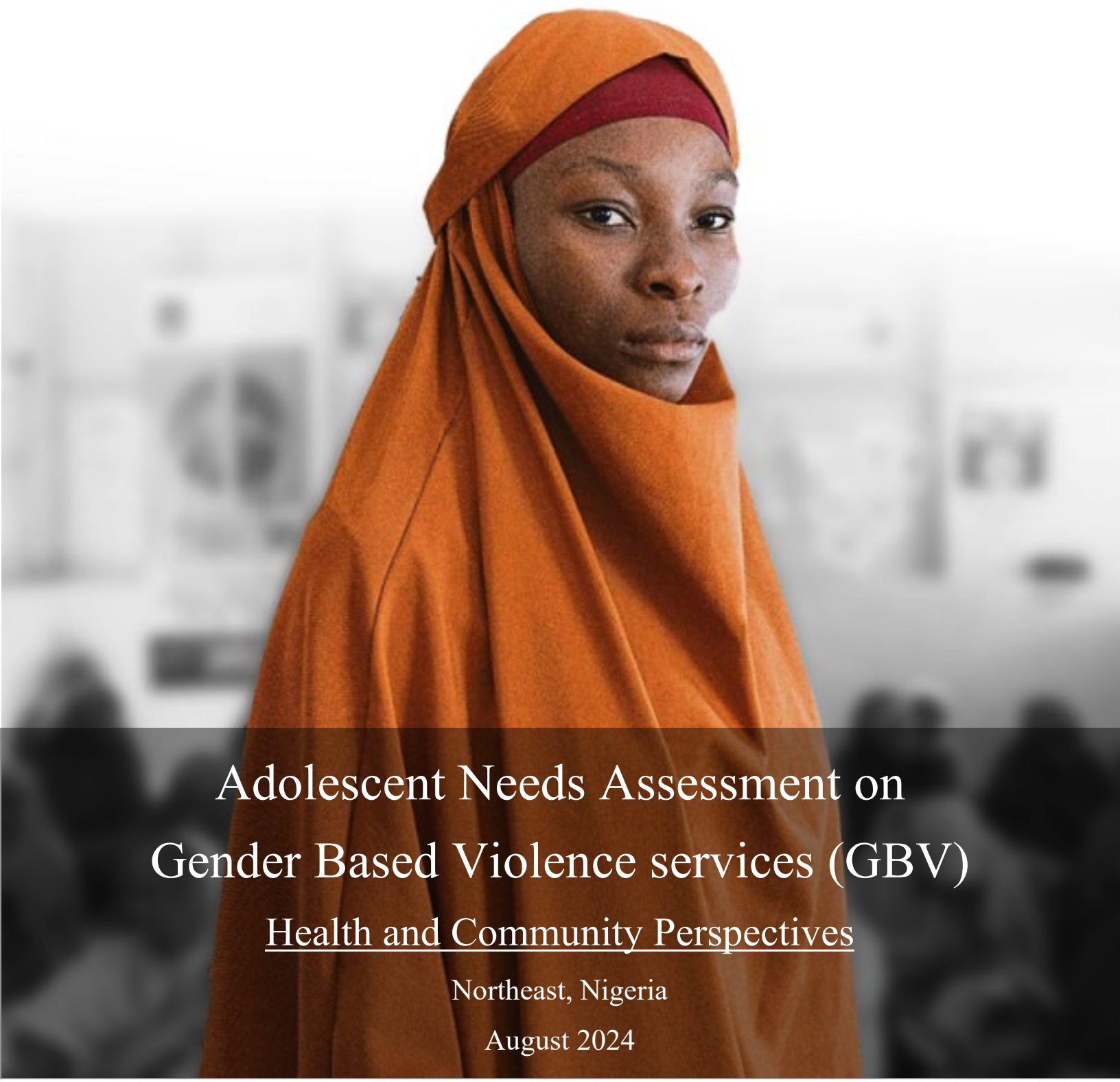
GBV Sub-Sector
Nigeria



Adolescent Needs Assessment on Gender Based Violence services (GBV)

Health and Community Perspectives

Northeast, Nigeria

August 2024

Contents

Disclaimer: The pictures in the report neither represent any GBV survivor nor HIV + patients, in the health facilities, safe spaces and communities (child, adolescent or youth). Prior consent has been taken by partners before capturing key programme interventions

Photo Credits: International Rescue Committee (IRC), Norwegian Church Aid (NCA), INTERSOS, EYN, GISCOR, AFREDEV, RHHF and PUI

ACKNOWLEDGEMENTS

The GBV AoR would like to express its deepest appreciation to all the partners in Borno, Adamawa, and Yobe (BAY) states, Northeast Nigeria, for their invaluable contributions in providing Adolescent Sexual and Reproductive Health (ASRH) services across fifty-nine health facilities. We also extend our sincere thanks for conducting insightful focus group discussions with women, girls, and boys, both at Women and Girls Safe Spaces and within communities.

We would also like to acknowledge with much appreciation the critical role played by healthcare providers and community mobilizers, whose dedication and full efforts were instrumental in achieving this important milestone. Your collaboration is essential in advancing the health and well-being of adolescents and in ensuring the integration of ASRH services within the GBV response. Thank you for your tireless commitment and continued partnership.

We would also like to extend our heartfelt thanks to following experts for their invaluable technical contributions.

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5. Mehtab, Saratu and Tersoo, IMMAP,
6. Dr Atika Jabeen, Research in Emergency Department, Hamad Medical Corporation, Qatar (LSHTM alumni)

Your expertise and guidance were pivotal in ensuring the quality and comprehensiveness of this assessment. We deeply appreciate your support and commitment to advancing ASRH services.

BACKGROUND

Nigeria is the most populous country in sub-Saharan Africa. It also has a very young population. The majority of the population is below the age of 25 years, with 22 percent of the country s population between the ages of 10-19 years. Data show that the average age at sexual debut is roughly 15 years of age among adolescent mothers in Nigeria. [1]

Adolescent girls face heightened risks of gender-based violence due to the interplay of age and gender, along with additional risk factors in emergencies. In order to better address ASRHR care access needs for young women and adolescent girls in NE Nigeria, greater insight was required into the needs and experiences of this population through quality assessment of key health facilities providing ASRH services, such as clinical management of rape services, prevention and management of STIs, including HIV, to women and girls subject to violence. The assessment also included barriers faced by women, adolescent girls and boys on availability of contraceptives, pregnancy, and abortion; intimate partner violence; and gender-based violence. The assessment has generated evidence to improve the delivery of ASRHR services for girls and young women subject to violence in North East Nigeria.

This assessment also provides complementarity to the review focused on adolescent girls in Northeast Nigeria. This review is first of it's a kind led by UNICEF and UNFPA's global teams. This Review is also an outcome of the High-level Roundtable in November 2023 hosted by the Emergency Relief Coordinator and the Call to Action on Protection from GBV in Emergencies (Call to Action), whereby UNICEF and UNFPA made a joint commitment to carry out an inter-agency multi-sectoral analysis in a humanitarian context to determine if and how adolescent girls' needs are being met. The review will highlight critical gaps and provide actionable recommendations to local, national, and global humanitarian stakeholders and will support advocacy efforts to improve the inclusion of adolescent girls' needs throughout the humanitarian programme cycle.

This Needs assessment report carried out by GBV AOR provides complementarity to the above-mentioned review. While the global review highlights a broad spectrum of needs; however, this local assessment has revealed immediate and high-priority gaps that require urgent attention by partners / sectors in NE Nigeria. The GBV AoR led assessment also provides evidence for state level policy change, while global review helps frame these needs within an international advocacy context. Together, they strengthen both local policy development and global advocacy efforts.

Methodology: The assessment employed three-pronged approach by conducting mapping of partners providing ASRH services,[2] evaluating ASRH services at the health facility levels (total: 59) [3]and understanding perceptions on ASRH at community levels (women, girls and boys) by conducting focus group discussions (#no of partners).

