Emergency Sexual Reproductive Maternal Child Health (SRMCH) Outreach Mobile Service Intervention - Northeast Nigeria

Comprehensive Final Project Implementation Report

Period covered: December 2017 to February 2018

March 2018
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1. Background

Close to a decade of violence due to Boko Haram armed conflict in Africa’s Lake Chad basin have led to a worsening humanitarian crisis that has displaced millions of people and forced them to live in fragile and emergency settings where health and social systems are weakened. Women and girls living here face health challenges as pregnancy and childbirth continue, and incidents of sexual violence increase.

According to UN OCHA, the humanitarian crisis in north-east Nigeria, now in its ninth year, remains one of the most severe in the world: 1.7 million persons remain internally displaced, and an estimated 7.7 million men, women, boys and girls are in acute need of protection and health assistance.

Through CARE Austria gap funding, CARE Nigeria has successfully completed the implementation of a 3 month integrated outreach SRH/HIV and GBV activities, providing Sexual, Reproductive, Maternal Child Health (SRMCH) services targeting the hard to reach Local Government Areas (LGAs) of Borno State, Northeast Nigeria between the period of December, 2017 to February, 2018.

The Northeast Nigeria maternal mortality rate is 1,549 compared to the national rate of 576. Only 22% of pregnant women deliver with the support of a skilled birth attendant, and the teenage pregnancy rate is 29%1. Communities in the newly accessible Kala Balge, Bama, Ngala, Dikwa and Gwoza Local Government Areas (LGAs) of Borno State have particularly low access to health services as at least 90% of all health facilities were destroyed during the conflict and a severe shortage of trained medical personnel exists due to displacement, insecurity and the killing of health staff by insurgent armed groups.

Pregnant women do not have access to antenatal care, and many women are giving birth in congested IDP camps without access to postnatal care. Where services are available, the quality of care is inconsistent due to the lack of monitoring and supervision from qualified technical personnel. Poor sexual and reproductive health is further due to the absence or shortage of medical drugs, equipment and supplies as well as low demand for services given lack of awareness and knowledge of them and social and gender norms inhibiting access.

This project aimed to provide gap-funding with the ending of UNFPA funds (August to November, 2017) supporting similar activities in the aforementioned LGAs, and with the objective to increase the availability and utilization of quality integrated SRH /Sexual and Gender-based Violence (SGBV) services (including family planning (FP), maternal health and HIV) by host communities and internally displaced persons living in formal, informal and host communities. To be achieved through active community mobilization and outreach activities to support women of reproductive age group, boys and girls in the respective LGAs.

Through critical funding from the Austria people, CARE Nigeria was able to support and continue to provide these critical SRH/SGBV services for women and girls in Kala Balge, Bama, Ngala, Dikwa and Gwoza LGAs, and ensured their needs for and related care was adequately met. Through the support of CARE Austria funding, CARE Nigeria was able to continue the provision of lifesaving SRH/SGBV interventions in the targeted hard to reach areas and to mobilize additional resources from UNFPA to support the delivery of long-term integrated SRH/SGBV services for vulnerable women and girls in Northeast Nigeria.

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1 Nigeria 2013 Demographic and Health Survey
The following is a comprehensive Implementation Report of the CARE Austria funded 3 month gap-funding partnership on integrated SRH/SGBV programming.

1.1. Sexual and reproductive health analysis in Northeast Nigeria

UNICEF reports and statistics show that a woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 13, and with a neonatal mortality rate of 46 per 1,000 live births and approximately 250,000 deaths occurring every year. It’s reported that most neonatal deaths, (neonatal mortality rate of 46 per 1,000 live births, and approximately 250,000 deaths every year), occur within the first week of life, mainly due to complications during pregnancy and at delivery. Main causes of neonatal deaths are observed to be birth asphyxia, severe infection including tetanus and premature birth. Most pregnant women do not access antenatal care, while some women have given birth while fleeing, or in a congested IDPs camps without access to postnatal healthcare. Some local socio-cultural norms limit access for women to quality SRH services as they need permission from their husbands for seeking the available health care. These, along with financial barriers, lack of access to transport, and inadequate information pose challenge to women in accessing quality health care services, including SRH.

