HEALTH SYSTEM RESPONSE TO SEXUAL AND GENDER BASED VIOLENCE AMONG ADOLESCENTS AND YOUTHS IN SOUTHERN NIGERIA: A LITERATURE REVIEW

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

By

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Declaration

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The thesis work with the title, Health system response to Sexual and Gender Based Violence among adolescents and youths in Southern Nigeria is my work

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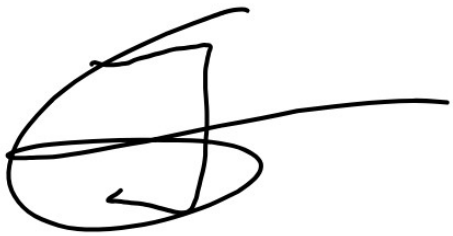

Contents

Acknowledgment

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List of Acronyms

CEDAW	Convention for elimination of all forms of discrimination against women
CBOs	Community Based Organizations
CRA	Child Rights Act
CSO	Civil Society Organization
FBO	Faith Based Organization
FGMC	Female Genital Mutilation and Cutting
FMWASD	Federal Ministry of Women Affairs and Social Development
GBV	Gender-Based Violence
HCP	Health Care Provider
HIC	High Income Country
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IPV	Intimate Partner Violence
IUD	Intra-uterine device
LARC	Long-Acting Reversible Contraceptive
LMIC	Low Middle Income Country
MCH	Maternal and Child Health
MCSP	Maternal and Child Survival Programme
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NBS	Nigeria Bureau of Statistics
NGP	National Gender Policy
NGO	Non-Governmental Organization
NHA	National Health Act

OSC	One-Stop Centre
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PTSD	Post Traumatic Stress Disorder
SDG	Sustainable Development Goal
SARC	Sexual Assault Referral Centre
SGBV	Sexual and Gender Based Violence
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infection
UHC	Universal Health Coverage
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Agency
VAPPA	Violence Against Persoon Prohibition Act
VAWG	Violence Against Women and Girls

Definition of key terms

Literature abounds on conceptual issues surrounding the definition of Sexual and Gender-based Violence (SGBV). There is no single, generalized and agreed definition for SGBV. Definitions are based on forms of violence, persons involved, type of relationship and the act of violence committed. In the past SGBV was only framed as women and girls issue, neglecting boys and men. Sexual violence and forced recruitment, which are some forms of violence experienced by men also violate their human rights. Global call for a gender-transformative approach to addressing GBV becomes necessary for re-definition of violence. Some forms of SGBV include physical and sexual violence, Intimate Partner Violence (IPV), Non-Partner Sexual Violence (NPSV), Child Sexual Abuse (CSA), Female Genital Mutilation/Cutting (FGM/C), child marriage, sexual harassment in the workplace and trafficking of persons.

Gender-Based Violence (GBV): This is similar to Violence Against Women, but is a more inclusive term than violence against women. GBV could include violence against men, provided the violence stems from a man's gender identity or presentation[1]

Sexual Violence (SV): Sexual violence is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object."[2]

Violence Against Women and Girls (VAWG): Defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[2]

Intimate Partner Violence (IPV): refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.[2]

Help seeking behaviour: Searching for or requesting help from others via formal or informal mechanisms, such as through mental health services [3]

Help-seeking can be defined as an "attempt to find (seek) assistance to improve a situation or problem (help)." (Oxford Dictionary)

Youth: Defined by World Health Organization as people within the 15–24 years age group.[4]

Adolescent: People within the age group of 10-19 years. It can be further divided into early (10-14 years) and late (15-19 years) adolescence.[5]

Young people: Age group between 10-24 years.[5]

Sexual Reproductive Health and Rights (SRHR) is important for sustainable development due to its relationship with gender equality and well-being, and the roles played in shaping future development and sustainability.

Sexual Rights (SR) are human rights and include the right of all persons, free of discrimination, coercion, and violence to achieve the highest attainable standard of sexual health, including access to sexual and reproductive health services.[6]

Sexual Health (SH) is defined as "A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity."[7]

Reproductive Right is the right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, to have the information and means to do so, and the right to attain the highest standard of reproductive health.[6]

"Reproductive Health (RH) is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."[8]

Abstract

Introduction

SGBV is both a public health issue and a violation of human rights, with adverse health consequences. Although women and men experience SGBV, women are disproportionately affected. SGBV is deeply rooted in gender inequality and harmful cultural norms. The exact estimates of SGBV among Nigerian adolescents and youths are unknown. Nigerian adolescents lack access to SGBV services and participation in national SGBV policies. The study aimed to assess the health system factors for SGBV, analyze policies and laws on SGBV and identify effective interventions for the prevention of SGBV among adolescents and youths in Southern Nigeria.

Methods

A literature review analyzing the components of the modified health system response framework by Garcia-Moreno et al. was used for the analysis. Relevant literature was retrieved from databases and websites of journals and organizations. The framework emphasized societal level support of health systems, health systems support of health care providers, and providers' support of SGBVclients.

Results

The study analyzed the health system factors for seeking care for SGBV by adolescents and youths in Southern Nigeria and policies on SGBV practiced in Southern Nigeria. Evidence-based interventions for the control/prevention of SGBV were identified. Effective prevention strategies were recommended to policymakers in Southern Nigeria to address SGBV among adolescents and youths. The Nigeria government has committed to international and national laws and policies related to gender equality and addressing SGBV among adolescents and youths, but the laws are insufficiently implemented. Adolescents have unmet SRH needs due to a lack of access to services, unskilled health providers, and costly services. Girls do not report SGBV or access services due to fear of stigma and blame, especially when the perpetrators are family members or partners. Effective primary interventions that successfully addressed SGBV among adolescents and youths were educational programmes, community engagement and male involvement programmes. Secondary and tertiary interventions identified were multi-sectoral responses and coordination of SGBV services using the One Stop

Centres (OSCs) approach for treatment, investigation, prosecution and social support services for survivors.

Conclusion

Government intervention to develop adolescent and youth-friendly laws and policies, provide funding and infrastructural support towards SGBV, coupled with community-based interventions to change social norms, will significantly address SGBV among adolescents and youths in Southern Nigeria.

Keywords: Sexual and Gender Based Violence, Adolescents and youths, policies, evidence-based interventions, Health Care Providers, Health Systems, Southern Nigeria.

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Chapter 1

Introduction and Background

1.1 Introduction

Sexual Gender-Based Violence (SGBV) is a global pandemic that affects 1 in 3 women in their lifetime.[9,2] SGBV is a public health problem with detrimental physical, psychological, and sexual and reproductive health outcomes on victims and survivors. It also violates the fundamental human rights of women, and is facilitated and sustained by gender inequality.

Terminologies linked with GBV include Sexual Gender Based Violence (SGBV), Violence Against Women and Girls (VAWG), Intimate Partner Violence (IPV), non-partner sexual violence and domestic violence. SGBV **is d**efined as "any act of Gender-Based Violence that results in, or is likely to result in physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[2]

SGBV cuts across countries, age groups, socio-economic status, occupations, cultures and ethnic groups. Global prevalence of violence is 36.5%, with varying widespread estimates.[10] It is alarming to note from latest world report that 1 in 3 women and 1 in 4 girls (15-24 years) would have experienced violence by 25 years of age,[11] despite global interventions and programmes. A multi-national research conducted in 106 countries between 2005 and 2017 reports that 18% of women and girls have experienced violence from a current or former partner in the 12 months before the survey.[12] Africa has a lifetime prevalence of physical and sexual intimate partner violence and non-partner sexual violence of 36.6% and 11.9% respectively. [13]

Young adults (10-25 years) comprise about 1.5 billion of the world's population.[14] In Nigeria, young people (10-24 years) constitute about one- third of the population.[15] The country's median population is 18.4 years.[16] Youths form a part of the productive age group and contribute maximally to global economic development and sustainability.[17] Adolescents and youths have special needs, including SRHR needs, which are mainly unmet and require urgent attention.[18]

The Sexual Reproductive Health (SRH) needs of adolescents and youths are different from that of adults for the following reasons. The physical and psychological changes and development make them prone to infectious diseases and risky behaviours, which also has implications on

their well-being in later adulthood; dependency on parents and caregivers, which makes it challenging to make effective health decisions and the low level of risk perception due to immaturity and lack of experience.[18] In developing countries, almost half of the women 15-19 years are sexually active and married, with about half of the pregnancies being unintended and ending in unsafe abortions.[19] Many adolescents are also prone to STIs, including HIV, following rape.

According to the United Nations Declaration of human rights, access to health is a fundamental human right of all people; therefore, no one should be left behind. The health needs of youths have been neglected in this regard. Their young age and naivety in handling sexual relationship matters make them prone to physical and sexual violence. Not having equal rights and opportunities to access care due to SGBV violates their human rights and predisposes them to adverse health challenges.

1.2 Background

1.2.1 Demography

Nigeria is the most populous country in Africa, with an estimated population of 200,963,599 million and a land mass of 910,710 square kilometres.[20] The country's population census was last conducted in 2006. The annual population growth rate for 2021 is 2.55%. It is projected that the country's population will double its current size by 2050.[21]. Nigeria has a tropical climate and experiences two main seasons annually; rainy and dry seasons. The country has six geo-political zones, 36 states, including the Federal Capital Territory in Abuja (Figure 1) and 744 Local Government Areas (LGAs).[22] Nigeria has a diversity of languages and ethnic groups, including the three major ethnic groups: Hausa, Yoruba and Igbo.[23]

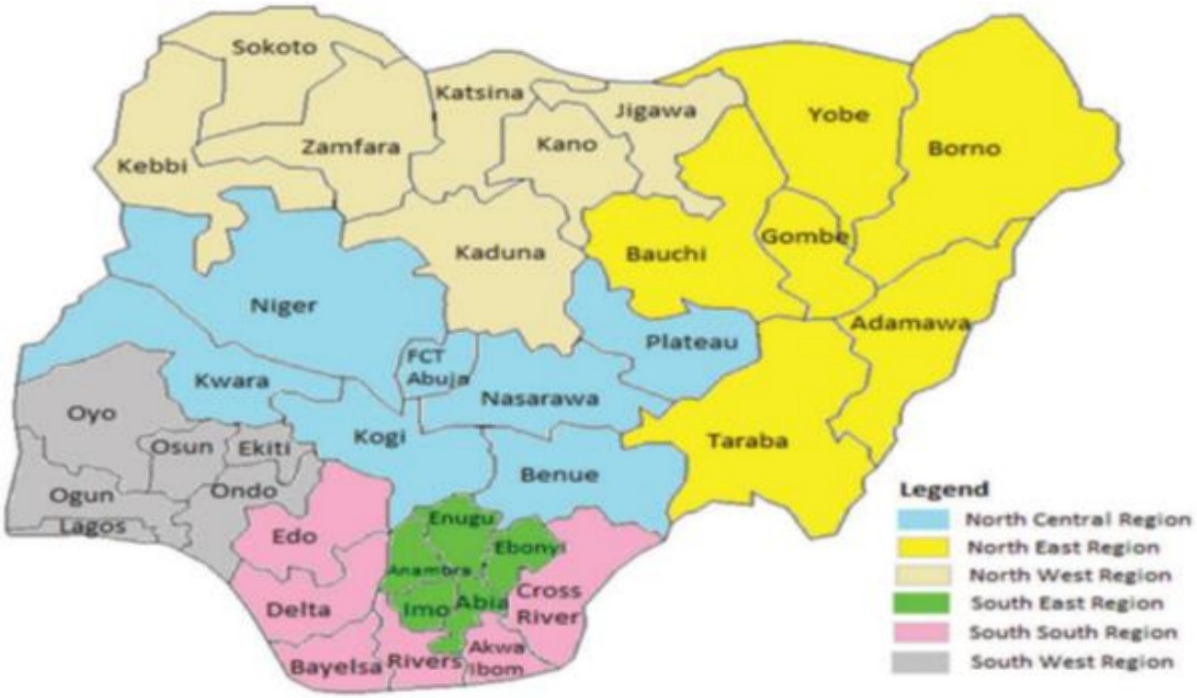

Figure 1 Map of Nigeria showing the geopolitical zones

1.2.2 Health System

Nigeria operates a complex health system model (Figure 2). Both formal and informal providers operate the health care system. The public health care system is controlled by the Federal, state and local governments, comprising tertiary, secondary and primary levels of health care.[22] About 4% of total government expenditure is spent on health.[24] The Federal

