WOMEN'S REFUGEE COMMISSION

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Gap between Supply and Demand for Contraceptive Services in Northeast Nigeria

Case Study

May 2020

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

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Cover photo: A midwife at a new health facility run by the International Rescue Committee, Stadium IDP camp in Maiduguri Metropolitan City, Borno State, northeast Nigeria. © Katherine Gambir/ Women's Refugee Commission

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Executive Summary

Since 2009, Northeast Nigerian communities have faced a violent insurgency led by fundamentalist extremists, including the militant terrorist group Boko Haram and associated fractured groups. An estimated 1.7 million women and girls of reproductive age have been displaced, and two-thirds of health facilities have been destroyed. There is a critical need for sexual and reproductive health (SRH) services, including contraceptive services, for people affected by the conflict.

Globally, studies have shown that conflict-affected and forcibly displaced women and girls face increased risks of maternal morbidity, mortality, and gender-based violence (GBV); higher risks of sexually transmitted infections (STIs); greater risks of unintended pregnancy; and heightened risks of unsafe abortion and its associated complications. Therefore, contraceptive services, including long-acting reversible contraceptives (LARCs), and post-abortion care (PAC) are included in internationally accepted minimum standards for humanitarian health responses. As a crisis stabilizes, the response should transition from the provision of basic, lifesaving SRH services to the provision of comprehensive SRH services for all affected women, men, and adolescents.

One of the areas most seriously affected by the insurgency in Northeast Nigeria is Borno State. In June 2019, the Women's Refugee Commission (WRC) conducted a case study of contraceptive service delivery in Maiduguri and Jere Local Government Areas (LGAs) in Borno State. While multiple reports have documented the SRH needs of women and girls in Northeast Nigeria since the onset of the crisis, this case study is the first to focus specifically on contraceptive service delivery and PAC in this region. It documents the important work that humanitarian actors, the government of Nigeria, and other stakeholders are undertaking to provide contraceptive services to internally displaced persons (IDPs) and host communities. It highlights challenges, documents how some of these challenges were addressed, and presents recommendations.

The case study employed mixed methods, including key informant interviews (KIIs) with the United Nations Population Fund (UNFPA) and nongovernmental organization (NGO) health and SRH program managers; health facility assessments, including SRH knowledge and attitudes surveys with service providers; focus group discussions (FGDs) with IDPs and community members; and a review of service delivery data from UNFPA and partner implementing agencies. Due to the security situation, WRC was unable to visit sites or conduct interviews outside of Maiduguri and Jere LGAs. The situation in the broader Borno State may vary significantly.

A global evaluation by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) published in 2014 found that the provision of sexual and reproductive health (SRH) services, including contraception, in humanitarian settings was weak, and pointed to a cross-cutting need for more systematic research and a robust program evaluation. This study is the second of three such case studies undertaken by WRC as part of a global landscaping to help fill that evidence gap by documenting contraceptive service delivery in humanitarian settings.

The global landscaping also comes after an important update to the Minimum Initial Service Package (MISP) for Reproductive Health in Crises, which added preventing unintended pregnancy as an objective. In addition, the importance of family planning in humanitarian settings has been elevated through key global moments, such as the Family Planning Summit in 2017.

The locations for the global landscaping were selected based on a set of criteria that included diversity of settings (geographic, type of crisis, phase of crisis) and the existence of family programming and partners. Northeast Nigeria was selected due to the geographic location (West Africa); existence of camp and host community settings; internally displaced population; protracted crisis due to long-term conflict; and WRC's ongoing partnership with Nigerian government health agencies.

Our key findings

- **Overall knowledge of the importance of child spacing and contraceptive methods was high,** especially among women, although lower for men and adolescents. However, knowledge about specific methods was moderate for women and low to very low for men and adolescent boys, respectively. Community members stated that the Boko Haram insurgency has increased the demand for contraceptives due to increased knowledge about birth spacing and contraceptives and harsh living conditions, especially among women.
- **Although short-acting contraceptive methods were widely available, LARCs were much less available and PAC services were even less available**. LARCs are the most effective form of reversible contraceptive. They are safe, last for an extended period of time, and once inserted, work without user action.
- **Emergency contraceptives (EC) were also less available than short-acting methods.** Even though EC was available in four of seven facilities, facility staff only provided EC to survivors of sexual assault in two of those four clinics, and it was therefore stored in a separate space from where the other methods were provided. Furthermore, community members, including adolescents, were generally unfamiliar with EC.
- **Overall availability of contraceptive methods and PAC services was hindered** by health provider turnover and shortages, commodity stockouts, and a lack of skilled providers, in addition to the insecurity caused by the crisis.
- **Key barriers to accessing contraceptive services** continue to be misconceptions about contraceptive methods, especially LARCs; community stigma and negative attitudes toward contraception; male partners' opposition to contraceptive use; and religious and religious leaders' opposition to contraceptive use.
- **Adolescents, unmarried, and divorced women experienced heightened stigma** from community members and providers in general, especially if they attempted to access or use contraceptives, which impeded their access to contraceptive services.
- **Mechanisms are in place to routinely collect contraceptive service delivery data** by all partners; however, data quality and late or missing data was a challenge.
- **Community mobilization and community health service delivery have been successful in reaching community members,** mostly women, to inform them of the importance of contraceptives and child spacing, and this strategy has encouraged women to use contraceptive services.

Our top recommendations

- **Partners should strengthen and expand community mobilization efforts that include community gatekeepers and key influencers,** such as traditional birth attendants (TBAs), community leaders, religious leaders, men, and boys. Activities should include messaging

and the dissemination of materials about the benefits of contraception to reduce stigma and combat misinformation; build support for child spacing and the use of contraceptives, including LARCs; and raise awareness of SRH services, including the availability of EC and PAC.

- **Donors and partners should invest in effective strategies,** such as adolescent safe spaces, **to ensure partners can engage adolescents on important SRH topics** and provide youth with confidential access to a full range of SRH services.
- **UNFPA and partners should transition from the provision of Minimum Initial Service Package (MISP) and Inter-Agency Emergency Reproductive Health (IARH) kits,** which were appropriate at the onset of the crisis, to full comprehensive contraceptive service provision and procurement of specific contraceptive commodities to meet demand, as recommended in protracted crises.
- **Partners should coordinate with government health agencies and UNFPA to ensure providers and health facility staff are well trained,** including on counseling and values clarification and attitude transformation, and have opportunities to develop, practice, and maintain their clinical skills.
- **Government agencies should collaborate with partners to ensure EC is available to all clients** rather than only to those seeking clinical management of rape (CMR) services, as mandated under Nigeria's 2017 National Guidelines for Emergency Contraception.
- **Partners should work with government health agencies, including SMOH and the Borno SPHCDA, and UNFPA, to ensure all health facilities provide a robust method mix**, including LARCs and EC; have a sufficient number of staff trained in contraceptive and PAC services; and have adequate and consistent stocks of commodities, supplies, and equipment to implement quality, confidential contraceptive and PAC services.

The Stadium IDP Camp is next to a former football (soccer) stadium in Maiduguri Metropolitan City, Borno State, Northeast Nigeria. Each tent may house several displaced families.

I. Introduction

This is the second of three case studies conducted by the Women's Refugee Commission that document contraceptive service delivery in humanitarian settings. The Inter-Agency Working Group on Reproductive Health in Crises' (IAWG) 2012–2014 Global Evaluation of Reproductive Health in Crises found that provision of sexual and reproductive health (SRH) service, including contraception, in humanitarian settings was weak, and pointed to a cross-cutting need for more systematic research and a robust program evaluation. The WRC case studies aim to build on and advance these efforts before the next Global Evaluation.

II. Background

For more than a decade, communities in Northeast Nigeria have endured a crisis resulting from an insurgency by the militant terrorist group, Boko Haram, and associated splinter groups. Thousands of civilians have been killed and millions forced to flee their homes. While some have found shelter with relatives or at government-run camps, most internally displaced persons (IDPs) live in makeshift settlements and largely rely on support from local communities and aid organizations.[1]

An estimated 26 million people live in areas affected by the conflict.[2] The conflict is concentrated in three Northeastern states of Nigeria: Adamawa, Borno, and Yobe. Across these states, an estimated 6.9 million people need health assistance, 5.1 million are food insecure, and 1.62 million IDPs live in camps and settlements.[3], [4]

The conflict continues to impact these areas. Between November 2018 and January 2019, 80,000 new IDPs were registered in Nigeria. Women and children made up 87 percent of the IDPs registered in that period. As of March 2019, 823,000 people were residing in areas where humanitarian organizations have no access.[5]

Borno State has been most impacted by the conflict and hosts the highest number of IDPs in Nigeria—more than 1.4 million.[6] The key drivers of this influx include displacement due to ongoing terrorist attacks, conflict between the insurgency and the military, fear of attack, and poor living conditions.[7]

Between August 2015 and 2018, 1.6 million people, including 650,000 in Borno State, have returned to or moved closer to their homes, indicating that conditions have improved in some locations. However, insecurity persists and a lack of access to basic services and infrastructure impedes safe

1 European Civil Protection and Humanitarian Aid Operations, *European Civil Protection and Humanitarian Aid Operations*, July 2, 2019.
2 The World Bank, *The World Bank in Nigeria: Overview*, December 12, 2017, http://www.worldbank.org/en/country/nigeria/overview.
3 World Health Organization, Health Sector response to the north east Nigeria emergency, 2018, http://www.who.int/health-cluster/news-and-events/news/north-east-nigeria/en.
4 UN Office for the Coordination of Humanitarian Affairs, Northeast Nigeria: Humanitarian emergency – Situation Report No. 3, January 6, 2017, https://reliefweb.int/report/nigeria/northeast-nigeria-humanitarian-emergency-situation-report-no-3-6-january-2017.
5 Ibid.
6 International Organization for Migration, *DTM Round 26 Addendum,* January 2019, https://reliefweb.int/sites/reliefweb.int/files/resources/Nigeria%20-%20Displacement%20Report%2026%20%28Addendum%29.pdf.
7 United Nations Children's Fund, *Nigeria Humanitarian Situation Report,* February 28, 2019, https://reliefweb.int/report/nigeria/unicef-nigeria-humanitarian-situation-report-1-28-february-2019.

and sustainable returns.[8] The majority of IDP camps are clustered in Maiduguri, the capital and largest city of Borno State. Due in part to a lack of available land in the city, challenges delivering services and humanitarian assistance, including sexual and reproductive health services, persist.[9]

Globally, studies have shown that forcibly displaced and conflict-affected women and girls face increased risks of maternal morbidity, mortality, and gender-based violence (GBV); higher risks of unintended pregnancy and unsafe abortion and its associated complications; and unmet need for contraceptives.[10] Consequently, SRH services are an essential component of the basic health response in humanitarian emergencies and therefore are included in internationally accepted minimum standards for humanitarian health response, as articulated in the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health.[11] In the 2018 revision of the MISP, provision of contraceptive services was included as a core objective within SRH service provision. The MISP for SRH is a set of priority lifesaving SRH activities and services that form a minimum standard that should be implemented at the onset of every humanitarian crisis to prevent excess morbidity and mortality, particularly among women and girls. The priority services in the MISP for SRH are integrated in the Sphere Minimum SRH and HIV Standards for Humanitarian Response.[12] As a crisis stabilizes, the response should transition from the MISP to the provision of comprehensive SRH services for all affected women, men, and adolescents.[13]

The 2012–2014 IAWG Global Evaluation of SRH services in humanitarian settings found that contraceptive services have lagged behind other SRH services.[14] Long-acting and permanent methods of contraception, as well as emergency contraceptives (EC), have been especially neglected.[15] This is despite evidence that a wide range of available methods increases overall contraceptive use,[16] and consensus that the provision of contraception is a lifesaving health intervention with far-reaching implications for recovery and resilience for individuals and communities[17] that accelerates progress toward global goals.[18] Across humanitarian settings, studies have shown that women demand contraception and will use it when it is available and of adequate quality.[19]

Nigeria has one of the highest maternal mortality ratios in the world at 814 deaths per 1,000 live births—consequently, the effects of this ongoing emergency are especially dire. In Northeast

8 United Nations Office for the Coordination of Humanitarian Affairs, *Humanitarian Needs Overview*, Feb 1, 2019, https://reliefweb.int/report/nigeria/nigeria-2019-humanitarian-needs-overview.

9 See note 8.

10 Austin J. et al., "Reproductive health: a right for refugees and internally displaced persons," *Reproductive Health Matters,* 16(31) (2008): pp. 10–21.

11 Sphere Association, *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response,* fourth edition (Geneva: Sphere Association, 2018).

12 Ibid.

13 Inter-Agency Working Group on Reproductive Health in Crises, *Reproductive Health in the Changing Humanitarian Context – Findings from the IAWG on Reproductive Health in Crises' 2012–2014 Global Evaluation,* September 2, 2014, http://iawg.net/wp-content/uploads/2016/08/IAWG-Global-Evaluation-2012-2014-1.pdf.

14 Ibid.

15 Sarah K. Chynoweth, "Advancing reproductive health on the humanitarian agenda: the 2012-2014 global review," *Conflict and Health*, 9(1) (2015), https://conflictandhealth.biomedcentral.com/track/pdf/10.1186/1752-1505-9-S1-I1.

16 John Ross and John Stover, "Use of modern contraception increases when more methods become available: analysis of evidence from 1982–2009," *Global Health: Science and Practice,* 1 (2013): pp. 203–212.

17 Inter-agency Working Group, 2017. "Family Planning Saves Lives and Promotes Resilience in Humanitarian Contexts." https://www.rescue.org/sites/default/files/document/1728/familyplanningwhitepapercompletespreadina4web.pdf.

18 Ann M. Starrs et al. "Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission," *Lancet*, 391 (2018): pp. 2642–2692.

19 Inter-Agency Working Group on Reproductive Health in Crises, *Family Planning Saves Lives and Promotes Resilience in Humanitarian Contexts*, 2017, https://iawg.net/resources/family-planning-saves-lives-and-promotes-resilience-in-humanitarian-contexts.

Nigeria, two-thirds of health facilities have been destroyed or severely damaged, and an estimated 1.7 million women and girls of reproductive age have been displaced.[20] Six in 10 girls and women in the Northeast have experienced gender-based violence.[21] Adolescent girls in particular face a heightened risk of exploitation, including GBV, child and forced marriage, and teenage pregnancy.

Nigeria's strict abortion laws are another key cause of maternal mortality.[22] Under the Nigerian penal code, abortion is only allowed when the woman's life is endangered and abortion is prohibited in cases of rape or incest or to preserve the woman's health, which violates the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) ratified by Nigeria in 2005.[23], [24]

Despite the Nigerian government's Family Planning 2020 (FP2020) commitment to reach contraceptive prevalence of 27 percent by 2020,[25] contraceptive prevalence remains low. As of Demographic and Health Survey 2018, only 17 percent of currently married Nigerian women age 15–49 are using any contraceptive method, with 12 percent using a modern method[26]; and 37 percent of sexually active unmarried women are using a contraceptive method, of whom 28 percent use a modern method.[27]

In Borno State, contraceptive prevalence is lower than the national average. Only 6.2 percent of currently married women (15–49 years) use any method, while 5.4 percent use a modern method.[28] Among currently married women (15–49 years) using any contraceptive method (e.g., modern methods and traditional methods, including withdrawal, rhythm, and others), injectables are the most common method, with 1.5 percent of women using them, followed by female sterilization (1.2 percent) and the pill (1.2 percent), withdrawal (0.8 percent), implants (0.6 percent), the male condom (0.6 percent), and intrauterine devices (IUDs) (0.2 percent).[29] Family planning services and counseling are available in private and public health facilities; however, public facilities provide free services and are widely used.[30]

UNFPA plays a critical role in procuring and distributing essential SRH supplies and commodities to health facilities and invests in helping the federal government fulfill its FP2020 commitments. UNFPA and partners provide training on the MISP for Sexual and Reproductive Health in Crises to support available health personnel to develop their capacity to provide SRH services.[31]

20 United Nations Office for the Coordination of Humanitarian Affairs, *Humanitarian Needs Overview 2019,* December 17, 2018.

