Utilization of Sexual and Gender Based Violence (SGBV) Response Services among Women and girls affected by Conflict in Northeast Nigeria: Barriers, Opportunities, and Strategies

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by:

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List of Abbreviations

AAAQ	Availability, Accessibility, Acceptability, Quality
BAY	Borno, Adamawa, and Yobe states
CBOs	Community-Based Organizations
CEDAW	The Convention on Elimination of all Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CSOs	Civil Society Organizations
FMOH	Federal Ministry of Health
FMWASD	Federal Ministry of Women Affairs and Social Development
FCT	Federal Capital Territory
GBV	Gender Based Violence
GBViE	Gender-Based Violence in Emergencies
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
LGAs	Local Government Areas or Councils
LMIC	Lower-middle-Income Country
IDPs	Internally Displaced Persons
INGO	International Non governmental Organization
IHL	International Humanitarian Law
IPV	Intimate Partner Violence
IRC	International Rescue Committee
KIs	Key Informants
KII	Key Informant Interviews
KIT	Koninklijk Instituut voor de Tropen
mCPR	Modern Contraceptive Prevalence Rate
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
MMR	Maternal Mortality Ratio
MWASD	Ministry of Women Affairs and Social Development
NDHS	National Demographic and Health Survey
NGOs	Non-Governmental Organizations
OOPE	Out-of-Pocket Expenditure
PHC	Primary Health Centres
PTSD	Post-Traumatic Stress Disorder
SARC	Sexual Assault Referral Centers
SDG	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infection
TFR	Total Fertility Rate
UN	United Nations
UNHCR	United Nations High Commission for Refugee
UNFPA	United Nations Population Fund
VAPP Act	Violence Against Persons Prohibition Act
VSLA	Village Savings and Loans Association
WHO	World Health Organization
WRA	Women of Reproductive Age

Definition of Key Terms

Humanitarian crises "*can be described as the sudden occurrence of an event caused by epidemics, technological or environmental catastrophe, strife, or natural/man-made causes and demanding immediate action*"(1).

Humanitarian setting "*is a country, region or society affected by conflict, natural disasters, slow- and rapid-onset events, or complex political emergencies"*(2).

Sexual and Reproductive Health (SRH) care "*encompasses a broad range of services that ensure people can decide whether and when to have children, experience safe pregnancy and delivery, have healthy newborns, and have a safe and satisfying sexual life*"(3)

Internally Displaced Persons (IDPs) *"persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border."* (4)

Sexual and gender-based violence (SGBV) refers "*to any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life*" (5)

Domestic violence/Intimate partner violence (IPV) refers *to "all acts of physical, sexual, psychological or economic violence that may be committed at home or in a public place by a person who is a family member or a person that has been an intimate partner or spouse or ex-partner, irrespective of whether they lived together"* (6).

Rape/rape attempt refers *to "Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape"*(6)

Survivor refers to "*the person who seeks help, which has or works to develop an ability to cope with trauma, which learns how to protect self, a person which struggles to take back their life. But, ultimate, the survivor is both a victim of Gender-Based Violence(GBV) and a survivor of GBV*" (6).

Victim refers to "*person harmed, injured, or killed as a result of a violent action or a person who has come to feel helpless and passive in the face of misfortune or ill-treatment. The term is technically accurate but in the same time it contributes to a feeling of powerlessness for those who have suffered some form of GBV*" (6).

Essential SGBV services refers to **"**a *core set of services required, at an absolute minimum, to secure the rights, safety and well-being of any woman, girl, who experience SGBV. Whilst the essential services may not be provided in the same way in every country or setting, they include a combination of universal services such as health, care and social welfare and well-being, statutory services such as policing and justice responses, and specialist social services*" (6) .

Referral refers *to "the process of how a woman gets in touch with an individual professional or institution about her case and how professionals and institutions communicate and work together to provide her with comprehensive support. Partners in a referral network usually include different government departments, women's organizations, community organizations, medical institutions and others"* (6).

Referral system refers *to "a comprehensive institutional framework that connects various entities with well-defined and delineated (albeit in some cases overlapping) mandates, responsibilities and powers into a network of cooperation, with the overall aim of ensuring the protection and assistance of victims/survivors, to aid in their full recovery and empowerment, the prevention of GBV and the prosecution of perpetrators. Referral mechanisms work on the basis of efficient lines of communication and establish clearly outlined referral pathways and procedures, with clear and simple sequential steps"*(6).

Reporting GBV case refers *to* "*disclosure of a GBV incident/case by a service provider to another service provider; sharing information about a GBV case to other institution/organization during the process of referral. The reporting could be made only with and within the limits of victim/survivor's consent, with few exception"* (6).

Sexual abuse/violence refers *to "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim/survivor, in any setting, including but not limited to home and work "*(6)

Sexual exploitation refers *to* ***"****any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another"* (6).

Violence against women *"any act of GBV 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 It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation"* (6).

ABSTRACT

Background

Sexual and Gender Based Violence (SGBV**)** is a life-threatening public health issue and a human right violation that negatively impacts the health and wellbeing of women and girls affected by conflict. The study identified factors influencing the utilization of SGBV support services among women and girls affected by conflict in northeast Nigeria to enhance the development of policies and interventions that influence the utilization of this services.

Method

The study was a literature review complemented by qualitative interviews with eight (8) key informants (KIs) from Northeast Nigeria. The literature review focused on scientific, peer reviewed and grey literature, policies, and programme documents on SGBV in conflict settings. The findings from the literature were triangulated with data from the qualitative interview using the socioecological framework.

Results

The findings revealed a lack of comprehensive legal framework and weak implementation of the SGBV related policies. Inadequate knowledge about benefits of utilizing SGBV service, non-availability of health and social infrastructure and inadequate skilled providers service exacerbated by the conflicts undermines the utilization of SGBV services. Pre-existing harmful socio-cultural norms that blame survivors for the act of violence and low socioeconomic status of women aggregated by the conflict also influence the utilization of SGBV services in these settings.

Conclusion

The study showed that coordinated and consistent multi-component culturally sensitive interventions - which include stakeholders' engagement, capacity building, mobile outreach, and psychotherapy can enhance the utilization of SGBV services by women and girls affected by conflict.

Key words: Sexual and Gender-based Violence, Sexual Violence, Women, Conflict, Humanitarian aid, Social ecological framework, Northeast, Nigeria

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INTRODUCTION

The number of persons affected by conflict, violence, human rights violations, and natural disasters globally has increased significantly over the last two decades (7,8). According to a 2017 report, about 65.3 million persons, including 26 million women and girls of reproductive age (WRA), were internally displaced globally (1). Nigeria has the third-highest number of internally displaced persons (IDPs) in Africa (9,10). The country is affected by several security challenges, mainly the protracted crises by the Islamist insurgent group "Boko Haram[1]" in the northeast (11,12). The ten-year protracted crises in the country's northeastern part have led to the displacement of over 26 million persons; about 54% are WRA (12,13).

Women and girls affected by conflict are at an increased risk of experiencing Sexual and Gender-Based Violence (SGBV)[2] and require urgent sexual and reproductive health (SRH) information as well as services to address these risks (14). The increased risks are due to factors such as disruption of societal norms, insecurity, extreme poverty, armed actors, and destruction of institutions providing care (15). SGBV is a life-threatening public health issue and a human right violation that negatively impacts the SRH and wellbeing of women and girls (7,15–17).

SGBV is rooted in discriminatory social norms and concepts of power between males and females that favor male dominance and undermine women and girls' personal, emotional and economic well-being (18). The culture of impunity for perpetrators, fear of repercussions, and social stigma contribute to continuous violence and underreporting of SGBV incidence. Additionally, destruction of the institutions providing care, insecurity, fear of further violence, and stigma limit survivors' access and utilization of the available SGBV services (7,15–17). Delayed or inappropriate care for SGBV survivors often leaves survivors with considerable life-threatening or life-long consequences (7,15–17). The elimination of SGBV in all settings, particularly in humanitarian settings, is essential for achieving the Sustainable Development Goal (SDG) targets, including promoting development and resilience and ending extreme poverty (19,20). Furthermore, the prevention and management of SGBV, particularly in conflict settings, is central to an effective humanitarian response and a fundamental human right.

[1] Bokoharam literally means education is bad or forbidden.

[2] Although the terms Gender-Based Violence (GBV) and SGBV are often used interchangeably, SGBV is used in this study ecause it emphasizes t he need for interventions that address the consequences of sexual violence for victims/survivors and their families.

CHAPTER 1: BACKGROUND INFORMATION ABOUT NIGERIA

This chapter describes the background information about Nigeria and the Northeast.

1.1Geographical and Demographic Profile

Nigeria, a country in West Africa, operates a three-tiered federal system of governance comprising the Federal, the 36 States, and the Federal Capital Territory (FCT) and the 774 Local Government Areas or Councils (LGAs). The states are divided into six geopolitical zones: South West, South East, South-South, North West, North Central, and North East (see annex 1 for Map of Nigeria) (21–23). Table 1 below shows an overview of the country's key demographic features.

Table 1: Overview of Nigeria Demographic profile (21–23).

Key	**Figures**
Estimated Population	198 million in 2018
Projected Population	396 million in 2050
	under 15 years= 45% Young people (10-24 years) =33% Women in the reproductive age group =22%
Life expectancy	54.7 years on average in 2019
Economy	1st in Africa and 26th in the world
Human Development Index (HDI) ranking	152 out of 188 countries

Nigeria is culturally, socially, economically, and geographically diverse, and this diversity is reflected in the country's public health challenges.

1.2 Socio-Economic Situation

Nigeria is currently classified as a lower-middle-income country (LMIC) despite its vast natural resources. Despite the country's economic growth, development shortfalls remain pervasive, shown in the country's low per capita income, poor social indicators, and significant disparities in income and education, with the highest disparities occurring in the northern part of the country (21–23). Poverty is predominant in the rural areas, where over half of the population lives. Additionally, over 90% of the country's poorest population lives in the northern region (21–23). The Nigerian society is patriarchal; women have higher poverty rates, lower educational attainment, lower formal employment rates, and are marginalized in almost all aspects of the decision-making process compared to men. This influences the experiences of women and girls, their chances of survival, and access to SRH information and services (21–23).

1.3 Overview of the Humanitarian Situation in the Northeast[3]

Nigeria currently faces several crises, protracted insurgency in the northeast, intercommunal clashes in the northwest, and farmers/herders crises in the middle belt (24). The armed conflict in the northeastern part of Nigeria, which began as a movement to form Islamic provinces in the region in 2009 by the *Jihadist insurgent group "*Boko Haram,[4]" has become one of the worst humanitarian crises in the history of Nigeria (9,10). The ensuing attacks and counter-attacks between the insurgent group and the Nigerian military forces have increased insecurity and protection concerns for women and girls, including violence, suicide bombing, and kidnapping (9,10). The crises mainly affect Borno, Adamawa, and Yobe (BAY) states, with Borno state being the epicenter (see Annex 2 for Map of affected areas) and table 2 for an overview of the humanitarian situation in Northeast Nigeria.

Table 2: An overview of the humanitarian situation in the northeast in 2018 (9,10,24)

Estimated Total Population in the Northeast		26 Million in 2016		
Affected Population		13.4 Million		
People in need across the BAY States (Millions)				
Population Category	**Borno**	**Adamawa**	**Yobe**	**Total**
Internally Displaced Persons	1.48	0.2	0.1	1.8
Returnees	0.6	0.8		1.6
Host Communities	1.81	0.7	0.3	2.9
Inaccessible Areas	0.76	-	0.06	0.8
Total	**4.7**	**1.7**	**0.7**	**7.1 (46% Male and 56% Female)**

The crises have resulted in massive destruction of infrastructure, mass displacement, forced internal displacements, disruption of essential social services, and limited access to livelihood opportunities (9–12). Most affected persons live in Internally Displaced Persons (IDP) camps - formal and informal camps, and in host communities[5] (13). About 1.7 million women and girls, including an estimated 30% in inaccessible areas, require urgent reproductive health care and support in the northeast (12,23).

1.4 Health System Organization: Nigeria and Northeast

Nigeria has a mixed health care system with public and private sectors, modern and traditional systems providing health services. The public health system is managed by the three tiers of government. About 88% of Nigerian health facilities are primary health centers (PHC) which form the basis of the health system (23). Nigeria also has a large private health sector which provides about 60% of the health services to the country's population. The health care system is characterized by high out-of-pocket expenditure (OOPE), low public investment, and poorly funded PHC facilities (21–23). Higher disease burden and lower

[3] The Northeast geopolitical zone comprises of six states: Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe.
[4] The group is linked to the Jama'atu Izalat al-Bid'a wa iqamat al-Sunna (Izala or JIBWIS) Islamic movement
[5] Most of the host communities are in the rural areas controlled by the Nigeria Millitary forces in camp-like settings.

access to health services are common in the Northeast compared to other parts of Nigeria (23,25).

1.5 Health Problems and Health Needs: Nigeria, including the Northeast

The most common causes of morbidity and mortality in Nigeria are malaria, diarrheal diseases, lower respiratory diseases, and maternal health conditions (23). Maternal morbidity and mortality remain significant determinants of Nigeria's health performance. Nigeria has one of the highest Maternal Mortality Ratios (MMR) globally, with a maternal mortality rate of 512 maternal deaths per 100,000 live births (23,26). The under-five mortality and infant mortality rates are 132 deaths per 1,000 live births and 67 deaths per 1,000 live births, respectively (23,26). Additionally, Nigeria has a low modern Contraceptive Prevalence Rate (mCPR) (13%), a high unmet need for contraception (23%), and a Total Fertility Rate (TFR) of 5.8 (26).

