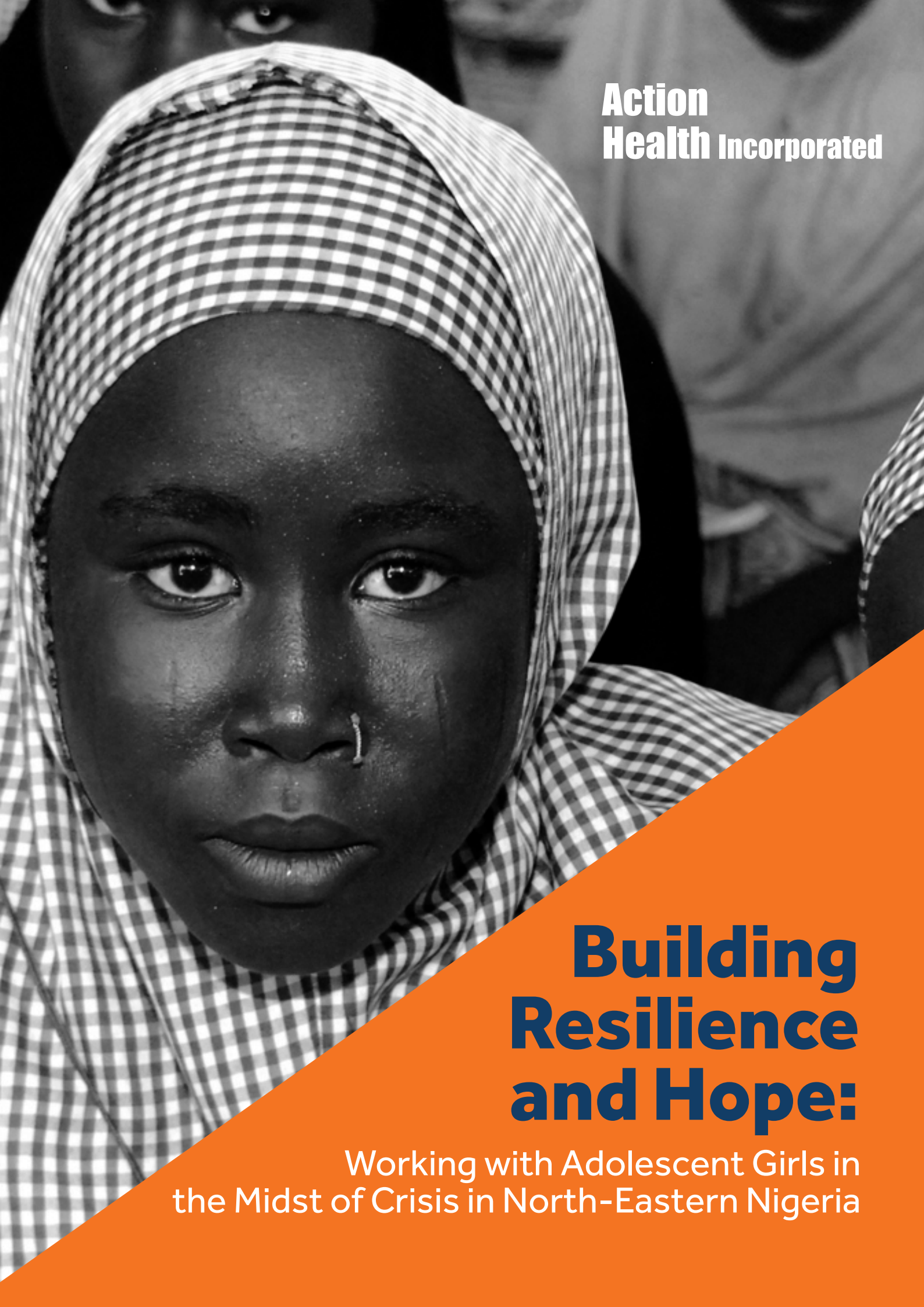

Action Health Incorporated

# Building Resilience and Hope:

## Working with Adolescent Girls in the Midst of Crisis in North-Eastern Nigeria

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This publication captures efforts to increase the reach of health sector humanitarian interventions through the implementation of two United Nations Office for the Coordination of Humanitarian Affairs, Nigeria-funded health projects implemented by Action Health Incorporated (AHI) in Borno State between 2018-2019.



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# Contents

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# Acronyms

| | |
|---|---|
| AHI | Action Health Incorporated |
| ANC | Antenatal Care |
| CMR | Clinical Management of Rape |
| DHS | Demographic and Health Survey |
| FGM | Female Genital Mutilation |
| GBV | Gender-Based Violence |
| GSS | Government Secondary School |
| HIV | Human Immunodeficiency Virus |
| IDP | Internally Displaced Persons |
| JSS | Junior Secondary School |
| LGE | Local Government Area |
| MCH | Maternal and Child Health Centre |
| MISP | Minimum Initial Services Package |
| PEP | Post-Exposure Prophylaxis |
| RMNCH+A | Reproductive, Maternal, Newborn, Child and Adolescent Health |
| SRH | Sexual and Reproductive Health |
| STI | Sexually Transmitted Infection |
| UNFPA | United Nations Population Fund |
| UNOCHA | United Nations Office for Coordination of Humanitarian Affairs |
| WHO | World Health Organization |
| YFS | Youth Friendly Services |

# Executive Summary

North-Eastern Nigeria has experienced a range of infrastructural and socioeconomic devastations since the advent of the Boko Haram insurgency in 2009. Thousands of lives have been lost and millions displaced from their original homes.

However, the most affected have been adolescent girls and young women who have been forced to navigate a range of gender-based discrimination and violent acts.

"Building Resilience and Hope: Working with Adolescent Girls in the Midst of Crisis in North-Eastern Nigeria" captures the efforts to increase the reach of the health sector and address identified gaps, through the implementation of two UNOCHA-funded health projects by Action Health Incorporated (AHI) in Borno State between 2018-2019.

Together, these projects –Sustaining Care and Integrated Response– helped address the immediate needs for services and health inputs for girls and women while also strengthening the sector by leveraging AHI's 30 years of experience in addressing the health services needs of adolescents in Nigeria.

