THE SOCIAL NORMS LEARNING COLLABORATIVE NIGERIA

BOOK OF ABSTRACTS

SOCIAL NORMS CONFERENCE

Empowering Women Through Policy and Practice Related to Social Norms

NOVEMBER 2021

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The Nigerian Social Norms Learning Collaborative

The Nigeria Social Norms Learning Collaborative (SNLC) was established in 2020 as a country-level Community of Practice (CoP) and facilitates building knowledge and developing tools among researchers and practitioners across regions and disciplines to advance effective, ethics-informed social norm theory, measurement, and practice at scale. The SNLC is currently focused on three states; Kaduna, Kano, and Niger State, but includes members from across Nigeria. Members work across multiple development focus areas including women's economic empowerment, sexual and reproductive health and family planning, infectious disease, gender-based violence, maternal and child health, nutrition, and immunization among others.

The Collaborative draws members from government organisations, donor agencies, NGOs, and academia with an objective to strengthen networks, build sustained expertise and capacity in Nigerian organisations and institutions, and support good quality programming. The CoP shares state-of-the-art social norm evidence, approaches and resources with key players and actors through proven learning strategies, with specific focus on gender norms and their impact on health and women's economic empowerment. The SNLC is made possible by the generous support of the Bill & Melinda Gates Foundation. The contents of this document are the responsibility of the SNLC and do not necessarily reflect the views of the Bill & Melinda Gates Foundation.

Acknowledgements

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Keynote Address

Empowering Women Through Policy and Practice Related to Social Norms

By Dr Amina Baloni, Honourable Commissioner of Health, Kaduna State

*This is a slightly revised version of the original speech

Empowering women through policy and practice related to social norms in Nigeria.

When the issue of women's empowerment comes into social or political discussion, the first thing that comes to mind of both project initiators and beneficiaries is the distribution of money and palliatives. Such kind handouts have helped many women meet their immediate economic needs like boosting their businesses and providing food for the family, however, empowering women with critical knowledge and supportive social norms has become even more important to make the necessary changes in society.

Women's empowerment promotes women's sense of self-worth, their ability to determine their own choices and their efforts to fight for social change for themselves and others. Policy is a deliberate system of guidelines for action to achieve desired outcomes. Social norms are the unwritten rules of beliefs, attitudes and behaviours that are considered acceptable in a particular social group or culture.

The leadership of Kaduna state and to a certain extent Nigeria has demonstrated their willingness to involve women at the highest level of policy formulation and governance. I hope that through engagements like this conference we will not only appreciate the efforts made towards equality in opportunity so far, but strive towards achieving women's empowerment. I wish to express my delight with the issues selected to be addressed and believe that the outcome of today's sessions will be enriching. I am hopeful that we will all be equipped with the proper knowledge and approach to improve our health and well-being as well as empower our women through enlightenment and economic independence besides acquainting ourselves with the prevailing social norms.

According to the 2021 gender gap report, the gender gap in political empowerment remains the largest of the four main dimensions of gender equality: 1) Access to economic opportunities, 2) Education, 3) Health and 4) Political power gaps, in Nigeria. Women are generally marginalised in government representation at both national and sub-national levels. For instance, in Nigeria's 2019 election 7.5% of the Senate and 3.1% of the House of Representatives are women, with no female state governors. Nigeria ranked 149th out of 156 countries in terms of the gender gap in political empowerment in the 2021 gender gap report. It is noteworthy that the United Nations women (UN Women) ranked Kaduna state as the best performing state in Nigeria in terms of women participation in government, with about 43% representation in government.

Impact of women in governance

Countries headed by women were found to be more effective in handling the COVID-19 pandemic than countries headed by men. Kaduna state government's success in the handling of COVID-19 was attributed to the effective leadership of a woman: Deputy governor Dr Hadiza Balarabe. Evidence suggests that the more women are in leadership, the more prosperous society can be.

The barriers to women's participation in governance however are linked to issues around discrimination which are supported by social, cultural and misinterpreted religious norms of society.

Men are the majority and they dominate the political parties and most activities. We also see a lack of adequate education of girls and women in Northern Nigeria that prevents them from having the adequate skills required to participate in governance; and during elections, there are cases of violence against women and women candidates. Another barrier to women's participation in government is the lack of adequate financial resources for women, as women usually devote more time to caring for their families and raising their children, limiting the financial resources they need to participate in politics and governance. And the last but not the least of these points is that women are largely marginalised when it comes to democratic processes. There have been situations where some women were denied the opportunity to purchase forms to participate as candidates in the democratic process simply due to their gender.

On the other hand, socio-cultural, and economic factors also encourage women to participate in governance. We need a sociocultural orientation and sensitization of the public on the roles of women geared at making it more acceptable for women to be in positions of politics and governance. Women also need economic empowerment, basically and majorly through education and technical training. Political interest and awareness need to be developed in women by women and also by the larger society for women to really have the confidence to step out and be part of the process. The quota system which mandates that women have a certain number of seats within the government has helped improve women's participation but this needs to continue to improve representation. A good example is the affirmative action that has been taken to allocate a certain number of political seats for women in government. We must also collectively discourage sexism and gender-based violence given that in recent years, we have had a number of cases where aspirants were attacked during elections.

In conclusion, government policies and practices must be designed to displace certain social norms that put women and girls at a disadvantage in our societies. This would provide a level playing field and empower women to live to their full educational, economic, health and political potential.

Dr Amina Baloni
November 2021

Maternal and Child Health and Nutrition

Theme: Maternal and Child Health and Nutrition

Knowledge, Attitude and Practice towards hospital delivery among women of reproductive age in Paikon-kore Gwagwalada, Abuja

By Udeani O.C, Nwankwo B.B

Background: High maternal mortality poses a major problem in public health in most parts of the developing world, including Nigeria. Poor and absence of maternal health delivery in resource poor countries results in more than half a million maternal deaths during pregnancy, childbirth or within a few weeks of delivery in limited-resource settings.

Aim/Objectives: To determine the Knowledge, Attitude and Practice towards hospital delivery among women of reproductive age in Paikon-kore Gwagwalada Abuja.