21 United Nations Population Fund, *Delivering Supplies When Crisis Strikes-Reproductive Health in Humanitarian Settings,* 2018.

22 Family Planning 2020, *Country Action: Opportunities, Challenges, and Priorities – Nigeria,* 2016, http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/11/Country_Action_Opportunities-Challenges-and-Priorities_NIGERIA_FINAL.pdf.

23 Center for Reproductive Rights, *Nigeria's Abortion Provisions,* 2017, https://www.reproductiverights.org/world-abortion-laws/nigerias-abortion-provisions#penalcode.

24 African Commission on Human and Peoples' Rights, *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, 2003, http://www.achpr.org/instruments/women-protocol.

25 Family Planning 2020, Nigeria, 2018, http://www.familyplanning2020.org/nigeria.

26 Modern methods include female sterilization, male sterilization, the oral contraceptive pill, the intrauterine device, injectables, implants, male condoms, the diaphragm, foam/jelly, lactational amenorrhoea method, and emergency contraception.

27 National Population Commission [Federal Republic of Nigeria] and International Community Foundation, *Nigeria Demographic and Health Survey 2018*, 2018.

28 Ibid.

29 Ibid.

30 National Population Commission [Federal Republic of Nigeria] and International Community Foundation*, Nigeria Demographic and Health Survey 2013, June 2014*, https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf.

31 Women's Refugee Commission, *Minimum Initial Service Package for Sexual and Reproductive Health Fact*

Multiple reports have documented the SRH needs of women and girls in Northeast Nigeria since the onset of the crisis[32], [33], [34]; however, this case study is the first to focus specifically on contraceptive service delivery and post-abortion care (PAC) in Maiduguri and Jere local government areas (LGAs) specifically. This case study aims to document the important work the Nigerian government, UN agencies, humanitarian organizations, and other stakeholders are undertaking to provide comprehensive contraceptive service delivery to IDPs and refugees in Borno State, while highlighting challenges and lessons learned.

Contraceptive supplies stored in the pharmacy of a government-run clinic in Mogcolis IDP camp.

Sheet. Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2009, https://www.womensrefugeecommission.org/srh-2016/resources/575-minimum-initial-service-package-misp-for-reproductive-health-cheat-sheet.

32 United Nations Population Fund*, Delivering Supplies When Crisis Strikes-Reproductive Health in Humanitarian Settings,* 2018.

33 United Nations High Commissioner for Refugees, Nigeria: Sexual and Gender Based Violence (GBV) Year-End Report, January-December 2017, 2018.

34 Champions of Global Reproductive Rights, *Access Denied: Nigeria, Preliminary Impacts of Trump's Expanded Global Gag Rule*, 2018, https://pai.org/wp-content/uploads/2018/03/Access-Denied-Nigeria-2.pdf.

III. Overview of Methods

Methods and sampling

The case study employed mixed methods, including key informant interviews (KIIs) with UNFPA and government representatives and nongovernmental organizations' (NGO) health and SRH program managers; health facility assessments, including SRH knowledge and attitudes surveys with service providers; focus group discussions (FGDs) with IDPs and host community members; and a review of service delivery data from UNFPA and partner implementing agencies.

Table 1: Case study data collection methods

Data collection type	Number
Number of key informant interviews	10* (including the SMOH, Borno SPHCDA, 1 UN agency, and 8 NGOs)
Facility assessments	7 health facilities, including 4 with NGO support and 1 private/NGO health facility
Provider knowledge and attitudes questionnaires	13
FGDs with community members	119 community members in 10 FGDs

** Multiple representatives included in interviews.*

Case study tools: Data collection tools were adapted from validated instruments used in the 2012–2014 IAWG Global Evaluation,[35] MISP evaluations,[36] and a multi-country baseline study on contraceptive services in humanitarian settings conducted by the Women's Refugee Commission (WRC), the United Nations High Commissioner for Refugees (UNHCR), and the Centers for Disease Control and Prevention (CDC) in 2011 and 2012.[37]

KIIs: WRC conducted individual interviews with key informants to understand contraceptive and PAC service delivery available to IDPs, including challenges and successes in implementing contraceptive services in Borno State. With guidance from UNFPA, key informants were purposively selected based on the following criteria:

- working at UNFPA, SMOH, Borno State Primary Health Care Development Agency (SPHCDA), a local NGO, or an international NGO that has been directly implementing or supporting contraceptive services in Borno State; and
- individuals within those organizations working as health or SRH program managers or coordinators and available in person in Maiduguri or Jere LGAs during the case study field work.

Based on these criteria, key informants from 20 humanitarian organizations were invited to

35 Sara E. Casey et al., "Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies." *Conflict and health* 9(1) (2015): S3.

36 IAWG, 2017. "MISP Process Evaluation Tools." http://iawg.net/resource/misp-process-evaluation-tools-2017/.

37 Erin McCoy , 2011. "Baseline Study: Documenting Knowledge, Attitudes, Behaviors of Somali Refugees and the Status of Family Planning Services in UNHCR's Operation in Nairobi, Kenya." Women's Refugee Commission. https://www.womensrefugeecommission.org/images/zdocs/family_planning_baseline_study_kenya.pdf.

participate in in-person interviews at a convenient time and place in Maiduguri or Jere LGAs. Eight international NGOs or national NGOs, two government agencies, and UNFPA responded and agreed to participate in an interview (see Appendix A, Table 10). Interviews were conducted in English, in a quiet and semi-private location, by a team of two WRC staff. One person facilitated the interviews and the other took notes. WRC then collated all responses and carried out thematic analysis to identify recurring and unique themes across the interviews.

Facility assessments: WRC conducted health facility assessments to evaluate the readiness of facilities to effectively provide contraceptive and PAC services. NGO participants in the case study purposively selected the health facilities to be assessed. While the case study was originally planned to expand beyond Maiduguri and Jere LGAs, due to security constraints during the time of the field research, all facilities were in Maiduguri or Jere LGAs. The assessments included interviews with facility staff and a room-by-room walk-through and inventory of essential drugs, supplies, and equipment. Seven facilities were assessed: one hospital, four primary health centers (PHCs), one dispensary, and one maternal health center (MHC). For analysis purposes, the PHCs, dispensary, and MHC were grouped together, as they are authorized to provide all short-acting methods, long-acting methods, and PAC services, and are meant to be open 24 hours a day and seven days a week.

Provider questionnaires: In each health facility, WRC administered a questionnaire to health workers providing SRH services to determine their knowledge and attitudes concerning contraception and PAC. Questionnaires were administered on paper forms in English. An interpreter verbally translated the questionnaire into the appropriate local language when necessary. WRC collected

A community health extension worker inside the intake/family planning/procedure room at a local government authority clinic supported by CARE in Jere.

14 questionnaires from doctors, nurse midwives, community health extension workers (CHEWs), and a community health officer (CHO). The results were entered into a spreadsheet for descriptive analysis. Only 13 questionnaires were included in the knowledge analysis, as one respondent copied the knowledge responses from a colleague. The attitudes of all 14 are included.

FGDs: The WRC researchers organized 10 FGDs with IDPs and host community members in order to elicit attitudes, experiences, beliefs, and preferences of community members toward contraception. FGDs were conducted with mostly unmarried adolescent girls (14–19), young married and unmarried women (20–24 years old), older married or widowed women (25–45 years old), adolescent boys (14–19) and married men (20–45). The groups included between six and 20 participants, with at least one person with a disability included in each group. The FGD participants were recruited by NGO partners from the catchment area of a health facility offering contraceptive services, with the expectation that the participants would have some prior knowledge of and exposure to contraceptive services in the camps or nearby host communities.

A total of 10 FGDs were held in private spaces. Five FGDs were conducted in a Ministry of Health (MOH) dispensary which served both host community members and IDPs. The remaining five FGDs were conducted in Bakassi IDP camp. The discussions were facilitated by a young woman and a young man from Borno State, respectively, who could speak both local languages, Kanuri and Hausa. With consent of the participants, the moderators audio-recorded the discussions. Subsequently, one of the moderators transcribed and translated the discussions from Kanuri and Hausa into English. WRC team then developed, piloted, and iterated a codebook. Each transcript was double coded by WRC staff in the NVivo 12 Plus software package, and discordances between coding were resolved through consensus of coders and/or adaptation of the codebook.

Service delivery statistics: WRC reviewed contraceptive and PAC service delivery data from UNFPA and the NGOs that participated in KIIs. The data were cleaned, aggregated, and submitted to descriptive analysis (see **Figure 1, page 21, and Figure 2, page 22**).

Ethics

WRC adapted the case study methodology from prior case studies carried out by WRC and in conformity with its established *Ethical Guidelines for Working with Displaced Populations*.[38] Before starting the study, its purpose and methods were discussed with the host partner, UNFPA, and representatives from the government health agencies, both of which subsequently contributed to the finalization of the case study methodology.

Key informants and FGD participants were informed of the study's purposes, risks, and benefits and given the opportunity to verbally consent to participate in the interview. Names or other identifying information were not collected from FGD participants. WRC provided an information sheet with WRC's contact information and directions for anonymous reporting channels to each informant. FGDs were audio-recorded with the consent of the participants; audio recordings were then transcribed into text and the recordings were subsequently deleted. Any names mentioned during the FGDs were deleted during transcription.

All data collected for this report were stored securely on password-protected devices and data were not shared outside of the WRC case study team. All individuals or entities named in this report were named with their explicit consent.

38 Women's Refugee Commission, 2016 (unpublished).

Limitations

Due to the security situation, WRC was unable to visit sites or conduct interviews outside of Maiduguri and Jere LGAs. Although the KII guide included questions related to Borno State as a whole, several of the informants were unable to share experiences from service provision further in the field. Therefore, this case study is focused only on Maiduguri and Jere LGAs. The situation in the broader Borno State may vary significantly.

This case study was intended to document the state of contraceptive and PAC service delivery available to IDP, refugee, and host populations at a specific point in time in Borno State. While the researchers spoke to the primary providers of these services, their responses may not be representative of service delivery for the whole IDP and refugee population in Borno State, or across all time periods. The organizations delivering contraceptive services may continually be changing practices, so it is possible that the situation of contraceptive service delivery in Maiduguri and Jere LGAs may have changed significantly since the time of the case study data collection.

This report may be implicated by response bias. One reason for potential response bias is that FGDs were conducted in locations with ongoing NGO-supported contraceptive and PAC service provision; therefore, participants may have been more likely to provide positive responses on contraceptive services, due to social desirability bias, compared to participants from communities without similar access. Furthermore, service delivery providers supported the selection of FGD participants and may have aimed to select participants who were knowledgeable about contraceptives and/or have used services to make their programs appear successful. Findings are reported to reflect these potential implications.

Finally, although the researchers intended to include refugees from neighboring countries (e.g., Cameroon, Chad, and Niger) in the sample, no refugees were identified in the final sample. Instead, a small number (approximately nine) members of the host community and returnees were included; therefore, the findings represent the perspectives of IDPs, returnees, and host community members.

WRC carried out analysis of the datasets in the United States. Due to the short reporting time frame, the WRC study team was not able to involve study participants in analysis or to share preliminary results with IDP community members for community validation; therefore, interpretation of some of the data may have been affected by researcher bias. The study team attempted to mitigate researcher bias by eliciting feedback, clarification, and corroboration from the local FGD moderators regarding key themes and questions they had about content in the transcripts that was not clear. Furthermore, preliminary results and a draft report were shared with, and feedback elicited from, the SRH Working Group (WG) members in Borno State, in June 2019 and January 2020, respectively. The FGD analyses were also reviewed by the local research assistants, who had knowledge of the IDP community and context.

IV. Findings from Key Informants

Service delivery

General context

All key informants brought up the issue of ongoing insecurity in the region (fear of attack from militant extremists and clashes between these groups and the Nigerian military) and the challenges it posed to successfully delivering health services. Informants reported that due to insecurity it is challenging to deliver commodities to the field, and for health workers to access communities in need. Moreover, health workers may not remain where they are assigned due to security concerns.

According to UNFPA, MOH, and Borno SPHCDA representatives, there were tensions between host communities and IDPs at the beginning of the insurgency, with host community members reportedly fearing some of the IDPs were part of the insurgency. Informants stated that time has helped to foster understanding of the IDPs' plight among host communities and to demonstrate that IDPs are not part of the insurgency.

Additionally, informants discussed tensions due to the general conditions of poverty and the underprovision of services in Borno State in general. According to informants, some host community members presented themselves as displaced persons in an attempt to access assistance and services. Monitoring measures have since been implemented to confirm the identities of beneficiaries, but host communities continue to struggle to meet basic needs, and tensions persist.

All partners reported that they are working with the government health agencies and supporting government facilities. In addition, several organizations are running primary health clinics (PHCs) or maternal health clinics (MHCs) in areas where the MOH and UNFPA have requested their presence.

Contraception

The government health agencies and UNFPA are supporting a range of contraceptive methods and seek to have contraceptive services integrated into other SRH services in facilities. All levels of health facilities can provide oral contraceptive pills (OCPs), injectables (including intramuscular and sub-cutaneous (SC) depot medroxyprogesterone acetate (DMPA)), implants, and copper IUDs. DMPA-SC, under the brand name Sayana® Press, was recently introduced to health facilities and KIIs reported that it is becoming an increasing popular method among women. DMPA-SC is an injectable providing protection for about 13 weeks that can be used by any trained person, including community health workers (CHWs), pharmacists, and women themselves through self-injection. However, all partners interviewed reported that their programming relies mostly on short-acting methods and condoms. UNFPA and government health agency representatives stated that a limited number of partners support the provision of LARCs. Several partners confirmed that the facilities they support do not currently offer LARCs. Moreover, those organizations providing LARCs in their facilities reported low uptake. They cited several reasons, including a lack of skilled providers, lack of demand from the community or cultural barriers, high prevalence of STIs, high risk for infection when placing IUDs, poor and unbalanced counseling, and providers' general attitudes toward contraception. Permanent methods can only be provided by two government hospitals in Maiduguri.

Most respondents said that the facilities they are running or supporting have EC in stock. However, most of these facilities use EC rarely, and even then, usually for clinical management of rape (CMR). EC is only available in facilities funded by donors supporting GBV programming.

As previously mentioned, insecurity makes it difficult for health actors to reach people, and for people to reach services. MOH and UNFPA representatives spoke about the widespread destruction of health facilities and attacks on health workers by fundamentalist militants since the start of the insurgency. The low use of facilities for contraception is consistent with low use of facilities for other services, including delivery.

Respondents also reported concerns about privacy and confidentiality of services. Some NGOs use mobile teams to reach populations in insecure or difficult to reach locations, but both the one respondent who had experience with mobile teams and government health agencies mentioned concerns about confidentiality when using this strategy. However, details regarding these concerns were not clear. Even where static facilities are functional, the extent of the damage has led to a lack of privacy and confidentiality, as services are conducted all in one space or in less private locations.

Some organizations tracked continuation of methods while others did not. Some stated they are currently not actively tracking contraceptive continuation or following-up with clients who do not return. Those who are tracking continuation are using CHEWs and/or midwives to call or visit women and girls who have missed their follow-ups. All organizations who discussed this issue said that respecting confidentiality was a primary concern for these activities. No organization had a system in place for tracking expired LARCs. However, at insertion, they reported providing women and girls with the most information they could about expiration and what to do for removal.

Post-abortion care

Although PAC is part of the SRH services approved and offered by the government health agencies in Nigeria, very few facilities are offering this service. Many of the partners reported that the facilities they are supporting do not provide PAC services, with reasons including a lack of supplies, providers that are not trained on the provision of PAC or are out of practice, and the inability to keep facilities open 24/7. Additionally, stigma and taboos surrounding abortion make the community hesitant to access any related service and make providers unlikely to approach the subject.

