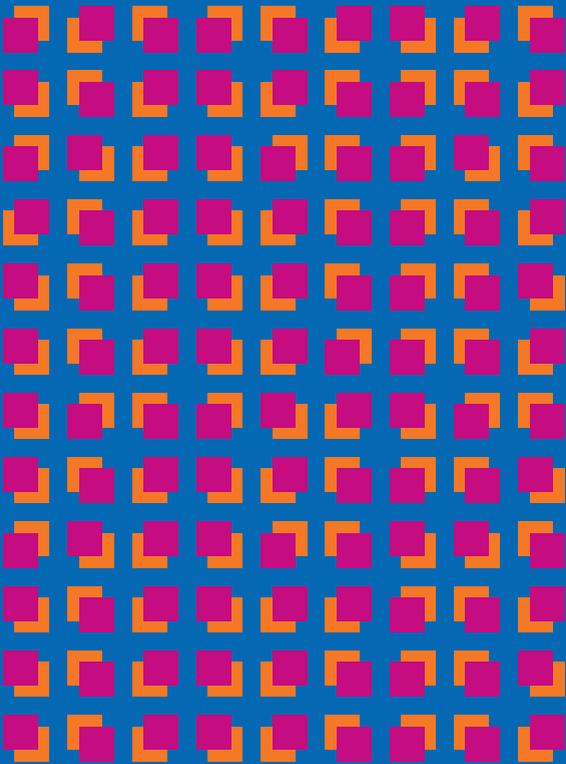


# PROVISION OF CLINICAL MANAGEMENT OF RAPE (CMR) IN CRISIS SETTINGS

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



SCIENTIFIC REPORT





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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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## LIST OF ACRONYMS

<b>BH</b>	Boko Haram
<b>CEDAW</b>	Convention on Elimination of all forms of Discrimination Against Women
<b>CFRN</b>	Constitution of the Federal Republic of Nigeria
<b>CJTF</b>	Civilian Joint Task Force
<b>CMR</b>	Clinical Management of Rape
<b>CRA</b>	Childs Right Act
<b>CSOs</b>	Civil Society Organizations
<b>FCT</b>	Federal Capital Territory
<b>FGDs</b>	Focus Group Discussions
<b>FGM/C</b>	Female Genital Mutilation/Cutting
<b>FMWASD</b>	Federal Ministry of Women Affairs and Social Development
<b>GBVSS</b>	Gender Based Violence Sub-sector
<b>HIV</b>	Human Immune Virus
<b>IDIs</b>	In-Depth Interviews
<b>IDPs</b>	Internally Displaced Persons
<b>IRB</b>	Institutional Review Board
<b>KIIs</b>	Key Informant Interviews
<b>LGAs</b>	Local Government Areas
<b>LMIC</b>	Low and Middle-Income Countries
<b>MdM</b>	Médecins du Monde
<b>MHPSS</b>	Mental Health and Psychosocial Services
<b>MPSS</b>	Medical and Psychosocial Services
<b>NECSOB</b>	Network of Civil Society Organizations, Borno state
<b>NGOs</b>	Non-Governmental Organisations
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PPMVs</b>	Patent Proprietary Medicine Vendors
<b>PSS</b>	Psychosocial Support Services
<b>RAs</b>	Research Assistants
<b>SEA</b>	Sexual Exploitation and Abuse
<b>SGBV</b>	Sexual and Gender-based Violence
<b>SPHCDA</b>	State Primary Health Development Agency
<b>STIs</b>	Sexually Transmitted Infections
<b>UDHR</b>	Universal Declaration of Human Rights
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>VAPP</b>	Violence Against Persons Prohibition Act
<b>VAW</b>	Violence Against Women
<b>VAWG</b>	Violence Against Women and Girls
<b>WHO</b>	World Health Organization
<b>WiNN</b>	Women in the New Nigeria



# EXECUTIVE SUMMARY

## 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, well-being, 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.



# INTRODUCTION

## BACKGROUND

Sexual and gender-based violence (SGBV) is a global public health concern that disproportionately affects women with negative consequences for health, wellbeing, human rights and equality.<sup>1,2,3,4</sup> According to the UNHCR, “**Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person’s will and is based on gender norms and unequal power relationships**”.<sup>5</sup> Lifetime prevalence of SGBV is estimated to be 30% although it is often underreported due to sociocultural norms, stigma and fear.<sup>6,7</sup> Gendered societal structures are strengthened during periods of conflicts causing patterns of violence to increase.<sup>8</sup> These gendered structures are rooted in gender roles that subjugate women as inferior and SGBV is perpetrated in crisis settings where vulnerability is increased and social/legal sanctions are reduced.<sup>9</sup>

Internally displaced persons (IDPs) are even more vulnerable to SGBV in conflict and post-conflict settings because of the resultant loss of socio-economic opportunities, housing, security, lack of institutional protection and separation from family.<sup>16</sup> Studies have reported multidimensional factors that are rooted in traditional gender norms, unequal power relationships, political and socio-economic domains which intersect to increase vulnerabilities to SGBV in emergency and post conflict settings.<sup>10</sup> Nigeria is not exempt; armed attacks in the North-Eastern region of Nigeria in the past decade have resulted in the displacement of over two million IDPs who are forced to reside in camps or host communities.<sup>11</sup> Although reports have documented the problem of SGBV in the North East of Nigeria, the context is poorly understood. Evidence based strategies for addressing medical and psychosocial recovery needs of SGBV survivors in the North East of Nigeria are urgently needed.

Findings from a rapid assessment of SGBV in a refugee camp in Sudan showed that reporting of SGBV to healthcare providers was rare because customary mechanisms were adopted for resolving the issues to avoid stigmatization and social ostracism.<sup>12</sup> Customary resolution mechanisms are set-up by community leaders, religious leaders and women representatives; issues relating to rape are reported to these community leaders and they mediate the resolution process.<sup>13</sup> Customary resolution mechanisms identified at the community include punishment of the perpetrator (if the identity is known) by the local chief, payment of a fine to the victim’s family or marrying the victim.<sup>12</sup> A UNHCR SGBV Assessment report for Nigeria in 2017 showed that the Sharia Law was preferred over the formal judicial system for addressing SGBV issues in camps and host communities in Northeast Nigeria. The assessment highlighted some challenges in addressing SGBV such as stigma, limited medical services (which were mainly donor driven) implemented by personnel who were not trained in CMR, limited services for IDPs in host communities, high levels of poverty among IDPs and limited opportunities to improve livelihood.

The National Guidelines and Referral Standard for GBV in Nigeria highlights seven priority areas including the provision of healthcare and psychosocial services. When GBV has occurred, the guidelines recommend referral to a healthcare facility for prophylactic treatment, forensic services and psychosocial support.<sup>7</sup> Referral to the police for documentation of the survivor’s account and referral to community based teams for additional support needed is also recommended.<sup>7</sup> Uptake of SGBV interventions such as medical and psychosocial support services (PSS) may be low due to lack of awareness about these services, stigma, lack of trust or self-efficacy to initiate conversations about SGBV with health providers.<sup>16</sup> There are gaps in evidence about health service needs of survivors and barriers to access to available services.<sup>14</sup>

## OVERVIEW OF NIGERIA AND BORNO STATE

Nigeria is ranked the most populous nation in Africa and the 7<sup>th</sup> in the world.<sup>15</sup> The 2017 population estimate for Nigeria was 199 million people with the ratio of men to women being 49.2% to 50.8%.<sup>16</sup> Nigeria is made up of 36 states and a Federal Capital Territory (FCT) grouped into six geopolitical zones: North Central, North East, North West, South East, South South, and South West. In 2016, life expectancy in Nigeria was 47 years for male, 51 years for female and 49 years for both.<sup>16</sup>

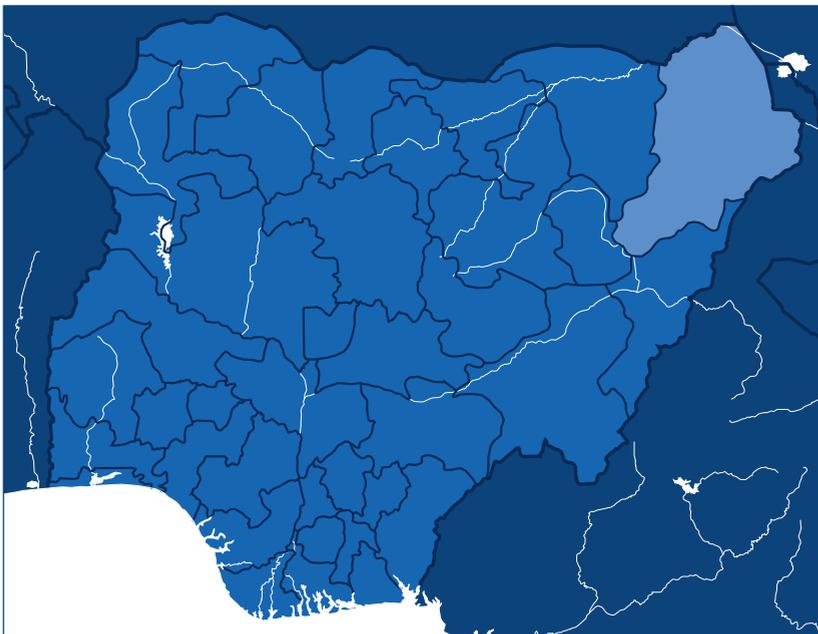
Borno State was created from the North Eastern State in 1976 and the capital is Maiduguri. The 2015 population estimate for Borno state was 5,860,183.<sup>16</sup> The State shares borders with Cameroon and Chad to the East, and Niger Republic to the North. Borno State has 27 Local Government Areas (LGA) and the major tribes include Kanuri, Babur and Shuwa Arabs who are

predominantly farmers and fishermen.<sup>17</sup> The main economic activities are farming and fishing; the northern part consists of Sahel Saharan-type, drier climate, dispersed, scattered population compared to the southern part which has thicker, Savanna-type vegetation.<sup>17</sup> The predominant religion is Islam with a minority Christian population.

### 1. INSURGENCY AND DISPLACEMENT IN NORTH EAST, NIGERIA

The North East region of Nigeria consists of Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe States. The violent conflict and insurgency in North-East Nigeria has resulted in an estimated 7.7 million people requiring humanitarian assistance and protection in Borno, Adamawa and Yobe (BAY) States.<sup>19</sup> As of May 2019, there were about 2 million IDPs (table 1, p. 16) with 55% females and 80% of the total IDPs were women and children.<sup>20</sup> The insurgency has resulted in mass abductions, survival sex, forced prostitution, forced and early marriage,

**Figure 1** Map of Nigeria showing Borno State.



Source: Wikipedia<sup>18</sup>

**Table 1** IDP population by May 2019.

State	Count of LGAs	May 2019
Adamawa	21	192,534
Bauchi	20	64,387
Borno	27	1,467,908
Gombe	11	36,872
Taraba	16	85,332
Yobe	17	133,003
<b>Total</b>	<b>107</b>	<b>1,980,036</b>

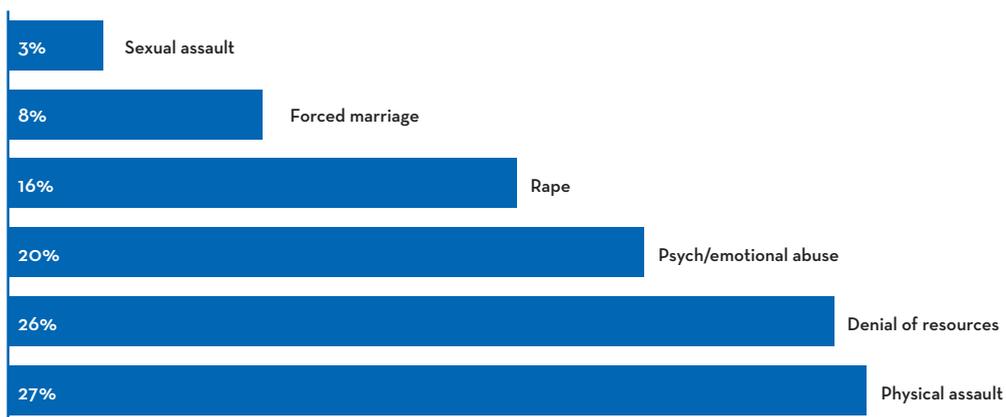
Source: Displacement Tracking Matrix<sup>23</sup>

**Table 2** Number of IDP sites and IDPs disaggregated by state.

State	Camp/Camp-like settings			Host Communities			Total No. of IDPs	Total No. of Sites
	No. of IDPs	Sites	% Sites	No. of IDPs	Sites	% Sites		
Adamawa	11,873	26	9%	180,661	454	22%	192,534	480
Bauchi	1,705	7	2%	62,682	369	18%	64,387	376
Borno	783,215	224	80%	684,693	460	22%	1,467,908	684
Gombe	N/a	N/a	N/a	36,872	203	10%	36,872	203
Taraba	13,874	11	4%	71,458	218	10%	85,332	229
Yobe	12,641	13	5%	120,362	398	19%	133,003	411
<b>Total</b>	<b>823,308</b>	<b>281</b>	<b>100%</b>	<b>1,156,728</b>	<b>2,102</b>	<b>100%</b>	<b>1,980,036</b>	<b>2,383</b>

Source: Displacement Tracking Matrix<sup>23</sup>

**Figure 2** Types of GBV reported in the North East Nigeria in 2018.



Source: GBVMIS<sup>34</sup>

physical, mental and sexual assault. SGBV occurs within IDP camps and host communities and is driven by limited access to services, lack of protection for vulnerable women and disruption of livelihood.<sup>21</sup> In 2019 alone, about 3 million people were estimated to be in need of protection from SGBV in North-East Nigeria.<sup>22</sup>

The insurgency in North-Eastern Nigeria accounts for 93% of the documented displacements and communal clashes account for 7%.<sup>23</sup> Borno had the highest proportion of IDPs (80%) in 2019 (table 2, p. 16).