Tool 1: mapping and assessment of partners providing ASRH services *(Sexual and Reproductive Service Mapping Tool)*

[1] NDHS 2003, 2008, 2013

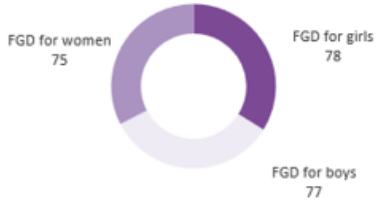
[2] Sexual and Reproductive Service Mapping Tool

[3] Health facility quality assessment for CMR and IPV services

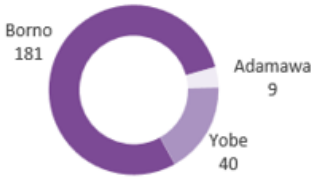
Tool 2: health facility assessment on ASRH services for GBV survivors will delve into following areas: *(Health facility quality assessment for CMR and IPV services)*

Tool 3: Focus Group Discussion and KII at community levels (*Engaging women and adolescent girls, boys and young people to understand their needs and perceptions on access to sexual and reproductive health information and services*

FGDs Conducted per population group



FGDs Coverage by State



Number of Partners per Assessment

FGDs	**INGO**	IMC, INTERSOS, IRC, MDM, NCA, PUI
	NNGO	AFRYDEV, AHSF, CCPRH, EYN, GISCOR, GREENCODE, GSF, LABDI, RHHF
MAPPING	**INGO**	CARE, FHI, IMC, INTERSOS, MDM, NCA, PUI,
	NNGO	AHI, AHSF, CCPRH, EYN, GEPADC, RHHF
HEALTH FACILITY ASSESSMENT	**INGO**	CARE, FHI 360, INTERSOS, IRC, MDM, NCA, PUI
	NNGO	AHI,AHSF, CCPRH, EYN, GREENCODE, RHHF

SECTION 1: MAPPING:

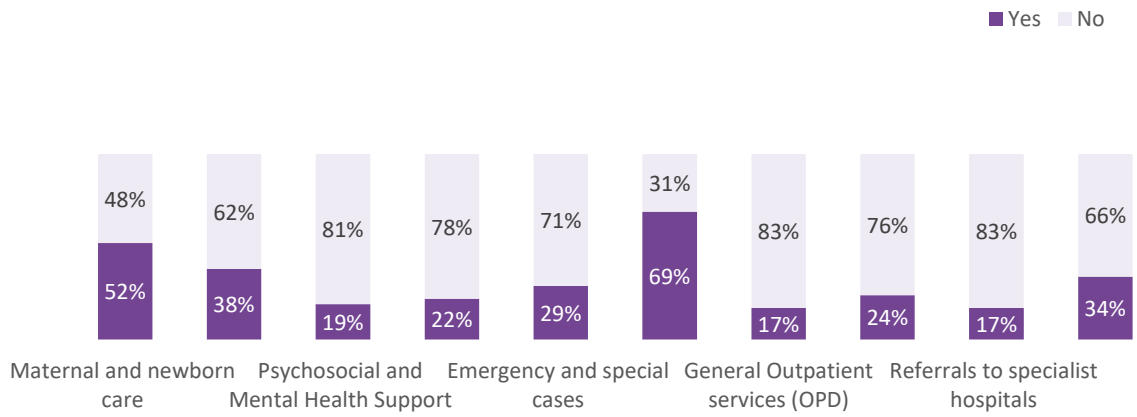
Findings

The assessment of the mapping of the distribution of service delivery points across different demographic groups suggests that the majority of service delivery points are targeted towards ***adolescent youth (91/283)***, followed by women, children, and other groups, with the ***smallest percentage dedicated to people living with disabilities***, including adolescent group.

The information provided by the partners suggests that **"Family Planning and Contraceptive Counseling"** is the most provided service, while **"Psychosocial and Mental Health Support"** is the least provided.

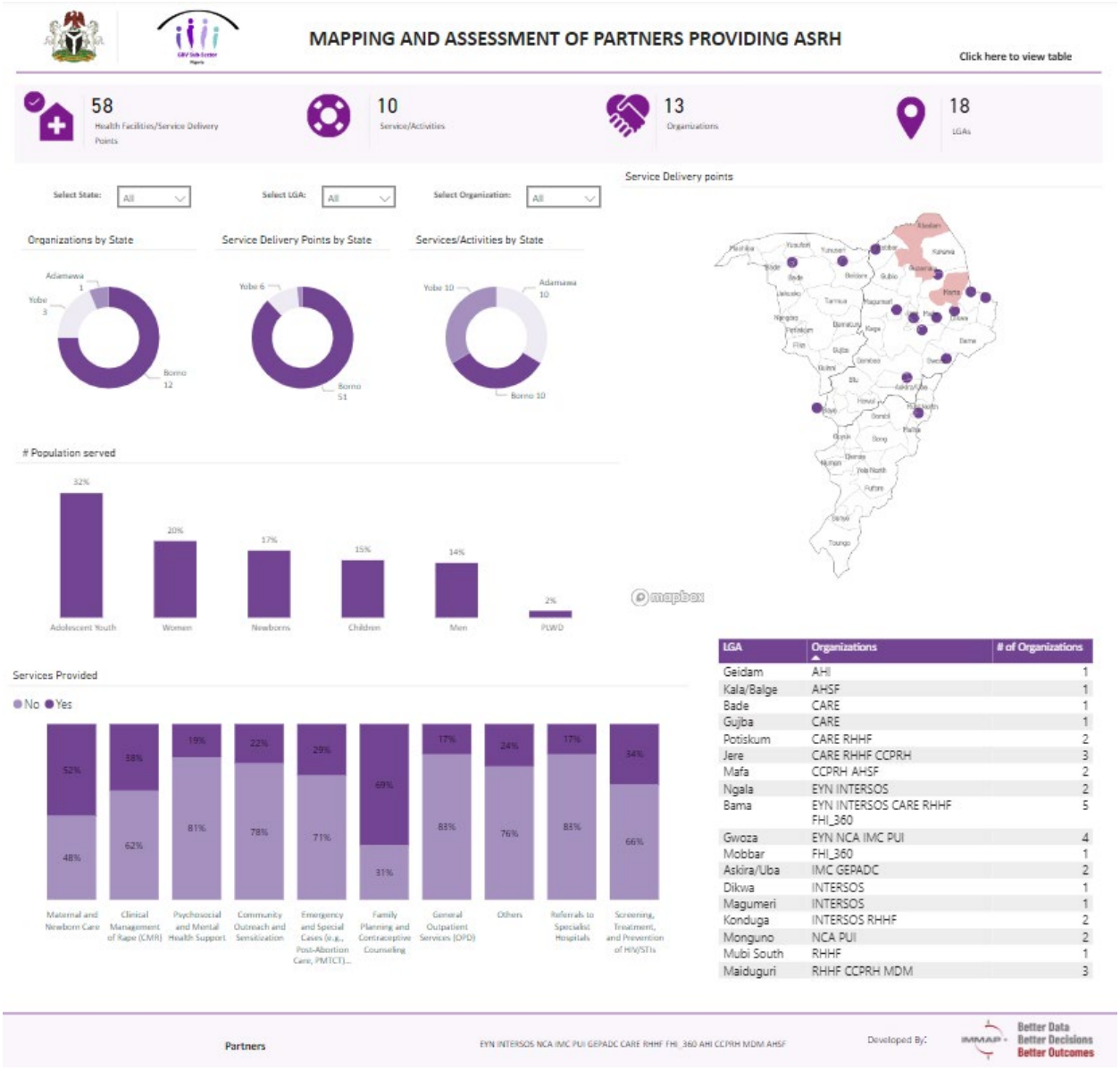
Only ***38% of health facilities are providing clinical management of rape survivors (CMR).*** indicating a significant gap in the availability of critical care for survivors of sexual violence. This shortfall can have serious implications, as timely and appropriate CMR is essential for addressing the physical and psychological needs of survivors, preventing further harm, and ensuring access to justice. Immediate and follow-up psychological care is crucial for survivors to cope with trauma, and low CMR coverage and psychosocial support (PSS) provision suggests that many GBV survivors might not receive this support.

Services Provided



The impacts of a lack of or inadequate provision of CMR include:

- Survivors may not receive timely or adequate medical care, increasing the risk of physical complications, sexually transmitted infections (STIs), and unintended pregnancies.
- Survivors may face untreated injuries and long-term health issues, including chronic pain, infections, and reproductive health problems.
- Exacerbate the psychological impact of GBV, leading to conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD).
- Lack of forensic examinations that are crucial for legal proceedings. Low availability means fewer survivors can access these services, hindering justice and accountability. The absence or scarcity of CMR services may discourage survivors from reporting incidents of GBV, perpetuating a cycle of violence and impunity.
- The low availability of CMR reflects broader systemic issues where GBV and women's health needs are not prioritized, perpetuating gender inequality.
- This also highlights potential gaps in prioritization of resource allocation, training, and infrastructure needed to support survivors effectively
- Due to the lack of CMR services, communities could perceive that health systems do not adequately support GBV survivors, which leads to lack of trust in the systems, affecting broader health-seeking behaviours.
- Also, the low focus on CMR may also indicate insufficient community outreach and education, leading to a lack of awareness about available services and support.
- The cumulative effects of inadequate GBV response services can lead to broader social issues, including increased violence, social fragmentation, and a lack of safety for women and girls.



LGA	Organizations	# of Organizations
Geidam	AHI	1
Kala/Balge	AHSF	1
Bade	CARE	1
Gujba	CARE	1
Potiskum	CARE RHHF	2
Jere	CARE RHHF CCPRH	3
Mafa	CCPRH AHSF	2
Ngala	EYN INTERSOS	2
Bama	EYN INTERSOS CARE RHHF FHI_360	5
Gwoza	EYN NCA IMC PUI	4
Mobbar	FHI_360	1
Askira/Uba	IMC GEPADC	2
Dikwa	INTERSOS	1
Magumeri	INTERSOS	1
Konduga	INTERSOS RHHF	2
Monguno	NCA PUI	2
Mubi South	RHHF	1
Maiduguri	RHHF CCPRH MDM	3

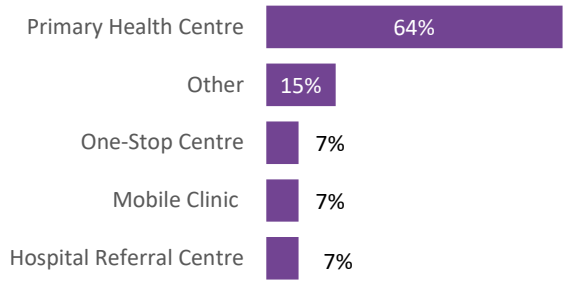
SECTION 2: HEALTH FACILITY NEEDS ASSESSMENT

Pre-counselling session with a client on family planning during a training session for health workers in Maiduguri, International Rescue Committee (IRC), August 2024

Findings

A comprehensive assessment was conducted by 14 local and international organizations across Borno, Adamawa, and Yobe (BAY) states. Most (85%) of the facilities were located in Borno state within 14 Local Government Areas (LGAs). In total, 59 health facilities located within 21 LGAs across three states were assessed. Most of these facilities were primary health care centers, which made up 64% of the total assessed.