When respondents were asked if they were aware of unsafe abortions occurring in the communities they served, their responses were mixed. Some stated that unsafe abortion is not a problem, while others reported a high incidence of unsafe abortion, especially among adolescent girls. Some believed PAC service utilization to be underreported due to the stigma meaning that adolescent girls and women are receiving PAC, but health providers are not recording these cases.

Two organizations reported community mobilization efforts to raise awareness of the importance of seeking PAC services. At the same time, these organizations are working to improve confidentiality at the facility, so community members trust the providers and services.

Respondents also reported that, although national policy allows the use of misoprostol for PAC, the use of misoprostol for this purpose was hotly contested among those creating the policy due to fear that it would be used for abortion in the facility. One organization reported they do not stock misoprostol in health facilities, but the drug is widely available in the marketplace or from chemists in the community.

Adolescents

The government health agencies reported that adolescents and unmarried women have a particularly hard time accessing contraceptive services due to stigma and negative attitudes toward adolescents, including married adolescents, and unmarried women using contraception among the community.

The government health agencies and another organization noted that before the insurgency, they established units for adolescents in many facilities, or even adolescent-specific centers. These places were safe spaces where adolescents could go, spend time, and learn about life skills, SRH, their bodies, their rights, and other topics without fear of stigma. Health workers were often present to answer questions and provide services. Due to the insurgency, these centers closed. Notably, the government health agencies and other partners are starting to reopen and expand these units with support from UNFPA.

Only three organizations reported they are actively conducting activities and programming specific to adolescents in schools and camps. Programming includes the use of peer educators and outreach to first-time mothers, who are often adolescents.

Skilled staff

Respondents were almost unanimous in reporting that there are not enough skilled health providers, especially for contraceptive and PAC services. Some respondents stated that health facilities are understaffed, with some relying on one nurse or midwife who is responsible for providing all services at the facility or in the unit. Consequently, if a client arrives for contraceptives, she may be asked to return or wait while the provider serves higher priority cases.

Understaffing has also resulted in lower level providers, like CHEWs, performing the work that had typically been done by midwives or nurses. Respondents spoke positively about the newly approved MOH task-shifting and task-sharing policies, which will allow lower level providers to provide short- and long-acting contraceptive services and also allow midwives to take on other tasks, ultimately increasing coverage and hopefully reducing the number of clients being turned away.

Many respondents also reported health workers currently staffed in facilities are not trained properly to be able to provide the full range of contraceptive services and noted the need for additional training on contraceptive service provision, especially LARCs and counseling. Those that have received training have limited practical experience.

Additionally, the geographical distribution of providers is uneven, and the government health agencies and NGOs have difficulties recruiting and retaining providers in rural or insecure areas. Even when skilled providers are placed or recruited in these insecure areas, many do not work the expected hours in their assigned facilities, if they show up to work at all.

Staff turnover is a further challenge. In addition to turnover due to insecurity, some NGOs and the government health agencies stated that providers may leave to work elsewhere after training, either by choice or by assignment from the government health agencies. Although these providers then have the skills to continue providing services, they may be placed at a facility or with an organization that does not have the other necessary components in place to provide contraceptive or PAC services.

A few NGOs noted that they tend to recruit and deploy staff from host communities or Maiduguri; NGOs rarely recruit providers from IDP populations and cited capacity as a reason.

Training

Half of NGO partners reported that they do not or have not yet provided training on contraceptive or PAC services, either because they believe staffs' prior training is sufficient, or they rely on UNFPA, the MOH, or another organization to provide such training.

Those organizations that provide contraceptive and PAC training use the national PAC and family planning (FP) guidelines. The training sessions are conducted by nurses, midwives, or doctors that have been trained as trainers, in conjunction with a trainer from the MOH. These organizations use competency-based training and include theoretical, classroom simulations, and clinical practice. They all expressed that they have plans in place both for training and subsequent follow-ups. Additional training on other topics related to good quality contraceptive and PAC service delivery are provided by almost all organizations, including infection prevention, logistics, and data completion and reporting. Notably, one organization reported that they have been training both MOH and their NGO direct service providers on FP and PAC, followed by series of on-the-job clinical coaching.

Respondents reported various challenges related to training. Due to understaffing at health facilities, it is difficult to secure staff time for training while ensuring services remain available; thus, there must be many training batches. In addition, many organizations support a range of services, and training needs extend beyond contraceptive and PAC services.

One organization tries to provide decentralized training but noted that staff motivation to attend in situ training is low, and logistics can be complicated. Consequently, providers spend substantial amounts of time outside facilities attending training. Because the providers need to come into the city and thus require lodging, per diem, and transport, the cost of training can be high.

Moreover, respondents noted that providers, organizations, and communities do not necessarily share priorities for services, which affects providers' motivation and their perspectives on training.

Finally, even when training does take place, trainers often struggle to secure a sufficient number of contraceptive service clients to ensure providers gain adequate, supervised hands-on experience during the clinical portion of the training or after the training.

Supervision

Almost all NGOs interviewed conduct clinical supervision. Most supervision assesses both individual providers and the function of the health facility as a whole. Supervision visits to NGO-supported facilities are planned, but only a few organizations reported having a system or database for tracking supervision. Five of eight organizations use checklists, and the remainder noted that they planned to implement the use of checklists soon. Supervision was described as a combination of observations, asking questions, and supervision of service delivery, both during consultations with clients and practice sessions using mannequins. Some organizations reported using coaching or on-the-job training for providers who are not reaching minimum competency levels. The majority of partners also said supervision is conducted by qualified midwives or doctors, and that they prioritize conducting supervision together with the government health agencies. The government health agencies also said that they encourage partners to conduct supervision visits and accompany partners on visits.

NGOs also reported that contraceptive services are only a part of the focus of the supervision, and their supervisors are generalists. Furthermore, even with best intentions and planning, security is oftentimes a barrier to accessing facilities to conduct planned supervision.

Commodities

All interviewees confirmed that UNFPA provides Inter-Agency Emergency Reproductive Health (IARH) kits, and that the kits required for contraceptive (Kits 1, 4 and 7) and PAC (Kit 8) service delivery have been available. UNFPA coordinates with the government health agencies to ensure the kits are available, while the Nigerian Red Cross facilitates transport. UNFPA also supports capacity

building of the Logistics Management Coordination Unit, which plans commodity distribution at the state level. Some partners noted that although the IARH kits are available, it is difficult to obtain them if their request was not included in UNFPA's proposal for IARH kits, and that there have been stockouts of the products in the kits. It is not clear whether there have been stockouts of the kits themselves at the state level.

UNFPA acknowledged this issue and noted that requests for IARH kits often come in past their deadline, or partners do not provide consumption data—one of the factors that UNFPA relies upon to determine distribution. To streamline this process, UNFPA created a standard template for partners to report on kit use; however, it is not clear whether this template has improved supply change management. Furthermore, the government health agencies and UNFPA expressed that they are working to improve systems for collecting and reporting data, including kit consumption.

The government health agencies also supply SRH commodities, including contraceptives, supplies, and equipment, to implementing organizations. If there is an urgent stockout of lifesaving commodities (like misoprostol), the government health agencies may ask UNFPA to assist in procurement. Some organizations procure additional commodities that they feed into the government health agency system while maintaining a small reserve to ensure they can supply the facilities they support in the event of an emergency. Only one organization procures and supplies commodities to their health facilities completely independently of the government health agency system.

Emergency contraception available at a local chemist in Maiduguri.

Photo credit: Falmata Musa Ali

Respondents discussed multiple supply chain challenges. The most frequently reported challenge was last mile delivery. Although insecurity poses a challenge for all field operations, there were reports of medical stock being searched, and contraceptives being singled out and destroyed by insurgents.

Another challenge is the availability of proper storage facilities, particularly climate-controlled facilities. Although most agencies noted that central warehouses provide proper storage conditions, they are unable to ensure proper temperatures at many facilities. Given the hot and humid climate in Borno State, this poses significant issues. Only two agencies had air conditioning units (solar-powered) at their facilities.

Most program managers described detailed stock management systems. Their facilities were restocked at regular intervals (weekly or monthly), and facilities kept a buffer stock (10 percent of average monthly consumption or three months' stock). Additionally, stock management and overall pharmacy management are included in training and supervision.

The government health agencies reported stockouts due to delays in the national supply chain, including delayed arrival of commodities and insufficient quantity of supplies obtained, particularly of short-acting methods. All but one informant reported stockouts in the last six months; although respondents provided a variety of reasons for the stockouts, including an oversight by an NGO staff person to submit the commodity request, lack of urgency by the NGO partner to pressure the government for supplies, and stockout of the commodities at the national and state levels. Informants said they had been stocked out of short-acting methods, or other needed supplies.

Waste is reportedly also a problem, with several respondents reporting implants and IUDs had expired due to a lack of demand.

Importantly, informants noted that partners share commodities as necessary and allowed by donors in cases of stockouts, stock that will expire, excess stock, and low stock. This collaboration is critical for ensuring stocks are used judiciously, and facilities can deliver quality services.

Community mobilization

All respondents discussed the importance of community mobilization as part of the broader health response in Borno State, but particularly as it related to SRH topics. All NGO partners reported having community mobilization strategies and having partnerships with various local actors to increase awareness and build support for contraception. Conversely, few respondents reported community mobilization activities focused on PAC.

Respondents expressed varied opinions about the perceived level of community awareness of contraceptive services and methods, with some saying community members were aware, and others saying awareness was low. UNFPA and several other partners said that community outreach should be strengthened, with UNFPA further recommending that partners engage more with the community to increase SRH knowledge and FP uptake and cultivate FP buy-in among community members by involving them in the design and implementation of programs.

All respondents agreed that social norms and community attitudes toward contraceptive use were key barriers to uptake. Opposition from men was the most discussed of these issues. Many men are reportedly opposed to contraceptive use and wish to maintain control over the number of children in the family. Although partner consent is not required for the delivery of contraceptive services, health workers reportedly request clients provide proof of their spousal consent out of fear of retribution by partners. In addition, health workers are also concerned about contraceptive service delivery provision. As previously mentioned, insurgents reportedly oppose the use of contraceptives in communities, and have destroyed supplies. The government health agencies reported implementing approaches to ensure that women understand their rights and are also strategizing on how to prevent providers from asking for spousal consent; however, they did not describe specific strategies or details for either initiative.

In addition, respondents mentioned other community attitudes that hindered use:

- stigma generated by religious and insurgent leaders;
- fears related to religious beliefs, such as if you die with an implant or IUD in your body, you will not go to Heaven, or that you should not prevent the will of God;
- rumors that the government or foreign NGOs are using contraceptive methods to control Nigeria's population or exert external control over Nigerian families;
- preferences for having large families;

- preferences for traditional methods; and
- fears or misconceptions about methods, such as the women's uterus will be destroyed, they cause cancer or infertility, and side effects, especially related to rumors of other women's experiences.

Additionally, one respondent stated that communities are not receptive to community sensitization activities on contraceptive and PAC services because they prefer "tangible" items such as cash, food, or shelter items, and they therefore do not perceive contraception as a priority. Organizations have framed their messaging accordingly and focus on the importance of birth spacing to protect women and children's health.

The respondents discussed other effective means of community mobilization, including the use of flip charts, mass media, contraception awareness campaigns, and engaging different cadres of community educators. All NGOs reported using multiple groups to spread messages, including traditional and religious leaders, traditional birth attendants (TBAs), women's groups, men's groups, CHEWs (formally credentialed by the government), and community health volunteers (engaged by NGOs). With one exception, NGO respondents engage a mix of men and women, and a mix of IDP (as community volunteers only) and host community members to deliver messages to communities. One organization engaged only women, and one organization only engaged members of the host community with the expectation that they would be less transient.

In addition, state advocacy groups comprised of traditional religious leaders who have been identified by the state are trained on health issues, including SRH. These leaders then leverage their status as community gatekeepers and influencers to disseminate information about FP and the importance of child spacing to community members.

Policy

Overall, partners said Nigerian national policy was supportive of contraceptive and PAC services and had little feedback on the topic. No respondents described barriers created by policy preventing the implementation of contraceptive or PAC services. The approved national MOH task-shifting and task-sharing policy was still being localized to fit the Borno State context at the time of publication, but all partners expressed support for these policies. More broadly, the Nigerian government is seen by the respondents as a strong partner in contraceptive and PAC service delivery, and the humanitarian response has been and continues to be adapted accordingly.

The government health agencies reported that, at the national level, there was no funding earmarked for contraceptives; instead, funding for contraceptives fell under the general budget line for maternal and child health. They also expressed that services in Maiduguri and in the outskirts of the city were better funded than in outlying areas of Borno State; however, additional information about whether this was due to the concentration of NGOs or other factors was not provided. The MOH in Borno therefore seeks complementary funding from external sources, such as UNFPA.

Several respondents reported that although the use of misoprostol for PAC has been approved in policy, it tends not to be provided in practice. Respondents shared that misoprostol is widely available in the community; however, resistance against misoprostol persists, and providers hesitate to use misoprostol in the facility. One respondent expressed that there is stigma associated with misoprostol, given its use in safe abortion care, and a result, some parties were afraid of approving misoprostol for use in health facilities for PAC. The respondent did not elaborate further but stated that misoprostol was ultimately approved for inclusion in PAC protocols and was therefore approved for use in facilities.

Coordination among partners

UNFPA collaborates with government health agencies to coordinate various aspects of the SRH response, including commodity provision, training, connecting SRH implementers and resources, needs and resources assessments, and research. Requests for support from partners on issues such as capacity building and commodity procurement are generally submitted to UNFPA, who in turn collaborates with the SMOH to address requests. UNFPA and the SMOH agreed that their partnership has been successful.

UNFPA, in conjunction with the SMOH, hosts a monthly Borno State Reproductive Health Sub Working Group (RHSWG) meeting. Respondents expressed that the meeting has been a useful forum to share best practices, gaps and challenges, to form and build relationships, and to coordinate the overall response. Several respondents noted that the meetings have been particularly useful to distribute commodities according to the needs of certain organizations, as previously described.

However, some respondents said the meetings have lost focus and become repetitive, resulting in decreased motivation and participation. When queried, UNFPA and partners explained that meetings suffer from inconsistent attendance, rendering it necessary to devote a considerable amount of time to recapping prior meetings and difficult to advance discussion and decision-making. Additionally, multiple respondents expressed that partners only coordinate during the meetings, and rarely collaborate outside of the structured meetings.

Respondents reported that further collaboration was required to coordinate and track training for providers. As previously discussed, training is not well harmonized across actors, hindering the efficacy and timeliness of training.

Additionally, although partners report being well trained on the MISP and CMR by UNFPA, there is a need for training on more comprehensive SRH services.

A few other issues that were raised regarding coordination included:

- lack of coordination with the broader health sector, including the fact that SRH data are not discussed in the health sector meetings;
- overlap or duplication of some activities; no additional information was provided on which activities; and
- strong coordination within Maiduguri, but lack of representation and coordination of actors working in LGAs outside the metro area

Data collection and use

Contraceptive service delivery data are routinely collected by all partners; however, the extent to which partners were routinely collecting PAC data was less clear. All NGO respondents reported using the standard registers and data reporting tools agreed upon and provided by the government health agencies. The government health agencies collect and review data using District Health Information System (DHIS2).[39] Most partners expressed that the data were collected monthly, and the review of data quality was part of routine supervision.

However, several partners expressed concerns over the quality of data they received from health facilities, including underreporting (i.e., not sending reports or not sending complete reports) and

39 DHIS2 was developed by the University of Oslo: https://www.dhis2.org/.

over-reporting (i.e., to show that more services were provided than in reality). Additionally, data are often provided late, or are missing. The government health agencies reported implementing training for data collectors and monitoring and evaluation officers.