## OVERVIEW OF SGBV

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*”.<sup>24</sup> CEDAW revised the definition to reflect the fact that SGBV affects women disproportionately. The five forms of violence; sexual, physical, economic, emotional and psychological, and harmful traditional practices are strongly driven by gendered power relationships and social roles ascribed to males and females in the society.<sup>25</sup> Violence Against Women (VAW) is rooted in unequal power relations that strengthen the social mechanisms and norms which drive women into subservient positions compared to men.<sup>26</sup> This implies that although GBV affects men and women, the risk is much higher for women and this is reflected in the reference to Violence Against Women and Girls (VAWG) by the UN.

The United Nations defined Violence Against Women (VAW) as “*[...] a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men*”.<sup>26</sup> These definitions highlight the fact that SGBV is rooted in gender inequalities between men and

women and power dynamics imposed by social norms, culture and behaviour. It is reinforced in societies and contexts where traditional gender roles and patriarchy disempowers the woman, increasing their vulnerability to violence.

## 1. FORMS/MANIFESTATIONS OF SEXUAL AND GENDER-BASED VIOLENCE

There are several forms or manifestations of SGBV and they can be grouped into the following five categories.<sup>27</sup>

- **Sexual Violence:** This includes attempted or actual non-consensual sexual acts, sexual harassment, exploitation, unwanted sexual comments or advances directed, against a person by another person regardless of the relationship to the victim at home, work or other settings.
- **Physical Violence:** This refers to intentional use of any form of physical force that can result in death, injury or harm. It usually involves the use of one’s body size, strength or weapons against another person.
- **Emotional and psychological violence:** This refers to actions that are directed at damaging self-esteem and self-identity of an individual and can involve intimidation, threats of abandonment, surveillance, isolation, verbal abuse, aggression, threats and humiliation.
- **Harmful traditional practices:** This includes traditional practices that are done to a person’s body with no therapeutic purpose but for socio-cultural reasons and which have harmful consequences on health, wellbeing and human rights. These harmful traditional practices include early/forced marriages, FGM/C, and widowhood rites.
- **Economic violence:** Economic violence involves obstructing a person’s access to resources or independent economic activity to ensure that the person is financially dependent on another person. This also involves denial of resources, denial of food, shelter, basic needs and control of access to health care, employment.<sup>28,29</sup>

## 2. SGBV IN CONFLICT SETTINGS (NORTH-EAST NIGERIA)

With the on-going conflict in the North East region, SGBV is reported to have escalated significantly since 2013.<sup>30</sup> A UN Interagency Humanitarian Needs Assessment highlighted SGBV among the top problems faced by IDPs and there are reports of women and girls experiencing forced and early marriage, physical, mental and sexual assault.<sup>31</sup> The experience of violence in North-East is presumed to be grossly underreported due to socio-cultural reasons.<sup>21</sup> Traditional norms that favour male dominance, weak community sanctions for SGBV and values that tolerate violence against women are potential drivers of SGBV.<sup>32</sup> The protracted conflict in Borno state has resulted in the killing and abduction of male heads of household by terrorists; this has resulted in women being more vulnerable to SGBV due to the changing dynamics of gender roles in IDP camps and host communities occasioned by the killing of their spouses.<sup>33</sup> These female household heads who have the responsibility for feeding and protecting their families are vulnerable to sexual exploitation and abuse (SEA) in exchange for resources (money, food, assets) and this has been reported to occur in IDP camps.<sup>33</sup> In 2018, 16% of the households in Borno were reported to be headed by women; Maiduguri and Jere LGAs, where IDP camps are located, reported 40% and 34% female household heads respectively.<sup>34</sup>

Overall, the types of GBV reported to service providers in the North East Nigeria in 2018 are summarized in figure 2 (p. 16).

## 3. REPORTING OF RAPE INCIDENTS

In 2018, rape constituted 16% of GBV cases reported to service providers in the North East; about 53% of those who reported rape visited a health service provider or was referred to one, irrespective of their time of reporting.<sup>34</sup> In Yobe, Adamawa and Borno states, 43%, 45% and 50% of rape survivors accessed health service providers or

were referred to one respectively.<sup>34</sup> In the North East, among women who reported being raped, 28% went in to the clinics within 72 hours. In Borno, 60% of rapes were reported after a month, and 17% were reported within 72 hours. This is compared to 32% in Adamawa and 80% in Yobe.<sup>34</sup> The large-scale violence and displacement occurring in Borno state may account for some of the delays survivors experienced in reporting rape and seeking care.

## POLICY CONTEXT OF SGBV IN NIGERIA

Nigeria's legal system ratifies the following human rights treaties that promote women's rights:

- Universal Declaration of Human Rights (UDHR), 1948.
- Convention on Elimination of all forms of Discrimination Against Women (CEDAW) 1979 and its operational protocol (Nigeria ratified it in 1985).
- Declaration on violence against Women, 1993
- Protocol to the African Charter on Human and People's Rights of Women in Africa, 2003.
- Childs Right Act, 2003.

By ratifying and signing these treaties, Nigeria like many other countries has a legal obligation to protect women and enforce these conventions. However, the effectiveness of these treaties is limited until the country domesticates them and passes them into law. Nigeria has multiple laws relating to the protection of women from violence, they vary across the country and have limitations in interpretation and implementation.

## 1. LEGAL FRAMEWORKS ON SEXUAL VIOLENCE IN NIGERIA

### 1.1. THE CONSTITUTION, HUMAN RIGHTS AND SEXUAL VIOLENCE

Section 34(1)(a) of the 1999 Constitution of the Federal Republic of Nigeria (CFRN) states that *every person has a right to dignity of person and*

as such shall not be subject to torture, inhuman or degrading treatment. This aligns with article 5 of the UDHR which indicates that no one should be subjected to torture, degrading or inhuman treatment.<sup>35</sup> While the CFRN generally provides for the protection of women's rights, it has been reported to be inadequate because it does not specify acts that constitute breach of human dignity and torture and leaves room for ambiguity.<sup>36</sup> The constitution gives powers and consideration for customary laws in family matters especially in cases of domestic violence. In addition, the law stipulates that cases of rape should be filed within two months of occurrence and failure to do so automatically makes the perpetrator unanswerable in the court of law potentially allowing sexual offenders to get away with the crime.<sup>37</sup>

## 1.2. THE CRIMINAL JUSTICE SYSTEM

In addition to the Nigerian Constitution, women's rights are also protected by the two separate criminal justice systems namely; the penal code which applies in 19 states in Northern Nigeria (including the Federal Capital Territory) and the criminal code which applies in 17 states in Southern Nigeria.

## 1.3. THE CRIMINAL CODE

The criminal code applied in the western states in Nigeria also has provisions against SGBV. Section 357 of the code describes rape thus:

*“Any person who has unlawful carnal knowledge of a woman or girl, without her consent, or with her consent, if the consent is obtained by force or by means of threats or intimidation of any kind, or by fear of harm, or by means of false and fraudulent representation as to the nature of the act, or, in the case of a married woman, by personating her husband, is guilty of an offence which is called rape.”*

The code stipulates that the punishment for the offence of rape is life imprisonment with

or without caning while that of attempted rape (felony) is fourteen years imprisonment with or without caning. It also states that any person who unlawfully and indecently assaults a girl or woman is guilty of misdemeanor and liable to 2 years imprisonment. Section 218 of the code highlights issues around defilement of girls under the age of 13 years. It states – *“Any person who has unlawful carnal knowledge of a girl under the age of thirteen years is guilty of a felony and is liable to imprisonment for life, with or without caning”*. An attempt to defile or have carnal knowledge of girls under 13 years of age is also punishable with 14 years of imprisonment with or without caning. The prosecution of perpetrators for defilement or attempted defilement of girls under the age of 13 years is expected to commence within two months of the act and corroborated with the testimony of at least one witness, for the perpetrators to be convicted. This portion of the code has received criticisms because two months might be too short for victims of sexual violence to be psychologically stable for court proceedings, perpetrators might still be at large within two months and it is impracticable to have witnesses in cases of rape and sexual violence as it is clandestinely perpetuated.<sup>37</sup>

## 1.4. THE PENAL CODE (SHARIA PENAL CODE)

The penal code is applicable in the 19 northern states in Nigeria and has provisions against SGBV. According to section 282 of the penal code, rape is said to occur where a man has sexual intercourse with a woman in any of the following circumstances:

- a. against her will
- b. without her consent
- c. with her consent, when her consent has been obtained by putting her in fear of death or hurt.
- d. with her consent when the man knows that he is not her husband and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married.

- e. with or without her consent, when she is under fourteen years of age or of unsound mind.

The punishment stipulated for rape in the penal code is milder (14 years imprisonment) when compared to that stipulated under the criminal code (life imprisonment). This has been argued to be too mild to serve as deterrence for perpetrators.<sup>36</sup> The penal code is however more protective of the girl-child against rape and sexual offences than the criminal code. For example, while section 221 of the criminal code regards sexual violation of a girl above 13 years, but below 16 years as mere defilement —a misdemeanour punishable with 2 years' imprisonment with or without cane, the penal code considers sexually violating a girl under 14 years as rape punishable by 14 years imprisonment.

The penal code does not recognize marital rape. It also permits wife-beating because it considers it as an attempt for the husband to “correct” his wife, provided it does not result in physical injury. Section 55(1) of the penal code states that

*“Nothing is an offence which does not amount to the infliction of grievous hurt upon any person and which is done...by husband for the purpose of correcting his wife such husband and wife being subject to any native law or custom in which such correction is lawful.”*

Under the penal code, acts of gross indecency attract a jail term of seven years with an option of fine while incest attracts a term of imprisonment which may extend to seven years. Other provisions of the penal code include:

- An individual becomes an adult at puberty. This implies a girl child who attains puberty at an early age can be given out in marriage which gives room for the abuse of her right.
- A man is permitted to dissolve marriage after repudiating his wife 3 times. By this, many women are rendered single mothers as ease of dissolving marriage is high.

→ The code permits husbands to admonish (beat) their wife provided it doesn't inflict physical injury on her. There must be a threat to death or hurt before a man can be arraigned for rape. This leaves women to suffer domestic violence without seeking redress in court as evidence gathering is not easy.

It is noteworthy that both penal and criminal codes do not recognize marital rape and are silent about the punishment for sexual offences that result in death of the victim.

### 1.5. THE CHILD RIGHTS ACT (CRA)

The Child Rights Act which was enacted in 2003 and recognizes a child as person under the age of 18 years, in alignment with United Nations Convention on Rights of Child (1989). It also provides for the protection of the girl-child against SGBV. For example, section 23 of the CRA imposes a fine of N 500,000 or imprisonment for a term of 5 years for:

- Anyone who marries a child.
- Anyone who a child is betrothed to.

The CRA also maintains that anyone who engages in sexual intercourse with a girl-child with or without her consent is guilty of rape and liable to life imprisonment upon conviction. The act also forbids all forms of sexual abuse, exploitation, prostitution and child labour and empowers the child with the right to sue his or her parents for any unlawful damage done to him or her before, during and after his or her own birth. As at 2019, only 24 states in Nigeria have domesticated the CRA. The CRA has been domesticated in 4 northern states namely Kwara, Jigawa, Nasarawa, Plateau and Taraba and is yet to be domesticated in 12 northern states including Borno State.<sup>38</sup>

## 1.6. VIOLENCE AGAINST PERSONS PROHIBITION ACT (VAPP)

The Violence Against Persons Prohibition (VAPP) Act was developed to fill the existing gaps in penal and criminal codes in protecting the rights of women against violence. It began as violence against women bill in 2002 but the nomenclature was changed to make it gender neutral. The Act which is composed of 47 sections, six parts and a schedule was passed into law in May 2015. The act defines violence as *“any act or attempted act, which causes or may cause any person physical, sexual, psychological, verbal, emotional or economic harm whether this occurs in private or public life, in peace time and in conflict situations”*. The act addresses issues of rape, physical injury, spousal battery, harmful traditional and widowhood

practices. It also prohibits female circumcision, forceful ejection from home, abandonment of spouses, children and other dependents without sustenance. The law prescribes punishments for these offences ranging from 2 years imprisonment (with an option of fine) for presenting false information to the judiciary to life imprisonment for certain cases of rape. The act provides for issuance of protection order for victims of domestic violence, compensation for rape and the establishment of a sexual offences register. The application of the law is only limited to the Federal Capital Territory (FCT) because it has not been domesticated in other states.<sup>39</sup> The act stipulates that a person over 14 years who is convicted of an offence of rape is liable to imprisonment for life. A summary of agreements on SGBV and SEA adopted at federal level in Nigeria is listed in table 3.<sup>38</sup>

**Table 3** Summary of Agreements on GBV and Sexual Exploitation and Abuse Adopted at Federal Level in Nigeria.

Title of Agreement	Year Adopted	Description	Ratification Status
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	1979	<ul style="list-style-type: none"> <li>→ Adopted in 1979, but the general recommendation 19 on violence against women was not adopted by the CEDAW committee until 1992. It recognizes GBV as a form of discrimination and recommends that states take measures to prevent and respond to violence against women.</li> <li>→ Article 6 calls for states to “suppress all forms of trafficking and exploitation of prostitution of women.”</li> </ul>	Although the federal government ratified this in 1985, the Nigerian constitution requires domestication through adoption by the National Assembly and State Houses of Assembly.
African Charter on Human and People’s Rights	1981	<ul style="list-style-type: none"> <li>→ Calls for the elimination of discrimination against women and protection of the rights of women and children.</li> <li>→ Prohibits all forms of exploitation, particularly slavery.</li> </ul>	Ratified in 1983.
Convention on the Rights of the Child	1989	<ul style="list-style-type: none"> <li>→ Defines a child as a person under age of 18.</li> <li>→ Commits state parties to protecting children from all forms of mental and physical violence, as well as sexual exploitation, child marriage, abuse, harmful traditional practices and prostitution.</li> </ul>	Ratified in 1991.
Africa Union Charter on the Rights and Welfare of the Child	1990	<ul style="list-style-type: none"> <li>→ Defines a child as a person under the age of 18.</li> <li>→ Commits states to protecting children from physical and sexual abuse.</li> </ul>	Ratified in 2000.
Rome Statute of the International Criminal Court	1998	<ul style="list-style-type: none"> <li>→ Recognizes a spectrum of GBV as war crimes and crimes against humanity, including rape, sexual slavery, forced prostitution, and forced sterilization.</li> </ul>	Ratified in 2001.
Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (Maputo Protocol)	2003	<ul style="list-style-type: none"> <li>→ Calls on states to protect rights of women and girls, such as property rights, rights to a consensual marriage, protection against child marriage, widows’ rights, inheritance rights and protection against all forms of violence.</li> </ul>	Ratified in 2004.