Type of Health Facility



The health facility quality assessment tool was adapted by Norwegian Church Aid (NCA) by incorporating recommendations from WHO Clinical Management of rape and intimate partner violence survivors and GBV Quality assurance tool – Facilitation guide. This tool helped to ensure that health facilities are equipped and prepared to provide quality care and service for SV and IPV survivors services while adhering to minimum quality standards. The tools were available through the kobo platform, and was divided in 7 sections as described below:

1. General information
2. Protocol
3. Personnel
4. Furniture/Setting
5. Childcare adaptations
6. Supplies
7. Medications (with age-appropriate dosages)
8. Administrative supplies

The checklist included items defined as minimum to provide quality care to SV and IPV survivors, have a score, and upon application of the full checklist, it gave a final percentage to each partner with a message reporting if the health facility meets or not the minimum requirements. The overall score for the facility was calculated by summing up the scores across all the 27 mandatory question and divided by 27 then multiply it by 100 to get the percentage. Based on the total score, the facility was classified into performance categories. There are partners such as NCA who classify only 100 % scoring as a qualified health facility to provide CMR services. Any facility scoring less than 100 % are deemed not qualified to provide CMR services based on not meeting the minimum service quality criteria. The findings and subsequent scoring are presented below:

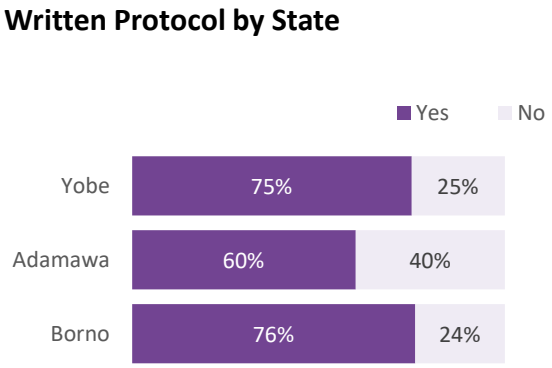
S/NO		LGA	ORGANISATION	NAME OF HEALTH FACILITY	SCORE
1	BORNO	Ngala	EYN	EYN /care	100.00%
2		Gwoza	EYN	Alheri Sardauna	96.00%
3		Gwoza	EYN	Pulka primary health care	74.00%
4		Bama	RHHF	RHHF One Stop Center, Bama, Borno State	81.00%
5		Konduga	RHHF	SRH/GBV	78.00%
6		Maiduguri	CCPRH	UNFPA	78.00%
7		Damboa	MDM	MDM MOBILE CLINIC	100.00%
8		Kala/Balge	AHSF	SRH	96.00%
9		Bama	EYN	EYN/CARE Primary health centre	96.00%
10		Maiduguri	RHHF	One Stop Center	89.00%
11		Maiduguri	RHHF	Integrated Health Facility	81.00%
12		Jere	CCPRH	El-Misnkin Transit	100.00%
13		Kala/Balge	AHSF	RANN PHCC CLINIC	89.00%
14		Monguno	NCA	FSP PHCC	78.00%
15		Monguno	NCA	General Hospital Monguno	81.00%
16		Jere	RHHF	Integrated Health Facility	89.00%
17		Gwoza	NCA	ZULUM PRIMARY HEALTH CARE	100.00%
18		Gwoza	NCA	PULKA PHC BALANGHELE	96.00%
19		Askira/Uba	GEPaDC	General Hospital	96.00%
20		Mafa	AHSF	Albarka health facility	52.00%
21		Gwoza	NCA	MCH PULKA	93.00%

22		Askira/Uba	GEPaDC	General Hospital Askira Uba	93.00%
23		Mafa	CCPRH	Ccprh mafa	89.00%
24		Dikwa	INTERSOS	General Hospital Dikwa	85.00%
25		Dikwa	INTERSOS	PHC Bulabulin	85.00%
26		Maiduguri	CCPRH	CCPRH Bolori1	22.00%
27		Dikwa	INTERSOS	Rabiri PHC	85.00%
28		Dikwa	INTERSOS	MCH Bama	85.00%
29		Bama	INTERSOS	INTERSOS Health post at Gssss IDP Camp	85.00%
30		Ngala	INTERSOS	PHC AJARI , GAMBORU NGALA	85.00%
31		Konduga	INTERSOS	PHC Dalori , 250 housing estate	85.00%
32		Askira/Uba	GEPaDC	Rumirgo Model Primary Health Care	93.00%
33		Ngala	INTERSOS	PHC HOYO	85.00%
34		Magumeri	INTERSOS	MCH Magumeri	89.00%
35		Maiduguri	CCPRH	Integrated health facility CCPRH	100.00%
36		Bama	EYN	Ex-bording health centre	70.00%
37		Mobbar	Fhi360	Fhi360 PHC	100.00%
38		Bama	FHI360	FSP Clinic	100.00%
39		Mobbar	FHI360	FHI360 / PHC	100.00%
40		Dikwa	GREENCODE	ICRC and GREENCODE	89.00%
41		Monguno	PUI	Gana Ali PHCC	96.00%
42		Monguno	PUI	ALGON PHCC, Monguno	96.00%
43		Monguno	PUI	Waterboard Clinic	96.00%
44		Gwoza	PUI	Damara	96.00%
45		Gwoza	PUI	Zulum PHC	96.00%
46		Jere	CARE	Cimari mobile clinic	89.00%
47		Bama	CARE	SOYE CLINIC	85.00%
48		Dikwa	GREENCODE	GREENCODE	100.00%
49		Dikwa	GREENCODE	GREENCODE	96.00%
50		Konduga	IRC	International Rescue Committee	93.00%
51	ADAMAWA	Madagali	IRC	Kirchinga PHCC	96.00%
52		Michika	IRC	Bazza Tssukumu PHC	81.00%
53		Mubi South	RHHF	Monica Chinda	93.00%
54		Yola North	IRC	Wuro Hausa PHC	78.00%
55		Yola South	IRC	Wuro Jabbe PHC	81.00%
56	YOBE	Gujba	CARE	Khadija Ahmad Yusuf	81.00%
57		Gujba	AHI	Hauwa Abdullahi	89.00%
58		Gujba	EYN PROJECTS	Kaltum Umar Baba/CARE International	96.00%
59		Potiskum	RHHF	OSC	81.00%

Personnel and medical protocol

The results show the availability and compliance with healthcare protocols, trained personnel, and gender-sensitive care practices within the examined healthcare facilities. For example, 75% of respondents indicated that they have written Medical Protocol for treating GBV survivors. When we analysed this

finding across the three states assessed, 76% of the facilities in Borno state have written medical protocol with 75% in Yobe and only 60 % have it in Adamawa.



75% of respondents also indicated that they have with trained Local Health-Care Professionals who are rostered on a 24/7 On-Call System (83%) and 100 % of the health facilities have a Female Health-Care Provider or Companion During Examination.

1. **Written Medical Protocols**: The majority of healthcare facilities (75%) have documented medical protocols in place for treating GBV survivors, which is a critical component for ensuring standardized and consistent care for GBV survivors.
2. **Trained Local Health-Care Professionals with 24/7 On-Call System**: Eighty three percent of facilities (83%) have trained professionals available around the clock, ensuring that survivors have access to necessary medical care at any time.
3. **Female Health-Care Provider or Companion During Examination**: All facilities reported the presence of a female healthcare providers (100%) or companion during examinations.
   Out of the 59 health facilities 83% stated that they do have trained employees when asked if they have medical professionals or staff who can provide healthcare services for GBV survivors. All facilities also reported having female medical professionals who are proficient in the local language and available to provide treatment and care to GBV survivors. This is a positive indicator of the facilities' ability to cater to the diverse linguistic and gender-related needs of the local population.

Observations

The availability of personnel and protocols is crucial for timely interventions, especially in cases requiring immediate attention, such as emergency contraception and post-exposure prophylaxis (PEP). However, having trained staff, established health protocols, and the availability of female healthcare providers without providing Clinical Management of Rape (CMR) services presents several significant implications particularly as survivors of rape and sexual violence require immediate and specialized care ideally within 72 hours to address physical injuries, prevent STIs, including HIV, manage potential pregnancy, and provide psychological support. The absence of CMR services means that survivors are denied these critical interventions, leading to untreated injuries, increased risk of infections, and long-term psychological trauma.

If healthcare providers are trained in CMR but unable to apply their skills to provide CMR services, this represents a misallocation of resources. The investment in training is not fully realized, and the knowledge and skills of the providers remain underutilized. Healthcare facilities have an ethical obligation to provide comprehensive care to survivors of GBV. Not offering CMR services despite having the necessary resources and protocols in place could be seen as failing to meet this responsibility.