Materials and Methods: A descriptive cross-sectional study and a multistage sampling technique was carried out among 215 women of reproductive ages (15-49 years) in Paikon-Kore Gwagwalada, Abuja. Data was collected using a semi-structured, interviewer-administered questionnaire. Data was analysed using SPSS version 26.0.

215 Women respondents

80.4: Proportion of respondents who think every pregnant mother should give birth in a hospital

74.5: Proportion of Respondents who believe it is necessary to have a skilled birth attendant during delivery

57.7: Proportion of respondents with good knowledge and general positive attitude

73.49: Proportion of respondents with a positive attitude towards

Results: A total of 215 women of reproductive age were enrolled in this study. The mean age was 27.09 ± 6.86 years. Majority of the respondents, 173 (80.4%), mentioned that every pregnant mother should give birth in the hospital. 160 (74.5%) women mentioned that it is necessary to have a skilled birth attendant during delivery. Majority of respondents (158 (73.49%), have a positive attitude while 57 (26.51%) of them have a negative attitude towards hospital childbirth. Education was found to play a major role in women's attitude towards hospital delivery as the higher the level of education, the higher the positive attitude. Only 62 (28.8%) of them consumed the local potash drink and 179 (83.63%) performed the ritual hot bath. 36 (16.74%) women were reported to have had foul smelling discharge following childbirth followed by 20 (9.30%) women who had perineal tear.

Conclusion and Recommendations:

Factors that influence maternal health services utilization operate at various levels - individual, household, community and state. This study shows that cultural beliefs and norms have an influence on maternal care practices.

"Allowing women make decisions about where and when to seek care will substantially reduce pregnancy related complications"

Maternal education plays a major role in determining usage of maternal health services. Productive strategies to encourage maternal health service utilization should target the principal individual, household, community and policy-level factors.

As traditional birth attendants are needed in maternal healthcare for reasons of acceptability, adaptability, and accessibility, their skills should be up-graded. Advocacy by healthcare personnel to community leaders on the importance of allowing women make decision about where and when to seek care, especially in the absence of their spouse during emergency situations will substantially reduce pregnancy related complications.

Key words: knowledge, attitude, cultural practice, maternal health services, hospital delivery

Psychosocial influences on pregnancy and childbirth behaviours in north-western Nigeria: a cross-sectional analysis

By Emily White Johansson[1,2], Udochisom Anaba[1,2], Dele Abegunde[1,3], Mathew Okoh[4,5], Shittu Abdu-Aguye[4,5], Paul C Hewett[1,3], Paul L Hutchinson[1,2]

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Antenatal care (ANC) and facility delivery are essential maternal health services, but uptake remains low in north-western Nigeria. To increase service use, social and behaviour change (SBC) programs target psychosocial influences across cognitive, emotional and social domains including knowledge, beliefs, self-efficacy, and social norms. Yet there remains limited research that measures and quantitatively examines the role of psychosocial influences on pregnancy and childbirth behaviours in Nigeria or elsewhere. A cross-sectional population-based survey of randomly sampled women with a child under two years was conducted in Kebbi, Sokoto and Zamfara states of north-western Nigeria in September 2019. Women were asked about maternal health behaviours during their last pregnancy. New psychosocial metrics were developed using the Ideation Model of Strategic Communication and Behaviour Change. Predicted probabilities for visiting ANC four or more times (ANC4+) and giving birth in a facility were derived using mixed-effects logistic regression models adjusted for ideational and sociodemographic variables.