**Table 4** Progress Report (January-October 2017) of number of people reached.

Response type	Reach
No. of partner, government and UNHCR staff trained on SGBV prevention and response	426
No. of PoC trained on SGBV prevention and response	3,339
No. of Military, Police and CJTF trained	210
No. of awareness raising campaigns on SGBV prevention and response conducted	104
No. of people reached through awareness raising campaigns on SGBV prevention	26,400
No. of community-based committees/groups working on SGBV prevention and response	15
No. of survivors benefitting from case management	1,639
No. of reported SGBV incidents for which survivors receive psychosocial counselling	560
No. of reported SGBV incidents for which survivors are provided with a safe shelter	15
No. of woman safe spaces established	2
No. of women and girls provided with sanitary and dignity kits	10,964
No. of SGBV survivors and those at risks, accessing livelihood programmes	608
No. of formerly abducted women and girls provided PSS and material assistance	2,637
No. of SGBV survivors accessing legal services	226
No. of perpetrators arrested and undergoing trial	109
No. of perpetrators convicted	58

Source: UNHCR SGBV report (January-December 2017).

**Table 5** Progress report (January-July 2019) of number of people targeted, reached and percentage coverage.

Indicators	Target	Reached	Coverage
Provision of specialized response service for GBV	209,441	59,085	28%
Service provision through Women and Girls friendly spaces (WGFS)	40,000	43,587	109%
Empowerment, skills building & livelihood	35,000	19,124	55%
Community engagement & sensitization	805,559	291,780	36%
Functional GBV referral mechanisms/pathways	200,000	174,265	87%
Socio-economic assistance for women/girls formerly associated with armed forces	7,000	387	6%
Capacity building on GBV Integration- GBV mainstreaming/risk mitigation	1,500	1,514	101%

Source: GBVSS Situational update<sup>22</sup>.

## INTERVENTIONS FOCUSED ON ADDRESSING SGBV IN NORTH-EASTERN NIGERIA

There are a wide range of actors from the government and NGOs at federal and state levels that have synergized efforts to respond to SGBV in the North East. In 2014, the Federal Ministry of Women Affairs and Social Development (FMWASD) which leads the coordination response partnered with UNFPA (the UN lead in the GBV humanitarian response) to create a specific GBV Sub-sector (GBVSS) for the North-East and areas affected by insurgency.

Similarly, the Call to Action on Protection from Gender-based Violence in Emergencies (Call to Action) is a global initiative that was launched in 2013 to ensure that every humanitarian response program right from design/inception provides safe and comprehensive services for SGBV survivors and reduces the risks of SGBV. Call to Action stakeholders include conflict affected states, donors, international organisations and non-governmental organisations. As a way of synergizing efforts in the GBV response, a 4-year roadmap; the Call to Action Roadmap (2016 - 2020) which provides an operational framework was developed globally. In Nigeria, the FMWASD and members of the Call to Action committee working in the North East piloted the development of a two-year Road Map for Borno, Adamawa and Yobe.<sup>40</sup> The Government of Nigeria through its 2018 Humanitarian Response plan, identified Protection and Gender as part of its top three priorities and considered the implementation of the Call to Action roadmap as critical in achieving the plan.

The Road Map highlights 5 intervention areas of focus for 2018-2019. These are:

- Strengthening coordination to ensure a timely, accountable, holistic, inter-sectoral approach to preventing and responding to SGBV.
- Improving access to quality services for survivors by ensuring that sufficient and timely

access to these services is an essential component of the humanitarian response.

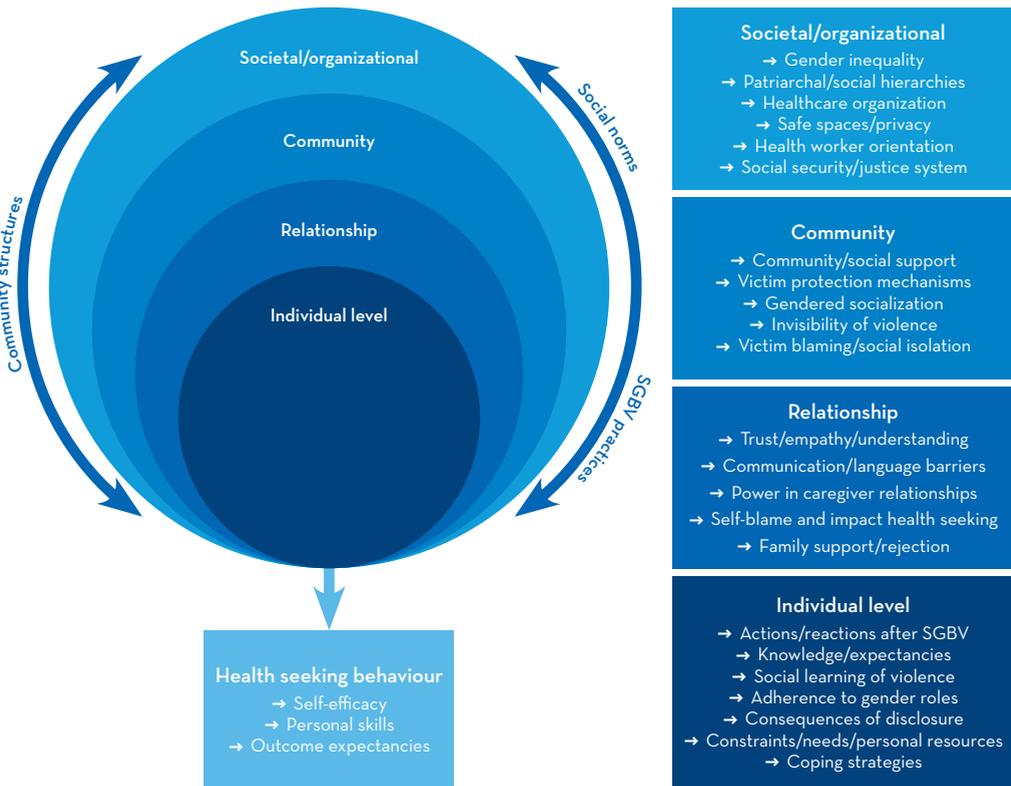
- Services that have been provided include access to justice, capacity building, community engagement, GBV case management, Medical care, skills building and empowerment, provision of dignity and risk mitigation kits. Others are psychosocial support, material support and legal assistance.
- Strengthening the capacity and expanding the engagement of local partners to improve GBV prevention and response efforts.
- Securing sufficient funding for GBV programming through improved coordination and advocacy.
- Engaging actors in the security sector to improve GBV prevention and response.

Overall, about 1.3 million individuals were targeted for the GBV response in 2019, and as of These citations are stated below July 2019, 590,499 individuals had been reached with GBV prevention and response services.<sup>22</sup>

## STUDY RATIONALE

Utilization of SGBV interventions such as medical and psycho-social support services is low in IDP camps, likely due to lack of survivors' awareness of any services, in addition to the stigma associated with sexual violence, insufficient trust in governance structures, and lack of self-efficacy for initiating conversations about SGBV with health providers. The context of SGBV in the North East of Nigeria is poorly understood, and evidence-based strategies to address the medical and psycho-social recovery needs of survivors are urgently needed. This study was conducted to document the barriers to access to medical and psycho-social support services for SGBV survivors in Borno state, Nigeria, especially during the critical 72 to 120 hours after assault, for CMR, to provide recommendations for the development of interventions to address both primary and secondary prevention needs among groups vulnerable to SGBV.

Figure 3 Theoretical Framework.



## THEORETICAL FRAMEWORK

The theoretical framework in figure 3 was drawn from the ecological model.<sup>41</sup> The approach was adopted in this study to explore the interaction of individual, community and institutional factors in SGBV. It explains risk or protective mechanisms at different levels that can be explored to improve programmatic strategies for addressing SGBV. Additionally, the theory of gender and power explains the social structures that depict the gendered relationships assumed by men and women are the sexual division of labour, sexual division of power and the structure of cathexis.<sup>42</sup> The social cognitive theory explores the influence of a person's experience, the actions of others and the socio-cultural context on the personal adoption of health behaviours.<sup>43</sup> These social structures that articulate the power imbalance in the subjugation of women shape social norms maintained as society evolves. They underpin gender relations and produce gendered inequities that constrain women's capacity to achieve social and economic independence.

## STUDY GOALS AND OBJECTIVES

The goal of this study is to understand the factors preventing sexual violence survivors to reach medical and PSS services, especially within the critical 72/120-hour window for CMR. The specific objectives are to:

1. Explore the barriers to survivors accessing medical and PSS services in MdM intervention sites.
2. Explore the context of access to health services (opportunities and health seeking behavior) for IDPs and host communities in MdM intervention areas.
3. Explore the context of socialization, gender role enactment and perceptions about SGBV in the study sites in order to understand their association with timely access to CMR.
4. Explore utilization patterns of CMR services by SGBV survivors presenting at MdM clinics.
5. Make recommendations for improving the quality of SGBV service provision in Borno state.



# METHODS

**Table 6** Study Sites: (IDP camps, size, and structure).

Camps	Camps sizes	Occupants	Languages
Kawarmaila	2,500 Majority women and children	IDPs are Kanuri from Northern Borno (Bama, Konduga), with others from Dikwa, Mafa, and Damboa; camp occupants as well as the host community are conservative Sunni Muslims.	Kanuri and Hausa
Garba Buzu	6,000 IDPs Majority women and children	IDPs are from Mafa, Konduga, Dikwa, Bama, Gwoza, Monguno, and Gubio; most are Hausa Muslims, while others are Kanuri Muslims.	Hausa and Kanuri
Elmiskin	4,793 IDPs Majority women and children	IDPs are Fulani and Shuwa Arabs, with a few Kanuris, from Marte, Mafa, Bama, Jere, and Gwoza LGAs; before displacement they worked as herdsmen, farmers, and small traders.	Hausa and Shuwa
Hausari	Camp population. 13,402 IDPs Majority were women and children	Most IDPs were displaced from villages around Damboa, while the first group was from Chibok LGA; the camp has become densely populated as more villages around Damboa LGA have been displaced.	Margi, Hausa and Kanuri

**Table 7** List of attendees.

Attendees
Four (4) female RAs
Three (3) Population Council staff
Five (5) MdM staff (attended on different days)
One (1) representative of the State Primary Health Development Agency (SPHCDA)
One (1) representative of the Reproductive Health and Family Planning unit (SPHCDA)
One (1) representative of Network of Civil Society Organizations, Borno state (NECSOB)

**Table 8** Interview participants from IDPs/host communities.

Description	Age	Details
Youth	16-19	Female
Youth	20-24	Female
Youth	16-19	Male
Youth	20-24	Male
Younger Women	25-35	–
Younger Men	25-35	–
Older Women	Above 35	–
Older Men	Above 35	–
Community leaders (religious)	n/a	Imams, Pastors
Community leaders (women)	n/a	Women group leaders, Market women leaders/ secretary
Community leaders (youth)	n/a	Leaders/presidents/ secretary
Community leaders (traditional)	n/a	–

**Table 9** Data Collection activities.

Activity	Projected	Status	Comments
KIIs with stakeholders	10	9	Unable to find additional participants. Activity Completed
IDIs with survivors who accessed care	10	8	Unable to find additional participants. Activity Completed
IDIs with survivors who did not access care	10	7	Unable to find additional participants. Activity Completed
IDIs with family members	10	7	Unable to find additional participants. Activity Completed
KIIs with service providers	10	12	Activity Completed
FGDs with community leaders and members	12	14	Activity Completed
<b>Total</b>	<b>62</b>	<b>57</b>	–

## STUDY DESIGN

Using narrative qualitative research approach, in-depth interviews (IDI) were conducted to explore narratives of SGBV survivors to understand the context of SGBV (including their knowledge of SGBV, disclosure, and experiences with disclosure, consequences, coping mechanisms), perceptions about services available, facilitators and barriers to access in three LGAs—Damboa, Maiduguri, and Jere. IDIs were conducted among self-identified SGBV survivors who had previously accessed services, as well as those who had never accessed services. Their verbal narratives were supported using photo narratives, field notes and observations to facilitate expression and meanings. Family members and caregivers of survivors willing to speak about issues relating SGBV within their communities and families also participated in IDIs. FGD sessions were conducted among community members to explore social norms facilitating SGBV in the camp settings and host communities. MdM community partners in Maiduguri and Jere LGAs assisted in FGD recruitment, while MdM volunteers recruited participants in Damboa LGA. Finally, the Key Informant Interviews (KIIs) obtained service providers' and stakeholders' perspectives of SGBV contexts and the barriers survivors confront in seeking help.