The maternal, child, and neonatal morbidities and mortality figures have tripled in the northeast compared to other regions of the country due to poor referral networks, inadequate human resources for health, limited access to essential health care, and increased vulnerabilities related to displacement and living in congested areas (12,23,27). Pre-existing gender inequalities compounded by the ongoing conflict have increased women's and girls' risks to SGBV (12,23). SGBV, including sexual violence, is a significant but neglected public health problem in Nigeria. About 36% of in-union women in Nigeria had experienced physical, sexual, or emotional violence in 2018. The number of women experiencing physical or sexual violence varies considerably across Nigeria, and the Northeast has the highest prevalence (28).

1.6 SGBV Service Delivery and Organization: Nigeria, including the Northeast

In Nigeria, formal and informal institutions support victims/survivors of SGBV. The informal institutions include family and community leaders and remain the primary source of support for survivors in rural and semi-rural areas. The informal institution provides support to survivors mainly through mediation. The formal institutions include health, social, legal, security, and shelter services provided through the government or non-governmental organizations, civil society organizations (CSOs), and community-based organizations (CBOs) (29,30).

The Federal Ministries of Women Affairs and Social Development (FMWASD) and Health (FMOH) oversee the provision of social and health services respectively and develop related policies and guidelines such as the national GBV referral guidelines (29,30). The implementation of these policies and guidelines at the state and LGA levels is headed by the state ministries and LGAs, respectively. The entry points for providing formal SGBV-related services at all health system levels are through the SRH service delivery points. The sexual assault referral centers (SARCs) were recently established to provide comprehensive SGBV (health, legal, security, and psychosocial) services to survivors within hospitals or medical centers. Most SARC centers are in the state capital and remain inaccessible to most people living in rural areas (29–31).

CHAPTER 2: PROBLEM STATEMENT, JUSTIFICATION, OBJECTIVES, METHODOLOGY, AND CONCEPTUAL FRAMEWORK

This chapter describes the problem statement, justification, objectives, methodology, conceptual framework, and study limitations.

2.1Problem Statement

Globally, SGBV remains the most prevalent and persistent human rights violation, disproportionately affecting women and girls (5,32). SGBV violates universal human rights such as "*the right to security of person; the right to the highest attainable standard of physical and mental health; the right to freedom from torture or cruel, inhuman, or degrading treatment; and the right to life*" (5,32). According to a World Health Organization (WHO) report, about 35% of all women worldwide have experienced some form of SGBV (5). Women and girls living in sub-Sahara Africa, especially those in conflict settings, are at an increased risk of experiencing SGBV (5).

A global survey showed that at least one out of five women affected by conflicts had experienced some form of SGBV (13). In Northeast Nigeria, about 6 out of 10 women affected by the conflict have experienced some form of SGBV (31). SGBV is prevalent in conflict settings due to increased tension within communities and households, large-scale population movements, poor welfare services, and breakdown of social networks and justice systems (5,33,34). However, the actual burden of SGBV in conflict settings remains relatively unknown due to stigma and the sensitive nature of SGBV that often prevent survivors/victims from reporting (35).

The most common forms of SGBV experienced by women and girls affected by conflicts are domestic violence (such as wife battering), trafficking, sexual violence and harassment, physical assault, economic violence (denial of resources), psychological and emotional abuse, and harmful traditional practices (widowhood rites, early marriages, female genital mutilation, among others) (31,36). SGBV is rooted in discriminatory social norms and concepts of power between males and females that favor male dominance and undermine women and girls' personal, emotional and economic well-being (18). SGBV is structural violence caused by several factors such as discriminatory socio-cultural norms, gender norms, patriarchal norms, unequal gender relations, and abuses of power occurring at the different levels of society (32,34).

SGBV is a life-threatening public health issue that negatively impacts the health and wellbeing of women and girls affected by conflict (7,15–17). The adverse health effects of SGBV include unintended pregnancy, unsafe abortions, sexually transmitted infections (STIs), including Human Immunodeficiency Virus (HIV), and increased maternal morbidity and mortality (37). Other consequences of SGBV include post-traumatic stress disorders (PTSD), ostracization, self-stigma, discrimination, and low economic performance (3,9,38). Although addressing the negative consequences of SGBV is critical to saving lives and improving the well-being of crisis-affected populations, survivors often do not disclose or report such incidents nor access or seek support (e.g., health, legal, psychosocial support, police services) (39,40). About 55% of the women who have experienced physical or sexual violence in Nigeria did not report such

incidents or did not seek help. The number is higher among women and girls living in conflict settings (28,41).

Some of the documented factors preventing women and girls from accessing SGBV support services include inadequate knowledge about the consequences of SGBV, stigma, shame, lack of trust in available services, lack of partner support, and pre-existing gaps in the provision of health services (5,12,16,35,40,42–44). The factors also include cultural norms that view experiences of SGBV as normal, gender inequality, lack of political will, and low social status of women. Breakdown of social and political structures, threats from combatant groups, compounded by pervasive stigma associated with experiencing SGBV are often significant barriers preventing SGBV survivors from seeking care or utilizing SGBV services (5,12,15,16,35,40,42–45).

Although research indicates high prevalence and significance of SGBV in various conflict settings, there is still limited knowledge about factors influencing the utilization of SGBV services in conflict settings, particularly in Nigeria, necessitating further research (6,46). It is essential to gain an in-depth and contextual understanding of the factors hindering the utilization of SGBV services, to enhance the delivery of effective programs and interventions that address this issue.

2.2 Justification

To enhance positive SRH outcomes and reduce excess morbidity and mortality during humanitarian crises, the prevention, mitigation, and management of SGBV has been recognized as a priority lifesaving humanitarian action (47,48). Activism and advocacy for the prevention and management of SGBV in conflict settings have led to the development of several United Nations (UN) resolutions, such as the UN Security Council resolution on ending sexual violence in conflict and the launch of the 2013 Call to Action on Protection from Gender-Based Violence in Emergencies (GBViE). However, these initiatives have not translated into adequate action for managing the consequences of SGBV in dynamic conflict settings such as in Nigeria (47).

The Inter-Agency Standing Committee (IASC) GBV guidelines state that appropriate and effective SGBV care requires a multi-sectoral approach (6,46). The multi-sectoral SGBV approach involves holistic SGBV prevention and response strategies coordinated by humanitarian actors (6,46). The prevention strategies include reducing and eliminating the root causes of SGBV and the situation-specific factors that contribute to, perpetuate, or increase the risk of SGBV. Effective response strategies target reducing the negative consequences of SGBV (6,46).

Studies have shown that utilizing a range of SGBV support services can improve the health, coping strategies, self-esteem, and safety of SGBV survivors (49). However, the utilization of these services remains consistently low in several conflict settings; despite these documented benefits (50). There is, therefore, a need to understand context-specific factors influencing the

utilization of SGBV services by women and girls living in conflict settings. Although great strides have been made to draw attention to SGBV issues, particularly in conflict settings, the lack of data on the prevalence, characteristics, and factors influencing the utilization of SGBV services have been highlighted as significant barriers to effective SGBV response and policy-making (40,51,52).

Additionally, the context of Northeast Nigeria conflict settings is poorly understood, and limited research has been conducted about the factors influencing the utilization of SGBV services in the region. A review of effective interventions and programs that can enhance the utilization of SGBV services among women and girls affected by conflict in Nigeria has not been extensively conducted (53). Since the factors influencing the utilization of SGBV services by women and girls affected by conflict are complex and multifaceted and occurring at various levels of society, it is essential to gain an in-depth and contextual understanding of these factors and identify evidence-based interventions and programs that can enhance the utilization of SGBV services. This study aims to provide the research community and service providers the necessary tools and resources to develop context-specific policies, strategies, and interventions that enhance the utilization of SGBV services in conflict settings.

2.3 Scope of the Study

SGBV response strategies are complex and multi-leveled, comprising medical/healthcare, psychological, social, protection, prevention of recurrence, and access to justice services (6,46). This study focused on the healthcare/medical and psychosocial support component of SGBV response services because they are often the first—and sometimes, the only—point of contact for survivors seeking SGBV services (39).

2.4 Objectives

2.4.1 General Objective

To explore factors influencing the utilization of SGBV services by women and girls affected by conflict in Northeast Nigeria towards providing recommendations to key stakeholders that support the development of policies, strategies, and interventions that enhance the utilization of SGBV response services among women and girls in conflict settings.

2.4.2 Specific Objectives

I To explore policies and strategies on the management of SGBV in Nigeria conflict settings, comparing with international standards.

II To explore the individual factors (knowledge, belief, and attitude) influencing the utilization of SGBV support services by women and girls affected by conflict in Northeast Nigeria.

III To explore the health and social system-related factors influencing the utilization of SGBV support services by women and girls in Northeast Nigeria conflict settings.

IV To explore the socio-economic, socio-cultural, and conflict-related factors influencing the utilization of SGBV support services by women and girls in Northeast Nigeria conflict settings.

V To examine effective practices and interventions for the management of SGBV in Nigeria and other conflict settings.

VI To provide recommendations to the Ministry of Women Affairs and Social Development (MWASD), Ministry of Health (MoH), and other relevant stakeholders that support the development of policies, strategies, and interventions that promote the utilization of SGBV services by women and girls in conflict settings.

2.5. Methodology

2.5.1 Study design

The study was a literature review complemented by qualitative interviews with key informants (KIs). The literature review focused on scientific, peer-reviewed, and grey literature, policy, and program documents on SGBV in conflict settings. The findings from the literature were triangulated with data from the qualitative component of the study.

2.5.2 Literature review

2.5.2.1 Search Strategy

Scholarly articles for the study were obtained from PsycINFO, PubMed, EMBASE, CINAHL Plus, google, Google Scholar, ScienceDirect databases, and Global Health Library regional indexes. The websites of United Nations agencies including WHO, United Nations High Commissioner for Refugees (UNHCR), UNICEF, UNDP, United Nations Population Fund (UNFPA), IASC, GBV Area of Responsibility (GBV AoR), international organizations (International Rescue Committee (IRC), Population Council, OXFAM, CARE international, and Relief Web), and Nigeria government (FMOH, FMWASD) were also searched for relevant articles, factsheet, reports, and policies.

The articles were obtained using a combination of search strategies such as free-text searching, searching subject headings, and searching related or recommended articles/ journals. The reference lists of included literature and publications were also screened for additional articles. The Boolean operators ªANDº and ªORº were used to combine the keywords used during the search process. Some of the keywords used in the search process included: conflict, SGBV, gender-based violence, violence against women and girls, outcome, (Northeast) Nigeria, (health) services, psychosocial support, humanitarian, survivors, factors, predictors, help-seeking, GBV, Africa. The combination of the search strategies is highlighted in Annex 3. Articles in English Language published over the last ten years (2011-2021) were used for the review except for a few relevant documents that were published before 2011.

2.5.2.2 Study Inclusion and exclusion criteria

The study inclusion and exclusion criteria are highlighted in table 3.

Table 3: Inclusion and Exclusion Criteria

Category	Included	Excluded
Population of interest	Women and girls affected by conflict in Africa	Women and girls affected by conflict in high-income countries and outside Africa
Intervention/ focus	Literature describing the utilization and factors influencing the utilization of SGBV support (medical/healthcare and psychosocial) services	Literature focusing on other aspects of SGBV support (security, legal/Justice) services Literature describing only needs, prevalence or risk factors, or prevention of SGBV without reference to SGBV response services
Article type	English peer-reviewed and grey literature	Non-English language studies and grey literature
Crisis type	Literature focusing on acute or protracted armed conflict	Literature focusing on disease outbreak or natural disaster
Timeline	Literature published between 2011-2021	Literature published before this period except for key relevant documents

2.5.3 Qualitative Interviews

2.5.3.1 Sampling and Recruitment of Participants for the qualitative Interviews

The KIs were identified using purposeful sampling and chain referral techniques with the support of the GBV sub-sector and the SRH working group in northeast Nigeria, and this was based on their professional role and expertise. A total of eight (8) persons participated in the qualitative interviews from the BAY States, Northeast Nigeria. The states were selected based on humanitarian needs and the presence of humanitarian actors providing SGBV response services. Each participant was at the directorate or deputy directorate cadre and had a minimum of six years of experience providing SGBV services to survivors directly or indirectly. Table 4 highlights the participant matrix.

Table 4: Key informant interview (KII) participant Matrix

Organization	Role in SGBV support services	Borno	Adamawa	Yobe	Total
GBV subsector	Coordinate GBV response across the three states	1			1
State Ministry of Health (SMOH)	Coordinate and operationalize provision of health services	1			1
State Ministry of Women Affairs and Social Development (SMWASD)	Address women's issues, coordinate and operationalize policies, supervise the provision of psychosocial support to survivors		1	1	2
Women-led CBO	Directly/indirectly involved in the provision of medical and psychosocial services to survivors	1			
SARC Center			1		
International/National Non-governmental Organization (INGO/NGO)		1		1	4
	Total				**8**

2.5.3.2 Data Collection method, processing, and analysis

All interviews, each lasting between 30 to 60 minutes, were conducted virtually via Zoom or Microsoft teams by the researcher using a semi-structured topic guide (SSIs) (Annex 4). The interviews were tailored to the respondents' area of expertise and focused on their experiences and perspectives on factors influencing the utilization of SGBV services in the BAY states using the socioecological framework. Interviews were audio-recorded with participants' consent. Audio records were encrypted and stored securely on password-protected devices used only by the researcher. The researcher transcribed all audio recordings and expanded the writing interview notes in line with audio recordings. The researcher coded the transcripts using a coding framework based on the topic guide, and emerging themes were added as needed. Data were analyzed using deductive and inductive approaches from the topic guides and by adding emerging themes. The data from the interviews were summarized per the theme and the findings from the literature triangulated with data from the qualitative interviews.