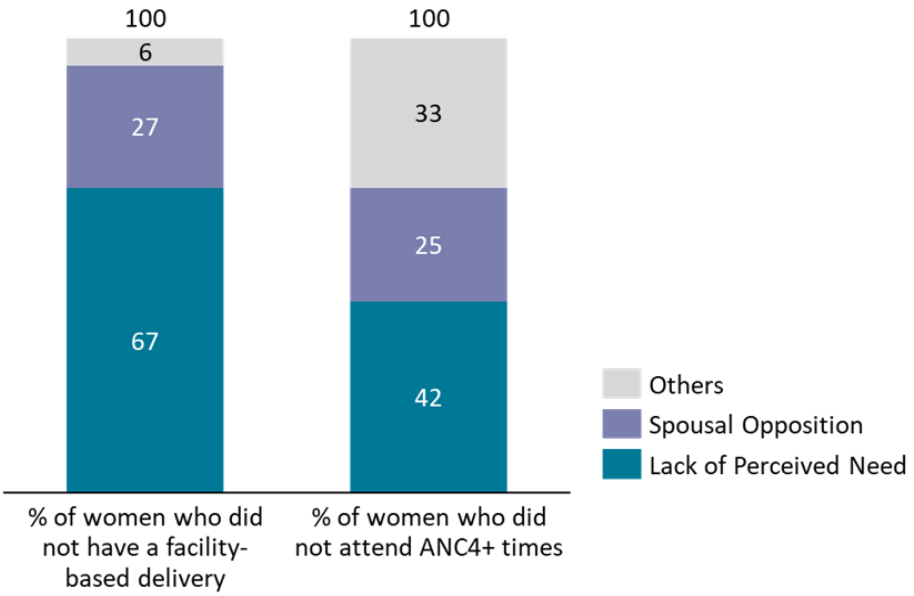
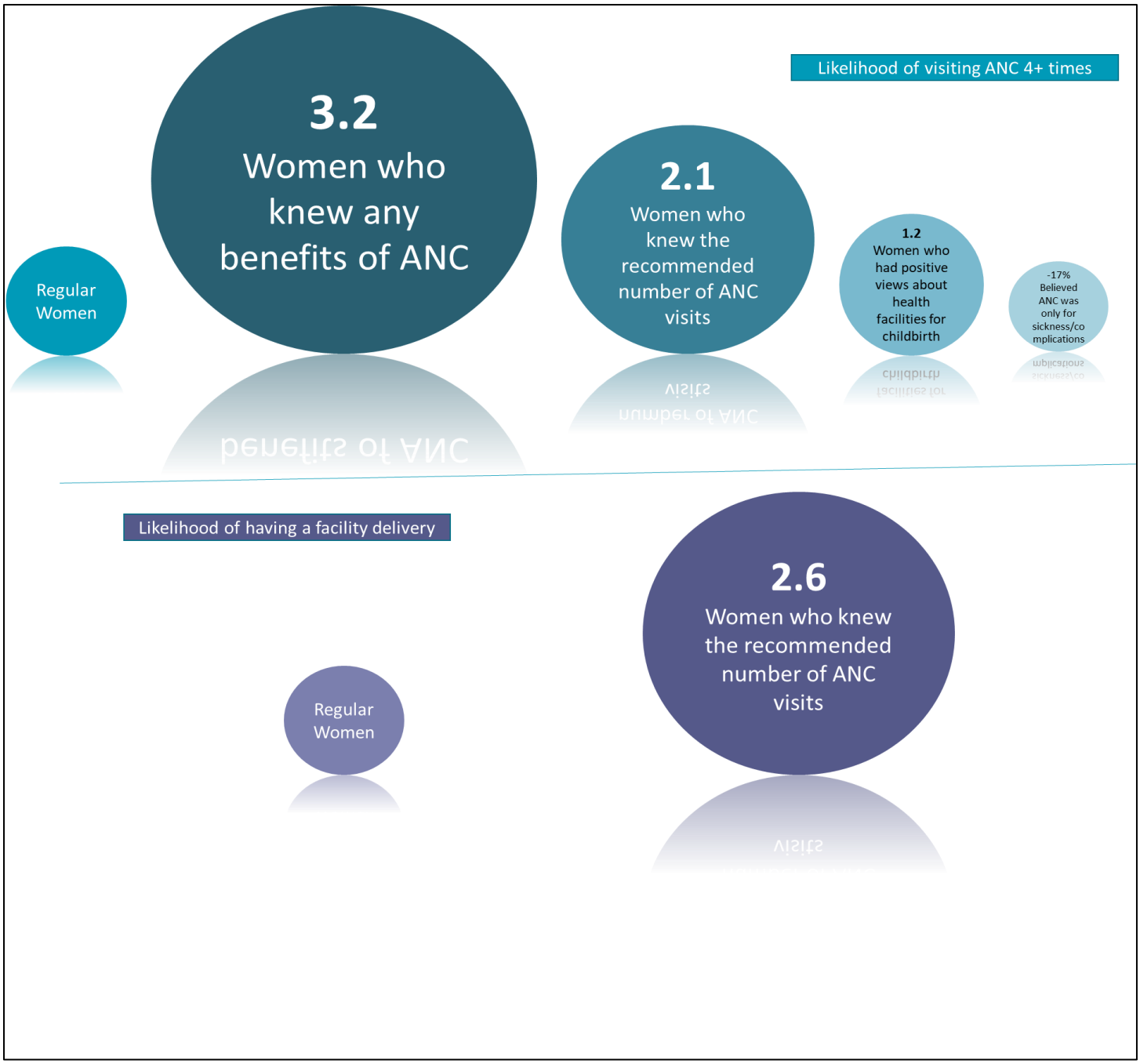


Figure 1: Graph showing the common reasons cited for low ANC 4+ and no facility-based delivery

Among 3,039 women, 23.6% (95% CI: 18.0%-30.3%) attended ANC4+ times and 15.5% (95% CI: 11.8%-20.1%) gave birth in a facility. Among women who did not attend ANC4+ times or have a facility-based delivery during their last pregnancies, the most commonly cited reasons for non-use were lack of perceived need (42% and 67%, respectively) and spousal opposition (25% and 27%, respectively). Women who knew any ANC benefit or the recommended number of ANC visits were 3.2- and 2.1-times more likely to attend ANC4+ times.



Women who held positive views about health facilities for childbirth had 1.2- and 2.6-times higher likelihood of attending ANC4+ times and having a facility delivery, while women who believed ANC was only for sickness or pregnancy complications had 17% lower likelihood of attending ANC4+ times. Self-efficacy and supportive spousal influence were also significantly associated with both outcomes.

To improve pregnancy and childbirth practices in north-western Nigeria, SBC programs could address a range of psychosocial factors – across cognitive, emotional and social domains – that were significantly associated with pregnancy and childbirth behaviours: raising knowledge and dispelling myths, building women's confidence to access services, engaging spousal support in decision-making, and improving perceived (and actual) maternal health services quality.

Adapting a gender norms scale and examining self-injection social norms in Nigeria/ Measuring Gender Norms and social norms around self-injection of contraception

By Erica Sedlander, Sneha Challa & Elizabeth Omoluabi, University of California, San Francisco (UCSF) & Akena Plus Health (AK+)

Background

"Norms" as an important concept in the behavior change literature has been operationalized in a myriad of ways, leading to inconsistencies in findings. We are seeking to resolve this issue by addressing missing important theoretical components, including differentiating between descriptive and injunctive norms, adding a referent group, and measuring social sanctions. We plan to include these missing pieces in two social norms measures: gender norms and social norms around self-injection of contraception. Contraceptive self-injection of DMPA-SC (also known as Sayana Press) is a novel product with promise to reduce unmet need and increase women's contraceptive autonomy. The WHO recently included it in their guidelines on self-care interventions.[1] The ease of use, convenience, and discretion of this innovative method holds much potential to enable women to overcome geographic, personal, and social barriers that limit their ability to make and act on their contraception choices. As part of the national family planning goals to address the unmet need for contraception, the Government of Nigeria is scaling the reach of DMPA-SC in both the public and private sectors[2,3], and also including the provision of DMPA-SC for self-injection as different programs are implemented across Nigeria.

Figure 1: The novel product that promises to "reduce unmet need and increase women's contraceptive autonomy"

There have also been calls to examine how gender norms are related to family planning but to our knowledge, studies have not examined the relationship between gender norms and self-injection [4,5].

Methods

Our team originally developed and validated the G-NORM, a gender norms scale, in India and then subsequently adapted it in Nepal. Confirmatory factor analysis in Nepal showed that the same two factor structure (descriptive and injunctive norms) held in Nepal, and we plan to adapt and test the scale in Nigeria and Uganda as part of a longitudinal study on self-injection of contraception.