Most organizations reported reviewing data regularly, usually monthly, with staff. Additionally, half of the program managers reported having quarterly data review meetings in which they invite key stakeholders, including government health agencies' representatives, community members, providers, and NGO staff, to review data over the latest period. They expressed that these meetings were a good opportunity to provide feedback to and receive feedback from communities and service providers, and to hold all actors accountable.

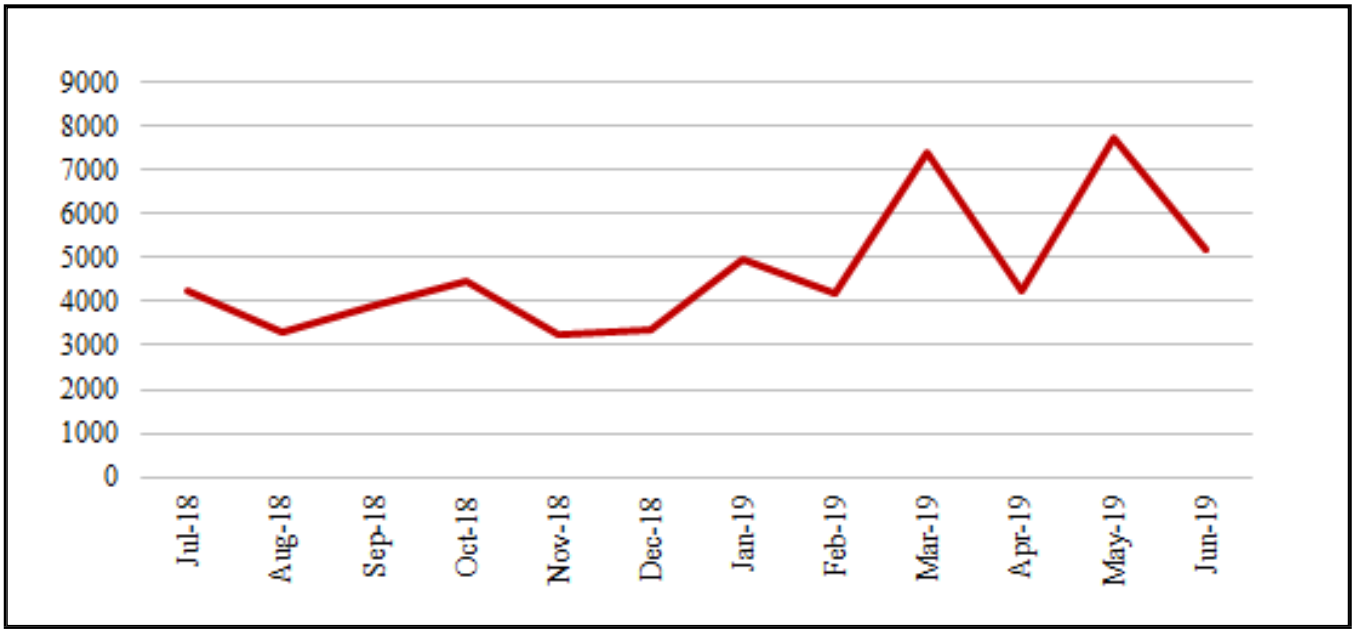
Some managers also reported that the quality of services is also being evaluated through client exit interviews, FGDs, and data reviews.

The head of family planning in the procedure room at the clinic in Mogcolis. There was no supplemental lighting in the room.

VI. Service Statistics

UNFPA provided aggregated data from all UNFPA-supported health facilities (n=127-143)[40] in Borno State from the 12-month period prior to the case study. The data show a modest, but general, increase in new contraceptive clients during this period (**Figure 3**).

Figure 1: New Contraceptive Clients (n=56,162), UNFPA-supported facilities (n=127-143), July 2018 - June 2019

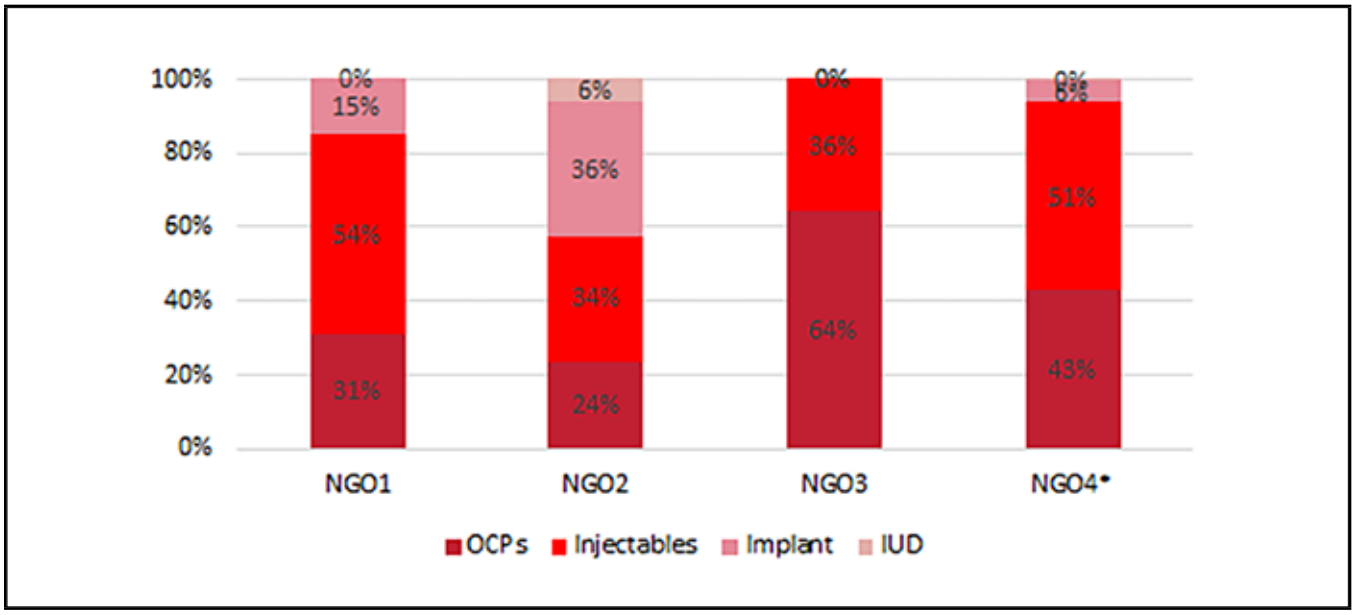


Additionally, the team received data on the method mix from four implementing agencies. The data was from July 2018 to June 2019 (**Figure 4**). The types of contraceptive data received varied by agency, so we only assessed the four contraceptive methods (OCPs, injectables, implants, and IUDs) that were reported consistently by all four agencies. One organization did not supply the data for three months of this period (January to April 2019). Overall, the data demonstrates a skew toward OCPs and injectables, with three NGOs having over 85 percent of the new clients accepting one of these short-acting methods. These trends are consistent with facility assessments and reports from KIIs.

**Data for nine months: July–December 2018 and April–June 2019.*

40 Between 127 and 143 health facilities reported between June and December 2018, and 132–143 health facilities reported their findings between January and June 2019.

Figure 2: Method Mix by Organization, July 2018 - June 2019



VII. Findings from Health Facility Assessments

Health facilities assessed

The WRC study team conducted facility assessments in seven health facilities: one hospital, four PHCs, one dispensary and one MHC (**Table 2**). Per national policy, PHCs, dispensaries and MHCs should offer short- and long-acting methods, operate 24 hours per day, seven days per week (24/7), and offer PAC services. For the purpose of the results, these facilities are grouped together as "primary facilities". The majority (5/7) health facilities were supported by an NGO.

Table 2: Health facilities assessed

Facility name	NGO(s) supporting	Type of facility
State Specialist Hospital	—	Hospital
Mogcolis IDP Camp	—	PHC
Teachers Village IDP Camp (UNICEF facility)	Action Health Incorporated	PHC
Farm Centre IDP Camp	Planned Parenthood Federation of Nigeria	PHC
Stadium IDP Camp	International Rescue Committee (IRC)	NGO/private PHC
Bakassi SRH Facility	IRC	NGO/private MHC
Bulabulin Dispensary	CARE	Dispensary

General infrastructure

Only three facilities (one hospital and two primary facilities) functioned 24/7. Three did not have electricity; however, one of these facilities is new and awaiting the installment of solar power. The remaining facilities had abbreviated hours due to understaffing.

Table 3: General infrastructure

	Available to function 24/7	Functioning power supply	Functioning water supply	Minimum infection prevention supplies*	Functional water supply	Washing station
Hospital (n=1)	1	1	1	1	1	1
Primary facilities (n=6)	2	3	2	1	6	6

**Minimum infection prevention supplies included presence of a washing station with soap, gloves (sterile or non-sterile), a regular trash bin, antiseptics, and an appropriate disposal method for medical waste. Sharps are separated from other waste.*

All facilities had functioning water supplies, washing stations, and safety boxes for the disposal of sharps at the time of the assessment (although one such safety box was overfull). However, only two of seven facilities had the minimum supplies required for infection prevention. Of the five that did not meet minimum standards:

- three facilities did not separate medical and nonmedical waste, but all other measures were in place
- one facility did not have essential supplies, including antiseptics and soap, and did not separate medical waste from nonmedical waste
- one facility did not have the above, nor did it have infection protections supplies or appropriate waste disposal systems

Contraception

Of the seven assessed facilities, one hospital and one primary health facility qualified as functioning contraceptive service delivery points, defined as having provided contraceptive services in the last three months, skilled staff present, and the equipment and supplies to provide a minimum method mix (IUDs, implants, OCPs, injectables (including DMPA-SC), condoms, and EC) (**Table 4**). All facilities provided short-acting methods and male condoms. Four of seven facilities had EC available, but facility staff only provided EC to survivors of sexual assault, and it was therefore stored in a separate space from where the other methods were provided.

Several facilities stated that although they were prepared to provide implants or IUDs, they had not provided one or both methods in the last three months due to low demand (e.g., women did not ask for them, and when they wanted them, husbands did not consent). Some health facility staff also noted that implants and IUDs were not provided because STIs were common. However, upon further assessment, these facilities also lacked the necessary equipment and supplies, and/or the number of trained providers were either insufficient, or providers had lost their competence in the absence of opportunities to apply and practice their skills. Additionally, two facilities reported

providing implants in the three months prior to the assessment but did not have the supplies and equipment to do so at the time of the assessment. Providers reported expiration of LARCs (namely IUDs and implants) due to low demand for these commodities. Health facility assessments also discovered expired LARCs, and at times, expired commodities were mixed with unexpired commodities in stock inventories. Providers also reported stockouts of OCPs and injectables were common because of high demand from women.

At four of the seven facilities, health workers had to gather supplies, equipment, and contraceptives from several different rooms or locations in the facility. In one facility, many of the supplies were locked in a cabinet and the person with the keys was not present that day.

Although all facilities reported being able to provide counseling, only four had any type of information, education, and communication (IEC) materials on contraceptives; of these facilities, two only had displays that showed the different types of methods available as opposed to contraceptive information leaflets, or contraceptive information flip charts. A significant finding was that at least three facilities had IEC materials specifically on DMPA-SC. While the lack of IEC materials did not preclude these facilities from being considered functioning service delivery points, it undoubtedly has consequences for the quality of counseling available.

Table 4: Functioning contraceptive service delivery points

	Health facility (n=7)*
Counseling materials available	4
IUD	2
Implant	3
OCP	7
Injectable contraceptive	7
Condoms	7*
EC	4†
Functioning contraceptive service delivery point	**2**

**Three provide male condoms only.*
†At two locations, EC available only for CMR, and not located in Family Planning Room.

All the facilities used the standard FP register provided by the MOH. This register listed new clients and referrals from other services in the facility but did not contain a space for complications from contraceptive procedures, nor a space to document method switching. Providers marked switchers in the method column or were unable to describe where this was documented. The registers were completed correctly and completely in three of the seven facilities assessed.

Post-abortion care

Only four of the seven facilities reported providing PAC services in the three months prior to the assessment. Of these four, two facilities qualified as a functional PAC service delivery point. A functional PAC service delivery point is defined as having skilled staff providing PAC services which are available 24/7 (PAC is considered emergency care), offering contraception to all post-abortion clients, and the equipment and supplies required to provide PAC with manual vacuum aspiration (MVA) or misoprostol.

Table 5: Provision of post-abortion care to an acceptable standard	
	Health facility (n=4)*
Post-abortion contraception is offered to all PAC clients	4
Skilled staff trained to provide PAC	4
PAC services available 24/7	2
Equipment and supplies to provide PAC with MVA	2
Supplies to provide PAC with misoprostol	4
Functioning PAC service delivery point	**2**

**Only facilities reporting that they offered PAC services were assessed.*

Two facilities had the supplies and trained staff to provide PAC with misoprostol but were not functional 24/7 and therefore did not qualify as functional PAC delivery points. Notably, at the hospital, all the necessary drugs (including misoprostol) were available, but they had to be purchased by the client prior to treatment. None of the facilities had protocols for PAC accessible to staff.

In two of the four facilities providing PAC, PAC clients were registered on a PAC-specific register. The remaining two facilities registered PAC patients on the observation ward register and the gynecological services register, respectively. Only one of the four registers was completed correctly. Additionally, in all but one facility it was not possible to assess the appropriateness of the treatments based on the diagnosis listed in the register, as the diagnosis either was not specific or was simply "abortion".

Pharmacy and drug storage

Six of the seven facilities had pharmacies on site. The remaining facility was waiting for the installation of electricity before establishing a full pharmacy. All the pharmacies had registers, could explain the mechanism in place for ensuring that expired medications and supplies were not distributed, and made requests for pharmaceuticals (including contraceptives), supplies, and equipment at regular intervals (monthly or weekly). Furthermore, all pharmacies either used First Expired, First Out (FEFO) or a combination of FEFO and First In, First Out (FIFO) for their stock management system.

Three of the six facilities reported stockouts in the last three months, although only two of these were reports of contraceptive stockouts. The two reports of stockouts of contraceptives were reported as the result of a stockout at the "supplier" (e.g., UNFPA or SMOH).

Only two of the facilities assessed had proper storage conditions. The remaining facilities did not have climate control in place, did not use shelving or slates, and had little to no ventilation in the room. Additionally, there was a security incident in which a purse was stolen out of one pharmacy while WRC staff was present at the facility, implying that the space was not secure. Furthermore, only three of the pharmacies appeared clean (e.g., free of dirt, dust, and cobwebs).

Table 6: Pharmacy and stock management				
	Stockout reported in the last three months	**Pharmacy available 24/7**	**Drugs properly stored***	**Pharmacy room was clean**
Hospital (n=1)	1	1	1	1
Primary facilities (n=5†)	3	3	1	2

**Properly stored means the pharmaceuticals were secured and protected from moisture, heat or infestation (e.g., placed on shelves or slats, ventilated).*

†One facility did not have a pharmacy and was not included in these results.

Data use

Only one facility displayed graphs of the contraceptive services data from the facility. Another facility stated their intent to do so but were unable to due to construction. Providers at these two facilities were the only ones who were able to describe trends in their contraceptive services data over the past few months. No facilities displayed graphs of PAC service delivery from the facility.

All the primary health facilities stated that they held regular data review meetings on a monthly basis, and they all reported that this meeting had happened at least once in the three months preceding the assessments. Although almost all assessed facilities had providers who could explain actions that were taken from those meetings, only two facilities had providers who could describe action taken based on the data and specific to contraceptive services.

Table 7: Data use at assessed facilities	
	Health facilities (n=7)
FP graphs displayed in facility	1
Provider could describe trends in FP data	2
Data review meeting held in last three months	6
Provider could describe action taken as a result of data	2

Knowledge and attitudes of service providers

Fourteen health workers completed the knowledge and attitudes assessment. Detailed tables with responses can be found in Appendix C.