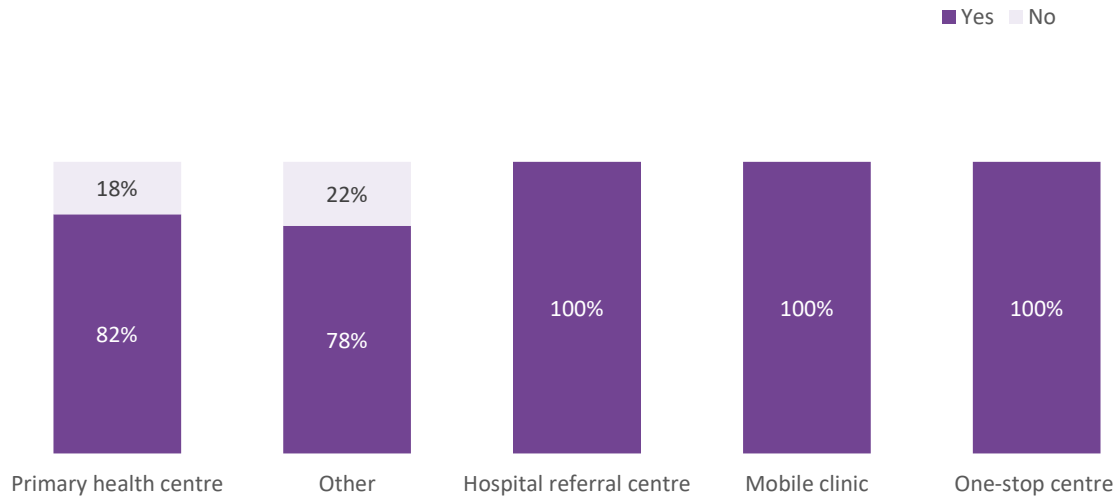
The absence of CMR services may weaken the overall response to GBV. Effective GBV response requires a coordinated effort across multiple sectors, including health, legal, and social services. Without CMR, the GBV response to the needs of the adolescents is incomplete, hindering a comprehensive approach to survivor care.

Most of the services to meet the needs of the adolescents are through primary health care centres (PHC). The PHCs are typically the most important level of health facility for access to CMR for GBV survivors, as they are usually the first point of contact for survivors. If they are not equipped to provide immediate medical care, including emergency contraception, post-exposure prophylaxis (PEP) for HIV, treatment for sexually transmitted infections (STIs), and psychological first aid, they are leaving a huge gap in service provision and are putting a huge burden on the higher-level facilities like Hospital Referral Centres (tertiary) offering more specialized services. Also, the referrals to other specialised services for livelihood, access to justice, mental health psychosocial support, will be weak.

Furniture/Setting

Among the 59 health facilities assessed, 85% reported that they have a clean, comfortable, quiet, accessible consultation room, with four walls and a door, curtain or screen where the patient cannot be seen or heard from the outside. Of the five health facilities assessed in Adamawa state, and four health facilities in Yobe state, 100% stated they have this type of consultation room. Whereas, 82% in Borno state indicated having this type of consultation room. Therefore, 18% of the health facilities assessed in Borno State (approximately 9 facilities) do not have designated consultation rooms equipped to conduct physical examinations or handle sensitive consultations, such as those related to rape and IPV. The absence of such facilities in a significant proportion of health centers impacts the quality and privacy of care provided to patients, highlighting an area that requires urgent attention and improvement.

Availability of Consultation Room of Health Facility



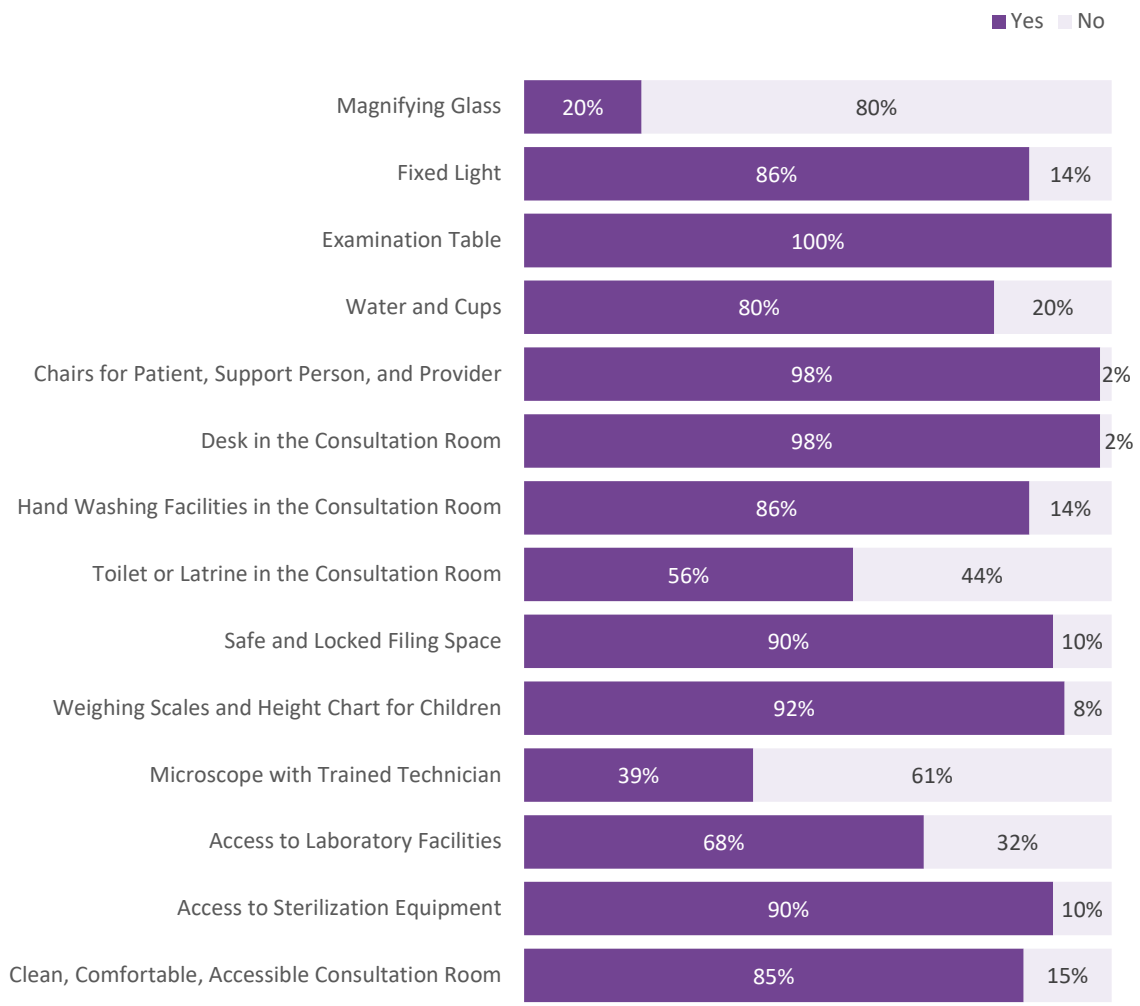
Of the health facilities that reported having a consultation room, 44 % indicated that there is no latrine inside the consultation room. This could present challenges, particularly in maintaining hygiene standards and privacy during patient consultations/ examinations. 86% of the health facilities that have private consultation rooms reported having functional hand washing facilities in the consultation room. This is a positive indicator for infection control practices, though there is room for improvement to ensure all facilities are equipped.

When it comes to furniture in the consultation room, all the health facilities have examination table, while 98% have a desk and 98% have a chair for the patient, support person and service provider inside the consultation rooms. With regards to drinking water and cup for survivor, 80% of the facilities provide this in the consultation room. 90% of the assessed health facilities reported that they have a safe and lockable cabinet where files are kept confidential.

86% of the 59 health facilities have a fixed examination light or torch that is utilized during physical examination for GBV survivors. Whereas only 20% of the total health facilities have a magnifying glass for close examination and disclose structural features that would otherwise be undetectable. 92% of the assessed health facilities have weighing scales and a height chart for children.

Of the total assessed health facilities 90% have access to an autoclave, to sterilize medical equipment. With regards to access to laboratory services, 68% of the facilities reported having access to these services, enabling them to conduct necessary tests and diagnostics. Whereas only 39% of the facilities have microscopes with skilled technicians. This can lead to delays to send samples to labs causing a gap in diagnostic capability which limits the effectiveness of healthcare delivery, particularly for complex cases requiring detailed analysis.