We conducted individual interviews with women of reproductive age in both countries to inform scale items. Additional items specific to East Africa include "girls get married before they are 18 years old," girls stopping school if they get married," "being sent away for disobeying your husband," and

[1] WHO | WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. https://www.who.int/reproductivehealth/publications/self-care-interventions/en/. Accessed September 10, 2019.

[2] Liu J, Shen J, Schatzkin E, et al. Accessing DMPA-SC through the public and private sectors in Nigeria: users' characteristics and their experiences. Gates Open Res. 2018;(2):73. doi: 10.12688/gatesopenres.12890.1

[3] Liu J, Schatzkin E, Omoluabi E, et al. Introducing the subcutaneous depot medroxyprogesterone acetate injectable contraceptive via social marketing: lessons learned from Nigeria's private sector. Contraception. 2018;98(5):438-448. doi: 10.1016/j.contraception.2018.07.005

“marriage issues if the woman earns money.” Cognitive interviews are complete in Uganda, and we are currently analysing transcripts and memos to revise items. Nigeria will follow suite.

We are also creating the first measure of social norms around self-injection of contraception. We plan to include both measures in a longitudinal (n=1000) cohort study examining the relationship between contraceptive agency and self-injection in Nigeria and Uganda (three data collection waves). We will also examine the relationship between contraceptive autonomy, gender norms, and social norms around self-injection.

Implications

These findings can contribute to greater theoretical consistency in the social norms’ literature, provide an improved measure of gender norms and a novel measure of self-injection social norms in Nigeria, and add to the body of evidence that gender norms are critical to consider for both agency and reproductive health outcomes.

Responsive Feedback

Theme: Responsive Feedback

Using Notable Local Event (Annual Women's August Meeting) to Change Social Norms in Favour of Family Planning in Nigeria: The Anambra Experience

By Onyedikachi Ewe, Aneotah Egbe & Folusho Emmanuel, The Challenge Initiative Anambra State; John Hopkins Center for Communication Programs (JHCCP)

Introduction

The month of August in Anambra state and the South East at large is marked with the notable Annual Women's August meeting. During the August meeting, members of the eastern communities, home and abroad converge in various religious and traditional gatherings to discuss the welfare and the progress of their community. New members are also inducted into the women groups during this period. The induction of new members into these groups is seen as a rite of passage and a transition into full womanhood.

In conjunction with government and other key stakeholders, The Challenge Initiative leveraged on this highly placed platform to mobilize more women for family planning (FP) services and shift social norms in favour of FP.

> **"The platform of the annual women's august meeting has been leveraged by the State Behavior Change Communication Technical Working Group to create awareness on family planning"**

In the last three years, TCI has provided technical assistance (TA) to Anambra State government in strengthening the State Behavior Change Communication Technical Working Group (SBCC TWG) in creating awareness, demystifying negative beliefs about FP and mobilizing women for FP services. The TA was done through the TCI Business Unusual Model tagged "Lead, Assist and Observe" methodology which involves leading through coaching and mentoring, allowing government lead while assisting and then observing them as they implement.

The platform of the annual women's August meeting has been leveraged by the state SBCC TWG through the coaching and mentoring by TCI to create awareness on Family planning.
In 2021, the social mobilization during August meeting was combined with health facility in-reach to provide increased access to family planning services across the 11 supported LGAs with the state team providing technical oversight to ensure compliance to standard operational procedures.
Health facility in-reaches describes mobilization of clients from the community to designated facilities on designated days to receive FP services.

Result

Data set for a 3-year period showed progressive significant increase in number of women reached with FP messages, number referred and percentage completing the referral for service uptake when compared to one month prior and after the August meeting. This translated to more women being referred for FP services in that month and more women taking up FP services both in the August meeting month (August) and in the subsequent month (Sept.)

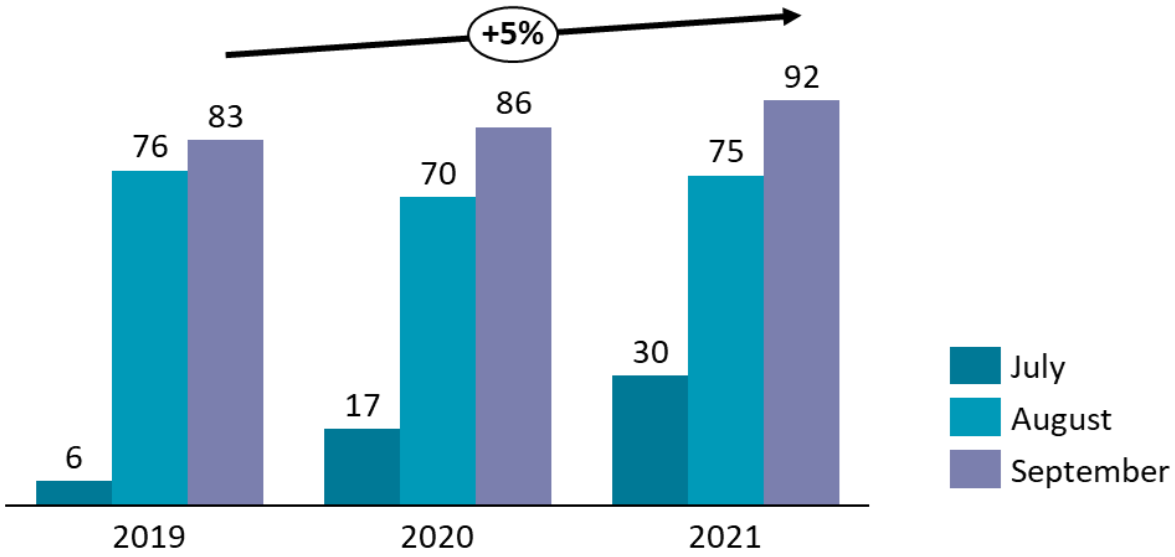


Figure 1: Trend of increase in uptake of family planning services within the 3 years of program intervention

Conclusion

The August meeting has proven to be a very useful platform in changing social norms in favour of FP as it provides an avenue to reach a wide audience of women of reproductive age with family planning messages, and the attendant change in attitude towards FP services uptake as a result of these strategic engagements, leading to the resultant change in social norms.