This document shares the reflections and stories of adolescent girls and young women who have benefitted from these interventions and begun to envision a life beyond the current crisis. It includes the perspectives of the programme implementers, health personnel and community mobilizers who understood the potential for short-term response to lay the foundation for longer-term solutions.

It also illustrates the value of leveraging humanitarian outreach to raise awareness for broader social change—most importantly in the context of North-East Nigeria, addressing the impact of gender-based discrimination and violence.

1The first-person accounts which informed and are excerpted in this document are derived from qualitative interviews with a purposeful sample of direct beneficiaries, community leadership, and program staff in selected camps for the displaced and host communities (Maiduguri and Bama and Gwoza LGAs). Respondents were identified by program staff, told about the objectives of the exercise and the option to decline an interview-for those who agreed to be interviewed, they were asked to sign a consent form (parents or a guardian signed for those under age 18). Interviews were conducted by the primary researcher in either the local dialect or English, recorded using a voice recorder, transcribed and translated where necessary. The primary objectives were to explore the experience of the interventions supported by AHI on the part of direct beneficiaries, community leadership and program staff. In addition, interviews with adolescent girls and young women at the community level explored their coping strategies and adaptations in the face of this humanitarian crisis.

# CHAPTER 1

## Impact of Boko Haram Insurgency on Adolescent Girls

Paulina Bulus is a 16-year old student in Gwoza Local Government Area, about 135 kilometres South-East of Maiduguri, the capital of Borno State. Originally from Fadagwe village in the hilly terrain of Gwoza, Paulina and her family were displaced as a result of the activities of Boko Haram insurgents in the region.

The Boko Haram insurgency–described as one of the most severe humanitarian crises in the world–has claimed more than 30,000 human lives and displaced over two million people in ten years.[2]

More than half of the total population of the three most affected states (Borno, Adamawa, and Yobe) were in need of humanitarian assistance in 2019–a figure which reflects the impact on the local, hosting communities and others fleeing conflict.

## Internal displacement as a burden

Home to almost 80 percent of the internally displaced, Borno State is the epicentre of the crisis which started in 2009. Nearly all its Local Government Areas have experienced displacement.[3]

"My father was killed. Boko Haram abducted me (and my mother) ... When we were released, we had to take refuge in the bush before we came to this camp," Paulina explains.

"I live here with my mother."

The Internally Displaced Persons' (IDP) camp at Gwoza is one of 49 of such facilities spread across the North-East, not including the 244 informal camps and settlements. However, in barely two months (December 2018 and January 2019), the burden of people flooding into Borno overwhelmed the existing camps for the displaced—the Teachers Village Camp, a camp initially set up to host 10,000, received 20,000 new arrivals, bringing the total residents to 30,000.

## Borno State's ability to address the increasing needs is severely compromised.

The economic cost of the insurgency in the North-East region is estimated at US$3.3 billion in housing and US$3.7 billion in agriculture, which employs over 60 percent of the population. Borno has borne two-thirds of the cost of this destruction, including huge losses in the education and health sectors as access to services has also been affected. [4]

Estimates for 2019 indicated that 70 percent of girls of primary school age were out of school and 75 percent of those in camps did not attend school; over five million were in need of health assistance.[5]

"I long to go to school but my mother doesn't have enough money to send me to school. But I am able to earn some money through cap knitting and hope that I will be able to further my education," says a hopeful and determined Paulina.

**49 IDPs**
Camps in the North East

**244**
Informal Camps and Settlements

**70%**
of primary school aged girls are out of school

**75%**
of girls in IDP camps did not attend schools

**>5million**
in need of health insurance

2 The CounterExtremism Project. 2019. Boko Haram. Accessed February 22, 2020. https://www.counterextremism.com/threat/boko-haram
3 UNOCHA. November 2018. Nigeria: Humanitarian Needs Overview 2019. Abuja, Nigeria, UNOCHA, Pages 4-14.
4 The education sector, which is commonly relied upon as a means to reach girls, has been severely impacted by the killing of teachers and the destruction of schools. Borno has also lost to destruction two-thirds of its existing health facilities while over 5 million are in need of health assistance and 75 per cent of them report that existing healthcare costs are beyond their ability to pay.
5 UNOCHA. November 2018. Pages 4-14.


## Females more disadvantaged by the crisis

As of 2019, the majority (62 percent) of the Borno population in need were female. Among the displaced, the percentage is even higher: of those arriving during the surge at the end of 2018, an estimated 87 percent were women and children.[6] The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) reports that the most vulnerable households include a significant number headed by adolescent females in which girls are forced to become breadwinners for the entire family and for which over 45 percent have no documentation to access services.[7]

Boko Haram's campaign is extraordinarily brutal -- targeting civilians, including those that are meant to be protected in IDP camps. [8] It is exceptional in its tactics of abuse and exploitation of girls and women through abduction, hostage-taking, sexual violence (including rape and impregnation), and coordinated use of girls and women as sexual slaves, political pawns and suicide bombers.[9]

The international outcry and campaign over the kidnapping of 276 schoolgirls from the Chibok community by the Boko Haram sect in 2014 focused a global spotlight on the group's intentional abuse of girls —a pattern which has increased with intensity as well as attacks on aid workers and protection agencies. This devastation is superimposed on a region in which life for girls was already very difficult.

Prior to the onset of the Boko Haram insurgency, Borno State had performed poorly on key human development and gender equality indicators compared to other states in the North East region in female education and literacy, maternal and child health, household decision-making and attitudes towards violence against women.[10]

7 UNOCHA. November 2018. Pages 4-14.
8 Alex Thurston. January, 2016. "'The disease is unbelief': Boko Haram's religious and political worldview". The Brookings Project on U.S. Relations with the Islamic World Analysis Paper | No. 22.
9 Bloom and Matfess. 2016.
10 Based on the findings of 2008 Nigerian Demographic and Health Survey, this included poor rates of schooling for girls (females of primary school age attending school 21.1%; females of secondary school age attending school 15.6%; percentage of women age 15-49 reporting no schooling 81.2%); women's lack of decision-making within the household (over 50 per cent of women of reproductive age report very low rates of participation in four key household decisions) and a high level of acceptance of wife-beating for infractions such as burning the food (over 58 per cent of women agreed that wife beating was appropriate in at least one of four key situations).