Government coordinates and regulates the activities of the tertiary health facilities; the university teaching hospitals and federal medical centres. The state government manages the general hospitals, while the local government operates the comprehensive health centres, primary health centres, health clinics and health posts. The Federal Ministry of Health formulates health policies that are implemented by the state and local health authorities. The state ministry of health coordinates activities of the local government at the primary health care level. There is also the existence of private hospitals and specialized health centres owned by individuals and not-for-profit missionary hospitals and facilities, which the government regulates.[22] The informal health sector includes patent medicine vendors, traditional birth attendants and traditional bone-setters.[25]

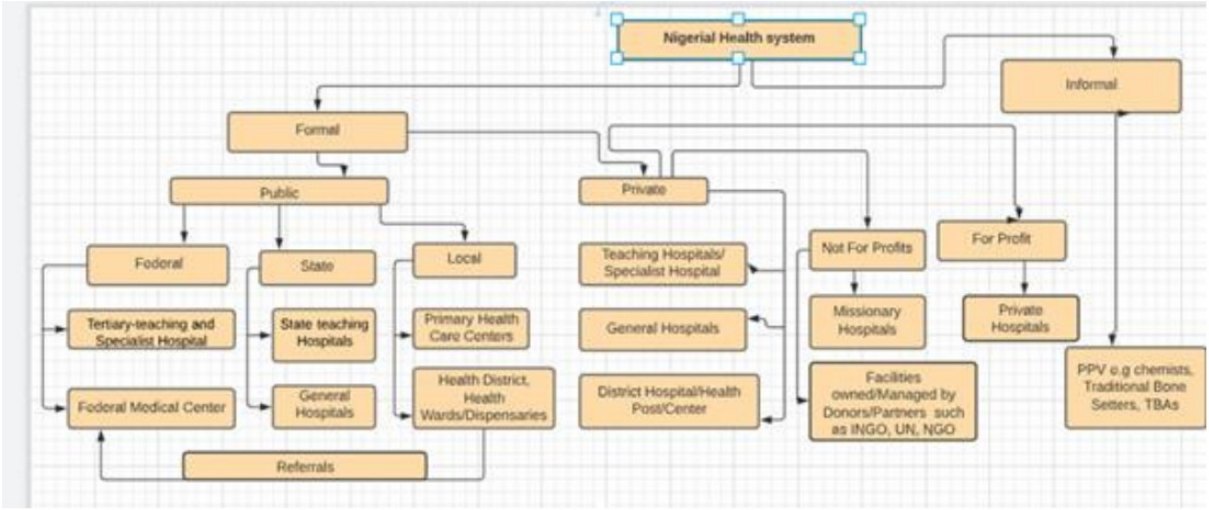

Figure 2 Health system of Nigeria (Source: HSPM project assignment)

Although Nigeria has one of the largest health workforce in Africa, nurses, midwives, and doctors are still too inadequate to deliver essential health services due to wide rural-urban disparities in the distribution of health facilities and human resources across the country. The ratio of doctors to patients is 4 to 10,000, while nurses/midwives to patients are 16.1 to 10,000.[26] Brain drain, consequent upon the government's lack of commitment to the health sector, further depletes the already scarce human resources for health.[27]

1.2.3 Health situation

The 5-year demographic and health survey (2018) provides significant demographic and health indicators for monitoring Nigeria's health status. The average life expectancy at birth is 54

years for men and 56 years for women. The adult literacy rate is 77%. The fertility rate is 5.5. Infant and under-5 mortality rates are 96 and 186 per 1000 live births, respectively. The Maternal Mortality Ratio (MMR) is 840 per 100,000 live births.[28] About 20% of global maternal deaths occur in Nigeria.[29]

Sequel to resolutions at the WHO and World Health Assembly 67th session, violence against women is now formally recognized as a health priority, as stated in the 2013 published guidelines.[30] This served as a call to action on the urgent need to strengthen the health system to address SGBV. There are no specific health services for post-SGBV care. Such services are mainly offered by donor agencies and private not-for-profit organizations; too inadequate to meet the needs of the large population.[31] Sexual reproductive health (SRH) services is usually integrated into maternal and child health services. The contraceptive prevalence rate increased from 8.6% in 2012 to 11.7% in 2020.[32] Poverty, low female education and socio-cultural issues are significant barriers to accessing SRH services, including post-SGBV services.

1.2.4 Economic situation

Despite the Abuja Declaration in 2001, where all African heads of state committed to contributing at least 15% of total government expenditure to health, Nigeria still falls under 10% of budgetary allocation for health care, approximately 3.8% in 2018.[24] Approximately 83 million people (40%) live on less than one dollar per day.[33] The COVID-19 pandemic has worsened the country's economy with a current inflation rate as high as 16%,[34] leading to fluctuations in prices of goods, increased unemployment, poverty and SGBV.[35] Current youth unemployment rate stands at 33.3%.[36] Majority (77%) of the population spend out of pocket (OOP) for health care expenditure.[33] Accessibility to health services is low for the poor, vulnerable groups and rural dwellers as only a tiny proportion of people who are employed in the formal sector are captured by the National Health Insurance Scheme (NHIS).[37]

1.2.5 Gender issues

Nigerian society is patriarchal in nature. Women and men assume roles as ascribed by society. These roles are influenced by religious and socio-cultural factors, which are discriminatory and cause unequal power relations between men and women.[38] Unequal gender imbalance is manifested in economic, social and political environments. Harmful gender norms and practices in both private and public life facilitate gender inequality, which is an underlying cause of gendered violence. Harmful traditional practices such as Female Genital Mutilation

and Cutting (FGMC) and early forced marriages, commonly experienced by adolescents and youths, exist in many Nigerian communities to date. Nigeria's rate of child marriage is around 44%, being the 11th highest rate in the West and Central African region.[39,40]

Chapter 2

Problem Statement, Justification, Objectives and Methodology

2.1 Problem statement

The prevalence of SGBV among women between 15-49 years in Nigeria is 32%; common types experienced and measured in the National data include IPV, sexual violence and psychological violence.[28]. There is no disaggregated national data on SGBV specific for youths and adolescents. A common type of violence experienced by female youths - especially in Southeastern Nigeria - is female Genital Mutilation and Cutting (FGMC), an illegal practice, which is culturally practiced to date.[39,41]. Child marriage is another form of violence that is culturally acceptable, especially in Northern Nigeria, where young girls are married off before 18 years to older men.[40] According to the 2018 NDHS, 15.7% of women were married or in a union before 15years and 43.4% before 18 years.[28]

Although men and women may be victims of SGBV, incidence is more commonly reported in women.[40] Types of violence experienced by boys and men include physical and sexual violence, commonly occurring in childhood but extending into adulthood.[42] Evidence has shown that boys who experience violence in childhood become perpetrators of violence later in life.[43]

Socio-ecological factors are implicated in SGBV perpetration, which is categorized into individual, relationship, community and societal factors.[44] Gender inequality, the root cause of SGBV, also fuels and re-enforces SGBV.[38] Unequal power relations create a perception of male superiority over females, reflected in socio-cultural, economic and political contexts.[38] The factors influencing SGBV in Nigeria, especially involving the youths, include young age, low level of female education, lack of economic empowerment, harmful gender norms such as cultural acceptance of wife-beating as being justified, and alcohol and substance abuse.[45, 46,47, 48, 49]

SGBV has many far-reaching consequences and significant implications on the health and well-being of young women and men survivors.[50] Physical injuries, Post Traumatic Stress Disorder (PTSD), depression and suicidal tendencies are reported among survivors. Specific outcomes are also likely sexual and reproductive health effects of violence. There is the risk of unintended pregnancies from non-use of contraception and sexually transmitted infections (STIs) - like HIV- resulting from indulging in unprotected sexual intercourse. [51, 52, 53]

SGBV invariably affects the well-being of survivors, families, friends and communities, and has socio-economic implications.[54] There is increased utilization of health services, with associated increased cost on the health system and economy, as well as increased absenteeism by victims of SGBV in order to access care.[54]

Adolescents and youths are at a developmental stage of life where they are being transitioned into adulthood. Many dramatic physiological and psychological changes occur in their bodies and minds;[17] hence they are more likely to indulge in aggressive and delinquent behaviours, including risky sexual behaviours like the non-use of condoms for sex. There is the ongoing development of physical features and sexual organs -with the ability for female adolescents to procreate- which increases vulnerability for SGBV experience.[55] Risk factors implicated for SGBV among youths are the experience of parental violence, sharing of a sleeping area with an adult, peer group influence, substance and alcohol abuse, as well as lack of economic empowerment.[47] Male youths are most likely to perpetrate sexual violence, including rape, as a show of masculinity, especially when they experience abuse as children. Some identified risk factors for female youths' violence experience are being single, sexually active, being found in secluded environments, and lacking parental support.[47]

Married youths may experience physical and sexual violence from their partners for refusal of sexual intercourse.[28] An unmarried teen raped by a close acquaintance or total stranger cannot seek help for fear of stigma and blame and may thus carry an unintended pregnancy, leading to unsafe abortion and maternal mortality.[56] There is limited access to information, counseling and referral services for survivors of SGBV.[18] Inaccessibility and limited choice of contraceptive methods and attitude and skills of health care providers serve as significant barriers to youth survivors utilizing post-SGBV services. [57]

SGBV experience among youths and adolescents is documented to be prevalent in conflict and emergency settings.[43] There is an alarming rise in the incidence of SGBV, including rape among female adolescents and youths in Nigeria since the onset of the COVID-19 pandemic.[58,59] In some cases, the lives of victims were terminated prematurely to prevent discovery, thus leaving many promising girls with unfulfilled dreams.[58] According to the United Nations Women, SGBV is acknowledged as the "shadow pandemic" due to an alarming rise in rape cases in Low-Middle-Income-Countries (LMICs) following the onset of the COVID-19 pandemic.[59] The life-threatening consequences of SGBV became more conspicuous during the lockdown period, with associated restrictions of movement. [59]

