behaviour

Partners' controlling behaviour refers to a range of acts designed towards a sexual partner to make her/him subordinate and/or dependent by isolating her/him from sources of support, exploiting their resources and capacities for personal gain, depriving her/him of the means needed for independence, resistance and escape and regulating her/his everyday behaviour. This study utilised fourteen questions to measure the extent of partners' controlling behaviour (Appendix 8.0 provided the details).

8.2 Experiences of Sexual and Gender-Based Violence

Evidence from the qualitative sources reiterates the commonality of cases of SGBVs, including those that are often reported and those hidden in most cases. As shown in Figure 50, the manifestation of SGBV cases reported across the communities included various forms of emotional abuse/controlling behaviour, physical violence, and sexual and economic violence.

Figure 50: Forms of sexual and gender-based violence prevalent in the study communities.



8.2.1 Sexual and Gender-Based Violence Cases Commonly Reported

Qualitative evidence from health care operatives and the police show that forms of SGBV commonly reported are wife battery, girls' defilement, rape and sexual assault, forced marriage, and denial of resources. The Police also included other incidences such as child labour, child trafficking, and child marriage. Both the police and the health workers confirmed that perpetrators are usually family members and neighbours. Excerpts in Box 8.1 give credence to these assertions.

BOX 8.1: Excerpts from KIIs with Health Workers and the Police

Talking of sexual abuse and gender-based violence, in our observation at the centre, the regular cases we see in this community, which you will also find in our records are actually physical assault, rape, sexual assault, denial of resources and forced marriage. **KII with health facility in Adamawa State**

Sexual exploitation of a child, unlawful sexual intercourse of a child, in some cases the father turns the child into his sex partner, rape, domestic violence, child marriage, child labour, trafficking, and abandonment of a baby. **KII with the Police in Kwara State**

8.2.2 Cases of Sexual and Gender-Based Violence not Commonly Reported

Cases of SGBV that are unlikely to be reported were also mentioned and they include psychological or emotional abuse, incest, battering, economic/financial violence, forced marriage, rape and other sexual violence especially if it was perpetrated by a spouse or a family member (see Box 8.2). Participants explained further that some people do not report these cases because they do not want their husband to be shamed so that it would not aggravate their violent experience with him. Some do not report due to ignorance of where to seek redress.

Stigmatisation is another reason some victims do not report, especially in the case of rape. They believed that if people should know about it, the survivor would not be able to move freely in the community without being ridiculed or stigmatised. The way rape cases are handled by the police also made some survivors choose not to report violations.

8.3 Estimates of Intimate Partners Violence in Nigeria

This section presents the estimates of the extent of exposure to intimate partners' abuse at different levels including national, zonal, and state levels. In addition, the extent of exposure across some important households and individual characteristics were presented. Two measures of abuse were used including lifetime exposure (ever) and current experience (within the last 12 months). These two measures were important as they provide an opportunity to tease out the extent of IPV, particularly within the context of COVID-19.

8.3.1 Estimates of Women's Experience of Intimate Partner Violence and Male Partner's Controlling Behaviour

Economic Violence by Intimate Partners

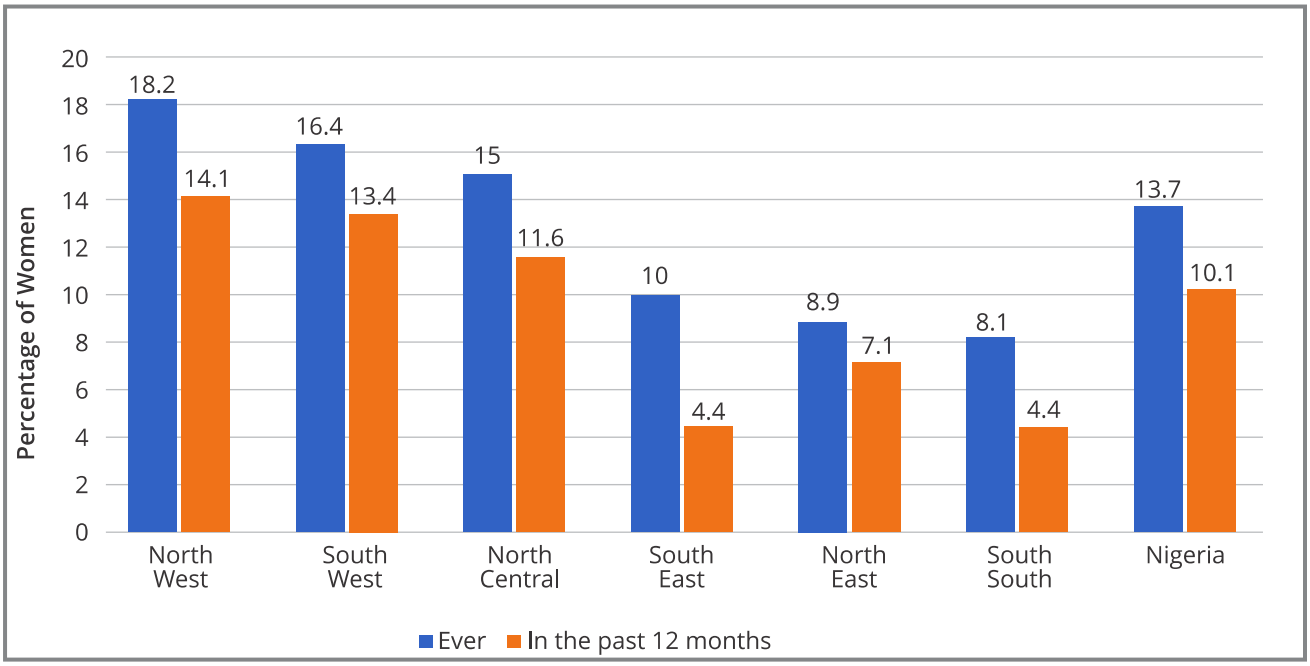
Overall, an estimated 13.7% of married Nigerian women reported ever experiencing financial abuse while about 10.1% had such experience within the last 12 months. At the zonal level, the proportion of women who reported either lifetime or current exposure to economic abuse ranged from 18.2% and 14.1%, respectively in the North West Zone to 8.1% and 4.4%, respectively in the South South Zone. The North West, North Central and South West zones recorded rates above the national rates while other regions recorded rates below the national rates, as presented in Figure 51. It is noteworthy that the North East zone experiencing over a decade-long insurgency and the worst humanitarian crisis since Nigeria's civil war reported the lowest rate among the Northern zones.

Box 8.2: Excerpts from FGDs & KIIs with NGOs/CBOs

In most cases, cases of rape are being underreported. In most cases, they don't report. One of the major reason is the issue of stigmatisation, they don't want other people to know because of the way they will be looking at them. Other issues are lack of trust in the judicial system, that even if they go, nothing will happen. **FGD with NGOs/CBOs in Kwara State**

Ignorance and not knowing where to go to. Some don't see it as something bad. They see spousal battery and spousal rape as normal in the society. The police don't help as they tell the victims it is a family issue. **KII with NGO in Edo State**

Figure 51: Women's experience of economic abuse by intimate partners by zones



Physical Abuse by Intimate Partners

The zonal estimates for women exposed to physical abuse are presented in Figure 52. Overall, 14.3% of the women interviewed had experienced physical abuse in their lifetime, while approximately 12.5% had the experience within the last 12 months. At the zonal level, the North Central and the North West zones had the highest proportion of women that had ever and in the last 12 months experienced physical violence (20.7% and 14.6%, respectively) while the South South Zone had the lowest proportions (4.7% and 3.4%, respectively). Women in the North Central Zone had rates above the national average, while curiously the rate in the North East Zone was the second lowest, much below the national average.

Sexual Abuse by Intimate Partners

Overall, 11.5% of the married women reported ever experiencing sexual abuse from their intimate partners while about 8.6% had such experience within the last 12 months preceding the study (Figure 53). At the zonal level, the proportion of women reporting either lifetime or current experience of sexual abuse was highest in the North Central Zone (ever: 20.8%; current: 17.6%) and lowest in the South West Zone (ever: 5.4%; current: 2.3%). The distribution is disproportionately higher in the northern zones compared to the southern parts of the country. It is noteworthy that the North East zone had the second highest rates of 11.5% and 8.6% of the women ever and currently experiencing physical violence, respectively.

Figure 52: Women's experience of physical abuse by intimate partners by zones

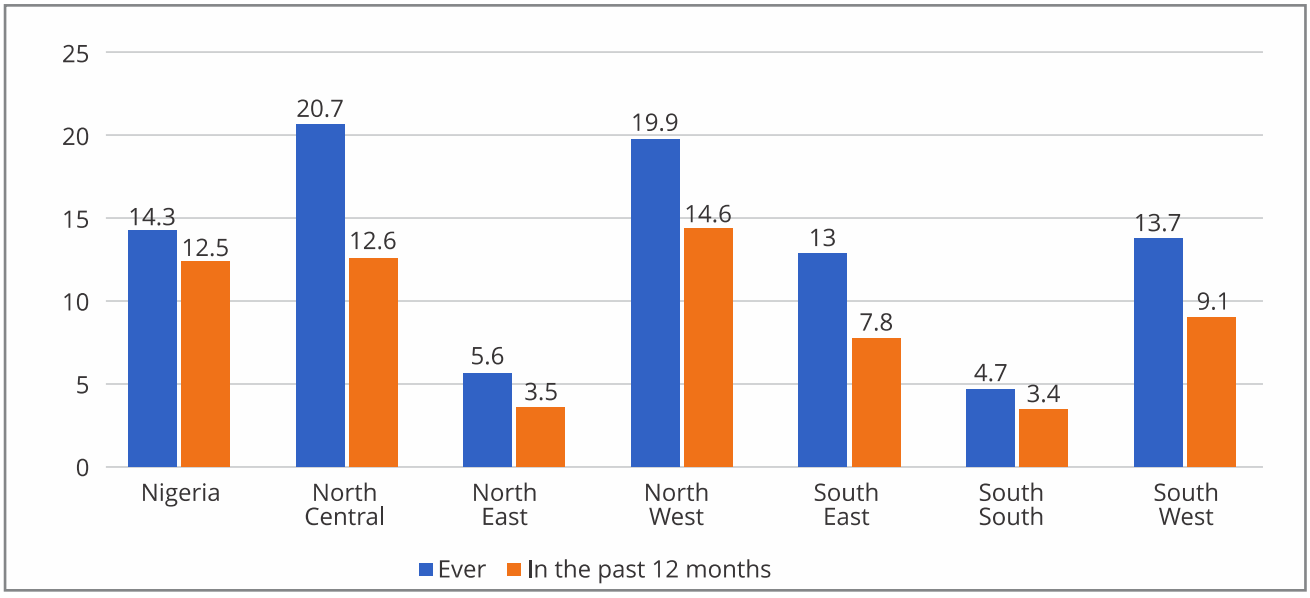
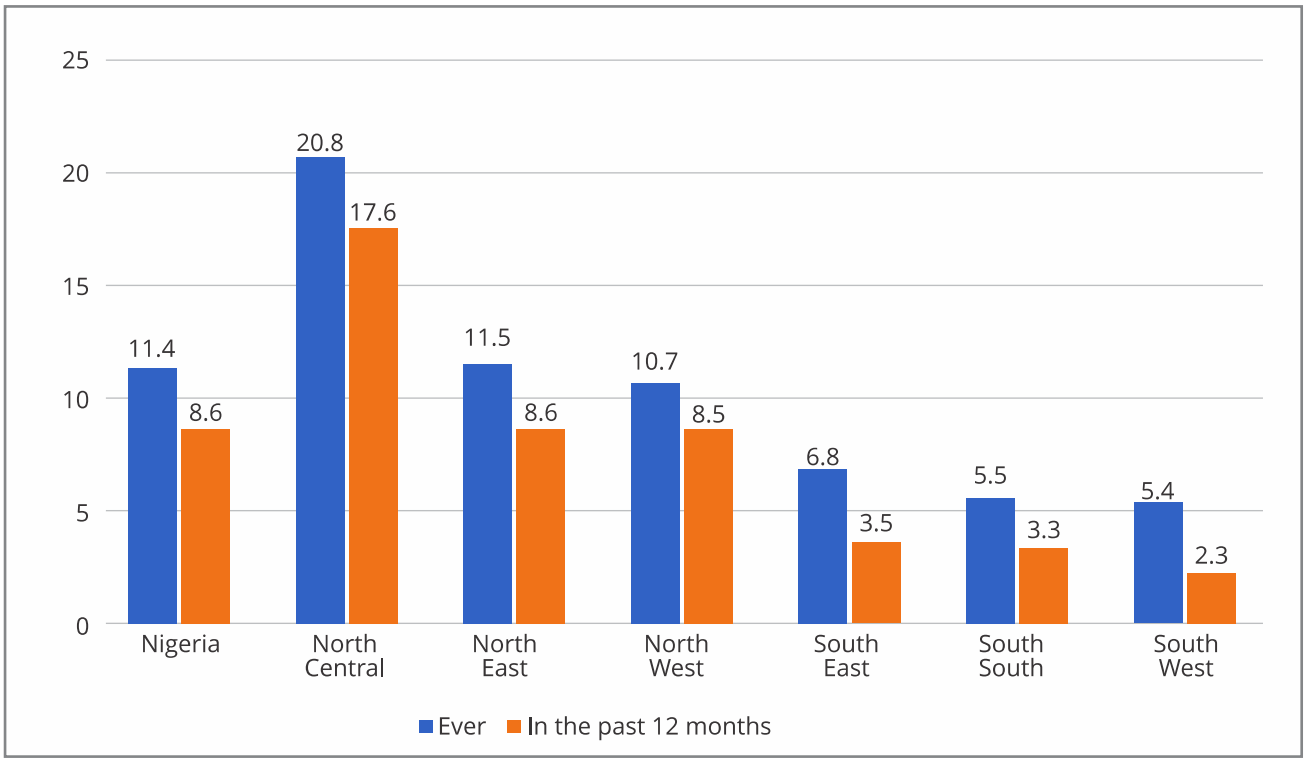


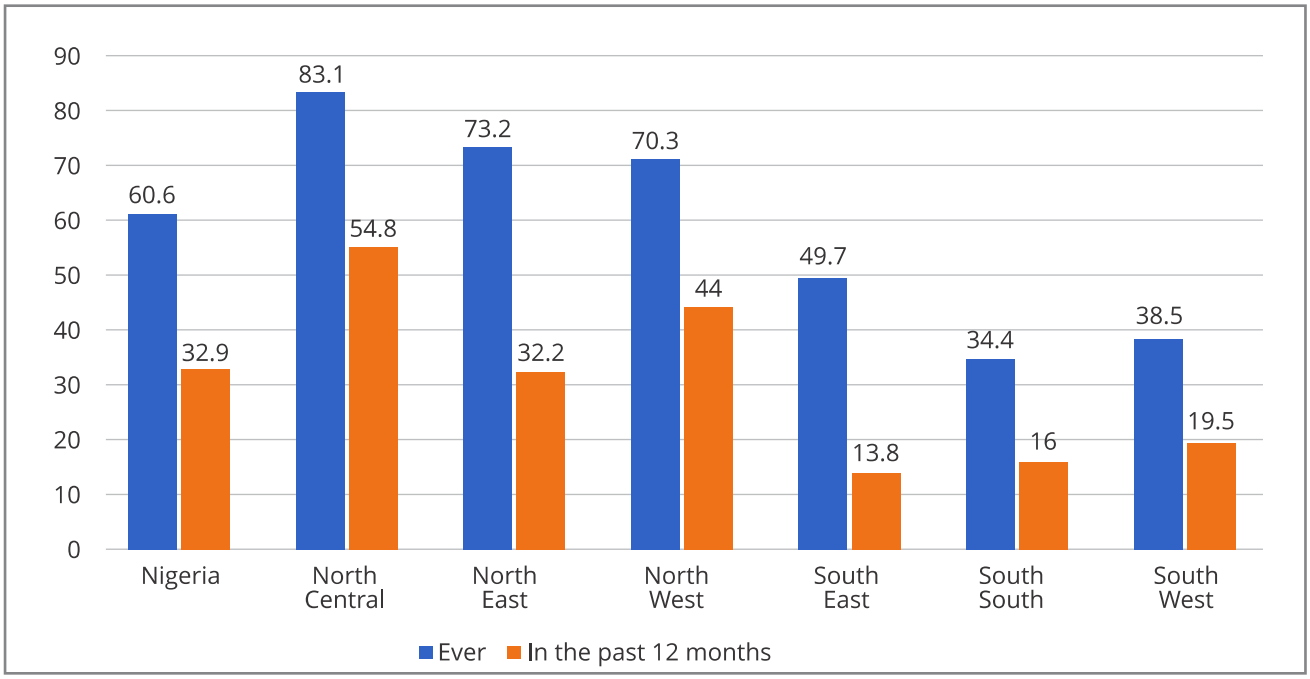
Figure 53: Women's experience of sexual abuse by zones



Women's Experience of Intimate Partners' Controlling Behaviour

Women's experience of intimate partners' controlling behaviour as presented in Figure 54 indicates an overall, 60.6% of Nigerian women interviewed had ever experienced a male partner's controlling behaviour and 32.9 % in the past 12 months. However, the lifetime prevalence in the North Central (83.1%), North East (73.2%) and North West (70.3%) were higher than the national average. The rates in the southern zones were considerably lower than that of the national level. Similar trends were observed in the last 12 months preceding the study.

Figure 54: Women's experience of intimate partners' controlling behaviour by zones



Evidence from the qualitative data further captures the enshrinement of a gendered differentiated sense of apportioning rights and privileges. Across the communities and groups, participants' description of roles, rights and responsibilities in intimate relationships was dominated by gender biases and discrimination to the disadvantage of women. Within this frame, men are largely favoured and permitted to a high degree to exercise socially approved rights and privileges on the bodies of their partners or spouses. However, women are encouraged to be passive and submissive to ensure relationship stability and social acceptance. Men are pardoned when these rights and privileges are poorly or over-exercised. Women, on the other hand, are sanctioned and punished for violating or resisting the expected submission that would help men retain their privileges and positions. Violations in different forms were then expressed and described within this sense of roles, responsibilities, privileges, and rights in intimate partner relationships.

Women's Experience of Intimate Partners Violence

The distribution of women's experience in each of the four IPV areas across some basic characteristics is presented in Appendix 8.1a. For economic abuse, a comparatively higher proportion of lifetime and current experience were reported among the women who were younger (10 – 14 years), urban residents, had primary education, Hausa by tribe and were from households with the lowest wealth quintile. Across some socio-demographic characteristics, economic abuse is more reported among women of younger ages 10-14 and those aged 15-19 years. About 23.3% of the young women 10-14 years old compared to 17.1% of those 15-19 years had ever experienced economic abuse, while 22.1% and 13.7% of the age groups, respectively, reported the experience in the last 12 months. Compared to other age groups, adolescent and young married women are disproportionately exposed to financial abuse compared to older ages. Interestingly, women in urban areas and those with no education or less than a secondary education were more likely to suffer financial abuse than other groups.

At the state level, the proportions of married women who reported financial abuse within the last 12 months were higher in Sokoto (24.7%), Ogun (23.3%), Adamawa (19.4%), and Nasarawa (17.6%) states. Married women from Bauchi (0.3%), Ebonyi (1.8%) and Kaduna (3.3%) recorded the least experience of financial abuse within the same reference period. Women in the lowest wealth quintile (13.1%) were twice more likely than women in the highest quintile (6. 5%) to report a current experience of financial abuse.

Lifetime experience of physical abuse by intimate partners was more prevalent among young women, in the age group 10 -14 years (21.7%), who had some primary education (16.3%), resided in urban areas (16.5%) and are Hausa by tribe (17.1%). Women in the lowest wealth quintile (12.5%) were twice as likely to report a recent experience of physical abuse as women in the highest wealth quintile (6.5%). There were wide variations in the experiences of physical violence at the state level. Remarkably, very high rates of lifetime and current experiences of physical violence were reported in Nasarawa (37.6% ever; 22.8% currently) and Sokoto (29.6% ever; 22.1% currently), compared with Bauchi (1.1% ever; 0.4% currently) with the lowest rates.