2.5.3.3 Ethical considerations

The Koninklijk Instituut voor de Tropen (KIT) Ethical Review board granted an ethical clearance waiver for the study (Annex 5). All respondents consented to participate in the study by filling an online informed consent form (Annex 6) shared via a google survey form.

During interviews, confidentiality was ensured by encrypting meeting links with a password and sharing them only with the intended participants. Audio recordings of interviews were carried out with participants' informed consent and stored in password-protected devices anonymously. Information and directions for contacting the researcher, seeking clarification, or providing feedback were also provided.

2.5.3.4 Quality Assurance

The researcher developed the topic guide based on standardized GBV interview guides and feedback from qualified researchers from KIT (54–56). The topic guide was pretested by interviewing an SRH/SGBV professional working in a Nigeria conflict setting by the researcher. The pre-test did not lead to any significant changes in the topic guide, and the data from the interview were added to the findings in the analysis. Audio recordings were transcribed, and interview notes expanded within 48 hours of data collection.

2.5.4 Analytical Framework

Several potential conceptual frameworks were reviewed for relevance and use in the study. They included Andersen's behavioral model of health services utilization, Levesque's access to healthcare model, the conceptual framework for reproductive health services, the García-Moreno-health system, and healthcare response framework, the adapted "Availability, Accessibility, Acceptability, Quality" (AAAQ) framework (57–64). These frameworks were considered but not selected because they involved a single-level analysis of factors influencing the utilization of SGBV services. They were also too specific to encompass all factors interacting at the various levels of the society that might influence the utilization of SGBV services.

The study used the adapted socioecological framework (figure 2) from a study conducted by Chynoweth *et al.* on barriers influencing the utilization of SGBV services by male survivors in three refugee-hosting countries (Italy, Bangladesh, and Kenya) (65). The framework was chosen because it provides a comprehensive, multi-faceted basis for conceptualizing the various factors influencing the utilization of SGBV services and their interaction at each level of society (63–66). The framework has been adopted in various studies to understand factors influencing behavior and to show the multiple factors supporting the occurrence of SGBV (63). However, only a few studies have used the framework to explore the utilization of SGBV services in conflict settings, particularly in Nigeria (63–66).

Figure 1: The social-ecological framework (63)

The framework has five layers, from the core to the outermost: individual, interpersonal, organizational, community, and policy. The framework assumes that factors in these layers influence behavior changes in individuals, and multilevel interactions across these layers are essential for influencing behavior (64). The study findings (from the literature and qualitative interviews) were organized according to the study objectives using the different layers of the framework. The presentation and analyses begin with objective 1, corresponding to the framework's outermost (policy) layer. The outermost layer of the framework signifies the local, state, and national policies, strategies, and guidelines influencing the provision of SGBV services. At this layer, the likely factors influencing the utilization of SGBV service include the availability of SGBV policies and strategies and the implementation of such policies and strategies.

The second objective corresponds to the framework's core layer (individual); likely factors influencing the utilization of SGBV service at this level include knowledge, belief, and attitude about SGBV and the availability and benefits of SGBV services. The second (interpersonal) layer highlights the influences of social networks and social support systems, including family, on the utilization of SGBV services. Factors such as self-stigma, financial capability, and partner/spousal support influence the utilization of SGBV service at this level, and this was analysed under objective 4.

The third objective corresponds to the third (organizational) layer of the framework. The layer signifies the health and social system/structures and resources influencing the utilization of SGBV services. The likely factors influencing the utilization of SGBV services at this layer include types and availability of SGBV services, availability, skills, and attitude of service

providers. The fourth objective corresponds to the fourth (community) layer of the framework that represents community and socio-cultural characteristics, beliefs and norms influencing the utilization of SGBV services. The possible factors influencing the utilization of SGBV at this level include stigma, community awareness and beliefs about SGBV, gender issues, social, cultural, economic, and religious norms about SGBV and SGBV service utilization. The fifth and sixth objectives do not fit directly into the framework layers and are presented separately. However, the findings for these objectives were guided by the socioecological framework layers.

2.6 Limitations of the study

The respondents for the qualitative interviews were selected based on their professional roles and expertise; this provides a limitation to the study because the individual experiences of women and girls affected by conflict regarding the utilization of SGBV services were not explored. Additionally, the study only looked at factors that influence the utilization of healthcare/medical and psychosocial support; this provides another limitation to the study. The limited number, varying methodology, and context of the included studies might influence the generalization of the study results. Nevertheless, the study presents a foundation upon which further research can explore the subject matter.

CHAPTER 3: FACTORS INFLUENCING THE UTILIZATION OF SGBV SERVICES IN NORTHEAST NIGERIA

This chapter explores factors influencing the utilization of SGBV services in Northeast Nigeria based on the study objectives 1 to 4. Findings from the literature and qualitative interviews are presented together.

3.1 Policies and strategies for managing SGBV in Nigeria conflict settings and beyond

Legal and policy frameworks form the foundation for victims/survivors seeking health and social services, and they need to be in place to enhance the delivery of quality services (67). This section describes SGBV management policies and strategies in Nigeria, the Northeast, and beyond.

3.1.1 International laws and standards for managing SGBV in conflict settings

Several complimentary international and regional laws and treaties form the legal frameworks for managing SGBV in conflict settings. They include the International Humanitarian Law (IHL), the Convention on Elimination of all Forms of Discrimination against Women (CEDAW), the Beijing Platform for Action, the Convention on the Rights of the Child (CRC), the African Children's Charter, the Maputo Protocol, the Rome Statute of the International Criminal Court, and the Call to Action on Protection from GBViE (23,33,68,69). Technical guidance documents such as the Sphere Handbook, the Inter-Agency Minimum Standards for GBViE Programming, and the Inter-Agency GBV Case Management Guidelines guide multi-sectorial SGBV responses in humanitarian settings developed from the framework (67,70–72). The documents provide universal guidance regarding the definition of SGBV, the legal age of consent for sexual activity, women's rights, and the provision of services to SGBV survivors. Nigeria has ratified most international treaties and affirms its commitment to gender equality, women empowerment, and women's human rights by developing complementary laws, policies, strategies, and guidelines (41,73).

3.1.2 SGBV-related Policies and Strategies in Nigeria and their Implementation compared to International Standards

The Nigerian legal system is based on four sources of law: English law, customary law, ethnic/non-Muslim law, and sharia law and judicial precedents. Laws such as the Penal code, the Criminal code, Child Rights Act (2003), and the Violence Against Persons Prohibition (VAPP) Act (2015), form the legal basis for all citizen's rights, including protection of women and girls from abuse and exploitation (30,31). Nigeria has no specific SGBV policy; however, some of the SGBV-related national policies, strategies, and guidelines from the health and social sectors' perspective, include the National Gender Policy (2006), National Health Policy (2016), the National Reproductive Health Policy (2017) and the national GBV referral guidelines. These documents provide policy frameworks and guidelines for the management and referral of SGBV cases across the various states in Nigeria (25,73–76) (36).

Despite the above commitments, legal frameworks, and policy initiatives, Nigeria's SGBV-related laws and policies are limited in scope and do not fully protect the right of women and

girls (30,31,36,77–79). For instance, there is an implied legal backing for assaulting one's wife in Section 55(4) of the Penal code and Section 6 of the Criminal code, and a lack of legal recognition for rape within marriage in both laws (14,36). Additionally, the sharia law, operational in northern Nigeria, including the BAY states, legalizes marriage with a child under 18 and requires a witness before an "allegation" of rape can be established (36). Nigeria also has a restrictive abortion law that violates Article 14 (2) (c) of the Maputo protocol on the need to provide medical abortion in cases of SGBV to women requesting such services (80,81). Most of the KI respondents also revealed that the restrictive abortion policy in the country undermines the provision of abortion services to SGBV survivors requesting it.

> *"Legally, abortion is not allowed; there are no conditions for procuring or providing abortion, including rape. Everybody in the community knows about this law, so they do not even come to the facility for abortion services."* SARC respondent

Although the BAY states have the autonomy to domesticate the national laws and policies to their local context, they are yet to domesticate two critical national SGBV-related laws (Child rights Act and VAPP Act). The non-domestication of these laws has created a legal environment that undermines women's rights and access to SGBV support services, especially for adolescent survivors (31,77). International guidelines on providing SGBV services highlight the importance of a comprehensive legal framework in facilitating a multi-sectorial SGBV response, which is absent in the BAY states (39,67). Lack of political will, discriminatory sociocultural norms that enforce patriarchy and limit gender equality, and women's empowerment seem to play critical roles in the non-domestication of the SGBV-related laws in the BAY States (14,30,31).

A qualitative report on the implications of human rights obligations and principles for women and girls in the BAY states confirmed that a lack of a legal framework prevents women and girls from accessing SGBV services (78). All interview respondents affirmed that the lack of a comprehensive legal framework and contradictory parallel laws about women's rights undermine the provision and utilization of SGBV services across the BAY states. The provision of SGBV services is not part of the recently launched Basic Minimum Package of Health Services (BMPHS)[6]; this serves as a barrier to SGBV services' utilization by survivors in the BAY states (23,76,82). This points to inequitable access to healthcare services, including SGBV services, by the population in Northern Nigeria. According to the national reproductive health-related policies, adolescent girls below the age of 18 require parental consent or need a chaperone to access health services; this serves as a barrier to the utilization of SGBV services for adolescent survivors of sexual violence (23,41,83).

In Nigeria, the implementation of health, social and SGBV-related policies and guidelines are generally weak and inconsistent (23,25,30,84). Although SGBV service provision in the BAY states is based on context-specific SGBV guidelines and Standard Operating Procedures

[6] The BMPHS is Nigeria Social Health Insurance package that finance and deliver priority health services to Nigerians especially the rural poor

adapted from international standards and national SGBV-related policies and guidelines, their effectiveness and implementation have not been evaluated (85). According to a study conducted by the International Rescue Committee (IRC) in South Sudan, public and private facilities require a police report before providing services; this requirement limits the utilization of SGBV utilization (86). Sexual violence (Rape) is a reportable offense in Nigeria, including in the BAY states (30,31,87). However, the lenient attitude of the law enforcement agents towards perpetrators discourages reporting by victims. This further limit the utilization of SGBV services by women and girls in the BAY states.

> *"Many survivors have reported the incident [SGBV] to the Police before coming to the partners [health facility]; it is often challenging to help them once the case is with the Police because of the technicalities involved and how they handle it. Once the case has been reported to the Police and the survivor did not get the required justice, they hardly return to access or complete medical or psychosocial support services*." SARC respondent

3.2 Individual factors influencing the utilization of SGBV support services by women and girls in Northeast Nigeria conflict setting

At the individual level, knowledge, beliefs, attitudes, and perceptions, often influenced by factors related to other layers of the socio-ecological framework were found to influence the utilization of SGBV services.

3.2.1 Knowledge and Awareness of SGBV and SGBV services

Providing context-specific information about SGBV, location of SGBV services, available options, and benefits of SGBV support services are essential for making informed decisions about utilizing SGBV services (46,67). Studies from Nigeria and African conflict settings showed that personal knowledge of what SGBV is, consequences of SGBV, and benefits of accessing care within the 72 hours window, promote help-seeking behavior and subsequent utilization of SGBV services (10,14,15,44,88–92). According to a United Nations Report on access to SGBV services in Nigeria, women living in hard-to-reach communities such as IDP camps have limited information about SGBV or how to access SGBV services, further limiting their access to care or support (93).

According to a qualitative study conducted in Borno State, most women and girls living in the IDP camps do not know how to formally report issues related to SGBV to formal authorities due to inadequate information about SGBV services and reporting mechanisms (10). Additionally, most of the officials are male (related to organizational layer- discussed in the next section) which may discourage survivors from accessing reporting since perpetrators are often male. An evaluation report of a CARE International project implemented across two LGAs of Borno State also showed that multiple factors (related to other layers of the framework), including adequate knowledge, influence the utilization of SGBV (94). Most of the respondents also revealed that inadequate knowledge about the consequences of SGBV, where to access SGBV services, and limited availability of institutions providing care (related

to organizational layer- discussed in the next section) undermines the utilization of SGBV services in the BAY states. The inadequate knowledge is related to other layers of the framework, which will be described under such layers appropriately.

3.2.2 Beliefs, attitudes, and perceptions

Studies conducted in the BAY states, Nigeria, and other African conflict settings revealed that attitudes and perceptions towards SGBV influence disclosure, help-seeking, and subsequent utilization of SGBV services (15,31,86,89,95). Studies conducted in Nigeria showed that personal exposure to SGBV and its severity influence help-seeking behavior and the utilization of SGBV services (49,92,96). An assessment report from the International Organization for Migration (IOM) in Adamawa and Borno states revealed a significant delay among survivors of sexual violence in reporting due to the perceived belief that the act is not severe (89).

Studies conducted in conflict settings in Nigeria and Africa showed that negative experiences with families and service providers, related to other layers in the socio-ecological framework, constrain survivors' help-seeking behavior and utilization of SGBV services (49,89,95). According to a cross-sectional study on child sexual abuse in Lagos State, Nigeria, among adolescent survivors of sexual abuse (n=93), about 66% did not disclose the incidents, and one of the reasons for non-disclosure was disbelief that the incident did not take place (97).

