

# “Auntie let me tell you”

Women and girls’ perspectives on Covid-19 impacts on sexual and reproductive health and safety in North-East Nigeria

MAY 2022



NORTH-EAST NIGERIA



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# Acronyms

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<b>ANC</b>	Antenatal Care
<b>BC</b>	Birth Control (contraception)
<b>CCSAS</b>	Clinical Care for Sexual Assault Survivors
<b>COVID-19</b>	Novel Coronavirus 2019
<b>CWC</b>	Comprehensive Women's Centre
<b>FGD</b>	Focus Group Discussion
<b>FP</b>	Family Planning
<b>GSS</b>	Government Secondary School
<b>IDP</b>	Internally Displaced Persons
<b>KII</b>	Key Informant Interviews
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MMC</b>	Maiduguri Metropolitan Council
<b>NGO</b>	Non-Governmental Organisation
<b>PAC</b>	Post Abortion Care
<b>PNC</b>	Postnatal Care
<b>RCCE</b>	Risk Communication and Community Engagement
<b>SRH</b>	Sexual and Reproductive Health
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>SRMNH</b>	Sexual, Reproductive, Maternal and Newborn Health
<b>WGSS</b>	Women and Girls' Safe Space
<b>WPE</b>	Women's Protection and Empowerment

# 1. Summary

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## 1.1 Background

In North-East Nigeria, where deeply harmful patriarchal norms prevail, and people live with the constant threat of militia violence, The International Rescue Committee (IRC) delivers woman-centred sexual and reproductive health (SRH) services along with Women's Protection and Empowerment (WPE) programming. Social norms mean that there is often stigma surrounding SRH and GBV services and women and girls who use them, so supporting their empowerment is essential for helping women and girls to access SRH and GBV services and empower them to protect themselves from violence.

The first case of Covid-19 was reported in Nigeria in February 2020, and since then the country has been severely affected by the pandemic, with both public health and health care systems endangered by it. The Nigerian government-imposed lockdown and restrictions on movement in late April 2020, and IRC began a scale-down of services during the same time. Restrictions continued until September 2020, and during the lockdown period, only approved health staff and vehicles could move around. IRC continued to provide most SRH services, however non-critical services such as antenatal care (ANC) were reduced in frequency, and larger quantities of short-acting methods were given to reduce the need for visits. More remote locations such as Gwoza faced difficulties with staffing because of UN Humanitarian Air Service quarantine protocols which made bringing staff in and out difficult. Women and Girls' Safe Spaces (WGSS) were not considered critical by the government and therefore WPE activities, including treating survivors of GBV, were limited to remote service delivery.

IRC's work in North-East Nigeria inevitably became more challenging during this acute phase of Covid-19, so this assessment was undertaken to understand the intersecting impacts of the pandemic on demand for-, access to- and delivery of- SRH services and protective measures, primarily from the perspective of women and girls and with input from service providers. It was also intended as a learning exercise, so that barriers to accessing SRH provision can be mitigated during future public health emergencies, and SRH services prioritised for emergency preparedness.

## 1.2 Method

This mixed-methods assessment used quantitative and qualitative data collected in Borno state, North-East Nigeria, in two Local Government Areas (LGAs), Gwoza and Maiduguri Metropolitan Council (MMC), between November and December 2021. Gwoza was selected to capture a rural community with pre-existing access limitations due to security and Maiduguri was chosen as an urban community.

For the qualitative study, 50 older adolescent girls and young women (15-24 years old) and women (25-49 years old) participated in separate focus group discussions (FGDs) to explore experiences and perceptions of SRH services during the pandemic. Three key informant interviews (KIIs) were also carried out with six SRH service provider staff in Gwoza.

Quantitative data on SRH and gender-based violence (GBV) service provision at IRC's Maiduguri and Gwoza Comprehensive Women's Centres (CWCs) between 2019 and 2020 was analysed alongside the qualitative data, to triangulate the perspectives of women and girls with trends in service provision.

## 1.3 Findings

Program data shows that between January 2019 and December 2020 there was a 25% decline in SRH services accessed in Gwoza compared to an 8 % increase in Maiduguri from May 2020. Based on qualitative findings, this could be attributed to the effects of Covid-19 being more pronounced in rural locations (e.g. availability of drugs and medical equipment). Another factor impacting service demand and supply was changes in the security context, as rural areas are more affected by conflict. GBV Information Management (GBVIMS) data on GBV cases showed a slight overall reduction in survivors reporting for care during 2020 for both locations. Spikes in cases for Maiduguri occurred in February 2020 and July 2020 when Gwoza saw dips. As WGSSs were forced to close between late April and September, the dips in Gwoza could be explained by lack of network but should not be concluded based on quantitative data alone.

The qualitative data provided rich insights into the lives of women and girls, both pre-Covid and during the acute phase. Participants narrated how their lives changed during the acute phase of the pandemic and how it impacted their ability to seek sexual reproductive maternal neonatal health (SRMNH) services, highlighting the many barriers they and their peers faced, some of which were pre-existing, and others exacerbated by Covid. Such barriers were lack of in health facilities, travel restrictions and fear of catching or being identified with Covid infection. Among the enablers for access to SRH services mentioned by women and girls were supporting and accompanying peers for services and trusted providers.



There was an increase in the domestic work for women and girls because the whole family was home all day and women were attending to the needs of both children and husbands. The demand for water increased due to hygiene practices, travel restrictions reduced income opportunities, and care seeking behavior changed because of fear of catching COVID or fear of being kept in isolation centers. While some women mentioned the lockdown period as an opportunity to get closer to their intimate partners, some reported increased violence in the home. Financial impacts of the pandemic were examined with participants. Findings revealed a shift in income and expenditure which made households focus on essential needs only and in the urban setting there were reports of adolescent girls exposed to transactional sexual exploitation to make ends meet. Women and girls gave suggestions for ensuring services are accessible during future public health emergencies.

## 1.4 Conclusion

While some of the barriers women and girls face are around availability of services and finances, the majority are either about shame associated with SRH or rooted in it. Based on this finding, this report concludes that a holistic approach of integrated SRH and WPE programming is needed to build resilience for future public health emergencies but also to dismantle the social structures centred around shame (and created by patriarchy), that make it difficult for women and girls to access vital, lifesaving SRH and GBV services whether there's a pandemic or not. Emergency preparedness should incorporate planning to mitigate the impacts of lockdowns, such as switching to systems supporting self-care and training health facility workers on rights, respect, and kindness.