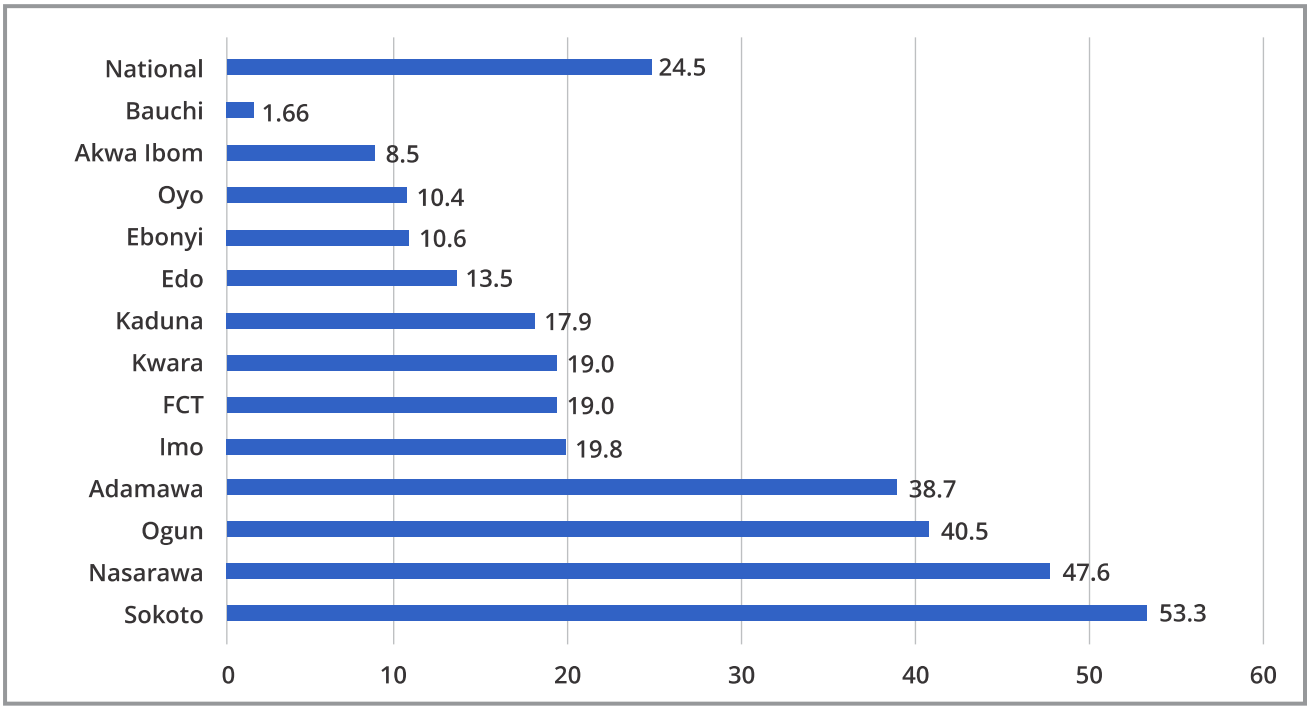
Regarding sexual abuse, respondents who were adolescents, from rural areas, with no education, Hausa by tribe, in the lowest wealth quintile and from Sokoto state reported higher rates than other groups. Generally, sexual violence decreased with age. Girls aged 10-14 years (21.7%) were twice and thrice more likely to report a lifetime and current experiences of sexual violence, respectively, compared to women in the age group 46-49 years (9.0%, 7.3%). Women in the lowest wealth quintile (lifetime 19.8%; recent 15.6%) are five and eight times more likely to report a lifetime and recent experiences of sexual abuse respectively than women in the highest wealth quintile (lifetime 3.9%; recent 2.0%). Hausa women (19.5% ever; 16.1% current) were three and five times more likely to report lifetime and current experience of sexual violence, respectively, compared to Igbo women (5.6% ever; 2.8% current). Across the states, the rates of sexual violence ranged from 35.0% lifetime and 31.6% current experience in Sokoto State to very low rates of 0.3% and 0.0% in Bauchi State.

Adolescent and young married women are more exposed to controlling behaviour from their partners compared to other age groups. About 71.8% of the young married women 10-14 years old and 64.3% of those aged 15-19 years had ever experienced a partner's controlling behaviour, with 40.4% and 42.3% of those aged 10-14 years and 15-19 years, respectively, reporting the same in the last 12 months. Rural women (lifetime 62.8%; recent 34.2%) and those with no (lifetime 62.8%; recent 32.2%) or only primary education were more likely than other groups to suffer controlling behaviour. Women from the North-Central (54.8%) and North-West (44.0%) were more exposed to their partner's controlling behaviour than women from other zones. At the state level, the proportions of married women who experienced the behaviour in the last 12 months were higher in FCT (81.5%), Kaduna (60.0%), Nasarawa (57.4%), and Kwara (48.0%), unlike in other states, especially Imo (13.5%), Ebonyi (14.2%), and Akwa-Ibom (15.8%). Women in the lowest wealth quintile (34.2%) were more likely to experience a current partner's controlling behaviour than those in the highest wealth quintile (24.4%).

Prevalence of IPV experiences by women

When women experiences of physical, sexual and economical abuses were aggregated (see Appendix 8.1b), the national prevalence of lifetime experience of IPV reported by women is 24.5%, while the aggregated experience of IPV within the last 12 months is 18.4%. Figure 55 present data on lifetime experience of IPV across states compared to the national average.

Figure 55: Women's experience of lifetime IPV by state compared with the national average



8.3.2 Men's Experience of Abuse and Female Partner's Controlling Behaviour

Women are not the only survivors of intimate partner violence; men also have their share of the menace. Men's exposure to each of the four IPV areas across some basic background characteristics is presented in Appendix 8.2. Overall, the experience of a female partner's controlling behaviour in a lifetime was more common among the men (66.9%), unlike physical (27.4%), sexual (8.1%), and economic abuse (6.0%). This pattern is comparable to the men's experiences in the last 12 months preceding the study. The rates are however lower than that of females.

Economic Abuse of Men by Intimate Partner

Overall, 6.0% and 2.7% of the men reported a lifetime and current experience, respectively, of economic violence by their female intimate partners. Disaggregated by zone, the North West (11.3% ever; 5.3% current) and the North Central (8.4% ever; 4.8% current) had the highest rates compared to the South West zone with the lowest rates, 1.8% and 0% of a lifetime and current experiences, respectively, of economic violence. The rates declined with increasing levels of education. Rural dwellers (6.3% ever; 3.1% current), and Hausa women reported higher rates than other groups. Lifetime and current exposures to economic violence were disproportionately more pronounced among young adults aged 25-29 years (10.2%) and the older ones aged 55-59 years (10.9%) than other age groups. A similar pattern was reported in the last 12 months preceding the study. At the state level, the lifetime and current experience ranged from the highest rates (13.7% and 4.0%, respectively) in Sokoto State to the lowest (0.9% and 0.4%, respectively) in Oyo State.

Physical Violence

The overall rates of lifetime and current experience of physical violence reportedly perpetrated by female partners were 27.4% and 21.7%, respectively. The lifetime experience of the violence showed a curvilinear pattern across the men's age groups, with higher rates at the extreme ages. However, the experience was similar across all age groups in the past 12 months. While urban and rural experiences were similar, it was more reported among those with primary education (half-literate) relative to those with no education or post-primary education. Interestingly, men's lifetime exposure to physical abuse was most prevalent in South-Eastern Nigeria (58.9%) compared to the Northern regions (7.3-25.4%) and the other Southern regions (9.8-15.7%). The regional disparities were also depicted in the corresponding ethnic groups - Igbo (52.2%), Hausa

(17.7%), Yoruba (17.6%) and other ethnic minorities (16.7%). At the state level, Imo state had the highest prevalence of men's lifetime and current exposure to physical abuse from their partners (72.6% and 41.5%, respectively). This is followed by Nasarawa (36.7%; 22.6%), Kaduna (35.2%; 25.3%), and Ebonyi (31.7%; 9.6%). Bauchi, Sokoto, Edo, Akwa Ibom and Edo states had the least prevalence of physical abuse (less than 10%) among the men, either in a lifetime or currently.

Sexual Violence

Overall, 8.1% of the men reported ever being sexually violated by their intimate female partners, with 4.2% reporting the incidence taking place in the one year preceding the survey. Lower rates were reported among older men and rural dwellers. The rate of lifetime sexual abuse among men was almost twice as high in urban (8.3%) compared to rural areas. The rates were also higher among those with some primary education and in the ethnic minorities. At the zonal level, the rates were highest in the North Central (ever – 19.7%; current – 12.6%) and lowest in the North East (ever – 2.2%; never - 0.9%). Men from Imo, Bauchi and Oyo recorded a near-zero current experience of sexual abuse.

The qualitative data provided more contexts and insights into the individuals' rights to the body and exposure to sexual abuse within and outside intimate relationships. The majority of the participants opined that, as humans, the inability to meet up with expected obligations is inevitable in every intimate relationship. However, men and women react differently to such failures and would sometimes adopt violence, abuse, and other measures that are presumed effective in enforcing expectations and compliance from their partners. Some men possess the capacity to sometimes accept their failures or that of their partners or spouses in good faith, but the majority were accused of being violent and reactionary to their partner's shortcomings. In contrast, women are expected to be submissive to their partner's sexual demands. This cultural pattern is also reflected in the current prevalence of sexual violence in Nigeria.

Controlling Behaviour

Partner's controlling behaviour is more commonly reported among young men (20–34 years); about 72.2-81.0% reported ever experiencing a female partner's controlling behaviour, unlike those in the older age groups which were about two-thirds or less. However, the prevalence extended to ages 20-54 years with about 40% reporting the experience in the last 12 months, unlike their counterparts outside the age bracket with lower exposure rates. Interestingly, men in rural areas and those with some primary education are marginally more likely to experience a partner's controlling behaviour than other groups. Hausa men from the North Central recorded the highest rates of exposure to controlling behaviour, either in a lifetime (80.4%) or in the last 12 months (59.6%), compared to other geopolitical zones. At the state level, the proportion of men who reported controlling behaviour within the last 12 months was higher in Kwara (67.8%), Akwa Ibom (61.3%), Nasarawa (56.1%), Kaduna (52.3%), Ogun (45.2%), Ebonyi (38.5%), Bauchi (38.4%), Oyo (33.0%), and Abuja (33.0%). Men from Sokoto (23.2%), Adamawa (23.2%), Edo (16.5%) and Imo (11.8%) recorded the least current experience of controlling behaviour.

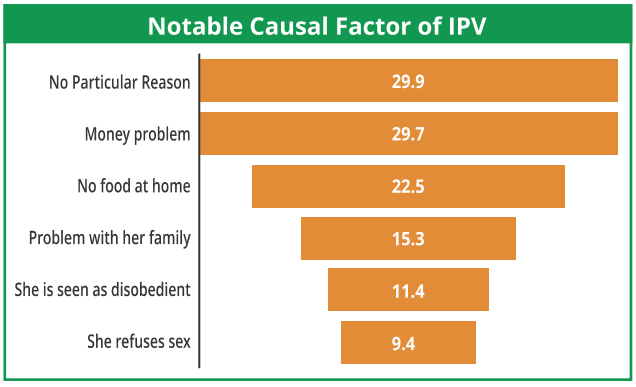
Women's Self-Report of Abuse against their Intimate Partners

Women self-reported their abusive actions towards their spouses (Appendix 8.3). Older women are more likely to perpetrate any form of abuse against their spouses. As women grow older, acts of physical, sexual, and emotional abuse also increase. Though, less than 10% of both rural and urban women perpetrated economic abuse, other forms of abuse were high in the urban area. At the sub-national level, women in Kaduna (12.8%) and Nasarawa (13.4%) reported more economic abuse than in other states. All forms of abuse were relatively high among women in the two states. North Central women perpetrated all other forms of abuse (Economic - 7.7%; Physical - 17.5%; Sexual - 25.9%; and Emotional - 34.9%) more than in other zones. More educated women (18.7%) were more likely to express abusive behaviours towards their spouses.

8.3.3 Narratives About Causes and Sustaining Factors of Intimate Partner's Violence

The major reasons adduced for precipitating IPV across the states bothered five issues ranging from money (29.7%), lack of food (22.5%), issues relating to extended families of the male partners (15.3%), female partners' disobedience (11.4%), and refusal to meet partner's sexual need (9.4%). However, about 29.9% of women believed that it is difficult to zero in on a particular reason for IPV, suggesting that it can be triggered by any slight provocation (see Figure 56).

Figure 56: Triggers of IPV



Results from the qualitative data provide further insights into the reasons for IPV. A woman who, for some reason, refuses her husband's sexual demand attracts the husband's ill- treatment, including physical, economic, and emotional violence. This opinion was expressed across all the states and even by some service providers and NGOs.

> *"If she fails in her wifely duties in the area of sex, not that she's sick, she eats your food, and at night, she sleeps like a log of wood, refusing the husband's overtures, she is asking for nothing, but some beating. This is a regular occurrence here, and no one is ashamed about neighbours' hearing. Let them hear. Sometimes, you hear a couple fighting, and you want to help them settle, and they are not shy to let you know what is going on. There is no secret about wanting to sleep with your own wife!"* **(FGD, Older married men, Nasarawa)**

> *"A man has the authority to beat his wife! The reason a man beats his wife is the same reason a parent beats the child. There are men that also beat their wives because they will want her to know that they are in charge. It is also a reason."* **(FGD, NGOs, FCT)**

The qualitative evidence reiterates sexual refusal as a form of deviant act that often attracts negative reactions from husbands, especially if poorly managed. In general terms, the participants believed that men have the right over their wife's or partner's body. A wife is expected to be submissive, loyal, and faithful to the husband. However, men are culturally not obligated to be loyal, and faithful to their wives. A wife caught in extramarital affairs is treated with disdain and as an outcast, unlike the husband when caught doing the same.

Box 8.3: Excerpts from FGDs with Community Leaders and the Service Providers

Illiteracy and tradition are causing all these (sexual rights violations. If the people are educated, this will reduce, and if not because of culture, it'll reduce too, but they will say this was how it was done to them. It's their culture and they'll continue doing this. **FGD with community leaders, Kaduna**

Another cause of violence against women is the exorbitant cost of bride price, because that alone makes a man feel like, after I have spent so much in marrying you, I have a right to do whatsoever I can do with you. You are my property, and I own you now. So, for them whenever they need sex or they want to consummate, you would have no right to say no because they own you, your body, and you are supposed to serve them. Your body belongs to them and all of that. **FGD with service providers, Akwa Ibom State**

Box 8.4:

Indecent dressing, over-displaying yourself causes sexual violence in the community. **FGD with opinion leaders in Edo State**

The way some girls dress, the way they look, that is one of the things that is causing this thing (sexual violence). You will see a girl going half naked, or even if the person is not going half naked, the type of trouser the person wear, you will be seeing everything. So, all those things will attract the men to go and rape the girl. **FGD with married women in Ebonyi State**

Those ladies too are the cause of rape, they dress seductively. A young man is walking on his own with no intention, the young lady seduce the young man and the game of raping came out. **FGD with married men in Ogun State.**

Men take prerogatives over all kinds of marital relations. They are considered as being in charge and therefore have the prerogative of dictating the pace of the relationship, conformity to normative expectations and the ability to sanction, in case of deviation. This sense of responsibility also gives men the privilege to appraise and approve the physical attractiveness of their partners/spouses, approve their movements, who to associate with, and what forms of relationships are beneficial to them. Similar censorship and evaluations are not expected from women despite their stakes and status in the relationship. Men, on the other hand, would want to explore new forms of relationships, without forcing similar conformities on them.

The right to the woman's body also exonerates the ills and misdeeds of a male partner. Women can negotiate and earn some level of respect from their husbands, depending on their economic status, educational levels, and social status. However, the common expectation for the average woman is submission and the obligation to forgive whether or not the husband or partner is accountable.

8.3.4 Network of Contexts and Situations that Support Sexual Rights Violations

The context and situations supporting sexual rights violations were explored across the selected states and geopolitical zones. Various factors (see Box 8.3) responsible for the sexual rights violations of women and girls either within or outside marriage were identified. Some of the factors include the patriarchal culture of male supremacy over women; the inability of women/girls to condemn patriarchal norms; the permissive lifestyle and indulgence of men in alcoholism, smoking, and drug/ substance abuse. Other associated causes of SGBV could be poverty and associated practices

Box 8.5:

This also happens as a result of using traditional concoctions for sexual potency by men. When such happens, a man can sexually assault the woman because of excessive use of the concoctions. **FGD with married men in Bauchi**

such as child labour which exposes the children to the risk of all forms of abuse including rape, ritual killing, and human trafficking. Frustrations caused by infertility among married couples can also expose married women to sexual abuse and ignominy.

It is generally believed that indecent dressing contributes to incidences of rape (blaming the survivor). Some participants believe that the mode of dressing often puts young girls into trouble, exposing them to sexual molestation (see Box 8.4). Some abhorred women wearing pants in public places and see this as the root cause of sexual violence against women. The indecent dressing of girls was more emphasised in the South East, South-South and the South West. These are regions where women are exposed to western education and lifestyle. The contradictions between local cultures and modernisation, especially affecting gender roles, norms and gender expectations are at the centre of this argument.

Notably, the rejection of a man's proposal for marriage and/or an intimate relationship with a woman can also result in sexual and gender-based violence. Evidence from Akwa Ibom State, in particular, shows that when a lady rejects a man's proposal for an intimate relationship, he can (as a result of personal frustration) turn around to sexually assault and/or gang rape the girl, causing her shame, physical and emotional pains.

Alcohol and hard drug intake are other strong factors acknowledged by participants as causes of sexual violence within marriage (See Box 8.5). This opinion was specifically expressed by participants from Akwa Ibom State where men's use of traditional herbs for sexual enhancement was identified as the major cause of sexual rights violations within marriage.

Religion was also considered a factor influencing sexual violence within marriage. Both Christianity and Islam, which are the two dominant religions across the study sites, prescribe that women should be submissive and obedient to their husbands. A woman's refusal to have sex with her husband could, therefore, be easily interpreted as an act of disobedience. This could be a possible reason for husbands' use of force to ensure wives' submission without minding the requisites to earning such submission in marriage. Many community members are likely to be indifferent to religious women who, for one reason or the other, question their husband's authority and demands. This may be linked to

Box 8.6:

There's no rape in marriage. Don't use that word rape. **FGD with service providers in Akwa Ibom State**

You people should stop giving it name, because what is rape in marriage? You see, if, husband wants his wife, and the wife does not want her husband, you see men are not as foolish as you think that they are. There is a way to communicate to the husband and he will let you be. But when you want to do it as if you know you can do it. Me, I will tear your pant, take me anywhere, do you understand. **FGD with NGOs in FCT**

The case of forcing a woman, I mean your wife to make love to her is accepted within this community in the sense that a woman doesn't have a right to report her husband to the elders or her parents that he raped her. We only believe that rape can only be done outside marriage. When two people agreed to marry each other as husband and wife, they are expected to also agree to engage in matrimonial responsibility like being available for each other at the time of sex. **FGD with male community leaders in Nasarawa State**

I don't know why you should ask such question about marital rape. I don't believe a man can rape his wife. In fact, there is nothing like that. Even if the woman should say that her husband raped her, nobody will believe such. People will assume that she denied her husband sex and we haven't heard of such report in our community. **FGD with men of reproductive age in Imo State**

the high proportion of believers in both religions, the likelihood of misinterpretations of what submission entails and possible reactions to insubordination in marriage. Participants in some of the FGDs explained that even if a woman reported an incidence of abuse caused by sexual refusal in marriage, the husband would go unpunished. Some of the participants claimed that rape within the context of marriage, religious beliefs and cultural expectations cannot be established (see Box 8.6).

The married women in Ebonyi State particularly expressed that *"some women use their bodies to wicked their husbands, tomorrow the man will come, she say no, the next he'll come, she say no, because maybe she is demanding for something from him, and for you to deny him to do that thing (sex), he return and say after all, she's a woman and he must overpower her"*. In the same vein, married women in Kwara State noted that *"it is a matrimonial right for husbands to undress their wives and access their bodies for sex as much as a woman lives under her husband's roof"*.

Figure 57: Network Showing Context Supporting Sexual Rights Violations

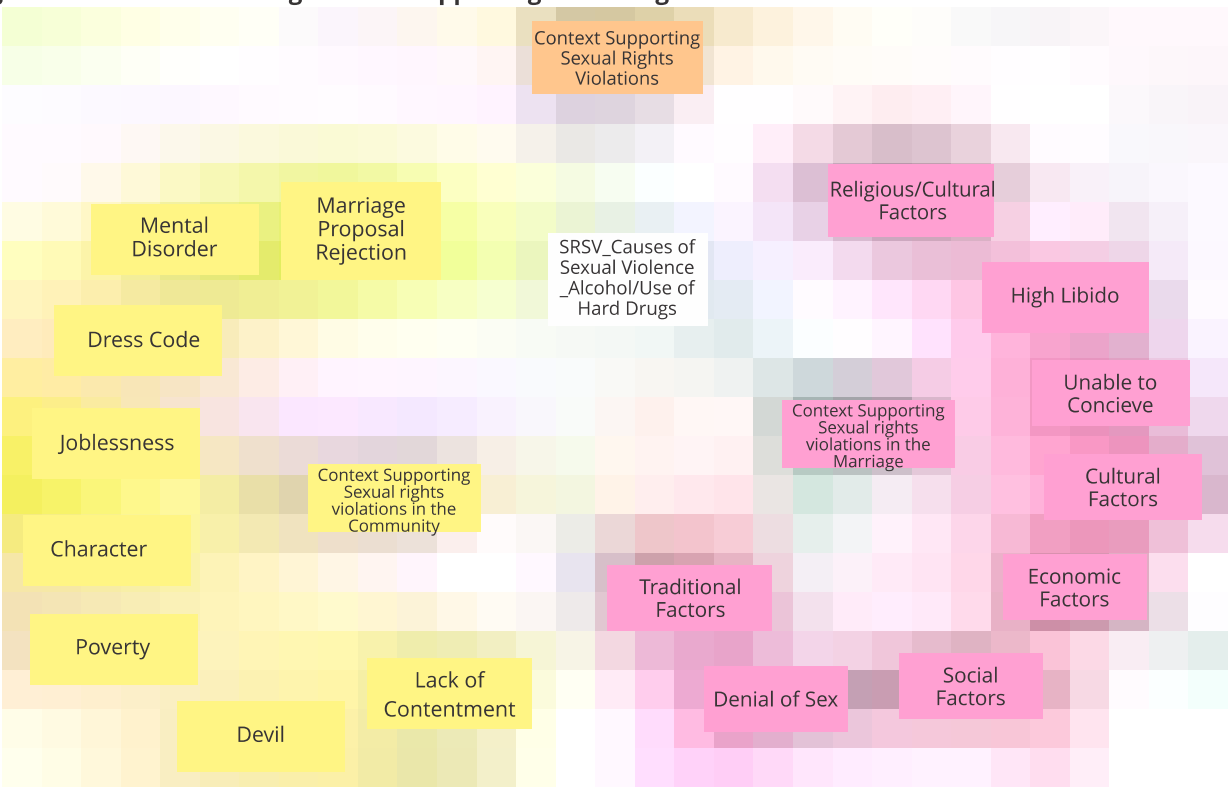


Figure 57 presents a contextual analysis of the violation of girls'/women's sexual rights across the study communities. The network analysis pictures the loci of explanations, dimensions and contexts within which sexual rights violations are sometimes justified or concealed in the communities. In the family, for instance, the violation of a girl's sexual rights by a family member would likely be concealed from public space. Such violations are "covered up", "not spoken about", "not discussed", 'abomination", and often seen as a "family secret". At the community level, sexual violations or abuse is seen "as a shame on the whole family", and women could sometimes be blamed for the occurrence because "they happened to be in the wrong place, and at the wrong time". Interestingly, the perpetrators (who are often males) when caught are likely to be exonerated or freed under the pretext of alcohol or hard drugs influence.