3.3 Health and Social System-related Factors influencing the Utilization of SGBV Support services by women and girls in Northeast Nigeria Conflict Settings

Health and social institutions providing services to survivors need to be available, accessible, and of sufficient quality to meet survivors' varying needs. This section explores these characteristics and their influence on the utilization of SGBV services.

3.3.1 Availability of Health and Social Institutions

Studies from various conflict settings, including Nigeria, revealed that conflict undermines health service delivery by impeding movements of health workers and individuals, drugs, other medical supplies, and general breakdown of infrastructure (31,86,98). This potentially hinders the utilization of SGBV services. There are significant gaps in the quantity and quality of health and social institutions such as PHCs, safe shelters, and SARC Centers providing SGBV services in Nigeria (23,30). A review of the National health strategic plan shows the inequitable distribution of health facilities in Nigeria, with rural areas having limited or no facilities and the Northeast having the worst figures (23). This points to inequitable access to healthcare services, including SGBV services, by the population in Northern Nigeria

The pre-existing limited availability of health and social facilities in the Northeast has been aggravated by the ongoing conflict (12). A health resource assessment conducted in Borno state revealed that the insurgency had destroyed about 252 of the 809 health facilities in the state (12). The same report also showed that only 60% of the available health facilities in the Northeast are functional, and the functional facilities only provide primary services due to limited capacity, staff, and equipment (12). According to needs assessment report from the

BAY states, comprehensive SGBV services, including clinical management of rape (CMR) and psychosocial support services, are not available in about 80% of health facilities in Borno state (12). Studies conducted in the BAY states also showed that insufficient infrastructure prevents survivors from accessing needed care, including SGBV services (10,12,30,31). From the qualitative interviews, the Ministries of Women Affairs and Health respondents revealed that the BAY states have only a few shelter facilities for survivors requiring alternative shelter. Furthermore, according to most of the respondents, a few SARC centers and one specialized Mental Health and Psychosocial Service (MHPSS) center provides support to SGBV survivors in the Northeast. The Ministry of women affairs respondent also revealed that livelihood supports that allow survivors to restart their lives are limited.

> "*The safe spaces are not enough; We only have three shelter facilities in the whole of Yobe state! What happens to survivors coming from other LGAs where these facilities are not available?"* Yobe State Ministry of Women Affairs respondent

> *"We are training the survivors on different skills of their choice, and after the training, we give them startup capital so they can stand on their own, but this one is not regular. Sometimes we do not have the total capacity to empower all the survivors; we often partner with other organizations that are willing to do so"* Adamawa State Ministry of Women Affairs respondent

3.3.2 Accessibility of Health and Social Institutions: Location and distance, Safety, Language, and Affordability

Studies conducted in Nigeria and South Sudan revealed that long-distance between survivors' residences and the health facilities was a barrier to the utilization of SGBV services by survivors (89,91). A mixed-method study conducted in the Dadaab refugee complex in Kenya and a qualitative study conducted in Borno state, Nigeria, revealed that a long waiting period at the health facility was a barrier to assessing SGBV services (14,15). This might be associated with survivors socio-economic status (the need to go to farm, most people are subsistence) or the need to take care of their children or might want to return from the facility before the husband or partners finds out (related to community layer- discussed in the next section). All the key informants noted that health and social services in the BAY states are mainly provided through outreach or mobile clinics and are always not available. Where these services or functions exist, they are located in selected, more urban areas, making it very difficult for GBV survivors to access them due to distance and transportation costs (related to community layer- discussed in the next section).

User fees and other indirect costs were frequently cited as a barrier to the utilization of health, including SGBV services in Nigeria and the BAY states in the literature (23,29,31,99). Due to weak institutional structures, low government investment in health, and a shortage of resources, providers often charge informal or formal user fees for the most basic services (23,76,82). This serves as a potential barrier to the utilization of SGBV services in the BAY states. According to a report, about 75% of IDPs, 61% of returnees, and 80% of non-displaced households in the

BAY states are not utilizing health services due to the high cost of quality medicines (12). In Nguru, Potiskum, and Geidam LGAs of Yobe State, most of the IDPs reported that poverty and lack of resources (related to community layer- discussed in the next section) were the cost-related challenges preventing them from accessing health services; according to the same report (12).

Most KI respondents revealed that user fees were a significant (socio-economic related to community layer- discussed in the next section) factor delaying women and girls from seeking help or utilizing SGBV services. They mentioned that insufficient financial means for household expenditures made medical treatment [direct and indirect cost] unaffordable. A qualitative study conducted in Borno state showed that language barriers and incorrect translations were significant barriers to the utilization of SGBV services by women and girls affected by conflict (14). Most of the KI respondents revealed that most of the essential services provided in the states are implemented by NGOs that are donor-dependent, projecting huge gaps for post-GBV care. Also, a Borno State key informant stated that health facilities were often staffed by INGO and NGO staff or external partners who often do not understand the local languages.

3.3.3 Health and Social Workforce: Availability, Knowledge, Competence, and Attitudes

The FMOH's task-shifting and task-sharing policy for essential health care services provision in Nigeria showed shortage of and inequitable distribution of appropriate cadres of health workers which limit the provision of essential health, including SGBV services in Nigeria (99). A review of the second National Health Strategic Plan (2018–2022) showed an inequitable distribution of skilled health workforce in the Northeast compared to other regions of Nigeria (23). Most health facility staff in Nigeria are not trained to address SGBV, although they may provide post-SGBV treatment and services (23,25). The few available SARCs also face understaffing and underfunding, affecting their ability to provide SGBV services (29). A rapid assessment conducted in Kogi and Ebonyi States revealed that service providers often see the provision of SGBV services as 'extra workload' to their already strained workforce and workload (29)-this related to weak retention policies and strategies. This might not be unrelated to their unfavorable and discriminatory attitude to SGBV survivor (explored further in this section).

Studies across the Nigerian States showed an insufficient number of female staff among national institutions providing care to survivors, while the available ones lack the skills and expertise to provide SGBV services (29–31)-This might not be unrelated to why some survivors finds it reluctant to disclose SGBV incident despite knowing the benefits of SGBV services (related to knowledge layer- discussed in the knowledge layer). Incidentally, SGBV survivors mostly women prefer to be attended to by female service providers due to social-cultural factors (related to community layer- discussed in the next section. Survivors may be discouraged from disclosing or asking for help for SGBV-related health problems if service providers do not demonstrate survivor-centered attitudes and are not adequately trained,

equipped, skilled, and knowledgeable in discussing and addressing SGBV. A mixed-method study in South Sudan showed that the lack of sufficiently trained staff, particularly in rural areas, prevented survivors from accessing needed care (86). A qualitative study from Borno state showed that shortages of skilled health care workers, particularly doctors, nurses, and midwives, and lack of female service providers undermine the utilization of SGBV services by survivors in the state (14)-related to the quality of SGBV services further discussed in this section

Most of the key informant respondents reiterated that inadequate knowledge of service providers prevents survivors from utilizing SGBV services. A few of the respondents revealed that some health facility staff had low levels of education and cannot correctly manage SGBV cases. The Borno Ministry of Health respondent revealed that SGBV services are provided by female staff, contrary to findings from a study conducted in Borno State, which states that lack of female staff (especially Doctors) undermines the utilization of health services (14).

> *"Based on our religion and culture here, we make sure that we select the female service provider we prepare the female for such services starting from our training. So that is why in most of our service delivery points, the female is rendering such [SGBV] services. We do same-sex service provision".* Borno SMOH respondent

Negative attitudes from service providers, including disbelief, lack of empathy, confidentiality, and humiliating comments, often negatively influence women's helping-seeking behavior and utilization of SGBV services (31,90,92,100). Some studies indicate that past survivors of SGBV tend to often have a favorable attitude towards the utilization of SGBV services. However, their previous experience with services often influenced this decision (14,95), which is further discussed in the next section.

> "*Attitude of the service providers is one of the key reasons why survivors decline the utilization of SGBV."* International NGO respondent

No study from the BAY states linked previous help-seeking behavior to the utilization of SGBV services. However, a few respondents revealed that negative experiences with service providers often deter survivors from reporting or utilizing SGBV services. The qualitative interview respondents also revealed that lack of trust in service providers often prevents SGBV survivors from accessing SGBV support services. When there are financial demands from the victim before services can be provided, the victim would prefer not to access the services, especially when she cannot afford the demands- related to socioeconomic factor discussed in the community section.

> "*Some of the medications will be provided for the survivors while others will say that the survivor has to go and buy it with their money which makes them not to trust the services again [*because during sensitization, community members are told SGBV services are free*]. That is why sometimes survivors develop the culture of silence, and they will not report the case because of these issues.*" Women-Led CBO respondent

3.3.4 Quality of Services

According to the IASC guideline, effective and quality SGBV services require adequate supplies of drugs and commodities. The provision of services requires adherence to fundamental principles and approaches that are survivor-centered, rights-based, community-based, and age, gender, and diversity sensitive.

3.3.4.1Equipment, drugs, consumables, and Protocol

A mixed-method cross-sectional study on progress and gaps in reproductive health in three humanitarian settings (Burkina Faso, Democratic Republic of the Congo (DRC), and South Sudan) showed that the inconsistent availability of essential drugs and consumables hinders the provision of SRH, including SGBV services and subsequent utilization of services by survivors (44). A recent Nigeria National Health Facility Survey showed that the northeastern states have the lowest supply of essential reproductive health drugs, commodities, and consumables compared to other regions (101)- related to implementation of policy discussed in the policy layer. This points to inequitable access to healthcare services, including SGBV services, by the population in Northern Nigeria

A service mapping conducted in Kogi and Ebonyi states, Nigeria, showed that most SGBV services facilities are under-equipped, resulting in very few survivors seeking services (29)- related to other parts of this section. Studies in the Northeast showed that the necessary equipment, drugs, and consumables to provide care to SGBV survivors are often lacking and inconsistent across the BAY states (12,102,103). The insurgency might have exacerbated this due to inability to transport drugs and consumables. A report from the BAY states showed that about 50% of SGBV survivors in Borno state could not access emergency contraceptives due to the non-availability of commodities (12). Most of the respondents also revealed that an inadequate supply of drugs and consumables undermines the provision of essential care to survivors.

A retrospective study of sexual violence management in a tertiary hospital in Lagos State revealed that the hospital lacked a written protocol for managing cases of sexual assault (104). A rapid assessment and service mapping conducted in two Nigerian states (Ebonyi and Kogi) showed that the essential component of health and psychosocial support services are limited in most PHCs, thereby undermining the provision of SGBV services (44). A similar assessment conducted in the BAY states showed that most states had limited shelter facilities providing alternate shelter for survivors or the duration of stay in such shelter is short. The shelters were not adequately resourced and generally needed improvements to meet international minimum standards (31). This point to the fact that survivors that report SGBV incident and decides to leave their abuser might be rendered homeless might not have a place to stay after the short duration in the safe shelter or survivors that returned home (to the perpetrator) might faced increased SGBV risks. This may not be unconnected to the poor utilization of SGBV services

3.3.4.2 Provision of Services according to Guidelines and Standards

The standard of clinical management of sexual violence involves documentation and treatment of injury, getting forensic materials, detecting prior pregnancy, screening for STIs including HIV, providing adequate contraception, and post-exposure prophylaxis provision within 72 hours of the incident (46,67). A five-year retrospective study conducted among 201 survivors of sexual assault presenting within the 72 hours window in Lagos state, Nigeria, showed that only 59 (29.4%) were referred for post-exposure prophylaxis of HIV (PEP). Additionally, only 55.7% of the post-pubertal victims had a pregnancy test done, 2.4% of the same group received emergency contraceptives, and no forensic samples were collected among survivors. The lack of forensic evidence (legal reporting requirement) was reported to likely discourage survivors from reporting ssimilar incidents or utilizing SGBV services (104)**.** This points to non-adherence to standard guidelines in the provision of care to survivors

A similar study conducted in Gombe state among 277 survivors of alleged rape showed that 42% of the survivors did not receive HIV prophylaxis treatment, 54% (150) did not receive STI treatment, while psychological counseling, including follow-up care, was not provided to over 71% (197) of the survivors (87). A health facility assessment report from the BAY state also showed that CMR services are not available in 19 of the 27 LGAs in Borno State, hindering the timely provision and utilization of SGBV services in line with the standard guidelines (12). No study in the BAY states explore the provision of care according to the guidelines.

3.3.5 Coordination and Funding

According to a mixed-method study conducted in the Dadaab refugee complex, Kenya, effective coordination between the various agencies providing care enhances SGBV service utilization (15). An assessment conducted in the BAY states showed that lack of collaboration between the various agencies leads to a fragmented approach in the provision of SGBV as the different partners respond to the issues of SGBV based on their thematic areas and funding. Furthermore, ineffective referral mechanisms, geographical limitations, and limited scope of projects further limit SGBV service utilization across the BAY states (31). A qualitative study in Borno state showed poor service integration as an institutional barrier influencing the utilization of SGBV services (14). A study conducted in South Sudan showed that the provision of health, including SGBV services, was inconsistent due to insufficient funds (89). Studies from various states in Nigeria also substantiate these findings (29–31). Similarly, the Ministry of Women Affairs respondents revealed that the non-availability of funds and inadequate human resources had limited the agency's ability to coordinate SGBV response, monitor implementation of SGBV support services, and support survivors' access to care.