# CHAPTER 2

## No Girl Left Behind:
## Taking the Broad, Long View

## Displacement as a long-term disruptor

Displacements due to humanitarian issues could last for 20 years on average for refugees, and more than 10 years for 90 percent of IDPs.[11]

Therefore, it is imperative to note that whilst the focus of the Humanitarian community is on managing the immediate needs of IDPs and host communities, efforts should be geared towards creating systems that will ensure prompt resolution of emergency needs in order to create a balance.

UNOCHA reports that "...the vast majority of displaced households report...no active plan to return, citing insecurity and lack of access to services such as food, health and education." [12]

With a long-term projection, Action Health Incorporated acknowledges that within the short-term timeframes of emergency response, sensitivity to the unique needs of particular groups is often not possible.

Adolescent girls like Paulina Bulus "are at a comparative disadvantage before, during and after crises...this transitional period between childhood and adulthood is...when girls begin to assume adult roles, but without key skills, capacities and networks that enable others to safely navigate forced displacement. Furthermore, the risks in these contexts—rape, abuse, early marriage and abduction—are greater for adolescent girls compared to other population groups."[13]

Social isolation of girls is a well-documented contributor to their risk of abuse.[14] Girls in Borno are already relatively isolated given constraints on their mobility, their heavy work burden, and their lack of education. Displacement magnifies these effects.

*"...the vast majority of displaced households report...no active plan to return, citing insecurity and lack of access to services such as food, health and education."*

- UNOCHA Report

## Schools and healthcare facilities highly impacted by displacement

In North-Eastern Nigeria, and Borno State in particular, the urgency of the situation and the poor conditions of those mechanisms most often used to reach girls—the schools—necessitates innovative approaches.

The health sector—which offers the possibility of mobile outreach, services, and referral—provides alternative mechanisms for reaching hard-to-reach populations and offers a basis for directly addressing the sexual and reproductive health issues critical to a fulfilling adolescent experience. For girls experiencing the effects of Boko Haram's brutality, health services also offer the possibility of providing spaces where girls feel safe to share and seek care for the effects of gender-based violence (GBV).

However, the health sector in the region has been severely impacted and now needs additional support. The few functional facilities are short of staff and lack safe water, basic medication and equipment. Restrictions on movement within the camps due to insecurity further limit access to services, particularly for girls. UNOCHA's reports highlight significant gaps in "...quality services and referrals for secondary care to prevent maternal deaths and maternal morbidity...the availability of GBV-specialized assistance -- including PEP kits, clinical management of rape cases); and GBV-trained medical staff including mental health and psychosocial services (which are) extremely limited." [15]

11 The European Civil Protection and Humanitarian Aid Operations, European Commission. June 19, 2019. Forced Displacement: Refugees, Asylum Seekers, and Internally Displaced People (IDPs). Accessed February 21, 2020.
12 UNOCHA. November 2018. P. 8.
13 Robles, Omar.2014. I'm Here: Adolescent Girls in Emergencies Approach and Tools for Improved Response. NYC, NY. Women's Refugee Commission; Siddiqui, A. 2013. Missing the Emergency: Shifting the Paradigm for Relief to Adolescent Girls, NYC, NY. Coalition of Adolescent Girls; Girls Not Brides. August 2018. Thematic Brief: Child Marriage in Humanitarian Settings, London, UK. Girls Not Brides.
14 Bruce, Judith and Kelly Hallman. July, 2008. "Reaching the Girls Left Behind". Gender and Development 16(2):227-245.; United Nations Children's Fund. 2014. A Statistical Snapshot of Violence against Adolescent Girls, UNICEF, New York.
15 UNOCHA. November 2018.

## Action Health Incorporated's interventions - a youth-friendly, community-based approach

AHI is a non-governmental organization established in Nigeria in 1989 which develops the capacity of both private non-profit and public actors in the health and education sectors to design and implement programmes and advocate for policies which address adolescent health and wellbeing through education, awareness-raising and mobilization, direct services, counselling, empowerment and support networks.

In Borno State, AHI partnered with a well-tested network of service providers and youth programmes, the State Primary Health Care Board and Coordination Units, and trained psychosocial support counsellors based within designated service points in selected IDP camps.

The project, Sustaining a Continuum of Care for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in Humanitarian Settings (Sustaining Care) supported broad-based outreach using community health providers and volunteers, health education and awareness-raising combined with provision of supplies for safe deliveries and self-care. This outreach and the incentives provided helped to facilitate referrals, and encourage girls and women to seek relevant healthcare services. The service points were further strengthened through the addition of dedicated adolescent-friendly sub-units.[16]

Key actors within the service hierarchy were trained in the two core components of reproductive health services within emergency response - the Clinical Management of Rape (CMR)[17] and the Minimum Initial Services Package (MISP)[18] together with training in the provision of Adolescent Friendly Services.[19]

The focus on the particular needs of adolescent girls was reinforced by encouraging clients to use the "safe spaces" for girls staffed by trained psychosocial counsellors, which had been previously established in selected IDP camps with UNFPA support. Girls engaged through the outreach programs were accommodated in the safe spaces. This afforded them the opportunity to build support networks, gain knowledge on how to protect themselves and envision their lives beyond the current crisis. The counsellors trained on addressing GBV and management of rape served as an additional referral point.

This project was implemented for 12 months, from December 2018 to December 2019 in Gwoza, Bama and Dikwa Local Government Areas of Borno State, the difficult terrain notwithstanding.

**12 months** for Project Implementation **from Dec 2018 to Dec 2019**

**In Gwoza Bama Dikwa** LGAs of Borno State

SAFE SPACES

**"A designated Safe Space for girls and women may be formal or informal but intended for the sole purpose of providing 'a place where women and girls feel physically and emotionally safe. The term 'safe' ... refers to the absence of trauma, excessive stress, violence (or fear of violence) and abuse."[20]**

**AHI provided psychosocial support (using the Safe Space strategy) to women and girls in three locations where the project was successfully implemented.**

16 "Adolescent-Friendly" services take into account service factors such as timing, accessibility, confidentiality, welcoming setting, appropriate equipment and referrals as well as the involvement of young people, their parents and other key actors in the community.
17 UNFPA. 2004. Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons. Geneva. WHO.
18 2018. Interagency Working Group of Reproductive Health in Humanitarian Settings. Interagency Field Manual on Reproductive Health in Humanitarian Settings. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-English.pdf. Accessed March 7, 2020.
19 WHO. 2015. Global standards for quality health-care services for adolescents: a guide to implementing a standards-driven approach to improve the quality of health care services for adolescents. Volume 1: Standards and criteria
20 UNFPA. 2015. Women and Girls Safe Spaces: A Guidance Note Based on Lessons Learned from the Syrian Crisis. NYC. UNFPA. Page 5.