## 2. Introduction & Background

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Covid-19 and previous public health emergencies, like the Ebola outbreak in West Africa, have resulted in reduced access to essential SRH and GBV services and denial of rights due to the indirect consequences of strained health care systems, disruptions in care, and resources being redirected to treatment and prevention of the disease causing the emergency.<sup>1</sup> Additionally, responses to epidemics – lockdowns and school closures, for example – further exacerbate GBV and health disparities, especially for people living with multiple other pressures in humanitarian settings. Women and girls are more likely than men and boys to lose their means of livelihood during a public health emergency, further exposing them to the heightened risk of GBV.<sup>2</sup>

The informal social safety nets and networks many women relied upon prior to Covid for support and discrete access to SRH and GBV services have been weakened by reduced mobility (travel restrictions and lockdowns) and social distancing, and women and girls are still struggling to access health services as a result. Governments and health clinics diverted energy and attention away from SRH services, and lockdowns and social distancing also reduced service provision and therefore access to services.<sup>2</sup> All this was exacerbated by fear of attending health facilities due to the risk of contracting Covid. Young people seem to be particularly affected, with the number of adolescents accessing health services decreasing.<sup>3</sup>

According to a Guttmacher Institute projection from 132 low-and middle-income countries, the Covid-19 pandemic has resulted in an estimated 10% reduction of SRH services. This equates to: 15,401,000 additional unintended pregnancies; an estimated 28,000 maternal deaths; 168,000 additional new-born deaths; and 3,325,000 additional unsafe abortions.<sup>4</sup> Similar studies on negative SRH outcomes have found that pregnant women are more likely to experience severe disease and hospitalization from Covid, in addition to increased risk of pre-term delivery and still-birth.<sup>5</sup>

Where abortion access is legally restricted and often unsafe, such as in most fragile settings, complications from unsafe abortion result in death and disability. Too often, only wealthy and educated women have access to safe procedures, leaving the poor and often marginalized women to suffer disproportionately.<sup>6</sup>

Reduced access to SRH and GBV services means more women and girls experience unplanned pregnancies; being unable to access medical care during pregnancy and birth; and being unable to access the care they need following rape and sexual assault. Combined with the increase in violence against women and girls during public health emergencies, this means that demand increases while access reduces.<sup>7</sup>



The first case of Covid-19 was reported in Nigeria in February 2020, and since then the country has been severely affected by the pandemic, with both public health and health care systems endangered by it. Covid is a greater threat to people affected by additional crises and those living in close proximity to one another, in refugee camps and slums, without proper infrastructure or health systems.<sup>8</sup> Across a number of states studied in Nigeria, there was only a slight decrease in the proportion of primary health centres offering family planning (FP) services, from 98% before the pandemic, 95% during the lockdown, to 92% following lockdown, but the number of clients who received care was reduced by half during the lockdown. There was a 3% increase in the number of clients after lockdown compared to pre-pandemic times.<sup>9</sup> United Nations Population Fund (UNFPA) has blamed the rise of unintended pregnancies in Nigeria and its consequences on delays in the distribution of contraceptives during the Covid lockdown. He said, "There was a delay in the distribution of commodities. It is quite unfortunate. Also, many women and girls are afraid of going to the hospital. It is a major problem."<sup>10</sup>

The majority (81.8%) of primary health care facilities in Nigeria offered delivery (childbirth) care before the lockdown. The proportion increased slightly during the lockdown to 83.7% and further increased to 94.1% after the lockdown.<sup>11</sup> Of course, this reflects the availability of delivery care and not the actual accessibility or quality of care.

Travel restrictions impacted the ability of frontline providers to reach the most vulnerable with SRH and GBV services. Donor-funded SRH provision in Nigeria often focuses on delivery for poor, rural, marginalised communities, but when mobile outreach programmes are suspended or heavily restricted, women and girls in these areas can be left with no alternatives; they are the least likely to access or be able to pay for drugs, to access any form of telemedicine or to be able to travel further to towns to find care. The flexibility to pivot towards self-care and telemedicine is also limited by national policy restrictions and lack of regulatory approvals in most countries (for example where medical abortion or injectable contraceptives for self-administration are not approved). The distribution and sale of products through pharmacies was also limited during the pandemic: travel restrictions, the reduced priority assigned to reproductive health products by distributors and pharmacists, limited credit, and loss of income, are some of the factors that make it difficult to maintain pre-pandemic stock levels.<sup>12</sup>

In North-East Nigeria, where deeply harmful patriarchal norms prevail, and people live with the constant threat of militia violence, International Rescue Committee (IRC) delivers women-centred SRH and GBV services along with Women's Protection and Empowerment (WPE) programming. Social norms mean that there is stigma surrounding SRH services and women and girls who use them, so supporting their empowerment is essential for helping women and girls to access SRH services and empower them to protect themselves from violence.

The Nigerian government-imposed lockdown and restrictions on movement in late April 2020, and IRC began adapting services around the same time. Restrictions continued until September 2020, after which things gradually returned to normal. During the lockdown period, only approved health staff and vehicles could move around. IRC followed its own protocol and provided PC1 and PC213 services which included a Minimum Initial Service Package (MISP), however non-critical services such as antenatal care (ANC) were reduced in frequency and larger quantities of short-acting methods were distributed to reduce the need for facility visits. Field locations such as Gwoza faced difficulties with staffing because of quarantine protocols which made bringing people in and out difficult. Women and Girls' Safe Spaces (WGSS) were not considered critical by the government and therefore WPE activities, including treating survivors of GBV, were limited to remote service delivery.

IRC's work in North-East Nigeria inevitably became more challenging during this acute phase of Covid-19, so this assessment was undertaken to understand the intersecting impacts of the pandemic on demand for-, access to- and delivery of- SRH services and protective measures, primarily from the perspective of women and girls and with input from service providers. It was also intended as a learning exercise, so that barriers to accessing SRH provision can be mitigated during future public health emergencies, and SRH services prioritised for emergency preparedness.



## 3. Methodology

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The main research question for the assessment was: How did the acute phase of the Covid pandemic (May to September 2020) influence the lives of women and adolescent girls, especially their access to and demand for SRH services, from the perspective of women and adolescent girls themselves?

This mixed-methods assessment was conducted in December 2021 and used quantitative and qualitative data collected in Borno state, North-East Nigeria, in two purposefully selected Local Government Areas (LGAs), Gwoza and Maiduguri Metropolitan Council (MMC), between November and December 2021. Gwoza was selected to capture a rural community and Maiduguri was chosen as an urban community.

For the qualitative study, older adolescent girls and young women (15-24 years old) and adult women (25-49 years old) participated in eight focus group discussions (FGDs) and one paired interview (two participants), to explore experiences with and perceptions of SRH services during the pandemic. Convenience sampling was used, with women and girls accessing services at IRC facilities post-lockdown being invited to join an FGD or interview.

In each location, FGDs were carried out separately for women and girls and separately for Internally Displaced Persons' (IDP) camp residents and 'host' communities (HCs) – apart from for women in Maiduguri's host community, where two women were instead interviewed. Three key informant interviews (KIIs) were also carried out with SRH service providers in Gwoza. A total of 50 female clients and six SRH service providers participated in the research.

The FGDs consisted of semi-structured discussion about changes to the lives of women and girls experienced during Covid's acute phase, along with participatory human-centred activities, designed to draw out women and girls' insights and perspectives. These exercises included listing income and expenditure for women and girls in their community, pre-Covid and during lockdown, and placing SRH services in order of ease of access during the pandemic acute phase and pre-Covid.