## STUDY SITE

The study was conducted in Borno State, North-Eastern Nigeria. Specifically, Kawarmaila and Garba Buzu in Maiduguri Local Government Area, Elmiskin camp in Jere Local Area, and Hausari camp in Damboa Local Government Area. These four sites where MdM interventions operated had a combined population of over 26,000 IDPs (table 6, p. 28).

## TRAINING OF RESEARCH ASSISTANTS

Data collection commenced in July 2019 and was completed by October 31, 2019. A six-day training workshop in Maiduguri, from July 2 to 9, 2019, introduced the four research assistants (RAs) to the study's objectives, the study population, concepts of SGBV, principles of qualitative research, research ethics, interview techniques, security, and confidentiality in sensitive research. The training was attended by the Council research team, MdM staff, and other stakeholders (table 7, p. 28). To ensure efficient and effective learning, various methods facilitated the sessions: PowerPoint presentations, demonstrations, group work, and role play. Vignettes for FGDs were developed during training, with insightful contributions from government representatives, community partners and MdM. Special sessions on security during fieldwork, referrals, and ethical sensitivity for working with survivors of SGBV were handled by MdM clinical and security teams.

The guides were tested in Ekklesiyar Yan'uwa a Nigeria (EYN) camp in Wulari area of Maiduguri, Borno state, on July 8, 2019. This test created an opportunity for data collectors to familiarize themselves with administering the guides in the local language, to understand the dynamics of the interview process, and to identify any challenges that may arise with translated guides during the actual study.

## SAMPLING TECHNIQUES

### 1. SELECTION OF RESEARCH PARTICIPANTS

#### *IDs with survivors, family members, and caregivers*

SGBV survivors who had not accessed services from an MdM clinic were recruited through local MdM partners already working in the community to provide support. These community partners working with MdM were informed about the

project by providing them with an overview of the project's aims, orientation on willing survivors' recruitment and voluntary participation, risks, benefits, and strict confidentiality measures. Local partners informed survivors that their participation was entirely voluntary and that if they declined their participation it would not affect any services they received. Family members and caregivers were recruited through MdM clinics and local partners, following similar procedures.

SGBV survivors who had accessed services were recruited through service providers at MdM clinics. SGBV survivors who received MPSS and appropriate referrals, to a wide range of clinical and support services for SGBV, were asked during their follow up visits if they were willing to participate in the study. Between June and July 2019, potential participants willing to participate were referred to the Council researchers. The IDI guides were written in English, translated to Hausa or Kanuri, and tested prior to use.

### *FGDs with community leaders and members*

FGDs were conducted among community leaders and members in the three LGAs, who were recruited through identified groups (such as women's or youth groups) with the aid of community partners as shown in table 8 (p. 28). To facilitate freedom of expression, groups were homogenous in terms of gender and age ranges. Recruited participants were at least age 16 and older.

FGDs explored social norms, gender roles, help-seeking behaviors, consequences of SGBV disclosure, community support mechanisms, and knowledge of SGBV within the four communities. Vignettes were developed in the local language during the training workshop by the Council research team, with support from community partners, for RAs' use in FGDs.

### *KIIs with stakeholders and service providers*

KIIs documented stakeholder perspectives to provide context for SGBV in Borno state, while

KIIs with service providers in MdM and non-MdM Clinic sites in Maiduguri, Jere, and Damboa LGAs provided their perspectives about the structure of service delivery, CMR service utilization, support available for SGBV survivors, and potential barriers to access. The Council team first contacted clinic administrators to notify providers who had been working in MdM clinics that the Council was seeking information on SGBV survivor services for at least six months and (for those willing) obtained their permission for KIIs. The KII guides were written in English and tested prior to use. The breakdown of data collection activities is provided in table 9 (p. 28).

### *Collation of service statistics*

Anonymized service data, through existing MdM documentation mechanisms, were obtained from GBV weekly compilation forms at four (4) MdM clinics (Garba Buzu, Kawarmaila, Elmiskin and Hausari clinics) selected for this study. A weekly GBV compilation form collates data on services provided to survivors, and referrals, with survivor codes, generated to indicate the types of services provided, specific clinic codes, and serial number. The study collated service statistics from January 2018 to July 2019. There are no personal identifiers on the GBV compilation forms. The Emergency Response facilities were not included among the service data collated.

## **2. INSTRUMENTS**

The study utilized multiple instruments—guides for the KIIs, Vignettes (FGDs), IDIs as well as service statistics collation. The KII guides contained questions targeted at documenting stakeholders' and service providers' perspectives on the context for SGBV in Borno State, the structure of service delivery, CMR service utilization, support available for SGBV survivors and the potential barriers to access.

The FGDs used vignettes to explore social norms, gender roles, help-seeking behaviours, available support mechanisms, coping mechanisms, gender

and power dynamics, consequences of SGBV disclosure and the knowledge of SGBV within the communities.

The IDI guides for survivors who had previously accessed care, survivors who never accessed care, and family members or caregivers targeted social construction and representation of a woman, survivor's experiences with SGBV, perceptions on barriers to help-seeking, facilitators and barriers to timely access.

### 3. DATA COLLECTION

#### *Data Collection Challenges*

1. **Recruitment:** Recruitment of survivors was challenging and time-consuming. MdM clinical teams and partners were extremely supportive during the process. Survivors who did not access care were more difficult to reach, but were recruited through MdM community partners
2. **Logistics:** Some family members and caregivers complained of distances to the clinic or interview venue, and this hindered the participation of some eligible participants.
3. **Farming Season:** FGD sessions with community leaders and members were difficult to schedule because field activities occurred during the planting season.
4. **Security:** The research team was guided by a strict security protocol that mandated daily updates on the security situation in Borno state. Although the research team did not experience security issues, in some instances field visits were cancelled as a precaution.

### DATA MANAGEMENT AND ANALYSIS

#### 1. QUALITATIVE DATA ANALYSIS

FGD, KII, and IDI audio recordings and transcripts were stored on password-protected

computers in folders on a secure network. Data analysis was planned for three phases:

- The first phase entailed analysis of FGDs to provide an understanding of SGBV contexts
- The second phase comprised an analysis of IDIs with survivors who were not part of the FGDs to provide an understanding of help-seeking behaviour, barriers to timely access, social support mechanisms, and coping strategies after SGBV, and
- The third phase consisted of analysis stakeholder and service provider KIIs to identify barriers to timely service access as well as recommendations for improving services.

Each phase involved three intermediate stages. The first stage was data familiarization, the second stage was the development of a codebook by a team of researchers, using a hybrid approach drawing from the study theoretical framework and emerging themes. The final stage was coding, extraction of themes, and report writing. NVIVO 12 was utilized to organize the data for analysis.

### ETHICAL CONSIDERATIONS

Due to the sensitive nature of SGBV research, strict measures ensured participant confidentiality. This research was informed by WHO guidelines on research on sexual violence in emergencies. Participation in this study was voluntary, and informed consent was obtained from every participant. The study teams received training on privacy/confidentiality, safety, security, gender norms, and referral of SGBV survivors for services. No personal information was obtained from any participant. Prior to the study a protocol was developed and submitted to the Population Council's IRB as well as the University of Maiduguri Teaching Hospital Health Research Ethics Committee, for the independent reviews and approvals.



# RESULTS

**Table 10** Demographics of KII/IDI participants.

Variables		IDIs: Survivors (n=15)	IDIs: Caregivers (n=7)	KIIs: Stakeholders (n=9)	KIIs: Service Providers (n=12)
Gender	Male	-	3	4	3
	Female	15	4	5	9
Age	16-19	4	-	-	-
	20-24	2	-	1	1
	≥ 25	9	7	8	11
Marital Status	Single	7	-	1	5
	Married	7	5	8	5
	Widow	1	2	-	2
Education	None	6	1	-	-
	Primary	4	5	-	-
	Secondary	4	-	-	-
	Arabic	1	1	-	-
Religion	Tertiary	-	-	9	12
	Muslim	13	7	4	4
	Christian	2	-	5	8
Occupation	Unemployed	8	-	-	-
	Employed	5	6	9	12
Ethnic group	Hausa	1	-	-	-
	Kanuri	3	4	4	-
	Igbo	-	-	-	1
	Yoruba	-	-	1	2
	Marghi	5	1	1	2
	Gwoza	3	2	-	-
	Minority ethnic groups	3	-	3	4
Not indicated	-	-	-	3	

**Table 11** Demographics of FGD participants.

Variables	FGD members		FGD community leaders		
	Male	Female	Male	Female	
Age	16-19	12	10	-	9
	20-24	8	14	-	2
	≥ 25	20	36	20	9
Marital Status	Single	20	21	-	12
	Married	20	37	20	8
	Widow	-	1	-	-
	Divorced	-	1	-	-
Education	None	3	29	-	12
	Primary	11	17	-	3
	Secondary	13	14	3	5
	Arabic	13	-	15	-
Religion	Tertiary	-	-	2	-
	Muslim	40	40	20	20
Occupation	Christian	-	20	-	-
	Unemployed	1	25	1	2
	Employed	23	29	19	15
	Not Indicated	16	6	-	3
Ethnic group	Students	6	6	-	-
	Hausa	1	3	7	-
	Kanuri	16	11	13	10
	Gwoza	-	20	-	2
	Shuwa Arab	5	-	6	-
	Bahuse	8	-	-	-
	Mulgua	2	4	-	-
Minority ethnic groups	2	12	-	8	
Not indicated	-	10	-	-	

## PARTICIPANT DEMOGRAPHICS

Demographic profiles of research participants are described in tables 10 and 11 (p. 34).

## SOCIAL NORMS EXPLORATION

This section presents the findings of the social norms exploration with community members and leaders.

### 1. DRIVERS OF SGBV

#### 1.1. CULTURE OF SILENCE

Silence was considered the normative way survivors responded to rape in their communities. Some older men and women leaders believed that the issue of rape was too sensitive to discuss, and women were expected to be silent on rape. The majority of community leaders and members believed that keeping silent about rape was the best way to protect the survivor and her family from being shamed, experiencing stigma and ostracism. A survivor's entire family is usually blamed if disclosure of rape occurs. In addition, some community leaders reported that they were cautious about issues relating to disclosure of rape because they perceived the perpetrator may be a victim of false accusation as rape was difficult to prove.

*"...We agree, they should keep quiet and not talk..."*

– FGD\_2, Older men

*"...If she talks about it, she will put herself to shame. She will also put her people/relatives to shame."*

– FGD\_1, Women Community Leader

*"She will not be able to mention the issue because she will feel weak and when she mentions it, she will be disturbed, it brings a lot of shame and people will laugh at us."*

– FGD\_1, Community Leader

*"...If they should voice out the issue of rape, it would be seen as lies and the person would say it was an allegation because of that she would be beaten because it would be assumed that she had told lies against the man and would be sent out of the house."*

– FGD\_8, Community Leader

Contrary to the views of older community leaders and members, the majority of female youths across the camps expected rape survivors to find ways of speaking up without disclosing their identities. They opined that if survivors kept silent, they will not have access to justice and healthcare. They understood that rape was associated with negative health outcomes such as infections and unplanned pregnancy that can only be prevented if survivors had access to information and care. Some male youth reported that religion and the rule of law did not support the concealing of SGBV because it constituted a violation of human rights.

*"I have learned to speak out and even if this happened to someone, even when you are asked not to talk about the issue, you don't have to be silent."*

– FGD\_13, Young women

#### 1.2. COVER UP OF RAPE

In addition to keeping silent about rape, some participants reported that even when it was disclosed to close family and friends, the consensus was usually to cover it up. Some participants expressed that the cover-up of rape was reinforced by the fact no one saw it happen and was best treated as a secret. Reasons for cover-up included protection for the family, fear of false accusation, fear of family rejection and fear of divorce, victim blaming and stigmatisation. Some male participants reported that they would divorce their wives if they discovered that had been raped. The majority of older women and men believed that it was more appropriate to cover up rape to protect the family image and prevent community backlash and family shaming. Although youth felt keeping silent about rape denied survivors

of healthcare, they acknowledged that cover up was necessary to preserve respect and future prospects of marriage.

*“Everybody would want to cover up their secret.”*

– FGD\_1, Women Community Leader

*“Keeping secrets is a good quality of a respectable person in society, people are socialized to keeping one’s secret with the belief that God will do the same to them.”*

– FGD\_10, Young men

*“Those that will hide this are more because most parents on hearing their daughters have been raped, it is very hard for her to get a husband, that is why they will do the best to hide it so that people will not hear this...”*

FGD\_10, Young men

### 1.3. POOR DECISION-MAKING POWER OF WOMEN

Women were not empowered to make decisions about key life issues such as the choice of a spouse. When asked if it was right for parents to make spousal choice for their daughters, some community leaders reported that girls could not decide on spousal choice because they were young and unwise. In addition, some male community leaders reported that parents make spousal choice for women because women were considered as having a poor sense of judgement and unable to choose a spouse for themselves. It was therefore the parents’ prerogative to make decisions for them and their future.