Table 8: Professional classification of respondents (n=14)

Professional classification	Number
Medical doctor	1
Midwife/Nurse midwife	7
Nurse	2
CHEW	3
CHO	1

Several respondents did not complete the entire questionnaire, so the number of responses varies by questions.

Thirteen of the 14 providers reported providing contraceptive counseling in the past three months. About a quarter (four) of respondents reported having provided an IUD in the last three months. Almost two thirds (nine) reported having inserted an implant; these are the same nine providers that reported having been trained on implant insertion.

Overall, providers' attitudes and competencies as reported in the provider surveys were more positive compared with key informants' views on PAC provision and providers' attitudes toward PAC. Eleven out of 14 health providers reported providing post-abortion contraceptive counseling. Seven respondents reported providing PAC with MVA, while nine respondents reported providing PAC with misoprostol in the past three months. Eleven respondents reported having been trained on providing PAC using misoprostol and MVA. These conflicting findings may be because the facilities were purposively selected by partners, meaning that providers in these facilities may have more positive views on and higher competencies in PAC than providers in other facilities.

Provider knowledge

The tool also included 10 questions to assess providers' technical knowledge of contraceptive services and PAC; 13 responses were included in the analysis for this section. Respondents demonstrated a reasonable level of knowledge of contraceptive services, with a mean score of 4.4 out of 6 (Appendix C, **Table 15**).

Only four out of 13 respondents were able to correctly identify the common changes in a women's menstrual period following the insertion of an IUD. This corresponds with comparatively fewer respondents reporting having ever received instruction or training on IUD provision. However, this has potentially negative implications for counseling women about IUDs and adequately preparing them for initial heavy bleeding.

Knowledge of PAC was lower, with a mean score of 1.8 out of 4 (Appendix C, **Table 16**). Less than half of respondents (six) were able to correctly identify when a woman's fertility returns after abortion or until what point, based on uterine size, MVA and misoprostol can be used to treat an incomplete abortion. Even fewer respondents (three) were able to correctly identify the recommended dosage of misoprostol to treat an incomplete abortion, while just under two

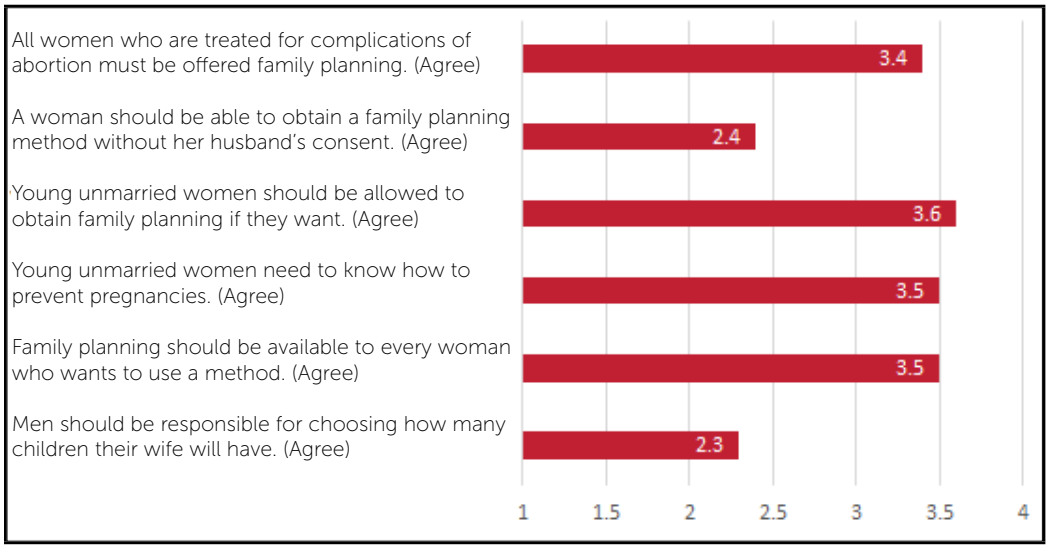
thirds of respondents (eight) knew that they should inform the PAC client on when she will be able to conceive again, provide contraception or a referral for contraception, and educate on the consequences of an unsafe abortion.

Provider attitudes

Results from the section of the questionnaire measuring provider attitudes are presented as mean scores ranging from one to four for each statement. All scores are based on Likert scale responses to each statement: strongly agree (4), agree (3), disagree (2), and strongly disagree (1). Some statements were reverse coded so that high means always signal attitudes that promote equitable and good quality contraceptive and abortion care.

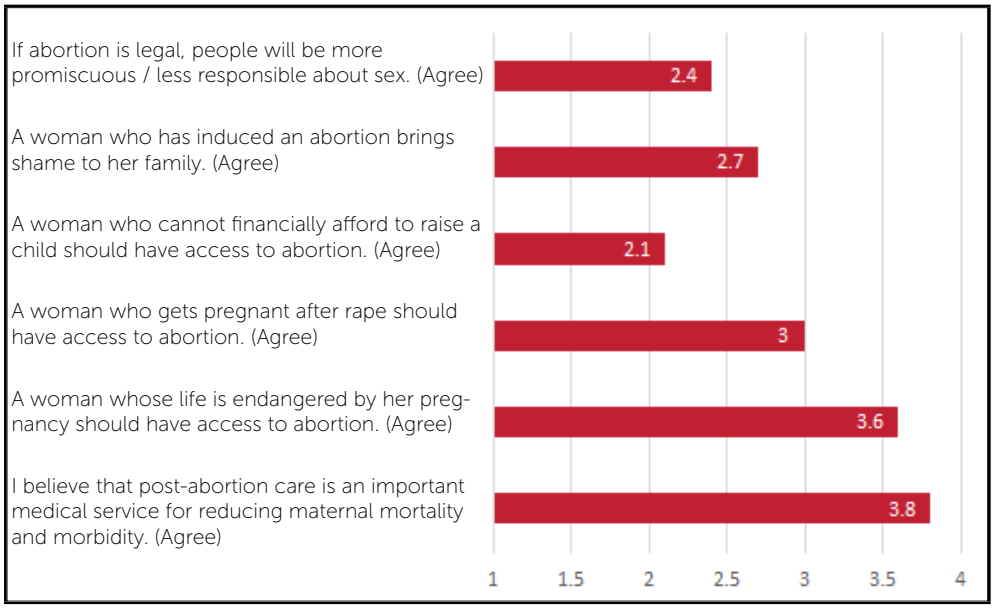
Respondents demonstrated attitudes that were generally supportive of access to contraceptive services (**Figure 3**). For example, the mean score for the statement "Family planning should be available to every woman who wants to use a method" was 3.5. Findings also pointed to attitudes that were generally supportive of access to contraceptive services and SRH information by young unmarried women, as evidenced in responses to the statement "Young unmarried women should be allowed to obtain family planning if they want," which had a mean score of 3.6, and "Young unmarried women need to know how to prevent pregnancies," which had a mean score of 3.5. However, attitudes were less favorable regarding women's decision-making regarding contraception, with the statements "A woman should be able to obtain a family planning method without her husband's consent" and "Men should be responsible for choosing how many children their wife will have" receiving mean scores of 2.4 and 2.3 respectively.

Figure 3: Provider attitudes toward contraceptive services (n=14)



Attitudes toward PAC were generally favorable (**Figure 4**). The statement, "I believe that post-abortion care is an important medical service for reducing maternal mortality and morbidity" had a mean score of 3.8. Respondents generally agreed that "A woman whose life is endangered by her pregnancy should have access to abortion" (mean score: 3.6).

Figure 4: Provider attitudes toward PAC (n=14)



In terms of induced abortion, respondents held less favorable attitudes overall. Respondents were more favorable toward induced abortion to save a woman's life (mean score: 3.6), but less favorable in cases of rape (mean score: 3) or poverty (mean score: 2.1). The statement "A woman who has induced an abortion brings shame to her family" showed a generally negative attitude and reflected stigmas against abortion (mean score: 2.7). Overall, providers seemed to believe that legalizing abortion would result in people being less responsible about sex (mean score: 2.4).

VIII. Findings from the Community

Ten FGDs were conducted with 119 individuals, including 13 individuals living with a disability. Five FGDs were held within an IDP camp in Maiduguri, while another set of FGDs was held in a host community in Jere LGA. The individuals who participated in the FGDs held in the IDP camp in Maiduguri were all IDPs. In contrast, the FGDs held in the host community in Jere LGA included members of the host community as well as IDPs and returnees.[41] See **Table 9** for additional information about the focus group composition.

Table 9: Focus group discussion composition

Group	Setting	Location	Number of participants	Marital status	IDP status
Adolescent girls (14–19 years)	IDP camp	Maiduguri	15	Mostly unmarried	IDPs
Adolescent girls (14–19 years)	Non-IDP camp	Jere LGA	6	Mostly unmarried	Mix of IDPs, host community members, and returnees
Women (20–24 years)	IDP camp	Maiduguri	13	Married and unmarried	IDPs
Women (20–24 years)	Non-IDP camp	Jere LGA	10	Married and widowed	Mix of IDPs, host community members, and returnees
Women (25–45 years)	IDP camp	Maiduguri	12	Married and widowed	IDPs
Women (25–45 years)	Non-IDP camp	Jere LGA	20	Married and widowed	Mix of IDPs, host community members, and returnees
Men (20–45 years)	IDP camp	Maiduguri	12	Married	IDPs
Men (20–45 years)	Non-IDP camp	Jere LGA	8	Married	Returnees only
Adolescent boys (14–19)	IDP camp	Maiduguri	9	Unmarried	IDPs
Adolescent boys (14–19)	Non-IDP camp	Jere LGA	13	Unmarried	Mix of IDPs, host community members, and returnees

41 Returnees are defined as individuals who were members of the community, but left the community due to the militant insurgency, and subsequently returned to the community.

Contraceptives

Desire for birth spacing and contraceptive methods knowledge

FGD participants across groups reported that overall knowledge about birth spacing and contraception had increased among community members and had therefore increased the demand for contraceptive services, especially among women. An adolescent boy explained:

> "Girls nowadays have been enlightened. If you have sex with them, they will take some drugs and some men will use a condom to have sex. As long as you are doing this, the girl will not get pregnant." (Adolescent boy, IDP camp).

Compared with participants in the host community's mixed group, adult women in the IDP camp group explicitly linked displacement to increased knowledge of contraception and birth spacing. Women reported that communities had learned about the importance of contraception and birth spacing since the onset of the crisis. Men in the IDP camp group were less likely to make direct connections between increased knowledge of contraception and birth spacing with displacement, though they made references to newfound knowledge and access more broadly. One married man in the IDP camp group described how knowledge and education have encouraged contraceptive use, though some women only use contraceptives if they have issues giving birth.

Women in the IDP camp groups expressed their desire for birth spacing and a respite from repeated pregnancy due to the challenging conditions resulting from the insurgency and displacement, along with their want to provide their children with food, clothing, education, discipline, and other necessities.

> Participant 1: "Our condition today is poor. If you have one girl and two boys that's enough. Before people had many children, but now they have become wise—the way of life has changed. You can't give children good care, training, and education if there are many." (Woman 20–24 years, IDP camp).

> Participant 2: "It is better to have one, two, or three children and then stop. Anything you get [income] you will use to send them to school. But if there are many children, there will be hardship, hunger, and sickness—you are the one handling this problem and then another problem arises. This is why we rest." (Woman 20–24 years, IDP camp)

These statements reflect the sentiments of many participants. Women and men in all groups—IDP camp groups and the mixed group—described the harsh conditions in which they currently live and expressed their desire to use contraception to limit births and enable them to improve their children's lives through adequate hygiene, nutrition, and education.

Participants in the non-IDP camp groups did not refer specifically to displacement as a reason for increased knowledge or increased desire to use contraception or space their births, likely due the fact that most participants were host community members. Instead, some participants in the non-IDP camp groups referenced the current living situation more broadly as a reason to use contraception and limit births.

A few women in the IDP camp groups reported that it was important to limit births because it was difficult to move with many children during an attack or emergency. Due to the insurgency, individuals were concerned that they may experience additional displacements. One woman said:

> "There are several things in this unpeaceful world today. If you are giving birth frequently and if something happens, which one will you carry, which one will you

> pack, and which one will you leave? I have had a contraceptive in my body now for five years and I am begging God to continue giving me rest." (Woman 20–24 years, IDP camp).

Although all groups demonstrated at least some limited knowledge about contraception, with most participants (except adolescent boys), especially women and adolescent girls, reporting that they support child spacing, knowledge regarding specific contraceptive methods varied significantly between sexes and to a lesser extent between IDP camp and non-IDP camp groups. Overall, women and girls had more knowledge on contraceptives than men and boys across groups, with the IDP camp groups having more knowledge compared with the non-IDP camp groups. In general, women and girls in the IDP camp groups had the most contraceptive knowledge and boys in the non-IDP camp groups has the least. Although adolescent boys in both groups reported that they have relationships with girls, most were not familiar with any contraceptive methods and reported that they do not access SRH services. Notably, men in the IDP camp group were not knowledgeable about most contraceptive methods and shared sentiments against contraceptive use. A few of these men knew about condoms and reported using them, though expressed their dislike for them. Men in the non-IDP camp had mixed opinions about contraceptive use, with most reporting that they use the withdrawal or calendar methods to prevent pregnancy.

Women and adolescent girls across groups could identify most short- and long-acting methods. Women in the older groups (25–45 years) were not familiar with IUDs. When queried about the methods with which they were familiar, women and adolescent girls were the most likely to identify both short- and long-acting methods, including tubal ligation, which they referred to as "turning the womb." However, across groups, no participants mentioned vasectomy. All groups were more knowledgeable about short-acting methods of contraception than long-acting methods. Even women—who were most likely to cite or discuss long-acting methods—discussed these methods with less accuracy compared with short-acting methods.

Men and boys in both groups, especially boys in the non-IDP camp group, had very low knowledge of specific methods. One married man in the IDP camp group clearly stated

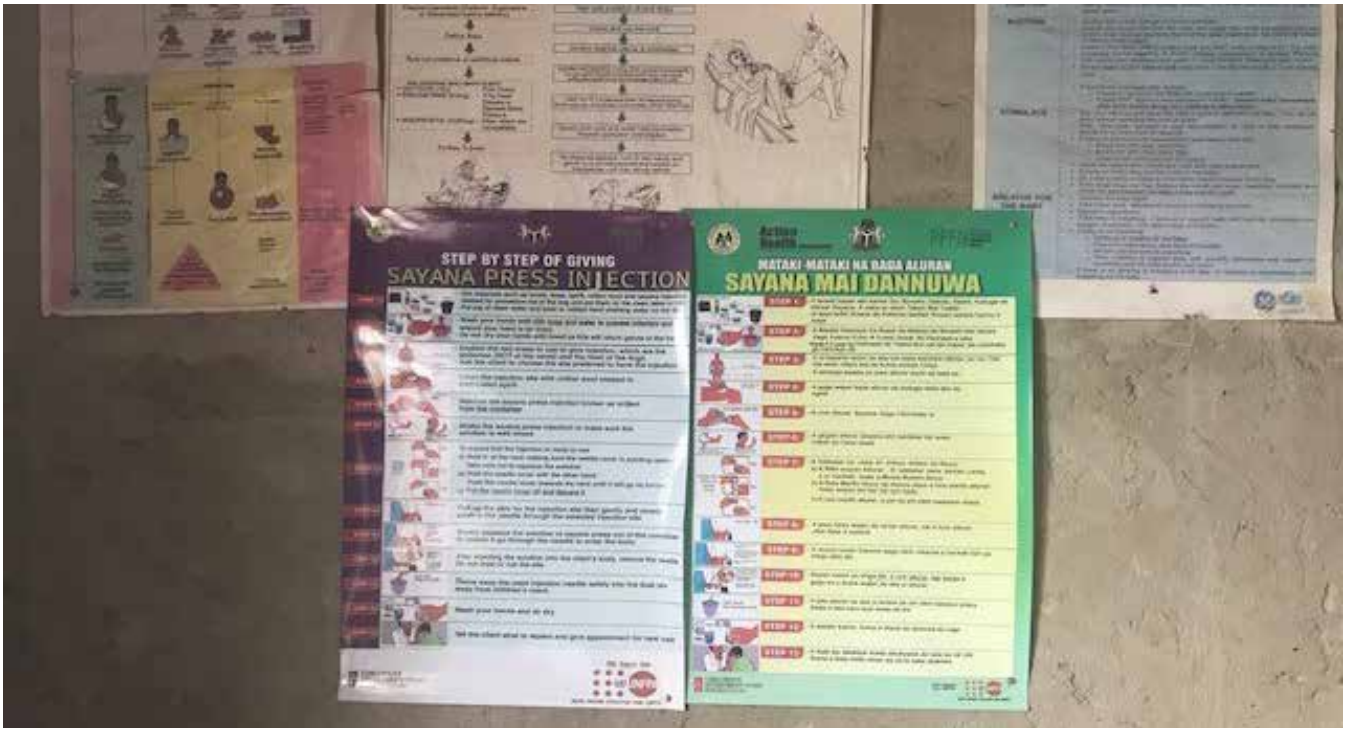
"I don't even know one [method] among them." Knowledge of IUDs in particular was very low, with condoms and injectables the most commonly identified methods of contraception. Some men and boys had very limited knowledge of "family planning," understanding it as being synonymous with "the pill." Adolescent boys referred to "drugs" as ways to prevent pregnancy, though defined such drugs as Ampiclox (antibiotic medication) rather than contraceptive pills. Many men and adolescent boys across groups identified the (male) condom as a method to prevent pregnancy.