Furniture/Settings



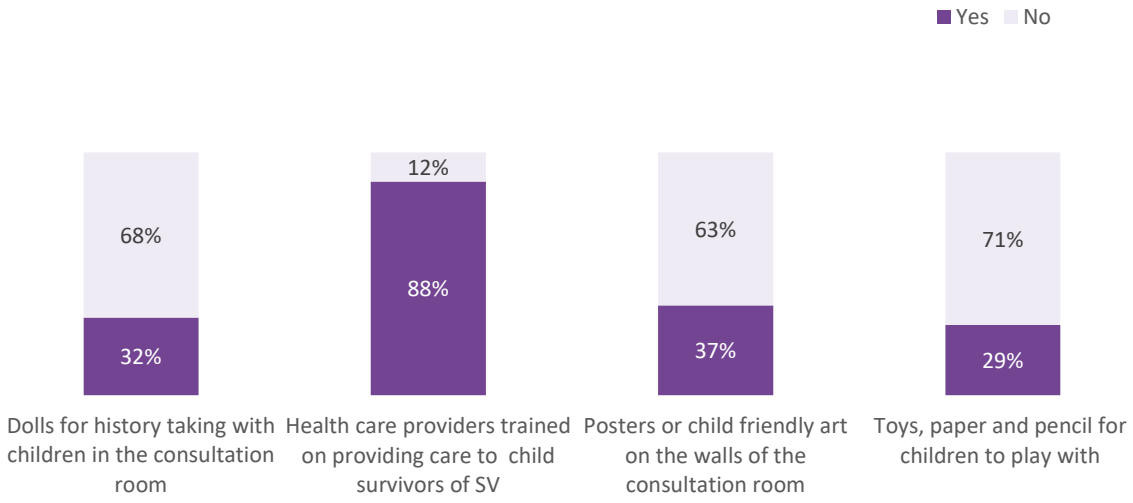
Childcare Adaptation

Among the health facilities assessed, 88% reported having medical care and service providers who are trained in delivering care specifically for child survivors of sexual violence. This high percentage indicates a strong commitment to addressing the needs of this vulnerable population across the majority of facilities. All five health facilities assessed in Adamawa State confirmed that they have medical personnel trained in caring for child survivors of sexual violence, demonstrating full compliance with training requirements in this region.

The assessment indicates that 37 % of surveyed health facilities' consultation rooms are decorated with child-friendly artwork and paintings. These visual elements are important in creating a welcoming and comforting environment for child survivors, helping to reduce anxiety and foster a sense of safety during consultations.

Despite the importance of tools like dolls for facilitating history-taking with child survivors, 68% of the surveyed health facilities reported a lack of such resources. This represents a significant area for improvement, as dolls can be essential for helping children communicate their experiences in a non-threatening way. With regards to creating a conducive environment for child survivors, 32% of the surveyed health facilities indicated that there are toys available for use by child survivors.

Child Care Adaptations



Medical Supplies and Medication

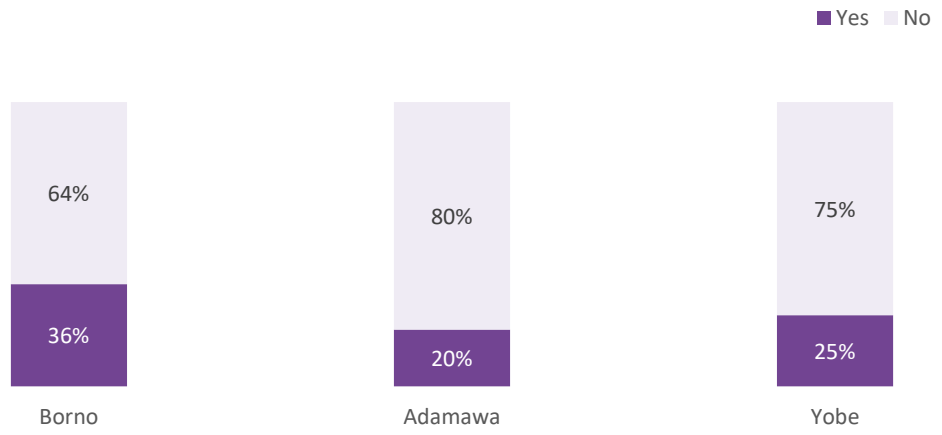
The assessment of health facilities revealed a high level of preparedness in terms of medical supplies and equipment necessary for providing comprehensive healthcare services. All surveyed health facilities (100%) reported having the necessary supplies for universal precautions, such as gloves, to ensure the safety of both patients and healthcare providers. This demonstrates a strong commitment to maintaining hygiene and preventing transmission of infections. With regards to sharp disposal, 97% of the facilities have boxes for the safe disposal of sharp and contaminated objects, highlighting an effective approach to handling medical waste and minimizing risks of accidental injury or infection.

76% of the surveyed health facilities are equipped with resuscitation equipment, which is essential for responding to medical emergencies and stabilizing patients in critical conditions. 86% of facilities reported having tourniquets, butterfly needles, venipuncture tools, and blood collection tubes.

A significant number of health facilities (90%) have the necessary wound care supplies, including bandages, dressings, sterile gauze, and sterile gloves. For the repair of tears and sutures, 95% of the facilities confirmed the availability of sterile medical equipment kits. Whereas 88% of the facilities have measuring tapes available to assess the extent of bumps, lacerations, and other physical injuries accurately.

Concerning forensic evidence collection, only 34% indicated that it is feasible to collect evidence. Of which, the majority of surveyed facilities lack most of the equipment needed. This represents a significant gap, particularly in supporting GBV survivors by providing the necessary evidence for their legal cases during the legal proceedings.

Forensic Evidence by State



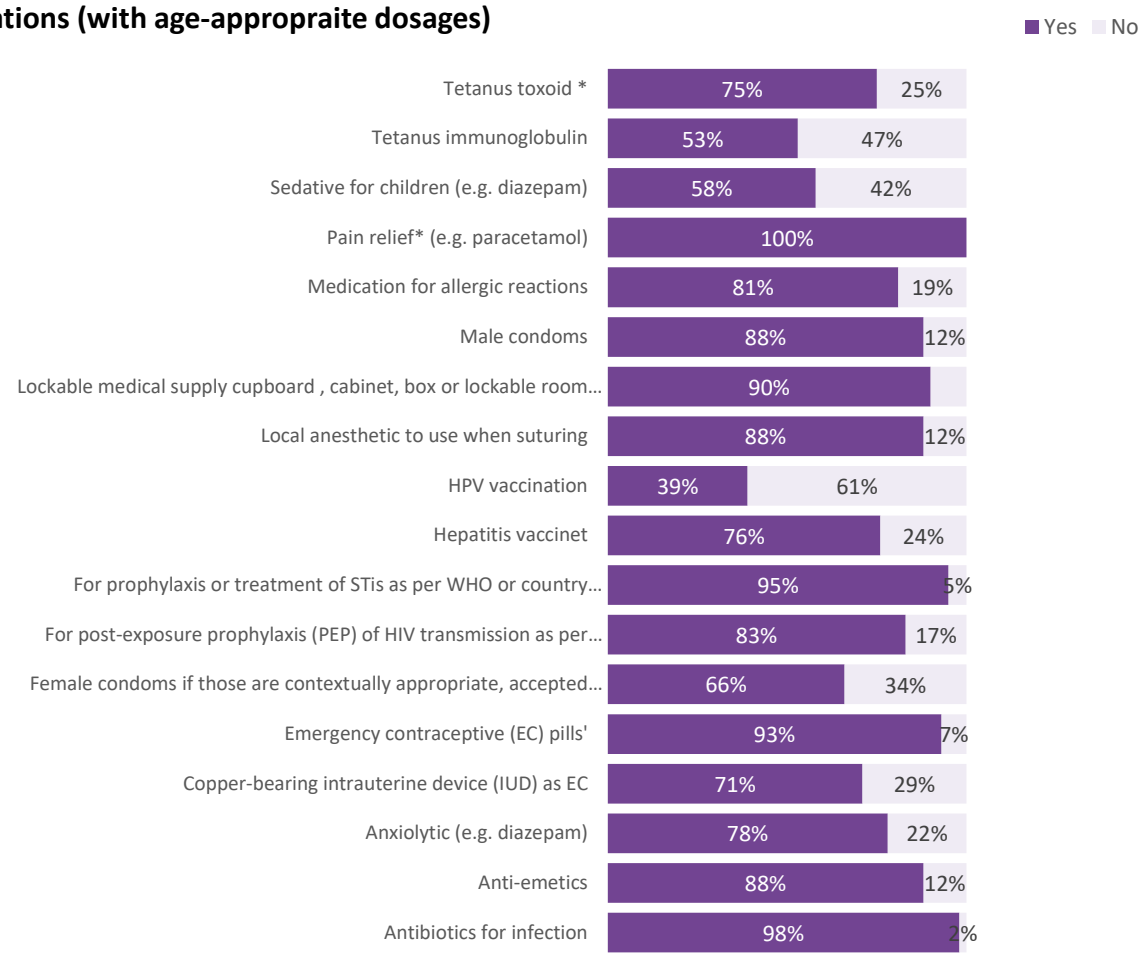
Among the surveyed health facilities, 58% reported a lack of spare clothing items for survivors to change into when necessary. On a positive note, 90% of the facilities indicated that they have disposable sanitary pads available to provide to GBV survivors as needed. Additionally, 71% of the facilities have gowns or clothes/sheets to cover survivors during examinations.

Thermometers are available in 93% of the surveyed health facilities, while 95% have blood pressure cuffs and stethoscopes. All the facilities surveyed offer pregnancy testing. In terms of sexually transmitted disease testing, 81% of the facilities have HIV testing kits, and 86% have rapid syphilis testing kits available during the assessment period. However, only 56% of the facilities have an otoscope. Additionally, only 25% of the facilities have a pregnancy calculator disc for determining gestational age. This limited availability suggests that many facilities may lack tools for accurately assessing gestational age, which can impact prenatal care and planning. At the time of the data collection for this assessment, 85% of the surveyed facilities have urinalysis kits.