*“...If they (women) become lovesick, they forget that, that disease is not a good one. Women are mothers and are weak, they are not like men. With men, even if your eyes get closed, [because of love] you can still think but women don’t...”*

– FGD\_8, Community Leader

*“...If the choice of her parents is good, she is supposed to agree with their choice and not reject it because if she goes astray her life will turn out somehow bad it will spoil, she can become a prostitute because she left the house it causes a lot of harm...”*

– FGD\_10, Young men

*“...Yes, according to culture, whatever your parents asked you to do, you have to do it...”*

– FGD\_2, Older men

*“...If I am religious leader and I have a disciple (Quranic school disciple), that I like I can take him to my daughter and tell her this is the man you will marry if not him I won’t agree.”*

– FGD\_10, Young men

### 1.4. SOCIO-ECONOMIC FACTORS INFLUENCING SGBV

Women were viewed as tools for economic exchange and an intersection of poverty, lack of education and culture were considered underlying factors. Unfortunately, the choice of spouse was sometimes based on agreements about economic exchange between the parents of the girl and the prospective husband resulting in the girl having no choice but to stay with her spouse even if she was being abused. Parents also arranged forced marriages for their daughters to settle specific debts they owed the prospective husband. In other instances, forced marriage was a punishment for a girl’s disobedience to her father.

*“...There are parents that give their children to someone because of the debt he owes because he needs to be free, I saw your daughter and I want her if you give her to me and I marry her the debt between us is paid.”*

– FGD\_10, Young men

*“...This forced marriage occurs, maybe she is doing something that her father is not happy with (disobedient), or the man (potential*

*suitor) they want her to marry did something for the father (carried out a favour for her father)."*

– FGD\_3, Young women

In some instances, the education of girls was stopped, and they were withdrawn from school to get married.

*"...What brings about this sometimes is poverty. If parents are not well to do, and the girl wants to continue with her studies, the parents are seeing a rich man who can take care of their daughter and assist them in any problem, they will say 'leave school and marry this man'".*

– FGD\_14, Older women

*"...Because their parents don't know the importance of education, that is why they force their children into forced marriage.*

– FGD\_13, Young Women

Unfortunately, when SGBV occurred within a forced marriage setting, it was difficult to support the survivor because her parents were inclined to cover up rape because of the financial exchange involved. There was a consensus among participants that awareness about the dangers and consequences of forced marriage were increasing due to community education programs organised by humanitarian organisations.

*"...Just like he said now it was not like before, there are people like that but now most people are educated. Also, our community leaders are now creating awareness, so these days it hardly happens. It has drastically reduced, and most people are now aware of the danger or the consequences..."*

– FGD\_9, Religious Leader

## 2. GENDER AND POWER DYNAMICS

### 2.1. DYNAMICS OF PATRIARCHAL PRIVILEGES

Women viewed men as the decision-makers, this was reflected in the perceptions about decision making regarding forced marriage. In addition, the decision-making power of men was reflected in the need for women to take permission from their husbands before going out of the house. This had a negative impact on help seeking and access to healthcare because women also had to obtain permission to visit the hospital. The decision-making power of men was also reinforced by the dependence on them to meet the financial needs of the family. Some older women acknowledged that they were resigned to fate and God's divine power because they could not challenge the decisions that were made by the male heads of the households. Younger women also discussed the tendency for community members to assume that the male was the leader even he was still a child.

*"...Most of our male husbands are the ones forcing their children into a forced marriage, he is exercising his power as the head of the family, taking pride and boasting that she is his daughter. Some will even give their friends their daughters to marry. Because he is the man in charge of the family. Someone will even take his very old friend and give the girl to because he will say he gave birth to her she is his daughter."*

– FGD\_6, Older women

*"...Honestly even if he is a child but he is a male, he is the leader..."*

– FGD\_3, Young women

### 2.2. EXAGGERATION OF RESILIENCE AND UNDERESTIMATION OF PSS IMPACT ON SURVIVORS

While responding to the vignette story about rape older community leaders and members underestimated the impact of SGBV on survivors

and the prevailing perception was that women were meant to be strong. They were inclined to view the impact of SGBV as mainly physical and expected hospital treatment with medication to address any issue rape survivors may have. This resulted in the underestimation of the PSS impact of rape on survivors and the expectation that women were resilient enough to handle rape.

*“What will I do knowing that Zuwaira (pseudonym) had been raped and she is my wife, she will be taken to the hospital for treatment and when she is healed, it is like a disease, the thing has already happened to her...This is nothing to worry about.”*

– FGD\_8, Men community leader

*“After Zuwaira had gotten well, after the thing has passed, the man has raped her, but she has ruined the man’s life for being in jail.”*

– FGD\_14, Older women

### 3. INITIAL REACTION AFTER RAPE

There were mixed views about survivors’ reactions immediately after rape. Some women reported that the immediate response or reaction after rape was to inflict harm on the perpetrator or kill him. Others mentioned reporting to the local authorities, confiding in close family members or running away from home. Prayers and resignation to God for succour was a common coping strategy for SGBV as well as speaking to a close confidant.

*“To me, I will take something and injure him...”*

– FGD\_3, Young women

*“She can report him or anytime he comes to have sex with her she can cut his private part and she can also kill him...”*

– FGD\_7, Young women

*“Since I told her what he is trying to do, and she did not take any action and did not tell anyone about it to know if it is true or not*

*and she refused to tell his father. I will report him to the authorities...”*

– FGD\_3, Young women

*“The truth is these forced marriages can make a woman to poison herself, or she may even poison her husband...there are those that killed themselves...”*

– FGD\_6, Older women

### 4. MECHANISMS FOR ADDRESSING SGBV

Community mediation mechanisms were commonly used and preferred for resolving SGBV issues. Because SGBV issues could be discussed, culturally competent solutions proffered, and resolutions reached without exposing the community.

*“If the issue of rape happens in the community, the community leaders should call everyone’s attention and tell the community members that this is what this man has done, then let them decide on the punishment that will he will serve, this will make other men to be afraid...”*

– FGD\_13, Young women

Resolution of SGBV issues could include asking the perpetrator to marry the survivor or take responsibility for caring for the child if the survivor became pregnant as a result of rape.

*“If she was raped and she got pregnant, they will call the boy and take an action, either they give him the child or the woman, among the two options he have to choose one...he will choose between the child or the woman he raped...”*

– FGD\_10, Young men

Humanitarian organisations working in IDP camps and host communities had increased awareness about rape and access to justice among community members; some older women reported that they were increasingly inclined to seek

legal help or report to community-based organisations that could link them with legal support.

*“In those days that there were no organizations, you will report to the court if you have money to arrest the person, but now you can report to organisations secretly and they will solve your problem...”*

– FGD\_16, Older women

## 5. CONSEQUENCES AND SANCTIONS FOR DISCLOSURE OF SGBV

Some perceived and actual consequences of disclosing SGBV reported by participants include victim blaming, denial of resources, loss of respect in the community, divorce, rejection, and under-estimation of physical and psycho-social impacts of SGBV on survivors. Sometimes the sanctions such as rejection and denial of resources were meted out by family members to punish a survivor for disclosing rape and exposing the family to shame and stigma.

*“If you have been raped and people know about it, people will be pointing fingers at you, ‘this is the woman that has been raped’...”*

– FGD\_3, Young Women

*“People will tell him everything that happened to his wife, they instigate him to divorce his wife by saying, ‘your wife is an adulterer’ and if he is the type that listens to people’s advice, he will divorce her...”*

– FGD\_13, Young Women

*“If her parents are living in a rented house, the community members will ask the landlord to send them packing out of the community...”*

– FGD\_13, Young women

The impact of rape was mainly borne by the survivor and her family; there were health and psychosocial effects on the survivor including feelings

of isolation, contemplation of suicide, infections, urinary and reproductive health problems.

*“They now marry her to a big man this thing now has become as rape. He destroyed her womb, uncontrolled urine, and vaginal discharge...”*

– FGD\_6, Older women

*“...Now that she has been raped even her husband will not trust her, because she has been infected with diseases, so he does not want to be infected... he (the rapist) destroyed her life...”*

– FGD\_6, Older women

## 6. HELP-SEEKING BEHAVIOUR OF SURVIVORS OF RAPE

Participants reported that rape survivors accessed care in four ways namely clinic/hospital care, chemists, traditional/herbal care, and self-medication. The majority of male community leaders and older men believed that traditional/herbal medicine was effective for the treatment of survivors and has the additional advantage of ensuring that the secret of rape was kept between the survivor and her mother. Although they considered the hospitals an option, they believed that survivors’ secrets were exposed in the process of seeking help from hospitals. The local drug stores, within the community run by informal medicine vendors, such as patent proprietary medical vendors, were also considered an option because they dispensed drugs without the thorough probing that was done by doctors before treatment. Underlying the reluctance for hospital visits and doctor’s examination despite awareness about the benefits was the need to keep the occurrence of rape a secret.

*“Yes! Once it is not traditional, then it is the hospital. Since traditional herbs consist of different herbs. The chemist is also a hospital. Now if you go to the hospital, a doctor will not attend to you until he proves*

*how it is. But the chemists will attend to you once you have money. In this community, the chemists are helping people with this problem...*

– FGD\_8, Men community leaders

*...“To me only a few will seek for help in the clinic, the moment you say to a doctor you are raped the doctor will ask by who before they give treatment, because they don’t want the doctors to ask them. You know even if you are sick the doctor will ask you question likewise the issue of rape-- they ask questions that is why they don’t want to go and seek help in the clinic if they go their secret will be let out...”*

– FGD\_13, Young women

Other factors that influenced the decision to visit hospitals after rape include lack of awareness about CMR services, perception about confidentiality, proximity to the health facility, health worker attitude and stigma. Some participants reported that women who were seen entering the hospital aroused suspicion in the community. Survivors were stigmatised for being seen entering the hospital.

*“The issue will spread from there even if the doctor doesn’t talk about it, the people that saw her when she went to hospital, will ask her ‘what happened to you’ and that’s it her secret will be open and everyone will hear about it...”*

– FGD\_4, Women community leader

*“...Most of our people are in the village and when this kind of issue happens if there is a certain herb/plant that they know of, they will take it instantly and use it... And most of the people in the village are not educated. But in areas where there are educated people, they will go to the hospital...”*

– FGD\_9, Religious leaders

In addition to the perceived therapeutic benefits of traditional herbs, these herbs were also believed to be effective in repelling evil words from people or addressing demonic attacks that were responsible for repeat occurrences of rape. In addition, in instances where there was no hospital close to the community, community leaders believed that traditional herbs were effective in addressing a survivor’s immediate health needs until she can access healthcare.

*“Some of the reasons they are using herbs is because it will prevent her from bad words of people or prevent her from the eyes of people or prevent her from other men who will rape her. They use traditional herbs to protect them from witchcraft and other demonic activities...”*

– FGD\_3, Young women

*“It was good she used the traditional herbs. She is a farmer and their place is a village, so if it were in the town, she would have gone to the hospital but before she access the hospital and if there is no traditional herb, the problem will escalate and becomes another thing...”*

– FGD\_8, Men community leaders

A major driver of self-medication was the need to conceal rape and avoid stigma. Mothers of survivors applied a wide range of remedies and herbs at home to treat their daughters after rape. This included immersing the survivor in warm water to soothe any injuries and promote healing.

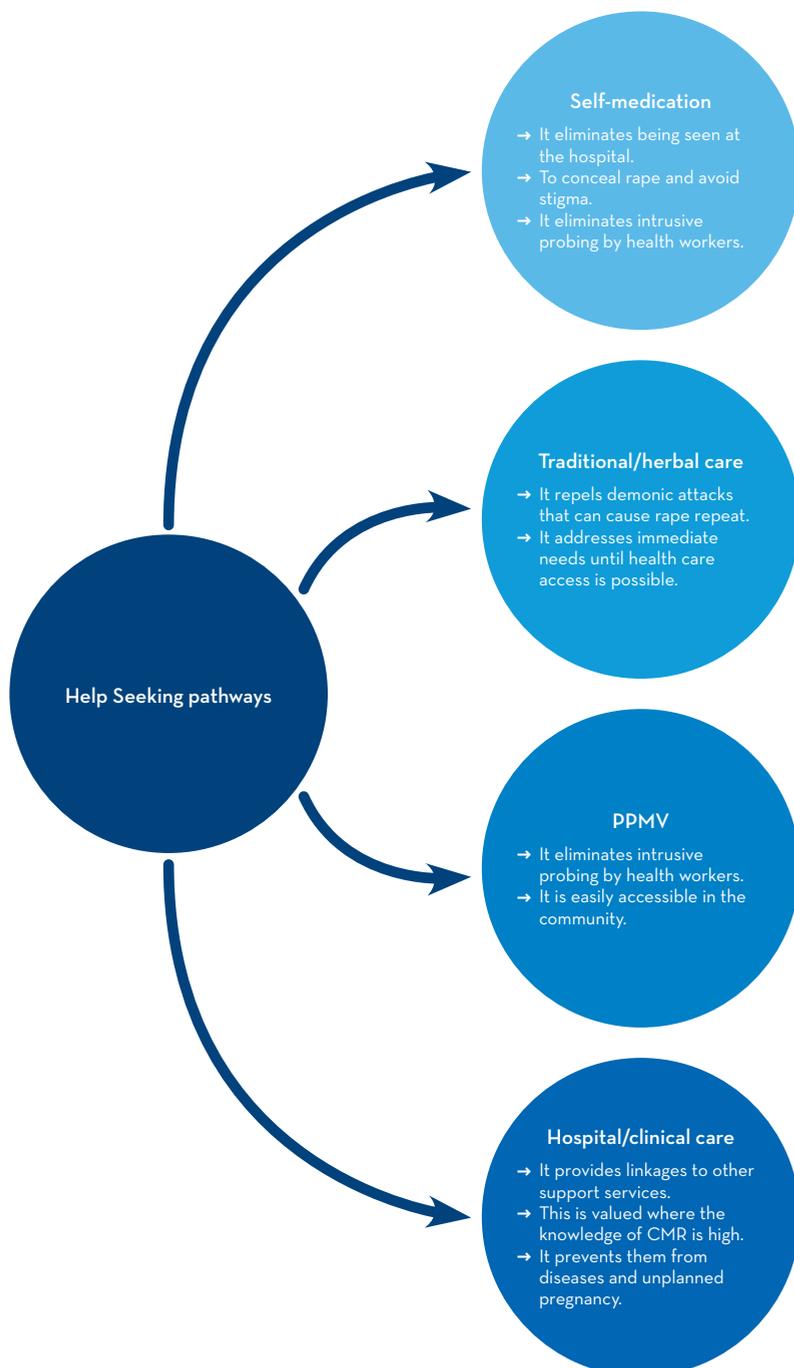
*“Apart from going to the hospital, there are some that know which drug is for which sickness so at home they can treat themselves and their secret is hidden...”*

– FGD\_4, Youth leaders

*“The mother should also try and get herbal medicine for her, so even if they don’t go to the hospital she will get better too. And the secret will be between the girl and the mother...”*

– FGD 2 Older men

Figure 4 Help seeking behaviour for rape survivors.