In general, participants in all groups were not familiar with EC, including emergency contraceptive pills. Most participants erroneously believed that EC is used to terminate an established pregnancy.

Participants also relayed misinformation about ways to prevent pregnancy after unprotected sex:

> "Paracetamol, one sachet will stop you from getting pregnant. Some take Flagyl [antibiotic medication]. The more a woman takes will abort the pregnancy. And some dissolve salt and drink it. It aborts the pregnancy or stops sperm." (Adolescent girl, non-IDP camp).

The concept of EC was also most unfamiliar to married men in the non-IDP camp group and adolescent boys across groups. When probed about EC, married men in the non-IDP camp group responded by discussing traditional methods of abortion instead of EC, such as a woman drinking



IEC materials displayed at the IPPF-supported clinic in Farm Centre IDP camp. Sayana Press is a new contraceptive method administered by IPPF-trained health workers in both clinic and community settings.

neem tree leaves so "the bitterness will abort the pregnancy." Men in this group also said Ampiclox can be used after sex to kill sperm and remove a fertilized egg via urine. When asked about EC, adolescent boys also shared misconceptions about abortion methods, stating that women can use "Coke and Ampiclox, Maggi [local seasoning], or something very bitter" to abort a pregnancy (adolescent boys, IDP camp).

Participants in all groups mentioned traditional methods to prevent pregnancy. Men in the IDP camp group explained that community members consulted the traditional healer, who tied a charm for them to prevent pregnancy. Adult men also referenced the calendar method and withdrawal, while adolescent boys referenced Ampiclox as a common method. Most groups agreed that these methods were commonplace and generally accepted practices within their communities. However, some women and adolescent girls noted that traditional methods had negative side effects and that modern contraceptive methods were preferred. For example, women in the host community discussed the following:

> Participant 1: "They go to traditional healers to get herbs that will prevent them from getting pregnant for a long time, but contraceptives are supposed to be obtained at the hospital."
>
> Participant 2: "Some write Qur'an surah on a board using black ink. They wash it using water and then drink the water."
>
> Participant 3: "Some take the traditional method and rubutu [written prayers]." (Women 20–24 years, non-IDP camp).

Attitudes and misconceptions about contraceptives

Participants in all groups reported misconceptions and negative attitudes toward contraceptives, particularly in regard to side effects. Common misconceptions mentioned included the belief that frequent or sustained use of contraception caused health issues, such as disease, infection, and damages to the womb. For example, one adolescent girl was afraid of condoms for this reason, explaining that "if you are frequently using condoms it causes disease. There is a chemical that causes diseases, damaging womb veins and the stomach, and you won't even know the specific problem." (Adolescent girl, non-IDP camp).

Participants reported that misconceptions and negative attitudes hinder individuals from obtaining contraceptives. One adolescent girl in the host community group stated:

> "They are complaining about giving birth frequently, they want to rest, but they are told it will lead to problems in the end—that is why they are afraid to obtain contraceptives." (Adolescent girl, non-IDP camp).

Sources of information on family planning and contraceptive methods

Participants reported various trusted sources for information on contraception, though most reported receiving information from hospital, clinics, and community mobilizers or "volunteers" (e.g., CHWs, NGO workers) who "enlightened" or "sensitized" people. All participants across both IDP camp and non-IDP camp groups, except for adolescent boys, emphasized the importance of and/or expressed appreciation for community mobilizers who traveled from house to house to educate women and their partners about the importance of contraception and provide information on where and how to access contraceptive services. Participants reported that volunteers and mobilizers were primarily women.

Some adolescent boys in the host community group and adolescent girls in both groups reported that friends or "word-of-mouth" encourage adolescents to access contraceptives. As previously noted, adolescent boys had very low knowledge about contraceptive methods and contraceptive services in general.

Some adult men and women across IDP camp and non-IDP camp groups noted that women received information on contraception during antenatal visits at hospitals and at health facilities more generally. Adult men reported that if they needed advice about contraception, they consulted women engaged in commercial sex. Some participants reported that information about contraception is shared between friends during social gatherings, such as wedding and naming ceremonies, and "wherever women meet." Other trusted sources of contraceptive information mentioned by participants included the radio, schools, and chemists. Respondents also reported that husbands and wives share information about contraception with each other at home.

Most participants reported that people in their communities obtained contraceptives from a hospital or a clinic. Some participants reported that people obtained contraceptives from chemists, and, to a lesser extent, from NGO workers and community mobilizers. Some adult men and adolescent boys reported that they received condoms from women engaged in commercial sex.

Factors influencing contraceptive use

Male partners

Participants in most groups reported that male partners' opposition to contraception was a significant barrier to its use. Both women and men perceived contraception to be the responsibility of women, particularly because women and girls were assumed to be the primary buyers and users of contraceptives.

However, male and female participants reported mixed perspectives on who was responsible for deciding whether to use contraceptives. Even if participants shared beliefs that the decision was the woman's or was to be made jointly between partners, participants reported that women needed their husband's permission to obtain contraceptives. Given that some husbands were against their wives using contraception, both women and men reported that some women obtained contraceptive services without the knowledge of their male partners. Some married woman traveled outside of their communities to obtain contraceptive services because they did not want community members or their husbands to find out.

One woman aged 20–24 years from the host community explained that women obtain contraceptives without their husband's knowledge because they are the ones who suffer from pregnancies and having many children, not the husband. Other women disagreed and reported that women do not disobey their husbands by obtaining contraceptive services without permission, but rather waited to do so until their husband consented. One woman explained: "Family planning is very important. You will advise your husband about contraception and if he accepts, good. If he does not, then you will advise him often until he understands and agrees. Then, you can go and obtain the implant." (Woman 25–45 years, IDP camp).

Some adult women and men across groups reported that once men learned about the importance of birth spacing and contraception, they supported their wives in using contraceptives. One woman explained how some husbands even encouraged their wives to obtain contraceptives:

"Your husband will trouble you, 'why don't you go and get family planning?' Before you go to the NGO for an injection, their volunteer has come and is encouraging you to go. 'Why do you not go and take it?' Your husband will always trouble you. It will even lead to fighting between you. NGO workers will come and talk to your husband, asking 'Why won't she use it?' Even the husbands don't like it—they understand the importance of family planning." (Woman 25–45 years, IDP camp).

This information also suggests that community mobilizers had an influential role in encouraging the uptake of contraceptives and may therefore be an important way to reach men with information on contraception and to encourage behavior change.

Some men acknowledged that despite knowing about contraception and the reasons why people in their communities used it, they and their wives did not use contraception and did not intend to do so. One man aged 25–45 years asserted that he would never use FP. In contrast to the IDP camp women's groups, who relayed that the insurgency and the harsh conditions of displacement were key drivers of their demand for contraception, a few men in the IDP camp groups explained that the insurgency and resulting frequent movement, harsh conditions, and fear of death were powerful reasons not to use contraception. One married man from an IDP camp explained that bomb blasts have killed some men's entire families, with one recent suicide bombing killing 30 individuals in a nearby community. The fear of dying was therefore fueling some men's desire to have a large

number of children, as they hoped that by having many, some might survive and may even be able to defend their families against militant insurgents.

Religious beliefs and traditional and religious leaders

Adult men and women reported that traditional and religious leaders, and religion more broadly, influenced community members' beliefs regarding contraception. In contrast, adolescents did not discuss the influence of religion or religious leaders on their perceptions or use of contraception. Some women and many men reported that God decides how many children an individual will have. Men in the IDP camp group also reported beliefs that doctors and religious scholars can also decide how many children a couple should have.

Most pointedly, some men clearly stated that they were against using contraception because it is against Islam. One married man in the IDP camp group explained that he and fellow Muslim community members did not use contraceptives to plan births as their religion prohibited it and it was therefore not for them to decide.

Reports of traditional and religious leaders' support of contraceptive use were mixed among men and women. Some participants reported that religious leaders spoke about the importance of contraception and birth spacing, while other participants reported that religious leaders did not promote the use of contraceptives. Women in the host community reported that religious leaders and other influential community members not only supported contraceptive use and birth spacing, but actively encouraged community members to do so. One woman explained:

> "Sheiks, bulamas, lawams, area religion leaders and all community leaders do briefings on contraception. They preach, 'if you have a problem, you should rest.' For example, if a woman is giving birth and she is suffering, or if they are operating on her during birth, or for those that suffer a lot even before giving birth. On all these kinds of women's problems the religious leaders preach 'let them rest or space for one or two years." (Woman 25–25 years, non-IDP camp).

This statement indicates that although religious leaders may preach about the importance of rest for women who have difficulties with childbirth, they may not support child spacing for women who do not have problems giving birth. This was confirmed by men in the host community group, who explained that the Islamic religious leaders only supported birth spacing if having more children would put the mother's health at risk.

A few participants in the IDP camp reported that religious leaders no longer actively opposed contraceptive use because they understood the importance of birth spacing due to the harsh living conditions in the IDP camp. When asked what religious leaders say about contraception, one woman responded:

> "In this camp they haven't said anything about it. We have never faced a problem, such as 'why do people use it' because of the displacement conditions that we are in. At this time, no one can say or ask, 'why do you rest,' or 'why are you seeking rest?' Everyone knows the problems inside here. No one is willing to be giving birth every day." (Woman 20–24 years, IDP camp).

A woman in the IDP camp suggested that if religious leaders espouse the importance of contraception and birth spacing in mosques, then men will listen to them and support their wives in using contraceptives. She stated:

> "Religious leaders only talk at the mosques and husbands must listen to them. If sheiks or imams will stand and talk about family planning, a man must listen to it. If he hears and is interested in it, when he comes home he will tell the wife that this is what they said at the mosques and see if the wife is also interested. But she wants the husband to talk first. Some women, even though they want contraception, because they fear their husband, they will wait until the husband has permitted it. If the religious leaders are sensitizing on it, the husband will hear and then the wives will also hear and apply it." (Woman 20–24 years, IDP camp).

Barriers for adolescent and unmarried women

Fear of stigma and lack of privacy

While participants frequently mentioned married women obtaining contraception without their husbands' knowledge, participants in all groups reported that adolescent and unmarried women also sought contraceptive services in secret and/or pretended to be married when seeking services. A woman explained that if unmarried girls seek out contraceptive services, they "will wear hijab and go out to other areas with her boyfriend as if he is her husband to obtain contraception." (Woman 20–24 years, non-IDP camp).

Girls and women are presumably taking these wary actions to protect themselves from the stigma and social consequences tied to girls and unmarried women who use contraceptives.

Men and women across groups reported that a lack of privacy at facilities was a barrier for girls, women, and men. One man explained: "Most of the people won't get the privacy they want for the doctors to give them the injection" (man 20–45 years, IDP camp). Men suggested that other women and men accessed services at night or accessed clinics from a back or secret door to avoid being seen by community members. One man aged 20–45 years in the IDP camp declared that the only barrier to contraceptive services was the lack of privacy: "Now, for example, if I head toward the direction of the clinic—even if that's not where I'm going—people will think am going to access the facility. That's the only problem if there is nothing wrong with them."

Providers' attitudes

Another barrier to contraceptive services for married and unmarried adolescent girls and unmarried women was providers' attitudes toward them. A girl in the host community noted that married girls who obtain contraceptive services at the clinic or hospital do not usually tell the doctors they are married because "if they told them, the doctors would be scared to provide the service to them, as sometimes it's caused them a problem" (adolescent girl, non-IDP camp). This statement suggests that married girls may face opposition from healthcare providers when they try to access contraceptive services and that doctors may also fear stigma from community members or others who disapprove of them providing contraceptive services to adolescent girls, including those who are married. Although most participants reported that adolescent and unmarried girls pretend to be married when accessing contraceptive services at the facility, this particular respondent may be referring to the doctors' fear of reprisals from adolescent girls' husbands if they oppose contraceptive use.

Participants in both of the boys' groups also reported that boys cannot access contraceptive services due to providers' negative attitudes, indicating that they believed women have much better access to services. The boys discussed these challenges:

> Participant 1: "They have more access than us. You will buy one condom, a lady will buy 50."

> Participant 2: "Women can say they are married. They can also say they don't want the marriage or pregnancy, while we can't use those excuses, so if we go on our own and we are not married, they will think we just want it for fornication. That's why they don't usually sell it to us."
>
> Participant 1: "But if a woman says she is married you can't argue." (Adolescent boys, non-IDP camp).

One boy from a non-IDP camp noted that women obtained contraceptive services in town, at pharmacies and even at hospitals for the injection, though at the hospitals, women would be prioritized with 10 women being seen first before a man. These statements highlight that stigma from health providers was not only an issue for adolescent and unmarried girls and women, but also for adolescent boys, which prevented them from obtaining contraceptive services. In contrast, several other girls reported that male condoms were only provided to men and would not be given to women or girls. Even so, when asked specifically about the care received from health providers, girls reported that girls and unmarried women were treated well by healthcare providers when seeking contraceptive services. One girl from a non-IDP camp described the care delivered to adolescent girls positively, noting that workers really tried to advise individuals with useful information that suits their situation, without making them feel embarrassed.

According to some men, no barriers exist for adolescent girls and unmarried women, while other men reported that obtaining contraceptive services was difficult for unmarried women and girls.

Quality of services

Participants in all groups reported that they were satisfied by the overall quality of services provided in health facilities, pharmacists, and chemists, though quality differed by type. Most participants spoke highly of the quality of services offered in clinics and hospitals, while participants in the non-IDP camp groups were less satisfied with the quality of services provided by chemists.

Although girls in the IDP camp group did not share many details about the quality of contraceptive services provided across facilities, possibly because they have not received these services themselves, women in the IDP camp groups shared positive opinions on the contraceptive services provided within the camp. One woman aged 20–24 years in particular noted that the clinic offering contraceptive services within the IDP camp was of high quality and that she would therefore recommend it to other women requiring such services.

Women and men in the host community reported that services provided by chemists were of lesser quality than those provided at clinics or hospitals. This perception appeared to be largely due to the fact that clinics and hospitals reportedly tested women's blood to determine the most appropriate contraceptive method—a practice participants seemed to approve despite it not being medically necessary. One woman explained:

> "Before that, people were not wise. They were taking drugs without the doctors testing their blood to give them the appropriate drug. They took them on their own—that is why it led to them bleeding. But now people are wise. You will go and they will test you before giving you the drug. The reason for this is that before, contraceptives were not really available at the clinic, except at the chemist, and women suffered to get it at the chemist. But now that the doctors are briefing people that they have

it, they should come and obtain contraceptives—that is why people are now going straight to the clinic." (Woman 25–45 years, non-IDP camp).