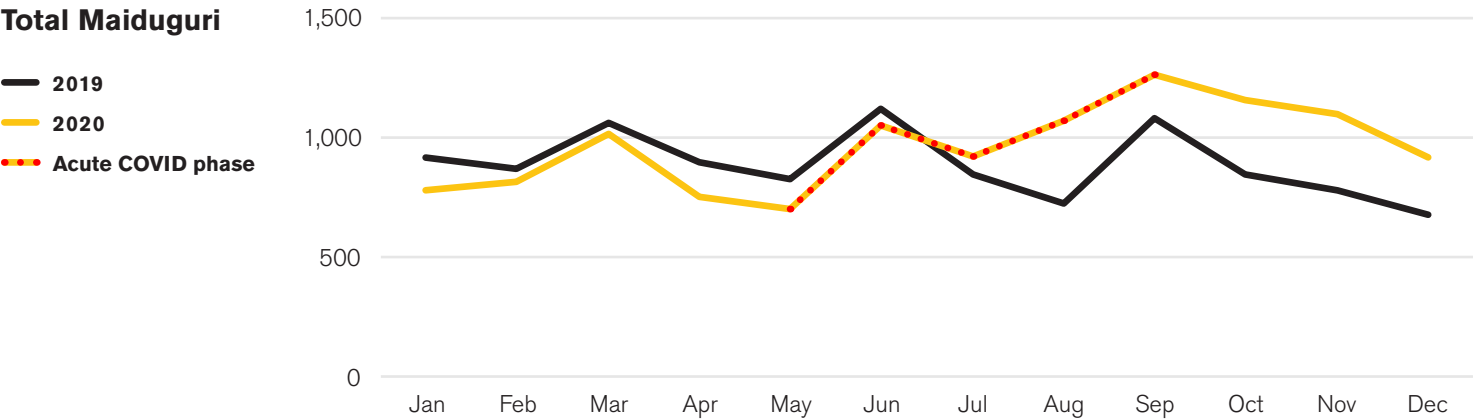
Quantitative data on SRH and GBV service provision at IRC's Maiduguri and Gwoza Comprehensive Women's Centres (CWCs) between 2019 and 2020 was analysed alongside the qualitative data, to triangulate qualitative data with trends in service delivery. Analysis and the writing of this report took place between February and March 2022.



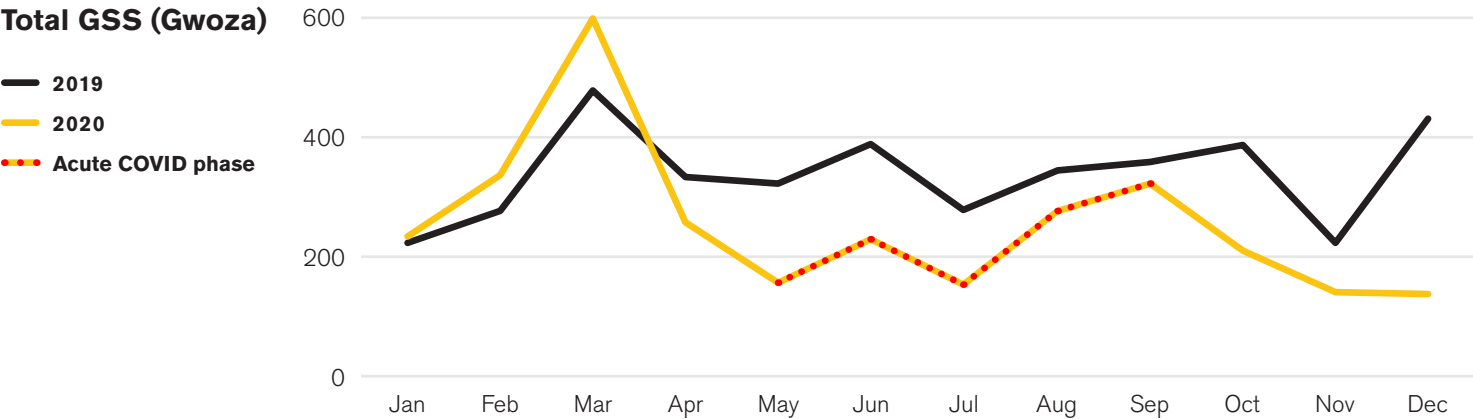
# 4. Quantitative Findings

Across all SRH services – antenatal care (ANC), skilled delivery (SD), family planning (FP), sexually transmitted infection (STI) treatment, post-abortion care (PAC), clinical care for sexual assault survivors (CCSAS) and postnatal care (PNC) – there was a significant decline in services accessed between January 2019 and December 2020 in Gwoza but an increase in Maiduguri from May 2020. This equates to an 8% rise in services accessed in Maiduguri in 2020 compared to 2019, and a 25% reduction in Gwoza. Based on qualitative findings, this could be attributed to the effects of Covid-19 being more pronounced in rural locations (e.g. availability of drugs and medical equipment). Another factor impacting service demand and supply was changes in the security context, as rural areas are more affected by conflict.<sup>14</sup>

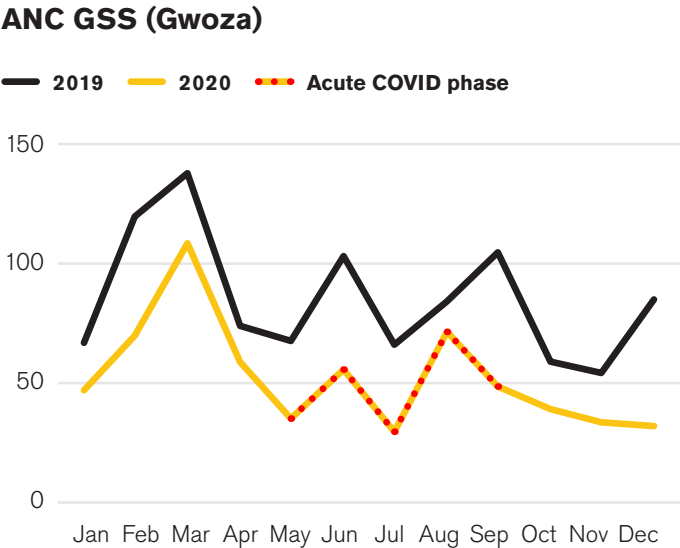
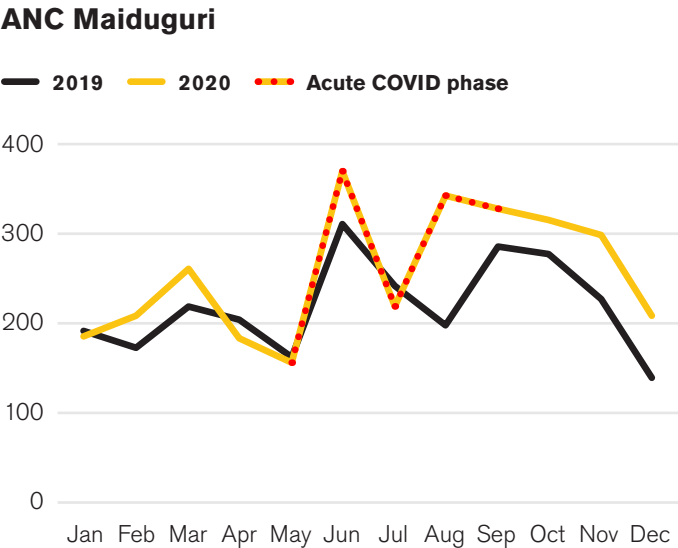
The rise in Maiduguri may be due to a combination of increased demand caused by the effects of the pandemic (e.g. increased GBV, conception and commercial sexual exploitation) and continued relative ease of access to services there. The overall increase represents different services being accessed more at different times between May and Sept. The biggest general increase was in provision of STI treatment, but there was also a spike in FP services accessed in August – possibly corresponding with contraceptive pills and injections prescribed before lockdown running out – and a steady rise of SDs. Need for all services could have risen more during this time than the number of services accessed.







In terms of specific services, there were no major outliers to the trend above – across the board, services in Maiduguri were accessed in roughly the same numbers in 2019 as 2020, with 2020 beginning with fewer services than 2019 but then rebounding from June onwards. At the Gwoza facility, there was a spike in all services accessed in February/ March for both years, especially for STIs which was the only service that was accessed more in February/ March 2020 than 2019. Apart from that, fewer services were delivered in 2020 than 2019.