8.3.5 Factors and Rationale Supporting IPV

Factors responsible for SGBV across the different communities were explored. The study found that the cultural contexts of the communities permitting certain rewards and punishment for norms violations as well as the contexts supporting sexual rights violations are largely responsible for the perpetration of SGBV, especially against women and girls. Other factors identified by the participants include infidelity of a spouse, breakdown of trust, loss of family values, wife's materialism, laziness and indiscipline and economic/financial difficulties within the home.

Some participants also mentioned that there could be 'beating for love' (see Box 8.7). The concept of 'beating for love' appeared strange but was documented as a common experience in some States, especially in Akwa Ibom State (South-South Zone) and Ebonyi State (South East Zone). Expression of love was, therefore, seen as one of the causes of sexual and gender-based violence. Some rural women in these States believed that women must be beaten by their husbands when they are wrong to show that their husbands still love them, otherwise the man is considered unloving. While beating is linked to expression of love in some states in the South East and the South-South Zones, it is linked to men's expression of 'power' over women in Nasarawa State and the FCT (North Central Zone).

Further enquiries on the role of infidelity on SGBV revealed that in the case of infidelity from either the husband or the wife, the wife bears the brunt. This is because a wife's involvement in promiscuity can result in a physical assault by the husband. Also, when the wife challenges a husband caught in extramarital affairs, he

Box 8.7: Excerpts from FGDs conducted with women

A man who loves his wife will do everything to correct her, including beating. Beating is strong signal that a husband is not happy with what the wife has done. It is a way of calling her back to her senses. **FGD with women in Akwa Ibom State**

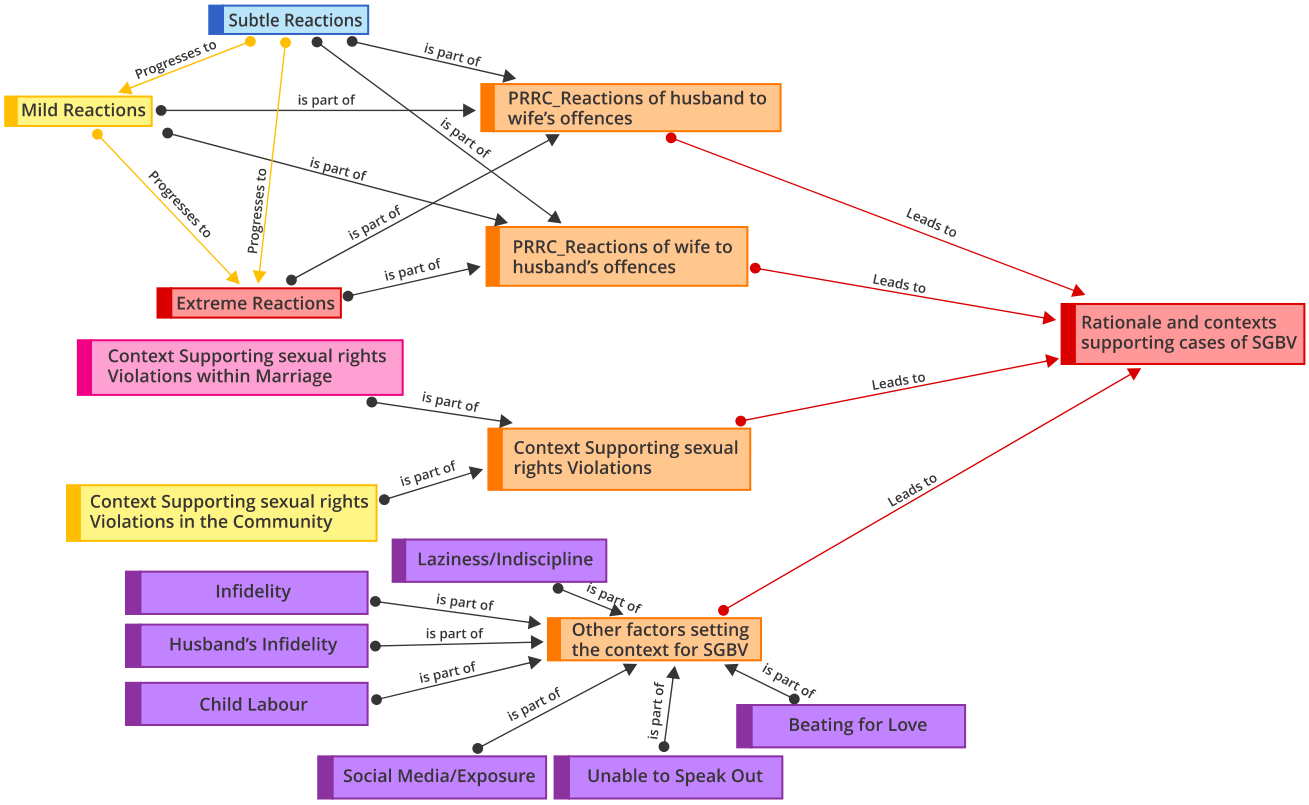
could be annoyed and physically assault her. This opinion is common across all the study states. Economic problems were also mentioned across all the states as one of the causes of SGBV. Participants were of the view that men's inability to fulfil their domestic financial obligations could make them turn aggressive and physically assault the wife or children at any little error from them.

The cultural norms which give men some sort of absolute power over women are often misused such that men treat their wives and children as mere properties. Men who indulge in incest, sometimes give excuses for this, claiming a right despite strong cultural taboos against incest. A Gender Desk Officer quoted the words of a perpetrator thus, "she is my child, I can do whatever I like with my child". Various FGD sessions across the study communities and KIIs with relevant stakeholders and community leaders also identified the factors supporting SGBV (see Figure 58).

Field discussions and interactions pointed to four major categories of factors supporting the perpetration of SGBV across the different study states, as presented in Figure 57. These are:

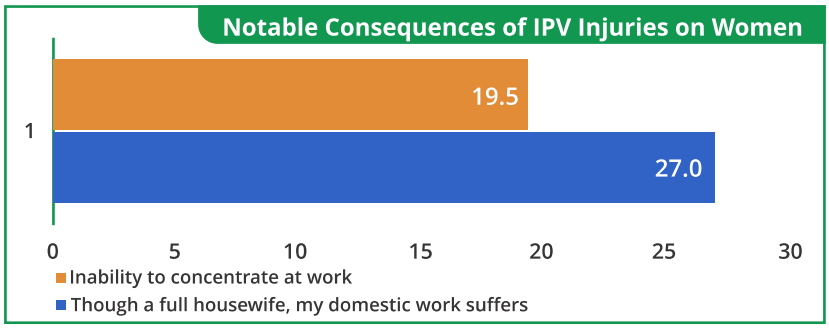
I. the gender and social norms on rewards and punishments for husbands' offences;
ii. the gender and social norms on rewards and punishments for wives' offences
iii. the socio-cultural context supporting sexual rights violations
Iv. individual, household and community factors setting the context for SGBV across the States.

Figure 58: Factors providing rationale and Context for IPV



The women's perceived consequences of IPV are reflected more in its implications on women's work roles. About 27.0% of the women believed that IPV hurt their effective functioning at home and in attending to domestic work. About one-fifth of the women believed that IPV affected them negatively in the workplace (see Figure 59).

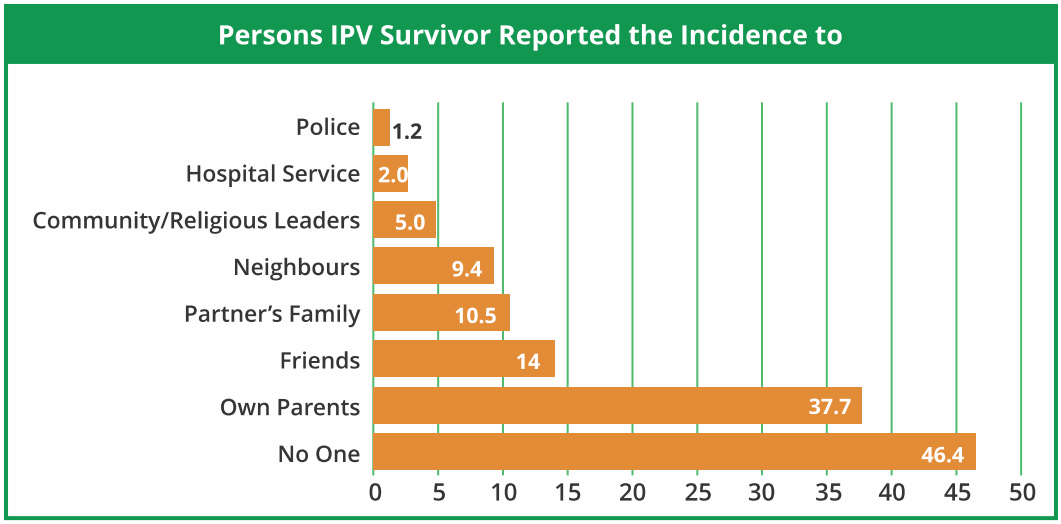
Figure 59: Impact of IPV Injuries among women



The consequences of IPV for survivors are obvious and concrete, though fluid and dynamic, within the contexts and networks of relationships. Thus, at this point, additional insights into the actions, inactions, interpretations and contextual expectations around the reality of SGBVs in Nigeria become more critical. The next section of this report highlights the evidence and the explanations that were provided across the study sites.

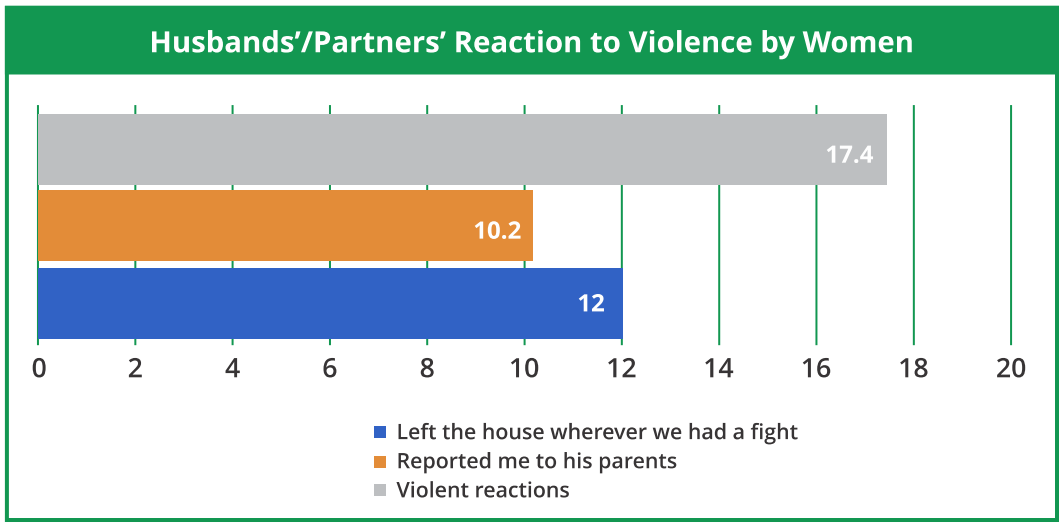
8.3.6 Actions and Inactions in the Occurrence of Abuse/Violation

Figure 60: Reporting of IPV



The central roles played by the different stakeholders in response to SGBV cases across the various states are explored in this section. These include the attitudes, as well as the actions taken by state and non-state actors. The state actors include the health workers, the police, the judiciary and other relevant government agencies, while the non-state actors were the survivors and their families (responsible for reporting, prosecution and seeking justice), the community (responsible for punishing the perpetrators, and providing care and support for the survivors), and the local NGOs/CBOs.

Figure 61: Partner's reaction to violence



Certain conditions such as the woman's state of health are permissible, even when a woman is not able to perform some rights and duties within intimate relationships. Under such conditions, a woman may not be violated or assaulted for her inability to cook or perform other wifely roles. In espousing the tenable excuse of health challenge, participants across the FGDs cited that ill-health permits women to decline their spouse's or partner's sexual demands. Moments of grief or mourning could also provide an avenue or opportunity to refuse sexual requests.

Women's Reactions to Abuse/Violation from Husband/Partner

In the event of intimate partner violence, nearly half (46.4%) of the survivors (women) reported their experience to no one. The rest of the survivors identified seven main sources of help they have enjoyed in the aftermath of IPV. Figure 60 shows that, while about 37.7% reported to their parents, significant others reported the experience to their friends (14.0%) and partner's family (10.5%). Only a few resorted to help from neighbours (9.4%), community/religious leaders (5.0%), hospital facilities (2.5%) and police stations (1.2%).

Men's Reactions to Abuse/Violation from Female Partner

Figure 61 presents the reports of women on the likely reactions of their husbands/partners to IPV. About 17.4% of the women reported that their husbands/partners were likely to react violently, 12.0% of the men vacated their homes while the rage lasted and about 10.2% took solace in reporting the issue to one or more significant other/s (friends, the partner's family members or/and parents).

The impact and response to violence and different forms of abuse inflicted by women varied by demographics. The qualitative data revealed that men reacted violently by beating or fighting their spouse and/or sending her out of the house. Other ways men reacted to women's abuse were leaving the house to drink, taking another wife, and reporting such a woman to her parents.

The findings revealed that survivors of sexual violence refrained from seeking justice because they did not trust the legal system. The belief that nothing would be done even if they reported the case hindered them from bringing perpetrators to justice.

8.4 Non-Intimate Partners' Sexual and Gender-Based Violence

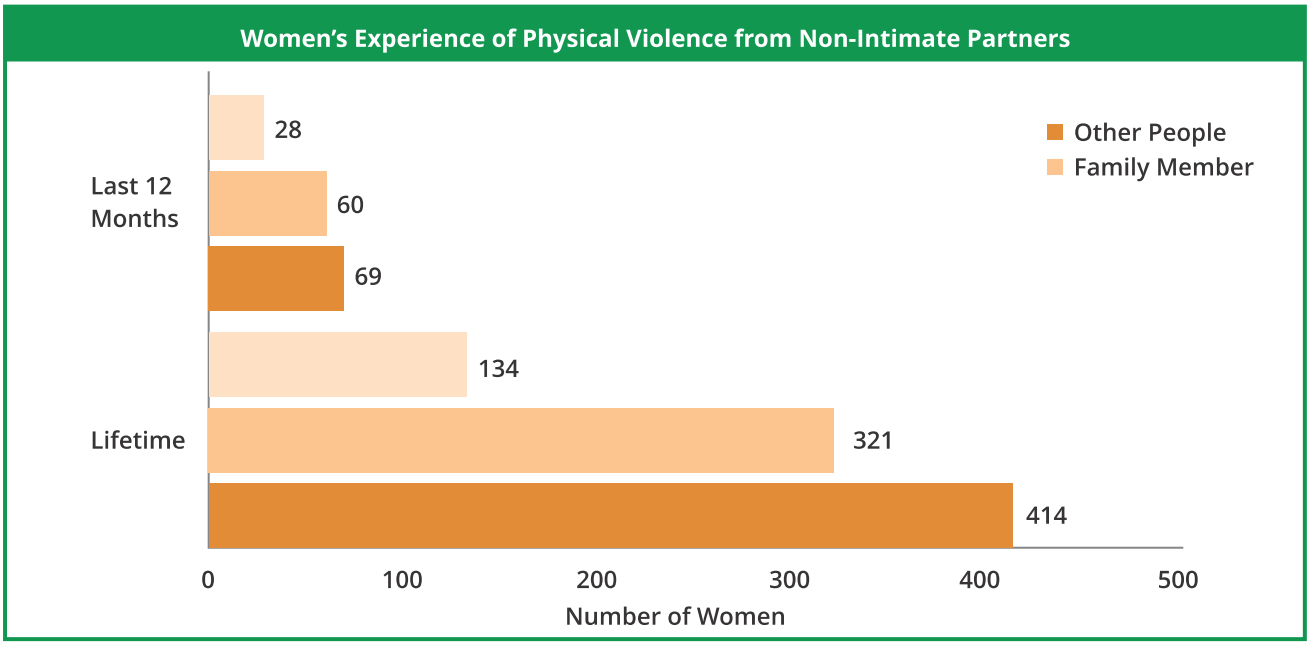
8.4.1 Women's Experience of Physical Violence from Non-Intimate Partners

Women's exposure to violence does not only emanate from intimate partners but also non- intimate partners. The majority of the physical violence from non-intimate partners was from a family member. As shown in Figure 62, about 414 (6.5%) of the women who participated in this study reported a lifetime experience of physical violence from non-intimate partners such as family members (321, 5.1%) or other people (134, 2.1%). About 70 (1.1%) of them had the experience in the last 12 months.

The result in Appendix 8.5 indicated that the lifetime experience of a non-intimate partner's physical violence was more pronounced among younger women between the ages of 10-24 (8.1 - 8.9%). The pattern of the women's experience of physical violence from non-intimate partners was similar for the last 12 months before the survey. The Yoruba women had the least lifetime experience of non-intimate partner's violence from either family members or other people (about 3.1%), unlike other ethnic groups (7.0-7.6%). The experience was more pronounced among the cohabiters (12.6%) and never married (9.8%) compared to other marital groups. Also, women with formal education (7.2%) and those with no formal education (5.5%) experienced more lifetime physical violence from either family members or other people compared to the women of other educational groups, Islamic (3.9%) and adult education (1.5%). The experience was also higher among the unemployed (7.4%) than the employed women (5.7%).

Examining the regional differences, the women's lifetime experience of physical violence from non-intimate partners was similar to that of the last 12 months and across the regions (7.0- 8.6%) except the South West (3.2%) with the lowest prevalence. Physical violence from

Figure 62: Women's experience of physical violence from non-intimate partners



either a family member or other people was most reported in some northern states including Nasarawa (11.2%), FCT Abuja (11.0%) and Bauchi (10.9%), and a Southern state, Edo (11.2%). The prevalence was lowest in Oyo, Kwara, and Akwa Ibom (less than 5%).The non-intimate partner's violence was similar for the women irrespective of religious affiliation, wealth quintile, place of residence, and either in a lifetime or in the last 12 months preceding the survey.

8.4.2 Women's Experience of Sexual Violence from Non-Intimate Partners

Figure 63 indicates the women's experience of sexual violence from non-intimate partners. Overall, about 145 of the women have experienced sexual violence from non-intimate partners in their lifetime and 12 in the last 12 months. The reported lifetime sexual violence was more perpetrated by other people (86) compared to the ones by family members (66), with a more glaring gap in the last 12 months (11 versus 2).

The result in Appendix 8.6 indicated that, generally, the lifetime experience of sexual violence from non-intimate partners, either from a family member or other people, was low (less than 5%). The experience was similar and less than 5% across all the background characteristics except for marital status with about 5.9% of the cohabiters reporting lifetime sexual violence from either a family member or other people since reaching the age of 15 years. The prevalence was much lower (less than 1% in most cases) in the last 12 months preceding the survey. The results in Appendix 8.7 further depict the women's lifetime experience of sexual violence before reaching the age of 15 years. As shown in the table, generally, just about 1.2% of the women reported sexual violence from a family member or other people before their 15th birthday. The prevalence was similar across the background characteristics of the women except for marital status with about 5.5% of the cohabiters being sexually abused by family members or other people when they were below 15 years of age.

8.4.3 Perpetrators of Violence against Women

The result in Figure 64 indicates the perpetrators of physical and sexual violence against women. The largest non-intimate perpetrators of physical violence against women were their fathers (37.5%) and other family members (23.5%). These are followed by other perpetrators including teachers (16.7%), male school/play mate (11.8%) and female family members (11.6%). However, cases of sexual violence against women are most committed by strangers (34.5%), male family member (25.9%) and male school/play mate (15.3%).