Gender-Based Violence

Theme: Gender-Based Violence

Intimate Partner Violence: Correlates from the Nigerian Demographic Health Survey 2018

By Christabel Akinyode, Researcher

Gender based violence is recognized globally by the WHO as a public health challenge. While violence in the Nigerian society is widely perpetrated by many adults, gender-based violence perpetrated against women and girls is one of the better researched areas.

"31% of Nigerian women have experienced domestic violence with majority of that number perpetuated by intimate partners"

Intimate Partner Violence (IPV) committed by men against women is popular, with approximately 30% of women who have ever had a male partner having experienced violence at various levels from their partners at some point in their lives. The 2018 Nigerian Demographic Health Survey found that 31% of Nigerian women have experienced domestic violence with majority of that number perpetuated by intimate partners.

Social norms are the implicit and explicit societal rules that influence human behaviour. Theories such as Ajzen's theory of planned behaviour have been used to prove that these rules influence the prevalence of behaviours including IPV. Social norms can be Injunctive and Descriptive: Descriptive norms are the things an individual believes others in their social group **do** in a given situation while injunctive norms are the extent to which the individual believes that others in the group would **approve** of behaving in a given situation. Norms that influence IPV correlate such as the causes of IPV, help seeking behaviour (whom and where to seek help from) and normalization of IPV in society. They can help public health practitioners learn what direction to focus policy and efforts on. Consequently, this abstract will examine the NDHS 2018 data to understand the social norms that play a role in the exacerbation of violence against women and suggest ways that policy can impact those norms.

Results from the NDHS 2018 survey finds that of the 31% of women who have ever experienced IPV, 84% have experienced less severe IPV (shoving, threats), 41% have experienced severe IPV (punching, choking, beating) and 33% have experienced IPV with a sexual component. Two social norms were examined by this survey, and both had relationships with IPV of all cadres. They were intergenerational abuse and help seeking behaviours.

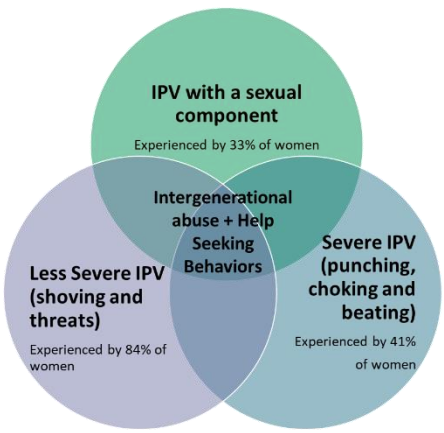


Figure 1: Common forms of IPV and the underlying causes (NDHS 2018

Help Seeking behaviour metrics show that most respondents (~50%) who experienced domestic violence did not seek help at all on many occasions. Those who sought help asked for it from their family/partners family, friends, or neighbours. Less than 5% of respondents sought help from a lawyer, the police, or a social service organisation. This

implies that descriptive norms in Nigeria regarding what should be done when IPV happens are still focused on 'keeping it within the family'. Studies have found that IPV continues to be perpetuated in communities where social norms discourage outside interference in private family matters. Unfortunately, this means norms may continue to be rife with continued cycles of intergenerational violence.

"Norms in Nigeria regarding what should be done when IPV happens are still focused on 'keeping it within the family'."

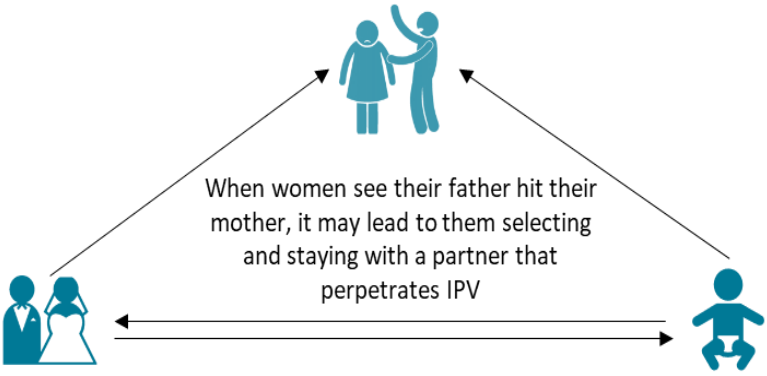


Figure 2: Witnessing parental IPV reinforces injunctive norms and may lead women to stay with partners that perpetrate IPV

Regression analysis showed that witnessing parental IPV positively predicted future IPV that women experience ($p < .000$). This implies that when women see their father hit their mother, it reinforces injunctive norms surrounding IPV and may lead to them selecting and staying with a partner that perpetrates IPV. It reveals that policy should be built dismantling this norm. Societal norms and social behavioural change communication need to remind women and girls that while modelled in the household, IPV in families is not acceptable as this could impact their choices in partnerships and how they interact with IPV.

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A thematic analysis of violence against women and girls in Rigasa, an urban slum community in Kaduna State, Nigeria

By Yusha'u Abubakar[1], Hafsatu Aboki[2], Inifon Inyang[3], Kingsley Essomeonu[2], Ezinne Okey-Uchendu[2], Taofeek Adeleye[4]

Affiliation: 1) Enhancing Communities Action for Peace and Better Health Initiative, Kaduna State, Nigeria. 2) National Agency for the Control of AIDS, Abuja, Nigeria. 3) Federal Ministry of Health, Abuja, Nigeria. 4) AIDS Health Foundation, Abuja, Nigeria.