Medications (with age-appropriate dosages)

Availability of relevant medication for prevention and treatment of STI including HIV was also an area of concern to this assessment. In line with this, 95% of the surveyed health facilities stated that they have prophylaxis or treatment of STIs as per WHO or country protocol. Additionally, 83% of the facilities have post-exposure prophylaxis (PEP) for HIV transmission as per WHO or country protocol and 93% of the facilities have emergency contraceptives. The majority (75%) of the facilities indicated that they have Tetanus toxoid, while 53 % have Tetanus immunoglobulin. Finally, 76% of the facilities have indicated having access to Hepatitis B vaccine.

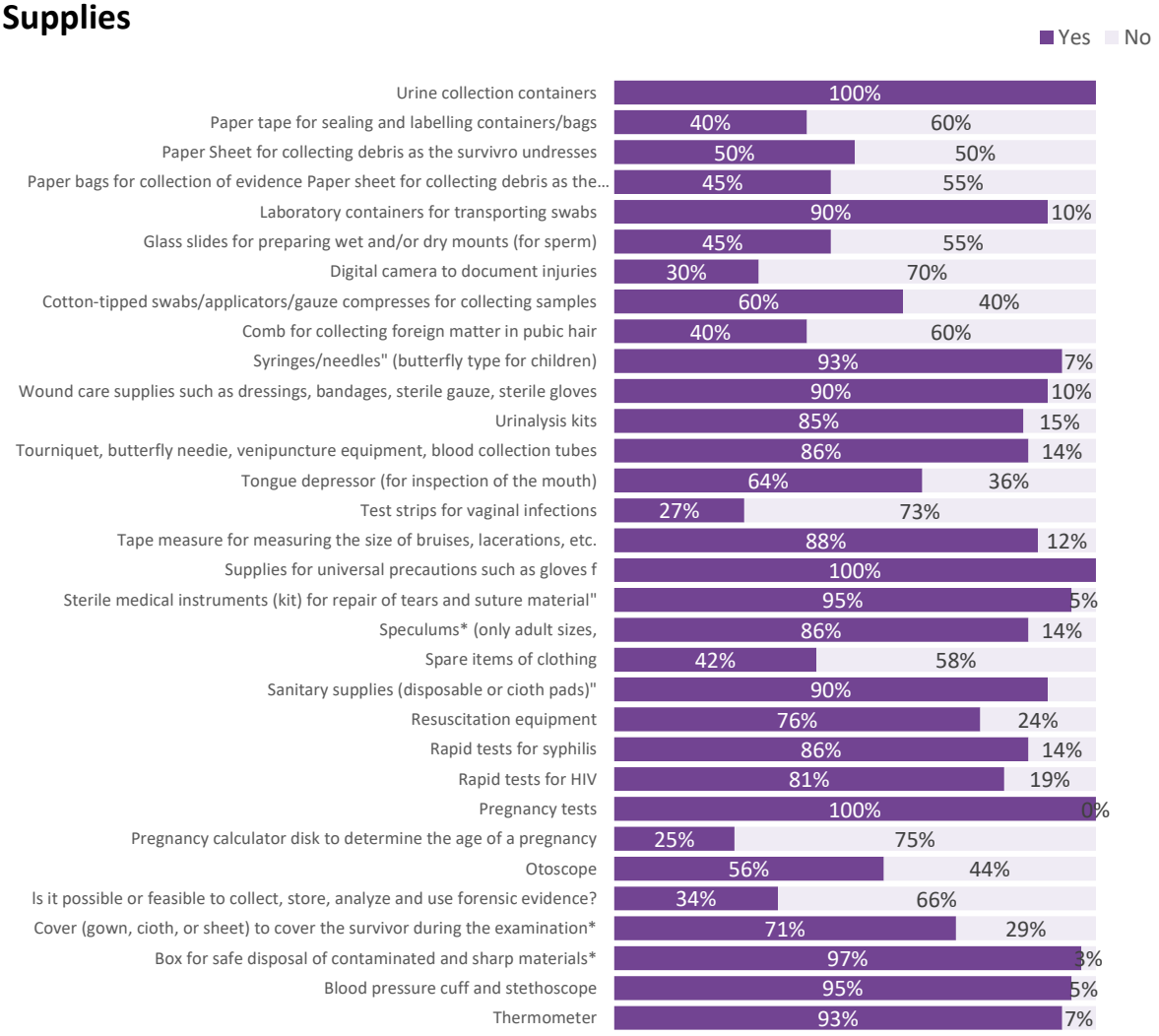
The assessment of health facilities revealed insights into the availability of medications for pain relief, infection treatment, allergic reactions, and preventive measures. Pain relief is available in all the facilities whereas antibiotics for infection treatment and medication for allergic reaction are available at 98%, 81% of the health facilities respectively. 78% of the facilities have anxiolytics and 58% of the facilities have sedative both for children and adults. 88% of the assessed facilities have local anaesthetics to use when suturing. In relation to the HPV vaccination, only 39% of the facilities have it in stock. The majority, (88%) of the surveyed facilities have male and female condom.



Administrative Supplies

Medical examination, and history-taking forms, including pictograms, are accessible in 71% of the health facilities. 92% of the health facilities indicated that they have system in place to check on a monthly or quarterly basis to monitor stock, whether medicines, vaccines, and tests are within validity/expiration date, safely discard those that have expired, or order new medications. With regards to consent forms, 92% of the health facilities indicated that they had them during the data collection period and 92% indicated having referral pathways in place. Only 37% of the health facilities amongst the 59 health facilities indicated having medical certificate/medico legal forms. This finding coupled with the lack of forensic evidence collection and preservation reveals the gap in supporting GBV survivors in their legal proceedings.

Supplies


Yes
No
Urine collection containers 100%
Paper tape for sealing and labelling containers/bags 40% 60%
Paper Sheet for collecting debris as the survivro undresses 50% 50%
Paper bags for collection of evidence Paper sheet for collecting debris as the... 45% 55%
Laboratory containers for transporting swabs 90% 10%
Glass slides for preparing wet and/or dry mounts (for sperm) 45% 55%
Digital camera to document injuries 30% 70%
Cotton-tipped swabs/applicators/gauze compresses for collecting samples 60% 40%
Comb for collecting foreign matter in pubic hair 40% 60%
Syringes/needles" (butterfly type for children) 93% 7%
Wound care supplies such as dressings, bandages, sterile gauze, sterile gloves 90% 10%
Urinalysis kits 85% 15%
Tourniquet, butterfly needie, venipuncture equipment, blood collection tubes 86% 14%
Tongue depressor (for inspection of the mouth) 64% 36%
Test strips for vaginal infections 27% 73%
Tape measure for measuring the size of bruises, lacerations, etc. 88% 12%
Supplies for universal precautions such as gloves f 100%
Sterile medical instruments (kit) for repair of tears and suture material" 95% 5%
Speculums* (only adult sizes, 86% 14%
Spare items of clothing 42% 58%
Sanitary supplies (disposable or cioth pads)" 90%
Resuscitation equipment 76% 24%
Rapid tests for syphilis 86% 14%
Rapid tests for HIV 81% 19%
Pregnancy tests 100% 0%
Pregnancy calculator disk to determine the age of a pregnancy 25% 75%
Otoscope 56% 44%
Is it possible or feasible to collect, store, analyze and use forensic evidence? 34% 66%
Cover (gown, cioth, or sheet) to cover the survivor during the examination* 71% 29%
Box for safe disposal of contaminated and sharp materials* 97% 3%
Blood pressure cuff and stethoscope 95% 5%
Thermometer 93% 7%

SECTION 3: FOCUS GROUP DISCUSSIONS:

FGD findings: Adult women and adolescent girls

Main health service needs

In the focus group discussions (FGDs) with adult women, 23% of participants identified gender inequality and domestic challenges as their primary concerns regarding life for women in the assessed area. Meanwhile, 29% of adolescent participants highlighted the lack of educational and economic opportunities as the main challenge for adolescents living in these areas. For adolescents, parental influence and responsibility were mentioned by 12% of respondents, followed by cultural and social expectations at 11%. For adult women, poverty was the second most mentioned challenge at 20%, with economic and livelihood hardships following at 17%. The remaining 40% of responses from adult women pointed to limited educational and employment opportunities, safety concerns, inequality and lack of access to health services. ***One of the participants said, "As adolescent girls, life has been different. Only few of us can afford school, most of us hawk, farm and sew caps to support the family. Some of us are orphans and have to go to farms for money to feed our younger ones"*** Among adolescent girls, 48% expressed concerns about health and sanitary challenges, sexual abuse, and general safety and security.

Among the adult women participating in the focus group discussions (FGDs), 20% identified infections and communicable diseases as their primary health challenge. While sexual and reproductive health as well as maternal health was identified by 20% of respondents. This was followed by 13% who mentioned chronic health conditions and general health issues, and 12% who cited malaria and vector-borne diseases. Lack of health care facilities and services as well as nutritional needs are another concern mentioned by FGD by 22% (11% each response) of the adult participants. Mental health needs and access to medication were barriers mentioned by 15% of adult women FGD responders. For the same question during FGD with adolescent girls, 28% of responders mentioned that menstrual hygiene management is the major problem

they have while 21% of them indicated STI to be the main health challenge and 23% also indicated that access to health facilities and sexual reproductive health services are the health needs in their respective community. Unintended pregnancy, nutrition, and wellness were also mentioned during the discussions with adolescent girls.