## SURVIVORS OF RAPE, HELP SEEKING AND ACCESS TO CMR SERVICES

### 1. HABIBAT'S STORY: THE TRAGIC PATH TO ACCESS TO HEALTHCARE AFTER RAPE

The story of Habibat (not her real name), a 23-year-old is similar to stories of other women and girls in North Eastern Nigeria and was obtained through an in-depth interview. Habibat was young secondary school girl full of hope and aspirations. Her father placed a very high premium on the education of the girl child, and he worked at a University in Borno state. Habibat's father ensured she had a wonderful childhood despite being divorced from her mother when she was a child. He deeply loved and cared for her and taught her to value the colour pink because it signified beauty.

*"So, he used to tell me, even me I asked him why he loved pink and he said that "the colour is just beautiful to him". Even you when you grow up use pink, it is beautiful. Anywhere you go, if you wear a bright cloth, you will be different, and it will make you shine. And because you are different among the people even if you are in any kind of darkness, you will be recognized."*

This experience of being closely bonded to her father is not the same for other girls in Borno State, Nigeria. Unfortunately, things took a sudden turn for the worse when Boko Haram terrorists attacked her family home and raped her. Habibat was in her final year in the secondary school when this happened. She narrated her rape experience,

*"He told me to take him to my father's room. He saw that everything was pink. I didn't know what they discussed. He came and met my father and told him that would you give us your daughter? My father said no! He then told my father that would you*

*agree to be punished [judged] because of your daughter? My father said yes if you would leave her alive, they can punish him. Then the man told my sisters to close their eyes. I was in SS3 second term then and he raped me. I was the only one raped, although there were others who were older than me in the room."*

Habibat's father knew that it was important to take his daughter to the hospital immediately after rape. He was focused on getting Habibat to the hospital as quickly as possible, he rushed out of the house carrying his daughter in his arms and placed her in his car. They were stopped by the Boko Haram terrorists on the way and he was shot dead.

*"He was rushing to take me to the hospital, as we went further, we realized that they were not the only ones so the rest of them stopped us. They now told us, so you want to run away. They shot my father on the leg... dragged us aside and burnt the car. They shot him again on the chest, they straitened my legs and laid him on my thighs."*

Habibat was later abducted by Boko Haram terrorists and raped a second time. She did not seek help immediately because she had no family support and thought seeking help will make her more vulnerable. The colour pink represents misfortune and pain because she was wearing a pink dress every time she was attacked.

*"I believe anytime I wear pink cloth, something terrible must happen to me. I have experienced it so many times. Even when I was kidnapped the second time, I was wearing pink cloth. Then we were four [4] women that were kidnapped. When they shared bed sheets to us, they gave me pink ... truly, I have never believed I would live. I don't even think my life will be sweet like anybody's."*

## 2. AISHAT, NAVIGATING STIGMA TO SEEK HELP AFTER RAPE

The story of Aishat (not her real name), a 30-year-old woman who lives in an IDP camp in Borno State. Aishat strongly believed that an ideal woman's dignity must be viewed through the lens of society's cultural and religious representations of womanhood. A woman was expected to be a homemaker, catering to the needs of her husband and children. She was assessed based on her ability to manage the home, do the house chores and prepare herself for her husband. Aishat took this responsibility seriously because she knew that was the only way to earn the respect of the community.

*"When you are using henna (henna tattoos symbolise womanhood, beauty and spiritual awakening), you are religious and good. When you are sweeping all the time people will not look down on you, the community people will see you and start saying, this is the wife of a person... she is always neat... even your husband will desire you and people will respect you. Yes, if you use henna your husband will desire you when you sweep, you burn incense, you dress well. Your husband will desire you for these"*

Aishat understood that the woman was supposed to stay at home, obey her husband and please him to receive favour from him. Like other women, she was expected to look up to the husband for her daily needs because did not earn a living.

*"Yes, like a woman in the house you cook for the children, bathe your children, wash their cloths and take care of your household. That's the role of a woman... the home belongs to the woman; the woman will cook in the house and she will fetch water and she will stay at home." "...And to obey her husband in whatever he wants, if she is living in peace, he will provide all her needs and if they aren't in peace he will not. Whatever he wants can be done for him if there is peace..."*

*We will go to our husbands and tell them we have nothing that I can do to earn, please if you have money give me, even if they have, some of them will say they don't have and you will go to somewhere else to get help, you will explain your situation to them and some maybe sympathetic with you and help you."*

IDP camps were replete with various forms of violence and women were highly vulnerable to violence. Aishat was taking her bath in the evening at the camp when a man walked into the bathroom and raped her. She pondered on the painful experience throughout the night and resolved to get help at the clinic the next morning because she had received health education about the importance of help seeking after SGBV. Aishat did not tell her husband or family members about the rape to avoid being blamed and stigmatised. This experience is not peculiar to Aishat but shared by many rape survivors who often experience stigma and ostracism from family and community members if they disclose their experience.

*"...What I remember about this toilet, I was taking my bath, without my knowledge a man came and open the toilet, I asked what was going on he did not say a word to me, he kept looking at me. So I drew the door harder...I finished taking my bath and I returned inside, I kept thinking about what happened through the night, early in the morning I came to the health centre and told them what happened...I did not tell anyone related to me even my husband and his relatives"*

## 3. THE DYNAMICS OF HELP SEEKING AFTER RAPE

The stories of Aishat and Habibat are not peculiar to them, these stories mirror the layered sociocultural barriers that women must navigate to access care. Social norms and gendered structures that accommodate violence against women put

them at risk of SGBV and limit their capacity to get help after rape due to the resultant loss of socio-economic opportunities and lack of institutional protection.

### 3.1. ROLE OF RELIGIOUS AND TRADITIONAL LEADERS

There were mixed views among survivors about the role of religious leaders in creating a conducive environment for help seeking. Some survivors and family members reported that religious and traditional leaders were increasingly speaking out against rape, showing disapproval of SGBV and encouraging survivors to seek healthcare after SGBV. Others believed that community norms that facilitate victim-blaming and stigmatisation were promoted by religious leaders. Other times, a passive stance by religious leaders regarding rape made survivors resign to fate and consider the events as an act of God they had to live with thus promoting a poor reporting culture. In addition, religious leaders sometimes perceived that women in the community lied about being raped or engaged in transactional sex.

*"...Our religious leaders view it as a way to get money, they did not think like some women did not do it intentionally, but they see it as some women are the ones giving themselves just to get money. And when they start preaching, they insult and curse us. They should just preach against it, but they will not..."*  
– IDI\_Survivor\_03, 20 years old

### 3.2. ROLE OF CULTURE

In some cases, there were religious and cultural norms that affected the way survivors viewed help seeking from formal settings. For instance, a caregiver mentioned that it was culturally unacceptable for a Kanuri woman to seek help outside her clan.

*"Our religion does not allow, and also our culture like the Kanuri culture does not allow a woman to seek help...if she has*

*any problem, she has her relative, or her husband's people or her parent. This is the people she is supposed to seek help from, but apart from these people, you cannot go to people who you did not know to seek help from them, we don't have it in our religion and culture..."*

– IDI\_Family member\_03, 36 years old

### 3.3. ROLE OF STIGMA

Community perceptions about rape created fears among survivors and reinforced stigma.

*"...In the community, most of the times, if a woman has been raped, the community knows it will be difficult for her to get a husband because everyone sees her as a bad person... rape is not good because it destroyed my life, the life of my daughter, I am thinking if she grows up how is life going to be..."*  
– IDI\_Family member\_01

*"Someone may see you and have pity/compassion on you because of what has happened to you, another person may not pity you and he may even insult/curse you. Someone may not insult you to your face, but he may insult you behind your back but in front of you he may show that he has pity/compassion for you. You may even be irritating/repulsive to someone..."*  
– IDI\_Survivor\_01

## BARRIERS TO TIMELY ACCESS TO CMR SERVICES

### 1. RAPE THAT OCCURS DURING LONG PERIODS OF ABDUCTION

Habibat's story demonstrated challenges that survivors face when the SGBV occurred during long periods of abduction. Survivors in captivity by Boko Haram terrorists who were aware about

the benefits of timely access to CMR could not access healthcare or seek professional help.

*“I was freed in January this year. When I came here, I spent like three weeks there (in captivity) before I visited the hospital...”*  
 – IDI\_Survivor, freed from abduction by Boko Haram

## 2. POOR ATTITUDE OF HEALTH WORKERS

Some survivors complained that poor attitude of health workers negatively influenced their decision making about seeking help based on previous experience. Healthcare workers' interaction with the clients for other medical conditions like malaria was a golden opportunity to maximize linkage to care for SGBV and increase awareness among community members.

*“Like now some of our people are complaining when they came to the clinic when they or their children are sick they are not well received well, they go outside to chemist to treat their children, they complained that they will never go to MdM again...”*  
 – IDI\_Survivor\_01, 30 years old

## 3. LOW AWARENESS ABOUT THE CLINICS THAT OFFER CMR SERVICES AND DISTANCE.

Although messaging about the clinics was circulated through the media and community mobilisers, some survivors were not aware about the existence of clinics providing CMR services. For some survivors residing in remote communities, they lacked financial resources to transport themselves to the clinics.

*“I told her father and he became angry... and he came and blame me, he said you are the responsible of what happened to your daughter, he shouted at me that you are*

*the one allowing your daughter to go out. He was very angry about going to a clinic... (later), he then permitted me to go, but I don't have transport then. I went out and I didn't know where to go... The (free) clinic I heard from the radio station I don't know the location, so I ask one, two-three people they asked me what happened, they said they want to know the reason (for my visit) before description ... I left them without saying anything. Finally, God helped me, and I later found the place.”*

– IDI\_Family member\_01, mother of survivor

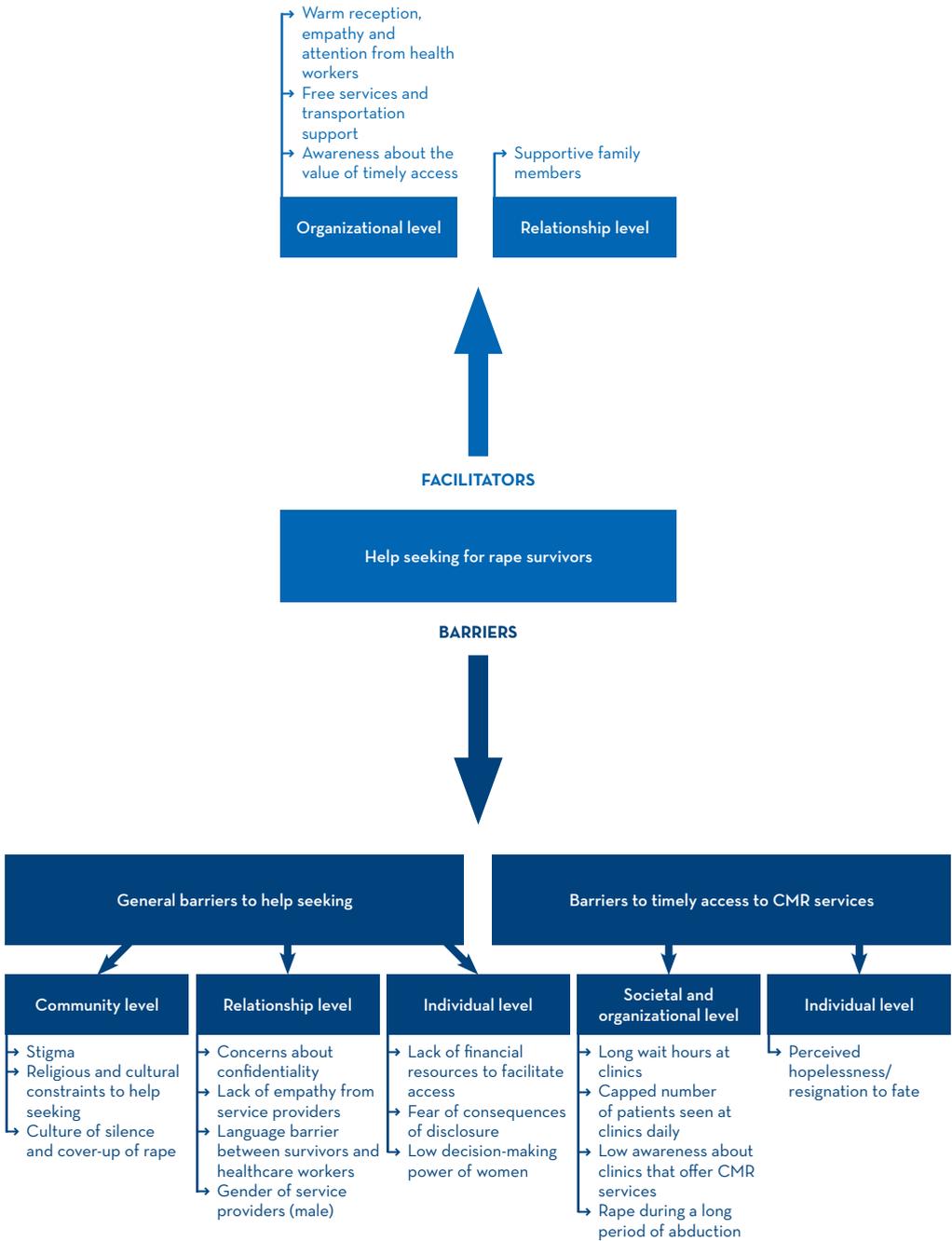
## 4. STIGMA

Survivors were afraid to access care immediately after rape because they were usually threatened by the perpetrators not to disclose their experience to anyone. They also feared that they will be judged by family members and blamed resulting in significant time wasted during contemplation about stigma associated with disclosure of rape.