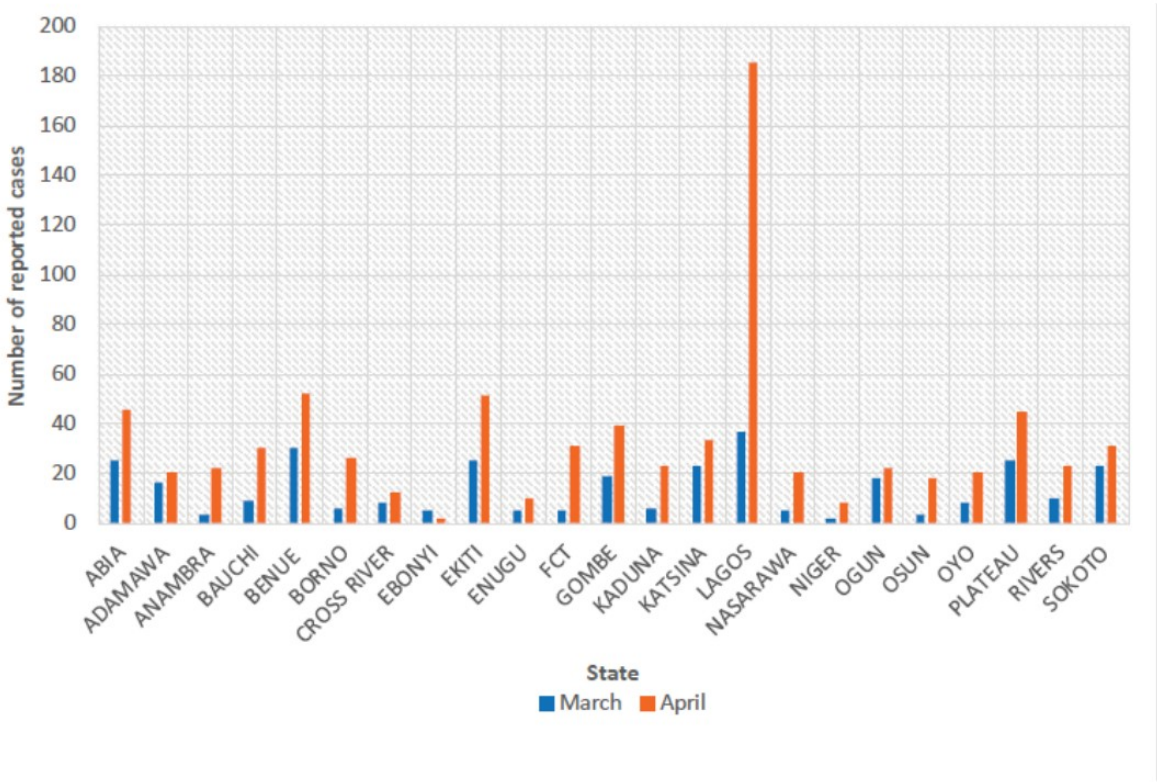

Figure 3 Increased number of reported cases of SGBV in 23 states in Nigeria between March and April 2020 Source: Federal and State Ministries of Women Affairs[59]

Previous, ongoing violence before the lockdown increased in severity and even involved the perpetration of many forms of violence happening simultaneously during the lockdown,[35] including emotional violence and controlling behaviours. Many young women were compelled to be in the presence of their male perpetrators - a spouse or significant other - for unduly more extended periods than accustomed. Girls found themselves in vulnerable positions due to disruptive educational activities, where they became easy prey for SGBV perpetrators.[58]. The culture of silence, discriminatory laws, and fear of stigma and blame make it difficult for young survivors to seek care, report violence and seek redress.[38]

2.2 Justification

Elimination of SGBV is a tool for achieving SDG 5 - promoting gender equality. SGBV has only recently been included as one of the targets in SDG goal 5, thus gaining fresh relevance.[12] The millennium development goal (MDG) 3 failed to meet its 2015 target to assure gender equality and the empowerment of all women and girls globally,[60], [61] hence the need for review with the existing 17 Sustainable Development Goals (SDGs), aimed at the transformation of financial, economic and political governing systems to assure human rights for all.[12] Achieving

the SDGs would be practically impossible without addressing gender inequality, which is an underlying cause of SGBV.

Little progress made to promote gender equality has stalled since the onset of the COVID-19 pandemic.[12,62] The goal remains far from reaching as young women and girls are hard hit by the pandemic. There is an unprecedented rise in cases of SGBV, [49], prompting the urgent need to intensify preventive efforts now, more than ever, against SGBV, especially among young people.

Evidence-based research is essential for policy formulation to improve the health of all people, women and girls inclusive. Available data on adolescents' sexual and reproductive health (ASRH) reveal that their sexual and reproductive health needs are largely unmet; therefore, research is required to understand young people's needs to develop effective interventions to promote their SRHR.[18] Also, interventions and programmes for SGBV are not usually explicitly targeted for youths, thus responsible for low uptake of health services.

The health systems factors influencing care-seeking for SGBV by young people have not been broadly documented, particularly in Southern Nigeria. Underreporting remains a major issue due to stigmatization and discriminatory laws. In addition, the NDHS data only contains information on violence for women and girls 15-49 years, leaving out young people under 15 years who also experience violence. There is also considerable knowledge and information gap on care-seeking and reporting of SGBV in the south, compared to the northern part of the country where most attention is focused because of the prevailing conflict situation of "Boko Haram" terrorist insurgency. Therefore, this research aims to add to the existing body of knowledge on care-seeking and identify gaps in the health system response for SGBV among adolescents and youths in Southern Nigeria and provide recommendations for effective evidence-based interventions.

2.3 General objective

To examine the health system factors, policies and evidence-based interventions for Sexual and Gender-Based Violence (SGBV) among adolescents and youths in Southern Nigeria and recommend effective strategies for prevention and control aimed at achieving the Sustainable Development Goals 3 and 5

2.3.1 Specific objectives

1. Identify health system factors in seeking care for Sexual Gender Based Violence by adolescents and youths in Southern Nigeria

2. Analyse laws and policies on Sexual and Gender Based Violence practiced in Southern Nigeria
3. Examine evidence-based interventions for the control/prevention of Sexual and Gender Based Violence
4. Recommend Prevention Strategies to policy makers in Southern Nigeria to address Sexual and Gender Based Violence among adolescents and youths

2.4 Methodology

A literature review was conducted to analyze health system response to Sexual and Gender Based Violence among adolescents and youths. The health system response framework designed by Garcia-Moreno was used for the review and guided the search strategy (Figure 4). A search strategy was conducted to retrieve scientific, peer-reviewed literature from the following databases: Vrije Universiteit Online Library, PubMed, African Journal Online and Google Scholar. Grey literature and reports were sourced from websites of credible organizations, namely, World Health Organization, United Nations organizations (UN Women, UNFPA, UNICEF) and Nigeria Demographic and Health Survey.

Snowball method was used to obtain more articles on Sexual Gender Based Violence among adolescents and youths. Keywords used in the search were “Sexual Gender Based Violence” OR “Gener-based Violence” OR “Violence Against Women and Girls” OR “Domestic Violence” AND “Care-seeking” AND “Barriers” OR “Enablers” AND “Health system response” AND “Healthcare system” AND “Health Care Provider” AND “Youths” OR “Adolescents” OR “Young people” AND “West Africa” AND “Nigeria” AND “Southern Nigeria” AND “sub-Saharan Africa” (Table 2). Only publications in English Language from 2005-2021 were utilized for the analysis, excluding papers on significant laws and policies formulated many years ago, the definition of key terms and the conceptual framework used for the analysis.

Table 1 Inclusion and Exclusion Criteria

Inclusion criteria	**Exclusion criteria**
Articles published from 2005 to present	Articles published before 2005
Published in the English Language	Literature published in other languages, apart from English
Age group between 10 -24 years	Literature focused on age groups not in inclusion criteria

Focused on care-seeking and health system response to Sexual and Gender-Based Violence	Studies not focused on answering research questions
Cross-sectional, quantitative and qualitative studies, randomized clinical trials	Literature reviews
Studies conducted in similar geographical contexts	Studies from other LMICs with different contexts
Articles with both abstract and full text	Absence of full-text publications

Table 2 Search table

S/N	Specific objectives	Issue	Factors	Location
1	Identify health system factors in seeking care for Sexual Gender Based Violence by adolescents and youths in Southern Nigeria	• Sexual Gender-Based Violence in adolescents and young people • Violence Against Women • Sexual Violence • Rape • Domestic Violence	**Health provider supporting clients** Knowledge and awareness Attitude Skills Principles Context **Health systems supporting health care providers** Leadership and governance Financing Health workforce development Service delivery Health infrastructure Information Coordination	Africa West Africa Nigeria Southern Nigeria
2	Analyze laws and policies on Sexual and Gender Based Violence practiced in Southern Nigeria		**Societal levels supporting health systems** Laws	Nigeria Southern Nigeria

			Criminal justice system Child protection	
3	Examine evidence-based interventions for the prevention/control of Sexual and Gender Based Violence		Social services Community-based services Law enforcement services Health systems services	Nigeria Africa Global
4	Recommend Prevention Strategies to policy makers in Southern Nigeria against Sexual and Gender Based Violence			

2.4.1 Framework

The adjusted WHO health systems framework developed by Garcia- Moreno et al was selected for use in this study because of the health system elements and health care response necessary to address SGBV (Figure 4). The framework also helps to address significant gaps in the health system.[30] The health system is broadly defined as all systems, organizations whose primary interest is promoting and protecting health.[63] But for this study, the focus will be on public and private health facilities and NGOs involved in caring for SGBV survivors and victims.

The framework provides an in-depth perspective of the state of the health system and could help identify health system and societal barriers and enablers for care-seeking for SGBV. The drawback of the framework is its complexity and weakness in addressing the individual and relationship determinants of SGBV, which are not objectives of the study. Another limitation is the focus on women-centered care, leaving out boys and men who also experience SGBV.

The Heise integrated ecological framework was also considered for the analysis because it describes the interaction of various factors for SGBV at multiple levels; individual, family/relationship, community and society.[64] The model has been subjected to various modifications and has broader use across various subjects and disciplines. It has the advantage

of easy adaptability. However, the non-specificity for SGBV and its inadequacy in addressing the specific objectives of the present study posed a major drawback to its use for this analysis.