8.4.4 Men's Experience of Physical Violence from Non-Intimate Partners

The result in Appendix 8.8 indicated that, generally, about 8.3% of the men reported a lifetime experience of physical violence from non-intimate partners, either from a family member (5.8%) or other people (4.8%). The experiences were more prevalent in the youngest age group 15-19 years (20.7%) and the oldest age groups, 65+ years (16.2%), and were more from family members than other people. The men's exposure to violence was also more reported among Christians (11.1%) compared to Muslims (5.5%) and traditionalists (2.4%); among Igbo (20.5%) compared to other ethnic groups which were less than 10%; among the divorced/separated (16.8%) and

Figure 63: Women's experience of sexual violence from non-intimate partners

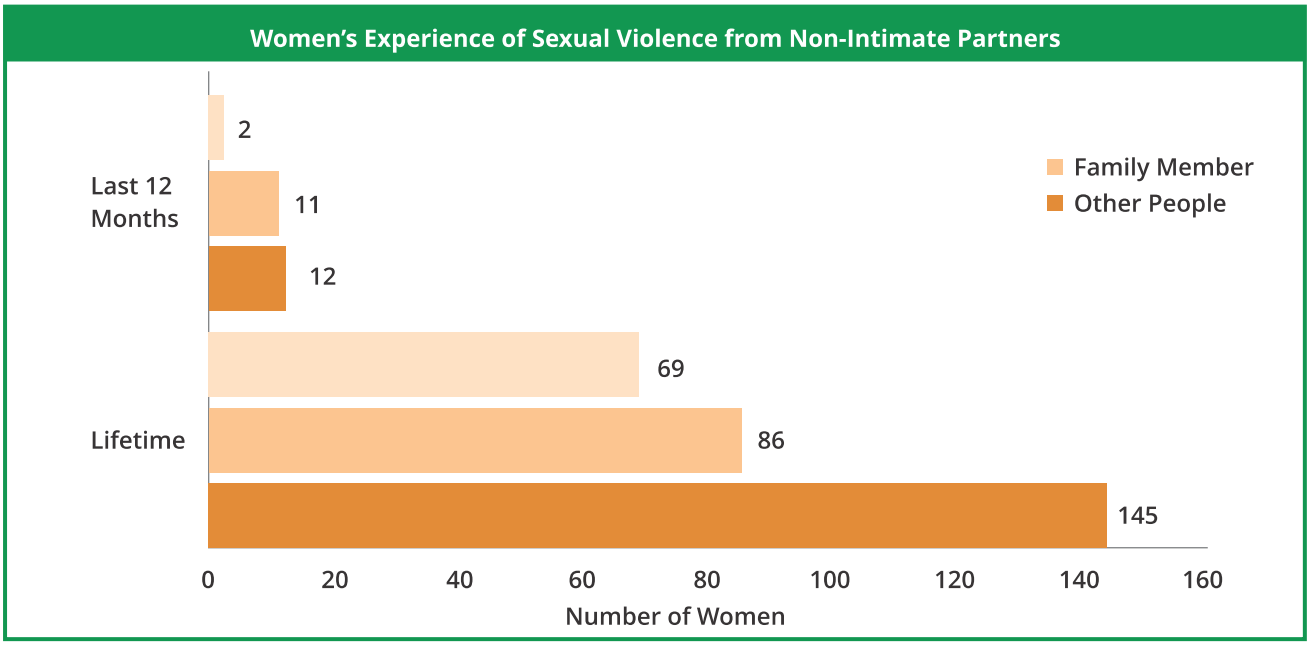
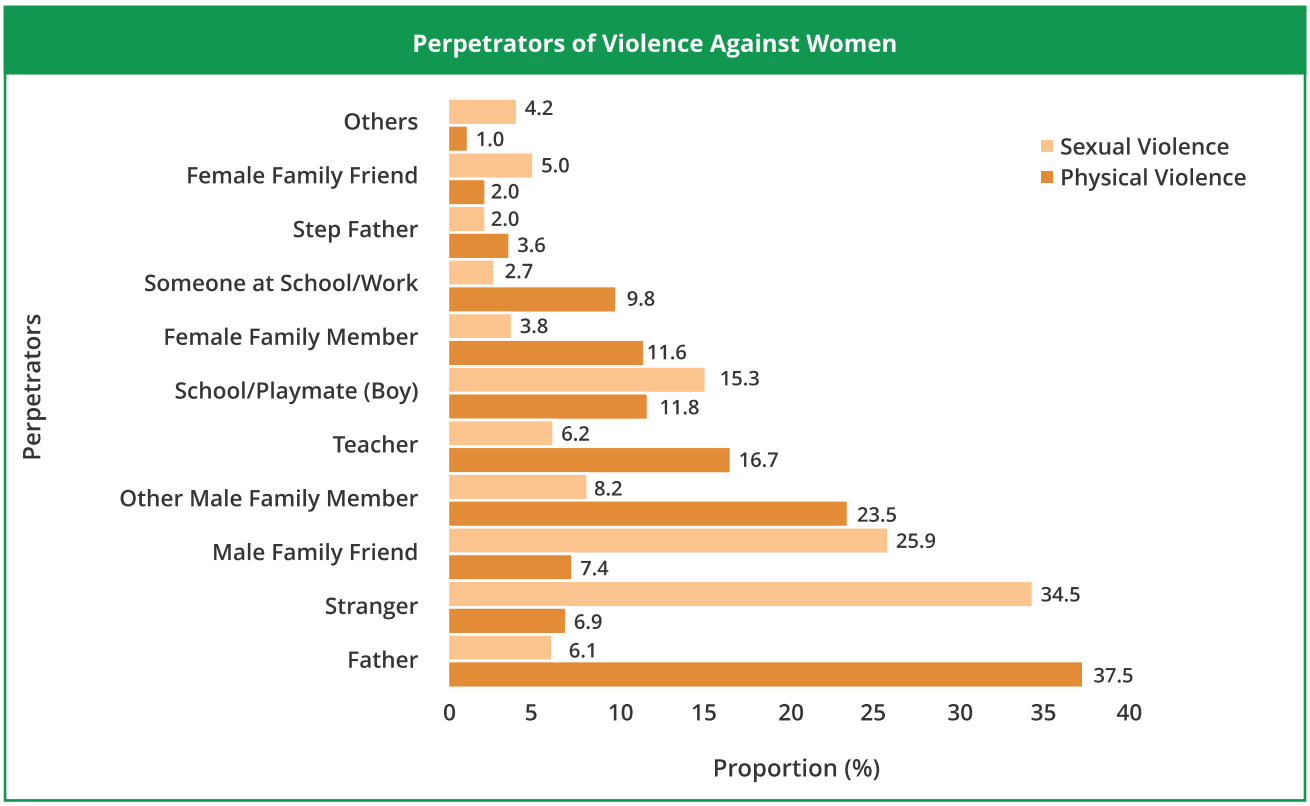


Figure 64: Perpetrators of Violence Against Women



never married (13.1%) compared to the married (7.8%) and cohabiters (8.0%); and among the men with formal education (10.0%) compared to other educational groups (less than 5%).

The non-intimate partner's physical violence was more reported in the South Eastern (24.4%) and North Central men (15.9%) than in other zones (less than 7% each). At the state level, physical violence from a non-intimate partner was more prominent in Imo (30.4%), and Nassarawa (28.8%), unlike other states which were less than 10%, except Ebonyi (12.3%) and FCT Abuja (11.4%). In most cases, the experiences were more from family members than other people.

However, less than 1% of the men experienced any physical non-intimate partner's violence in the last 12 months, except the youngest men, 15-19 years (9.9%), never married men (1.2%), in the North Central (1.2%) and FCT Abuja (9.2%). The experience, either in a lifetime or in the last 12 months, was similar for the men irrespective of place of residence and employment status.

8.4.5 Men's Experience of Sexual Violence from Non-Intimate Partners

The result in Appendix 8.9 indicated that the lifetime experience of sexual violence from all the identified non-intimate partners was low (less than 5%). The experience was similar and less than 5% across all the background characteristics and states except in Nasarawa where about 5.3% of the men reported lifetime sexual violence since their 15th birthday. The prevalence was much lower (less than 1% in most cases) in the last 12 months, except among the young men aged 15-19 years (3.0%).

The results in Appendix 8.10 further depict the men's lifetime experience of sexual violence before the age of 15 years. As shown in the table, less than 1% reported sexual violence before their 15th birthday. The prevalence was highest among the divorced/separated (6.0%), but similar across zones, states and other characteristics.

8.5 Sexual and Gender-Based Violence Against Persons with Disabilities in Nigeria

FGDs and KIIs were conducted among PWDs to understand their specific experiences of SGBV and various coping strategies. They were asked about their social interaction with members of their respective communities. This study found that various categories of PWDs described that their experiences with community members were unpleasant including their experiences with immediate family members. They noted that more often than not, PWDs are disrespected, neglected and regarded as inferior to others in society. Respondents further noted that women with disabilities are particularly more disadvantaged and regarded as beggars irrespective of their academic attainment (see Box 8.8).

Box 8.8: Excerpts from KIIs with PWDs

It takes the Grace of God, what makes someone a disabled are because part of his/her body is not as God created it. Being a man with disability is not easy because most time, a disabled man is not always remembered in any activities. What makes a man disabled is just about social constraint.
KII with PWDs in Akwa Ibom State

Considering the norms guiding relationships between members of the society and PWDs, the majority of them claimed that there were no specific rules or norms to guide their relationships, thus relationships outside their circle were unpleasant. They lamented that society members relate to them as outcasts who they are not willing to interact with.

Some respondents especially in Federal Capital Territory (FCT), Abuja noted that Article 22 of the Disability Act, safeguards the rights of PWDs to privacy and family life. They, however, believed that there were some peculiarities in marriage relationships with PWDs. For instance, unless the person without a disability understands "sign language", it is always advisable for the deaf to marry the deaf to be able to communicate with each other. They added that the visually impaired are to marry able-bodied individuals who will be able to assist them. This does not, however, always work out, especially for a disabled person to marry somebody without a disability. This is because of negative societal perceptions about the intimate relationships between PWDs and able-bodied persons. Some communities view such relationships as taboo and discourage such unions. An able-bodied man or woman that ventures into it can become a subject of ridicule in some communities. Although some men like to engage in casual sexual relationships with them, they never marry them. The FGD data revealed that there were instances when men who impregnated handicapped ladies reportedly ran away from the community because the men did not want to marry them. Also, some parents would do everything possible to stop their children from marrying a PWD because they believe they are cursed by God. This societal negative attitude was found more endemic in the Southern part of the country than in the Northern regions.

8.5.1 Contexts and Situations that Support Sexual Rights Violations of PWD

The experience of sexual and gender-based violence among PWD was explored. The majority of PWD face different kinds of violence daily. These include discrimination, physical abuse and sexual abuse such as rape. Notably, sexual abuse is peculiar to women and less to disabled males. No male PWD had ever reported being raped.

In their opinion, PWDs face sexual rights violations because they cannot fight for themselves. In some instances, an able-bodied man may like a disabled woman probably because of her beauty. He may, however, feel ashamed to approach her properly due to the societal negative beliefs and attitudes toward such a relationship. Since the disabled woman cannot defend herself, the man may take advantage of that, to rape her.

Another reason adduced for the susceptibility of female PWDs to sexual violence is joblessness. They noted that persons whose disability condition marginalised them from formal education or learning a trade or handwork, who stays at home most of the time could be at risk of being sexually violated. Thus, physically challenged women with low socioeconomic status are more likely to experience sexual violence than high-status women with disabilities (see Box 8.9). Some PWDs also expressed that some people, under religious pretext, violate disabled individuals. Low income and high prevalence of poverty among PWDs predispose them the violence while their low self-esteem also reinforced the risk. In the opinion of some PWDs, especially in Kwara State, indecent dressing among ladies with disability also triggers sexual assault. They added that wears that reveal a woman's private parts would expose such a woman to rape and other forms of sexual violence. Others, however, believed that the PWD violators have psychological problems or lack a good family background or bad associations.

Generally, the culture of silence on rape is facilitated by societal attitudes toward the female gender, especially women with disabilities. More often than not, rape survivors desist from speaking out to avoid discrimination and stigmatisation in the society. The case of women with disabilities is peculiar because they lack confidence in the society perceived to be hostile to them. Thus, they often remain silent to avoid further violence and other negativities in society (see Box 8.10).

In the case of sexual violence within marriage, the study participants noted that women with disabilities often bear the brunt because they are the ones in need of companions. They, therefore, endure the relationship challenges and do their best to protect their marriage. In some cases, they have to fend for themselves even when the husband/partner is irresponsible. They believe they are better off staying married than leaving their husbands.

Likewise, religious beliefs around sex in marriage also reinforce violence against women in society. Religious beliefs that discourage denial of sex within marriage, in a way influence the attitudes of men to women with

disabilities, resulting in the acceptance of rape within marriages.

Even in the workplace, study participants in Oyo noted that PWDs generally face discrimination. There is the general belief that physically impaired persons cannot perform excellently, hence, the violent attitude toward them. A particular respondent referred to a disabled woman facing discrimination in her workplace and was banned from teaching because of her blindness until she enforced her right to teach.

The majority of the PWDs explained that they often did not report abuse to authorities due to their financial situation, lack of support and fear of further exposure to threats from the perpetrator, especially if the husband is the perpetrator. Some concealed the secret to prevent divorce. Others opined that a disabled person being abused by her husband would not open up because she believed the man has done her favour by marrying her;

Box 8.9: Excerpts from KIIs with Male PWDs

Yes, it contributes to some extent. If somebody with disability has no hand work, and not educated to be engaged, but only dependent on someone else, there is high risk of being raped. Because, most times you are often at home, and the people around the environment always see you, and you are at home, as a person with disability, there is no person there to protect you. **KII with male PWD in FCT**

Number one is family background, second is economic situation, peer group, friends backing, lack of patience, lack of understanding, so those are the things that cause physical violence from the perpetrators. **KII with male PWD in Oyo**

the society also shares a similar belief. Therefore, she should endure whatever she faced in such relationships.

They further associated their non-disclosure of abuse with ignorance of their rights and lack of education. They did not even know when they were being denied or when their rights werebeing violated. Some respondents opined that some families did not want to be identified with people with disabilities; hence, the non-readiness to support them in filing a lawsuit against the offender. The disabled on their own did not have what it takes to pursue justice because the legal process is too cumbersome and stressful, and there is no assurance of getting justice in the long run. The police officers' complicities were also part of the reasons the survivors do not disclose their experience of violence. Shyness and timidity about people's comments and reactions also prevented some from disclosure.

Some PWDs in Oyo State opined that the reason the majority of them did not report cases of violence against them was that the expected vindicators were able-bodied who did not understand their problems. A disabled woman claimed that when one reports sometimes, they would not take it seriously or respond to it in a way that one will regret ever reporting such cases (see Box 8.11).

Some PWDs however confessed that they and their colleagues did report cases of abuse to appropriate authorities such as the Police and Ministry of Women Affairs. In the FCT, some PWDs reported to the "Purple Corner", an organisation established to protect the rights of the disabled (see Box 8.12). This organisation takes up cases and links survivors to the available support system. They, however, raised their concern about reporting such issues to the community members who usually discriminate and humiliate the disabled whenever they reported their plights. This discouraged the majority of them from disclosing it to the community. They rather

Box 8.10: Excerpts from KIIs with Male PWDs

Some of our women with disability are raped, but they would not want to voice out because of what people will say. The problem is very common. **KII with male PWD in Oyo State.**

report such abuse to formal authorities.The participants appraised the activities of the authorities on the cases reported to them, stating that some successes had been recorded and, in some cases, the offenders were prosecuted.

8.5.2 Critical Stakeholders' Roles in Addressing Sexual and Gender-Based Violence Against PWDs

The study participants noted that some stakeholders are supporting PWDs when they face SGBV problems; though they still need to do more. They explained that there are some structures and platforms for protecting the rights of PWDs experiencing violations of their rights. Both government and non-Governmental organisations provide some services to PWDs who are sexually abused. The services provided to PWDs include shelter, healthcare and counselling among others.

Participants in Ebonyi and Oyo States particularly commended the efforts of the governments of their respective States in supporting PWDs whose rights were violated. There are also structures for dealing with the

perpetrators some of whom have been punished. Participants, however, complained of the Nigerian judicial system as not being fair, especially when the perpetrator is well connected to important people in the society.

The efforts of the NGOs were also recognized especially in FCT and Oyo State. Participants reiterated that there are many NGOs and Development Partners in the FCT supporting PWDs including the Centre for Citizen with Disabilities and UNFPA, unlike in Oyo State where very few NGOs provide support to PWDs. The role of UNFPA was particularly emphasised by many PWDs in Oyo. There were no reports of substantial government efforts, especially in other States where this study was conducted. Thus, the participants demanded more action and support, especially from the government to address various kinds of violence including IPV against PWDs. Some of the areas that need government intervention include the implementation of empowerment programmes for PWDs. Participants opined that when PWDs especially Women with Disabilities are engaged and economically empowered, they will be less vulnerable to Intimate Violence. This view was particularly emphasised by participants in Kwara State.

Another area is the need to improve PWDs' access to formal education as well as proper education of PWDs on SGBV issues. Formal education will get them more enlightened andeducated to be able to fight for their rights. Also, when PWDs are properly educated on violations of their rights, they will be able to report to appropriate authorities when due. Most PWDs, especially women, often refuse to disclose their abuse due to their misconceptions about themselves and the perpetrator. This is particularly true when the perpetrator is a close family member who provides care and support for them. For instance, some participants noted that many WWDs who are married are abused by their husbands/partners without disclosing it.

Participants further noted that the family members have a role to play in the education of PWDs. They, therefore, urged parents or family members of PWDs not to ignore their roles of educating and encouraging them to acquire necessary skills or support them to get the best education. Parents of PWDs also need to train and empower their daughters rather than forcing them into early marriage. Disability should not be a hindrance to a child's education.

Box 8.11: Excerpts from KIIs with Male PWDs

The survivors, if you report to the community, if you report to the people in the community, there is a form of discrimination on it. Once you come and tell people that, this is what this person just did to me, they will be like emm.... So, that discrimination of person with disability is times two of it. So, most of them can't come out and say that they have been raped within the community. They will like to keep it private; they will not go to appropriate authority and pick the culprit that is involved in it. **KII with male PWD in FCT**

Box 8.12: Excerpts from KIIs with Female and Male PWDs

Yes, I heard one from; I will not call the local government. She had multiple disabilities. Someone reported to me, so close to me that is why we are careful in reporting it. We are taking some measures to report that case. She had multiple disabilities and someone, a truck driver in the community raped her and she is now pregnant, and the person is still alive. And because of that the parents don't know where to get justice. So, the case is not reported and the victim is there, already pregnant. **KII with female PWD in Bauchi**

Firstly, they have to report the case to the appropriate authority, from there they move to organisation for disability who can support them, just like purple corner. We help them file the case and direct them to the appropriate authority that will take up the case. **KII with male PWD in FCT**

8.6 Covid-19 and Sexual and Gender-Based Violence

8.6.1 Changes in SGBV Experience During COVID-19

The result in Figure 65 indicates the effect of COVID-19 on sexual and gender-based violence among women of reproductive age in Nigeria. The majority of the women who had ever experienced SGBV (70.0%) indicated that the economic, physical and sexual violence from husband/partner remain the same during COVID-19. More than one-quarter (26.6%) of them reported an increase in economic violence during the pandemic, unlike other SGBVs with only 12.1% and 3.5% reporting an increase in sexual and physical violence, respectively. About 30.6% and 22.0% of the women reported a decline in physical and sexual violence, respectively, from the husband/partner, unlike economic violence (6.4%) with minimal decline.

Figure 65: Effect of COVID-19 on SGBV among women in Nigeria

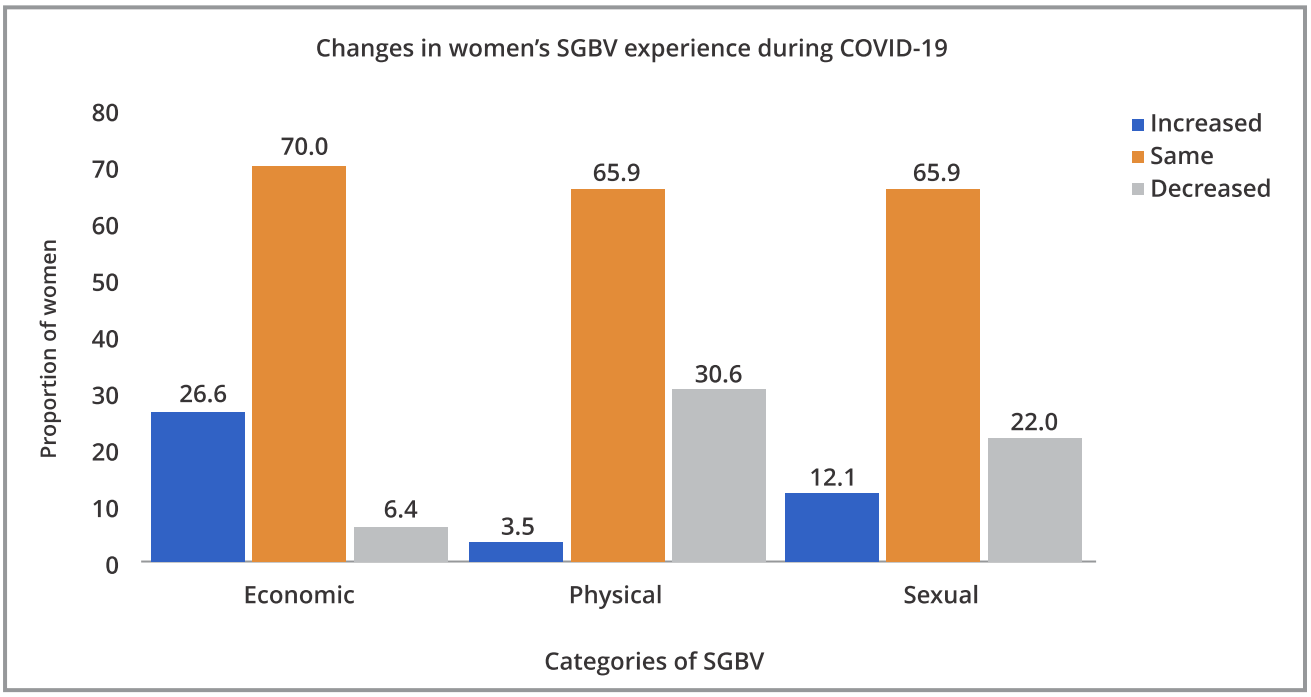


Figure 66 reveals men's SGBV experience during COVID-19. As shown in the result, the majority of the men (62-81%) who had ever experienced SGBV indicated that the economic, physical and sexual violence from wife/partner remain the same during COVID-19. More than one-third (35.6%) reported an increase in sexual violence, unlike other SGBVs with 19.3% and 16.5% reporting an increase in physical and economic violence, respectively. The decline in the men's experience of SGBVs from wives/partners during the COVID was minimal (less than 5%).