The 2013 Nigeria Demographic Health Survey, (the latest of its kind), indicates that Northeast Nigeria has an extremely low contraceptive prevalence rate of 3 per cent. This translates to a high fertility rate and very high mortality ratio. Only 20 per cent of pregnant women deliver with a skilled birth attendant.

With a neonatal mortality rate of 46 per 1,000 live births, and approximately 250,000 deaths occurring every year, most neonatal deaths occur within the first week of life, mainly due to complications during pregnancy and delivery. The main causes of neonatal deaths are birth asphyxia, severe infection including tetanus and premature birth. Pregnant women do not access antenatal care. Some women have given birth while fleeing, or in a congested IDPs camps without access to postnatal healthcare.

Negative local socio-cultural norms limit access for women to quality Sexual Reproductive Health and Rights (SRHR) services as most women need permission from their husbands for seeking healthcare and family planning services. These, along with financial barriers, lack of access to transport, and inadequate information pose challenge to women accessing health care services that include SRHR.

According to UNFPA, 1,725,000 women of reproductive age required immediate life-saving reproductive health services in Northeast Nigeria conflict affect states, while the crisis has dramatically worsened access for women and girls to quality SRHR services, resulting in high morbidity and mortality rates.

1.2. Gender-based violence

Gendered power dynamics exposes Nigerian women and girls to risk of gender based violence including widespread harmful traditional practices (such as widowhood abuse, early and forced marriage and female genital mutilation). One in three of all women and girls aged 15 - 24 has been a victim of violence.

In NE Nigeria, 54% of the 1.7 million IDPs in the 3 affected States are women and girls, more than 20,000 people have been killed and 4,000 women and girls abducted since the conflict began in 2009. Separated from families, women and girls are living in overcrowded conditions with high risks of violence and the burdened responsibility of providing for and protecting their family. The poor living conditions in camps/camp-like settings increase the risks of GBV (44% say there is no lightning at all in camp, 69% bathing areas are not separated by sex; 53% of toilets do not lock from the inside; 71% of toilets are not separated by sex, 70-80% of IDP children are out of school.
The insurgency has increased GBV risks by 7.7% with 1,112 Incidents of GBV been reported between January and April 2017. For example, cases of SEA, transactional sex, exchange of sex for food assistance and freedom of movement; rape, sexual abuse, sexual harassment, domestic violence, physical abuse have been reported in more than half of IDP sites around Maiduguri.

According to UNFPA, 50% of perpetrators are Boko Haram insurgents, 23.7% are unknown and 17.8% are police and armed forces. 97% of reported GBV cases for which survivors sought help in April 2017 are females, with 56% and 44% of the cases reported by adults and children respectively. Survivors of GBV are at elevated risk of severe and long-lasting health, emotional, social, economic and security problems. They may die from injuries, suicide or unsafe abortion. Rape survivors need access to life saving medical treatment. But survivors face significant challenges accessing GBV response services. Health and other basic infrastructure are inadequate to enable survivors to access quality systems for GBV response, especially for Clinical Management of Rape services and supplies. There is also an urgent need to strengthen case management services.

Culture of impunity for GBV perpetrators prevails due to gaps in the legal framework, limited access to legal recourse, fear of reporting among others. Local actors (health workers, police officers, security actors) have limited capacity to prevent and respond to GBV but they must become part of the solution.

Women and girls known or suspected to have been associated with Boko Haram either abductees, slave, wife, voluntarily or by force, are stigmatized by association with the group. These women are referred to as "Boko Haram wives", "Sambisa women", "Boko Haram blood" and "Annoba" (meaning epidemics') while their children are seen as having "bad blood". These IDP women, girls and their children are often excluded from mainstream society, affecting their social, political and economic prospects and, more broadly, society's cohesion and stability, thus put a significant barrier to their reintegration into community life. Further, the crisis has brought suspicions and mistrust toward women and girls because female followers and forced conscripts by Boko Haram are being transformed as suicide bombers.