During the FGDs with adult women, 59% of respondents identified sexually transmitted infection (STI) including HIV was a consequence of unwanted/ unprotected sexual activity while 28% of responders mentioned unintended pregnancy and 11% of respondents also mentioned unsafe abortion, reproductive health complications and emotional & social results of unprotected sexual activity. Similarly, 49% of adolescent FGD respondents mentioned that sexually transmitted infection including HIV as a consequence of unwanted/ unprotected sexual contact. While 30% of responders identified unintended pregnancy and unsafe abortion while 12% of responders indicates emotional consequence and other health problems.

With regards to early marriage in the 15 LGAs of BAY states, 54% adult women FGD participants indicated that poverty, cultural and traditional norms to be main reasons. Additionally, 29% responders indicated that lack of education and unintended pregnancy as contributing factor for child marriages while 11% respondents indicated family pressure and lack of alternative opportunities. Whereas 56% adolescent girls FGD participants indicated that poverty, cultural and traditional practice contributes to early marriage while 25% of respondents mentioned that fear of unintended pregnancy as well as lack of education contributes to early marriage. ***The girls mentioned during the FGDs that "Girls who have dropped out of school are getting married forcefully at an early age and hawking on the streets and some are having sexual affairs". Others said that "they feel bitter about life, have low self esteem as so many engage in prostitution which results in pregnancy leading to unsafe abortion".***

Adult women FGD participants mentioned that health complication and increase in maternal mortality and morbidity were also the consequences of early marriages. Additionally, 26% of respondents mentioned psychological and emotional distress, as well as the impact on education and career opportunities.

SRH Service Need

Adolescent girls were asked to describe the SRH needs and demands within their community. Among the respondents, 26% identified a general shortage of healthcare services and infrastructure as a significant issue, pointing to the broader challenges in accessing adequate SRH care. Additionally, 18% highlighted the need for access to comprehensive sexuality education, indicating a gap in the information and resources necessary for making informed decisions about their sexual health. Another 11% of the respondents emphasized the need for better access to menstrual hygiene management products, reflecting a crucial aspect of SRH that is often overlooked. The girls also mentioned the need for family planning services, STI prevention and treatment, and the need for stronger community support and sensitization around SRH issues. "***Unwanted pregnancies are a problem for adolescents in our community. The lack of proper menstrual hygiene management items and the challenges of dealing with unintended pregnancies contribute to the difficulties we face in managing our health and daily lives".*** These insights suggest a multifaceted demand for improved SRH services that go beyond just medical care, encompassing education, resources, and community involvement.

Similarly, adult women in the FGD expressed concerns about the limited availability and quality of SRH services in their communities. The majority, 24%, mentioned a limited availability of services in general, reflecting widespread challenges in accessing essential SRH care. Additionally, 16% of the women pointed out the inadequacy of medication and supplies, which further hindered their ability to receive proper services. The distance to healthcare facilities was also a significant barrier, with 13% of respondents stating that the facilities are too far away, making access difficult. Financial constraints were mentioned by 11% of the women, indicating that the cost of services is a prohibitive factor for many. Furthermore, 7% of the respondents mentioned the inconsistency in the availability of SRH services, underscoring the need for more reliable and continuous care.

These responses from both adolescent girls and adult women highlight the complex and interconnected challenges they face in accessing adequate SRH services. The need for improved infrastructure, comprehensive education, affordable resources, and consistent service delivery is evident, pointing to areas where targeted interventions could significantly improve the overall well-being of the community.

Knowledge on SRH Related Issues

Adolescent girls were asked “If someone your age got an STI, what would they do?” 66% of respondents said that they should seek medical care while 13% of them mentioned using traditional or local remedies whereas, 14% of respondents noted that they should consult trusted adult or/ and go to GBV case workers and other individuals (god mothers, parents, peers). Only 2% of respondent indicated that they are not aware about the solutions to such challenges. Additionally, 43% adolescents’ girls who attended the FGDs, said that some one who thought about being pregnant, should seek medical care. 26% indicated that they should consider abortion and confide to trust an adult to seek advice and support. 9% adolescent girls mentioned to opt leaving their communities or getting married to the perpetrator.

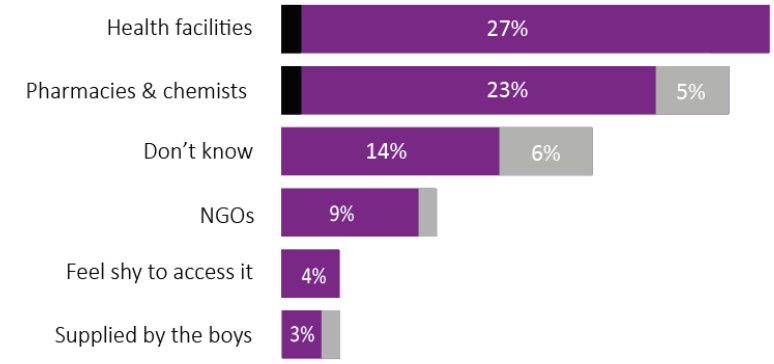
Adult women were asked to describe the impact of unintended pregnancies on young girls in their respective LGAs. The majority (38%) of adult women mentioned school dropouts and an increased risk of STIs,

including HIV, while 12% cited heightened economic dependency. Other concerns raised during the discussion included the loss of childhood, stigma, forced marriages, and psychological impacts. ***As said by the participants, "people look at you with disrespect, people look at you as spoiled child. Due to disrespect the girls end up in aborting the pregnancy and it might leads to death and further stigmatization".***

Information on available SRH services

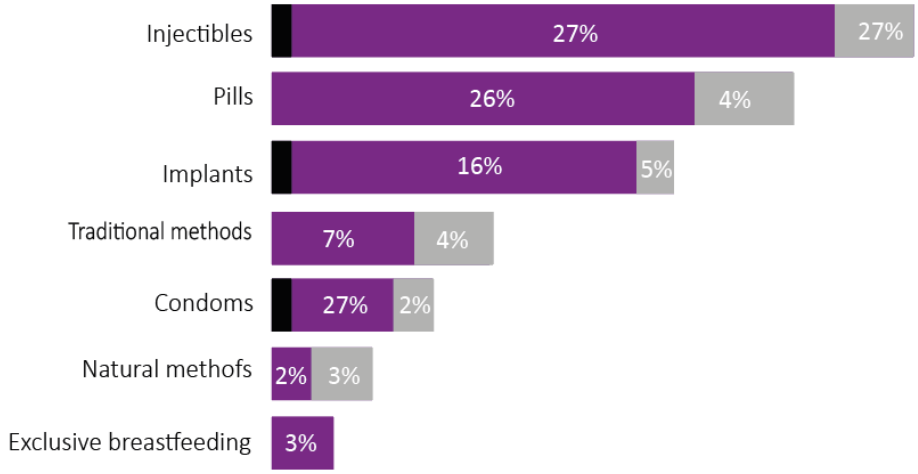
Regarding knowledge of where to obtain condoms, 62% of adolescent girls participating in the FGDs indicated that condoms are available at health facilities and pharmacies. However, a significant portion, 21%, stated that they were unaware of where to access condoms. Additionally, 10% of the respondents mentioned that NGOs in their area distribute condoms. Some participants expressed feeling too shy to obtain condoms themselves, while others noted that boys typically supply them. These findings highlight gaps in awareness and accessibility, as well as cultural barriers that may hinder safe sexual practices among adolescent girls.

Sources of Condoms for Someone Your Age



Injectables appeared as the most preferred family planning method, with 30% of adult women identifying it as their preferred choice. Following closely, 25% of participants mentioned oral contraceptive pills as their primary method of family planning. Implanon, a long-acting reversible contraceptive, was noted by 19% of the women. Additionally, 8% of participants mentioned the use of condoms, 5% relied on natural methods, and 3% practiced exclusive breastfeeding as a form of contraception. Furthermore, 10% of the women indicated that they use traditional methods for family planning. ***As quoted by women: we don't want family planning due to fear of the side effects. We prefer traditional methods such as withdrawal***

Typical Family Planning Methods in the Community by Category



Similarly, among adolescent girls, 31% indicated a preference for oral contraceptive pills, while 27% favored injectables. Condoms were preferred by 17%, 11% chose implants, and 4% mentioned traditional methods. Notably, 9% of the participants stated that they were unaware of available family planning methods. These findings reflect varying levels of awareness and access to contraceptive options among different age groups

In the FGDs, 52% of adult women reported that various family planning methods are accessible at health facilities. Meanwhile, 21% noted that these services are available at community health centers, and 14%

mentioned pharmacies or chemists as sources. Additionally, 8% of participants identified NGOs as providers of family planning options, while a smaller group, (4%) indicated that they obtained such services from herbalists. The assessment revealed that adolescent girls also have similar information when it comes to where to access these family planning method. 42% indicated that these FP methods are accessible at the health facilities, 19% said at the pharmacy while 13% stated NGOs provide these services. These responses suggest a diverse range of sources for family planning methods, reflecting varying levels of accessibility.