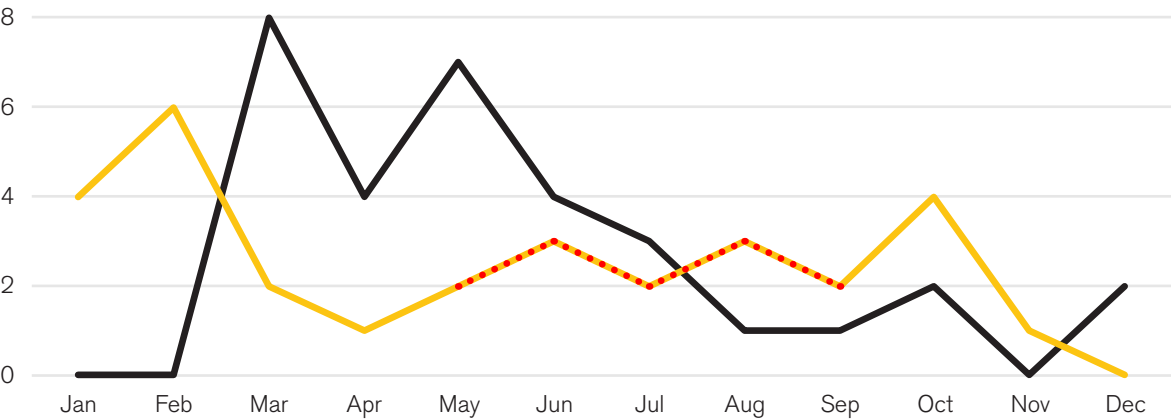


In Gwoza, there was a spike in skilled deliveries (SD) in March/April 2019 and a significant drop at the same time of year in 2020, corresponding with the start of the pandemic.

The Women's Protection and Empowerment (WPE) teams' data on GBV cases showed a slight overall reduction in survivors reporting for care during 2020 for both locations and no significant difference between 2019 and 2020. Spikes in cases for Maiduguri occurred in February 2020 and July 2020 when Gwoza saw dips. As WGSSs were forced to close between late April and September, the dips between spikes in Gwoza compared to Maiduguri could be explained by network accessibility in the urban context, which allows women and girls to report violence and receive treatment remotely, whereas the case in Gwoza was different due to a lack of network coverage- it is possible that the number of incidents experienced by women and girls simultaneously increased. However, it is not possible to draw any solid conclusions on within the scope of this study, because while some women and girls participating in the qualitative research reported increased violence (and quantitative data for Nigeria, West Africa and globally all show large increases in GBV, and IPV in particular, experienced by women and girls<sup>13</sup>), many focus group participants felt that intimate relationships had improved as a result of lockdown.

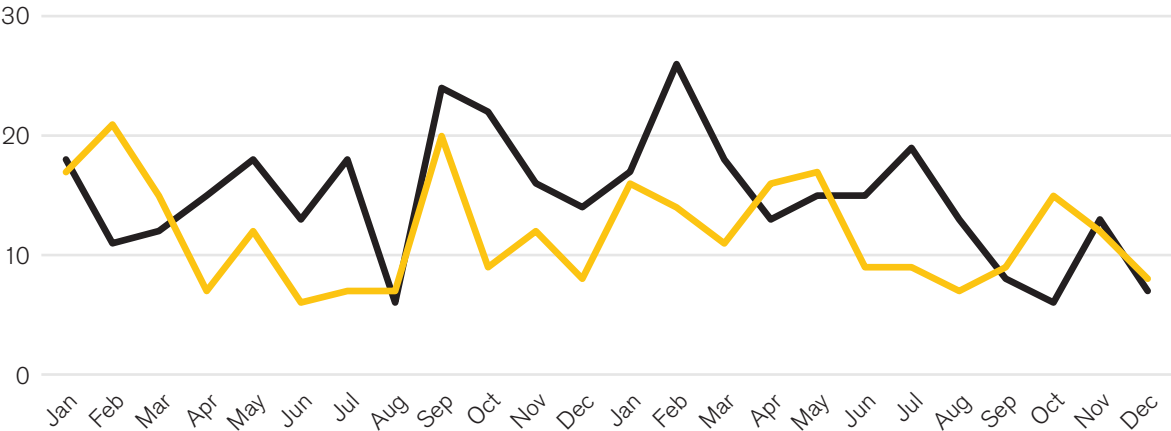
**Skilled Delivery  
GSS (Gwoza)**

— 2019  
— 2020  
- - Acute COVID phase



**GBV Cases  
2019–2020**

— Maiduguri  
— Gwoza



## 5. Qualitative Findings

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### 5.1. What changed during Covid?

During lockdown, housework increased for women because the whole family was at home all day, every day, and women were attending to the needs of both children and husbands. The demand for water also increased due to the adoption of Covid-preventing hygiene practices, whilst collecting water was feared due to the risk of contracting Covid in the queue.

*"What affected us the most [...] was no means of earning, no schools to take our children, no Arabic schools, no education. We were all at home and no movement."*

– HC GWOZA WOMAN

Several groups said that a major change was their loss of freedom during Covid's acute phase. However, some women and girls felt they found it easier to adapt to lockdown than men, because in this context women and girls traditionally stay at home, look after the family and some have work that they can do at home. Men usually travel around trading to earn their incomes, which are usually the main household income; *"You know we, the women, don't go out often, normally, because the women are used to staying at home"* (IDP Maiduguri woman). For some women, being confined to their homes alongside their husbands provided an opportunity to bond and improve their relationships, and they were grateful that the pandemic forced men to spend more time with their families;

*"During the Covid period we got to understand each other. He tells me what he doesn't like; I also tell him what I do not like – life goes on with no arguments, so Covid-19 has helped us to understand each other and live in peace"*

– HC GWOZA WOMAN

*"My neighbour said she's happy because before lockdown her husband was going after women and coming home late. But during lockdown he is always at home. Now she will dress up and show him how beautiful she is."*

**– HC GWOZA WOMAN**

*"Some don't have time to spend with their husbands and interact with them, but the lockdown made it possible for him to be at home and interact with both his wife and children and also open up to advice from his wife and so on."*

**– IDP GWOZA WOMAN**

Unsurprisingly (aligned with global statistics), though, some respondents reported increased friction and intimate partner violence (IPV) as men often took out their frustrations of being confined to their homes and lack of money to support the family, on their partners.

*"Some were behaving like we are the ones who enforced the lockdown, when we all shared the same fate, a little action which normally shouldn't be a problem could cause a fight"*

**– HC GWOZA WOMAN**

Some women whose husbands were working away from home throughout the lockdown were unable to communicate with them, and the husbands were unable to send their wives money, leaving the women with less or no income. Communication with friends and relatives was also very difficult, and women and girls struggled with being cut off from loved ones. *"There was hunger, poverty, not being able to keep in touch with family and friends."* – Gwoza HC girl

New mothers normally get support with chores and housework from other women in the community, but this wasn't possible during lockdown, so women with new babies were much more isolated than usual.

Women and girls regularly described putting their faith in God to get themselves through lockdown, because they felt powerless to do much or anything about their pretty desperate situations and had no idea how long they would need to survive like that for.



**PARTICIPANT 2:** *"There was no enjoyment or freedom at all, during which we could not go out freely and get something to eat. We spent what we had to the last and we just left everything in the hands of the Almighty." [...]*

**FACILITATOR:** *"How did you cope with that condition?"*

**PARTICIPANT 5:** *"We don't know how this thing came and went. It's only God that saved us."*

There were changes in how people celebrated milestone life events, because the economic impacts of Covid meant that many avoided big traditional celebrations like naming ceremonies, where the celebrants are expected to slaughter a ram. Most people couldn't afford to buy rams during the acute phase of Covid, so they named their children without a celebration. Weddings were also cancelled during the acute phase, due to lack of food, travel being expensive or impossible and lack of attendees (which people were fearful would be gossiped about). This is likely to also have been impacted by the government-imposed movement restrictions, but it was not mentioned by the participants.