> "*We don't have provision of fund for referrals or for taking the survivors from the other local government down to the pace where the one stop center or SARC center is domicile*" Yobe State Ministry of Women Affairs respondent

3.4 Socio-Economic, Socio-Cultural, and Conflict-Related Factors Influencing the Utilization of SGBV Support Services

This section described the socio-economic, socio-cultural, and conflict factors influencing the utilization of SGBV services. This is related to all the other layers of the framework.

3.4.1 Sociodemographic Characteristics

Studies conducted in various conflict settings in Africa and non-conflict settings in Nigeria showed that sociodemographic characteristics, including age, sex, education, religion, and residence location, did not influence help-seeking behavior and utilization of SGBV services (92,95). Studies conducted in Nigeria showed that wealth, marital status, employment status, history of violence and relationship to the perpetrator were positively associated with help-seeking behavior (49,100). According to these studies, these sociodemographic characteristics, related to other layers of the socio-ecological framework, can influence help-seeking behavior Regarding the relationship to perpetrator, survivors without a father or that are not living with the partner are more likely to seek help for SGBV related incidents(49). Women with previous history of SGBV such as witnessed their father beat their mother are more likely to seek care(100). However, unmarried women living in communities where violence is tolerated were less likely to seek help and utilize SGBV services (100).

3.4.2 Norms: Socio-Cultural and Gender Norms

A mixed-method study conducted in Kenya revealed that deep-rooted sociocultural norms on the role of women in protecting marriage and family privacy were barriers to the utilization of SGBV services (15). In Nigeria, women are often socialized to remain gatekeepers of their marriage, thus, making abuse public is often interpreted as resisting the normative patriarchal role, and women who assert their agency are socially sanctioned by their families(49). Similarly, a multilevel analysis on the predictor of help-seeking in women exposed to violence in Nigeria showed that unmarried women are less likely to seek help (100). A qualitative study conducted in Borno State revealed that unequal power balance in the community affects the perception of women about themselves and their capacity to make decisions about their health (14). The same study also showed that low decision-making power by women on their health and well-being posed a significant barrier to timely access and subsequent utilization of SGBV service (14). A study on community perceptions of children born from sexual violence also affirmed this (49).

Most of the respondents revealed that most women and girls living in host communities and non-priority LGAs are entirely unaware of the laws and policies that exist to protect them. This has prevented them from exercising their rights or accessing SGBV services. They also revealed that the BAY states are highly patriarchal and do not value or respect women's rights. At the same time, a few respondents mentioned that most women and girls could not make autonomous decisions regarding SGBV services due to poverty and limited access to income-generating activities**.** All the respondents also revealed that fear of not getting suitable partners often prevent survivors from utilizing SGBV services. All these are significant barriers preventing women and girls from accessing SGBV services in the BAY states.

"*Another major barrier to women seeking care is that most of them depend on their husband who is the head of the family for resources to access health services since most of the services are not entirely free."* Women-led CBO Borno respondent

"Most people in the community see women as people that should be seen and not heard. That is, they should stay at home and do nothing. This is the society we live in, and gender norms are the key things preventing women and girls from accessing services." Adamawa State Ministry of Women Affairs respondent

"Some people will not report or seek help because of fear of not getting a suitable partner in the future; this is because we attached too much importance to marriage in this context." Women-led CBO Borno

Studies from the BAY states, Nigeria, and other African conflict settings revealed that community structures that promote victim-blaming and ostracization of survivors and their families shaped the social norms that drive SGBV and undermine survivors' access to services (10,14,15,31,92,100). Furthermore, all the respondents revealed that sociocultural norms that blamed survivors for the act(s) of violence or labelled them as promiscuous or the 'cause' of the incident are barriers to reporting and utilization of SGBV service. They also revealed that unmarried girls and married women are often cconcerned with their future value as a wife and their children's social well-being, respectively, and often choose to remain silent about the SGBV experience.

"Cultural norms, like some parents, will be saying they do not want to expose their child, that it is better not to report, so that is some of the barriers stopping them from accessing the services." Adamawa State Ministry of Women Affairs respondent

3.4.3 Socio-Economic Factors

A study conducted in South Sudan showed that worsening economic conditions resulting from conflict limited SGBV services utilization (89). An Amnesty International 2017 report on women's rights in Nigeria revealed that women from IDP camps in Maiduguri who needed urgent medical care could not pay for such services resulting in death or poor health-seeking behavior (79). A multilevel analysis of the predictors of help-seeking behavior among Nigerian women exposed to violence showed that state socioeconomic development impacts help-seeking behavior (100). According to the VAPP ACT 2015, the perpetrator has only to compensate the survivor when guilty, leaving survivors to bear most of the cost associated with care and support (31)—poor survivors may be deterred from utilizing SGBV services because of this. According to a study conducted in Borno State, the culture of silence regarding rape among families is usually reinforced by socioeconomic factors such as poverty and family indebtedness to potential suitors or perpetrators, which undermines their ability to disclose or

utilize SGBV services (14). All the key informant respondents substantiated the findings from the studies.

> "*Most of the time, those perpetrators are using the vulnerability of the family of the survivor, by giving them money, taking care of the family, this will make them not expose the secret [the incident] because if they [parent] expose the perpetrator, there is nobody that will support the family."* Adamawa State Ministry of Women Affair respondent

> "*Most of the time, they [security personel] will tell the survivor to go and come back in the next one week, and to the extent that the survivor family loses interest in the case and then they will stop going to access justice, sometimes the frequent trips [at survivors cost] to the police station make some survivors lose interest in the cases and any medical support."* Yobe State Ministry of Women Affair respondent

3.4.4 Stigma

Studies from the BAY states, Nigeria, and other African conflict settings also showed that self-stigma and community stigma often prevent survivors from disclosure, seeking help, and utilizing SGBV support services (10,14,15,86,92,96,97,102,104). SGBV is sensitive and highly stigmatized among many cultures and hidden due to shame. For instance, in a qualitative study in Borno State, families had a prevailing consensus to conceal rape to protect the family reputation and avoid stigma in the community (14). All the KIs respondents expressed concerns that stigma and discrimination often prevent survivors from seeking help or utilizing SGBV services. They also noted that lack of awareness and moral judgments associated with socially ascribed 'proper' behavior from community members often prevent people from utilizing SGBV services. A few respondents also mentioned that communities' and service providers' stigmatizing statements and negative attitudes further prevent survivors from accessing or utilizing care (related to earlier sections).

> "*The stigma and pointing of fingers at survivors have made them not to receive care, and the ones that come out to receive care, the community members often look at them with disdain, and it has made some of them relocate to other locations*." Adamawa State Ministry of Women Affair respondent

> *"The community will stigmatize any woman that is raped; most of the time, we even hear of cases where girls become school dropouts because of rape incidents. When she goes to public places such as schools, people point fingers at her, and because of that, she might stop going to school increasing her chances of becoming a victim of child marriage. Since she is not schooling, the next thing is for her to get married."* Women-led CBO Borno respondent

CHAPTER 4: EFFECTIVE PRACTICES AND INTERVENTIONS FOR MANAGING SGBV

This chapter explores evidence-informed health, psychosocial and multi-component interventions for managing SGBV in conflicts settings.

4.1 Health sector responses

Effective health sector interventions to respond to SGBV in conflict involve three main approaches: training service providers, screening to identify survivors, and using a standardized protocol to provide care to survivors (5,42,105). Training involves improving the capacity of the individual or institution to provide confidential and survivor-centered care (5,42,105). It specifically targets the knowledge, attitudes, and practices of healthcare providers. An evaluation report of a training project in Guinea showed that training improved knowledge and facilitated procedures for providing survivors care (5,42,105). Similar training has been conducted in the BAY states by various partners and organizations (106,107).

Additionally, screening uses a range of validated tools and protocols to identify survivors of SGBV and link them to services in a more proactive manner, and it has proven effective in antenatal settings (90). The Standardized protocol launched in 2014 based on 2013 WHO guidelines guide healthcare workers on providing quality care to survivors using survivor-centered approaches (90,105). The provision of CMR services in the BAY states is through the adapted CMR protocol; however, the evaluation of the protocol's effectiveness has not been reported (106).

4.2. Psychosocial Support

Mental health and psychosocial supports (MPHSS) are essential components of the multi-sectoral SGBV response package (39,108). Effective MHPSS interventions are based on needs assessment and aimed to build or strengthen existing MHPSS resources. Effective MHPSS interventions involve a combined multilevel intervention at the individual and community level to promote and protect survivors' well-being or prevent mental health-related disorders (39,67,108). Figure 2 gives an example of multilevel MHPSS interventions for SGBV survivors (42,109).

4.2.1 Individual Psychosocial Support Interventions

At this level, the intervention focused on the survivors, their immediate family, and social networks. The recommended intervention includes providing non-specialized MHPSS services such as psychological first aid (PFA), psychoeducation, and referral for specialized mental health services. These services can be provided by local staff such as PHC workers or social workers with limited MHPSS experience (19,39,42,67,108–110). The specialized mental health services include services such as psychotherapy provided by mental health specialists. Individual counseling has been shown to improved anxiety disorder and PTSD symptoms when provided by specialized mental health service providers in humanitarian settings (19,42,108–110).

An evaluation of psychological care for women affected by sexual violence in Brazzaville Congo showed that post-rape psychological support integrated improved the psychological status of survivors (19,110,111). The capacity of local staff and other professionals needs to be enhanced on practical communication skills, provision of services, confidentiality, and personal skills for self-care to enhance the delivery of MHPSS intervention at this level. SOPs for service delivery and referrals need to be available and regularly updated (19,110,111).

4.2.2Community-focused Psychosocial Support Interventions

Evidence-based interventions at this level address harmful socio-cultural norms, SGBV-related stigma, myths, and misconceptions about SGBV using various mutually reinforcing approaches such as support groups, group counseling, community mobilization. The interventions aim to enhance survivor well-being and prevent mental health disorders by improving overall recovery (39,67,108). A study conducted in the DRC showed a significant reduction in depression and anxiety disorder in SGBV survivors who received group counseling services (19,110,111). An evaluation of support groups activities in Kenya and Zambia was found to help survivors share their experiences with other survivors, thereby facilitating their healing process (112).

Group counseling and support groups initiatives that link psychosocial support with livelihoods programming such as village savings and loans associations (VSLA) have the potential of improving survivors' well-being, reducing stigma, and enhancing utilization of SGBV services (19,108,110,111). An evaluation of the CARE international VSLA project in South Sudan showed that VSLA increased financial independence and enabled women to make decisions that improve their economic situation, including using SGBV services (113). A similar project implemented by SOS children's villages in Ogun State (southwest) Nigeria showed that VSLA improves self-reliance and ability to make informed decisions (114). OXFAM Nigeria is currently implementing a five-year VSLA project in 5Nigerian states, including Adamawa state, to enhance rural women's access to essential insurance services (115).

Additionally, psychosocial support services that are socially inclusive and engaged local leadership can effectively address stigma, change harmful social norms and improve the utilization of SGBV services based on evidence (19,39,67,108,110). Evidence suggests that using culturally sensitive multi-component approaches and integrating MHPSS into existing service delivery point have a long-term positive impact in conflict settings with few mental health professionals (19,39,67,108,110,111).

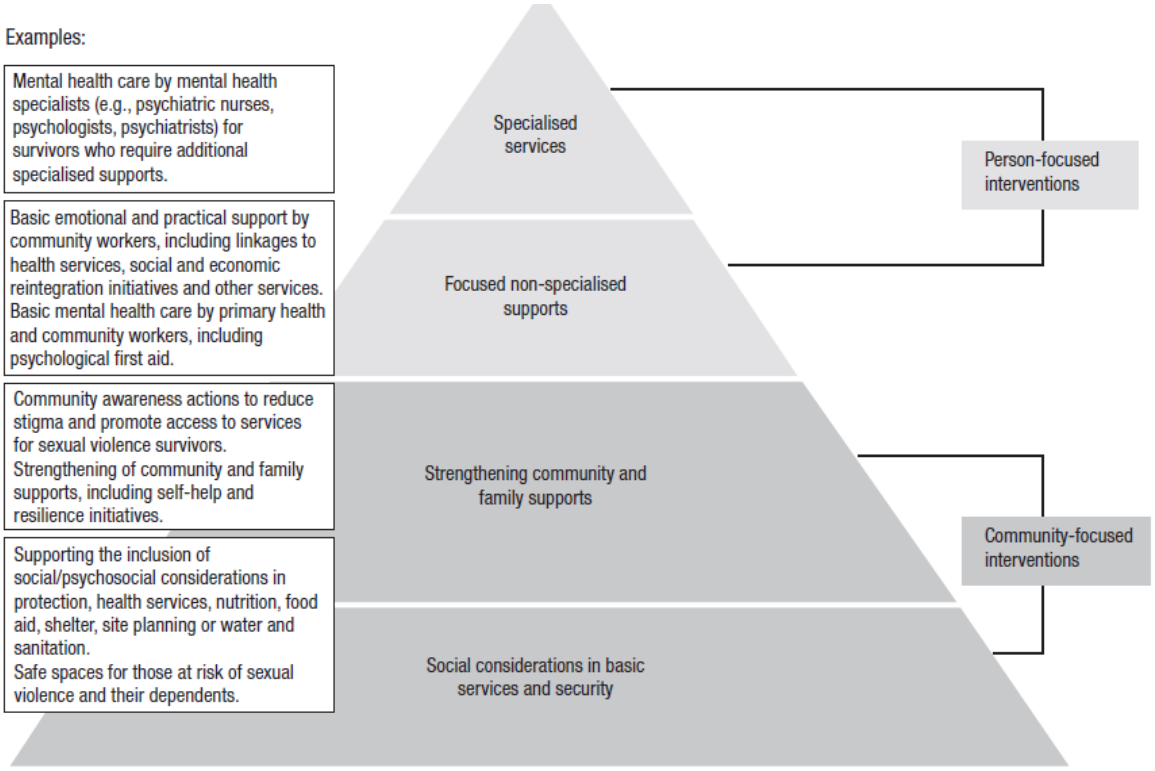

Figure 2: example of multilevel MHPSS interventions for SGBV survivors (42,109)

4.3 Multi-Component Interventions

Several effective interventions that respond to SGBV in conflict can use a mix of health and psychosocial support intervention (105). Evidence suggests that using combined multi-component approaches, at the various level of the society, effectively improve the utilization of SGBV services (5,42,105,110,116). Some effective multi-component interventions are discussed below:

- Community Mobilization and sensitization

Evidence showed that community mobilization activities that include women's and men's support groups, dialogue groups, community education, and advocacy are essential for transforming harmful social norms and improving survivors' access to care (19,110,111). For instance, Oxfam's Protection Programme in Eastern DRC, Raising Voices *SASA!* Community Mobilization Programme in Uganda, CARE's Refugee Assistance Programme in Dadaab, Kenya, and CARE's Emergency Needs Response Programme in Borno State Nigeria have used community mobilization strategies to reduce the social acceptability of SGBV and improve survivors' access to care (42,94,111,117,118).