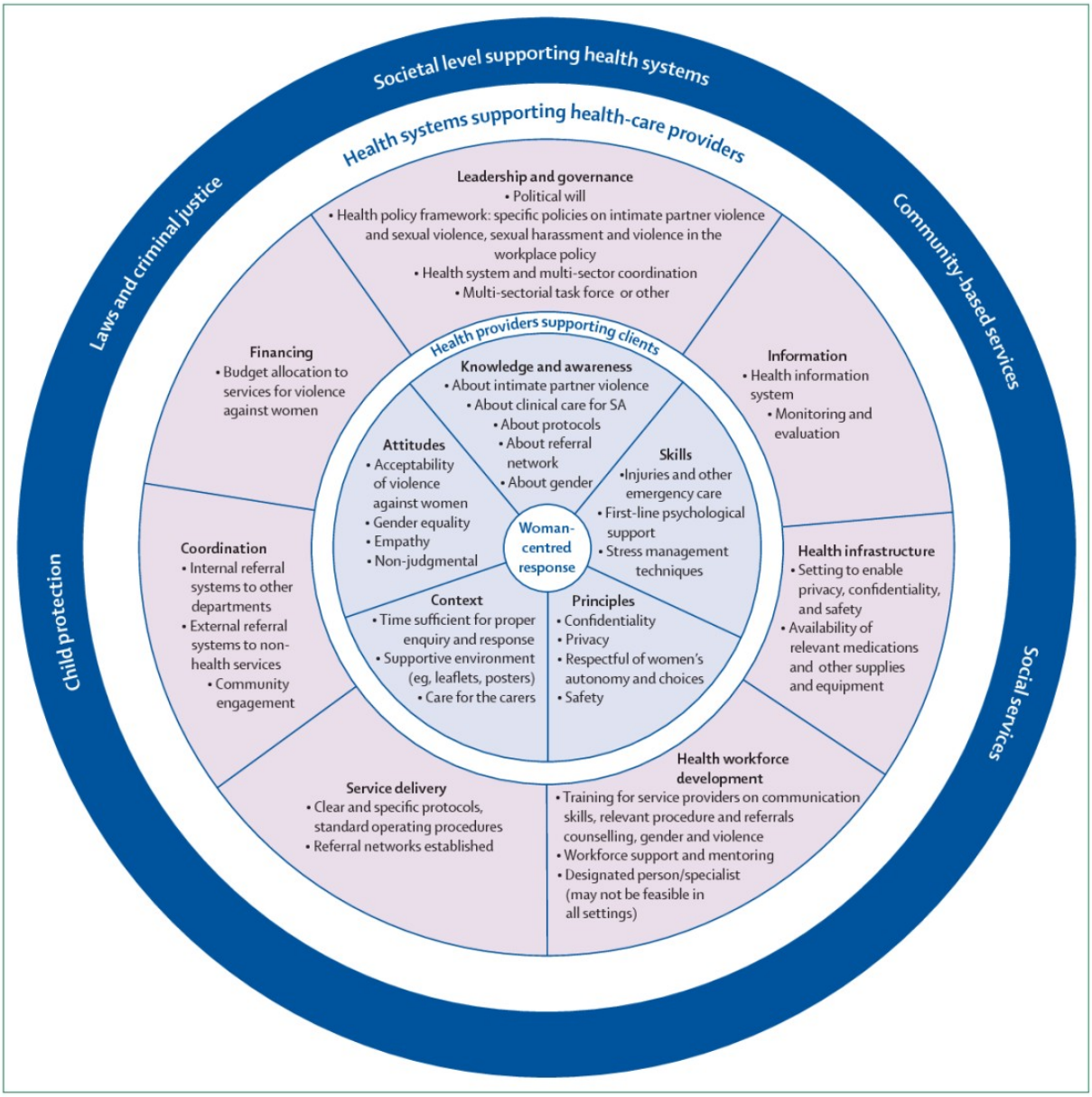

Figure 4 Modified health systems response framework for SGBV by Garcia-Moreno et al.[30]

Chapter 3

Results and Findings

3.1 Results

This chapter gives an overview of health system response at three levels: societal level support of health system, the health system supporting health care providers and health care providers supporting clients. (Figure 4). The following components was analyzed at the societal level: laws and criminal justice, child protection, community and social services. The health system level is organized by the WHO building blocks: leadership and governance, financing, service delivery, health workforce, health information, infrastructure and access to essential medicines. Also included is the coordination of the health system response, essential for effective response, though not a component of the WHO health system building block.

Health care providers and health system factors that influence adolescents and youths' access and utilization of SGBV care will be discussed in this chapter. Adolescents and youths face different sexual challenges throughout life as the period represents their functional and active reproductive life.[65] The chapter also examined SGBV policies practiced in Southern Nigeria and evidence-based interventions from other countries.

3.2 Societal level supporting health systems

3.2.1 Laws and criminal justice

Laws provide frameworks for the implementation of SRHR interventions. Laws either guarantee human rights protection or impose regulations on human rights. Legal barriers to health service access are more significant in adolescents than in other age groups, due to many adolescents being below the legal age of consent, which is 18 years in Nigeria.[66]

Nigeria has established policies and national laws to address SGBV, though not explicitly targeted at the youths. The National Gender Policy was formulated and adopted in 2006 by the Federal Executive Council to promote and protect the human rights of women and children in all the states.[67] There is also the existence of the Criminal and Penal Codes.[68,69] The criminal code is used principally in Southern Nigeria, while the penal code is applicable in the Northern part of the country. There are provisions in the codes pertaining to criminalization of SGBV, with sometimes conflicting laws and conditions. For example, rape committed within the confines of a marriage union is not punishable by the penal code. In addition, the laws justify

wife-beating by husbands.[70,69] Such discriminatory laws hinder rape survivors from seeking help due to fear of stigma, discrimination and personal security.[71]

Nigeria's constitution, established in 1999, makes provision for the protection of human rights. Part II, Chapter IV, Nos 33, 34 and 42) addresses the 'right to life, 'right to freedom from discrimination and 'right to dignity of human persons' respectively.[72]. However, there has been a recent call by policymakers and civil society organizations for review of the amended 1999 constitution, which is regarded as outdated and faulty- symbolizing a breach of the social contract between the government and the citizens- hence no longer relevant for the country's sustainable development.[73] One of the reasons for the urgent call for amendment is due to the present state of insecurity in the country following the activities of Boko Haram terrorists and 'killer herdsmen,' resulting in killings and an increased rate of abduction of schoolgirls, who eventually become sex slaves.[74]

FGMC is a form of SGBV and an issue of human rights violation, mainly affecting girls and still culturally practiced in many parts, especially Southern Nigeria.[41] Evidence shows 86% of circumcised Nigerian women as being circumcised before five years of age and 5% at fifteen years or older.[28] Although section 6 of the Violence Against Persons Prohibition (VAPP) Act prohibits FGMC of the girl child and criminalizes the act with a 4-year jail term or an option of fine of 200,000 naira (equivalent $500) or both, this does not deter offenders.[38] The laws are not strictly enforced; the practice is culturally acceptable and is perceived to reduce promiscuity among girls and women.[39]

The Nigeria constitution stipulates the legal age of marriage as 18 years.[75] However, section 282 of the Penal Code attempts to exonerate perpetrators of child rape - under the guise of marriage - in making allowance for rape within marriage. This law is also applicable in cases of child marriage.[71] Nigeria has one of the highest numbers of child brides in Africa, over 23 million, and mostly from poor rural communities.[76] There are also provisions for the protection of the rights of the child in the Child Rights Act (CRA) established in 2003.[77]

Arising from child protection issues against FGMC and other forms of SGBV are disparities in different laws and policies regarding the definition of the actual age of a child. Upon disparity between the CRA and the Children and Young Persons Act (CYPA), it might be challenging to determine what age is considered the maximum for a child.[78] However, irrespective of what the age limit says, the constitution already goes against any form of violence, abuse or harm against children as stipulated in Section 17(3) of the Nigerian constitution.[72]

Some laws restrict adolescents' access to SRHR services, requiring parental consent or Health Care Providers (HCPs) reporting patients' information, thereby breaching confidentiality.[79] Unmarried adolescents and youths experience barriers in seeking family planning and HIV services due to strict policies and regulations that hinder them from accessing information and services.[80, 81,18] In Nigeria, same-sex relationship is considered illegal and attracts a 14-year jail term for offenders.[82] Hence, gender non-conforming adolescents or youths who experience SGBV may not seek care due to fear of discrimination and criminalization.[83]

3.2.2 Child protection

It is an acknowledged phenomenon for children (less than 12- years old), adolescents and young adult women to experience sexual assault and rape in Nigeria.[71] Six out of ten children experience some form of SGBV.[76] Thirty percent of girls and ten percent of boys have been victims of sexual violence.[76] Less than 0.05% of those who reported SGBV received any support.[76] The increased rate of SGBV has been attributed to the vulnerable state of children and adolescents.[84] These crimes are being perpetrated under very familiar circumstances; for example, a teacher raping his student, a religious leader raping a member of his flock, a father raping the biological daughter, an 80-year old man raping an 8-year old girl, and the list goes on.[85] The rapists take undue advantage of their relationship with the victims to perpetrate SGBV, making it difficult for victims to report or seek help.[84]

The Nigerian government has made some remarkable efforts regarding the establishment of child protection services.[86] However, poor monitoring, weak coverage of programmes, inadequate funding and lack of human resources have hampered the success of these interventions.[86] The government passed the Trafficking in Persons Prohibition Law Enforcement and Administration Act in 2003 to fight against child trafficking, raise awareness and ensure prosecution of offenders.[87] The National Agency for the Prohibition of Traffic in Persons (NAPTIP) collaborates with United Nations agencies and other government institutions at both federal and state levels to perform these functions.[87] However, enforcement of the laws and prosecution remains a considerable challenge.[88]

The Nigerian Federal Ministry of Employment, Labour and Productivity regulate child labour laws through the Child Labour Unit by training, raising awareness and conducting inspections in high-risk areas, such as agriculture and mining.[86] However, efforts have been ineffective mainly because the coverage has not reached the rural and marginalized populations because inspection is limited to formal sectors with a low rate of child labour. In addition, the labour

law states the non-engagement of children in illegal or immoral work, but fails to define specific activities considered illegal or immoral.[86]

Other small-scale interventions by the government to address child protection vulnerabilities include the existence of units to deal with SGBV against children in the police and other law enforcement agencies.[86] Additionally, the Federal Ministry of Women's Affairs and Social Development (FMWASD) operates shelters, provides medical care, counseling and legal services for female survivors of SGBV.[86] The government also works through the media, communities and religious organizations (churches and mosques) to sensitize parents on their responsibilities towards their children.[86]

UNICEF is also supporting the Nigerian government to protect children.[76] The programme aims to provide preventive and response interventions to children victims of SGBV by strengthening legislative and institutional frameworks. The programme employs a multi-sectoral approach to generate evidence for legal reforms, improved funding and development of age and gender-specific services. Identified child survivors of SGBV receive comprehensive services and referrals for specialized care. The programme is being implemented at both national and local levels; specifically in Cross Rivers, Gombe, Lagos, Plateau, Adamawa, Borno and Yobe states.[76]

3.2.3 Social services

Social services for SGBV in Nigeria are organized mainly by NGOs and inadequate for effective SGBV responses and prevention because many of these services are provided in the humanitarian context, not specific for adolescents and youths and limited to the Northern part of the country due to the Boko Haram insurgency.[89,90] The services aim to improve and integrate comprehensive services for SGBV; post-rape care, psychosocial support, legal support, shelters, helplines and welfare services.[91]

The USAID Maternal and Child Survival Program (MCSP) aims to strengthen post-SGBV services in supported health facilities. MCSP conducted a rapid quantitative and qualitative assessment, as well as service mapping to determine the availability of SGBV prevention and response services in 30 health facilities in Ebonyi and Kogi states, involving key stakeholders: the State Ministry of Women Affairs and Social Development (SMOWASD), State Ministry of Health (SMOH), Local Government Areas (LGAs), head of Community-Based Organizations (CBOs), Faith-Based Organizations (FBOs), gender officers at legal and law-enforcement agencies, head of health facilities and community leaders. Key findings included

lack of essential health services for SGBV, insufficient funding, inadequate knowledge and information sharing, as well as lack of coordination.[92]

Community-based interventions in Ebonyi state include providing seed grants by the Ministry of Women Affairs to women start-ups, community mobilization and skills acquisition programmes; Simultaneously, SGBV-related activities in Kogi State SMOWASD have been put on hold owing to funding challenges.[92] Many CBOs have their office based in the state capital, with field officers that visit rural sites occasionally. The implication of this is the inaccessibility of SGBV services for poor survivors of SGBV living in rural areas. However, some NGOs help to identify survivors by conducting community outreaches.[92]

3.2.4 Community-based services

A Community-Based Intervention (CBI) is a response that is working in or for a community and encourages community participation and engagement.[93] Nigeria for Women Project (NFWP) is a World Bank-funded initiative being implemented by the FMWASD in three geopolitical zones of Nigeria, including the Southwest, to improve the socio-economic status of women in targeted rural and semi-urban communities by providing livelihood grants and skills training.[9] A successful programme implementation implies that women in rural communities are economically empowered to make decisions about help-seeking for SRH and SGBV services to improve their health and well-being.