key drivers of high maternal and neonatal morbidity and mortality.
The key drivers of high maternal and neonatal morbidity and mortality include: critical shortage of essential medical drugs, equipment and supplies (including reproductive health kits), poor community knowledge, attitude and practices of reproductive health services, family planning and post-abortion care. This includes the poor uptake of the available SRH services due to the absence of effective community mobilization, education, sensitization, cultural/religious beliefs, and knowledge of services.
2. Specific program intervention (Areas of Interventions: SRHR, GBV and HIV)

Key areas of intervention and services packages, delivered through a community mobile outreach approach included the following:

- Antenatal care
- Treatment of STIs (Syndromic)
- HIV Counselling and Testing including PMTCT
- Family Planning Services (On site and referral for other methods)
- Post Rape Treatment and Counselling
- Health Education
- Post-natal care
- Identification of Chronic conditions like Fistula and Tears
- Referral for Secondary care

3. Project locations

The project targeted hard to reach LGAs of Kala Balge, Bama, Ngala, Dikwa and Gwoza LGAs of Borno State, Northeast Nigeria. The project operated at 6 sites (Rann, Dikwa, Ngala, Bama, Banki and Pulka) and in 14 different IDP Camps and Host Communities.

4. Overall assessment of project implementation progress

The project was successfully completed by the end of February 2018. Starting in December 2017 as an interface to UNFPA funded activities, the project has substantially contributed to the continuation of lifesaving services, and in increasing the availability and use of integrated sexual and reproductive health services (including family planning, GBV, maternal health and HIV) that were gender-responsive and met the human rights standards for quality of care and equity in access.

Implementation Methodology: The CARE Nigeria outreach team initially met with local authorities and religious leadership, women and youth groups and peer partners in the various LGAs to communicate on the 3 month continuation project, including the services package for outreach clinics in order to improve communication and to avoid potential overlap with other partners who were planning to fill gaps.
CARE continued to adopt the Community Mobile Outreach strategy where locally recruited and trained health service providers moved from one IDP camp and communities to another creating awareness on SRHR issues, enlightening communities on the availability of services, providing SRHR services and commodities to those in need as per the standards and involving in local coordination mechanisms in the targeted hard-to-reach LGAs.

CARE also enlisted the services of gender-balanced local Community Health Volunteers (CHVs), 2 per site, oriented and provided with family planning manuals, including Family Planning Job Aids and charts and other SRH/GBV IEC materials to facilitate community mobilization efforts to increase demand for SRH and GBV activities, referral to services and undertake community follow-up. The work of Community Volunteers was integral to finding cases of Gender Based Violence and SRH Complications such as VVF that would otherwise not report to outreach sites.

The Rann Outreach Centre supported by CARE remains the main referral hub for SRH services. Referrals continued to be made from the UNICEF Health Center and other peer organizations to CARE’s outreach site for services comprising of emergency deliveries, family planning, HIV Counselling and testing, GBV and STIs.

The fruitful synergy with IDP Camps Managers, sister organizations and the free-of-charge service at CARE supported sites provided through outreach teams increased demand for SRH/GBV services from IDPs due to increased access.

CARE Nigeria’s strategic advocacy and linkages with the State and Local Government health authorities, UN, and INGOs SRH partners have improved coordination, including contingency planning, sharing of best practices and lesson learnt. During project implementation, CARE supported outreach SRH/GBV activities have received assorted in-kind family planning commodities and HIV test kits from the State MoH and UNFPA. CARE has facilitated the safe delivery to the outreach sites, storage, distribution and consumption reporting to the State as well as UNFPA.

Fig.2 CARE supported Outreach Mobile Clinic in Rann, Kala Balge LGA

Fig.3 A mother coming for antenatal care services receives medical drugs at Rann Mobile Clinic, supported by CARE, in Kala-Balge LGA, Borno State.

SRHR Outreach Gap Funding - Final Report
Monitoring and evaluation, including HIMS tools, data collection, reporting and use of Nigeria national guidelines and protocols: A variety of standard data collection tools were created to support reporting. These included daily Outreach Activity Report Register, Weekly Outreach Summary Register, Daily Outreach Service Delivery List, Appointment Cards and Referral Forms. The project team continuously tracked service utilization and uptake through monitoring project progress against set targets on a periodic bases.