*“I am ashamed of them and if I tell them they will abuse me.”*  
 – IDI\_Survivor\_01 Never accessed help, 18 years old

*“...When it happened the guy warned me not tell anybody, it happened on a Friday until in the evening I noticed her scratching this thing, I asked what happened to her she said nothing because the guy said if she tells me he will kill her even on the road or anywhere else so she was afraid. So, I told her if she doesn't tell me who did this to her, I will deal with her she was just crying she did not tell me who. On a Wednesday the guy approached me and told me I did this to your daughter when she came back from school and you were not around... she was still wearing her uniform when he forced her, he even covered her mouth with pillow...”*  
 – IDI\_Family member\_02, mother of survivor

Figure 5 Barriers and facilitators of help seeking for rape survivors.



## ENABLERS OF HELP-SEEKING

### 1. AWARENESS ABOUT THE BENEFITS OF HELP SEEKING

As seen in Aishat's story, some survivors and their family members clearly understood the risks associated with late reporting such as pregnancy and STIs. Therefore, there was consensus among survivors and caregivers who sought help within the 72/120-hour window period for CMR services that awareness about the services and its benefits was a critical factor in timely access. When survivors were raped outside clinic operating hours, they visited the clinics once they opened the next day to get care.

*"...When this thing happened to me, for example, is like 5 pm and the service providers have gone home, I waited till the morning, then I went to them and told them what happened... I came to protect myself from diseases... I know about it because all the time when things happen to us, we go there, and they have enlightened us that if such happens to you must come to the clinic... I remember that is why I came to seek help from MDM, so they can help to prevent pregnancy that's why I came..."*  
 – IDI\_Survivor\_01, 30 years

### 2. WARM RECEPTION, EMPATHY AND ATTENTION FROM THE HEALTHCARE WORKERS

Aishat's story depicts that of most survivors who sought care; they were motivated by the warm reception at the clinics. Some survivors reported that they were motivated to visit the clinics based on the warm reception they had previously received.

*"We were well received, they asked us some questions based on what happened. When they were through there was only one thing,*

*they don't have card, they said we should go and buy card... the second one blood test they said they are not doing it... (Name withheld) gave money, I don't know if he removed it from his pocket or from their office. He was the one that paid the money, before they did blood test then the next day we came for the result of the test and we made photocopy of the result and we submitted the result in the police station..."*  
 – IDI\_Family member\_03

In the case of Aishat, availability of free services was also an enabling factor for seeking help at the clinic.

*"I told the service provider what happened, she gave me injection and drugs then I used it and I enjoyed it. They understood me, and with the way I was treated, I was happy, they did well, I am not unhappy with anything they did they showed justice and fairness. I enjoyed their services and they did not ask me for money..."*  
 – IDI\_Survivor\_01, 30 years

## SERVICE PROVIDERS' AND STAKEHOLDERS' PERCEPTION ABOUT UPTAKE OF CMR SERVICES

### 1. SERVICES PROVIDED

CMR services at the clinics include medical and psychosocial services (PSS), mental health counselling, prevention of pregnancy and sexually transmitted infections (STIs) treatment. When survivors reported within 72 hours, the clinics were able to provide the full range of CMR services including PEP kits. Pain relief, treatment of injuries and administration of anti-tetanus was also carried out. Service providers further mentioned that pregnancy and HIV tests are carried out on survivors.

*“According to our protocol, we give them [drugs], to take care of the common organisms through antibiotics that will target these organisms. The one that will target the gonorrhoea. So, we give them drugs for the STI. We also want to give very important emergency contraception... but the patient must present within the first 72hrs. During the time of rape, there will be injuries and many associated traumas that can occur, we have analgesics...we have PEP kits. So, inside the PEP kits, we have all the drugs there. For the prevention of pregnancy, for the prevention of STI and HIV prevention...”*

– KII\_Service provider\_04

*“We give anti-retro viral drugs, we give STI drugs, and we do pregnancy tests in case she is pregnant so that we can take immediate care right from the day of conception up to the day of delivery. So, if she sustains injuries, they will give her intermediate treatment...”*

– KII\_Service provider\_01

## **2. COLLABORATION WITH OTHER PARTNERS TO ENSURE LINKAGE TO OTHER SERVICES**

Camp clinics had linkages with other organizations to provide support services to survivors. The clinics also provided referral linkages for other services such as safe spaces, livelihood, entrepreneurial and legal services. Survivors were sometimes reluctant to access referral services due to concerns about privacy and distance. Some service providers also reported unclear referral pathways to facilitate care.

*“There are some collective things they do there, they teach them how to do caps, so all these things they can use to generate fund from it. So, these are the linkages... Now we tend to incorporate other services into GBV...”*

– KII\_Service provider\_04

*“We collaborate with other organizations that provide different services as related to GBV, for MdM is with regard to clinical management of rape... and also individual counselling and also psychological first aid...”*

– KII\_Service provider\_02

*“I remember working with a nine-year-old client that was raped and we had to refer the case to ‘Save the Children’, because where she was living there was chances of repeated rape if she continued to live there... The mother is married to another man and the man doesn’t love the children; they don’t have good space. We referred to ‘Save the children’ and they were able to intervene...”*

– KII\_Service provider\_05

## **3. BARRIERS TO CMR SERVICES UPTAKE**

### **3.1. PERSONAL AND FAMILY LEVEL BARRIERS**

Some service providers reported that survivors who were financially dependent on the perpetrators for daily needs because they were their spouse or family members could not access CMR services at the clinics due to fear of losing the support, threats from perpetrators and lack of funds for transportation to the hospital or to purchase commodities.

*“There are some persons who because they are not stable financially and the person, they rely on financially may be the perpetrator, and so, they get silent about such...”*

– KII\_Service provider\_11

*“Because some of these survivors, they cannot even get twenty to fifty naira to transport themselves to the health facility let alone to come to the health facility where, in some of the health facilities, we don’t have all the necessary things available. They may*

*be asked to go and do something, maybe do a particular test or buy something of which most of them, they cannot afford. The services are entirely free but because of one reason or the other you cannot say, you cannot get everything at a particular place at a particular time..."*

– KII\_Stakeholder\_06

### 3.2. COMMUNITY-LEVEL BARRIERS

There was a consensus among service providers and stakeholders that the stigma and discrimination that survivors experienced in the community were key barriers to access to care. Survivors were frequently blamed for the circumstances surrounding rape and the perpetrator was shielded. Survivors sometimes did not feel protected enough to report and feared that they would lose privileges in the community if they did so.

*"Some of them are scared of what people will say, some look at the stigma, some look at the belief, the tradition around them. It is an abominable act. Just like what is going on in my camp they are being treated, some are scared of not getting married, some look at culture..."*

– KII\_Service provider\_06

*"Some of them are afraid of the stigma, they may think if I come and talk to this health provider, anywhere she sees me, she will likely say 'oh this is the girl..."*

– KII\_Service provider\_01

In addition, normalisation of violence especially in marriages and the culture of silence in the communities implied that survivors viewed rape as normal and consequently were not inclined to report.

*"It happens but in older women the thing is normal, they think that it is normal because they are used to it. And it happens in some marriages, but they don't take it as GBV they think it is normal..."*

– KII\_Service provider\_07

*"They (survivors) think they will not be believed, secondly, they think they will be blamed for whatever happened..."*

– KII\_Stakeholder\_06

*"The survivors may not feel like they would have enough protection if they were to bring this kind of information out, in the open..."*

– KII\_Service provider\_11

*"I also learned that some cultures in our area you will see the parents will now stop younger ones from opening up..."*

– KII\_Service provider\_08

### 3.3. INSTITUTIONAL-LEVEL BARRIERS

Stakeholders and service providers listed barriers such as:

- Perceived high cost of receiving care in non-MdM clinics.
- Cumbersome nature of the referral pathways for SGBV.
- Poor sensitisation about SGBV services in hard to reach communities.
- Communication and language barriers.
- Preference for female gender as service provider.
- Religious and cultural barriers.
- Long waiting time at the clinics.
- Lack of empathy of service providers.

Although the cost of accessing CMR services was free in MdM clinics, some government stakeholders mentioned that survivors in other clinics were required to pay some user fees such as health facility registration cards.

*"Sometimes parents will be going to clinic, they don't even have the means to pay for the medical examination and other things, so this is also one of the challenges..."*

– KII\_Stakeholder\_02

*"As a survivor you go to a health facility and you are asking me to pay for your medical bill and card... which one are you going to*

*face? Is she going to face the trauma or is she going to look for money to provide for her medical services?"*

– KII\_Stakeholder\_05

Poor sensitisation about SGBV services by community mobiliser working with the health facilities especially in hard to reach communities was identified as a barrier to access. Lack of awareness about services significantly limits uptake of services.

*"I will say improper information. Up till now, especially for those our people outside the state capital, they still lack information about services that are available for them in the health centre. They don't even know that there are such services in the health facilities so that they will come and access."*

– KII\_Stakeholders\_06

*"... The community mobilizer and the sensitization did not reach them because we do the sensitization at different levels. Some of the sensitization is done in the clinic every morning by health talk and we incorporate GBV sensitization in it. And then some in the communities, and it's not all the communities that we reach because, there are still outskirts communities."*

– KII\_Service provider\_03

Religious differences between service providers and survivors was perceived by a service provider as a hindrance to service uptake who perceived that a Muslim survivor may find it difficult to open up to a Christian health service provider and vice-versa.

*"If you talk about religion, the place I work most of them are Muslims... For them to come to me it takes them a lot of thought, some of them have thoughts over it, deep thinking... We are not from the same faith how will I come and talk to her..."*

– KII\_Service provider\_08

Another key challenge experienced by service providers in providing CMR services was the language barrier. Some service providers reiterated that in some cases the patients could not communicate in the major local language because they belonged to ethnic minority groups. This challenge was mitigated by engaging interpreters who could communicate in multiple languages, but some believed this triggered concern about confidentiality.

*"... Another challenge language barrier, a survivor may like to come and disclose everything to me but because I don't understand Kanuri... and then incorporating another individual to translate is not practically okay because the confidentiality now is really threatened..."*

– KII\_Service provider\_03

The gender of service providers was identified as a major barrier to CMR uptake. Due to cultural reasons, survivors preferred to see female providers. Survivors sometimes visited the clinics and could not open up fully because the attending doctor was male.

*"As for me, one of the challenges I usually face is, I am a male, hardly will a survivor come directly to me. But we have hard cases where some of them actually open up to me... but mostly, because of the cultural context, sitting with a woman or a man to discuss issues of sexuality, they see that with reproach. So, that's one of my challenges as a man handling GBV cases..."*

– KII\_Service provider\_03

*"Let's start from gender. It impacts services negatively. If a lady should come to me and I am the only person available that can offer CMR, then she will have to see me. She will have to open, and I will also examine her, which is something that she will find difficult. She will prefer a female doctor..."*

– KII\_Service provider\_04

After initial treatment, follow-up was difficult because the clinics lacked social workers and most of the survivors did not have mobile phones and could not be reached. Some clinics also did not have official phone lines to contact survivors and service providers were forced to use their personal phones.

*“... For the follow-up, we don't have a contact, most of them don't have a cell phone that we can contact them to remind them for follow-ups. And then most at times, there is a limitation for us in the unit, we don't have official phone lines...mostly it's our phones and it's not okay.*

– *KII\_Service providers\_03*

*“... Lack of social workers is causing us to have a high default rate...”*

– *KII\_Service providers\_04*

The cumbersome nature of referral pathways for SGBV services was an institutional barrier to uptake of CMR services. When services were not integrated within one organisation especially for case management, it was difficult for survivors who have to make multiple trips to different service providers for care. Survivors may not follow through with the referrals because of the perceived impact this may have on confidentiality as more providers have to discuss with them about the SGBV experience.

*“... The challenge is with the lack of case managers. In the clinic, we provide purely health services and other organizations do the case management, like IMC do case management, they manage most of our cases and then at some points, I don't feel okay, I want one organization thing to a large extent, if you are providing the services, let it be about 70-80% sure that you've covered most of the issues and then if there is a referral, let it be a minimal referral.”*

– *KII\_Service provider\_03*

*“So, for before you, if we refer to another organization, they might be limited in some ways and then you see there are multiple referrals of a case which would really threaten confidentiality too. Because almost, four, three organization or 3-4 individuals know about this case. The survivor will start thinking that everyone knows about her condition and her ordeal. So, assuming now in the clinic she has met with the Sexual and Reproductive Health (SRH), and then the SRH has to refer her... for wound dressing and then probably did not know that it is GBV case he just did it, that's the second person. Then I might be the third person as a counsellor to counsel the client... And then, where I see there is a need if it is recurrent for case management, I refer to the organization, fourth person knows. That's the perception of the survivor... so before you know, too many hands are on the same case.”*

– *KII\_Service provider\_03*



# DISCUSSION AND CONCLUSION

The goal of the study was to expand access to medical and psychosocial services for SGBV survivors in Borno State, Nigeria especially within the 72 to 120-hours critical window for CMR. This study uniquely explored perspectives about help seeking from different participants: survivors who access health services, survivors who did not access services, caregivers, service providers and stakeholders. This discussion of findings is presented using the ecology model to describe personal, familial, community, and institutional barriers or facilitators of access to CMR services as well as the contribution of gender and power dynamics.