Death customs including attending to loved ones' bodies were abandoned or not allowed, and people were unable to offer the usual support for bereaved friends and relatives. One woman described her horrendous ordeal when her daughter died during lockdown, and she wasn't allowed to take the body from the hospital until the next day – bodies being tested for Covid was another change brought about by Covid.

While girls in Gwoza said that if anyone started showing signs of Covid symptoms, they were rushing to hospital immediately, other groups reported that people would only go to hospital if they were very seriously ill, due to fear of contracting Covid and/or fear of being told they had the virus and being made to stay in an isolation unit.

As for children and young people across much of the globe, girls' education in Maiduguri and Gwoza was greatly impacted by Covid, with schools closed and learning paused;

*"What bothered me much during Covid-19 is that schools were shut down. Everything you learned will be faded away."*

**– IDP GWOZA GIRL**

With no fresh food available (due to travel restrictions and cargo rotting before it could reach its destination), people learned how to preserve food for longer, despite reports of no electricity. But even so, with so little if any food available or affordable – food became much more expensive – several groups mentioned not having any food or treats to break their fasts during Eid, the lack of fresh food must have had negative effects on people's health.

Most groups mentioned improved hygiene practices in response to Covid and awareness-raising efforts on Covid prevention measures.

## 5.2. Income and expenditure

During the FGDs, there was a focus on examining the sources of women and girls' income and what they spent it on pre-Covid and during lockdown. There were of course straightforward connections between finances and access to SRH services, but this exercise also revealed some more nuanced important socio-economic links and gendered economic pressures.

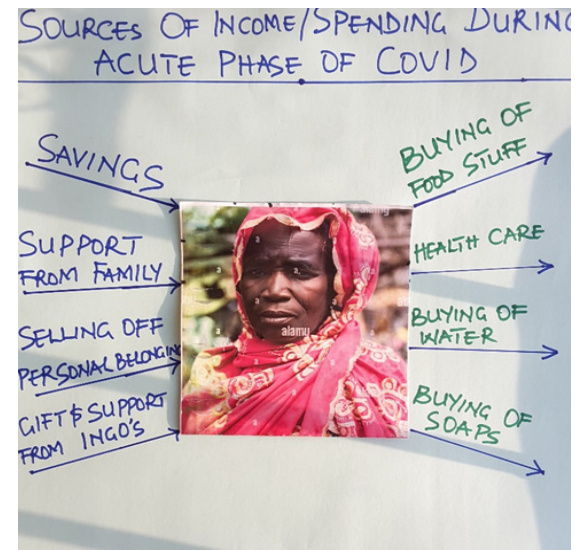
Prior to the pandemic, income sources consisted of petty trading, making traditional hats, making food to sell, tailoring, farming, hair braiding, henna painting], and paid labour. Adolescent girls also had financial support from parents and caregivers. Women and girls were able to meet their basic needs – for example, sanitary pads, food, children's school fees and medicine – as well as being able to buy non-essential items like clothes, cosmetics and gifts for family and friends, and put money aside in savings.

Across all groups, women and girls described dramatic economic impacts due to lockdown and travel restrictions. Essentially, women and girls' diverse incomes drastically reduced or completely dried up during lockdown, so they relied on savings, money from family members, support from NGOs and limited ways to make money from home, such as making food and hats to sell, and clothing repairs as people couldn't afford to buy new clothes. Restrictions were lifted once a week so that some men could go out and earn a little bit of money for their household. Significantly reduced incomes during the acute phase of Covid led to changes in spending habits, with only the basics for sustenance, health and hygiene being purchased – basically, food, water, soap and medicine, but even these were unaffordable for some.

*"Children were hungry with no food and their clothes were dirty with no money for soap and all that."*

– IDP GWOZA WOMAN

**Gwoza women's FGD – income and expenditure activity – pre-Covid (left) and during lockdown (right)**



One simple connection between finances and SRH was that pre-covid, women and girls spent money on sanitary pads and were very grateful that during lockdown, some were supplied with menstrual hygiene kits from IRC and other NGOs, but the way they accessed menstrual hygiene products changed. “...They gathered us and shared hygiene kits and other materials for women that helped a lot” – HC Gwoza girl.

Lack of money meant that one IDP woman in Maiduguri couldn't pay for transport or food when she had an antenatal appointment, and had to walk all day without food – pregnant, of course – to get to a facility and was initially turned away for arriving too late, until she expressed her anger and a cleaner advocated for her;

*“I came here with no transport to go back, I came from Madiganari trekking, my husband was not in town and I left the children with just breakfast to eat, I don't know what happened but I was here till evening, couldn't eat, I had no money, if I had known it would take the whole day I wouldn't have come.”*

A worrying finding that emerged from the financial inquiry was that some girls and young women in Maiduguri (it wasn't mentioned in Gwoza) reported ending up in transactional sexual exploitation when they had no income during lockdown, and some of them have continued beyond Covid. This reportedly increased their needs for contraception, treatment of infections, abortion and maternity services, as well as exposing them to heightened risks of GBV including rape and psychosocial trauma. One mother of a teenage girl in Gwoza host community said that she normally buys things for her daughter to protect her from being exploited by men – “... clothes to wear, make-up kits they see elsewhere, perfumes. When she's turning into a lady, you cater for her so a man cannot deceive her”. The girls in Gwoza asked specifically and

enthusiastically for skills training and materials so that they will be able to gain an income during future lockdowns. The HC FGD in Gwoza discussed how most civil servants (who are comparatively rich and continued to be paid during Covid) are men, and that there are also fewer girls than boys in school, because *"where would a girl go to? It is to her husband's house? she is under her husband. A girl does not prosper ahead of a man"* – an ingrained patriarchal view that perpetuates a system in which girls are more vulnerable financially and therefore more vulnerable to sexual exploitation and abuse. Respondents expressed a perception that women and girls are valued primarily for sex and – post-marriage – fertility, so their education is not prioritized. Despite how common commercial sexual exploitation (and other sex) is, unmarried young women and girls struggle to access the SRH services they need due to the gendered shame of pre-marital sex. This situation demonstrates the need for integrated SRH and WPE programming, and for engaging women and girls on the intertwined influences on their lives of education, economic empowerment, GBV, staying safe, gendered shame and all SRH needs.

One upsetting and worrying quote from the girls' FGD in Maiduguri describes how girls were sexually exploited and then paid tiny sums of money to compensate them due to economic impacts of Covid. *"So most of the young girls were seriously starved, they would be raped and at the end of the day, they would be given some little amount of money."*

Conversely, women and girls felt they coped with lockdown better than men, because they are used to creating an income for themselves at home, whereas men tend to only really know how to make money through travelling. Some girls and women in Maiduguri HC and IDP learned how to make traditional embroidered hats called 'caps' during lockdown and this became a new source of income, although materials were expensive, and the market value of caps dropped. Every group named cap production as a source of income pre- and during Covid. Others started new businesses, including selling charcoal and frying potatoes to sell.

The sources of income are similar for girls and women, although walking around selling food and water (which wasn't possible during lockdown) seems to be largely the preserve of girls, which may increase their vulnerability to sexual exploitation and abuse.