In 2017, in response to SGBV, humanitarian services were provided for people in Northern Nigeria by CARE Nigeria (an international NGO), with 867,850 persons reached (about 87% of project target). Interventions included distributing dignity kits to 17,400 women and adolescent girls, psychosocial support for 239,750 persons, skills building and support services for 15,450 persons. Engagement with community leaders and policymakers on SGBV protection services, strengthening community structures and scaling up services in terms of geographical accessibility, training HCPs and quality service delivery are significant focuses of the programme.[90]

There was no literature found on the evaluation of the community-based interventions. Developing countries rely on qualitative or process evaluation to measure the effectiveness of interventions, while High-Income-Countries (HIC) depend on impact evaluation.[91] Reason is that there is a paucity of literature on evaluations of social services interventions, especially in developing countries. This is due to challenges in defining and measuring success indicators related to violence without extended follow-up.[91]

3.3 Health systems supporting health care provider

According to World Health Report (2000), the Health System (HS) consists of all institutions and organizations whose primary goal is to promote health.[63] The role of the health system in SGBV is mainly supportive; to prevent violence before it occurs and mitigate against the effects of SGBV. Sequel to resolutions at the WHO and World Health Assembly 67th session, violence against women is now formally recognized as a health priority in the 2013 published guidelines.[30]

3.3.1 Leadership and governance

The Nigerian government has demonstrated a considerable commitment to addressing SGBV by ratifying various international, regional and national treaties and agreements on SGBV and gender equality.[94,95] The United Nations Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW) was ratified in 1985 to advocate for the promotion and protection of women's rights, but is yet to be domesticated into federal laws of the country.[94,96] The Maputo Protocol was adopted in 2003 following a commitment by African leaders to promote gender equality and protect women's rights.[95] The 2006 African Youth Charter calls for the development of legal, physical and psychological interventions to support girls and young women survivors of SGBV to enable them to reintegrate into society.[97]

A specific policy for SGBV in Nigeria is the Violence Against Persons Prohibition (VAPP) Act, passed in 2015 to address SGBV.[98] The law has provisions for the protection and rights of survivors of SGBV. However, it is not domesticated in the 36 states of the nation yet, hence not applicable in the non-compliant states where young women experience violence.[9] The VAPP Act has a provision for the criminalization of sexual violence and rape. However, inconsistencies in the definition of rape by the plural legal systems weaken the right of survivors to seek legal redress, as the victim may end up becoming the sanctioned, for example, in situations of marital rape. Rape within the confines of marriage is excluded from the Penal and Criminal codes; while IPV is higher than other forms of SGBV (20-31% of women experience sexual violence).[69]

Everyone, including adolescents and youths, has a right to decide their sexuality and reproduction and use of SRHR services free of stigma, discrimination and violence.[18] SRHR and SGBV services should be accessible to everyone in need, irrespective of age, gender, socio-economic status and gender orientation. Adolescents and youths have the right to access SGBV services free of discrimination and violence, and the government must respect, protect and

fulfill such rights.[18] Provisions for access to SGBV services is visibly absent from the national policies on the health and development of adolescent and young people in Nigeria.[99,100] There is a need for an urgent review of these policies due to emerging sexual health issues of young people in present times.[101,62]

3.3.2 Financing

Health facilities and organizations delivering SGBV care in Nigeria are funded by international donor agencies, which restrict the type and scope of service delivery.[102] Weak political commitment, financial constraints, and non-prioritization of adolescent and youth health needs prevent the government from delivering comprehensive SRH services to young people to prevent pregnancy and STI after experiencing rape and sexual violence.[17,103] Furthermore, SGBV is not included in the sub-optimal budgetary allocation for health,[22] hence domestic funding for SGBV is limited. Funding is required for infrastructure development and purchase of medicines and equipment, as well as for the capacity building and motivation of HCPs to facilitate effective response.[104]

The cost of accessing SRHR services may pose a barrier to youths seeking or using services, as many Nigerian youths are still dependent on their parents for financial and health care needs due to the country's high level of youth unemployment. [36] A mixed-method study among adolescents in Enugu, Nigeria, revealed that though services were geographically accessible, many could not afford the financial cost.[105]

3.3.3 Health workforce development

There is a high demand for a skilled health workforce but a low supply in Nigeria.[26] This is coupled with unequal distribution of health workers, with more health workers in urban areas than rural areas.[26] High turnover of HCPs and unwillingness to work in rural environments due to poor motivation contribute significantly to the shortage of human resources.[27] Additionally, ongoing brain drain following weak political commitment on health matters also contributes to the health workforce shortage.[106] There is a lack of trained, designated focal personnel on SGBV in health facilities, and the few remaining workers are already overburdened with work and not willing to take on more roles with no additional incentives.[92]

3.3.4 Service delivery

SGBV and SRHR are intersecting essential life-saving components linked to gender inequality and social determinants of women's health and rights.[107] Experiencing SGBV leaves survivors

with poor SRH outcomes.[50] Integration of SGBV into SRHR services is an approach that enhances the availability and accessibility of SGBV services.[107] In Nigeria, SGBV services are usually integrated into SRH services, especially at the primary level of care.[108] Although services for SGBV among adolescents and youths in Southern Nigeria is not comprehensive; there is the availability of specific services based on the form of SGBV experienced, for example, post-rape care, Post-exposure Prophylaxis (PEP) for prevention of HIV/AIDS and treatment of other STIs, as well as contraceptive services. There is also the existence of youth-friendly-centres distributed in states across the country.[109] These services are integrated into health facilities and deliver SRHR services and health education to adolescents and youths.[110]

HCPs deliver available services for SGBV in Nigeria in private and public health institutions, funded mainly by non-governmental organizations (NGOs) and international donors, particularly in humanitarian and crisis settings. Due to the ongoing insurgency in North-eastern Nigeria, SGBV survivors receive support via intervention programmes organized by international humanitarian agencies.[90] However, there is a massive gap in the delivery of comprehensive services for survivors of sexual violence in Southern Nigeria. State ministry parastatals, civil society organizations and private individuals run the few available services, and not specific for youths.[111,112]

3.3.5 Information

Information is needed to inform policies and monitor services and should be collected in a timely and safe manner. Underreporting remains a significant issue in SGBV. Many adolescents and youths do not report sexual violence and rape for fear of stigmatization, retaliation and abandonment, as well as fear of not getting someone to marry if found out.[75]

Data and information on marginalized groups like early adolescents (10-14 years), slum dwellers, displaced persons, refugees and commercial sex workers are limited as these groups are often not captured by household surveys.[18] Adolescents and youths compose a large proportion of these groups, with largely unmet SRHR information and service needs.[18] Many adolescents and youths do not have access to necessary information for making informed choices about sexuality issues. A cross-sectional study conducted among facility heads of 230 PHC centres in Plateau State revealed information and counselling delivered on sexuality, safe sex, contraception and SGBV care were in 11.3%, 17.0%, 11.3% and 3.0% of health facilities, respectively, and only 2.6% of the surveyed facilities had youth-focused ASRH information posters on display.[113]

3.6.6 Health infrastructure and access to essential medicines

Appealing environments with private and confidential spaces are major boosters to young people's acceptability of SRHR services. There is insufficient availability of youth-friendly centres, with friendly and non-judgemental HCPs in many Nigerian health facilities.[113] There is also an inadequate supply of family planning commodities and limited contraceptive options to help young people make informed choices.[114] Although contraceptive commodities are supposedly free, some user fees are still required, which many youths cannot afford. Long-acting reversible contraceptives (LARCs) – intra-uterine devices (IUDs) and sub-dermal implants - are usually out of reach of adolescents and unmarried people due to misconceptions by some HCP on the use of specific methods promoting promiscuity among adolescents and youths.[115] There is also a lack of emergency contraceptives for post-rape care to prevent unwanted pregnancies.[114]

3.2.7 Coordination

Multisectoral coordination of response is essential for preventing violence recurrence and providing ongoing care for survivors of SGBV.[116] Care for SGBV can be delivered through multi-disciplinary or hospital-based One-Stop Centres (OSCs).[117] OSCs deliver integrated, multi-disciplinary care for SGBV care in a single location. Collaboration of the HCP with law enforcement agencies and judicial and welfare organizations ensures that survivors get access to comprehensive care, which may be delivered in one location. Survivors are assured of safety and shelter, and better positioned to seek redress.

In Nigeria, there are no specific guidelines for multi-sectoral responses to SGBV, unlike in Malawi, Zambia and Kenya, where there is the availability of OSCs, which has been proven effective in the delivery of SGBV care to children and adolescents.[118,119] Integration of SRH services into facility-based services in Nigeria has been proposed with the OSC approach - to reduce stigma and barriers to service access by adolescents.[120] The OSC model could also be applicable in a multi-sectoral environment., with effective referral systems.[117] to pave easy access to SGBV care for adolescents and youths in Nigeria.