## Mitigating surging influx of displaced persons

Following the major new influx of displaced populations in early 2019, AHI joined in the response to the critical needs identified during the development of the 90-day emergency Response Plan for Borno State.

While expanding AHI's geographic scope, the project, Integrated Sexual and Reproductive Health Emergency Response (Integrated Response) provided the opportunity to test some of the more innovative elements of the Sustaining Care project while meeting the immediate demand for health inputs and access to trained reproductive health service providers.

The programme included the distribution of family planning commodities and RMNCH essential drugs together with material support (as kits). Mobile health educators were deployed within camps, working with host communities to undertake health education, facilitate linkages with existing facilities to support services provided by skilled birth attendants, and provide gender-based violence prevention education linked with services and psychosocial counselling.

The project was implemented in two Local Government Areas (LGAs) of Borno State -- Maiduguri Metropolitan Council and Monguno between May and October 2019.

# KEY OUTPUTS OF BOTH PROGRAMMES

## Sustaining a Continuum of Care for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in Humanitarian Settings (Sustaining Care)

**20,400**
reached with health education and promotion messages

**7,204**
direct beneficiaries of emergency drug supplies, dignity kits and delivery kits and other sanitary items

–

**2,115**
births attended by skilled birth attendants

**90**
trained on Clinical Management of Rape (CMR), Minimum Initial Service Package (MISP) and Provision of Youth Friendly Health Services.[21]

## Integrated Sexual and Reproductive Health Emergency Response (Integrated Response)

**17,015**
reached with health education and promotion messages

**4,522**
direct beneficiaries of emergency drug supplies, dignity kits and delivery kits and other sanitary items

**1,527**
attended at least three antenatal care (ANC) visits

**956**
births attended by skilled birth attendants

**479**
reached with psycho-social support and SRH/GBV Services

[21] Examples of the issues addressed can be found in WHO, 2015. Global standards for quality health-care services for adolescents: a guide to implementing a standards-driven approach to improve the quality of health care services for adolescents. Volume 1: Standards and criteria.


# CHAPTER 3

## Reaching Girls and Women through Healthcare

Aisha Timta is a midwife and team member of the MCH facility at the public health centre in Gwoza. Besides conducting deliveries, she is now one of the healthcare support volunteers trained by Action Health Incorporated.

She explains her routine: "We visit IDPs to educate them on personal hygiene and refer them to the Maternal and Child Health (MCH) facilities and hospitals. We also teach them about gender-based violence and encourage antenatal care (ANC) visits for pregnant women, among other things."

Another volunteer, Fatima Abba Kyari serves as a community health extension worker at the Bama Camp. She narrates her routine as well: "We sensitize them (younger girls) on hygiene. We go from house to house to check the living conditions of our clients... We teach those between the ages of 13 to 15. Some don't know how to use the (sanitary) towels because it is the first time they are seeing and learning about (them)."

## Incentivising use of healthcare services and facilities among women and girls

The combination of community outreach, education and provision of supplies to encourage the use of clinical services is a well-tested strategy within maternal health circles -- especially as part of emergency response.

Emergency response to reproductive health needs was officially expanded in the late 1990s to include the minimum standards addressing sexual violence, HIV and broader sexual and reproductive health (SRH) concerns and, subsequently, a special focus on clinical management of rape. Adolescent girls, however, continue to face particular challenges and risks, which may not be addressed by such programmes.

In an effort to address this gap, AHI organised community outreach programs for pregnant women with a dedicated focus on young girls. This intervention propelled the young girls to seek services—both adolescent-friendly clinical services and the safe spaces linked to those services. The testimonies of the girls, along with those of community members and service providers emphasize the value of the education, products and services focused on self-care, reducing risk, and addressing broader social change.

The majority of providers noted that outreach together with the provision of basic delivery and self-care supplies contributed significantly to girls' and women's decisions to seek services—whether or not they were pregnant. The field staff raised awareness about using services and trained providers; made formal referrals to services; and provided delivery, dignity and hygiene kits which served as both an introduction and an incentive to pursue services.

Halima Hamidu, a Community Health Officer in Gwoza raises awareness on the importance of child delivery in a health facility as part of outreach efforts in teaching women about the importance of family planning, birth spacing, exclusive breastfeeding, and regular HIV testing. She refers pregnant clients to the health centre first, but admits, "even if they won't give birth in the health facility, let it be under a trained traditional birth attendant."

One of the key healthcare personnel to whom referrals are made is Dr Suleiman Sabo of the Primary Healthcare Facility, Teachers Village Camp in Maiduguri. "When AHI staff go out for community outreaches to create awareness and they find any persons who need medical attention, they refer them to me. I run a diagnosis to find out their health issue and treat them, but if there is further need for me to (also) refer (them for advanced care), I do so," he confirms.

## Innovative kits as incentives for health facility visits

Midwife Aisha Timta firmly believes that the strategy of distributing kits has increased the turnout in antenatal care as well as postnatal clinics. The Delivery Kit contains items to ensure cleanliness throughout the birthing process thus, preventing infection and related deaths in newborns: ***clean hands, clean perineum, clean delivery surface, clean cord cutting blade, clean cord ties and clean cord care.***

The Dignity Kit for women includes items such as toothbrush, toothpaste, hairbrush, comb, flashlight, sanitary towels, socks, nail cutter, hijab (for head covering), t-shirt, panties, towel, blanket, laundry and bathing soap, bucket, bathroom slippers (flip-flops), paracetamol, and vaseline. The Hygiene Kit for adolescent girls includes bathing and laundry soaps, toothpaste and brush, and sanitary towels.

