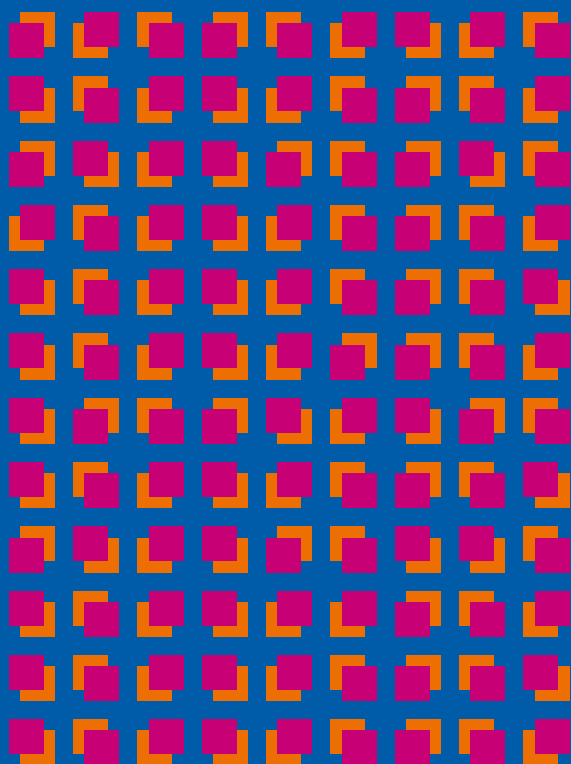


PROVISION OF CLINICAL MANAGEMENT OF RAPE (CMR) IN CRISIS SETTINGS

ANALYSIS OF FACTORS AFFECTING DELAYS
IN ACCESSING SERVICES IN BORNO STATE, NIGERIA



EXECUTIVE SUMMARY



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INVESTIGATORS AND PARTNERS

The study was designed and implemented by the Population Council collaboration with Médecins du Monde. The Population Council was principal Investigator in this project. The Council designed the methodology and the Standard Operating Procedures for the study, and had an implementing role including researchers' training, technical assistance, field activities study monitoring and data analysis. Médecins du Monde provided support in training, security guidance, recruitment and follow-up of participants and logistic coordination. Women in the New Nigeria, and Youth Empowerment Initiative (WINN) supported engagement and recruitment at community level. Médecins du Monde ensured the coordination of humanitarian organisations for the research and dissemination meetings.

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DRAFTING COMMITTEE

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BACKGROUND

Sexual and gender-based violence (SGBV) or gender-based violence is a global public health concern that disproportionately affects women with negative consequences for health, wellbeing, human rights and development. In 1992, the Convention on Elimination of all forms of Discrimination Against Women (CEDAW) defined GBV as *violence that is directed at a person on the basis of gender or sex*. CEDAW revised the definition to reflect the fact that SGBV affects women disproportionately. There are five forms of violence; sexual, physical, economic, emotional and psychological, and harmful traditional practices. They are driven by unequal power relationships and social roles ascribed by society that subjugate women and produce gendered inequities. One in three women were reported by the World Health Organisation (WHO) to have experienced physical and/or sexual violence by an intimate partner or violence from non-sexual partner in 2013. Findings from the Nigeria Demographic and Health Survey show that the proportion of women aged 15-49 who report having experienced physical violence increased from 28% in 2008 to 31% in 2018. These estimates are likely conservative as women tend to underreport experiences of violence.

Gendered structures are strengthened in conflicts and post conflict settings causing patterns of violence and SGBV to increase. Internally Displaced Persons (IDPs) are even more vulnerable to SGBV because of the resultant loss of socio-economic opportunities, housing, security, lack of institutional protection and separation from family. The violent conflict and insurgency in North-East Nigeria have resulted in an estimated 7.7 million people requiring humanitarian assistance and protection in Borno, Adamawa and Yobe (BAY) States. As at May 2019, there were about 2 million IDPs and 80% of the total IDPs were women and children. The insurgency has resulted in mass abductions, survival sex, forced prostitution, forced and early marriage, physical, mental and sexual assault. In 2019 alone, about 3 million people were estimated to be in need of protection from SGBV in North-East Nigeria.