The CARE SRH Field Supervisor visited outreach locations 3 days a week to evaluate activities of outreach staff, work quality, relationship with clients and other NGOs, level of acceptance and awareness of SRH by the community while providing on the job training and data validation.

5. Key programmatic achievements

General SRH/GBV services/improved results: During the 3 months of activities implementation, CARE reached a total of 223,094 persons, (78% women) with assorted SRH/GBV assistance, including 55,939 people supported with direct SRH/GBV assistance, obstetric and maternal clinical consultations and medication, SRH commodities, counselling and referral services. 167,155 people were also reached with general health and SRH/GBV information, sensitization and awareness of CARE SRH service availability and thus indirectly benefitting from the project activities.

Quick mobilization and deployment of outreach health staffs and volunteers: 14 Outreach Teams of 3 Members (42 in total including 28 females and 14 males) - Midwives, Nurses and Health workers - were quickly redeployed and made available to provide SRHR services in the selected Outreach sites. Staffs rotation system was followed to ensure rest and relax breaks for teams’ members.

Coordinated Logistics arrangements: UNHAS provided regular flight for CARE outreach staffs and cargo (medical and SRH commodities) to and from the outreach hard-to-reach locations through choppers. CARE has provided local transport for the outreach errands, security as well as staff’s/service providers’ accommodation in the selected LGAs.

Communication and outreach support: Pragmatic communication through Whatsapp group was established. This worked well due to the poor network access challenges in most of the outreach sites and LGAs covered by the projects. Outreach staffs were hosted on a WhatsApp platform to improve communication means. Through this platform, most information was timely shared through this channel. Outreach teams began with the preliminary work of creating access to the Heads of the community; Camp Managers and other NGOs already working in the sector as well as mobilizing the community to anticipate CARE services.

Supportive supervisory field visits: A total of 22 supportive supervisory spot checks were conducted to outreach sites by the Outreach Supervisor to facilitate activities onsite and to evaluate/build capacity through on-job supervision and training.

Coordination with stakeholders: Health sector and SRH /GBV sub-sector partner meetings and synergy. Weekly field level program coordination meetings were held to coordinate and consolidate efforts aimed at improving Sexual and Reproductive health activities implemented by CARE and its partners in the field. CARE is now a major stakeholder of Borno State Sexual and Reproductive Health Coordination forum, held
to coordinate all SRH activities within the state and led by the government of Borno State and includes all major stakeholders involved in SRH response amongst which include the WHO and UNFPA. CARE is also an integral part of the Health Partners and Humanitarian Managers Working Group amongst others that have provided the necessary coordination and linkages as well as leverage that facilitate program delivery.

6. **Results matrix**

   A. **Ante and Post-natal Care**

      A total of 28,314 pregnant and lactating women (PLWs) were reached with Antenatal (22,323) and post-natal care (PNC) (5,991) cases. The decline in uptake of PNC services is attributed to population movement and provision of similar services by other primary healthcare providers. The CARE outreach team will conduct additional home visits for PNC mothers, and establish mother-to-mother group discussion to increase uptake of the PNC coverage.

      ![Safe motherhood -ANC/PNC](image)

      - No of women and girls reached with PNC
      - No of women and girls reached with ANC

   B. **Family Planning**

      A total of 13,519 women and girls were reached with FP services and commodities, including assorted methods and options, e.g. barriers, Orals, Injectable and Implants. As practice, all clients were provided with general group awareness FP sessions and good FP seeking behaviors, including individual counseling on the various options and methods of FP available for informed client’s decision making and to be able to confidently choose from the various methods available.
During project implementation, a total of 7,919 clients opted for Barriers, 2,673 were reached with Oral, 1,283 with Injectables and 24 cases with Implants.

The high uptake on Barriers and Orals as opposed to Injectables and Implants is attributed to women and community negative beliefs and misconceptions on these methods, especially on the Long Acting Reversible Contraceptives, (LARC). CARE is undertaking active education and awareness sensitization; including working with local authorities and community leadership structures, such as religious and clan elders.