"We used to give only the pregnant women who were close to delivery the (safe) delivery kit (Mama Kit) (but) because of the kits, women turn out in large numbers to

attend the antenatal clinic," says Hannatu Fuqu, Nurse-Midwife-in-charge, Primary Health Care, Teachers Village Camp, Maiduguri. "Now, with the women armed with these kits ahead of delivery, when they deliver at the clinic, it is easy to guide them through the (child) vaccination process (for example)."


## Community stakeholder engagement necessary for making inroads

Reaching the girls and women in Borno and neighbouring states through healthcare services is a deliberate and strategic effort that involves key stakeholders.

"We ask all the beneficiary local governments to bring (the names of) at least 50 adolescent girls (to whom we then distribute) the items (provided by AHI, such as drugs, hygiene kits and sanitary pads)...those coming include some from outside the camp (who are living in) the community (where services are overwhelmed)," explains Hannatu Fuqu of the Teachers Village Camp in Maiduguri.

Aishatu Lawal, a woman leader in the Wakane, Gwoza IDP Camp confirms: "AHI volunteers came to me as the women leader and asked me to bring girls to receive the dignity kits. I selected beneficiaries based on their level of need. Before this initiative, the girls used unhygienic pieces of cloth in place of sanitary towels during their menstrual period. This programme has taught them how to use and dispose of used towels..." They get practical guidance on the use of sanitary pads.

Eventually, "Adolescent girls (also)...come (to the facility) for the dignity kits to support their personal hygiene," states Dr Suleiman Sabo. "This program is significant because it has encouraged pregnant women to come and deliver in the health facilities in the hands of skilled birth attendants rather than delivering at home or through traditional means. They know that once they come, they do not need to buy drugs and they also get free delivery kits and medical attention," he adds.

"It is a thing of joy for me to see mothers coming here, delivering safely and going back home with healthy babies."

Community Health Officer, Halima Hamidu also confirms that girls now visit the health facilities to report and to treat infections and dysmenorrhea. The medication available at the clinics include antibiotics, intravenous fluids, zinc tablets and analgesics.

Midwife Aisha Timta noted that most of the girls had never been sensitized on personal hygiene (menstrual hygiene) but they are now better informed because of AHI's intervention.

The first clinic experience is critical and thus a key component of the overall programme.

In keeping with the efforts to bring girls to the clinic, AHI supported the development of dedicated adolescent-friendly health service areas within the clinics together with training of key personnel on serving adolescents. This is an area in which AHI has been at the forefront of developments in Nigeria.

To ensure that girls seeking clinical support would have a good experience and return, AHI supported the development of youth-friendly centres where adolescents and young people receive the care and attention they require from personnel trained for this purpose.

As explained in the WHO 2015 publication on global standards for clinical services for adolescents, "Adolescents have significant needs for health services. They pose different challenges for the health-care system than children and adults, due to their rapidly evolving physical, intellectual and emotional development." Thus, youth-friendly services for girls need to be accessible, confidential and designed to fit different levels of maturity.

> *"It is a thing of joy for me to see mothers coming here, delivering safely and going back home with healthy babies."*
>
> - Dr Suleiman Sabo

# Youth Friendly Services

Youth Friendly Health Services are designed to address those factors which have been shown to be critical to young people's decisions to seek care and return for care. These reflect global standards for quality of care with special emphasis on factors such as time of day, appropriately sized equipment, welcoming settings, and confidentiality, including separate or dedicated entrances. Development of such services also emphasizes the need to involve young people, their parents and other key actors in the community to support a holistic approach.


# CHAPTER 4

## More than Clinical Care: Addressing Safety and Protection


## The self-care contents and accompanying messages provided with the Dignity Kits are potentially lifesaving for adolescent girls navigating the passage to adulthood in a context which demands they play adult roles -- for which they are unprepared, and present the daily threat of sexual violence.

Both the community-based outreach and the services-based education provide opportunities to engage the girls on issues beyond personal hygiene to consider safety and develop an awareness of skills to avoid gender-based violence and discrimination.

"The girls have also been enlightened on how to keep safe and free from violence and how to avoid risky behaviours that expose them to dangers," says Aishatu Lawal. "Those unable to abstain and who are sexually active are advised to use family planning (FP) in order to avoid unplanned pregnancies."

On the most pragmatic level, provision of kits and access to free services imply that girls are not taking risks to be able to purchase essential items such as soap or pads or pay for basic care. Both the community and the girls themselves understand this "protective" element of the programme.

According to Bulama Aji, a male community leader in Kasugula Motor Park Ward, Bama LGA, girls who receive the kits are less at risk because they no longer need to look for resources to buy those necessities. "If the girls (did not have the kits) they could be exposed to exploitation by men in seeking these items because their parents (could not provide them as they) are already burdened with ensuring that all the children get food to eat and paying for their education and other urgent and important needs."

Where the girls decide to work to earn the income to enable them to afford the hygiene materials, other life options like schooling may be relegated due to time constraints.

"Before receiving the (dignity) kit, I used to go to various homes to work to earn some money, which I then used in buying some of the items provided in the kit," says Zainab Lawal, an orphan and JSS 1 student at a secondary school within the Wakane Camp in Gwoza.

She reminisces, "I did not always have soap to take my bath. Most times, I did not even have N20 to buy a razor to cut my nails. But now, I have a nail cutter and also a comb for my hair."

"I am learning how to knit caps (though) I don't even have money to buy the materials I need for knitting the caps for sale."

The pregnant girls and women who receive the safe delivery kits save time and money as they are able to reserve their resources for other essential items during the early days after childbearing; including return trips to the clinic for post-natal care and vaccinations for their newborn.

"I got the Delivery Kit (when my 10-month old son was born) including items such as a bucket, towel and kettle, (plus) a Dignity Kit," confirmed Yakaka Mohammed, a client at the Maternal and Child Health Unit in Bama.

"During my previous pregnancy, I bought the stuff in the Delivery Kit with my money, but now I got it for free and I am very happy that I have saved over N5000."