Background

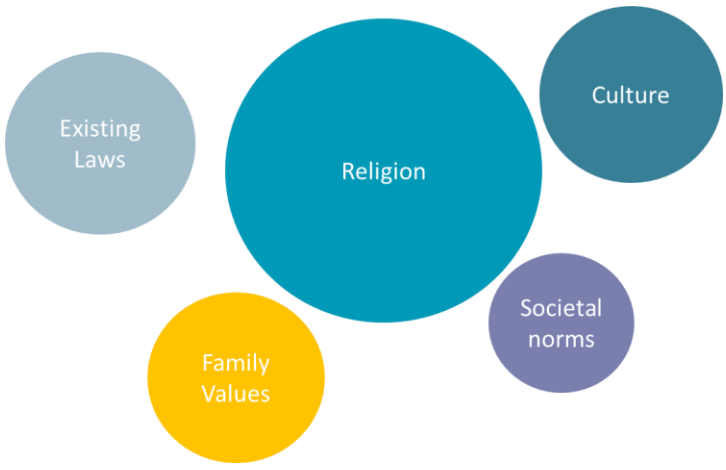
The 2018 National Demographic and Health Survey showed that 31% of women in Nigeria experienced violence from 15 years of age. The situation in Rigasa, a densely populated urban slum in Kaduna State where women and girls (WG) suffer different forms of violence, without justice due to lack of reporting is alarming. The aims of this study were to identify the risk factors relating to violence against women and girls (VAWG) and assess their knowledge, attitudes and practices about VAWG.

Methods

The study used a mixed methods approach comprising key informant interviews (KIIs) and survey. The study also involved the use of structured questionnaire, purposive sampling technique, transect work, and field enumerators with targeted respondents from various districts that make up Rigasa. Eight KIIs were held with multisectoral stakeholders (health, social, legal and police). Descriptive and thematic analyses were done.

Results

About 75% of respondent reported witnessing either sexual or physical violence towards WG. 63% of respondents were unaware of the legal rights that protect WG against violence. About 70% indicate that they would report VAWG, 45% agreed to confront the perpetrator of VAWG while 10% indicated that they would ignore an incidence of VAWG. Over 70% of respondents viewed religion as the key determinant of the legal rights of WG; 26% viewed existing laws of Kaduna state, 24% the culture, 22% family values, and15% societal norms.



"Over 70% of respondents viewed religion as the key determinant of the legal rights of women and girls"

Figure 1: Perceived key determinants of legal rights of women and girls

Conclusion

This study underscores the need to increase the knowledge, and promote good attitude and positive behaviour of the legal rights of WG. We recommend that abridged versions of laws that protect women right in Kaduna be produced and disseminated in the community, Education on the forms of abuse and their proscribed punishment is essential for all demographic groups, coordinating with traditional leaders, community-based organizations, police/lawyers and primary health care centres.

The Effect of Social Norms on Sexual Harassment and Corporal Punishment in Public and Private Schools in Kaduna State, Nigeria

By Hadiza Umar, Dr. Ben Cisghali & Dr. Abubakar Attahiru

The dilemma of Gender-Based Violence (GBV) which has been globally accepted as a violation of basic human rights is also affecting our schools. The UNICEF Survey on Violence Against Children (VACS 2014), revealed that 50% of boys and girls aged 13-24 years old have experienced physical, sexual or emotional violence, while 22% of girls and 14% of boys are affected by sexual exploitation and abuse. Based on estimation from MICS 2016-2017, at least 10 million children aged 11-15 are out of primary and junior secondary school, most of cases happening in the Northeast of Nigeria.

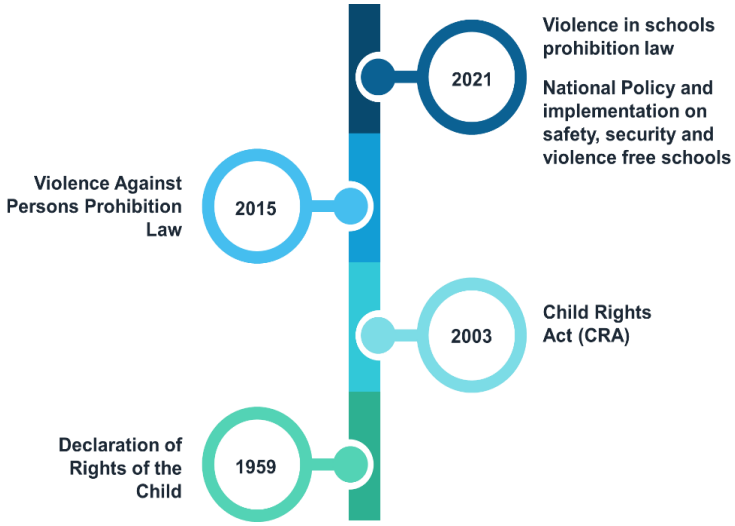


Figure 1: Timeline of Children's Rights Laws in Nigeria

Being a signatory to the convention on Rights of the Child, Nigeria has passed several laws which include the Declaration on the Rights of the Child 1959, Child Rights Act (CRA) in 2003, the Violence Against Persons Prohibition Law (VAPP) in 2015. And most recently, The Violence in schools Prohibition Law and the National Policy and implementation on safety, security and violence free schools (August 2021) still battles with achieving successful implementation and creating the needed enabling environment to achieve learning outcomes especially for girls.

The current Foreign and Commonwealth and Development office goal to get 40 million Nigerian girls in school and 20 million able to read may be rendered an overly ambitious target given the challenges inhibiting negative social norms pose to creating a safe learning environment, access, retention, and completion especially for the girl child.

To reinforce this motion, we will share the findings of a social norms research on the effect of social norms on sexual harassment and corporal punishment in public and private schools in Kaduna state, Nigeria.