Chemists, therefore, are perceived to provide inferior services compared with the care women receive in clinics and hospitals.

Availability and accessibility of services

Overall, participants expressed that contraceptive services were available from clinics, hospitals, and chemists. When queried, participants initially reported that contraceptive services were available or that no barriers to services existed for both IDP and host community members, although some participants, particularly men, acknowledged that they could not be sure, as they were not users of contraception. However, when probed further about the subject, participants acknowledged the existence of stigma and negative attitudes toward contraceptive use in their community and that they either did not know whether adolescents received services or if adolescent and unmarried girls and women faced barriers to accessing services.

Some adult participants across groups noted that the availability of contraceptive services had increased compared with previous years, as services were now available in clinics and hospitals, rather than only at chemists.

Compared with participants in the non-IDP camp group, participants in the IDP camp group spoke more positively about the access to and quality of contraceptive services available to them. Adult participants in the IDP camp group noted that host community members travel to the clinic inside the IDP camp to obtain contraceptive services, as they were easy to access and free. Women also

The procedure room at the new IRC health facility, Stadium IDP camp.

noted that awareness of the services had increased and that people recognized the services were there to help them.

However, some participants noted that women wanted certain types of contraceptives that were not available to them inside the camp. The women reported that they had access to injections, implants, and tablets, but that IUDs were unavailable to them, which was a contraceptive they wanted.

Despite this limitation, IDPs living inside and outside the IDP camp, as well as host community members, sought contraceptive services inside the camp, as they services were available, free of charge, and provided respectfully.

Distance and cost

Most participants reported that the distance to the health facilities and cost of services were not barriers to contraceptive uptake. However, some women and men reported that even though contraceptive services were free, women were reluctant to access services within their communities because they were embarrassed to be seen entering a contraceptive clinic and feared they would be stigmatized. Instead, women preferred to be provided services within the privacy of their own homes or to travel further distances to clinics outside of their communities. One woman noted:

> "Recently, even at this clinic, they give contraceptives. They are free but few women are coming. They are scared of meeting someone they know that will go and tell people at home. But, if you are going from house to house, giving women advice, often, if a woman agrees, you can provide contraceptives to her or tell her ways that she can come and obtain them." (Woman 20–24 years, non-IDP camp).

A few women in the non-IDP camp group reported that the distance to the hospital was a barrier to obtaining contraceptive services. Distance also hindered access to services for persons with disabilities. One woman (25–45 years) in the host community group with a physical disability noted that the health facility was far away, involved a difficult journey, and had no accessible entrance, meaning she could not enter once she had arrived.

Most community members who spoke about obtaining contraception reported that services, including contraceptive commodities, were free. Cost was therefore rarely reported as a barrier to accessing FP services. However, free services and commodities sparked suspicion about the contraceptives among some men, who reported that community members do not trust them when they are offered for free compared with other drugs that have a cost. Men in the host community group explained:

> Participant 1: "This is something that people usually complain about. You see, you will find these drugs in the hospital. You will come with a patient and they will not give you 500-naira worth of medicine, but they will readily give you these family planning drugs for free. That's why our people are scared and don't trust them."
>
> Participant 2: "You've been given a prescription to go and buy drugs outside and then you get this one for free—that's why our people say there is no sincerity in it." (Married men, non-IDP camp).

Unsafe abortion and post-abortion care

Knowledge and attitudes toward abortion

Although participants were not asked about abortion or unsafe abortion practices, when asked more generally about contraceptives, these topics were frequently cited. Participants across groups, with the exception of adolescent boys in the IDP camp group and women aged 25–45 years in the non-IDP camp group, reported that induced abortion was common in their communities, particularly among adolescent girls and unmarried women, including divorcees and women who were widowed as a result of the insurgency. One woman aged 20–24 years in the non-IDP camp claimed that more women were practicing abortion compared with those giving birth, which was supported by another woman that noted abortions happen so often that they cannot be counted.

Some adult participants said the incidence of induced abortion was higher among younger people, with some participants citing displacement as the reason why adolescent girls and women sought induced abortions. However, other adult women reported that increased contraceptive uptake had resulted in few women attempting to end their pregnancies. One woman explained:

> "Family planning is very important. For example, it is mostly divorcees that are giving birth and throwing away the child or getting pregnant and aborting at the same time. But now, since we are enlightened with different methods, we can now avoid unwanted pregnancies and prevent ourselves from shameful things. All these things that were happening [abortion or throwing away a child] are not happening as much today." (Woman 25–45 years, IDP camp).

All participants shared negative attitudes regarding abortion, which was associated with stigma, shame, commercial sex, and "bad training" or "bad upbringing." Some participants reported that the shame associated with a woman or girl who had an abortion extended to the individual's family, particularly her parents. When participants discussed the incidence of and negative attitudes toward abortion, both men and women consistently associated abortion with women having a live birth and then "throwing away" or "killing" the newborn baby. An adult woman attributed the act of throwing away the baby to a lack of available abortion services in the camp, asserting that:

> "Doctors that know you inside here will never do the work to you. So women will go outside and pay their money to someone else to do the work for them. But we don't have doctors who will provide abortion here at the camp. If people inside here become pregnant, they give birth and throw the baby away." (Woman 25–45 years, Maiduguri).

This quote suggests that women either travel outside of the camp to obtain clandestine abortions or are forced to give birth, then get rid of the baby.

Unsafe abortion methods

Participants across groups reported that many women use traditional abortion methods at home. Women in the 20–24 years non-IDP camp group referred to methods involving Coca-Cola and ajino (cooking seasoning), "bitter things," and henna root ground in water. Women aged 20–24 years in the IDP camp group reported that women commonly consume herbs or detergents, such as "bulla" (a blue detergent used to dye clothes), or Omo (a washing detergent). One participant reported that women dissolve an eyeliner product and drink it.

Due to fear of stigma from community members, participants across groups reported that women

and adolescent girls also obtained clandestine abortions and medication from doctors and chemists, with some women traveling to another state to obtain these services. A few participants reported that women received these services from volunteers working in their communities. Some participants, including adolescent girls, reported that women die in the process of obtaining abortions, including those who receive clandestine abortion services from a doctor. One adolescent girl explained that another girl in her community had died from complications during an abortion provided by a local doctor in a hospital:

> "She made an agreement with the boy that she will abort the pregnancy and the boy accompanied her to get the abortion. When they went to the hospital, the boy signed for the doctor to operate on the girl to remove the pregnancy because she couldn't deliver it herself. During the operation process she lost her life. After, the boy acted as if he didn't know about the matter." (Adolescent girl, non-IDP camp).

The above quote also suggests that men are less likely to confront the consequences of abortion compared with women and adolescent girls, which was a topic that was also addressed by other groups. For example, women and adolescent girls were more likely to experience shame or be ostracized by community members compared with their male counterparts.

Unlike other SRH services, which were offered for free at clinics and hospitals, participants reported that abortion services were provided for an under-the-table fee and conducted in secret. One adolescent girl in the non-IDP camp group said doctors request 30,000–40,000 naira or approximately $80–110 to provide medical abortion drugs or perform a surgical abortion.

Post-abortion care

Most participants reported that if a problem with the induced abortion arose, the woman or adolescent girl tended to return to the person that provided the service or medication (e.g., doctor, healthcare provider, chemist) or would go to the chemist or hospital if she attempted the abortion at

A health worker at the IPPF-supported clinic, Farm Centre IDP camp.

home. Some women and adolescent girls noted that women did not always seek support outside of the family or male partner due to fear of stigma and shame, meaning that some women died from post-abortion complications. Adolescent girls explained that a lack of PAC services also had the severe consequences of women dying from abortion-related complications due to having no one to turn to for help.

IX. Discussion

Discussion of findings

Case study findings indicated that short-acting contraceptive methods were widely available in Maiduguri and Jere LGAs, whereas LARC and PAC services were much less available. Of the seven assessed facilities, one hospital and one primary health facility qualified as functioning contraceptive service delivery points. All facilities provided short-acting methods and male condoms. Many partners reported that they did not provide PAC services in any of their facilities, with the assessments showing that of the four facilities that delivered PAC services, only two were functional PAC service delivery points. Findings from the FGDs indicated that community members, especially men and adolescent boys, had limited contraceptive knowledge, particularly of LARCs. Most partners reported that the UNFPA-coordinated RHSWG contributed to the availability of contraceptives at their health facilities.

Long-acting reversible contraceptives

Several barriers hindered the provision of LARCs by partners. Key informants acknowledged the shortage of qualified health workers overall, especially those who were qualified to provide contraceptive services. NGO respondents were hopeful that the upcoming task-shifting and task-sharing policies from the SPHCDA and SMOH would help address barriers associated with health worker shortages to better meet the demand for equitable, high quality, and effective contraceptive services. Providers reported that while they had been trained on LARCs, they had few opportunities to practice and maintain these skills or worked in facilities that were not equipped to provide LARCs. Health facility assessments showed that only two facilities were equipped with supplies and staff to deliver IUDs and that only three were equipped with supplies and staff to deliver implants. Facilities and KIIs also reported stockouts of injectables and expired IUDs and implants.

Key informants also acknowledged the need to improve counseling, citing a skewed method mix at facilities as evidence that the counseling was unbalanced. Providers who said they had lost their LARC skills were unlikely to counsel women on LARC as options. Facility assessments confirmed that counseling needed improving, as facilities either lacked IEC materials or had materials that were limited to showing a "demo" of available contraceptive methods.

At the facilities and in a few KIIs, the most common justification given for the low uptake of LARCs was that the community members did not want them. FGD participants, particularly men and adolescents, expressed a lack of awareness, inaccurate knowledge, or a belief in myths about LARCs. These findings suggest that communities need increased education to understand the complete method mix and that healthcare providers should ensure they provide information about all available methods, including the advantages and disadvantages of each method, so that individuals can make an informed decision about which method is best for them with support from a qualified health provider.

It is therefore crucial that health facilities are stocked with an adequate supply of LARCs and have the appropriate supplies, equipment, privacy, and skilled health workers to provide these services.

Emergency contraceptives

Although the demand for a method to prevent pregnancy after sex seemed to be high among community members, knowledge of EC was very low, with KIIs and facility assessments revealing that the supply and provision of EC as a contraceptive method was very limited. The majority of FGD participants were not familiar with EC. Many participants cited incorrect, ineffective, and sometimes dangerous methods of EC, mostly referring to traditional medicinal methods to end pregnancies rather than to prevent them. Community mobilization and awareness-raising efforts should include EC to ensure that individuals know how to safely and effectively prevent pregnancy after sex and to increase knowledge of and demand for EC.

EC was available in four out of seven facilities assessed, though it was primarily associated with post-rape care. EC was available only for CMR in two of those facilities and the medication was not kept with the other contraceptive methods. EC supply and provision should be better integrated as part of the broader method mix and contraceptive service delivery, in addition to being made available as part of CMR.

Post-abortion care

PAC services were mostly unavailable. Only two out of seven facilities assessed were classified as functioning PAC service points, one of which was a referral hospital. Some FGD participants reported that community members sought care for post-abortion complications at health facilities. However, most participants reported that women would return to the individual who provided the abortion or abortion medication, so it was unlikely that women received PAC services from qualified providers. Participants also cited other sources of post-abortion information and care, including chemists, family members, and traditional healers. Many participants reported that stigma and shame around abortion and contraceptives more generally prevented women and girls from seeking PAC.

Similarly, facility assessments found that facilities lacked trained PAC providers and the necessary supplies and equipment, particularly for MVA, and that facilities were largely unable to function 24/7.

Program managers reported that negative attitudes toward abortion impacted the utilization and provision of PAC services, which was supported by findings from the FGDs and knowledge and attitudes surveys. The surveys further revealed a lack of knowledge about PAC services among providers. All aspects of PAC must therefore be strengthened, including training, provision of supplies, community awareness, and values clarification and attitude transformation among service providers.

Opportunities and challenges for contraceptive uptake

Notably, participants in the IDP camp FGDs and KIIs suggested that community awareness and knowledge about contraceptive methods, and in turn, the demand for these services, have increased since the beginning of the insurgency, while participants in the non-IDP camp groups reported a general increase in knowledge and demand for services over time. Many FGD participants, especially women in both settings, could explain important reasons for using contraception and expressed positive attitudes toward use, particularly due to their desire to space births.

However, barriers to meet women's contraceptive demands persist and all community members need to increase their knowledge about the benefits of contraceptive use and the range of available

methods. FGD discussions demonstrated that community members had limited knowledge and awareness about contraceptive and PAC services, with women found to be much more informed than men. Primary barriers to contraceptive use include male partner opposition to contraceptives and community stigma, which result in women and girls hiding contraceptive use and traveling far distances to access services. NGOs reported that they have been using varied approaches to increase contraceptive knowledge among community members, including a cadre of community mobilizers comprised of both male and female IDPs and host community members. While these community mobilizers play an important role in encouraging the use of contraceptives, it is important to ensure that they understand that it is ultimately the woman's decision whether she uses them.

Concerns regarding spousal consent was a common barrier preventing contraceptive uptake among women, given that many men did not support their wives in using contraceptives. Additionally, findings from the providers' knowledge and attitudes survey and some KIIs reflected a widespread belief among providers that husbands' consent was required to obtain contraceptives. Efforts to educate providers that consent is not required and to inform men and adolescent boys in the community about contraception and its importance should therefore be intensified.

Similarly, organizations should strengthen their efforts to engage religious and traditional leaders, as religion was frequently mentioned as a barrier to contraceptive uptake. Respondents indicated that religious leaders had a strong influence on attitudes, in particular men's attitudes, toward contraceptive use and that engaging them on the topic could increase support for contraceptive uptake among all women (not only those with health issues) and effectively combat stigma associated with using contraceptives.

Provider attitudes were also cited by FGD participants as a barrier to contraceptive uptake, with results from the KIIs and provider knowledge and attitude survey corroborating this finding. However, one organization reported that they had engaged in concentrated efforts to improve provider attitudes, an effort that was positively reflected in the results of the knowledge and attitude surveys administered in their facility. This particular organization's facility was also well prepared to provide contraceptive services and reported an increasing use of LARCs among its clients, with many FGD participants expressing high satisfaction with treatment from providers and the availability of services in the organization's facility. Some FGD participants noted that host community members travel to the IDP camp to receive contraceptive services from this organization. The success of this facility was anomalous when compared with others assessed, which indicates that efforts to improve all aspects of service provision, including providing balanced counseling and improving provider attitudes, leads to positive results and high satisfaction among clients.

Findings from KIIs, FGDs, and facility assessments showed that barriers to access contraceptive services—while present for all women—are particularly onerous for adolescent and unmarried girls and women. FGD participants confirmed that adolescent and unmarried girls and women experienced increased difficulties accessing services due to stigma. Adolescents, especially boys, demonstrated low awareness and knowledge about contraception and where to receive contraceptive services compared with adult women. In the facilities assessed, minimal to no measures were in place to provide adolescent-friendly services, with just a few providers reporting that they were trained in adolescent-friendly service provision.

Many FGD participants described a high incidence of unsafe and ineffective abortion practices in their communities, with some participants relaying detailed anecdotes regarding community members who had died from unsafe abortions, including those who were unable to access adequate PAC services from trained providers. Program managers reported witnessing cases of

women suffering from unsafe abortions in their clinics, yet few facilities provided lifesaving PAC services. There is a clear and immediate need to expand the availability of PAC services across Borno State and to increase contraceptive use, both of which would contribute to decreasing unsafe abortion. FGD participants also reported that some women "throw away" or "toss" newborns, particularly unmarried and divorced women, which also indicates the need to improve access to contraceptive, PAC, and safe abortion care services.