## Learning about self-care and personal space

The work of many agencies on ending "Period Poverty" has focused the world's attention on the importance of adequate sanitary products and safe, hygienic spaces in which to use them. Also, the right to manage menstruation without shame or stigma is equally a serious concern in achieving the global development goals. These investments have a direct impact on the key gender indicators, which inform the global discussion through improvements in girls' health (better hygiene), education (reducing school days missed due to menstruation), safety and freedom from violence (through privacy as a tool for protection), livelihood and self-actualization (through the mobility afforded by addressing hygiene and stigma).[22]

Many of the reflections shared by beneficiaries from the project in Borno State highlight the contributions of the sanitary pads and other items in the kits to the larger objectives of protection and safely accessing the world around them.

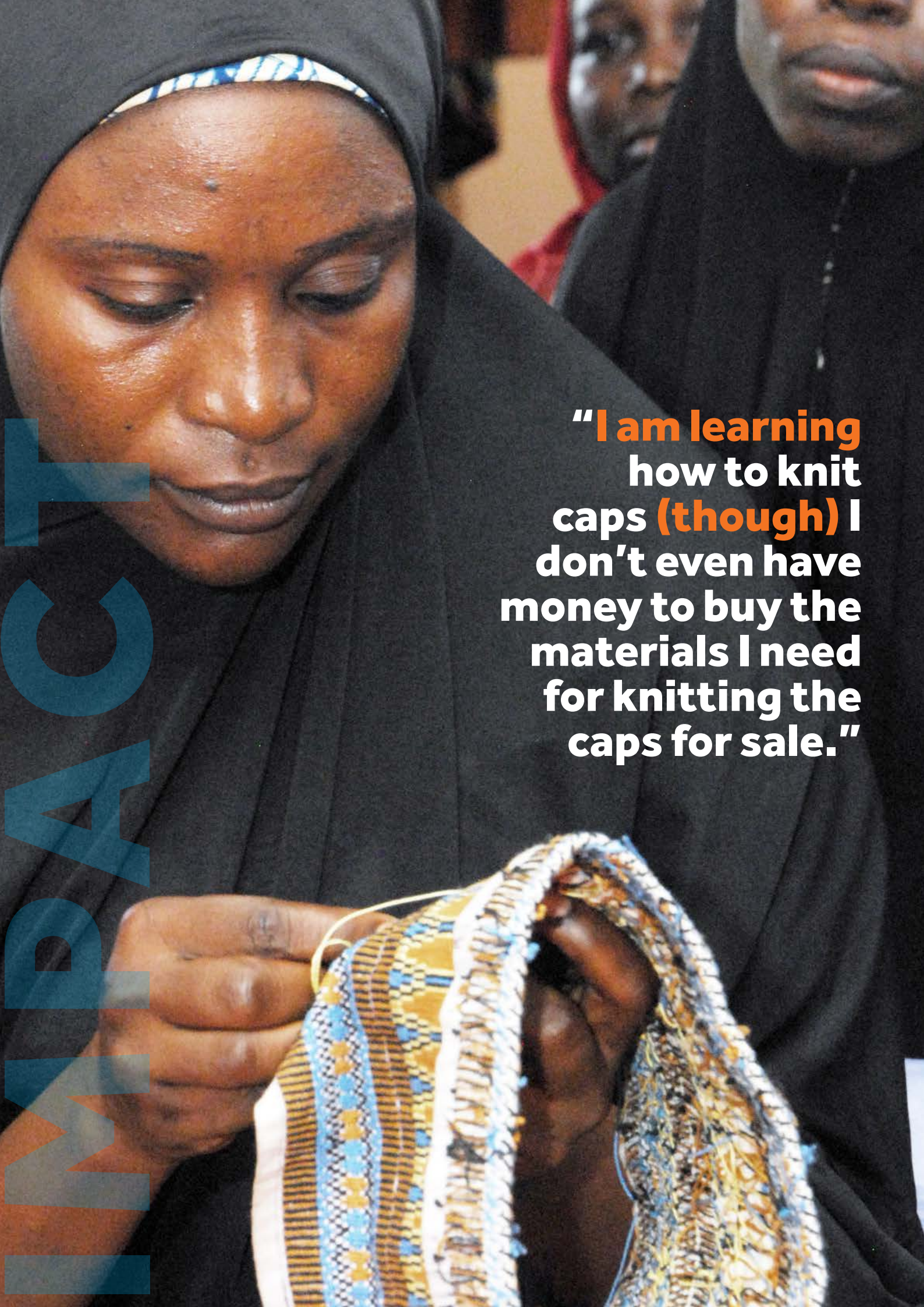
"Dignity and Hygiene Kits have changed the lives of girls in our community. Before this intervention, girls would get stained during their menstrual period and this makes the girl ashamed," says Falmata Adamu, a Women Leader at GSS Camp in Gwoza LGA. "With the use of sanitary towels, they move around with greater confidence... (Everyone is) safer now because it is difficult to detect their menstrual cycle."

The bag itself, in addition to the contents, represents a place to protect their few possessions and their private supplies. "I now have a bag to put my clothes in, soaps to wash my clothes and sanitary pads to use during my menstrual period. I also have blankets with which I cover myself to sleep," says Paulina Bulus. "We have been taught about personal hygiene and how to protect ourselves from violence. (For example) we were taught not to follow any male to a secluded place to avoid rape because if the male is stronger, one would be unable to resist and overpower him if he becomes violent. We learned that if a male friend wants to talk to us, he should meet us at home with other people close-by."

### Protective Element of the Programme

Provision of kits and access to free services imply that girls are not taking risks to be able to purchase essential items such as soap or pads or pay for basic care.

22 ActionAid. 2020. Period Poverty. https://www.actionaid.org.uk/about-us/what-we-do/womens-economic-empowerment/period-poverty. Accessed March 6, 2020. .



IMPACT

"I am learning how to knit caps (though) I don't even have money to buy the materials I need for knitting the caps for sale."

# CHAPTER 5

## From Personal Space to Shared Safe Spaces - Next Steps

## It has been established that the lack of traditional sources of protection may result in even more restrictions on opportunities for the girl child.

Social isolation, a risk factor for abuse, is magnified during displacement—not only because girls lose their established networks and alternative safe spaces such as familiar houses of worship or schools or friends, but also because the camp becomes the only protection from the very real violence beyond its borders.