Information, communication, and technology (ICT) strategies such as mobile phones, hotlines, social media, edutainment models, and computer management systems have been used in community mobilization and engagement interventions to reduce access barriers, generate data, and facilitate access to care for survivors (109). For example, the Through Our Eyes project in five post-conflict countries (South Sudan, Uganda, Thailand, Liberia, and Rwanda) uses a

participatory video project that stimulates community dialogue and action to influence positive attitudinal and behavioral changes about SGBV disclosure and utilization of SGBV services (119).

- Mobile outreaches

Community-based service models such as mobile clinics are an alternative approach for providing services in remote, hard-to-reach locations or in areas where health facilities are overstretched (120). For example, a community-based intervention conducted across six rural villages in the DRC has effectively improved access to SGBV services using mobile outreaches. The intervention focused on providing CMR service, psychosocial support, health education, stakeholders engagement, follow-up care, and referral services to survivors of SGBV (121). Other similar initiatives include Médecins Sans Frontières (MSF) model of service, interventions in eastern DRC, and refugee camps in Kenya (116). In Nigeria, Organization such as UNFPA and UNICEF has also used mobile outreaches to provide services to survivors (no evaluation reports available).

- Women and Girls and Safe Spaces (WGSS), One-stop and SARC centers

These centers have been used to provide safe and confidential life-saving information, psychosocial support, and referral to survivors of SGBV(67). One-stop and SARC centers have also increased women's access to justice and support services through awareness-raising activities (120). For instance, the evaluation of the SARC centres in Zambia and Nigeria showed that stakeholders' engagement, capacity building, and community sensitization effectively changed attitudes about SGBV and promoted the utilization of SGBV services (110,122). Local Organizations in the BAY states has also used this approach to provide age and context specific comprehensive sexuality education to adolescent girls (undocumented report from CBOs in Borno state).

- Engaging men and Boys

Evidence showed that interventions that promote gender-equitable relationships between men and women through dialogues on gender and masculinity effectively transformed gender norms, which supported the utilization of SGBV services. A CARE Rwanda's Village Savings and Loan program that deliberately engaged men as partners showed the importance of male involvement in household cooperation (5).

- Standard Operating Procedures and protocols

Furthermore, developing national or local SGBV protocols, including standard operating procedures (SOPs), referral pathways, and establishing minimum standards for quality of care, have proven effective in managing SGBV cases in conflict settings (110,120). CARE International's program in Dadaab Kenya has increased institutional and technical capacity to respond to SGBV by using community neighborhood forums, the media (radio and newsletters), and strengthening SGBV reporting structures (42).

CHAPTER 5: DISCUSSION

This study indicates that the utilization of SGBV services by women and girls in the BAY states is influenced by several factors occurring at the various layers of the socioecological framework and multilevel interaction occurs in each of these layers. Based on the study findings, legal and policy frameworks form the basis of effective SGBV response services at the public policy level. The lack of a comprehensive legal framework due to the non-domestication of the SGBV-related laws in the BAY states undermines survivors' access to SGBV support services. The inability to access SGBV services is compounded for adolescent girls due to multiple contradictory laws and policies about the age of consent for sexual activity and the need for parental/spousal consent before service utilization. This may not be unconnected to the poor utilization of SGBV services among adolescent girls in the BAY states.

The lack of comprehensive SGBV-related legal frameworks may be due to gender imbalance in the legislature and judiciary composition, suggesting that policymakers and judiciary's lack the political will to establish the SGBV-related legal framework. In addition, the strong patriarchal system in Nigeria, especially in the Northeast, backed up by the religious system, are critical factors in determining the formation of relevant SGBV laws as religious leaders are critical stakeholders in this process. Policy and legislative measures must be undertaken to prevent violence, eradicate discrimination against women in law and practice, and promote women's rights. Stakeholders' engagement and ccommunity mobilization are crucial for harnessing stakeholder's support in domesticating the SGBV-related laws

The weak and inconsistent implementation of the SGBV-related policies and guidelines in Nigeria, including the BAY states, may not be unrelated to gender inequalities embedded in socio-cultural norms about the role and status of women in the country linked to multiple contradictory laws and policies about women rights. The MWASD's inability to coordinate SGBV response and oversees the implementation of SGBV related policies may also suggest a lack of priority for women's rights at the country and state levels. There is a need to develop state-specific implementation guidelines and policy implementation task-force to enhance the utilization of SGBV services at the state and national levels. Allocating financial resources to FMWASD and MWASD to monitor the implementation of SGBV-related policies and social initiatives are essential for women's development and improved access to SGBV information and services.

At the individual level, findings from these studies showed that inadequate knowledge about the consequences of SGBV, where to access SGBV services, attitudes, beliefs, and self-perceived severity of the act(s) of violence influence help-seeking behavior, and the utilization of SGBV services. The inadequate knowledge among women and girls in the BAY States may not be unconnected to poor educational status because women in Nigeria, especially in the Northeast and rural areas, have low educational attainment, lower formal employment rates, higher poverty rates, and are marginalized in the decision-making process. Studies have linked low socioeconomic status, inability to make autonomous decisions and low educational attainment to poor health-seeking behavior and increased vulnerabilities (23,25,123).

Initiatives that enhance the ability of women and girls to develop life skills are essential for changing discriminatory norms that limit women and girls' participation in economic, social, and political activities. Providing context-specific information about SGBV, location of SGBV services, available options, and benefits of utilizing SGBV support services are essential for enhancing the utilization of SGBV services by women and girls.

Issues related to self-blame, shame, and fear about the consequences of disclosure, such as isolation and ostracization, are rooted in discriminatory socio-cultural norms that often blame women for SGBV incidents. This may not be unconnected to the poor reporting and utilization of SGBV services observed in the BAY states. Most women and girls in the BAY states have experienced violence, repeated displacement, separation from family members, accumulated stress, and weakened resilience due to the insurgency. This may make them accept the act of violence as normal or use other coping strategies such as ignoring the incidents, praying, or resigning to fate to deal with the stress and consequences of SGBV rather than utilizing SGBV services. A mixed-method study conducted among Lebanese and Syrian refugees also states that women and girls often use prayers to cope with the mental health consequences of displacement and SGBV (124). Initiatives that address harmful socio-cultural norms, stigma, myths, and misconceptions about SGBV using various mutually reinforcing interventions such as support groups, group counseling, community mobilization that target individuals and the community at large are crucial.

The increased risks of SGBV, non-reporting, and lack of partner and community support common in the BAY states may not be unconnected to the unintended consequences of several developmental programs that have primarily focused on women and girls leaving the men in disadvantaged or vulnerable positions. Male involvement is key in effective SGBV response and important for the utilization of SGBV services. It is essential to explore and address the root causes of SGBV by engaging men as partners and implementing interventions to change the negative perception of masculinity.

At the organizational level, the limited availability of skilled providers, social and health institutions providing care to survivors, especially in rural and inaccessible areas across the BAY states, may not be unconnected with the non-utilization of SGBV services observed in this study. The repeated attacks on health infrastructure, kidnapping, and killing of health workers by the insurgent group may prevent some services providers from working in rural areas where attacks are common and frequent. A study conducted in Yobe states on human resources for health showed that most health workers relocated to other less volatile areas due to insurgent activities (98)- for obvious safety reasons. Most of the crisis-affected populations are poor and may not be able to afford user fees associated with SGBV service. This may not be unconnected to the low utilization of SGBV services common in the BAY states. Alternative strategies for delivering health and social services such as mobile health services and the use of local community structures and organizations to provide basic health and social service are essential for reaching the most vulnerable population. Training and equipping of traditional birth attendants and community health workers may be useful in achieving this. There is a

critical need to remove user fees and include the provision of SGBV services in the BHCP package to improve access and overall health outcomes.

At the family and community level, the study showed that norms and attitudes that undermine the utilization of SGBV services are deeply rooted in socio-cultural norms, stigma, and the restrictive legal framework that undermines women and girls' access to SGBV support services. In the Nigerian context where most women are economically dependent on their male partners, are socialized to believe in the inherent superiority of men, auspices to male authority, and accept violence as a means of resolving conflicts within relationships, this may not be unconnected to the non-utilization of SGBV services observed in the BAY states. It is essential to address the harmful social norms related to SGBV while increasing women and girls' access and utilization of SGBV services. Evidence showed that the most successful interventions for enhancing community support seek to transform gender relations (e.g., increasing women's economic participation), resulting in changes in attitudes and supporting SGBV services utilization.

The socioecological framework was useful in conceptualizing the factors influencing the utilization of SGBV services and their interaction at the various level of the society. However, the framework currently lack a layer on conflict, adding such a layer would have enhance an in-depth understanding of how the conflict influence the utilization of SGBV in the other layers. This study did not explore the utilization of SGBV services by women and girls living in IDP camps and women living with disabilities, However, based on findings from this study, they may likely face similar situation or peculiar risk regarding the utilization of SGBV services. There are few articles/studies available on this subject from this setting, this might be due to the challenges of conducting research on SGBV particularly in conflict settings.

Furthermore, most conflict affected countries are LMICs and studies are generally scanty in LMICs. Ethical considerations, insecurity, logistic challenges, shifting priorities, and limited donor funding may have limited the duration of some SGBV programs before they are evaluated. Some grey literature or relevant SGBV project reports in Northeast Nigeria especially from small NGOs or CBOs might have also been missed because they were unpublished.

The results of this study also showed that that there is little published in the formal literature on SGBV among women and girls living in IDP camps and research gaps remain that would help to better inform both program and policy. Additionally, gaps exist regarding providers' skills and competencies and quality of SGBV services provided in conflict settings, research to enhance the delivery of SGBV services is also essential. Research is also required to better understand barriers faced by adolescents, young people and women living with disabilities including people living in IDP camps in each of the BAY states.

Further research and considerations are needed to determine the generalizability of findings from other settings on effective male engagement, group education, and economic

empowerment strategies as an SGBV response in populations affected by conflict in the BAY states. Rigorous evaluations of SGBV prevention and response efforts in conflict settings where the risk of SGBV may be highest are also critical. A better understanding of these issues can enhance the utilization of SGBV services by women and girls in conflict settings, because it can provide context-specific data for designing policies and intervention that enhance the utilization of SGBV. Furthermore, the number of KIs included in the study is too small to provide robust data for the study.

Despite the limitations, this study synthesized information from various studies on factors affecting women's and girls' utilization of SGBV services in conflict settings, especially in Nigeria, thus providing an overview of why SGBV services are not used in this setting. The strength of this study was that the KIs were conducted with the dual purpose of validating literature findings and complementing gaps in the literature. The selection of the KIs through chain referrals and purposeful sampling might have introduced biases because some non-traditional service providers might have been overlooked. Some participants might have exaggerated or hesitated to critic programs or policy, given that they represented their organizations

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study aimed to identify factors influencing the utilization of SGBV services by women and girls affected by conflict in northeast Nigeria using the socioecological framework. The findings showed that factors influencing the utilization of SGBV services by women and girls affected by conflict in the northeast are complex, multifaceted, and occurring at various levels of society. Based on the study findings, there is a lack of comprehensive legal framework and weak implementation of the SGBV related policies in the BAY states. Inadequate knowledge about benefits of utilizing SGBV service undermines the utilization of SGBV services. Non-availability of health and social infrastructure and skilled service providers exacerbated by the insurgency further limits utilization. Harmful socio-cultural norms that blame survivors for the act and low socioeconomic status of women aggregated by the conflict limits the utilization of SGBV services in the BAY states.

The socio-ecological framework helped to contextualize and better understand these barriers and to identify evidence-based interventions corresponding to each layer of the framework to promote service utilization. The study showed that coordinated and consistent multi-component culturally sensitive interventions - which include stakeholders' engagement, capacity building, mobile outreach, and psychotherapy can enhance the utilization of SGBV services by women and girls affected by conflict. Additional research on effective SGBV prevention and response interventions in conflict settings, where the risk of SGBV is high, is also required.

6.2 Recommendations

Based on the above study findings, the following recommendations are proposed to the SMWAD, MOH, and other stakeholders.