3.4 Health providers supporting clients

The health care system refers to the institutions, people and resources involved in delivering health care to individuals.[121] Health Care Provider (HCP) factors preventing adolescents and youths from seeking care for SGBV include the knowledge and attitude of the HCPs towards gender and sexuality, as well as contextual factors as the lack of a supportive and enabling environment whereby the right to privacy and confidentiality is protected.[113,115]

A national youth survey conducted in 2012 by the Federal Ministry of Youth and Development in collaboration with the National Bureau of Statistics reported that about half (47.4%) of youths access and utilize public hospitals, compared to 19.5% who utilize private hospitals.[122] One would expect that more youths would prefer private hospitals due to shorter waiting times. This implies that the non-affordability of services influences the non-utilization of services as public hospitals are less expensive than private hospitals in Nigeria, and many youths are also unemployed.[36]

3.4.1 *Knowledge and awareness*

In Nigeria, medical practitioners lack adequate knowledge and skills to respond to SGBV cases. Skills are deficient in the identification of SGBV but limited to the treatment of physical injuries.[92] Many HCPs cannot provide basic first-line support involving counseling, safety planning and referral services. Knowledge of appropriate referral mechanisms for psychosocial support, police and legal services is also poor among HCPs.[92] A rapid assessment by the USAID Maternal and Child Survival Programme (MCSP) to determine knowledge of SGBV among HCPs in Southern Nigeria showed that the majority had not received any form of training on SGBV.[92]

Although there are available guidelines and protocols for the management of SGBV, developed mainly for use in crisis settings and for all age groups, there are none specifically for adolescents and youths.[123] Many HCPs are not aware of available guidelines and Standard Operating Procedures (SOPs) for SGBV care and those who are aware do not adhere to recommended guidelines.[9] Medical services for SGBV in Nigeria are primarily dependent on international donor agencies for medical supplies, drugs and equipment. However, the scope of services is limited due to inadequate resources.[124]

3.4.2 Attitudes and skills

Health care providers' attitudes are crucial in whether adolescents and youths will access an SRH service. Cultural beliefs and values about the rightness of action due to a client's age, marital status, or parental consent may influence the care of a young person by an HCP.[17] Some HCPs may be biased towards delivering contraceptive or abortion services to adolescents and unmarried girls who experience rape due to perceived moral obligations and a judgemental attitude. A cross-sectional observational study conducted in Ebonyi and Kogi States, Nigeria, among private health providers reported 60% disagreeing that a woman could choose family planning without her husband's consent. In comparison, 23.2% disagreed that unmarried young women should be allowed to use family planning services.[125] Moreover, cultural norms and beliefs of the health provider could also impact negatively on the delivery of required care, as revealed by a Southern Nigeria study among HCPs, where none of the providers provided information, services or referrals for SGBV.[125]

Additionally, SGBV survivors may experience challenges accessing services due to inadequate referral centres, which also suffer under-funding.[126] Socio-cultural norms and fear of stigma and discrimination by HCPs may also prevent many survivors from seeking help and reporting SGBV.[59] For instance, a female adolescent who experiences rape may feel ashamed and, for fear of being blamed or judged, decide not to seek care, only to discover an unwanted pregnancy soon, leading to an unsafe abortion and mortality. In a cross-sectional study conducted among health workers in public health facilities in Kaduna, Northern Nigeria; HCPs agreed to give contraceptive counseling and services to adolescents, but none were ready to offer IUD to unmarried adolescents.[115]

The skills of medical personnel in the identification, treatment and appropriate referral of cases of SGBV also call to question whether young survivors of SGBV will seek care services.[124] During pre-service training in medical schools in Nigeria, gender and SGBV is not usually included as part of the medical school curriculum.[127] Medical students are also not exposed to clinical training for the management of SGBV. Services for SGBV are mainly limited to the treatment of physical injuries. Many HCPs lack the knowledge and skills to screen, treat and refer patients for SGBV. Training is required to provide age-appropriate care, responsive to the needs of adolescents.[128] However, literature on the perception of the quality of SGBV services among adolescents and youths in Nigeria was not found.

3.4.3 Principles

Often, ethical principles of autonomy and confidentially are not adhered to by HCPs, especially when dealing with young clients.[129] Fear of being reported to parents by the HCPs makes many youths shy away from accessing SGBV services, even when needed.[130] The right to privacy is not protected according to the international human rights convention,[129] although youth survivors of violence expect health professionals to be professional and offer privacy and confidentiality in the delivery of services, as reported in a qualitative survey conducted in South Africa.[131]

Ethical principles sometimes serve as barriers to youths accessing SGBV care as the legal age of consent in Nigeria is 18 years.[66] HCP may not be willing to offer SGBV service to an adolescent without obtaining parental consent. This may hinder adolescent accessibility of the service as they may not want their parents to be aware because of fear of parental disappointment or losing the trust and confidence of parents and caregivers.[17] Caregivers may also be the perpetrators of the SGBV, making it difficult for the survivor to seek care or report violence.[85] Additionally, female contraceptive users may not want their partners to be aware for fear of violence and coercion but are denied these services due to the need to obtain prior spousal consent.[132]

3.4.4 Context

Adolescent care-seeking behaviour varies according to context. A large multi-country study among urban disadvantaged adolescents across five countries; Nigeria, South Africa, India, China and the USA, found that a large proportion of adolescents do not seek care even when needed.[133] Further exploration with qualitative data revealed a lack of trust in HCPs, safety issues, feelings of embarrassment, and stigma were reasons for not seeking care.[133] However, parental and family support increased the chance of seeking care by adolescents in Johannesburg and Baltimore.[133] Global research has shown that less educated, poor and rural dwellers have a high unmet need for SRHR services than people residing in urban areas and have good socio-economic positioning.[18] Similarly, poor youths living in rural areas in Nigeria are marginalized in terms of access to SRH services compared to their counterparts in urban areas.[126]

3.5 Evidence-based Interventions for prevention and control of SGBV

This section describes evidence-based interventions and responses to SGBV for adolescent and youth survivors of SGBV in Nigeria. Effective programmes for prevention and control of SGBV, piloted in other LMICs of similar context, are also showcased for learning opportunities.

Primary, secondary and tertiary levels of prevention is key to effectively addressing SGBV among young people.[30] (Figure 5) Primary prevention can be achieved by awareness-raising on harmful gender norms, documenting violence and its effects (health burden and socio-economic costs), and advocacy for multi-sectoral action. Primary prevention would be to provide immediate and long-term care such as post-rape and sexual assault care and support for survivors of SGBV, including appropriate referrals. For the tertiary level of prevention, rehabilitation of survivors and support for employment, shelter and legal services are crucial multi-sectoral health system interventions to address SGBV.[30]

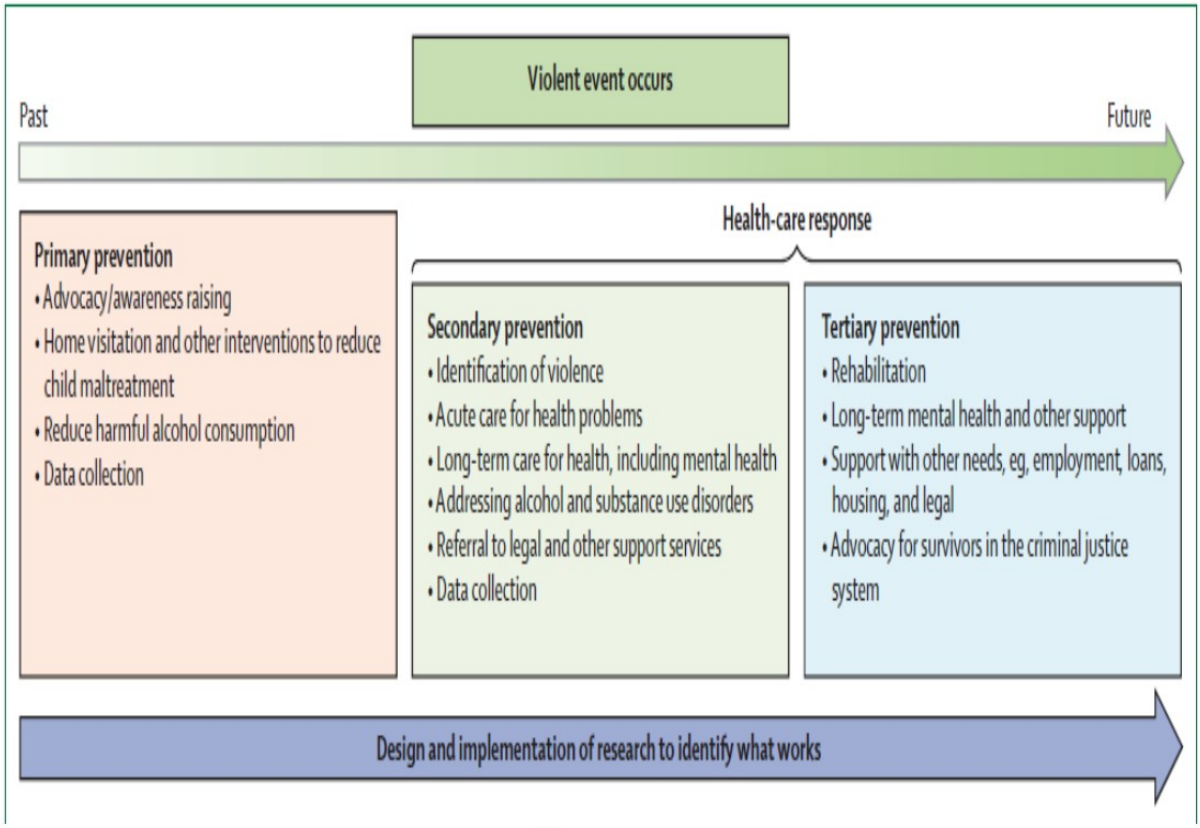

Figure 5 Levels of SGBV prevention[30]

3.5.1 Interventions from Nigeria

The strengthening the response to SGBV in Nigeria project by Pathfinder International was implemented in collaboration with United States Agency for International Development (USAID) and relevant government stakeholders.[102] The project aimed to strengthen the response and preventive efforts for SGBV by providing comprehensive services in ten Sexual Assault Referral Centres (SARCs) in nine Nigeria states. The centres provided medical, forensic, counseling and referral services for SGBV.[102]

The programme's objectives were to support SARCs to provide quality health services for survivors of SGBV by training of staff on service delivery in terms of counseling and examination, operational procedures, as well as provision of equipment; provision of feedback on the quality of services so that decisions can be made on service improvement.[102] This evidence-based intervention relates to the health systems supporting the healthcare provider in the Moreno framework. The project also aimed to administer funds to improve sustainability after USAID withdraws its support. This aspect not only administered funds but also assisted in developing organizational policies and procedures to ensure adherence to universal guidelines towards providing support. This brought about the increase in the commitment of several states by providing dedicated budgets and free medical services.[102] This provided some measure of societal support for the healthcare system, evidencing the tertiary support structure.

Another vital aspect that the intervention sought to address was to provide a better avenue for collecting and analyzing data to provide a means to utilize data for policy action and respond effectively to the future needs of SGBV survivors. Data assessment showed an increase in components assessed from the beginning to the end of the project, utilizing the Organizational Capacity Assessment (OCA) methodology across nine components.

However, there was no primary intervention component of the project. Also, the study did not find literature on the evaluation of the project to prove programme effectiveness and impact.