Social Norms that drive Child, Early and Forced Marriage, Intimate Partner Violence and Adoption of Family Planning in Ebonyi and Sokoto States, Nigeria

By Yusuf Samaila, Meroji Sebany, Sylverius M. Obafemi, Myra Betron, Chioma Oduenyi

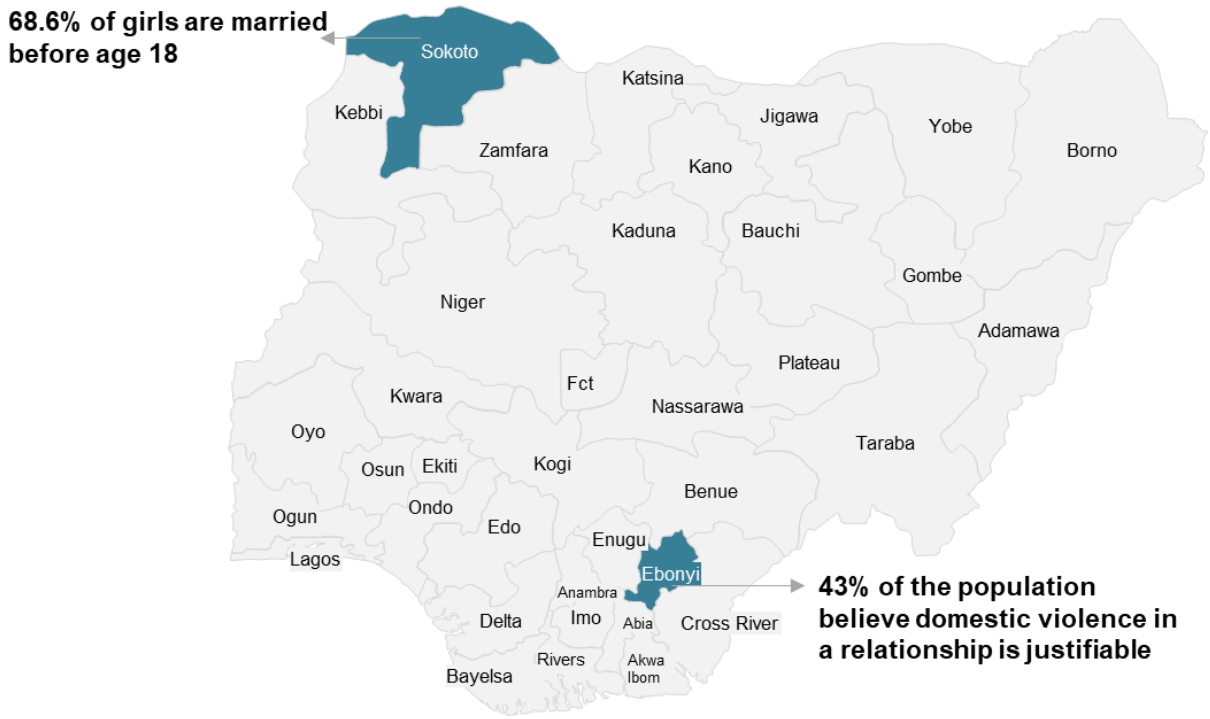


Figure 1: Prevalence of negative social norms in Ebonyi and Sokoto states

Background

Gender-Based Violence primarily affects women and girls and remains a public health and social development concern with far-reaching consequences for survivors, perpetrators, families, and the broader society. The 2018 Nigerian Demographic Health Survey (NDHS) indicates that 31% of women aged 15-49 years have experienced physical violence at least once. Forty three percent of the general population in Ebonyi state believe that domestic violence in a relationship is justifiable, and 68.6% of girls are married before age 18 in Sokoto State. Gender inequality is constructed, reinforced and perpetrated through harmful social norms and remains the root cause of GBV.

Objective

Given the growing prevalence of GBV in Nigeria, USAID's/MOMENTUM Country and Global Leadership in implementing a five-year project, conducted a social norms exploration to understand the social norms that drive child, early and forced marriage (CEFM), intimate partner violence (IPV) and early adolescent pregnancy, and identify the individuals who uphold or enforce social norms by approving or disapproving of certain behaviours in Ebonyi and Sokoto States, Nigeria. Results of this exploration will be used to inform programme interventions that will transform identified harmful social norms.

Methodology

Four Local Government Areas (LGAs) and eight communities were selected in Ebonyi and Sokoto States based on large population density, poorest indicators on CEFM, IPV and early adoption of FP, secured and accessible to researchers and participants. Two populations of interest were interviewed in this study - the main population groups and their reference groups.

Results

Social Norm	Adolescent girls have limited decision-making power regarding marriage choices and timing	Sex is a man's right, and failure to oblige will result in disagreements or conflict and, ultimately, IPV which will be justified
Subject	Adolescent girls	Men
Reference Group	Mothers of adolescent girls, fathers and mother in-laws, male neighbors/friends of married men, fathers of married women and mothers of first-time mothers	Mothers of adolescent girls, fathers and mother in-laws, nurses, community health care providers

Table 1: Social Norms that drive Child, Early and Forced Marriage and Intimate Partner Violence, and the reference groups that uphold them

In all discussions held with the main population and reference groups across study communities in Sokoto, participants mentioned that adolescent girls have limited decision-making power regarding marriage choices and timing, and thus are expected to obey and agree with the parents' decision to marry them off. In Ebonyi State, the respondents noted that sex is a man's right, and failure to oblige will result in disagreements or conflict and, ultimately, IPV. They agreed that physical violence was justified and acceptable if women did not meet their husband's needs. Mothers of adolescent girls, fathers and mother in-laws, nurses, community health care providers were found in Ebonyi as individuals who uphold or enforce social norms by approving or disapproving of certain behaviours while mothers of adolescent girls, fathers and mother in-laws, male neighbours/friends of married men, fathers of married women and mothers of first-time mothers were found in Sokoto State.

Conclusion

Both the social norms driving GBV and reference groups found in this study are consistent with growing GBV prevalence therefore, targeted interventions must be designed to engage parents, family and prominent community members to facilitate community-wide consensus building to address norms that drive CEFM and IPV.

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Women's Economic Empowerment

Theme: Women's Economic Empowerment

Occupational Sex Segregation in Agriculture Evidence on Gender Norms and Socio-Emotional Skills in Nigeria

By Smita Das, Clara Delavallade, Ayodele Fashogbon, Wale Ogunleye, and Sreelakshmi Papineni[4].

Occupational sex segregation is a key driver of the gender gap in earnings. Using data from 11,691 aspiring agribusiness entrepreneurs in Nigeria, this paper explores the gender gap in the value chain choice decision, and especially the role played by norms around gender roles. When given a choice of 11 agricultural value chains in a government program, the majority (54%) of the applicants chose to enter into poultry, a value chain with relatively lower profit potential, and women were more likely to choose poultry than men.