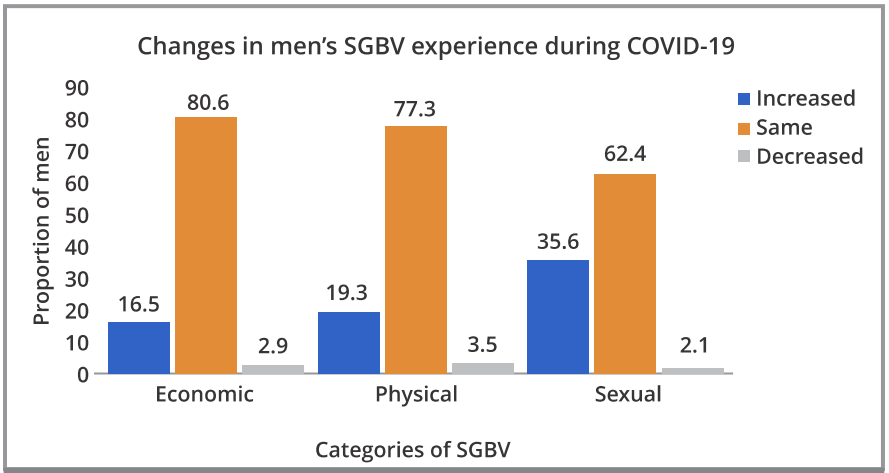


Figure 66: Effect of COVID-19 on SGBV among men in Nigeria

8.6.2 Changes in Women's SGBV Experience during COVID-19

The result in Appendix 8.11 reveals women's appraisal of their SGBV experience before compared to during the COVID-19 pandemic. While majority of the women, reported static rates during the COVID-19 pandemic, the proportion reporting increase or decrease varies across some background characteristics. Economic violence from husband/partner, for instance, was reported to have increased by about 23.1-34.4% of the women across all age groups except age group 10-14 where only 6.5% reported an increase. The decline followed an irregular pattern. Less than 5.8% of the women claimed an increase in physical violence while a decline was reported by about 15.9-37.8% without any age pattern. The report of an increase in sexual violence was higher among young women aged 20-34 (11.1-18.5%) and the age group 40-44 years (15.3%) compared to other age groups (0.0-8.0%). Accordingly, report of a decline in sexual violence from husbands/partners during COIVD-19 was highest among the female adolescents aged 10-14 (43.9%) and 15-19 (30.6%) and among women aged 45-49 (31.1%), unlike other age groups (14.9-22.8%).

The increase or decrease in the experience of physical violence was similar across the religious affiliations. A higher proportion of Christian women reported increased economic (32.0%) and sexual violence (17.8%) compared to their Muslim counterparts, 23.5% and 10.1%, respectively. A decline in sexual violence was more reported among Muslim women (25.2%) compared to Christians (11.9%).

An increase in economic violence was more reported in other ethnic minorities (40.2%) compared to Igbo, Hausa and Yoruba (17.0-24.0%). While a significant proportion of the women reported an increase in sexual violence among Yoruba (20.9%), other ethnic minorities (18.9%) and Igbo (15.2%), it was least reported among the Hausa women (8.2%). Though the decline in SGBV was similar across ethnic divisions, it was least reported among the Igbo women – economic: 1.6% compared to others (4.9-7.8%); physical violence: 12.1% compared to others (28.7-38.5%) and sexual violence: none compared to others (13.7-26.7%).

The report of increase in economic violence was more reported among rural women (33.3%) compared to their urban counterparts (15.9%); whereas, it was similar for other SGBVs. Declines in physical and sexual violence were more reported in urban areas (36.2% and 31.8%, respectively) compared to rural (26.9% versus 17.6%, respectively).

More cohabiting women reported increased economic (46.2%) and physical violence (34.1%) during the pandemic compared to other women (25.9-36.9% and 0.0-3.5%) respectively, whereas the increase in sexual violence was similar across marital statuses. On the other hand, while a large proportion of the widowed (50.8%) and divorced/separated (45.9%) women reported reduced physical violence, a smaller proportion reported the same among the married (29.1%) and cohabiters (19.8%). Similarly, more widows (34.8%) reported decreased sexual violence compared to others (18.8-21.6%).

Increased economic violence was least reported among women with Islamic education (15.7%) compared to their counterparts with formal, adult and no formal education (28.1-37.0%). Increased sexual violence was also more reported in the formally educated women (16.1%) compared to those with Islamic education (5.7%). While the declines in physical and sexual violence were similar across various categories of educational background, that of physical violence was more reported by women with formal education (35.7%) compared to other groups (25.2-25.6%).

A higher proportion of employed women reported increased economic (31.8%) and sexual violence (17.0%) from husbands/partners during COVID-19 compared to the unemployed (19.7% versus 8.6%, respectively). Though the report for economic violence was similar across the wealth quintiles (21.3-33.5%), a higher proportion (9.5%) of those in the middle wealth quintile reported increased physical violence compared to others (1.5-3.0%) while a higher proportion (27.2%) of those in the highest wealth quintile reported increased sexual violence compared to others (9.8-14.2%). Those who experienced a decline in economic (2.4-9.1%) and physical violence (22.8-39.2%) were similar across the wealth quintile groups; whereas more women in the lowest, second and fourth quintiles (20.9-28.5%) reported a decline in sexual violence against them during COVID-19 compared to their counterparts in the middle (15.8%) and highest (4.2%) quintiles.

The table further indicates that an increase in economic violence was most reported in the North Central (57.1%) compared to other regions (19.3-22.0%). Similarly, increased sexual violence was more reported in the North Central (29.6%), South East (16.6%) and South South (13.5%) compared to the North East (2.1%) and South West (9.0%). Increased physical violence was most reported in the South West (12.7%) compared to other regions (2.1-3.5%). On the other hand, while North Central (1.4%) and South East (1.8%) had the least report of a decline in economic violence compared to other regions, they also had the least report of a decline in sexual violence (5.1% versus zero percent) compared to others (26.5-31.6%) except South South (16.9%). The decline in physical violence was most reported in the North West (36.1%), South West (33.8%) and North Central (33.3%) compared to other regions (13.0-16.0%).
At the state levels, an increase in economic violence was most reported by women in Nasarawa (73.8%), FCT Abuja (59.5%), Akwa Ibom (48.1%) and Bauchi (41.5%), and least reported in Ebonyi (12.1%) and Edo (12.6%) compared to other states (16.5-29.0%). However, Oyo (19.5%) and Akwa Ibom (15.2%) women had the highest report of a decline in the SGBV experience during COVID-19, unlike other states (0-8.9%). Ogun women had the highest (16.1%) increase in physical violence compared with other states (0.0-8.8%). A decline in the physical violence experience was most reported in Oyo (72.4%) and Kaduna (67.3%), and least reported in Ogun, Edo and Adamawa (0.0-9.1%). About 13.1-39.6% of the women in other states reported a decline in the SGBV during COVID-19. For sexual violence, an increase was most reported in Abuja (100%) and Ebonyi (40.5%). However, it should be noted that the two states had one of the least samples. Bauchi, Ogun, Adamawa, Imo and Sokoto (0.0-7.7%) had the least report of an increase in the experience, while about 12.3-33.9% reported the same in other states. In many of the states, about 22.1-38.6% of the women reported a decline in sexual violence during COVID-19, except Kwara and Nasarawa with a minimal reduction (2.9-7.2%) and Bauchi, Ebonyi, Edo, FCT Abuja and Imo with no decline.

8.6.3 Changes in Men's Experience of SGBV during COVID-19

The result in Appendix 8.12 reveals the men's SGBV experience during COVID-19 compared to their prior experiences. As shown in the table, while the majority of the men, irrespective of background characteristics, reported that their SGBV experience remained the same

during COVID-19, the proportion reporting increase or decrease varies across some background characteristics. An increase in economic violence was most reported in age groups 35-39 and 45-49 years (26.4-27.3%) compared to other age groups. The proportions reporting a decline were higher in the age group 20-24 (27.6%) and 30-34 (12.1%). No report of decline virtually in other age groups. About 11.9-24.5% of the men claimed an increase in physical violence while a decline was reported by about 1.4-10.5% without any age pattern. There are, however, cases of 100% where samples are too few. An increase in sexual violence was reported by about 13.8-51.0% of the men without any particular age pattern. The report of a decline in sexual violence from wives/partners among the men during COVID-19 was highest among the oldest age groups 60 years or above (22.0-35.1%).

A higher proportion of Christian men reported increased economic (20.0%) and sexual violence (39.8%) compared to their Muslim counterparts, 13.4% and 32.1%, respectively. The proportion of men who reported a decline in all the SGBVs followed similar patterns irrespective of religious background. Increases or decreases in the experience of physical violence were also similar across the religious affiliations.

An increase in economic violence was more reported in other ethnic minorities (30.9%) compared to Igbo, Hausa and Yoruba (7.0-13.5%). While a significant proportion of the men reported an increase in sexual violence among all the ethnic groups (36.9-41.6%), it was least reported among the Hausa men (26.2%). Though the decline in SGBV was similar across ethnic divisions, the decline in economic violence was most reported among Hausa men (5.0%) while the decline in sexual violence was most reported among Igbo men (9.3%).

The report of both the increase and decrease in SGBVs was similar for urban and rural men, except for physical violence which was reported to have increased during COVID-19 in the urban areas (26.2%) more than in rural areas (15.3%).

Proportion reporting increase and decrease in economic and sexual violence among the men were similar across educational groups. Increased physical violence was also reported by men with no formal education (26.2%) or with formal education (19.1%) more than in other educational groups. A decline in physical violence was more reported by women with adult education (41.9%) compared to other groups (less than 5.6%). The unemployed men reported increased economic (32.3%), physical (31.6%) and sexual violence (61.6%) from wives/partners during COVID-19 more than the employed (16.0%, 18.6% and 34.3%, respectively). The proportions of men reporting a decline in SGBV were similar across employment statuses, except in sexual violence with 13.3% of the unemployed reporting a decline compared to the employed (1.5%).

Also, an increase in economic violence was reported by over one-fifth (20.3-29.8%) of the men in all the regions except South East (5.5%) and North West (12.5%). Increases in physical violence were more reported in the North East (45.4%), South West (34.6%) and South South (32.9%) compared to other regions (10.6-19.3%). Similarly, about 42.9-73.5% of the men reported an increase in sexual violence in all the regions, except North West (25.9%) and North Central (23.7%). On the other hand, men's reports of the decline in all SGBV were similar across the zones.

Increased experience of economic violence was most reported in Bauchi (49.7%), FCT Abuja (35.5%) and Nasarawa (32.6%), and least reported in Imo (3.9%) and Ebonyi (8.8%). It was not reported in Adamawa and Oyo. Kwara men (15.4%) had the highest report of a decline in the SGBV experience during COVID-19, unlike others: Sokoto (5.4%) and Nasarawa (2.6%). All other states reported no decline. An increase in physical violence was most reported in Adamawa (45.6%), Bauchi (45.2%) and Oyo state (44.7%), and least reported in Imo (6.9%) and Kaduna (11.5%). There was no report of any significant decline in all the states. About 30.8-85.6% of the men in Adamawa, Akwa Ibom, Edo, FCT Abuja, Nasarawa and Oyo reported an increase in sexual violence during COVID-19. Kwara men reported the least (8.8%) of the increase. Only the men in FCT Abuja reported about 13.4% decline in sexual violence during the pandemic. Ebonyi (8.3%) and Nasarawa (6.3%) reported minimal decline, while others reported no decline.

8.6.4 Partner's Controlling Behaviour During COVID-19

The result in Appendix 8.13 revealed the proportion of the respondents (men and women) reporting an increase in their partner's controlling behaviour since the onset of COVID-19. About two-thirds (32.9%) of the women who have ever experienced a husband's/partner's controlling behaviour reported an increase in the experience since the onset of COVID-19. The proportion of men reporting the increase was higher among men (39%).

However, there are some variations. An increase in partners' controlling behaviour decreases with age. It was most reported among the adolescents aged 15-19 (42.3%) and 10-14 years (40.4%) and least in the age group 45-49 (24.1%). For men, the proportion reporting an increase was highest among the young adults and middle-aged men 25-44 years (40.7-47.7%) and lowest in the older age groups 65+ (18.6%). It was most reported among Muslim women (37.2%) and least reported in traditional religion (19.9%). Conversely, among men it was highest in traditional religion (45.9%) compared to the Christians (37.9%).

The increase in husband's/partner's controlling behaviour was highest among Hausa women (38.3%) compared to Igbo (14.9%) which has the least; whereas it was highest among the Yoruba men (45.9%) and men of other ethnic groups (45.8%) compared to the Igbo with the least (22.3%). The differences between urban and rural areas were minimal for women (30.7% versus 34.2%) and men (37.9% versus 40.2%). The married (34.2%) and divorced/separated women (30.0%) had the highest report of increased partner's controlling behaviour during COVID-19 compared to other marital statuses, 13.7-24.7%. Conversely, it was highest among cohabiting men (49.2%) and married men (39.7%) compared to the widowed (14.2%) and divorced/separated (22.9%). The increase was also most reported among the respondents with Islamic education for women (41.8%) and formal education for men (42.9%) but least reported among women and men with no formal education, 30.3% and 26.6%, respectively. The unemployed women (34.3%) and employed men (39.6%) reported increased partner's controlling behaviour during COVID-19 more than the other group, 32.1% and 33.5%, respectively. The report of the increase was lowest in the highest wealth quintile group (24.4%) but similar in other wealth quintile groups (33.8-36.7%).

Further variations were observed among the regions. Increased partner's controlling behaviour was more reported by women in the North Central (54.8%) and North West (43.9%) compared to the South East (13.8%) and South South (16.0%) where the increase was lowest. The pattern was similar among men. At state level, the increase was more reported by women in FCT Abuja (81.5%), Kaduna (59.9%) and Nasarawa (57.4%) compared to Imo (13.5%), Ebonyi (14.2%), Akwa Ibom (15.8%) and Edo states (16.3%) where the increases were least reported. Conversely, the increase was most reported among men in Kwara (67.8%), Akwa Ibom (61.3%), Nasarawa (56.1%) and Kaduna (52.3%), Nasarawa (56.1%), unlike the men from Imo (11.8%) and Edo (16.5%) who had the least report of an increase in partner's controlling behaviour during the COVID-19.

Focus group participants expressed a rise in SGBV during COVID 19 and this is coupled with the problem of access to health facilities during the period. Thus, many cases of SGBV were not reported either in the health facility or the Police Station. Consequently, some survivors of SGBV died while others were infected with STIs due to their inability to access medical services.

Participants expressed that the period was also characterised by the fear of being infected with COVID 19. The fear was aggravated by the news of the daily number of infections and deaths. This, according to them, affected their social interactions and relationships. Thus, as part of the strategy to avoid COVID 19 infection, some people became drunk due to the misconception about alcohol-based hand sanitiser. Some people have the erroneous belief that since alcohol- based hand sanitiser had been medically prescribed for prevention; the intake of alcohol can also help an infected person (see Box 8.10). The people who are drunk and intoxicated began to misbehave, resulting in sexual and physical violence including rape in many families across all the study sites irrespective of the region. Participants also added that many youths were idle during the period, and the economic hardship also contributed to an increase in criminal activities as well as unwanted pregnancies among young people.

Box 8.10: Excerpts from FGDs with adult males

Many men became drunkard because when they could not get cure from outside the country and they said we should drink bit of alcohol and rub some on our hand (laughing), so we used our own mind here that they already said we should buy shinap and ogogoro (laughing), that's the truth. We never rejected it but the ogogoro helped us to solve part of it and God did the rest. **FGD with adult males in Oyo State**

The lockdown of women, their spouses and children in the home caused a lot of tensions in the home environment. Across the states, respondents reported that during the lockdown, mistrust between couples, especially those whose partners were going out during this period caused tensions. It was also revealed that some wives did not allow their husbands to enjoy their stay at home, due to persistent financial pressure and demands which resulted in quarrels and fights. There were tensions over insufficient food at home. Staying together in a restricted environment for longer hours than unusual also caused tension for some couples.

The majority of the participants expressed that they were more frustrated than happy during this time, and the situation was worse in some families to the extent of triggering divorce. Increased sexual activity, including marital rape, was also reported. Some children experienced maltreatment due to tension associated with hunger and abuse within the families. Participants in Edo State expressed that children experienced incest and fingering from older adults, especially family members. They were involved in child labour and transactional sex to generate income for the survival of their household.

SAFETY NETS AND PROGRAMMES FOR CURBING VIOLENCE AGAINST WOMEN IN NIGERIA

KEY FINDINGS

- Nigeria adopted a number of global, regional, national and sub-national legal instruments and policy frameworks that are meant to protect women against sexual and gender-based violence including sexual. More importantly, they were adopted to allow women and men to have equal rights and opportunities to participate in the development process. Notable among these legal instruments and policy frameworks within the Nigerian system were the VAPP Act (2015), now adopted by 26 of the 36 Nigerian states in November 2021; the development of the 2021-2025 National Development Plan (NDP) which stated as one of its goals, the improvement of gender parity point of the country from 128 Gender Equality Index to 100 and to reduce sexual and gender-based violence cases from 17.4% to 10%; and other individual state-driven legal instruments and policies on SGBV. The weak legal and policy implementation structures have hindered the achievement of many of these laudable efforts.
- **Awareness of Programmes and Activities Curbing Violence Against Women (VAW):** Only 6.3% of the female respondents and 5.4% of the male respondents were aware of programmes and activities addressing violence against women in the country. The level of awareness was highest at the FCT (22.5%) while Imo (2.9%) state had the lowest level of awareness.
- **Perception of Government Policies on Rape:** Three-quarters of the female respondents (75.6%) and about two-fifths of the male respondents (39.5%) were aware that government policies on rape exist at the community level.
- **Availability of sanctions for perpetrators of VAW at the community level:** Almost half (44.7%) of the female respondents and a little above half (58.5%) of the male respondents were aware of the availability of sanctions for perpetrators of VAW at the community level.
- **Community Support for Survivors of VAW:** Few of the female respondents (1.2%) and male respondents (1.9%) reported that there was support initiated at the community level for survivors of VAW

9.0. Introduction

Nigeria has adopted a number of global, regional, national and sub-national legal instruments and policies (see Annex 1) promoting gender equality and social inclusion. Despite this development, weak legal and policy implementation architectures have led to little or no change in the normative order. No doubt, violence against women continues unabated, and thus becomes a daily experience in the homes, workplaces, marketplaces and on the streets. The tripartite legal system in Nigeria, which includes the Sharia, Customary and Common laws, has implications for the domestication and implementation of SGBV legal instruments and policies, and most times makes it difficult for survivors of SGBV to get justice. Also, while Nigeria is a signatory to many of the global treaties and conventions on gender equality and the elimination of all forms of discrimination against women, such treaties are not binding unless they are ratified by the National Assembly – such as CEDAW. In addition, legislation passed by the Federal Government of Nigeria is only operational within the FCT and can only be applicable at the state level after a process of ratification, which many States Goverments might not assent. Although the VAPP Act of 2015 and other state-level SGBV laws are supposed to protect survivors of SGBV, in many cases, fear of reprisal by perpetrators, social stigmatisation, and the burden of proof often discourage insistence for justice. Worse still, 'marital rape' is still frowned at within the Nigerian legal system.

Violence against women and girls is one of the most prevalent human rights violations in the world. It knows no social, economic, or national boundaries. Sexual and gender-based violence undermines the health, dignity, security, and autonomy of its survivors, yet it remains shrouded in a culture of silence (UNFPA, 2021). Data from this landscape study shows the following prevalence: Intimate Partner Violence (24.5%), Female Genital Mutilation (39.7%), Child Marriage (25.4%) and Vesico-Vaginal Fistula (0.24%). Irrespective of the forms of violence, like many other studies, this landscape study also found that sexual and gender-based violence disproportionately affects women and girls. Although in few instances, men and boys may suffer from sexual and gender-based violence; in most cases, such men could take action and seek redress, whereas, for women and girls, the situation is not the same. Often, women and girls suffer in silence and are not culturally allowed to seek redress. Hence, this chapter focuses on 'violence against women' (VAW) - as a unifying factor for the expression of what women and girls go through across the various domains explored in this landscape study: HPs, SGBV, and OF. The sustainable development goals (SDGs) emphasied the need to promote gender equality and women's empowerment, such that women are seen as persons with rights rather than as objects of exploitation, marginalisation and abuse.

Traditional cultural practices reflect values and beliefs held by members of a community for generations. Every social group in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. These harmful traditional practices include FGM, child marriage, taboos and practices sustaining men's control of women's fertility, harmful traditional birth practices, son preference and its implications for the status of the girl child, and other pregnancy-related taboos, amongst many others.

9.1 Awareness of Programmes and Activities on Violence Against Women

Appendices 9.1 and 9.2 present comprehensive data on women's and men's awareness of programmes and activities on VAW. On the whole, only 6.3% of the female and 5.4% of the male respondents were ever aware of programmes, campaigns, and activities addressing the issues of VAW in their respective communities (see Figure 67).

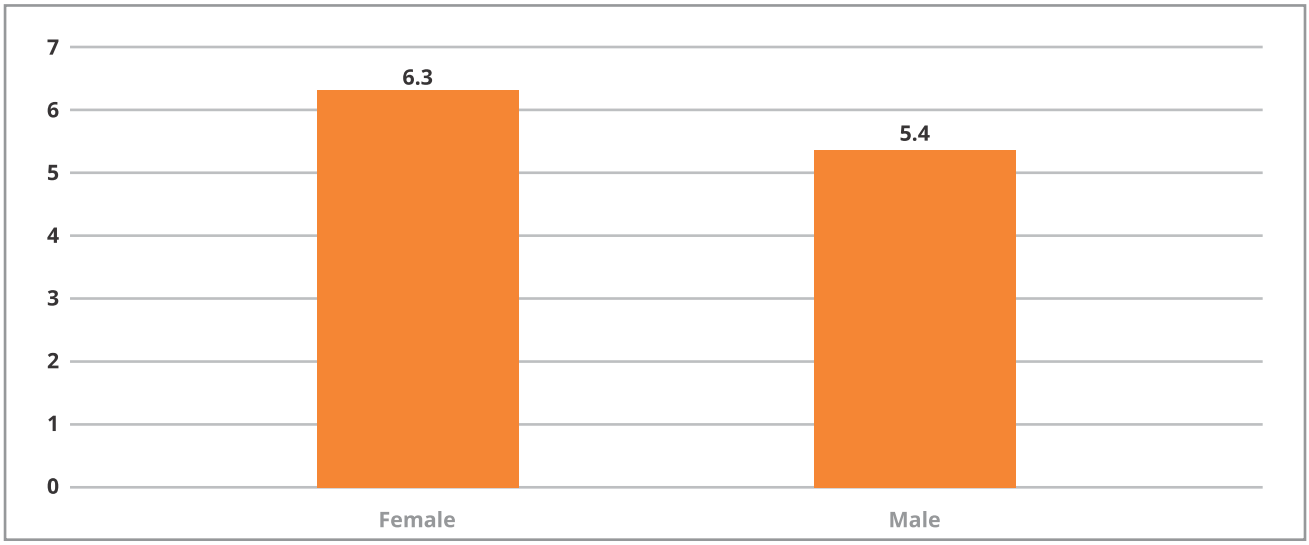


Figure 67: Awareness of programmes and activities on violence against women by men and women

The spread of this awareness across states is presented in Figure 68. Notably, many of the females who were aware of programmes and interventions on VAW are mainly from FCT, Abuja (22.5%), Kwara (14.2%), Kaduna (8.7%), Sokoto (8.3%), Ebonyi (7.3%), and Nasarawa (6.6%) States. For males, they are mainly from Ebonyi (34.4%) and Imo (20.0%) States. In the South West, more women from Oyo State (6.2%) were more aware compared to men and women in Ogun State; while men from Oyo State (4.5%) were more aware than men (1.3%) and women (0.5%) from Ogun State.