Women said that the main topic of conversation with other women in their community was the economic impact of Covid;

*"When you see women gathered, we are all discussing this Corona. Our husbands couldn't go out to engage in the petty trading they do, which made feeding [everybody] very difficult for most families"*

– HC GWOZA WOMAN



### 5.3. Barriers to and enablers of accessing SRH services

Many of the barriers women and girls described in accessing services were present both before and during the pandemic, and while some are around availability of services, finances or lack of awareness, the majority relate to gendered shame associated with SRH or rooted in it. Women and girls expressed shame around accessing culturally sensitive and potentially stigmatising services like contraception, safe abortion care (SAC), PAC and even CCSAS, due to the religious, cultural, and patriarchal context in North-East Nigeria. Many adolescents reported believing SRH services are only available to married women so they don't realise they can access contraceptive services and abortion care counselling. This leads girls and unmarried young women to resort to unsafe alternatives, such as salt solutions, potash, paracetamol overdose, metronidazole overdose, antibiotics and bitter-lemon carbonated drinks containing quinine, to prevent or end unplanned pregnancies. Adolescent girls were particularly worried about providers' confidentiality and the lack of youth-friendly services with female staff. These findings highlight the need for ongoing community engagement work and education targeted at women and girls (and boys and men) on services available to them and the consequences of girls and young women not accessing contraception and SAC. Of course, if contraception was easily accessible without any shame associated with it, the need for SAC would be reduced. It could help adolescent girls enormously if they had the support and understanding of older women for their SRH needs, which seems to be missing currently.

Even issues with service delivery that make services less accessible are often wrapped up in shame. For example, worries about staff confidentiality and girls not wanting to seek STI treatments or contraception in the same space as older women are receiving ANC as they feel judged. If men understood the vital importance of contraception and it was no longer stigmatised, clinics wouldn't feel the need to ask for men's permission to prescribe their wives contraception, in order to prevent marital conflict. Similarly, male staff would not be an issue for women and girls if shame wasn't.

Married women face barriers from their husbands, also due to harmful patriarchal norms that stigmatise contraception and do not value women's SRH, despite potentially life-threatening risks, pain and trauma. Many of the issues with service delivery that form barriers to access would be eliminated by the eradication of shame. In the meantime, it would help women and girls if health implementing partners could become better at creating access points that acknowledge and address the gendered barriers.

#### **Barriers to accessing SRH services described by women and girls (non-COVID):**

Shame and fear of stigmatisation are associated with all SRH services for girls and unmarried women, especially in accessing STI treatments, contraception, abortions and even with SD. Judgement and fear of judgement of unmarried women and girls for accessing these services by their parents, others' parents and health workers. Girls feel unable to confide in mothers, some hide pregnancies so that they won't be forced to abort (and likely to avoid being blamed and labelled for it) while others keep it secret that they self-induced an abortion to terminate the pregnancy.

**FACILITATOR:** *"...Is there any other factor that hinders women from receiving family planning pills or implants?"*

**PARTICIPANT:** *"They do hear complaints at home about unmarried ladies going to insert family planning items"*

**FACILITATOR:** *"Who lays this complaint?"*

**PARTICIPANT:** *"Parents at home and also at the hospital there"*  
– Gwoza HC girls' FGD

Lack of knowledge on the benefits of family planning (exacerbated by Covid), there were widespread misconceptions about contraceptive methods and side effects, high levels of illiteracy and lack of awareness on SRH amongst women and girls. The unwillingness of partners to provide financial/moral support for hospital bills/visits impacts women's ability to access SRH services with some providers requesting consent from spouses or parents. *"For birth control, a man could be against it and at the hospital they tell us we need consent from our husband."* – Gwoza HC woman

Adolescent-friendly and unmarried-women-friendly services including privacy and confidentiality are facilitators to service uptake, the lack of these therefore portends a significant barrier. *"It would've been better if the rooms were different. They [girls] are intimidated by the married women there, some might think they are pregnant when they see them there"* – HC Gwoza girl.

### **COVID-specific barriers to accessing SRH services**

With everyone in lockdown, it was impossible to go anywhere unnoticed, so discreet clinic visits were difficult. *"Some of them were in need of some services but couldn't go out because of the lockdown and people would ask where they were going."* – HC Gwoza girl. Travel restrictions made getting to facilities difficult and expensive, also, fewer patients were allowed in facilities at any one time, and all screened for Covid, so visits took a long time.

Fear of contracting Covid – this was particularly for facilities where isolation centres had been established; clients feared that if they visited the facility, they may get infected and they were scared because people had died after being quarantined. Additional, fear of being told they had Covid and being made to stay in an isolation unit. *"Even the service providers are not available. People are afraid to go to the hospital because they might be told they have Covid."*; *"People were afraid to take complaint of their sickness to hospital, but they were afraid they might be taken to the isolation centre."* – HC Gwoza women.

However, health providers perceived that the quality of services remained the same during the Covid acute phase, but less staff meant that they were more stressed resulting in longer waiting time for clients which is consistent with women and girls' statements. Providers also faced increased hostility from some patients refusing to wear masks, insulting staff, blaming staff for restrictions on visitors etc. In-person WPE services were not running, so – according to health providers – although GBV cases received clinical care and evidence was gathered by another INGO, there was no psycho-social support for survivors of rape and violence. In fact, remote services were provided to survivors, so it is noteworthy that this was health providers' perception. Some providers' attitudes to patients were even worse than usual, as, according to providers, staff need training, some aggressively enforced Covid rules, sometimes incorrectly.

Reduced access to SRH services during Covid had dire consequences for many women and girls;

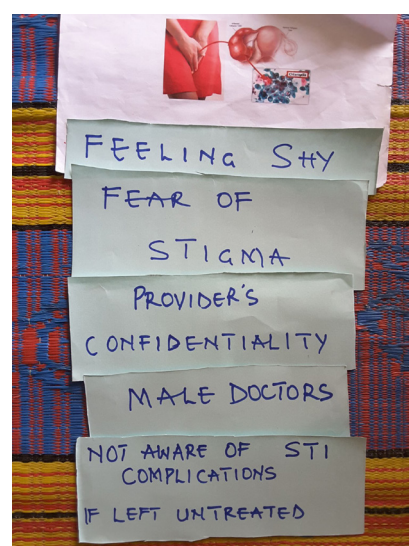
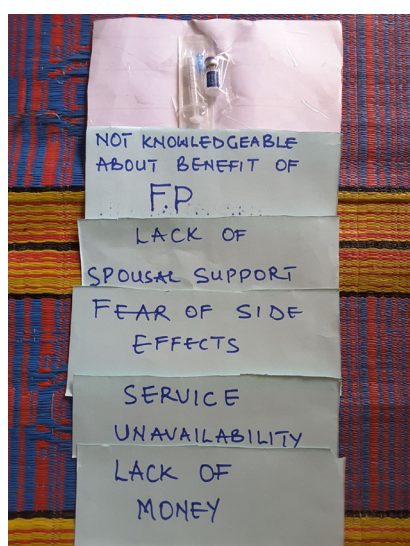
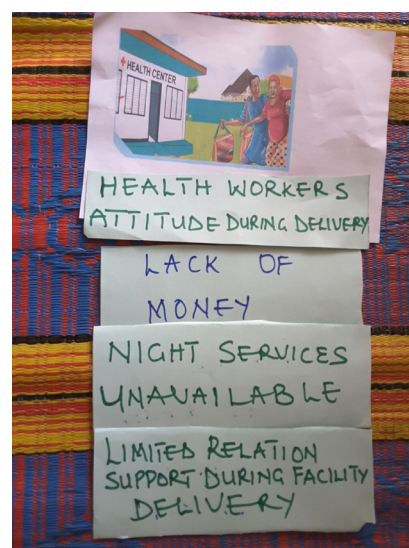
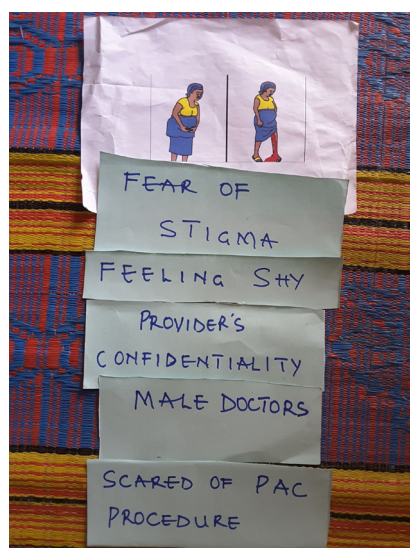
*"My neighbour used to take the family planning injection, but during the lockdown she was not able to get the injection and later she got pregnant which she didn't plan for".*