6.2.1 Individual-level

- Involve women and girls in the design and delivery of health and psychosocial support programming (with due caution in situations where this poses a potential security risk or increases the risk of SGBV).
- Enhance the active participation of women and girls in local health committees and community groups to enhance their decision-making skills.
- Promote life-skills and livelihoods training using for women and girls that enhance their financial independence.
- Engage men and boys to support the transformation of harmful gender norms by involving men in the implementation of project, however consideration should be given to women to lead the process.

6.2.2 Family and community levels

- Build community protection committees and link them to other existing structures such as camp coordination committees.

- Engage communities to transform gender norms that lead to discrimination against women and girls by involving women, community, and religious leaders in community sensitization and educating activities

6.2.3 Organizational level

- Integrate SGBV services into existing facilities (especially PHC and Reproductive Health services) and as stand-alone centers (SARCs or One-Stop Centers or mobile clinics or mobile services) to provide services in remote, hard-to-reach locations.
- Train service providers on applying the standard protocols and conduct regular supportive supervisory visits to monitor adherence to the standard protocol.
- Develop and institute standardized systems of care (i.e. referral pathways) and procedures that safely and confidentially link survivors with additional services (e.g., legal/justice support, mental health and psychosocial support, police services).

6.2.4 Policy level

- A review of laws (including customary law), legal definitions, and policies related to SGBV that may impede survivors' access to quality care (e.g., access to service for adolescent survivors; policies regarding emergency contraception; laws regarding post-abortion care; legal definitions of rape) is essential.
- Develop implementation strategies for SGBV-related policies and guidelines; a policy implementation committee that includes women and girls is essential for achieving this.
- Support the integration of SGBV management into the medical school curricula and health- and social service-related continuing education programs.

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Annex

Annex 1: Map of Nigeria

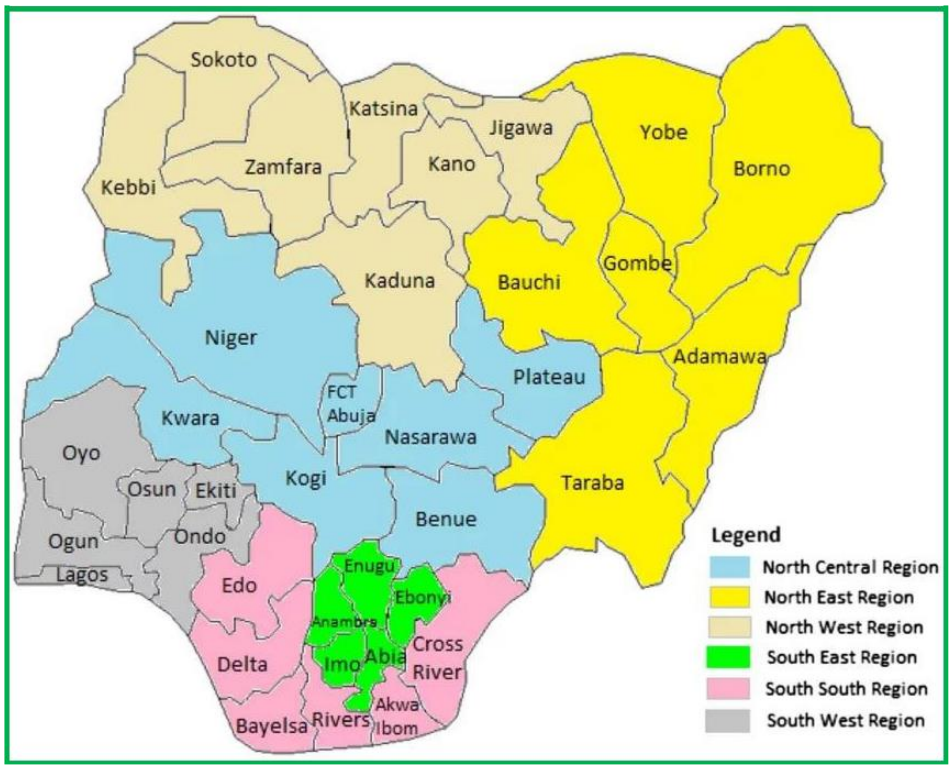

Fig 3: Map of Nigeria (23)

Annex 2: Map of the BAY states

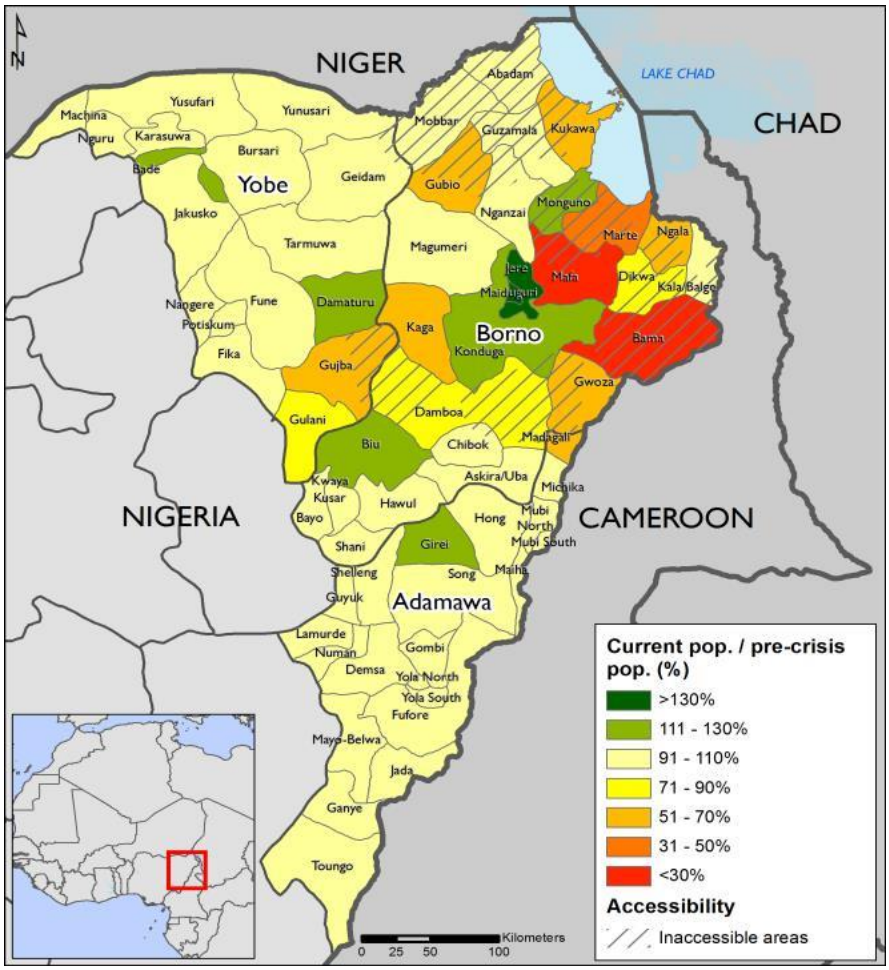

Fig 4: Map of BAY states (94)

Annex 3: Search Strategies and Terms

Table 5 Search strategies and terms

Topic	**Search terms**
Population	Women, adolescent girls, girls, OR Women and girls
Sexual Violence	Rape, sexual assault, sexual abuse, gender-based violence OR sexual violence
Health status Coverage/ Intervention/services/Barrier	Reproductive, Sexual, Rights, Health, Evaluation, Evidence, Program, Health Services, Integration, Intervention, Best Practice, Models of Care, Response, Access, Barriers, Obstacles, Sexual, Rights, Consent, Age, Sex, Policy, Strategy, Plan, Support OR Response
Location	northeast, Nigeria, sub-Saharan, OR Africa
Setting	Crisis, humanitarian setting, conflict, internal displacement, OR IDP

Annex 4: Ethical Waiver

KIT Royal Tropical Institute

RESEARCH ETHICS COMMITTEE

Contact: Meta Willems (secretary REC)
Telephone +31 (0)20 568 8514
m.willems@kit.nl

To:
Esther Osime, KIT ICHD Student
By email: estherosime@yahoo.com
Cc: Hermen Ormel

Amsterdam, 6 July 2021

Subject Decision Research Ethics Committee regarding a waiver for a "study to identify factors influencing the utilization of Sexual and Gender-Based Violence (SGBV) services among women and girls affected by conflict in northeast Nigeria" (S-159)

Dear Esther Osime,

The Research Ethics of the Royal Tropical Institute (REC) has reviewed your application for a waiver for a "study to identify factors influencing the utilization of Sexual and Gender-Based Violence (SGBV) services among women and girls affected by conflict in northeast Nigeria" (S-159) which was submitted on June 28, 2021.

The study takes place in in the context of KIT thesis research. The study aims to look at factors influencing the utilization of SGBV services among women and girls affected by conflict in Northeast Nigeria to inform policies and interventions on how to promote use of these services.

The study consists of a literature review and eight – online - interviews with key stakeholders. These key stakeholders, who will be interviewed in their professional capacity, will be purposeful selected from the Ministry of Health, the Ministry of Women Affairs and Social Development and (International) NGOs. All eight respondents are either directly or indirectly involved in the provision of SGBV services in Northeast Nigeria.

The study team consists of Esther Osime.

The study is exempted from full ethical review based on the following reasons:

a. the participants will be involved in their professional capacity only; the issues to be covered in the topic list cover information related to the duties of the respondents and information in the public domain; questions related to any personal questions are not included;
b. the participants will be asked informed consent before the data collection to make sure participation is voluntary and participants are informed that they can decide to decline or withdraw from the interview at any moment without any effect on reputation, or other consequences;
c. participating in this study does not foresee any physical, psychological and/or socio-economical risk or discomfort;

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ABN AMRO 40 50 05 970
ABN AMRO USD 62 62 48 183

d. all information will be derived, processed, stored and published anonymously.

The Committee grants this waiver provided that you inform the KIT GDPR project officer about your research for GDPR monitoring purposes.

The Committee requests you to inform the REC once substantive changes to the protocol are made, important changes to the research team take place or researchers are added to the research team.

Moreover, the Committee requests you to send the final report of the research containing a summary of the study's findings and conclusions to the Committee, for research monitoring purposes.

Please note that in case the final report is not submitted to the REC, or GDPR measurements are not taken care of sufficiently, this may have consequences for review of your next research proposal.

Wishing you success with the research,

Pam Baatsen, MA
Chair of the KIT REC

Annex 4: Informed consent for Key Informants

KIT Royal Tropical Institute

Introduction

I am Esther Osime, a student from KIT Royal Tropical Institute Amsterdam. I am conducting a study to identify factors influencing the utilization of Sexual and Gender-Based Violence (SGBV) services among women and girls affected by conflict in northeast Nigeria.

The study aims to explore factors influencing the utilization of SGBV Services among women and girls affected by Conflict in Northeast Nigeria towards providing recommendations to key stakeholders that support the development of policies and interventions that promote utilization of SGBV services among women in conflict settings.

Since you (indirectly) provide SGBV services to women and girls affected by conflict, I would like to invite you to participate in this study. This informed consent form has two parts: Information Sheet (to share information about the study with you) and declaration of consent (for signatures (initials) if you choose to participate).

Informed Consent Form- Information sheet

Introduction

Hello, my name is Esther Osime, I am a Master of Public Health (MPH) student from KIT Royal Tropical Institute Amsterdam, the Netherlands. I am currently conducting a study to identify factors influencing the utilization of Sexual and Gender-Based Violence (SGBV) service among women and girls affected by conflict in northeast Nigeria. If you agree to participate in the study, we hope that the information you provide will help in the development of policies, strategies, and interventions that enhance the utilization of SGBV services by women and girls affected by conflicts. The study will take place between June and August 2021.

Procedures including confidentiality

You are being invited to take part in this research because we feel that your professional experience can contribute to our understanding and knowledge of factors influencing utilization of SGBV services by women and girls affected by conflict in Northeast Nigeria. If you agree to participate in this study, we will interview you about the socio-economic, cultural, conflict and health system-related factors influencing the utilization of SGBV services among women and girls affected by conflict in Northeast Nigeria as well as the knowledge and attitude of women, girls, men, and boys in Northeast Nigeria towards SGBV. We will also ask about current policies and actual interventions for the prevention and management of SGBV including the effectiveness of such policies and interventions.

You can express your honest opinion freely in this interview. The interview will take place virtually in a setting of your choosing and will last for about to 60 minutes. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. Your participation in this research is entirely voluntary. It is your choice whether to participate or not. The choice that you make will have no bearing on your job or any work-related promotions, evaluations, or reports. You may change your mind later and stop participating even if you agreed earlier.

To make sure that we do not forget or change what you are saying we will record the answers you give if you agree with that. Everything that will be said and written down will be kept confidential. Your name will not be recorded or written down, only a predetermined code will be used. Notes will be kept in a locked place. Only the researcher will have access to the anonymous notes. The recorded files will be deleted 6 months upon the completion of the study. In publications, the findings will focus generally on the utilization of SGBV services among women and girls affected by conflict in northeast Nigeria and not on your particular answers, so that nobody can recognize you and your opinions.

Risk, discomforts, and right to withdraw

After having agreed to participate in the interview, you are still free to refuse to answer any question that makes you uncomfortable and it will not have any consequences on your job or anything else. There is low probability that you may share some personal or confidential information, insights and experiences based on your professional roles by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen.

You do not have to answer any question, share personal experience or take part in the discussion/interview if you feel the question(s) are too personal or if talking about them makes you uncomfortable. You can also withdraw from this study at any time. Some of the questions may trigger emotions, if so, we can stop the interview and or refer you to a trained counselor in case you would like that.

Benefits

This study may not help you directly, but the results will help to inform the development of policies, strategies, and interventions that enhance the utilization of SGBV services by women and girls affected by conflicts.