A little over half (59.8%) of these female respondents got their information on VAW from the radio. About 27.2% got their information from television and 14.3% from social media. Most men (66.4%) also got their information on VAW from the radio. One–fifth (20.9%) got their information from television and 12.8% from social media (see Tables 42 and 43).

Figure 68: Percentage distribution of female and male respondents by awareness of programmes on violence against women by states

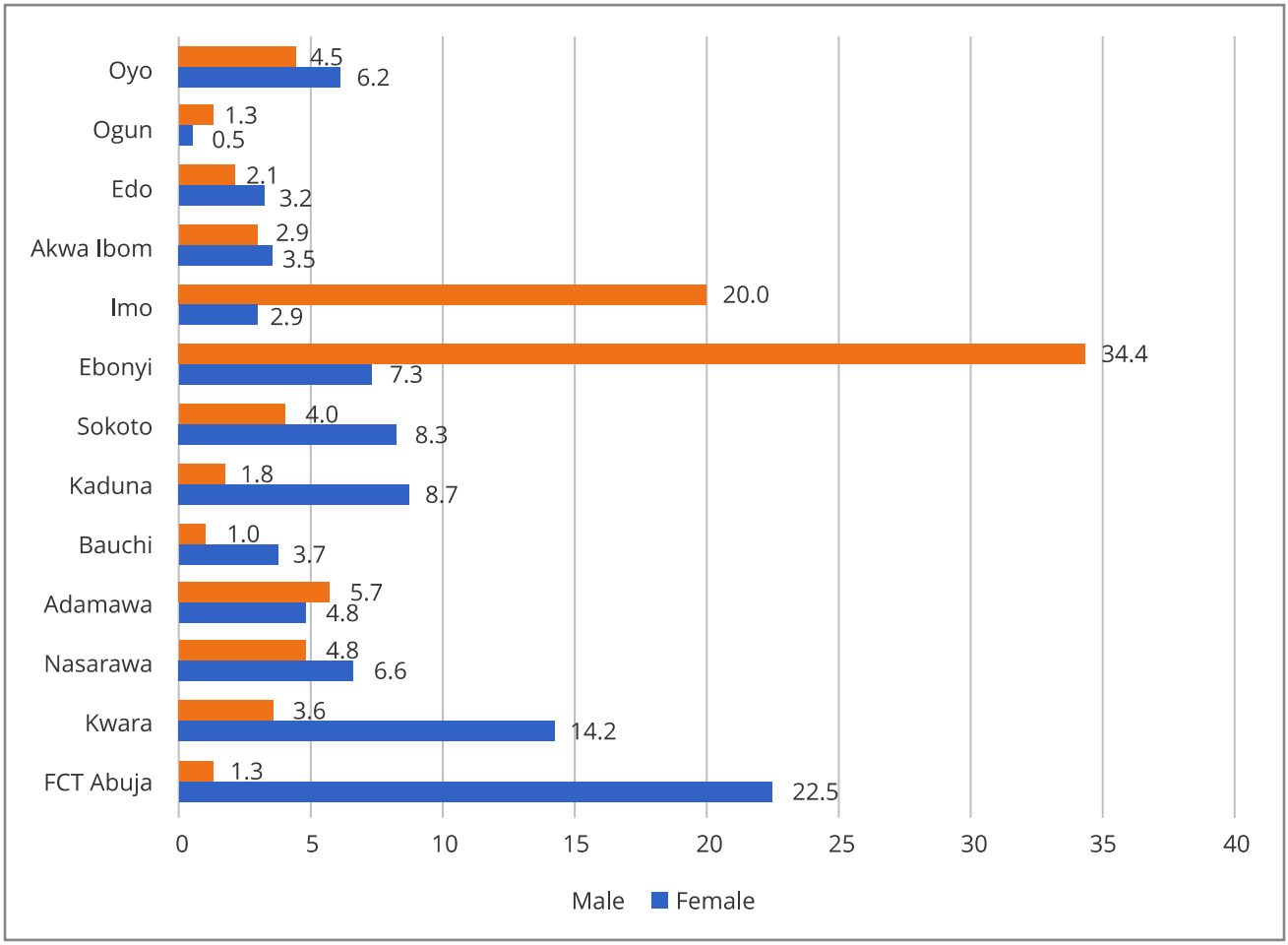


Table 42: Distribution of Female Respondents by Awareness of Programmes and Activities on Violence Against Women

Awareness of programme/campaign/activity that addresses issues of VAW	Frequency	Percentage
	n	(%)
Yes	400	6.3
No	5,940	93.5
Don't Know	13	0.2
Total	6,353	
Source of information n = 423*		
Radio	253	59.8
TV	115	27.2
Social Media	61	14.3
Health Workers	86	20.3
Community	65	15.4
Religious Leaders	28	6.6
NGOs/CBOs	8	1.9
Others	3	0.7

**Multiple responses*

Table 43: Distribution of Male Respondents By Awareness of Programmes and Activities on Violence Against Women

Awareness of programme/campaign/activity that addresses issues of VAW	Frequency	Percentage
	n	(%)
Yes	168	5.4
No	2900	93.8
Don't Know	24	0.8
Total	3,092	
Source of information n = 211*		
Radio	140	66.4
TV	44	20.9
Social Media	27	12.8
Health Workers	37	17.5
Community	52	24.6
Religious Leaders	43	20.4
NGOs/CBOs	25	11.8
Others	2	0.9

**Multiple responses*

9.2 Awareness of Programmes on VAW by the Respondents' Background Characteristics

- Younger women aged 15-19 years were less likely to have heard about programmes and activities on Violence Against Women than women aged 45-49 years (4.0% versus 7.3%)
- Women with formal education were more likely (7.1%) to know about programmes and activities on Violence Against Women than women with no formal education (4.4%)
- Women in urban areas (9.3%) were more likely than those in rural areas (4.3%) to have heard about programmes and activities on Violence Against Women
- About 11.9% of women in the North Central zone were aware of programmes and activities on Violence Against Women, as compared with 4.6% of women in the South East and 3.7% in the South West. Also, the level of awareness was high among women in the FCT and low among Ogun and Imo State women. These sharp differences between the states and the geo-political zones are possibly a direct impact of social development intervention programmes targeted at the Northern States in the last 2 decades compared with the Southern States which have recorded less resistance to girl education and related socio-cultural changes.
- Women in the highest wealth quintile (10.2%) were more knowledgeable about programmes and activities on Violence Against Women than those in the second wealth quintile (4.9%) (Appendix 9.1)

9.3 Perception of Government's Policy on Rape

The perception of female respondents on the government policy on rape is presented in Table 44. Three-quarters (72.7%) of the female respondents felt that the government policy on rape is not well understood at the community level. 36.4% of them also believed that if a policy on rape is available at all, it is not functional in the communities. 36.4% of the female respondents also opined that it is not possible to accuse husbands of raping their wives. In the same trend, the male respondents (39.7%) felt that few community members understood the government policy on rape. About 29.1% believed that, if a policy on rape is available, it only works for the elites, while 54.5% felt that it is not possible to accuse husbands of raping their wives.

Table 44: Distribution of the Female Respondents By Perception of Government's Policy on Rape

Perceive that government policy on rape is still not well understood by many people in the community	Frequency	Percentage
	n = 22	(%)
Yes	16	72.7
No	4	18.2
Don't Know	2	9.1
The perception that if the policy on rape is available, it is not working in this community		
Yes	8	36.4
No	12	54.5
Don't Know	2	9.1
Not possible to accuse husbands of raping their wives		
Yes	8	36.4
No	12	54.5
Don't Know	2	9.1

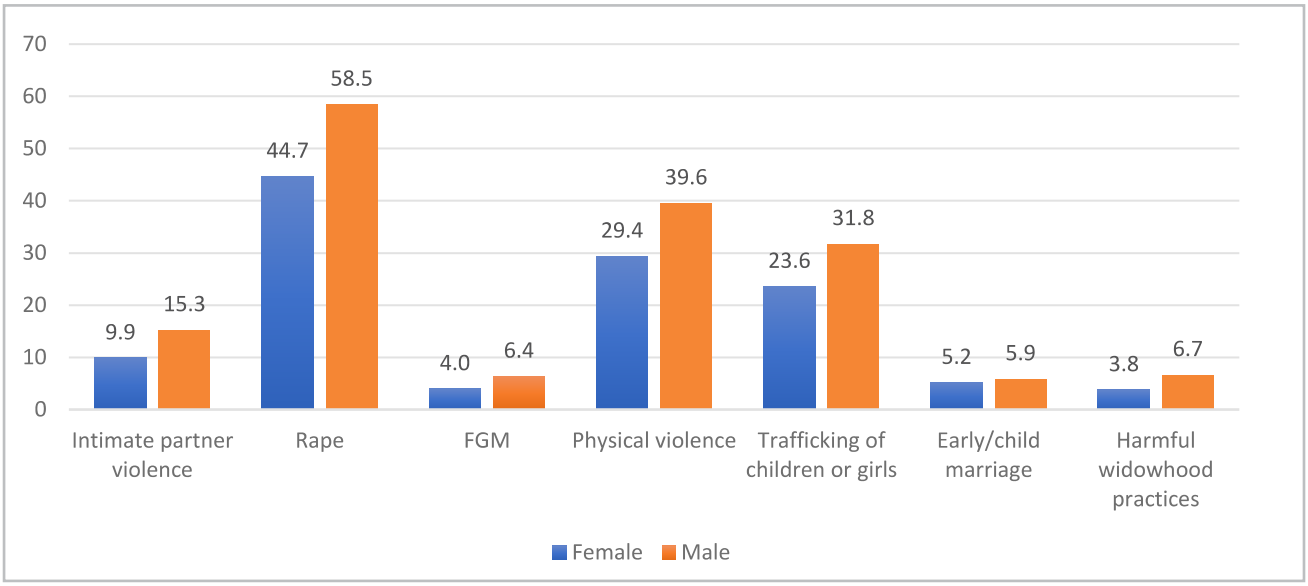
Table 45 Distribution of Male Respondents by Perception of Government's Policy on Rape

Perceive that government policy on rape is still not well understood by many people in the community	Frequency	Percentage
	N = 237	(%)
Yes	94	39.7
No	132	55.7
Don't Know	11	4.6
The perception that if the policy on rape is available, it is not working in this community		
Yes	69	29.1
No	148	62.5
Don't Know	20	8.4
Not possible to accuse husbands of raping their wives		
Yes	129	54.5
No	106	44.7
Don't Know	2	0.8

9.4 Availability of Sanctions for Perpetrators of Violence Against Women at the Community Level

Figure 69 shows the data on the awareness of the availability of sanctions for the perpetrators of VAW at the community level. The awareness of the female respondents was highest for perpetrators of rape (44.7%), followed by physical violence (29.4%) and children and girls trafficking (23.6%); while for the male respondents, it was 58.5% for rape perpetrators, 39.6% for perpetrators of physical violence, trafficking of children (39.6%) and girls (31.8%). Awareness of sanctions for FGM, early/child marriage, and harmful widowhood practices was very low for both female and male respondents (Appendices 9.2 and 9.3)

Figure 69: Awareness of Availability of Sanctions for Perpetrators of Violence Against Women in the Community



9.5 Perceptions of Sanctions Against Perpetrators by Background characteristics

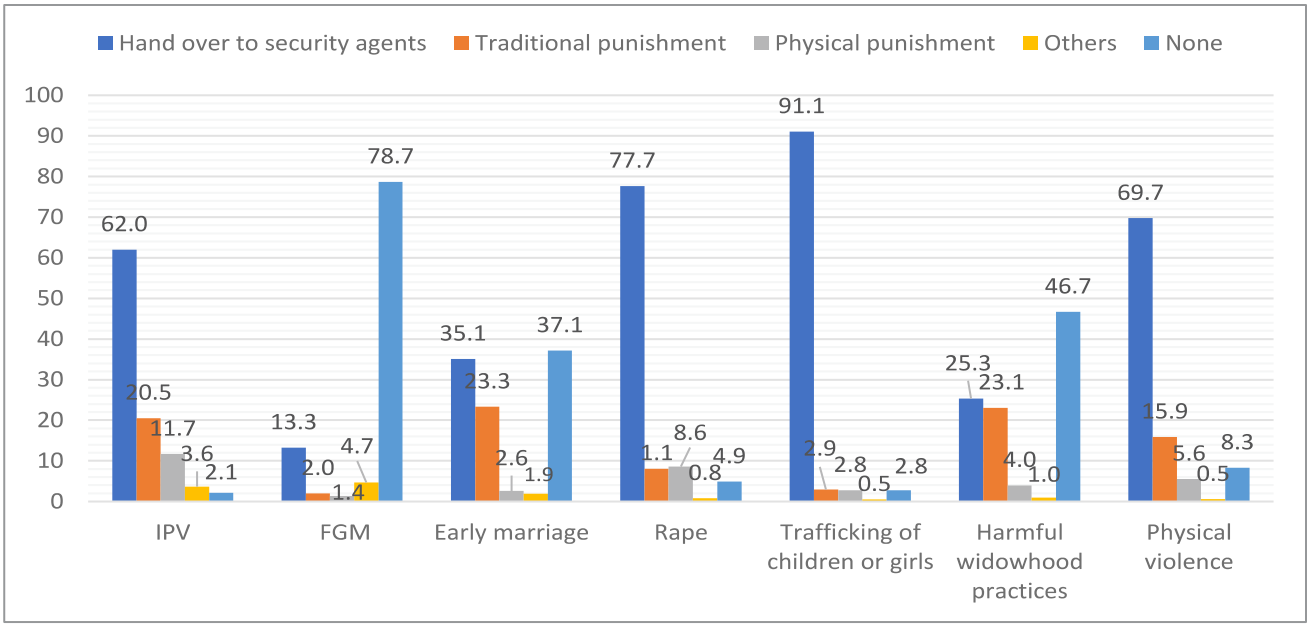
- Older women aged 45-49 years were more aware (53.6%) of the availability of sanctions in the community for perpetrators of rape compared to younger women aged 20-24 years (43.1%). In the case of SGBV, the level of awareness of sanctions in the community for its perpetrators was low across the age groups of women ranging from 3.2% in women aged 15-19 years to 4.8% in women aged 45-49 years. Less than one- third (28.4%) of the women aged 45-49 years knew of community sanctions against trafficking of children or girls compared to the 23.1% of those aged 20-24years.
- Women with secondary education (50.6%) and post-secondary education (48.5%) were more likely to know about the availability of community sanctions against perpetrators of rape compared to women with no formal education (30.9%). Also, women who did not complete primary education were less knowledgeable (12.2%) about sanctions in the community for trafficking of children or girls as compared to those who had post-secondary education (27.7%).
- Women in urban areas (48.1%) were more likely than those in rural areas (42.4%) to have heard of community sanctions against perpetrators of rape. In the rural areas, 21.1% of the sampled women knew of community sanctions against the trafficking of children or girls, which was less than what was obtainable for women in urban areas (27.2%)
- In the South East Zone, 78.6% of the sampled women knew about community sanctions against perpetrators of rape compared to a lower proportion (38.8%) of women in the South West and 34.4% in the North East Zones. Almost one-tenth (9.7%) of the women in the South West alluded to the availability of community sanctions against perpetrators of SGBV in contrast to only 0.8% in the North East. Women in Bauchi (0.3%) and Edo (0.2%) States had a lower level of knowledge about community sanctions against perpetrators of SGBV.
- Women in the highest wealth quintile (53.0%) were more knowledgeable about community sanctions against perpetrators of rape than those in the lowest wealth quintile (34.5%). Furthermore, 35.7% of women in the highest wealth quintile were more likely to know about sanctions in the community for perpetrators of physical violence than those in the lowest wealth quintile (23.3%) (see appendix 9.4).

Evidence from the qualitative component also revealed that most of the community members across all the States were aware of community sanctions against perpetrators of SGBVs. There was low awareness regarding formal and legal regulations against offenders, alongside the existence of support facilities for survivors. The high level of ignorance of such legal provisions and laws could be attributed to the absence of the much-needed awareness that such laws exist and perhaps the cultural disposition of grassroots people towards legal redress as a pathway to retributive justice. Additional qualitative data captures the high premium that stigma caused by SGBVs across communities. The reluctance to reveal the identity of perpetrators and even report or escalate cases could be understood when a case is situated in context. Some of the perpetrators are known family members, and the fear of losing the family dignity was considered higher than individual rights and pains. Cases, where family and community members preferred silence over exposure and litigations, emerged across various groups and communities. A participant in one of the FGDs, for instance, narrated how a mother covered up for her husband in the case of child defilement. It was only in few instances that family members insisted on taking the case to court; the majority cover up the case.

9.6 Types of Sanctions Meted out to Perpetrators of Different Kinds of Violence Against Women

Figure 70 presents information on the type of sanctions generally meted to perpetrators of violence against women in this landscape study. For example, violence against women such as rape, intimate partner violence, and trafficking of children and girls meet with the course of the law and sometimes prosecutions. Violence committed under the aegis of FGM, traditional widowhood practices, and early marriage, among others, are often committed with impunity. The community members hardly take any legal redress against such actions. More data is provided on this in Appendix 9.2. Ironically, the majority of those who would like sanctions against harmful widowhood practices and trafficking of children and girls were mainly male respondents (see Appendix 9.3 for more detailed data on this).

Figure 70: Distribution of Female Respondents by the Types of Sanctions Against Perpetrators of all forms of VAW in the respective Communities.



9.7 Community Support for Survivors of VAW

Notably, very few respondents (females - 1.2%; males - 1.9%) reported any form of support for survivors of gender-based violence including sexual at the community level (see more data on this in Appendices 9.5 & 9.6). The Figures below present opinions of men and women on the kinds of support systems available to survivors of VAW

Specific Community level Supports for Survivors of VAW

Below are graphs presenting the specific community-level supports for the various survivors of different kinds of VAW (see Figures 71 to 77).