At the end of the project, 3440 clients received post-SGBV services; emergency contraceptive provision increased from 45% to 70% and PEP from 62% to 75% (reporting period April to September 2018 to April to September 2019)

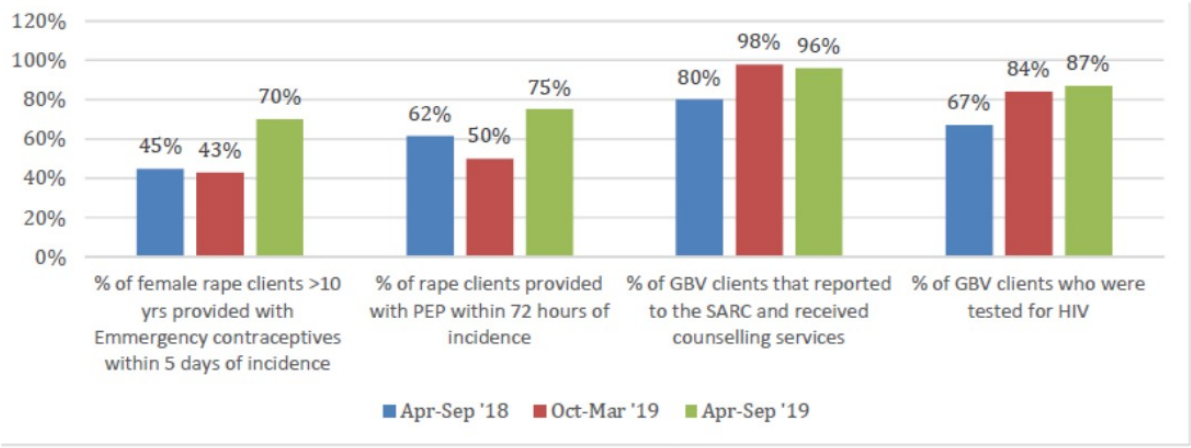

Figure 6 Quality of services provided by the SARCs[102]

3.5.2 Interventions from other LMICs

The Adolescent Girls Initiative (AGI-K)

In Kenya, the adolescent Girls Initiative (AGI-K) delivered baseline interventions to over 6000 girls between 11-15 years in two marginalized areas: Kiberia and Wajir. AGI-K comprising a combination of four different individual, household and community interventions from 2015-2017, utilizing randomized controlled trials: violence prevention, education, health and wealth creation (Figure 7). The violence prevention arm of the intervention used community dialogues and planning, where community leaders (local government officials, religious leaders, school heads, teachers, parents of beneficiaries and young women and men) had facilitated meetings to brainstorm and identify critical issues responsible for undervaluing of girls and perpetration of SGBV against girls in the community. An action plan was developed after identifying the issues and each community conversation group was given funds to implement their projects. The health intervention arm used age-appropriate health education on SRH and life skills, which was delivered in weekly group meetings under the guidance of a female mentor in the community for one year.[134] Other interventions were education, through cash transfer to a household for enrolment in school and wealth creation via financial education for the girls.

At midline, girls in Kiberia who received all other interventions reported experiencing less violence by a male in the past year compared to girls in the violence-only intervention arm.

While in Wajir, there was no change in violence reporting by girls at midline survey. However, there were positive gender norms, with over 95% of households reporting that girls should complete secondary school and marry after 18 years.

At the endline, there was an improvement in school enrolment and completion rates and household wealth status, improvement in SRH parameters ranging from knowledge of SRH, condom self-efficacy, and social safety nets in both regions. Delay in sexual debut and pregnancy increased by 27% and 43%, respectively; a slight increase of 5% on primary school completion and transition to secondary school in Kibera.[135] While the health intervention did not have a sustained impact on the quantitative measures after the intervention ended, the qualitative data collected one year after the intervention reported that girls who participated in the girls' groups retained a sense of confidence, assertiveness, and voice.[135]

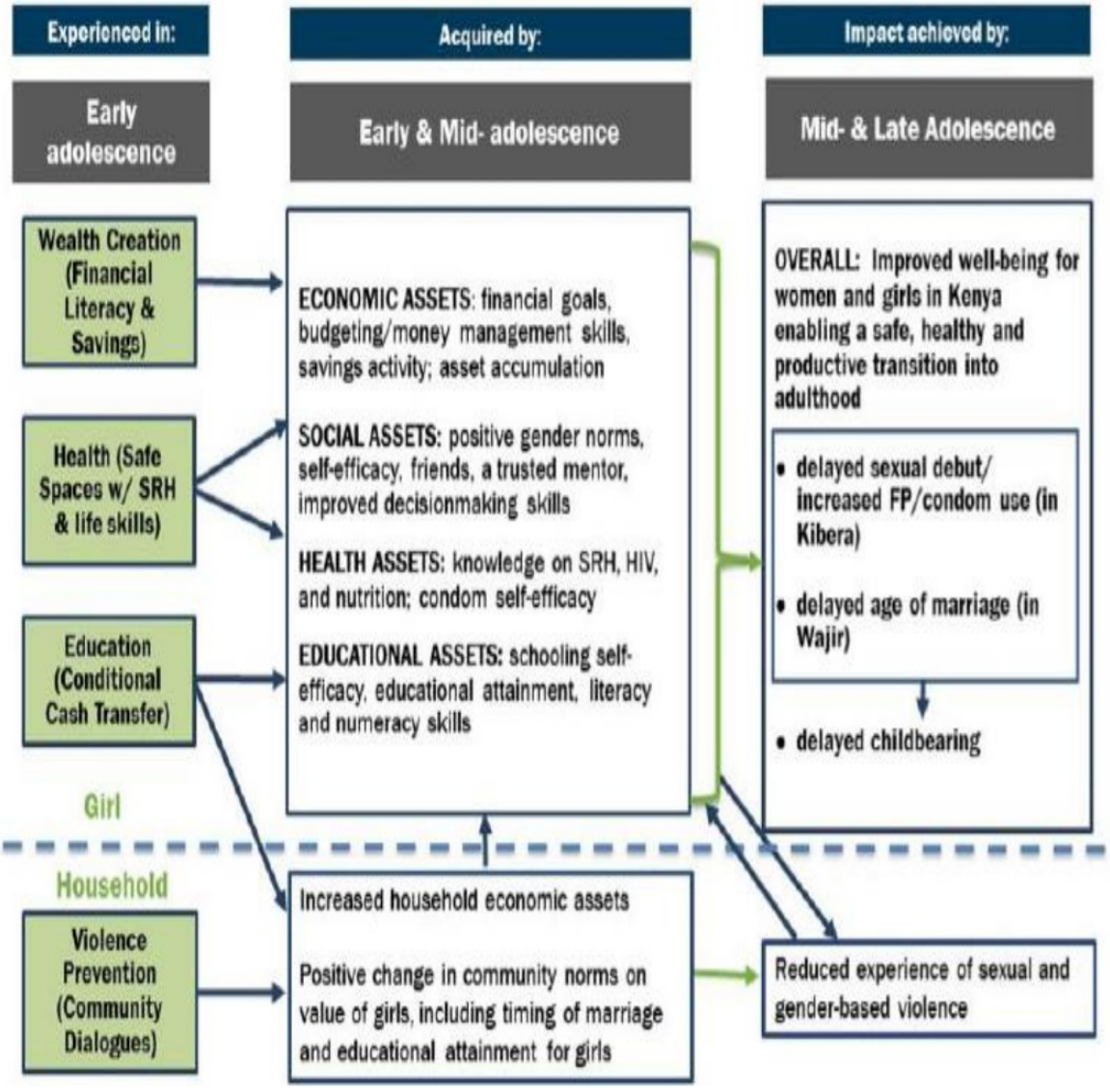

Figure 7: AGI-K Theory of Change[135]

The Champions of Change (CoC) programme

The Champions of Change (CoC) for Gender Equality and Girls' Rights programme, established in 41 countries, promotes gender equality by engaging youths.[136] The programme empowers girls and boys to challenge harmful, negative masculinities that perpetuate discrimination and inequality. Girls and boys exchange views on gender-transformative approaches and work together to bring about change in their communities. CoC also equips youths with the knowledge and skills to fight for their LGBTQI peers and contribute towards a stigma-free and violence-free community.The programme also engages parents and relevant community stakeholders in intergenerational conversations on gender equality, SRHR and SGBV.

In Malawi, the CoC was part of the 'Yes I Do' intervention components.[137] The CoC aimed to reduce child marriage and teenage pregnancy as root causes of gender inequality by exploring community engagement towards gender equality and girls' rights. An impact evaluation was conducted using a mixed-method approach.[137]

The end-line qualitative survey reported that 94% of respondents agreed that "girls and boys are valued equally and enjoy the same level of respect in the community." The proportion of girls who felt their spouse was justified to beat them dropped from 41% to 32%, while for the men the proportion reduced from 34% to 25%. The proportion of men that reported being able to negotiate condom use was 55%, compared to 43% of girls, while 69% of the respondents agreed on negotiating condom use to prevent pregnancy and STI.[137]

Figure 8 Perceptions of sexual violence [137]

Proportion of respondents who agreed with the statements. Baseline N=358; Endline N=315

The Soul City Project South Africa

Male involvement is essential in addressing SGBV because boys and men play gatekeeping roles to girls and women, for example, in decision-making to seek SRH services. Community interventions involving boys and men have effectively contributed to changing harmful cultural attitudes and beliefs towards gender.[138,139,140] The Soul City project conducted in South Africa is a notable example of an effective intervention to address SGBV through a gender-transformative approach. The study was conducted via a mixed-method approach, involving women and men 16-65 years, using community outreach and mobilization strategies (Figure 9).[141]

Soul City Scheepers et al. (2001) Usdin et al. (2005) South Africa	Men and women 16–65 years old from metropoli-tan areas and rural areas	**Community outreach and mobilization** • Nationwide mass-media and advocacy campaign on domestic violence • Campaign conducted through: television series, distribution of print materials and radio series • Community events	**Gender-transformative** • Increase public debate (societal level) • Promote interpersonal and community dialogue • Shift social norms (community level) • Shift attitudes, awareness, knowledge and practices (individual level)	**Rigorous** *Quantitative:* National survey; stratified random sampling Pre- and post-testing (8–9 months = relatively short period) n = 2000 adults • No control • Analysis: multiple statistical analysis; regression to relate changes to differing levels of exposure *Qualitative:* Focus groups (n = 29) Interviews (n = 32) Post-testing only • No control • Analysis: profiling of respondents according to change or exposure; coding of themes or subthemes	**High** Knowledge: Increased awareness of help-line for gender-based violence (16% with no exposure and 61% with exposure had heard about the help-line) Attitudes: Increased perception that violence between a man and a woman is not a private affair (from 37% to 59%) 11% more men in the post-test than in the pre-test said that women never deserve to be beaten Policy-level impact: contributed to passage of an act on domestic violence Possible but unclear effect on behaviour	**Effective**	One of the most comprehensive evaluation designs in work with men and gender-based violence Excellent example of effectively combining quantitative and qualitative research methods

Figure 1: Effective study on male involvement in SGBV (Soul City)[141]

Chapter 4

4.1 Discussion

The literature review analyzed the health system response to SGBV among adolescents and youths in Southern Nigeria and discussed in line with the study objectives

4.1.1 Health system factors in seeking care for Sexual and Gender-Based Violence by adolescents and youths in Southwestern Nigeria

This section discusses two perspectives: the health system supporting HCPs and the health provider supporting the clients. Health system response for SGBV is crucial for addressing the health, social and economic consequences of SGBV among adolescents and youths. The strengthening of Nigeria's health system is necessary for a more effective response to SBGV.