"I fled with my family to escape from Boko Haram attacks. If we stayed outside this camp, there would be no food for us to eat. So, we decided to join others here," says Hafsat Shu'Ibu, a teenager who lives in the Teachers Village Camp (TVC) in Maiduguri with her mother.

"I am not in school presently because when I went to enrol, spaces were filled up already. Right now, I want to go to school and be educated but my mother will not allow me to go to school outside this camp or even for any reason spend much time outside the camp."

Leveraging prior investments supported by the UNFPA, AHI linked dedicated "safe spaces" for girls to the Sustaining Care project. Against the backdrop of an environment that forces them to take on adult roles earlier than expected, these locations allow adolescent girls like Hafsat to just "be girls".

Hadiza Umodu, a Maternal and Child Health Coordinator / Clinician-in-charge at Shehuri Ward in Bama LGA explains further: "In the Safe Space, we address gender-based issues. Safe Spaces were set up specifically to support adolescent girls. This is where they come often to find succour from the outside world where they are constantly being deprived of their basic human rights."

Through the shared Safe Spaces, adolescent girls learn about their body and health. Girls who have experienced rape and other forms of sexual abuse and related trauma access counselling support and other services like HIV testing, and post-exposure prophylaxis such as pregnancy tests and treatment of sexually transmitted infections (STIs).

"We also provide family planning commodities to sexually active clients to prevent early and unplanned pregnancies," explains Hadiza.

Most importantly, the girls develop relationships with other girls, thereby reducing the social isolation aggravated by the displacement that put them at the risk of abuse. The spaces also provide a place for girls to undertake their own small-scale income generation efforts. Such skills have been shown to help reduce the risks for adolescent girls in other contexts.[23]

23 Hallman, Kelly, Kasthuri Govender, Eva Roca, Rob Pattman, Emmanuel Mbatha, and Deevia Bhana. 2007. Brief Number 4. Enhancing financial literacy, HIV/AIDS skills, and safe social spaces among vulnerable South African youth. In Promoting healthy, safe, and productive transitions to adulthood. NYC. The Population Council.
24 UNFPA. 2015. Page 5.

**SAFE SPACES**

**The key objectives of Safe Spaces are to provide an area where women and girls can:**

- Socialize and re-build their social networks
- Receive social support
- Acquire contextually relevant skills
- Access safe and non-stigmatizing multi-sectorial GBV response services (psychosocial, legal, medical)
- Receive information on issues relating to women's rights, health, and services[24]

Hafsat learnt about the Safe Space supported by AHI after "overhearing other girls talking about the teachings, discipline and togetherness they enjoy there."

She explains excitedly, "My friends told me they were being taught about how to succeed in life by working hard and having a good relationship with one another."

"Spending time in the Safe Space reduces the tensions I experience, and I can benefit from other programmes, including how to resist or prevent violence. I now have a better understanding of how to protect myself from sexually transmitted infections and from sexual abuse," she affirms.

Hauwa Shettima, a psychosocial support counsellor at the Safe Space hosted at the Teachers Village Camp in Maiduguri highlights the diversity of the facility users: "Here, we have persons with different kinds of disabilities including those who who have lost their limbs or living with hearing and/ or visual impairments. Many of them are adolescents. We interact with them and make them feel happy."

## Building resilience and a vision for the future - testimonials

The girls' benefitting from this work have begun to develop a stronger sense of self; understand the value of working in a relationship; acquire concrete skills for negotiating the significant challenges which face them in their environment; articulate hopes and plans for the future and understand the importance of being able to act for themselves. The Safe Space represents a place where practical skills and services are combined with developing a sense of self.

"They are now better positioned to cope with their situation as IDPs," concludes Hauwa. Perhaps the testimony of the girls is the best indication of success in this regard—they plan to "take control" of their lives based on their life circumstances.

Fatima Jidda, a Safe Space user at the MCH, Bama says, "I got to know about the AHI programme when I came to the facility on ANC visit. It's exciting to be one of the beneficiaries of this programme. I am very happy because I have received the maternity kit (Mama Kit). I will adopt an appropriate child spacing method as I have been advised until I am ready to bear more children."

Aisha Ahmadu, a 20-year-old woman from Wakane Camp, Gwoza testifies, "I benefited greatly from the Dignity Kit and sensitization programmes. Right now, I know almost everything I need to know about puberty and growing up. We really need skill acquisition training to help us do meaningful things for ourselves. For example, we can learn to sew and earn some money. I am not currently in school because I can't afford the school uniform. For us adolescent girls, we need more programmes like this one to help us."

## Addressing gender-based discrimination and Boko Haram's legacy of sexual abuse

According to Hadiza, the MCH Coordinator / Clinician-in-charge from Shehuri Ward in Bama, "the major challenge among adolescent girls here is the lower educational attainment. Many stop schooling at the Junior Secondary School level. Supervisors usually come to give them lectures (on life skills) before distributing the dignity kits and ask the girls to inform them about any gender-based challenges they are experiencing. Halima Hamidu, Community Health Officer at Gwoza, also explains how the outreach team also talks to men about the implications of rape and how to protect their daughters—leveraging fathers' concerns for their daughters as a powerful tool in changing the mindset about gender issues.

**Social isolation, a risk factor for abuse, is magnified during displacement.**

The team also addresses the more difficult topics head-on—noting that addressing gender-based violence is an important topic "because men often beat their wives and send their wives out to work to earn a living." The small seeds of change planted through work with the girls and their communities need much more cultivation.

For the humanitarian actors focused on the displaced, there are signs that the situation is changing in the North East (Adamawa and Borno have both seen large movements of the displaced returning to their home areas).[25] However, recent events suggest it may simply be a displacement of the conflict across national borders.[26] In both cases, the crisis in North-East Nigeria has highlighted the need to invest in the self-reliance of displaced communities unlikely to return to their homelands—both internally displaced and refugees.[27]

The hopeful visions of the adolescent girls benefitting from the work described here—girls who already bear the greatest burden as de facto heads of household and as explicit targets of the Boko Haram attacks—are among the most promising signs that a new future is possible. However, for those working directly with these girls, an overriding concern is the long-term impact of the 10 year period of exposure to Boko Haram's targeting and abuse of adolescent girls and the sense of impunity, which puts all girls and women at risk.