Figure 71: Specific community support to survivors of Intimate Partner Violence

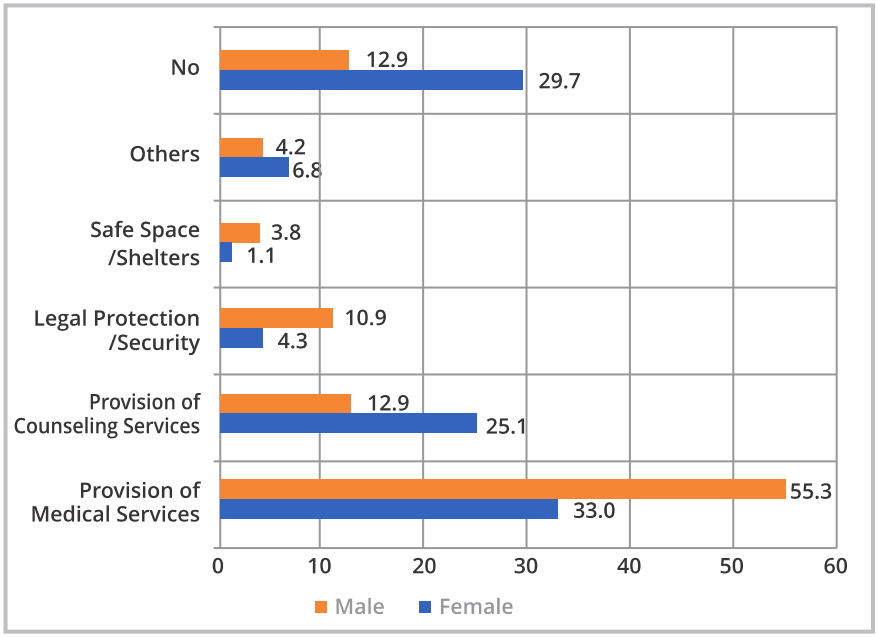


Figure 72: Community support to survivors of FGM

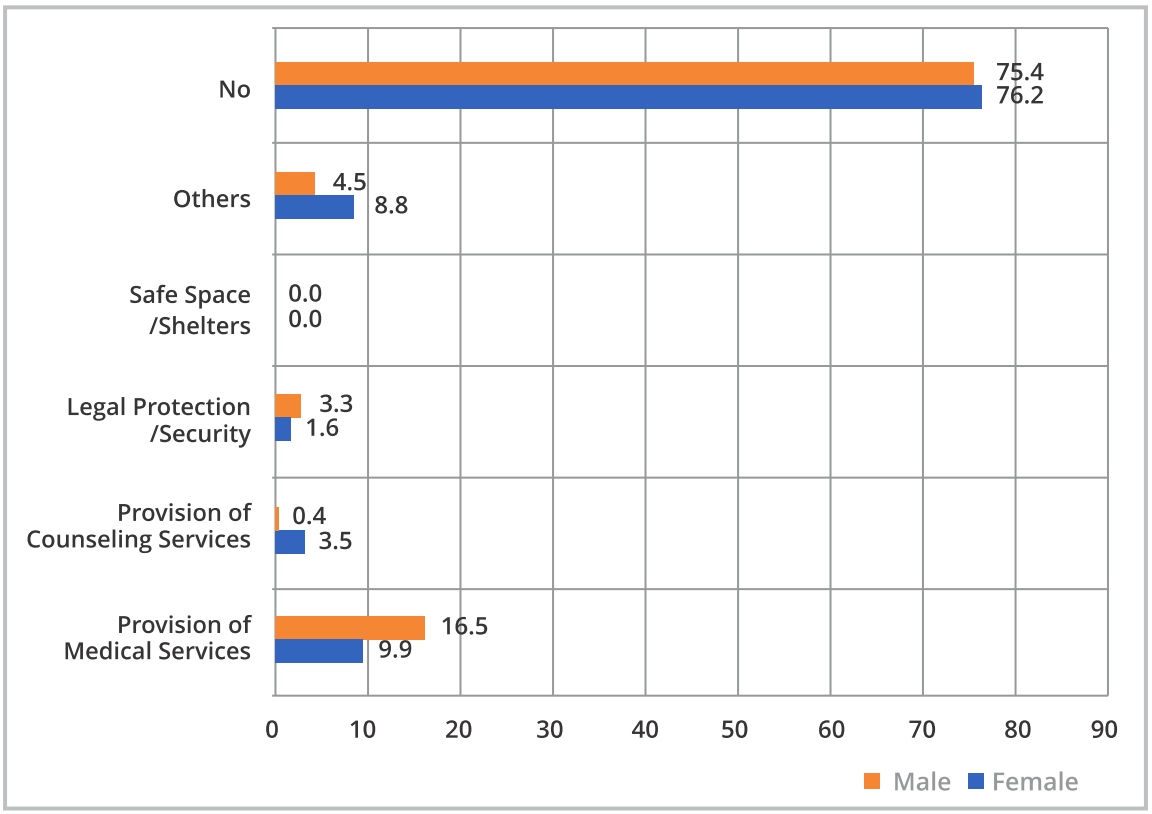


Figure 73: Community support for survivors of early marriage

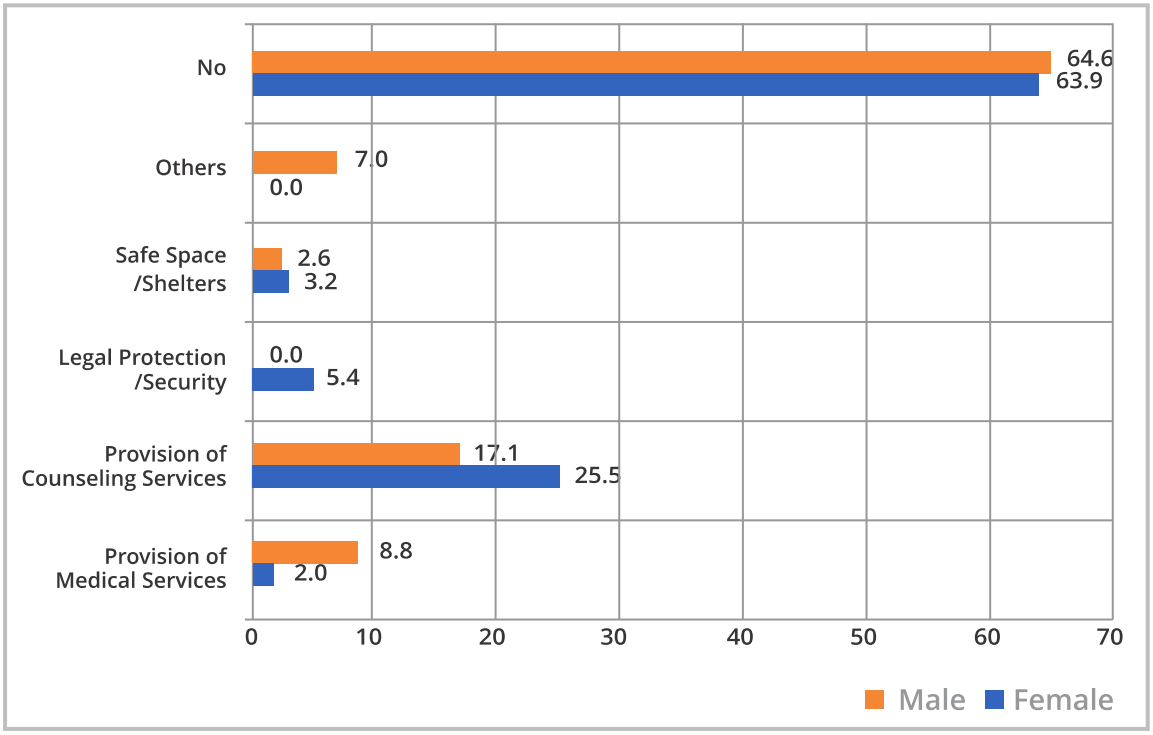
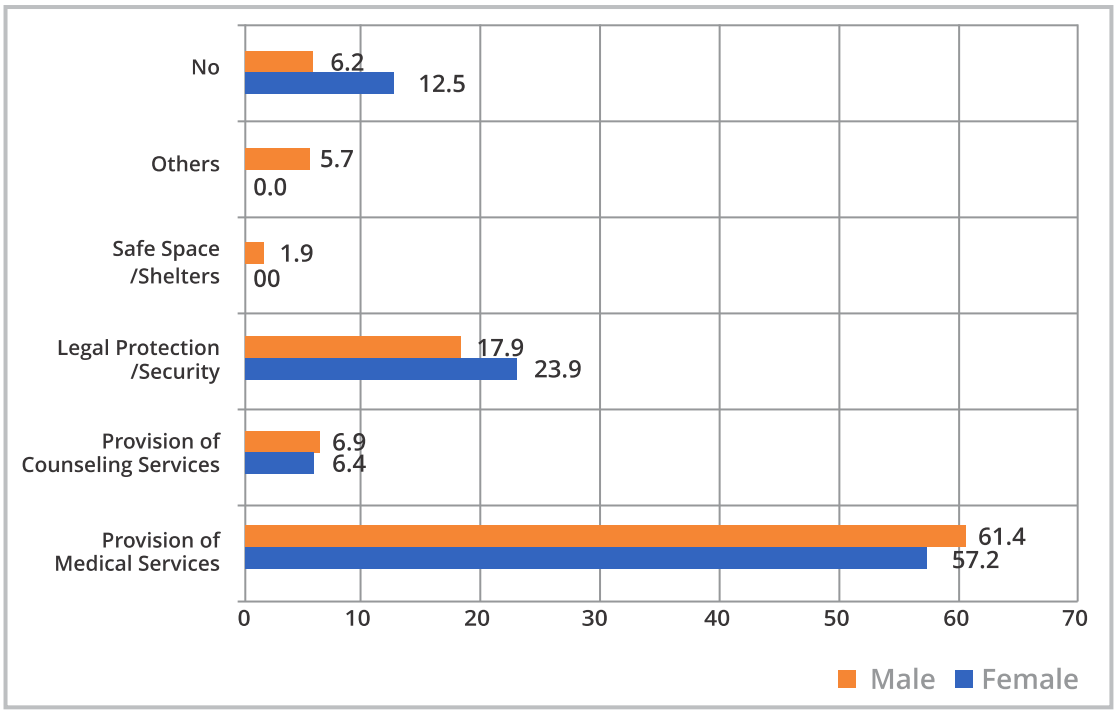


Figure 74: Community supports for survivors of Rape



Community-level supports for survivors of SGBV are more likely to be available to survivors of IPV and rape compared to survivors of early marriage and FGM. Some community leaders had positive dispositions toward collaborating with other stakeholders in bringing perpetrators to justice. Data from Kaduna, Oyo, and Kwara States show that some religious and community leaders now help to bring the known perpetrators of VAW to justice.

Figure 75: Community Supports to Survivors of Physical Violence

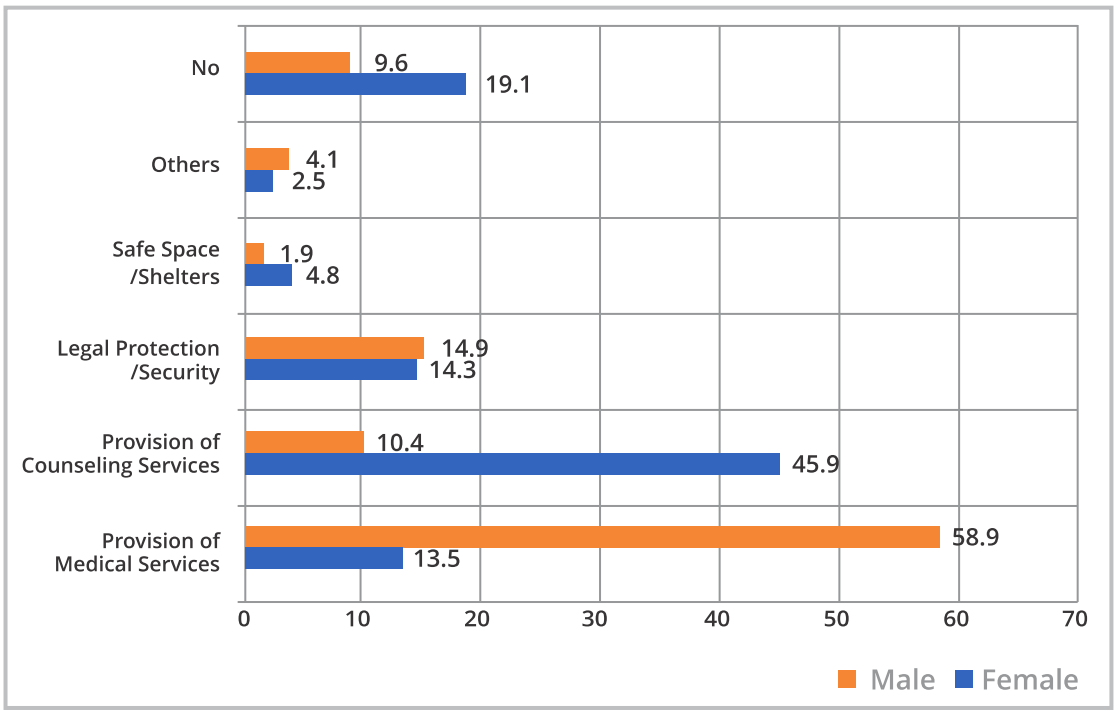


Figure 76: Community Support to Survivors of Vesico-Vaginal Fistula (VVF)

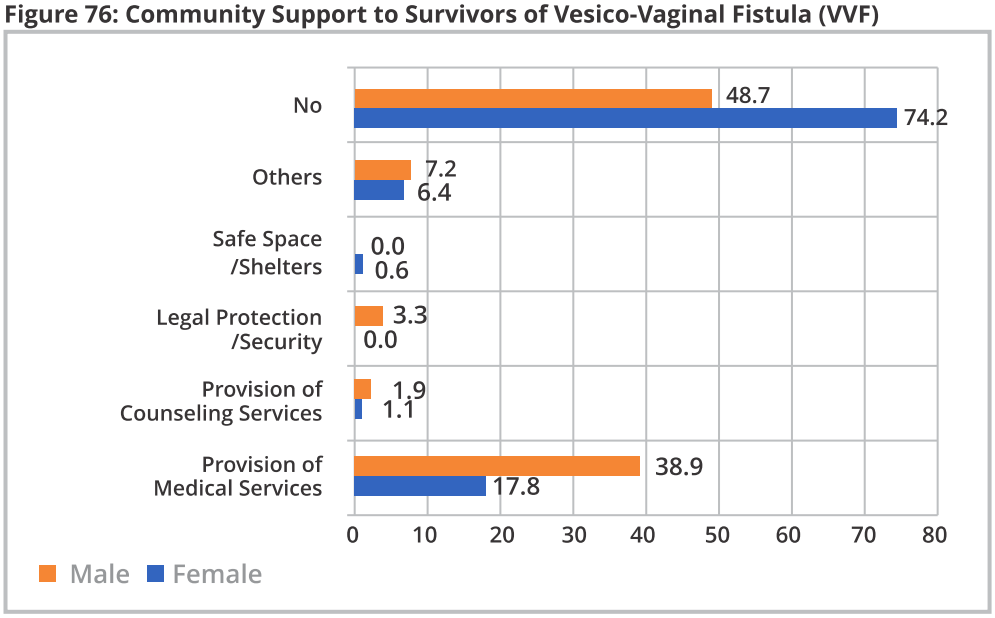


Figure 77: Community Supports to Survivors of Trafficking in Children & girls

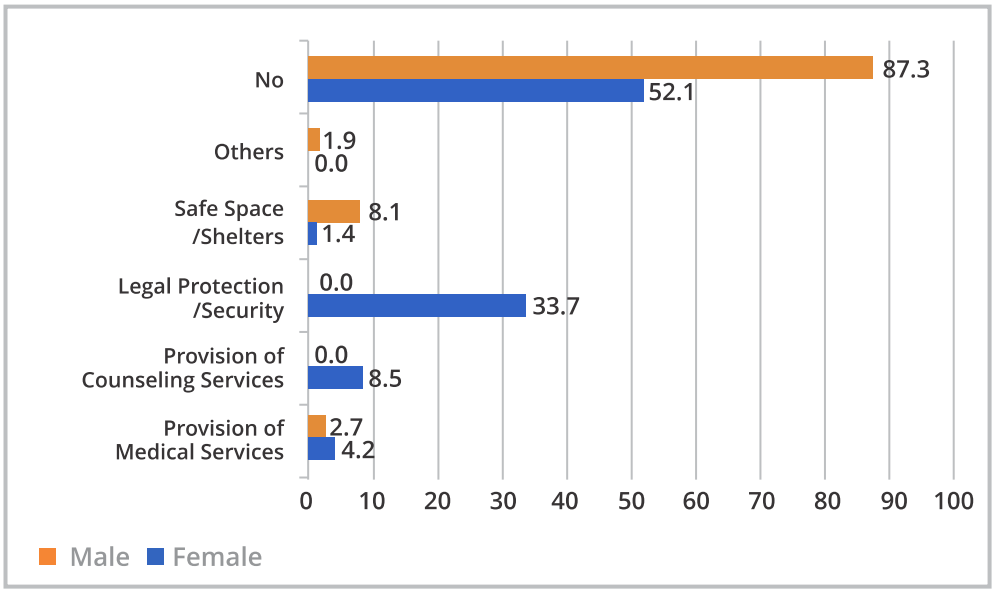
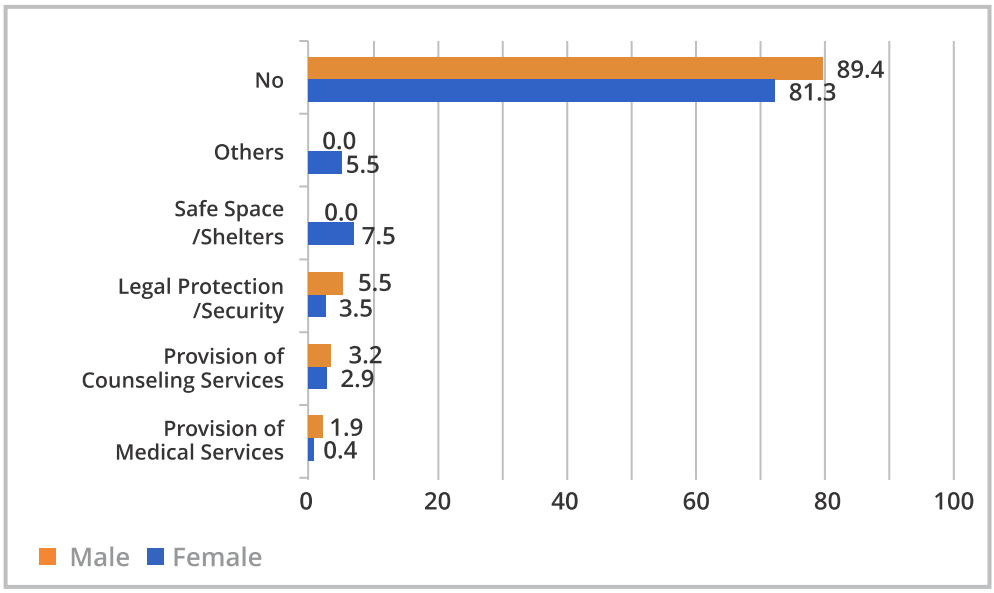


Figure 78: Community Support to Survivors of Harmful Widowhood Practices



Data on IPV (Figure 71) showed that men reported more community support for survivors, while women reported less (males – 87.1%; females - 70.3%). For cases of rape, respondents (males - 61.4%; females - 57.2%) reported the provision of medical services, but less on legal protection, security, counselling and safe spaces/shelter. Also, for physical violence, men (58.9%) reported some level of medical services for survivors, while women (45.9%) emphasized counselling more. However, for this group too, there is less support in the area of legal protection, shelters and safe spaces.

For survivors of FGM, very little or no support was reported by both men and women, while the issue of early marriage was also treated as a private affair, with little or no support for survivors from the community (Figures 72 & 73). Although both men and women recognized the need for medical assistance for the survivors of VVF/OF, there was almost zero support from the communities (Figure 76).

Trafficking in children (see Figure 77) also attracted little or no support for survivors from the community. Although some women reported some level of legal support and counselling, this is very minimal. For harmful widowhood practices (Figure 78), survivors received little or no community support. Although few women reported cases of provision of safe spaces/shelter, such women had no access to legal protection, proper counselling, and medical care.

9.8 The Role of State and Non-State Actors in Curbing Violence Against Women

Both state and non-state actors have been united in curbing violence against women given the current global spotlight on this problem. Few relevant pieces of evidence on Nigeria are presented in this section. The state actors are usually policymakers or those working in government establishments who either formulate laws and policies and/or regulate the implementation of these laws and policies on behalf of the government. The non-state actors are international and/or local NGOs and development partners who provide services in the sector and/or sponsor these services for the benefit of survivors and members of the local communities.

9.8.1 The Role of the Nigerian Police in Curbing Violence against Women

The qualitative evidence also revealed that security agencies, especially the police, have been very active in cases relating to SGBV since they are the only government agency permitted by law to prosecute criminal cases in court. Participants interviewed among the police officers revealed various steps taken by the police on SGBV including a thorough investigation, meeting with the legal department, drafting of the charges, and taking the survivors to a health facility for medical treatment. The Police in Ebonyi State specifically has a legal department to peruse the draft to ascertain its adequacy before taking the case to the court.

The police in Akwa Ibom, Ebonyi, Kwara, and Imo States particularly noted that they partnered with other government agencies and NGOs/CBOs to receive training on SGBV and this has improved their skills and capabilities to handle cases successfully. The training included how to handle survivors, counselling skills, reporting duration in the case of an investigation, and how to handle both the survivors and the perpetrators. This was confirmed by both the gender focal persons in government agencies and the police GBV departments.

Box 9.1:

There are some. If there is no evidence, we can't prove a case. For verbal abuse, if there's no evidence, no case. Also, for rape, if there are no visible evidences like, blood-stained clothes, proof of broken hymen, etc., the case will be difficult to prove.
KII with the Police in Kwara State

The police also keep records of SGBV in the crime diary, but this documentation was found to be done manually across all the study sites. The process of the documentation includes getting to the documentation office, registering all the information in the register, and other procedural actions for follow-up , and possible prosecution. The police officers interviewed across across all the states, however, lamented the inadequacy of facilities to discharge their duties. Many of them also emphasized the need for more training of police officers on SGBV for effective investigation, handling of the survivors, and prosecution of perpetrators. The different areas that need improvements identified include employment of personnel and appropriate capacity building of personnel in forensic evidence retrieval during the investigation, to build strong evidence against perpetrators and aid the prosecution process (see Box 9.1). They also requested improvement in the provision of a conducive physical infrastructure with modern technology, like computers, to make documentation easy for filing and retrieval via the database management system. In addition, the police mentioned that their vehicles were not always in good condition. Special vehicles are needed to fast-track handling of SGBV cases, in particular, the perpetrators, and more importantly to facilitate the movement of police officers to the crime scenes.

The Nigerian Police and the Spotlight Initiative

The Spotlight Initiative is a global initiative between the European Union and the United Nations to eliminate all

forms of violence against women and girls[7]. The initiative has reportedly impacted positively on the Nigerian Police Force (NPF) and other stakeholders in the sector. Through the Spotlight Initiative, the Nigerian Police now have an SGBV Department across the 36 States of the Federation, with a focus on 6 mutually reinforcing programmatic actions, including laws and policies; institutional building; prevention; services; Data on SGBV and working with grassroots women and their movements. These efforts have resulted in partnership and system strengthening for both state and non-state actors in the sector. However, there are still problems with women's access to justice, while community response to SGBV is still very weak. Also, efforts in transforming structures that continue to perpetuate gender inequalities at the grassroots level are still very limited. Sustained infrastructural and technical skills in SGBV response are also still daunting. The police SGBV Units at the State level are less organised and appear to be the weakest link in engaging with SGBV in the country.

9.8.2 Ministry of Women Affairs

The Ministries of Women Affairs at federal and state levels have been very active, ensuring the implementation of global, regional, national, and sub-national legal instruments and policies on SGBV (see Annex 1). The Ministry of Women Affairs had developed a standard operating procedure for the handling of SGBV cases which includes care and treatment; case prosecution; and provision of shelter for the survivor (short or long term, as the case may be). This is done through support from development partners and in particular, under the Spotlight Initiative on SGBV). Currently, there are about 23 states with Sexual Assault Referral Centres out of the 36 states of the Federation. The Centres provide psycho-social counselling and empowerment programmes for survivors including skill acquisition in catering, carpentry, bleach making, tailoring; and rehabilitation of survivors. The Centres also provide legal support to survivors of SGBV. Box 9.2 presents some evidences from Nasarawa, Kwara, and Kaduna State.