The findings of the study revealed that various health system factors are considered in seeking care for SGBV. The government of Nigeria has framed up policies in line with those of international standards. These policies, laws and regulations are geared towards ensuring the protection of adolescents and youths against SGBV. Policies like the Violence Against Persons Prohibition (VAPP) Act and Child Rights Act have provisions for promoting and protecting the rights of adolescents and youths in Southern Nigeria against sexual abuse and exploitation. However, the drawback of weak implementation and multiplicity of policies by different governmental institutions render the laws ineffective. Policy somersault and unstable political terrains also pose significant challenges to policy implementation. Continuity must be encouraged in governance so that there can be harmonization of these relevant policies and laws. The study also found a lack of coordination of comprehensive services for SGBV in Southern Nigeria, which hampers effective prevention and response efforts. Harmonization between government, agencies, HCPs and clients/patients must be encouraged for quality service delivery like documented in the OSC programme in Zambia, Kenya and Malawi.

On funding, the analysis found that international donors majorly fund SGBV services. However, this form of funding is likely to place restrictions on service delivery type and scope and not sustainable in the long run. Although these interventions are done in collaboration with government and government institutions, the role of government is limited. Non-affordability of SRH and SRHR services was also a key challenge in accessing available services. The government should show more significant commitment in its role as a duty bearer to uphold the right of women and girls by providing subsidized services for SGBV. Increasing budgetary

allocation for health and providing services for the poor and those residing in rural areas will reduce the inequality girls and women face in accessing services timely. Also, more girls in Southern Nigeria would be able to access SGBV services if the government commits to providing SGBV services instead of complete dependence on humanitarian actors. Government interventions and local budgetary allocation would also assist in meeting the specific SRH needs of adolescents and youths in resource-constrained areas, and also assist in the provision of funds for essential medical materials and drugs, infrastructural development, staff training as well as other needs which might not be covered by international intervention. Lack of funds or insufficient government funding cripples development, innovation and access to quality services by victims and survivors of SGBV

The study reported high demand for the health workforce in the country amidst the current brain drain in the health sector. Many HCPs now prefer to move out of the country for greener pastures, hence, high demand and low supply of health workforce. The available workforce is unevenly distributed, with high disparities between rural and urban areas, affecting access to SGBV services in rural areas. HCPs should be incentivized and motivated to provide quality service to survivors of SGBV. When HCPs deliver quality service, adolescents can have access to information for informed decision-making and agency. Government and other agencies should ensure good service delivery in the country's southern parts, especially for youths and adolescents. The confidence bred by these services will improve access to quality information for and by survivors and also improve reporting. Reporting of SGBV will also assure the availability of data for policy formulation. Giving vital, accurate information to HCPs will inform what steps to take to address SGBV. However, information is not readily available, as revealed by the study. Hence, there are bound to be challenges regarding policy formulation and implementation.

Another significant finding from the study is the lack of skilled HCP for SGBV response. HCPs lack skills in recognition, counseling, treatment and referral for SGBV. Most services provided by HCPs for SGBV are limited to the treatment of physical injuries alone. SGBV is not prioritized in pre-service and in-service training of medical practitioners. The implication is that the health system will be dysfunctional and unable to respond to the specific SRH needs of adolescents and youths.

4.1.2 Analysis of laws and policies on Sexual and Gender Based Violence practiced in Southern Nigeria

The Nigerian government has demonstrated commitment to international laws and treaties on gender equality and SGBV and the sustainable development agenda. Various policies and plans of actions are in place; however, implementation remains a significant challenge. The study found that youths have large unmet needs, which are not prioritized in national policies. The national action plan for adolescents has not been updated since first developed and makes no provisions for SGBV. There is a need for more meaningful participation in policies affecting adolescents and youths based on their unique needs. The VAPP Act established in 2015 to address SGBV and prosecute perpetrators is yet to be implemented in all Nigerian states. There is no strict enforcement of FGMC laws as the practice is culturally acceptable in many parts of the country, especially in Southern Nigeria. Child marriage is still being practiced, despite laws prohibiting child marriage and stating the legal age of 18 years.

The Nigerian criminal laws are conflicting due to the Federal system of government in operation. For example, conflicts arise regarding the definition of rape and what age is legally acknowledged as a child. These policy conflicts tend to create loopholes in the formulation, implementation, and strict enforcement of policies and due punishment of offenders. Laws and policies that align with international best practices and compliance, which also consider the peculiarity of Nigeria and Southern Nigeria, must be implemented. Government, policymakers and other relevant stakeholders must harmonize discussions on policy guidelines and implementation to control SGBV among youths and adolescents in Southern Nigeria. The Collaboration of the Ministry of Women Affairs and Social Development and development partners should urgently look beyond service provision into policy formulation, implementation, and reforms related to SGBV and young people.

4.1.3 Examine evidence-based interventions for the control/prevention of Sexual and Gender Based Violence

The study documented promising programmes and interventions to address SGBV among adolescents and youths in Southern Nigeria and other LMICs. Studies found on evidence-based interventions from Nigeria focused on secondary and tertiary levels of prevention and were mostly limited to the Northern part of the country. These were interventions set in humanitarian

settings, done in collaboration with government parastatals and focused more on service delivery for response to SGBV. There was an improvement in reported cases of SGBV. Evidence from other LMIC showed effectiveness in interventions from Kenya, Uganda and Burundi. As shown by evidence, the importance of response intervention is the availability of early care to reduce the health effects and complications of SGBV and allow survivors the opportunity to seek help for other services such as legal, social, and protection. Also, if interventions are more adolescent and youth-centered, privacy and confidentiality will be assured, resulting in openness and satisfaction with the services.

The interventional studies from other countries were carried out at the primary level through awareness-raising and community engagement. Research shows that intervention at the primary level helps prevent SGBV from occurring and produces a more positive impact for effectively preventing and controlling SGBV. SGBV, as we know it, is rooted in gender inequality and cultural norms; hence community sensitization to change harmful cultural norms and promote gender equality will effectively reduce SGBV and is strongly advocated for Nigeria. The study also found that boys and men experience SGBV. Boys and men are viewed as perpetrators of SGBV but may also be survivors and need to be supported, as many do not report due to harmful masculinities. Primary prevention programmes involving men and boys help change cultural norms and attitudes towards gender and foster equitable relationships between boys and girls. It is essential to work with boys and men to address SGBV because they play roles as supportive partners and allies in SGBV prevention.

4.2 Study limitations

First, the literature review method adopted does not allow for in-depth exploration of barriers and enablers to seeking care for SGBV, with survivors, as opposed to conducting primary, qualitative research. Second, there was a paucity of literature on some components of the Moreno framework, like the government's response to child protection, service delivery for SGBV and evidence-based interventions for adolescents and youths in Southern Nigeria, especially those below 15 years of age. The stigma and underreporting of violence made obtaining literature on violence among boys and men in the region even more challenging. However, obtaining data on male survivors from other LMICs having similar contexts compensated for the detected limitations. Finally, most of the interventions from Nigeria had not been evaluated for assessment of their effectiveness, but evidence from other African

countries showing promising and effective interventions for SGBV was analyzed and applicable in Nigeria.

4.3 Conclusion

SGBV is both a public health problem and a human rights violation issue, with adverse SRH effects and public health implications. Women and men experience SGBV. However, women are disproportionately affected. SGBV is supported and strengthened by gender inequality and harmful cultural and social norms. The advent of the COVID-19 saw an alarming rise in SGBV, including the rape of young girls in Southern Nigeria.

Health systems play significant roles in preventive efforts and responses towards addressing SGBV. The Nigeria health system is complex, with multiple actors and stakeholders. SGBV response is mainly organized by humanitarian actors in collaboration with the government and CSOs that address SGBV, and the focus of these services is more in the Northern part of the country. The Nigeria government should be more committed to providing comprehensive SGBV services for adolescents and youths in Southern Nigeria. Despite the need for these services, the provision of services for SGBV is not explicitly targeted at adolescents and youths. In addition, adolescents and youths are marginalized in national policies, and existing laws and interventions on SGBV are not youth-friendly. Despite the existence of laws regarding SGBV, FGMC and child protection, implementation remains a challenge. Also, the Nigerian laws are sometimes conflicting and challenging to enforce, making perpetrators of SGBV unpunished.

Although it is essential to respond early to SGBV, research shows it is more effective to prevent SGBV by addressing it at the community level through awareness-raising campaigns and community engagement. Therefore, interventions involving primary, secondary and tertiary levels of care are necessary to prevent and control SGBV in Sothern Nigeria youths. The primary intervention will prevent the occurrence of SGBV; the secondary intervention will assure access to timely care and ongoing treatment; the tertiary prevention will enhance economic empowerment and agency. Also, male involvement in programmes and interventions was highly effective in reducing SGBV and gender inequality among young people.

Literature on programmes and interventions for SGBV is sparse in Southern Nigeria, compared to the Northern part of the country, where much attention is focused. More research is required to address the unmet SRH need of adolescents and youths in Southern Nigeria.

There is also a need for more studies on SGBV prevention and evidence-based interventions among adolescents in Southern Nigeria, especially those below 15 years.

4.4 Recommendations

4.4.1 Government and policymakers

- Government should ensure that laws and policies regarding SGBV, especially among youths in Nigeria, are enacted. While findings showed that there are policies and laws to address SGBV, these policies and laws are only made at the national level and not y enforceable at the state and local levels. Also, these policies are not designed to address the SGBV needs of youths and adolescents in Nigeria. Harmonized efforts at different levels of government would ensure applicable universal policies.
- Laws against gender identity and sexual orientation in Nigeria should be amended and decriminalized. Gender non-conforming adolescents or youths who experience SGBV may not seek care due to fear of discrimination, criminalization, and stigma. Also, there should be strict enforcement of laws sanctioning perpetrators of SGBV
- Government should be more committed to providing funding for SGBV by increasing budgetary allocation for health and including SGBV in national health policies and budgets
- Provision of comprehensive services (health, police and social services) as part of essential services for SGBV and scale-up of comprehensive SGBV prevention and responses to ensure strong multi-sectoral collaboration and coordination with protection services and other sectors
- Pre-service and in-service training for health care providers on recognition, counseling, treatment and referral for SGBV services. Trends, events and societal issues related to SGBV should be discussed among HCPs so that prejudices can be demystified to enable them to deal professionally with the medical, social and emotional well-being of victims and survivors

4.4.2 Civil Society Organizations

- Raise awareness on available services for SGBV and provide psychosocial support, as well as develop innovative approaches to address SGBV among adolescents and youths

4.4.3 Development partners

- Re-direct resources to include SGBV response and prevention in all programmes

4.4.4 Media

- Raise awareness and ensure the voices of girls and women are heard
- There should be societal sensitization on the implications of SGBV on the health of survivors

4.4.5 Research

- Viable research should be conducted on the prevalence, risk factors, and consequences of SGBV against youths and adolescents in Nigeria and the types of SGBV commonly experienced by them. This will inform policy and proramme interventions to be developed in addressing SGBV. There should be more research for early adolescents below 15 years of age
- Interventions should be responsive to the unique needs of adolescents and youths, geared towards providing adequate information and services to both girls and boys on the implication of SGBV on personal and public life.

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