Addressing this problem requires adaptation of those approaches pre-dating the conflict. This should be informed by new efforts with a dedicated focus on engaging men and boys on gender issues in post-conflict settings.[28] Some of this work is based on the experiences of Uganda—a country which has experienced both a protracted internal conflict much like that currently affecting North-East Nigeria as well as the continued influx of refugees from neighbouring countries. Uganda is a leading advocate on a new approach to work with the displaced and host communities, very much in keeping with new initiatives on self-sufficiency emerging within the humanitarian community (referenced above).[29]

25 UNOCHA. November 2018.
26 United Nations Special Representative of the Secretary-General on Violence against Children. February 21, 2020, Press Release: UN Officials call for enhanced protection of civilians facing escalating violence in Cameroon (accessed February 22, 2020).
27 The European Civil Protection and Humanitarian Aid Operations 2019.
28 Barker, G., Contreras, J.M., Heilman, B., Singh,A.K., Verma, R.K., and Nascimento, M. January, 2011. Evolving Men: Initial Results from the International Men and Gender Equality Survey (IMAGES).Washington, D.C. International Center for Research on Women (ICRW) and Rio de Janeiro: Instituto Promundo; Slegh, H., Barker, G. and Levtov, R. May, 2014. Gender Relations, Sexual and Gender-based Violence and the Effects of Conflict on Women and Men in Northern Kivu, Eastern Democratic Republic of the Congo: Results from the International Men and Gender Equality Survey (IMAGES). Washington, DC, and Capetown, South Africa: Promundo-US and Sonke Gender Justice.
29 UNFPA. 2018. Corporate Evaluation of UNFPA support to the prevention, response to and elimination of gender-based violence and harmful practices (2012-2017), NYC, NY, UNFPA.


# CHAPTER 6

## Key Lessons from the Early Phases of AHI's Work

There are many concrete operational and strategic lessons learned from the experience of the first year of AHI's work with the UNOCHA projects. These lessons, drawn from programme staff and reflections on the inputs of those benefitting from the work, are summarized here to encourage continued dialogue.

**1)** The distribution of "in-kind" health and other supplies through the Delivery, Dignity and Health kits not only encouraged good hygiene and safe delivery practices but also helped women and girls to be more comfortable talking with health workers about their sexual health issues. This message was reinforced in health education outreach provided with the commodities and mobile services - all of which encouraged girls and women to access service points. *It would be important to see if such use of services is sustained over a longer period of time after the initial contact and, if so, what factors supported this (e.g. Safe Spaces).*

**2)** Engaging government staff in training and implementation was intended to provide sustainability after the conclusion of the project: although this requires continuous follow up on dissemination and handover of knowledge. *It would be valuable to trace how the various levels of training supported changes in practice, policy and additional capacity building (including both training of community-level actors, health system personnel, and ministry staff).*

**3)** Stocktaking of commodities at the LGA level helped in planning and distribution. Also, delegating the duty of monitoring data at the LGA level improved reporting. *It would be valuable to see if these structural changes can also be integrated into government capacity building going forward.*

**4)** Health education focused on self-care and protection provided a useful entry point for talking about broader issues related to gender-based discrimination and, potentially, experiences with violence. The outreach workers noted that when girls were unable to access answers to their questions in the field, they were referred to the clinics. As clinics and Safe Spaces with trained counsellors and psychosocial support provided critical backup for community-level support, *it would be important to assess whether there was any follow up on these more informal referrals.*

**5)** The youth-friendly services linked with the Sustaining a Continuum of Care for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in Humanitarian Settings project were intended primarily for young women and girls. *It would be valuable to determine whether sex-segregated services are viable in this setting.*


# Conclusion

The special needs of adolescent girls in the humanitarian emergency in North-East Nigeria are being addressed, though still in the early stages, by the work of Action Health Incorporated with funding from UNOCHA.

These efforts leverage previous investments in working with girls in this uniquely challenging context.

Girls—who are transitioning from childhood to adulthood but without sufficient preparation, isolated, and lacking access to services—are at particular risk of sexual violence and abuse.

Within the short timeframe of emergency response, AHI's experience has offered many practical lessons in addressing these special needs. The girls' own testimonies also make clear that as the humanitarian community begins to come to terms with the reality of protracted conflicts in which the displaced are unable to return home, adolescent girls may be one of the driving forces behind a new approach towards sustainable development.

AHI brings to this challenge substantial experience in clinical services, health education and community outreach, together with a focus on sexual and reproductive health, which can serve as an entry point for addressing broader gender issues.

# Appendix

*Contents of Humanitarian Kits*

## Hygiene Kit

1. Bathing soap (2x)
2. Laundry Soap (2x)
3. Toothpaste (1x)
4. Toothbrush (1x)
5. Sanitary pads (2 packs)
6. Petroleum Jelly (1x)

## Dignity Kit

1. Toothbrush (1x)
2. Hair Comb (1x)
3. Torchlight (Solar) (1x)
4. Sanitary Pads (3 packs)
5. Socks (2 pairs)
6. Nail Cutter (1x)
7. Hijab/Shawl (1x)
8. T-shirt (1x)
9. Pants (2x)
10. Towel (1x)
11. Blanket (1x)
12. Toothpaste (1x)
13. Laundry Soap (2x)
14. Bathing Soap (2x)
15. Bucket (1x)
16. Bathroom Slippers (1x)
17. Petroleum Jelly (1x)

## Delivery Kit

1.Soap (1x)
2. Absorbent Delivery Mat (2x)
3. Sterile Surgical Gloves (2x)
4. Sterile Surgical Blade (1x)
5. Cord Clamps (2x)
6. Sterile Gauze (2x)
7. Methylated Spirit (1 Bottle)
8. Disposable Apron (1x)
9. Chlorhexidine Gel (1x)
10. Cotton Wool (1x)
11. Bottle of Olive Oil (1x)
12. Baby Covering Flannel (1x)
13. Mucus Extractor (1x)
14. Miso-Fem Tablet (1 Pack)
15. Placenta Disposal Bag (1x)
16. Disinfectant (1x)
17. Baby Diapers (1 Pack)
18. Sanitary Pads (3 Packs)

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