The context of SGBV in North-Eastern Nigeria is poorly understood and evidence-based strategies for addressing medical and psychosocial recovery needs of SGBV survivors are urgently needed. Lack of awareness about available services, stigma and lack of self-efficacy to initiate conversations about rape with health providers are some factors that can limit uptake of medical and psychosocial support services (PSS). This study documented the barriers to access to medical and psycho-social services for SGBV survivors in Borno state, Nigeria especially within the critical 72/120-hour window for CMR and make recommendations for developing interventions to address the primary and secondary prevention needs of vulnerable groups to SGBV.

METHODOLOGY

The study utilized a qualitative narrative approach to understand the context of SGBV and the barriers to access to health services in four IDP camps located in three (Damboa, Maiduguri and Jere) local governments in Borno state. In-depth interviews (IDIs) were conducted among self-identified SGBV survivors who had previously accessed services, and those who had never accessed services. Focus group discussions (FGDs) were conducted among community members and the Key Informant Interviews (KIIs) obtained service providers' and stakeholders' perspectives on the context of SGBV in Borno State. The study collated the survivors' service statistics in MdM clinics to ascertain the characteristics of survivors and the pattern of service utilization. Descriptive statistics were used to summarise the service statistics and the qualitative interviews were digitally recorded, transcribed, transferred to NVIVO 12 software and analysed using narrative and thematic analysis. Ethical approval was obtained from the Population Council's IRB as well as the University of Maiduguri Teaching Hospital Health Research Ethics Committee.

FINDINGS

The findings reflected that seeking services was related to multilevel personal, familial, community, and institutional barriers as well as gender and power dynamics. Stigma, lack of awareness of the value of timely access to CMR, fear of the consequences of disclosure and low decision-making power by women for their own health and wellbeing were barriers to timely access. Unequal power balance in the community affects the perception of women about themselves and their capacity to make decisions about their health. There was a prevailing consensus among families to conceal rape in order to protect the family reputation and avoid stigma in the community. The culture of silence regarding rape among families was reinforced by socio-economic factors such as poverty and family indebtedness to potential suitors that constrained their capacity to disclose or discuss SGBV to facilitate help seeking. Community structures that promote victim blaming and ostracization of survivors and their families shaped the social norms that drive SGBV and limits survivors' self-efficacy to seek help. Poor access to justice for rape normalises violence and empowers perpetrators to continue to violate the rights of women and girls. Long waits at clinics, lack of empathy of health workers, gender of the healthcare provider, language barrier and poor service integration were institutional barriers to access in this study.

CONCLUSION

This study highlights key barriers to access to CMR within the critical 72/120 hours window. Increasing awareness about the need for CMR within 72/120 hours is important as well as identifying and addressing institutional barriers to access. Participatory community education programs should be used to engage families and communities on the health and human rights of women, the availability of confidential services for survivors and address potential barriers to access to healthcare. Despite the challenges in the health service delivery in temporary structures in IDP camps, instituting user feedback mechanisms is a valuable way of addressing service gaps and improving care.

RECOMMENDATIONS

1. Participatory community education programs should focus on destigmatising and demystifying conversations of rape to address cultural and social norms that promote concealment of rape as this will improve service utilisation and address potential barriers to access to healthcare. There is need for clear communication and appropriate messaging about the benefits of CMR in the communities.
2. Health education programs should target families and not just individuals using a participatory approach to ensure that survivors can discuss without fear within the home and receive family support to facilitate access to care. These programs should also address broader issues relating to health and human rights of the girl child especially as it relates to forced marriage and missed opportunities for educational as well as economic empowerment.
3. Key service components for providing healthcare to SGBV survivors should be available and well-integrated with referral services to ensure that seamless care is received without increasing layered barriers to access.
4. Training and retraining of service providers is important to ensure they are up to date with best practice for the provision of competent, confidential and empathetic care that is delivered with considerations for cultural competence, gender sensitivity and clear communication.
5. Survivors were concerned about being seen visiting the clinics for CMR services; provision of CMR services in neutral spaces at the clinics can help address concerns that other community members will suspect that they visited for SGBV related reasons.