Although short-acting methods were widely available across the seven health facilities assessed, LARCs were less available and providers reported stockouts, particularly of IUDs and injectables. Most partners—particularly those who relied primarily on the MOH supply chain—also reported stockouts. Despites these reports, key informants also reported that robust stock management systems were in place and proper stock management practices were being implemented, an assertion that was echoed by those responsible for pharmacy management during facility assessments.

Additionally, at the time the case study was conducted, UNFPA, and subsequently the facilities assessed, relied almost exclusively on IARH kits. Given the duration of the emergency in Borno State, UNFPA should move away from reliance on the kits and focus on procuring contraceptive commodities individually based on the population's method mix demand. Procurement based on consumption or projected method mix data will enable organizations to better meet their clients' demands, thus preventing overstock and expiration of certain commodities (namely IUDs and implants) and the under-availability and stockout of others (injectables and OCPs, for example). In addition, the MOH supply chain should be strengthened by improving forecasting, increasing capacity strengthening for those who manage stock at facilities, ensuring earmarked funding for contraceptives, and evaluating other barriers in the supply chain.

Furthermore, stock storage conditions at four of the seven facilities were suboptimal. Commodities in these facilities were stored in hot, overcrowded, unclean, insecure spaces, and/or in a disorganized manner. Although it may be unrealistic to expect all facilities to have air conditioning, other measures, such as organizing pharmaceuticals on shelves, ensuring ventilation, and keeping the storage room clean, can and should be put implemented everywhere.

Promisingly, partners, including the MOH and UNFPA, have included capacity building and on-the-job coaching for supply chain management in their training and supervision. Additionally, the community did not report that stockouts were a large problem, with most FGDs showing overall satisfaction with the availability and quality of drugs and supplies at health facilities.

The case study reveals that there is a strong reliance on short-acting methods in Maiduguri and Jere LGAs. It is therefore critical that organizations improve their monitoring of contraceptive continuation among clients, including the timely return of contraceptive users. Although some organizations reported having a system in place to track contraceptive users, the systems were not well followed and were not present in all organizations. Monitoring FP users and continuation must be confidential and private, particularly given the stigma attached to the use of contraceptives.

Effective strategies

This case study identified effective strategies and enabling factors that supported success in contraceptive service delivery and uptake in Maiduguri and Jere LGAs:

- Strong support for contraceptive services within the government health agencies and policies

that support its implementation, including a national policy for task shifting and task sharing for contraceptive service provision, currently being finalized in Borno State.

- Successful implementation of short-acting methods, including DMPA-SC, which has the potential to further increase contraceptive uptake.
- When provided, training is robust and competency-based, and is conducted by qualified trainers in line with national policies. Partners should have a plan for on-the-job support and follow-up after the training.
- Good coordination of partners through the UNFPA and SMOH-led SRH WG meetings and widespread knowledge on the MISP and its components among partners.
- Supervision is part of project plans for all organizations interviewed. Most organizations reported the use of checklists and databases to track progress and performance.
- Community mobilization and community-based health service delivery, using various actors and tailored messages to reach communities in Maiduguri and Jere LGAs.
- Contraceptive services being provided free of charge in health facilities.

The head of family planning at the Mogcolis clinic (left) reviews the family planning registry with WRC's project consultant.

X. Recommendations

Based on the case study, recommendations for all partners providing SRH services in Maiduguri and Jere LGAs were identified.

All partners should:

- **assess the structure and design of health facilities** to ensure that women and girls can receive confidential contraceptives services and maintain their anonymity;
- **provide all short- and long-acting contraceptive methods, EC, and PAC services in all facilities,** including primary health facilities in alignment with national policies;
- **ensure that a confidential, private protocol is in place and followed to track short-acting method continuation and follow-ups;**
- **strengthen LARC service provision** by generating service demand through community mobilization activities that also include mitigating misconceptions about LARCs;
- **strengthen PAC services delivery** by improving the capacity of healthcare providers to deliver these services in line with established SMOH policy, ensuring that appropriate PAC materials are stocked, and by addressing the importance of accessing these services as part of community mobilization;
- **revive and expand the creation of adolescent safe spaces** as a platform to deliver evidence-based SRH content and services;
- **combat stigma surrounding contraceptive use among adolescent and unmarried girls and women** by engaging providers through cultural and attitude training, and communities through community mobilization;
- **strengthen the engagement of men, religious leaders, and traditional community leaders and improve their knowledge and support for contraceptive use** in the community and to combat misconceptions about contraception;
- **transition from reliance on the IARH kits to procuring each contraceptive commodity individually in line with a method mix** to allow for more efficient procurement of needed supplies;
- **implement strategies to improve the supply chain**, particularly "last mile delivery," including increased capacity of supply chain managers, improved forecasting, and improved pharmaceutical storage conditions at health facilities, including the use of temperature control where feasible.

UNFPA should:

- **expand its coordination role outside of the RHSWG and coordinate with partners on training** to ensure that providers are not overloaded and that training courses are harmonized and not duplicated—provider training should also address the suite of services that UNFPA supports;
- **support government agencies and partners to scale-up community-based distribution of DMPA-SC and CHEW/community health volunteer (CHV) training** on this to complement health facility-based services, and support DMP-SC training for private and public-sector providers.[42]

42 Jenny Liu, Jennifer Shen, Eric Schatzkin, Olanike Adedeji, Eugene Kongnyuy, Chidinma Onuoha, Morenike Fajemisin,

Organizations should:

- **build on the existing system of supervisions** and ensure that government health agency representatives are included;
- **improve infection prevention at facilities,** which includes ensuring that minimum materials are available and increasing infection prevention knowledge among facility staff;
- **provide values clarification and attitudes training for providers** to mitigate negative attitudes among providers who do not believe that girls and unmarried women should seek contraceptive services.

SRH partners should strengthen community mobilization and service delivery activities, specifically focusing on actions to:

- **engage women and girls to strengthen their contraceptive negotiation skills and engage men and boys with social and behavioral change programming** to increase their acceptance of contraceptive use;
- **provide IEC materials to CHEWs/CHVs, health providers, and others responsible for community mobilization and community-based service delivery activities** to support their awareness and knowledge-building approaches;
- **explore how satisfied clients may be mobilized to implement peer-to-peer strategies to increase contraceptive uptake,** and also how TBAs may help debunk misconceptions and rumors around contraception.

Government health agencies should:

- **continue to collaborate with UNFPA to lead the RHSWG;**
- **leverage existing networks of CHEWs/CHVs/TBAs to support SRH partners on the expansion of community mobilization and community-based service delivery activities** to increase contraceptive knowledge and reduce community stigma around contraceptives, including EC, and PAC services;
- **collaborate with partners to ensure that EC is available to all clients** and not only those seeking CMR services.

Kazeem Ayodeji and Elizabeth Omoluabi, "Accessing DMPA-SC through the public and private sectors in Nigeria: users' characteristics and their experiences," *Gates Open Research*, 2(73), https://www.researchgate.net/publication/330030693_Accessing_DMPA-SC_through_the_public_and_private_sectors_in_Nigeria_users'_characteristics_and_their_experiences.

XI. Appendices

Appendix A: Data from key informant interviews

Table 10: Organizations and agencies interviewed

Organization	Number of interviews
Action Health Incorporated (AHI)	1*
The Alliance for International Medical Action (ALIMA)	1
CARE	1
FHI360	1
International Committee of the Red Cross (ICRC)	1*
International Rescue Committee (IRC)	2*
Borno State Ministry of Health (SMOH) and Borno SPHCDA	1*
Planned Parenthood Federation of Nigeria (PPFN)	1*
Première Urgence Internationale (PUI)	1*
United Nations Population Fund (UNFPA)	2

**More than one representative present during the interview.*

Table 11: Service delivery as reported in key informant interviews

Organization	Implant	IUD	Pills	Injectable	Condom	EC	PAC
AHI			X	X	X		
ALIMA			X	X	X		
CARE	X	X	X	X	X	X	X
FHI360	X	X	X	X	X	X	X
ICRC			X	X	X		
IRC	X	X	X	X	X	X	X
PPFN	X	X	X	X	X	X	X
PUI	X	X	X	X	X	X	*

** PUI reported one facility providing PAC.*

Appendix B: Data from health facility assessments

Table 12: Facilities with essential components to provide contraception

	Hospital (n=1)	Health center (n=6)
OCPs provided in last three months	1	6
Staff trained to provide short-acting methods	1	6
Blood pressure cuff	1	6
Stethoscope	1	6
Daily combined OCPs	1	6
Progestin-only contraceptive pills	1	3
Facility able to provide OCPs	1	6
Injectables provided in last three months	1	6
Staff trained to provide short-acting methods	1	6
Blood pressure cuff	1	6
Stethoscope	1	6
Injectable contraceptive (progestin-only)	1	6
Needles and syringes	1	6
Facility able to provide injectables	1	6
Facility able to provide DMPA-SC	1	4
IUD insertion or removal performed in last three months	1	1
Staff trained to provide IUD	1	4
Sterile gloves	1	2
Graves speculum, medium	1	2
Uterine sound	1	1
Uterine tenaculum	1	1
Sponge forceps, straight	1	3
Mayo scissors, curved	1	1
Gauze/cotton	1	4
Antiseptics	1	4
IUD	1	1
Facility able to provide IUD	1	1
Implant insertion or removal performed in last three months	1	4
Staff trained to provide implants	1	5
Sponge forceps	1	2
Sterile gloves	1	2
Needles and syringes	1	5
Antiseptics	1	4
Lidocaine	1	2

Table 12: Facilities with essential components to provide contraception

	Hospital (n=1)	Health center (n=6)
Gauze/cotton	1	4
Implant	1	4
Facility able to provide implant	1	2
Emergency contraceptive pills	1	3
Facility able to provide EC	1	3
Male condoms	1	6
Female condoms	0	4
Facility able to provide condoms	1	6

Table 13: Facilities with essential components to provide post-abortion care

	Hospital (n=1)	Health center (n=3)
PAC performed in last three months using MVA	1	1
Staff trained to perform MVAs	1	3
Vaginal speculum, graves medium	1	2
Sponge forceps	1	2
Uterine tenaculum	1	2
Uterine dilators, sizes 13–37 (French)	1	1
Vacuum aspirators/syringes	1	2
Flexible cannulae, 4–12 mm	1	2
Adapters	1	2
Kidney dishes	1	2
Antiseptic solution	1	2
Gloves (sterile or non-sterile)	1	2
Lidocaine	1	2
Paracetamol or ibuprofen	1	1
Oxytocin	1*	1
Needles and syringes	1*	2
Facility able to provide PAC using MVA	1	1
PAC performed in the last three months using misoprostol	1	2
Misoprostol 200 mcg tablets	1*	3
Facility able to provide PAC using misoprostol	1	2

** Must be purchased by client.*

Appendix C: Provider knowledge and attitudes data

Table 14: Providers' provision of services and training

Service	Provided the service in the past three months (n=14)	Ever received instruction or training on how to provide this service (n=14)
Counsel women and girls about family planning	13	11*
Provide OCPs	14	10**
Provide injectable contraception (e.g., Depo-Provera)	12	12
Insert an IUD	4	8**
Insert a post-partum IUD (within 24 hours of delivery)	4	6***
Insert an implant (e.g., Implanon, Jadelle)	9	9**
Provide DMPA-SC	10*	8**
Provide EC	9**	8***
Perform MVA for PAC	7	11*
Provide PAC using misoprostol	9*	11**
Provide post-abortion FP counseling	12	11

** = One missing response. ** = Two missing responses, etc.*

Table 15: Providers' knowledge: family planning

Family planning	n=13
The person responsible for deciding the FP method is the: a. healthcare provider **b. client** c. client's partner d. village elder	11/13
The most important part of counseling is: **a. informing the client about all available methods and answering her concerns and questions about using contraceptives** b. making a good decision for the client c. using up all surplus supplies in the health facility d. making friends with the client	13/13

Table 15: Providers' knowledge: family planning

Family planning	n=13
The most common side effect of Depo-Provera is: a. jaundice and liver damage b. increased facial hair c. reduced sexual desire **d. changes in the menstrual cycle**	12/13
Most women experience changes in their menstrual cycles following the insertion of an IUD. You should explain to new IUD users that they can have: a. less bleeding than usual but more menstrual cramping during the first few periods following insertion b. more bleeding than usual and less menstrual cramping during the first few periods following insertion c. less bleeding than usual and no menstrual cramping during the first few periods following insertion d. m**ore bleeding than usual and more menstrual cramping and pain during the first few periods following insertion**	4/13
A mother who is less than six months post-partum and amenorrhoeic (her periods have not returned after delivery) is protected from pregnancy as long as she: a. breastfeeds her baby during the day and the baby sleeps at night **b. breastfeeds the baby on demand day and night** c. bottle feeds the baby d. breastfeeds the baby at night and bottle feeds during the day	7/13
Potential users of EC include: a. unmarried women b. young women c. women who smoke under the age of 35 **d. any woman who has had an episode of unprotected sex**	10/13
Total correct (mean)	**4.4/6**

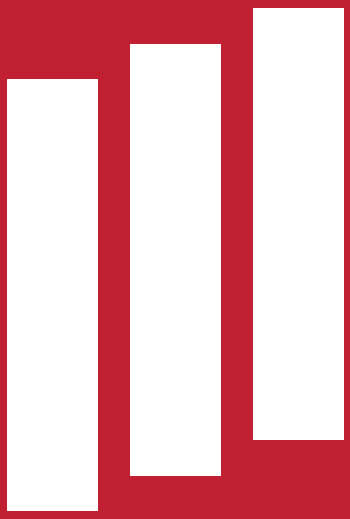
Correct answers are marked in bold.

Table 16: Providers' knowledge: post-abortion care	
Post-abortion care	**n=13**
Both MVA and misoprostol are effective methods to treat an incomplete abortion if the uterine size is not greater than: 10 weeks 12 weeks **13 weeks** 16 weeks	6/13
Which one of the following is a WHO recommended regimen for misoprostol for treatment of an incomplete abortion and miscarriage? a. 400 mcg oral b. 600 mcg oral **c. 600 mcg sublingual** d. 800 mcg sublingual	3/13
After uterine evacuation for an incomplete abortion, a woman's fertility may return: a. after four weeks b. after her first menstrual period **c. within 7–11 days** d. after her first ovulation	6/13
What information do you give patients who were treated for an incomplete or unsafe abortion? a. About when a woman can conceive again b. Referral for FP or provide FP methods c. About the consequences of an unsafe abortion **d. All of the above**	8/13
Total correct (mean)	**1.8/4**

Correct answers are marked in bold.

Acronyms and Abbreviations

AHI	Action Health Incorporated
CDC	Centers for Disease Control and Prevention
CHEW	Community health extension worker
CHO	Community health officer
CHV	Community health volunteer
CMR	Clinical management of rape
DMPA-SC	Depot medroxyprogesterone acetate, sub-cutaneous
EC	Emergency contraceptives
FEFO	First Expired, First Out
FGD	Focus group discussion
FIFO	First In, First Out
FP	Family planning
GBV	Gender-based violence
IARH kit	Inter-Agency Emergency Reproductive Health kit
IAWG	Inter-agency Working Group for Reproductive Health in Crises
ICRC	International Committee of the Red Cross
IDP	Internally displaced person
IEC	Information, education, and communication
IRC	International Rescue Committee
IUD	Intrauterine device
KII	Key informant interview
LARC	Long-acting reversible contraception
LGA	Local government area
MHC	Maternal health center
MISP	Minimum Initial Service Package
MOH	Ministry of Health
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
OCP	Oral contraception pill
PAC	Post-abortion care
PHC	Primary health center
PPFN	Planned Parenthood Federation of Nigeria
PUI	Première Urgence Internationale
RHSWG	Reproductive Health Sub Working Group
SMOH	Borno State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization



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