Ministries of Women Affairs at federal and state levels work with some Civil Society Organisations and local NGOs who provide SGBV services with support from development partners. Some of these organisations were identified across the zones. In the South East are the National Association of Fraternal Insurance Counsellors (NAFIC), Federal Teaching Hospital Abakaliki (FETHA), and the Sexual Assault Referral Centres (SARCs). Other ministries and government departments collaborating with the Ministries of Women Affairs on SGBV interventions and programmes are the Ministries of Health; Justice; Humanitarian Affairs; Human Rights Commission; International Federation of Women Lawyers (FIDA) Nigeria; and the Nigerian Police Force among others.

Box 9.2: KIIs with Gender Focal Persons & Policymakers

You asked, what have we done on SGBV? Yes, we have done a lot! We have at the State House of Assembly right now, a bill for provision of free medical services for those who were raped, especially children. **KII with Gender Focal Person in Akwa Ibom State**

Shortage of facilities in the health centres affect our work. Survivors cannot afford even transport fares to get to health facilities, even to take care of the people from the village is a challenge. How can they pay for forensic examination? **KII with Policymaker in Nasarawa State.**

We need to equip the Sexual Assault Referral Centre. In fact, we wrote a memo to his Excellency, because he was the one that renovated that place, and the place is very okay. We even invited the Chief Justice to go and look at the place and he said that the place is very okay. We have written to his Excellency in order to equip the place, but if there is any assistance the foreigners can render to us too, we wouldn't mind because we still have much to do there. Also, the implementation of the law is the major gap in Kwara State, but we are still using the VAPP law to tell people that we have laws that guide these offences and anybody who commits such offence will face the judgment. **KII with Policymaker in Kwara State.**

When you want to set up laws, you can't just sit down and come up with a law, there has to be a process, so we didn't just come up with a law. We went through a process, we had to call for a meeting and talked about it. The women, also, were called for meetings to make everyone understand what would be done and to have a general agreement **KII with Policymaker in Kaduna State**

Ministry of Women Affairs (both at federal and state levels) in their work on SGBV are still confronted with problems of:

- provision of shelter to survivors;
- technical skills for standard operating procedures on

7. *https://www.spotlightinitiative.org/*

SGBV
- weak collaboration with other organisations and partners
- weak engagements with rural communities on gender transformative development
- the state Ministries of Women Affairs appear weaker in their response to SGBV and exhibit poorer infrastructural support for effective programming on SGBV.

9.8.3 Ministry of Justice (Judiciary)

The Ministry of Justice has a central role to play in adjudicating justice on SGBV and ensuring proper prosecution and procedures. Many of the Justice departments have received training on SGBV, although fewer at the state level compared to the federal. Both the Ministries of Justices and Health would need to work closely together to ensure that evidence of the assault is kept and that justice is delivered.

At present, these Ministries are not adequately funded to engage with SGBV cases, and in most cases like the police departments, public officers often had to help survivors from private pockets. In many cases, survivors could not pay their bills for health/forensic investigations. Notably, lawyers from FIDA and other support councils provide free services to survivors.

It was affirmed by the gender officers and the judiciary officers in the South West and North East that the judiciary collaborates with police, NSCDC, the State Action Committee, the National Human Rights Commission, and a few NGOs across the states (see Annex 2 for the list of NGOs working on SGBV across Study site).

Government agencies need to work with local institutions and local community leaders to bring about respite to survivors and curb violence against women. This appreciation has led to closer collaborations among the various actors (state and non-state actors) in the sector. The government departments rely on local NGOs to provide shelters for survivors of SGBV, while the police departments would have to work closely with community interest groups to bring culprits and perpetrators to justice (see Box 9.3. for evidence of collaborations between the judiciary and local NGOs in Bauchi State).

Box 9.3.: KII Excerpts - the Judiciary

There are a lot of lawyers working on free legal charges. We have FIDA, we have NBA, and we have Legal Aid Council. We are giving little stipends and at times refer them to other organisations that provide livelihood support.
KII with Judiciary in Adamawa State

We collaborate with other units. Sometimes, the police call to report cases... NGOs will call, if it comes to us, we call others to collaborate to assist the victims and then find ways of prosecuting the perpetrator. We do collaborate a lot with the Office of the First Lady, the State Action Committee, the National Human Rights Commission, Ash Foundation, Ikra Foundation, Child is Gold Foundation and National Human Right Commission.
KII with Judiciary in Bauchi State

9.8.4 Health Workers

The roles and capacity of the health workers in addressing SGBV were also assessed in this study. The health workerswere knowledgeable and proactive in handling SGBV cases, while they collaborate with relevant partners across the states. They often administer first aid to the survivors and run other laboratory tests before the commencement of further treatment. The specific supports provided by health facilities to the survivors include mental and psycho- social services, counselling, reintegration of the survivors into society, and presentation of detailed and robust documentation of medical evidence in court. The health workers noted that there is a clear procedure to be followed for the tests and medical treatment of survivors while some of the tests are provided for free as part of the support to the survivors. A referral form is also available if needed for further medical care in another medical facility. Box 9.4 presents excerpts from KIIs with health workers from Oyo, Bauchi, and Adamawa States, showing that health workers are now specially trained to handle SGBV cases. A lot of support from Development Partners (including UNFPA and GAC) was reported in these states, especially in training and re-training of health workers on SGBV issues.

A major setback is the high cost of forensic and other health investigations often borne by survivors. This limits interests in prosecutions and further legal engagements that could ensure justice. Stigmatisation is also a major concern deterring survivors from prosecuting perpetrators. Thus, many survivors are not ready to speak up or follow up on prosecution because of social reprisals from the society. In most cases, lack of evidence often 'kills' the case against the perpetrator, said an observer.

9.8.5 NGOs/CSOs

Several NGOs and CSOs now work in the SGBV sector and have become a big voice for women and in particular, for the survivors. A number of these NGOs have been

Box 9.4:
Excerpts from Health Workers KIIs

We have the personnel and we have the professionals with good knowledge and well trained on SGBV. We are mostly involved in treatments, counselling and reorientation of the person back to the society...or giving evidence in court when the case arises. **KII with Police Health Facility in Oyo State**

We receive training like say 3 to 4 times in a year, this makes us different from those that have not received any training. **KII with a Health worker in Bauchi State**

Like the refresher training on SGBV that we did in March 2021, for clinical, all the aspects, because it is for staff. So, we covered all aspects, legal, security, it was comprehensive. We also have mental and psycho-social service training. **KII with Health Worker in Adamawa State**

formed into coalition groups on SGBV and supported by development partners and foundations working in the country, including UNFPA; UN Women; UNICEF; GAC; DFID; the World Bank; the Ford Foundation, Mac Arthur Foundation, African Development Bank; Action Aids, Foundation Resilient Empowerment and Development (FRED), Integrated Health Project (IHP) and Momentum Country Global Leadership (MCGL), among others.

These organisations have worked closely with local NGOs providing support to survivors in various capacities, such as awareness creation on SGBV and its negative impacts; counselling; financial support to survivors and their rehabilitation; and/or shelter and empowerment. Radio programmes and radio jingles have been used for sensitisation against VAW. It is, however, saddening that many of these programmes have very little effect at the grassroots level.

9.9 National SGBV Strategies

The National SGBV strategies are informed by the global, regional, and national legal instruments and policy frameworks, especially the provisions of the VAPP Act of 2015; the National Action Plan on UNSCR 1325; and the National Gender Policy adopted in 2006, revised in 2021. The Spotlight Initiative, a UN sponsored initiative on curbing SGBV across countries, also provided the needed impetus to policy and programmatic engagements in this sector in Nigeria. However, the extent to which local communities are active participants in this process became a matter of discussion in this landscape study.

The national accountability framework for addressing sexual and gender-based violence which was developed under the UN Women Spotlight Initiative in collaboration with the Federal Ministry of Women Affairs was a clarion call to action. One of the primary achievements of the Spotlight Initiative SGBV was the establishment of the Gender Units across Nigeria Police Force formations, with the mandate to handle cases of sexual and gender-based violence, in the areas of prevention, care and treatment, prosecution, and shelter. The study report shows that poor understanding of gender issues, lack of funds, lack of technical capacity to handle SGBV cases, and lack of shelters for the survivors, among others, stand out among the current problems facing the NPF in carrying out their responsibilities in this sector.

The landscape study takes significant notice of the central elements in the Nigeria national accountability framework on SGBV (see Figures 79 and 80), while the baseline data from this landscape study points to the very weak implementation of these earlier projected principles, laws and policies.

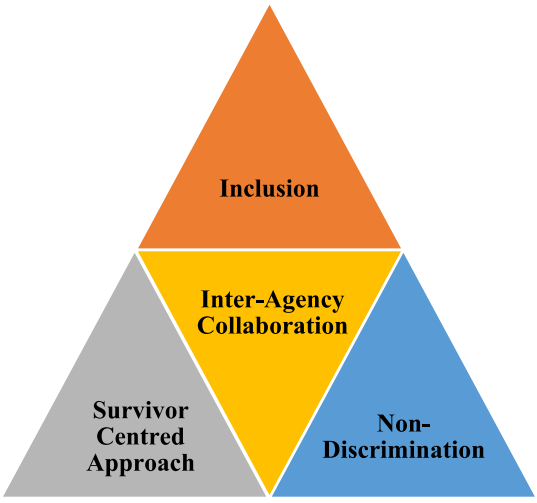


Figure 79: Guiding Principles for the Nigeria SGBV Framework

Figure 80: Enabling frameworks for ending SGBV in Nigeria

In the light of the challenges surrounding the prosecution of SGBV offenders, the participants expressed that creating laws and policies centred on violence against persons requires a holistic approach. The processes must be transparent and inclusive enough to accommodate all stakeholders' contributions toward fighting all forms of sexual and gender-based violence in the society. For such policies to achieve any significant success, policymakers must localise such policies by taking inputs from the stakeholders in the communities. This will reflect a robust approach in the fight against sexual and gender-based violence. The participants in Kaduna specifically noted that the process of making the VAPP law was thorough and rigorous, involving contributions from stakeholders within the community such as the traditional rulers, religious leaders, health workers, security agencies, and civil organisations to make the laws and policies reflects the reality of situations in the local communities. However, little efforts have been made to translate the VAPP law into local languages, and/or ensure that institutional frameworks are strengthened for its implementation.

9.9.1 Challenges of Implementing the VAPP Acts of 2015

VAPP Act of 2015 was identified as one of the important legal instruments and a proviso for engaging with SGBV in the country (see Annex 1). Ironically, this legal instrument appeared not too well known by local communities. This is due to lack of awareness and advocacy of such a law, and possibly lack of proper consultation and involvement of communities and other stakeholders in the development process of the law. Although the production of the VAPP Act involved Nigeria women's movement activism and social mobilising. Such mobilisation was elitist, and without a clear voice for the rural and the uneducated populace. Therefore, implementing the VAPP Act (2015) in many Nigerian States lacks a clear understanding. Responses from many of the women in the landscape study still show a lack of understanding of the basic elements of women's rights and the need for a gender transformative development. Androcentric values of gender roles and norms remain unquestioned and even justified by women.

Though the staff of the Federal Ministry of Women Affairs reported that "a lot of efforts have been carried out, we have the honourable minister advocating to the state governors, taking advocacy to the state to ensure that the states that are yet to domesticate the national VAPP Act should do so". This language needs to be translated to the local language of the citizens, not just that of policymakers. The Federal Ministry of Women Affairs still needs to ensure that the advocacy for the VAPP Act (2015) is taken to all the geo-political zones, especially the 8 states that are yet to domesticate the VAPP Act, while also advocating the domestication of the newly revised 2021 National Gender Policy; only 6 of the 36 States have domesticated that of the 2006 National Gender Policy. A major hurdle is the passivity of the national and the state assemblies to laws and policies relating to gender equality and women's empowerment issues.

Also, prosecuting perpetrators of violence against women requires cooperation from all stakeholders

involved. Qualitative study findings reveal that some cases of violence against women, especially rape and intimate partner abuse, were difficult to handle because of the various challenges faced by security agents and other stakeholders involved. Some challenges mentioned are reluctance from women to report their husbands to the police and its dire consequences; the voluntary withdrawal of the survivor from the case after reporting; denying of allegations after reporting; lack of funds for medical examinations and treatment of the survivors, among others. Box 9.5 presents excerpts from KIIs with programme managers and the police. Poor women are reluctant to report abusive husbands because of the backslash on their children, especially in matters relating to children's schooling and upkeep. Also, survivors could not report cases of abuse because of stigmatisation; social labelling; lack of relevant drugs and test kits in the health facilities; corrupt practices by the police officers who sometimes comprise the true details on incidence; and the incessant industrial action of the judiciary which is considered as a big hindrance in the pursuit of justice for survivors of VAW. Also, irregularities in the court proceedings such as unnecessary adjournment to prolong the case by the defendants' lawyers and/or by the police officers; frustrating the survivors and dissuading them from seeking justice; and interference by the community and religious leaders or family members who mediate to protect both the survivors and/or the perpetrators based on what they called 'family honour' are other important challenges facing VAPP implementation.

Box 9.5: Excerpts from KIIs with Policymakers & the Police

... you mean why women don't report abuse from husbands? economic circumstances, sometimes You have women who are completely dependent on their spouses for support, so they feel like if they report, their children will no longer be able to go to school, so they sacrifice themselves on account of their poor economic situation. These are serious challenges which sometimes stop women from taking advantages of provisions of the law which protect women from abuse.
KII with Policymaker, Ogun State

It is also important that all evidence rape cases, especially, are kept intact as these will help the cause of investigation by the security agents, and justice would be served accordingly. However, there are challenges in establishing a rape case or intimate partner abuse, especially with a lack of evidence. Many participants noted that one major challenge is tampering with evidence, cleaning or washing away evidence in the case of sexual violence or assault, and /or taking actions that could destroy the available evidence. Thus, prosecuting the offenders becomes difficult without existing evidence. Excerpts from KIIs with police officers in Imo and Kwara States (see Box 9.5) present crudity in the police investigation of rape and related cases. The implication for the woman's honour may discourage a woman from reporting cases of rape, for example, to the police.

9.9.2 Overcoming these Challenges

Some solutions to the identified challenges according to the respondents are provisions of fitting shelter/facilities to protect the identity of the survivors. State governments were also advised to implement VAPP and other related laws to serve as a deterrent to others. Survivors should not be stigmatized; they should be able to speak up freely. Corruption should be discouraged among the security agents, and cases should be promptly presented in court.

Respondents further suggested that although evidence is very important in proving a case, what is taken as evidence may need to be reconsidered. For instance, cases like FGM or rape may not have physical evidence to prove that it happened, but evidence like a doctor's report after examination of the hymen and other parts of the private part can provide vital information needed to establish the case (see Box 9.6). Other tenable pieces of evidence are video recordings of such acts, stains on the body or the clothes of the perpetrators. In the case of domestic violence, the scars could be tendered as evidence of such an act.

Box 9.6:
Excerpts from KIIs with Police Officers

In the case of rape, doctor's report then exhibits. That is why the duration matters because we need to go to the crime scene to get something. If someone was raped and is coming days later, we ask for her undies. It is tough especially for someone who is not a virgin except we see bruises. **KII with the Police in Imo State.**

In case of Female Genital Mutilation, the evidence cannot be shown because it will be the hymen that has been cut away, its only medical report that can be used. For psychological imbalance, medical report that the person is psychologically infected or if the person was beaten and injured. Some women do record what their husband says, that can be used as evidence also as verbal abuse will give us more evidence. **KII with Police in Kwara State.**

Effective collaborations among state and non-state actors in the sector are encouraged to ensure immediate response to survivors and ensure that perpetrators receive instant judgement. The government are encouraged to establish judicial institutions such as family court to focus on the issues emanating from the family front and to implement laws protecting individuals against violence. The government also need to provide facilities for treatment and support of survivors. NGOs, CBOs, and other stakeholders also need to join hands with the government by providing awareness through various means to the general public on ways of addressing VAW cases. Health institutions, the judiciary, security agencies, support groups, and local and international organisations are also encouraged to work together by partnering with the government in tackling SGBV.

A Series of approaches have been proffered, ranging from a survivor-centred approach to a multi-sectoral approach and a variety of strategies for programmatic actions to help the survivors and/or bring the perpetrators to justice.

Participants emphasized the importance of improving the help-seeking behaviour of the survivors through an awareness campaign and sensitisation programs. Creating awareness through the media, such as radio jingles, organising counselling clinics, and rehabilitation for survivors of SGBV have the potential to improve the help-seeking behaviour of survivors. Regular training of security agents, health workers, and government administrators, and organising workshops on ways of handling SGBV cases would also enhance the quality of response to SGBV cases.

However, there are challenges to establishing a case of sexual and gender-based violence, and most importantly is that of getting evidence. As noted by a key participant, one of the challenges are the ease at which some privileged persons pervert justice by tampering with evidence, cleaning or concealing evidence, especially in sexual violence or assault cases. The fear of stigma and family shame also act as constraints to evidence gathering and prosecution of offenders. Against this backdrop, interviews with police officers affirmed the difficulty in evidence gathering and prosecution within the existing penal system in Nigeria.

Some of the possible solutions to the identified challenges included provisions of fitting shelter/facilities to protect the identity of the survivors. State governments were also admonished to implement SGBV/VAPP laws to serve as a deterrent to others. The survivor should not be stigmatized; they should be able to speak up freely. Corruption should be discouraged among the security agents, and cases should be promptly presented in court.

Responsive collaborations among the key stakeholders were also cited as an area that requires urgent attention for more strategic impact and solutions. The government alone cannot single- handedly proffer solutions to SGBV issues. However, the government needs to fund and strengthen judicial institutions such as family courts to focus on the issues emanating from the family front, and to implement laws protecting individuals against various acts of violence. More functional facilities are also needed within the judiciary system for a proper and effective response to the challenges of SGBVs. Health facilities also need to be adequately funded and collaborate more with the police or law enforcement agencies and the judiciary system.Mobilisation of NGOs, CBOs, and other stakeholders should be more rigorous in the campaigns and reportage of cases within and across communities.

The need for a more enabling environment cannot be over-emphasised, as revealed across the zones and states. NGOs and CBOs were credited with playing active roles in the struggle against SGBVs across communities and the creation of awareness of the dangers of FGMs and other forms of SGBVs. These organisations should be motivated more to cooperate with the government by providing awareness through various means to the public on ways of addressing SGBV issues. These organisations also need to collaborate more with health institutions, the judiciary, security agencies, support groups, and local and international organisations in tackling SGBV.

9.9.3 Promoting Help-Seeking Behaviour among Survivors

Across the zones and states, findings revealed that creating awareness through the media such as radio jingles, organising counselling clinics, and rehabilitation for survivors of SGBV would contribute to the help-seeking behaviour of survivors. Regular training of security agents, health workers, and government administrators and organising workshops on ways of handling SGBV cases would enhance the quality of response to SGBV cases. Collaborations among government institutions, and local and international NGOs on handling SGBV cases, would improve the quality of services rendered to the survivors of sexual and gender-based violence.

9.10 Key Findings

The findings in this section give credence to the low level of awareness of safety nets, programmes and policies on sexual and gender-based violence, harmful traditional practices and obstetric fistula at the community level. Furthermore, this chapter showed clearly that policies related to SGBV and HPs are not well understood in the community and some of the traditional harmful practices are not sanctioned in the community.

The findings, therefore, suggest the need for the review of policies and programmes on gender equality issues and social inclusion problems, and enforcement of relevant sanctions for harmful traditional practices in the community. Policy implementation and communication at the community level are needed to improve the understanding at the grassroots.

9.11 Recommendations

Following the field evidence, the following recommendations are made:

i. Communities are to be enlightened on the existing SGBV laws and other gender- related policies which protect the interests of women, men, girls, boys and other vulnerable groups in the society; taking redress against perpetrators of SGBV of any form;

ii. Provision of legal aid services to survivors of SGBV and other groups at risk of violence;

iii. Capacity building for key front workers in the fight against and elimination of SGBV in the society;

iv. Integrated SGBV referral system which aims at reducing the cost of treatment and legal provisions for survivors of SGBV;

v. Provision of shelter to survivors of SGBV among other services, including psycho- social and trauma treatment, etc;

vi. The root cause of SGBV lies in patriarchal gender norms and unequal power dynamics between women and men in the society. This must be addressed if we are to fast-track reduction in SGBV cases. The following options are suggested:
   - Raising awareness against SGBV and promotion of behavioural change towards zero tolerance for and prevention of SGBV;
   - Support for gender transformative change such as addressing social, cultural and religious norms, and practices that perpetuate SGBV and other risk factors which increase the vulnerability of women and girls;
   - target social media messaging to address the vulnerability of women and girls, and persons with disabilities;
   - Work with men and boys to stop SGBV, and reject gender asymmetry behaviours and practices;
   - Empower women, girls, and other vulnerable groups (especially persons with disabilities) to fight SGBV and its perpetrators.

vii. More local NGOs/CSOs are now involved in the provision of comprehensive SGBV treatment (including shelter for survivors), in collaboration with key stakeholders, such as government departments and development partners. The local NGOs need more support and technical inputs;

viii. A proper M & E system for monitoring progress on SGBV interventions and reduction is not possible without support for SGBV research, collection of SGBV data (Strengthening of the SGBV data bank); and support for gender education in schools, both at pedagogical and instructional levels, to ensure that children and adolescents imbibe gender symmetry culture early in life.

ix. Under-reporting of SGBV cases because of social stigma, reprisals from perpetrators, and lack of financial resources should be incorporated into programmatic actions.

x. Limited male involvement in SGBV prevention and response does not provide the impetus for SGBV policy implementations