Sharing the results

After the study is completed, we will share the result at workshops with stakeholders relevant to SGBV service provision, including community leaders and women and girls affected by conflict. The findings will also be shared at national, regional, and global SRH/GBV conferences and events. Additionally, articles from the study will be submitted to relevant journals for publication. If you would like to participate in the stakeholder meeting or would like to receive a copy of the report, please let us know and we will make this possible.

Consent and contact

Do you have any questions that you would like to ask? If yes, contact the researcher via same email where you received this link

Declaration Of Consent: To be Signed by the Respondent

Agreement by the respondents

I have been invited to participate in the study about factors influencing the utilization of Sexual and Gender-Based Violence (SGBV) services among women and girls affected by conflict in northeast Nigeria. I have read the foregoing information. I have had the opportunity to ask questions about it and any questions I asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study …….. (name of respondent or initial).

_____

Signed Date

WITNESS SIGNATURE

_____

Signed Date

If you have any questions or want to file a complaint about the research, you may contact:

Contact information researcher	Contact for Ethics Committee
Esther Osime estherosime@yahoo.com, +2348065095138	

Annex 5: Data collection tool guide for Key Informants

KIT Royal Tropical Institute

Introduction

I am Esther Osime, a student from the KIT Royal Tropical Institute. I am conducting a study to identify factors influencing the utilization of Sexual and Gender-Based Violence (SGBV) service among women and girls affected by conflict in northeast Nigeria.

The study aims to explore factors influencing the utilization of SGBV services among women and girls affected by Conflict in Northeast Nigeria towards providing recommendations to key stakeholders that support the development of policies and interventions that promote utilization of SGBV services among women in conflict settings.

Since you (indirectly) provide SGBV services to women and girls affected by conflict, I would like to invite you to participate in this study.

Before beginning the interview, read the consent form and obtain the participant's consent to proceed with the interview. DO NOT proceed without informed consent. Inform the participant that you would like to start recording the interview & take notes and start the audio recorder.

ASK PARTICIPANT: Do I have your permission to continue?

Yes, consent is given → fill introduction and go to question 1

No, consent is not given → Interview with the respondent must END.

Introduction

Participant code	
Gender	Female | Male| Other
Age	<30| 30-40 | >40
Location	
Organization	
Education	

Professional background	Health provider | program management | Policy Maker | others (please specify)

Introductory questions: Does your Organisation provide SGBV services? If yes, where, what and how? What are your main functions and responsibilities in your Organisation?

Section One: Knowledge, awareness, and attitude about SGBV

1. What are the expected gender roles and responsibilities of men and women in this community/ in Nigeria? How are women viewed differently from men in this context? (Clarify roles and gender expectations)

2. What do people in this setting (state, community, IDP camps) understand about Sexual and Gender based violence (SGBV)?

3. What forms of SGBV do you think occur the most in this setting? (Probe for common forms of SGBV in the setting for example, intimate partner violence, rape, sexual coercion, child sexual abuse, female genital mutilation, forced marriage and VAWG)

1.1.1.1.

4. Which people are most at risk of gender base violence in this context? (Probe for groups of people at risk and why, probe if SGBV incidents are reported including frequency of such reports, Probe if data are available on reporting, accuracy of such data)

5. What services are typically available to SGBV survivors in your context (Probe for services provided to address the health, mental health, safety, and economic needs of GBV survivors. (Probe for who provides such services? For example, is it NGO/community-based organization, UN Agency, International Organization, the government? Probe: For when and where the interventions and services are offered, cost of such services? Probe for community awareness of such services)

6. What principles, standard or approach are used for the provision of SGBV services in this setting (probe if principles, standard and approach specific to the conflict/insecurity setting, probe if principles, standards, and approach are applicable to all organizations working in the conflict/?)

Section Two: Factors influencing the utilization of SGBV services

7. What barriers and facilitators do women and girls face in reporting GBV in your context? (Probe: For example, stigma against survivors, acceptance of violence as normal, fear of intimidation, logistical (cost, distance, hours of operation, etc.), lack of awareness of services, lack of trust in the benefits of services, lack of coordination

between services, lack of follow up, or lack of the quality of services, conflict/ insecurity)

8. What barriers and facilitators do women and girls face in seeking care? (Probe: For example, stigma against survivors, acceptance of violence as normal, logistical (cost, distance, hours of operation, etc.), lack of awareness of services, lack of trust in the benefits of services, lack of coordination between services, lack of follow up, or lack of the quality of services, conflict/ insecurity)

Section Three: Accessibility and quality of SGBV Services

9. What is the quality of the existing GBV services in your context? (Probe if services are provided by Skilled service providers with the right skilled mix, availability of relevant medications, equipment and other supplies, availability of same-sex service provider or a chaperone, availability of job aids and SOPs for the service providers, Probe if services are provided in settings that enable privacy, confidentiality, and safety of survivors and promote autonomy of choices, Probe if service providers are trained regularly to enhance knowledge and skills)

10. What are the potential gaps in the SGBV services provided by organizations in this setting? (Probe for attitude of service providers, concepts of consent, confidentiality, privacy, referral and required follow-up visits, if supportive environment (eg, leaflets, posters in indigenous languages are available))

Section Four: Policies, interventions and strategies for the management of SGBV

11. Do existing services to manage SGBV employ a survivors-centred approach? (Please explain, Probe: if services are provided using multi-sector approach such as integrating Child protection, social services, Laws and criminal justice into existing health services? Gender transformative approach, Engaging men as partners, Women and Girls safe spaces)

12. Do existing Health policy framework have specific policies on SGBV? (Probe for available policies, the implementation of such policies including gaps in implementation as well as what can be done to improve such policies)

13. What do you think needs to be done to enhance the utilization of SGBV services by women and girls? (Probe for roles of Community-based services, how health systems can support health-care providers, How current services and policies could be improved? etc)

Close the Interview

I have finished the questions that I had for you. Is there anything else you would like to share with me? Thank you for the time you spent with me today. If you have any questions or concerns following this, please feel free to call or write to the contact on your copy of the consent form.

Annex 6- Research Table

General Objectives: To explore factors influencing the utilization of SGBV services by women and girls affected by conflict in Northeast Nigeria towards providing recommendations to key stakeholders that support the development of policies, strategies, and interventions that enhance the utilization of SGBV response services among women and girls in conflict settings.

Table 6 Research Table

Specific Objectives	**Issues**	**Methods**	**Respondents**
I To explore policies and strategies on the management of SGBV in Nigeria conflict settings, comparing with international standards.	• Availabilities of SGBV policies and strategies and • Implementation of SGBV policies and strategies. •	• Literature • Semi structured Interviews (SSI)	• Key informant interview with Member of the GBV sub sector, health worker, CBO/INGO/NGO staff
II To explore the individual factors (knowledge, belief, and attitude) influencing the utilization of SGBV support services by women and girls affected by conflict in Northeast Nigeria.	• Knowledge, belief, and attitude about SGBV • Sources of SGBV information • Gender and gender roles • Sociodemographic characteristics • Community and Self-stigma • Formal help-seeking behavior, • Financial capability • Spousal, family and community support	• Literature • Semi structured Interviews (SSI)	• Key informant interview with Member of the GBV sub sector, health worker, CBO/INGO/NGO staff
III To explore the health and social system-related factors	• Types of SGBV services provided in conflict	• Literature	

influencing the utilization of SGBV support services by women and girls in Northeast Nigeria conflict settings	• Availability of health and social structures • Availability of service providers with right skill mix • Attitude of services providers to SGBV survivors • Provider attitudes and/or discriminatory practices • Availability of SGBV job aids and SOPs related to conflict • Supportive environment including • Availability of relevant medications and other supplies and equipment • Referral and coordination systems	Semi structured Interviews (SSI)	• Key informant interview with Member of the GBV sub sector, health worker, CBO/INGO/NGO staff
IV To explore the socio-economic, socio-cultural, and conflict-related factors influencing the utilization of SGBV support services by women and girls in Northeast Nigeria conflict settings.	• Social stigma • Community awareness and beliefs about SGBV • Gender issues • Acceptability of violence against women • Social, cultural, economic, and religious norms about SGBV and SGBV service utilization • Myth and misconception about SGBV • Gender issues • Conflict-related factors	• Semi structured Interviews (SSI)	• Key informant interview with Member of the GBV sub sector, health worker, CBO/INGO/NGO staff

	• Sociocultural factors • Economic Factors • Religious norms		
V To examine effective practices and interventions for the management of SGBV in Nigeria and other conflict settings	• Gender transformative approach • Multi-sectorial approach and integration such as integrating Child protection, Social services, Laws and criminal justice into health services	• Literatures • Semi structured Interviews (SSI)	• Key informant interviews with Member of the GBV sub sector, health worker, CBO/INGO/NGO staff
VI To provide recommendations to the Ministry of Women Affairs and Social Development (MWASD), Ministry of Health (MoH), and other relevant stakeholders that support the development of policies, strategies, and interventions that promote the utilization of SGBV services by women and girls in conflict settings.			

THESIS WORKPLAN

S/N	Date	Description	Expected Outcomes/Deliverables
1	7th January to 14th June 2021	Write thesis proposla	
		Review all previous thesis write up (introduction, background, problem statement, Justification, objectives, methodology and conceptual framework)	The first half of the thesis is review and ready for Milestone 2 submission
2	15th June 2021	Draft Key Informant Interview guides and complete ethical waiver letter	• KII guide drafted
			• Ethical waiver filled and ready for submission and approval
3	15th June 2021	Share Review writeup (Proposal) including Ethical waiver form with Thesis Advisor for comments and feedbacks	• Reviewed write up including filled Ethical waiver form shared with Thesis Advisor
			• Ethical waiver form shared with Academic Advisor
4	16th June 2021	Submit Thesis Milestone two on VG	• Thesis Milestone two submitted
5	17th June 2021	Share proposal and filled ethical approval (exemption) form with thesis and academic advisors	• Proposal, KII guide and Ethical shared with Thesis Advisor for review
6	17th to 18th June	Geneva Online Session	• Participated in Geneva Online Sessions

7	21st June 2021	Meet with Thesis advisor to finalise Framework and receive guidance on starting the result session of the thesis and ethical approval	• Conceptual Framework Approved
			• Feedback regarding the Ethical Exemption form obtained from Thesis and Academic Advisor
			• Tips and feedback regarding next steps (conducting KII and starting the Result) session obtained
8	22nd June 2021	Work on Thesis and Academic advisors feedbacks for proposal and ethical approval (exemption) form	• Finalise proposal, KII guides and Ethical form for submission and approval
			• Document shared with Thesis and Academic Advisor for signature and final approval
9	23rd June 2021	Submit proposal and ethical approval (exemption) form to REC with Thesis and Academic advisors' approval	• Proposal and Ethical Exemption Application submitted to REC
10	23rd to 2nd July 2021	Write Study findings/results session	• Findings/result session of the proposal completed
			Note: the KII part will be completed upon REC approval
11	24th June 2021	Contact Key Informants for interviews	• Key Informants contacted
			• Tentative date for completing the KII fixed.
12	5th July 2021	Share study findings/result session with Thesis advisor for feedbacks and comments	• Findings and result session shared with Thesis Advisor for feedback and guidance
13	7th July 2021	Meet with Thesis Advisor to discuss study findings/result session	• Guidance and feedback regarding the Findings and result session obtained
			• Tips and guidance for progressing to the feedback and result session obtained
14	6th July to 16th July 2021	Write discussion, conclusion, and recommendations part of the Thesis	• Findings and result session shared with Thesis Advisor for feedback and guidance

15	17th July 2021	Share first draft of Thesis with Peers/Colleague for feedback and suggestions	• First draft of thesis (without the KII) shared with peers for feedback
16	20th July 2021	Meet with Peers and colleagues to discuss Thesis first Draft	• Feedback and peers impression obtained
17	21st to 23rd July 2021	Conduct Key informant interviews with Key Informants	• KII conducted *Note: Tentative date based on REC approval*
18	24th to 26th July 2021	Analyse KII results and include in Result and discussion session of the Thesis	• KII analysed and included in the result session *Note: Tentative date based on REC approval*
19	27th July 2021	Share Discussion, Conclusion, and recommendations (Complete first draft) with Thesis Advisor for feedbacks and comments	• Complete thesis first draft shared with Thesis Advisor for feedbacks and guidance • Clarify if write up meets objectives and thesis guidelines
20	29th July 2021	Meet with Thesis Advisor to discuss completed Thesis first draft	• Feedback and guidance about improving completed first draft obtained
21	27th July to 3rd August 2021	Review and Edit first Thesis Draft	• Draft Thesis review and edited for spelling, tenses and other grammatical error
22	3rd August 2021	Share second draft of thesis with Peers/Colleague for feedback and suggestions (Check for grammar, spelling, tense etc)	• 2nd draft shared with peers for feedbacks
23	5th August 2021	Meet with Peers/Colleagues to discuss feedback and comments	• Feedback regarding Thesis structure, grammar, clarity, and coherence received from peers.
24	5th August 2021	Share review 2nd draft with Thesis advisor for review, comments, and feedback	• Reviewed 2nd draft shared with Thesis Advisor for feedback and comments

25	9th August 2021	Meet with Thesis Advisor to discuss progress and finalise Thesis for submission	• Feedback about Thesis 2nd draft received from Thesis Advisor
			• Tips for improving the Thesis obtained
26	9th to 10th August 2021	Edit and finalise thesis for submission	• Thesis review, edited and finalised for submission
27	11th August 2021	Submit thesis on VG	• Thesis submitted on VG