*"My neighbour experienced bleeding during the lockdown, she bled for like 20 days, the husband is not aware that she's having contraception's. He later found out and he beat her mercilessly." HC Gwoza woman*

There was limited data on the differences between accessibility to specific services pre-Covid and during lockdown, but most FGDs were aligned on the following:

- SD and ANC were easiest to access during Covid, followed closely by post abortion care, as these are all considered life-threatening.
- ANC appointments were reduced during lockdown in order to limit numbers at the clinic. Some groups and providers thought this had led to complications and even increased infant and maternal mortality.
- New mothers were sent home immediately after giving birth during Covid, and not given time to recover like they normally would.
- Clinics are closed for security reasons during the night whether there is a pandemic or not, so women who give birth at night (or experience GBV, rape, miscarriage or any other SRH emergency) have no option but to do so at home without medical assistance, and often turn to traditional birth attendants (TBAs) for help – that they have to pay for. This is a dangerous situation and leading to infant and maternal deaths, preventable complications, and traumatic births.

## Various FGDs – activity on barriers to accessing SRH services



Other experiences varied depending on location; contraception and STI treatments were available throughout the pandemic, but waits were long due to social distancing measures and patients being checked for symptoms of Covid before being seen. There were instances of unplanned pregnancies due to lack of access to contraceptives, mentioned by women and girls in Maiduguri and Gwoza. STI and UTI treatments were not prioritised by women and girls as they didn't consider them urgent enough to risk going to facilities and either being exposed to Covid or being told they had contracted it already. They felt they could "manage" infections by themselves for a while.



### **Enablers of access to SRH services experienced by women and girls, pre-Covid and during lockdown:**

There was generally a good level of SRH knowledge among some of the groups (particularly those in Gwoza), but they did not consider themselves representative of the general population. This is not surprising as they were recruited from CWCs/ WGSSs had access to services and information. There was a decent understanding of the possible implications of STIs (e.g., on fertility) and the need to get them treated and knowledge of free, discreet, and confidential services and provision of menstrual hygiene and delivery kits, which were especially helpful during lockdown.

Girls support each other to access services in terms of accompanying each other to SRH providers and explaining the issue for girls who are too ashamed to explain for themselves. Clearly, this wasn't possible during lockdown. A named member of staff mentioned by groups in Gwoza has had a significant positive impact on the mindsets of girls in particular, empowering them in multiple ways, educating them and helping to break down shame associated with STIs. This demonstrated the value of a youth friendly service provider.

*"Aisha advises them [girls] not to be shy, even it means meeting her privately, she also provides transport fares when it is late and guides you on how to take the prescriptions"*

**– GWOZA HC GIRL**

Some husbands encourage their wives to take the contraceptive pill rather than use condoms – at least they are supporting one form of protection.

Service providers also highlighted some potential enablers, including improved hygiene and quality of medical services due to Covid, and the positive impacts of community engagement work, particularly with adolescent girls. They also reported that because referral papers were issued to women and girls on arrival during Covid, they were directed to the correct unit quickly. Providers in Gwoza HC 'not allowing' home births and Provision of PPE at facilities during lockdown enabled hospital visits. When asked what they do at the hospital, a participant answered: *"They provide adequate healthcare. They don't allow for childbirth at home"*  
– HC Gwoza girls' FGD.

**Maiduguri women's FGD  
– ease of access to SRH  
services ranking activity**



Improved hygiene practices due to Covid prevention have persisted both at health facilities and at home, which an HC Gwoza woman said had the additional benefits of reducing prevalence of other diseases. *"Maintaining personal hygiene like washing of hands after using the restroom was not observed before, but at the inception of Covid-19, they are not just scared of Covid-19 alone but even other diseases like cholera, so the diseases have reduced now [...] because of proper hygiene".* – HC Gwoza woman

According to providers, only about half the additional patients they saw during the acute phase of Covid (who would normally have used other facilities) have now returned to their previous choice of facility, meaning that 50% of those patients remained, and demand is now higher than it was pre-Covid.

## 5.4 Differences between urban, rural, girls' and women's experiences

Each group had its own 'character', particularly with the girls' groups. Maiduguri HC girls appear to be more vulnerable generally but especially to commercial sex, than the Maiduguri IDP girls, who – although they suffered greatly during lockdown – sounded slightly more sheltered than the host community girls. The IDP girls had savings to fall back on, having encouraged each other to save before the pandemic (possibly thanks to IRC's integrated SRH and WPE programming), and they were supplied with sanitary pads by NGOs during lockdown, when they were not allowed to leave the camp. The HC girls described having to become more self-reliant during Covid.

In Gwoza, the IDP girls were strikingly studious, with all of them saying they like going to school (other FGD participants like sleeping, gossiping, chores, eating and cooking), two of them with aspirations to be doctors and one a teacher. They describe supporting peers to access the SRH services they need. The Gwoza HC girls seemed to be older than the IDP ones, with more responsibility for families, and spending pre-Covid on more grown-up items like fancy plates and saving for housing.

One conclusion that could be drawn from the above is that there is more NGO support for girls in IDP camps than host communities, making them less vulnerable during public health emergencies. They will also have had easy access to services because there were no travel restrictions within the camp, while their counterparts in host communities were confined to their homes.

Differences between women's and girls' experiences are not unexpected. Girls feel judged and shamed by older women for having SRH needs, while their mothers are – unbeknownst to the girls – trying to protect their daughters from being exploited or harmed by men. Everyone went hungry during the lockdown, but women said they felt the additional pain of seeing their children hungry, which girls without children would not have experienced.

*"It's not the men who are staying with the children. If there is a problem, as a mother you feel the pain more than the man."*

– HC GWOZA WOMAN

The girls we spoke to were generally able to access the SRH services they needed during Covid (being less affected by barriers around shame and lack of awareness than other girls they know – perhaps because they were less affected by other barriers they identified, like illiteracy and lack of awareness), whereas the women, as we've heard already, did not get the care they needed during pregnancy and labour.

However, an exception among the girls was the Maiduguri IDP group, who felt so uncomfortable discussing SRH, that according to the facilitator's notes, the girls 'became less receptive and were [too] shy to continue the discussion, thus the decision to turn off the audio.'