Under the framework of another CARE USA funded project, (SAFPAC) currently implemented in 3 other LGAs, CARE has engaged the services of 2 local Civil Society Organizations (CSOs) to undertake objectively focused Family planning and Post-abortion care awareness and education to address key advocacy gaps and issues, along with key stakeholders.

C. Treatment of Sexually Transmitted Infections (STI’s)
A total of 11,328 clients, 77% women, have received STI syndromic management, through systemic testing of cases. The rise in the number of clients seeking STI treatment is attributed to increase community education and services coming closer through outreach mobile clinics to the affected population.

D. HIV/AIDS
During the project period, a total of 44 687 Clients, (66% women), were counseled and tested for HIV/AIDs, 23 positive cases, (6 of them pregnant women) with Banki LGA recording the highest caseload, were referred to ARV treatment services, including the Prevention of Mother-To-Child Transmission (PMTCT) for pregnant mothers.
E. Clinical Management of Rape cases
A total of 216 women were counseled for post-rape and provided with medical assistance. Pulka recorded the highest caseloads, and Potential stigma due to confidentiality risks and negative community perception of rape survivors has drastically reduced case reporting by survivor. This is further compounded by the fact that most perpetrators of rape are close to the survivor, are extended family members, and or combatants (Boko Haram fighters) in the bush. The lack of access to post-exposure prophylaxis in the first 72 hours of rape and clinical care means additional risk to complication and exposure to STI/HIV.

F. Community outreach and SRHR awareness and education to increase SRH/FP uptake and referral to services and assistance to other providers.
CARE has undertaken a community situation analysis, in which key barriers of quality SRHR has been mapped with key community stakeholders. Through contracted local CSOs under a sister project, SAFPAC, CARE is actively leading in community advocacy, communication and sensitization activities in 20 catchment areas of Maiduguri, Jere and Konduga LGAs with aim creating an enabling environment for women and girls to freely talk about and access quality SRHR and FP activities without discrimination, stigma or unfavorable gender control. The community engagement efforts are aimed at demystifying the family planning and post-abortion care services, as well as providing the vulnerable women and girls an opportunity to access their adolescent reproductive and maternal health rights.

7. Key challenges in project implementation and way forward

Poor weather (Hamattan Season- Jan/Feb) and fuel shortages have limited UNHAS flight availability: This has resulted in the reduced movement of outreach staffs to some locations for extended periods of time, hindering the implementation of set work plans and targets.

Community and social barriers affecting SRHR and SGBV service uptake: SGBV incident reporting and access to appropriate medical care (Post Exposure Prophylaxis) in the first 72 hours of the incidents remains a big concern. CARE is working actively on community sensitization and working closely with key community groups and actors, including leadership to enhance active case surveillance, management and reporting.

Communication challenges: Due to lack of network coverage, insecurity and appropriate accommodation to staffs to improve their welfare duration their stay on the field was a real challenge. CARE has received funding from UNFPA to support in the establishment of field accommodation, transport for outreach staffs, and referral for obstetric complication.

Continued insecurity: Including an insurgent attack in Rann, Kala-Balge LGA in late February 2018, where a number of humanitarian workers lost their lives, resulting in mental and psychological trauma to the
humanitarian community, especially to the outreach teams. All humanitarian staffs were temporarily relocated to pave way for security re-assessment and reviews. This incident has not adversely affected the CARE Austria funded activities, as it happened during the phase-out period.

**SRH service disruption:** expected in Dikwa post CARE Austria funding. Due to donor shift in priorities, UNFPA has excluded Dikwa from target locations to be supported under the 2018 CARE/UNFPA SRH partnership, while adding other LGAs - namely Damasak, Konduga, Magumeri, Askira-uba and Nganzai. As a result and due lack of funding overall, CARE’s outreach activities have been suspended in Dikwa despite existing needs. To ensure the continuation of much needed SRHR/GBV services in Dikwa, CARE has coordinated with the SRH working group and health sector members to support the gaps in Dikwa.