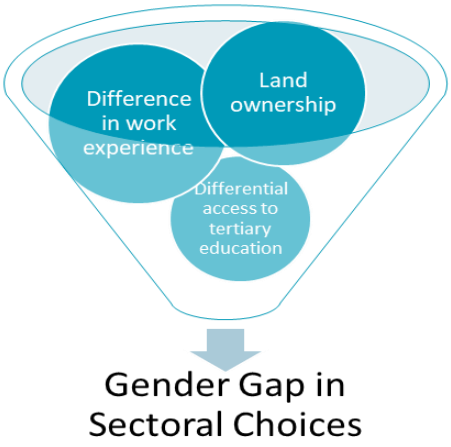

Figure 1: Factors contributing to the gender gap in sectoral choices

"Women are more likely to enter a business value chain with relatively low profit."

This paper finds evidence of more restrictive gender norms in the Northern Nigeria states, which lowers women's likelihood of entering into potentially more lucrative agricultural value chains. The gender gap in sectoral choice is also attributed to differences in work experience especially in agricultural activities and in the chosen value chain, as well as in land ownership and differential access to tertiary-level education. The paper shows that women with more experience in male-dominated agricultural value chains exhibit lower self-efficacy, which could reflect the challenges they face when deviating from social norms to operate within these non-traditional value chains.

Keywords: Gender, Occupational Choice, Agriculture, Entrepreneurship, Norms and Socio-Emotional Skills. JEL codes: J16 J24 O12 O13 Q12

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"Health providers play an important role in empowering women"

By Allison Annette Foster, WI-HER

Background

Inequitable gender norms negatively affect the wellbeing of individuals, families, and societies.[5] Addressing gender-based barriers is key to achieving effective health services.[6] USAID's Integrated Health Program (IHP) works in four States and the Federal Capital Territory (FCT) to identify gender barriers and facilitate sustainable solutions toward improved health for mothers and babies.

Gender transformative programming often focus on "demand" side rather than the "supply" side of primary health services. However, IHP believes that health providers are uniquely positioned to partner with women in addressing harmful gender norms that thwart ANC enrolment, facility births, healthy spacing, and positive health-seeking behaviours. **Our theory of change is that if health providers use their influence to address women's empowerment, then women may be capacitated to claim greater agency toward service utilization and improved well-being.** Testing this theory, we selected 'Learning Lab' facilities in the four states and FCT to actively engage providers in facilitating women's empowerment among clients. As we learn promising practices that providers can adopt and sustain, we share our learning to strengthen health systems and empower others.

Methods

IHP trained Learning Lab providers to expand their identities as health professionals and embrace their role in not only addressing medical needs but also tackling cultural challenges that impact the health of their clients. Providers have adopted new ways of communicating with clients and leveraging their leadership to invite collaboration in overcoming gender-related challenges and forging positive norms. A key theme in improving MNCH is women's empowerment. Learning Lab providers convene pregnant clients and challenge them to define what empowerment means to them, and then work with them towards that ideal. Results have surprised all involved. In Ebonyi, adolescent mothers needed help returning to school. Mothers wanted one-on-one conversations with providers, so hours were established for private consults. In Bauchi, women established a WhatsApp and SMS groups to enable direct access with providers to answer questions and concerns. Health teams also use that platform to disseminate information and educate their clients.

Results

The WhatsApp/SMS members are growing; class enrolment increases, and facility utilization improves. Still in initial stages, learning lab results are promising. Providers, all female, have expressed their own feeling of empowerment with new ways to facilitate positive results and fresh identities as influencers inside and outside their facility. Providers in the WhatsApp group enabled one woman to recognize danger symptoms and proceed immediately to a facility. One woman reported, **"…I'm more confident to approach life and understand I can become anything I want to be."**

Conclusions

The health system can be leveraged toward greater women's empowerment. As providers continue to collaborate with clients, we will capture women's empowerment, and track resulting MNCH access and outcomes.

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Assessment of Practices and Policies on Gender Norms and Women Economic Empowerment in Kaduna State

By Auta, Elisha Menson, PhD, Budget Research & Development Policy Advocacy Centre

Gender discriminatory social norms are widely recognized barriers to women's economic empowerment, affecting both their access to means of livelihood. Social norms are collective definitions of socially approved conduct, stating rules or ideals, while gender norms are social norms that express the expected behaviour of people of a particular gender, and often age, in a given social context. Social norms are embedded in formal and informal institutions and are produced and reproduced through social interaction. They are often implicit and invisible rather than clearly articulated in many spheres of economic, social, and political life. Norms can be held in place by expected sanctions for violating norms and by social approval for conforming to them.

Studies have documented evidence about the ways in which discriminatory social norms affect women's access to economic opportunities and their work experiences. The findings explain discrimination in women's economic, social or political participation in some contexts signifies barriers and challenges that disproportionately affect women. Studies from East and West Africa highlighted the role of education as a route to higher quality economic and social engagement.

In research context not much has been done on impact of policies on social norms that affect women's economic empowerment especially on what norms facilitate women's economic empowerment; the ways in which norms affect women's economic activity at different stages of life and among different social groups; the processes of social norm change (or lack of change) associated with significant economic transformations; the design of economic empowerment programs to support processes of change to egalitarian social and gender norms. Furthermore, how religious or cosmological beliefs influence social and gendered norms about suitable economic activities; how practices shift without significant normative change; how supportive family and social networks enable women to break new ground; and how normative restrictions on suitable work for women affect their economic opportunities and wellbeing.

This study therefore aims to strengthen social norms research and practice in Nigeria by conducting research on practices and policies on social norms that affect women in Kaduna state. It also aims at providing evidence for institutional support, strengthen networks, and supporting good quality programming, particularly in areas of the country with weak gender supporting systems. This will be achieved through shared social norms evidence, approaches and resources, integrating social norms into ongoing and new normative and behaviour change initiatives, improving social norms program implementation and networks within and across norms-shifting programs to improve learning and practice, and generate and share knowledge between practitioners in Nigeria and the global community.

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