## PERSONAL FACTORS

Findings from this study show that stigma, lack of awareness of the value of timely access to CMR, fear of the consequences of disclosure (such as divorce and social ostracism) and low decision-making power by women for their own health and wellbeing were barriers to timely access. Similar studies also found that women and girls in the humanitarian settings who experienced SGBV suffered from stigma, self-blame and shame which stifled their decision-making power to seek care.<sup>1, 8, 44, 45</sup> This study highlighted a combination of risks that women face before and after they are settled in IDP camps from terrorists, intimate partners, male IDPs and other community members. This reflects the continuum of SGBV risk that women face in conflict and post conflict settings<sup>1, 10</sup>.

Underlying the stigma experienced by survivors was the unspoken consensus that disclosure could increase their vulnerability. Coping mechanisms such as prayers and resignation to God reflect the perceived helplessness of the situation as seeking redress or mediation from the local authorities was perceived to increase vulnerability and consequences of disclosure. Survivors of rape already feel vulnerable because the experience of rape occurs in the context of violence or force and may be accompanied by threat.<sup>45</sup> This vulnerability

is layered on the emotional trauma that these survivors may have experienced as a result of displacement, social disruption and loss of income, changing dynamics of gender roles due to loss of spouse and lack of shelter.<sup>1</sup> The anticipation of further harm from the perpetrator or society during the help seeking process may explain the reluctance of survivors and care givers to seek help from formal health systems.

Some survivors and community members preferred to patronise the services of traditional herbal medicine providers or informal medicine vendors to avoid the lengthy questioning associated with treatment by health service providers. The lack of understanding among survivors of the value of history taking and clinical examination before treatment could be addressed through community health education about the care process and reassurance about the confidentiality of the doctor-patient relationship. Health service providers should also be encouraged to clearly communicate the confidentiality of the consultation process and explain all procedures carefully before commencing treatment to further reassure survivors. Lack of awareness of the benefits of timely access to CMR hinders the uptake of services irrespective of other barriers or facilitators of uptake. Other studies have highlighted the linkage between poor uptake of CMR and lack of awareness about its value.<sup>46, 47</sup> This underscores the need for clear communication and appropriate messaging about the benefits of CMR.

This study showed how unequal power balance in the community affects the perception of women about themselves and their capacity to make decisions about their health. The potential risk of being rejected and excluded from society at a critical point when social support is needed to cope with the trauma of rape may lead survivors to rationalise the decision to conceal rape and not seek care. Awareness programs should utilise participatory strategies that empower women to feel confident about discussing their health. The use of participatory videos as innovative approaches to promote community dialogue, improve awareness

about SGBV, human rights and empower women to seek help was documented in a multicounty study in conflict settings.<sup>3</sup> Programs that are focused on destigmatising and demystifying conversations of rape to address cultural and social norms that promote concealment of rape will improve service utilisation.<sup>48</sup>

## FAMILIAL FACTORS

The most important familial factor highlighted in this study was the 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. Norms that shape gender and social roles portraying the ideal woman as submissive and dependent may increase vulnerability.<sup>49</sup> In other words, an “ideal” woman may have to depend on her husband, male figure or male reference groups for help. In instances where the male family members were the perpetrators of violence, women were not only excluded from receiving healthcare but trapped in repeated cycles of violence. The inclination to underestimate the impact of SGBV and exaggerate women’s resilience may be reinforced by the perceived role of a woman as a strong pillar in the home.

The closest confidant to majority of survivors were their mothers who were better able to navigate barriers and ensure their daughters had access to care. 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 necessary to access 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.<sup>38</sup>

## COMMUNITY LEVEL

Community structures that promote victim blaming and ostracization of survivors and their families shape the social norms that drive SGBV and limits survivors’ self-efficacy to seek help. These norms are linked to mechanisms in the community for addressing SGBV that protect men, sanction women, condone gender-based discrimination and facilitate unequal power relations.<sup>50,51</sup> These norms are more pronounced in humanitarian or conflict settings.<sup>52,53,54</sup> Women who have experienced rape are viewed negatively by society and this drives them to become hidden after the experience.<sup>44</sup> The inclination of young people in this study to explore innovative ways of speaking out about violence without disclosing their identities publicly may reflect a shift towards positive social change in the community. Older community members may be reluctant to speak out because they have witnessed survivors and their families experience consequences of disclosure. A study that explored attitudes towards help seeking for SGBV in humanitarian settings showed that tolerance of SGBV and violence hindered the acceptance of help seeking.<sup>46</sup>

The preference for community mediation mechanisms for resolving SGBV may also hinder reporting and help seeking because survivors may perceive that the resolution will expose them to greater harm if they are forced to marry the perpetrators. The justice system may not be considered as a better option because of fear that the confidentiality of the process may be compromised. Mistrust in the capacity of the justice system to address SGBV confidentially affects disclosure.<sup>55</sup> Poor access to justice for rape normalises violence and empowers perpetrators to continue to violate the rights of women and girls. This further limit the capacity of women to seek help because it reinforces their limited economic and decision-making power for healthcare access.

## ORGANIZATION OF HEALTHCARE

This study highlighted the critical importance of well-coordinated health services to support the delivery of culturally competent healthcare to survivors. 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. Other studies have shown that poor attitude and knowledge of service providers lead to the provision of poor quality services that may increase the survivor's trauma.<sup>56</sup> Key service components for providing healthcare to SGBV survivors should be available and well-integrated with referral services to ensure that care received is not cumbersome and increase layered barriers to access.<sup>51,57</sup> Training and retraining of service providers is important to ensure they are up to speed with best practice for the provision of competent, confidential and empathetic care.<sup>56,58</sup>

Findings from this study revealed that survivors were more inclined to seek care in clinics where healthcare workers exhibited positive attitudes and compassion. Restructuring health services to ensure that clients receive quality at different service points is key because clients who receive poor quality care for malaria or other services are unlikely to return for SGBV treatment. In addition, to encourage survivors to engage meaningfully with service providers, issues relating to communication and gender sensitivity must be addressed. 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 community members will suspect that they visited for SGBV related reasons. Perceived mistrust about healthcare workers' capability to keep the secrets of survivors sometimes arise because healthcare workers are considered as members of the community.<sup>56</sup> Providing reassurance about confidentiality of the care process is essential prior to commencement of treatment.

## LIMITATIONS

This study has some limitations. Due to logistic and resource constraints, we covered a limited number of camps and host communities in Maiduguri, Jere and Damboa local governments in Borno state. As a result, study findings cannot be generalised to other areas or states with markedly different contexts, norms and health system structure. We did not interview the desired number of participants in every instance due to challenges with recruiting participants for sensitive research. We, however, covered four sites that serve a large number of IDPs/community members and we interviewed a wide range of participants and stakeholders to triangulate information about barriers to CMR. Despite these limitations, however, we believe some important conclusions can be drawn and recommendations made to improve CMR services and prevention programs for SGBV at community level.

## CONCLUSION

This study highlighted barriers to timely CMR access that have serious implications for the health and well-being of survivors of rape. Awareness about the availability of services is a critical starting point for survivors who need CMR services irrespective of other barriers they may face. The prevailing consensus among families to conceal rape in order to protect the family reputation and avoid stigma in the community was an important familial factor driven by the culture of silence regarding rape. It was demonstrated in this study that social norms that drive SGBV and limit survivors' self-efficacy to seek help are shaped by community structures that promote victim blaming and stigmatization of survivors. Uptake of CMR services at the health clinics will be improved by restructuring health systems to provide services that are culturally adapted to address issues relating to gender, language and religious barriers.

## 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.



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# APPENDIX

## SUMMARY OF THE STUDY FINDINGS

	Young Women	Younger Men	Older Women	Older Men	Community/ Traditional and Religious Leaders
<b>1. Drivers of SGBV</b>					
<b>a. Culture of silence</b>	Some young women expected survivors to speak up. There is high rate of cover-up of SGBV especially rape. This also affects help seeking at the clinic because they think this will break the silence	They believed that culture, religion and law do not support cover-up of rape	Expectation that women should be silent about incidents of violence.	Expectation that women should be silent about incidents of violence	Some community leaders expected that survivors should speak up
<p><b>Reasons for culture of silence:</b> Across board, participants highlighted the reasons for culture of silence. Survivors' fear of being accused of wrongly accusing the perpetrator, victim blaming, image protection of the family to avoid community stigmatisation and shame, survivors and family members fear that the survivor of rape may not get a suitable spouse in the future and fear of divorce for married survivor or family disruption.</p>					
<b>2. Gender and power dynamics</b>					
<b>a. Objectifying female gender</b>	For forced marriage, women are used to seal friendship	Some use girl child as a means to settle financial debt	Girls are used as object of economic exchange. They are forced into marriage for economic or financial benefits		
<b>b. Dynamics of patriarchal privileges</b>	Women do not speak-up in the community. There is male preference in the community.		Men are considered as decision makers. Reported male dominance in the family		
<b>c. Over exaggeration of resilience and underestimate of psycho-social impact on survivors</b>			Some older women believed that rape survivor in the vignette should not have reported the rape case to law enforcement agents because the incident had passed, and the survivor is now well. Therefore, there is tendency to underestimate the psychosexual effect of the rape on the survivors	There is an underestimation of the impact of sexual and physical violence on survivors and the perception that women are meant to be strong after being a victim of sexual and physical violence.	

	Young Women	Younger Men	Older Women	Older Men	Community/ Traditional and Religious Leaders
<b>3. Coping mechanisms and reactions to SGBV issues</b>	Inflict harm on the perpetrator, report to authorities, report to friends and other trusted allies. Resigns to fate through prayer		In the case of forced marriage and rape, survivors may commit suicide, run away		
<b>4. Mechanisms for addressing SGBV</b>	Reported to NGOs, CSOs and human rights organisation.	Report rape cases to local security like Joint Task Force (JTF).			Report to community leaders who then settle the issue between the parties
<b>5. Consequences and sanctions for SGBV disclosure (forced marriage and rape)</b>	For forced marriage, survivors at times have psycho-social effect such as thought of being a loser, community stigmatization especially for rape. Sanctions include beating, rejection, and disowning		For forced marriage, the outcomes are psychological problems and divorce. Forced marriage sometimes lead to infections and other sexually transmitted infections.	Victims of forced marriage may commit suicide and kill her partner	
<b>6. Help-seeking behavior and factors influencing it</b>	Majority seek help from the hospital while the minority utilise traditional medicine. People utilise traditional herbs as a form of protection against future occurrence of assault. Across board, a key factor is fear of stigmatisation. People would not want to report so as not to raise suspicion. And they fear that clinic consultations will disclose their secrets	Mentioned that there has been enlightenment and awareness creation about where to seek help, however, some still have low awareness of available services at the clinics. Distance is another crucial influencing factor		Survivors would prefer traditional help seeking so as to keep the secret within the family and avoid suspicion at the clinics	Some religious leaders believed that survivors of rape will visit the hospital. Survivors also seek help from the humanitarian actors. Survivors also utilize PPMVs because of their quick response to treatment. Most people from rural areas would prefer to seek help from traditional healers due to low literacy level. Fear that confidentiality will be broken if service providers are aware that they were raped or sexually assaulted

s/n	Themes	Summary of findings
<b>1.</b>	<b>Enablers CMR services uptake</b>	
a.	Comprehensive services available	Usage of PEP kits to treat survivors, Infections treatment, Pain relief treatment. Pregnancy test for survivors, service providers refer cases beyond their capacity, they provide psycho-social support for survivors to prevent future abuse.
b.	Availability of linkage to other services providers	Partnering with other humanitarian actors and organisations to provide safe space, provision of livelihood and skill sets to support survivors
<b>2.</b>	<b>Barriers to CMR services uptake</b>	
a.	Personal and Familial level barriers	Survivors are inclined to have low value placed on follow-up. Illiteracy, negligence, poor economic status, the fear of being stigmatised, and the fear of the perpetrator or receiving threats from the perpetrator hindered CMR service uptake. Poor socio-economic status prevents some from timely access Low self-esteem of survivors also affects service uptake Survivors' perception about the fear of not getting a suitor Poor awareness of the existing clinic services by the survivors and poor access to clinics due to distance
b.	Community level barriers	Negative social norms such as culture of silence, cover up of violence, victim blaming, perpetrators invincibility and image protection of the family Service providers reported that strong presence of culture of silence and victim blaming has negatively affected the uptake of CMR services
c.	Institutional level barriers	Perceived high cost of accessing care and inadequate awareness of the available services sometimes hindered access to CMR services and At times, the service providers do not have access to the contacts of the survivors while in some cases survivors have no contact addresses to enable follow-up Communication gap between the service providers and survivors Attitude of service providers such as unreceptiveness, lack of sympathy and clients delay during consultation due to overwhelming numbers of clients. Clients satisfaction of the previous consultations facilitate CMR uptake, the availability of incentives or kits motivate survivors to access care, Increased sensitization facilitates uptake Poor communication between survivors and service providers The sex of the providers sometimes deters the clients from disclosing rape incidents