Once the audio was no longer being recorded, the facilitator was able to get the discussion going again, with the following findings:

- Girls mostly access STI services, which were easy for them to access both pre-Covid and during acute phase.
- Most girls do not access other services like contraception, SAC, PAC, ANC, and CCSAS 'because they believe these services are meant for married women only and so rely on unorthodox means to meet their SRH needs [...]. Others visit local chemists to meet their needs.' The 'unorthodox means' consisted of the list of home remedies for preventing and ending pregnancies outlined earlier in this report.

It is positive that for this group the stigma around seeking STI treatments has apparently fallen away, but there is clearly work to do, to help girls feel that all the services they need if they are having sex or are survivors of GBV are for them as much as they are for married women.

It is interesting to note that the information about the home remedies girls use as contraceptives and to try to induce abortion came only from the group with the audio recording switched off.

## 5.5 What women and girls want: Suggestions for preparedness

Women and girls gave suggestions for preparedness in SRH provision during future public health emergencies and lockdowns.

- Keep services open 24/7, suggested by women in FGDs in both areas who described the devastating impacts of facilities being closed at night and on non-workdays, and of staff turning people away during Covid if they didn't arrive early in the day. Providers were in agreement with the women and girls they serve, with one Assistant Midwife giving an account of a woman dying due to facilities being closed. The patient was medicated for pre-eclampsia and sent home when her blood pressure dropped while the labour progressed, only to return to give birth in the middle of the night when the centre was closed and consequently dying.
- Pay better attention to the needs of adolescent girls- a suggestion from Maiduguri HC girls was for staff to listen more to girls who might not be able to talk to their parents or get help at home; *"Most of the medical personnel pay more attention to the older women. My advice to the medical personnel is that whenever a young girl comes to them, they should consider her and pay attention to her because possibly she may not be able to express her problem at home and that is why she brought herself to hospital"*. One suggestion from Gwoza IDP girls to ensure all patient information is kept confidential. There were two requests from providers for staff training on such skills.



- More staff to keep services running incl. IPC and isolation centres – suggested by HC girls in Gwoza and seven times by providers.
- Provide free medicines on site – suggested by two HC girls in Gwoza, although multiple FGDs particularly in Gwoza mentioned difficulties in accessing medicines and not being able to afford to buy them. Also suggested six times by providers. "They should help us with medications and other items that are valuable to us." – HC Gwoza girl.
- Stock condoms – HC women in Gwoza described having to buy them from the chemist. This was suggested once by a provider.
- Offer community- and home-based service delivery during lockdowns (one provider suggested this too); *"If there is another outbreak and another lockdown occurs, the same way they allowed people who create awareness to go around, they should also allow health care providers to go around and treat people at their homes. They should go around with medications."* – HC woman, Gwoza
- Continue to provide food at facilities for clients staying for longer periods: suggested by IDP women in Maiduguri and HC girls in Gwoza. Lack of food provision at facilities was cited as a problem in several FGDs. There was less or no food provided during Covid – just when people needed food the most – whereas previously there was quite a generous provision.
- Provision of PPE (facemasks, sanitiser) was mentioned as an enabler to accessing services by women and girls (and providers), and Maiduguri IDP women suggested provision for future public health emergencies; *"Because when you get here, you will receive a facemask and handwash, but if they had told us to provide these things, honestly it would make some not to come."* – Maiduguri IDP woman.
- Host community girls in Gwoza also suggested provision of toiletries and hygiene products (soap, moisturiser, Vaseline) and detergent.
- Three participants requested skills training and materials starting immediately so that they will be equipped to earn an income during future lockdowns – essentially to build future financial resilience (and therefore make it easier for them to access what they need, e.g. if they have to pay for treatments or contraceptives from a pharmacy), but this could also make them less vulnerable to sexual exploitation, GBV and all the associated risks. *"If they can help provide skill acquisition so we can sustain ourselves in case this ever happens again."*

## 6. Conclusion & Recommendations

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Even without the virus outbreak of COVID-19, access to SRH in humanitarian settings is uneven. As focus shifts towards recognising the impact of COVID-19 on communities, it is important to recognise that barriers to SRH are not “new” but represent existing, highly entrenched inequalities. Solely fixating on the impacts of COVID-19 may neglect the structural, systemic inequalities affecting SRH and GBV access. We can deduce from global and national statistics and from the voices of women and girls we heard from in Borno state, that the reduction in GBV services provided in Gwoza and Maiduguri during the acute phase of Covid was due to reduced access, not reduced incidence. We have also seen that SRH needs did not decrease, and (based on global statistics that IPV and sexual exploitation increased during lockdown) bringing with it increased need for SRH and GBV services. The reported increase in transactional sexual exploitation and decrease in access to contraception will also have brought more SRH and GBV needs. The implications are that the gap between need and provision widened during this time, due to all the barriers described and due to WGSSs having to close.

As the majority of barriers to accessing SRH and GBV services described by women and girls were either around gendered shame associated with SRH or originate in shame, a holistic approach of integrated SRH and WPE programming is needed to build resilience for future public health emergencies, and to dismantle the social structures centred around shame (and created by patriarchy), that make it difficult for women and girls to access vital, life-saving SRH and GBV services whether there's a pandemic or not.

Measures taken during the Covid acute phase that had positive impacts, such as provision of menstrual hygiene kits and increased community-based activity should be replicated or expanded during future public health emergencies, so should be included in preparedness planning.

## Recommendations

The following recommendations aim to improve preparedness of services and resilience of women and girls for future public health emergencies, as well as break down barriers and improve general access to SRH services for women and girls.

- 1 Invest in community-based service delivery and self-care for SRHR**, including longer prescriptions of contraceptives and advocating for access to contraception without the need for prescriptions and consent, to ensure access to essential services when health facility services are disrupted.
- 2 Provide toll-free telephone numbers** that women can call to request SRH and GBV services and receive free SRH/GBV advice and referrals (in locations with network). Women could also call ahead making a trip to a facility to confirm the availability of the services they need.
- 3 Advocate for facilities to remain open 24/7 during lockdowns** and ensuring continued access to the MISP and comprehensive GBV care during a public health emergency.
  - Allow new mothers time to recover after giving birth before being discharged.
  - Ensure clear and updated referral protocols for women experiencing obstetric emergencies.
  - Ensure GBV case management is considered a part of the health package
- 4 Provide adolescent-friendly services at all times**, including future lockdowns
- 5 Deliver integrated SRH and WPE community engagement**, to reduce stigma around services and to protect women from GBV including as a consequence of accessing services. This should include:
  - Engaging men and boys on contraception, with the aim of eradicating facilities requirement of husbands' permission for their wives to use contraception, and of eradicating the need for women to keep contraception secret from their husbands with the associated risk of IPV.
  - Engaging older women on the SRHR and WPE needs of girls and young unmarried women, to increase women's support of girls and reduce girls' feelings of shame, stigma and being judged.
- 6 Support and prioritise socio-economic empowerment of women and girls** via multipurpose cash interventions to protect them from damaging, exploitative coping strategies as a result of disrupted livelihoods.
- 7 Leverage Risk Communication and Community Engagement (RCCE) activities to provide women and girls with SRH and GBV information**, including up to date information on the availability of services and safety precautions at health facilities.

- 8 **Provide clients with required PPE** (e.g. facemasks) to enable access to facilities – women and girls reported that this measure encouraged them to access the facility during the acute phase of the pandemic.

**Additional recommendations from providers:**

- **Partner with WASH NGOs to improve sanitation and running water at all facilities.**
- **Train all staff on Human Rights and women-centred care; treating every patient with dignity, respect and kindness.** Support and train staff on dealing with aggressive members of the public during tensions caused by restrictions, health fears and coping with stress.





# Endnotes

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