32% of the adult women who participated in the FGDs indicated that menstrual hygiene management (MHM) products are usually found in the market. Additionally, 24% reported receiving these through NGOs and another 20% said they improvise or use old clothes. Some women also mentioned hospitals and pharmacies as sources for these products.

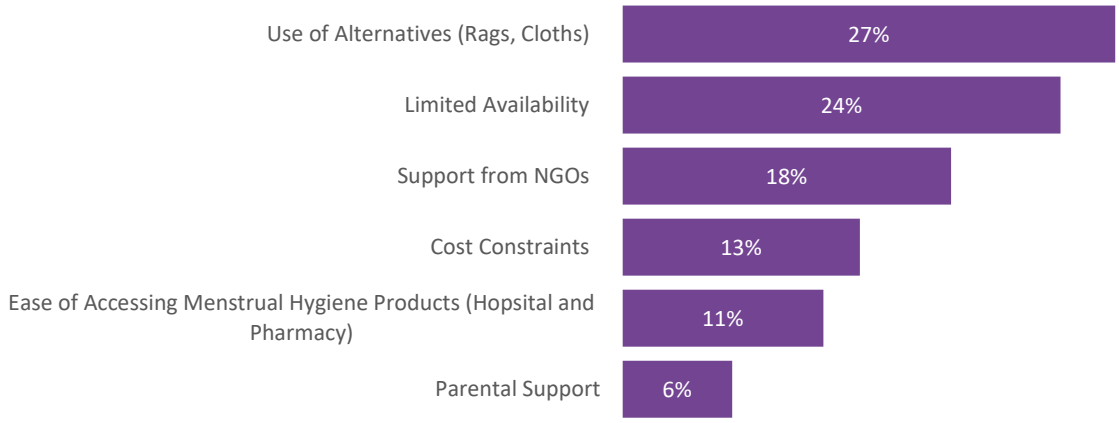
Consequently, when female adolescents were asked the same question on MHM, most of them (34%) mentioned being helped by NGOs while a third (32%) identified them with commercial outlets. Furthermore, 16% of the girls said that these products can be found at home,11% revealed they use home made reusable / disposable pads and 6% stated they find them at the health facilities.

These findings show different ways in which adult women and girls access menstrual hygiene products indicating differences in accessibility, economic circumstances and support networks among others. They also reveal areas where further intervention and support would be beneficial especially in improving access to affordable and adequate menstrual hygiene products such as reliance on NGO support or need for improvisation.

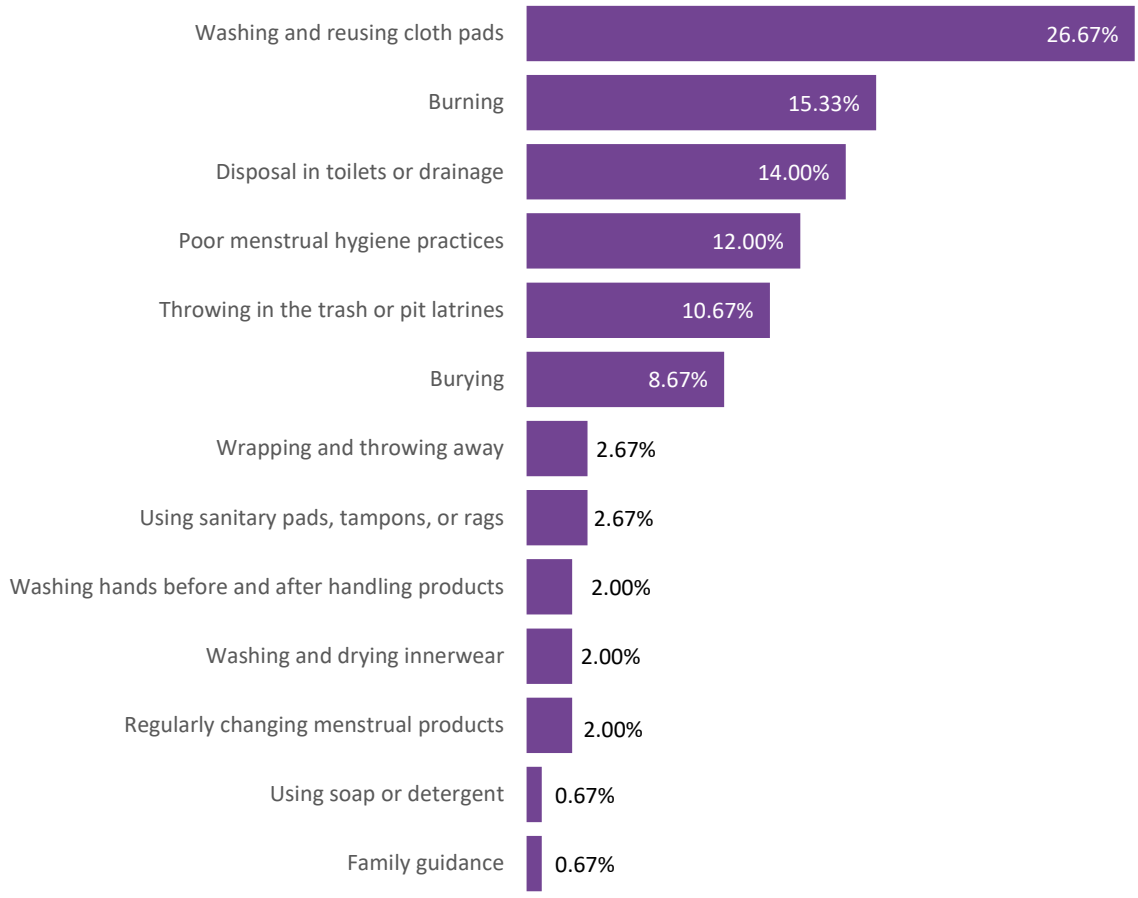
Menstrual Hygiene and Management (MHM) Items

Of all adolescent girls who took part in FGDs, 35% admitted that they received education about personal hygiene and menstrual hygiene management at school. This indicates that a significant portion of either curriculum or extra-curricular activities at certain schools is embedded with vital aspects of this topic. 19% confirmed that they have learned about sexual health and safe practices. Only 6 percent responded that nothing was taught about reporting issues and seeking help when necessary, showing a potential gap in empowering students with knowledge and confidence to address sensitive issues concerning their sexuality. Contrarily, a substantial number (19%) of adolescent girls disclosed not being educated on SRH subjects at their respective schools. This finding underlines a considerable discrepancy between schools regarding the provision of SRH education thereby resulting in many adolescents being without the necessary information to guide them to make informed decisions about their reproductive health and well-being. In general, the reactions from FGDs disclose the strengths and weaknesses that are in the current ways that schools teach on SRH. For instance, there are students who gain knowledge on menstrual hygiene management and safe sexual practices while others are left with no guidance which might have a lifetime impact on their health and safety.

Ease of Access to Menstrual Hygiene Products



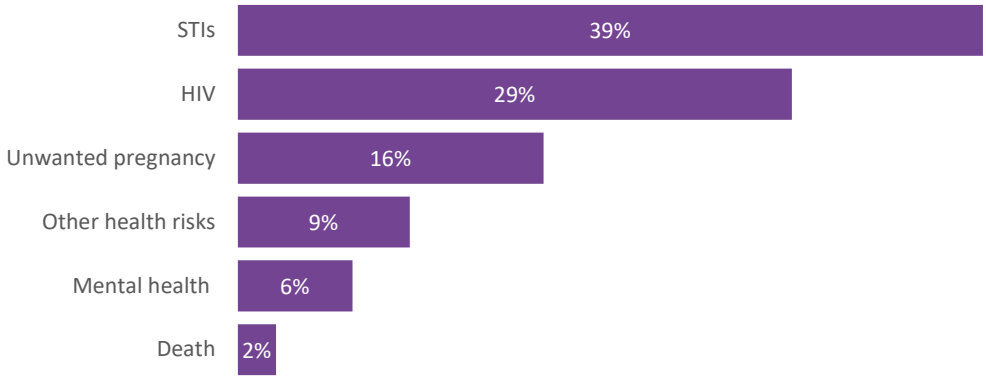
Menstrual Hygiene Practices and Disposal Methods Among Adolescents in the Community



ADOLESCENT BOYS

- Seventy-one (71%) of adolescent boys were not fully understand or recognize the risk of HIV transmission through unprotected sex. This low level of awareness is concerning, given the seriousness of HIV as a health issue.
- Only thirty-nine (39%) of adolescent boys were aware of the risks associated with unprotected sex, particularly the risk of contracting STIs. However, this also means that 61% may not be aware or fully understand this risk, indicating a knowledge gap
- With only 16% aware, the vast majority (84%) of adolescent boys may not understand the basic consequences of unprotected sex, specifically the risk of causing or contributing to an unwanted pregnancy. This lack of awareness is alarming, given that unwanted pregnancies can have significant social, economic, and health implication
- This low level of awareness might reflect broader issues related to gender dynamics, where discussions about pregnancy prevention are often targeted more toward girls than boys. It's important to ensure that boys are equally educated about their roles and responsibilities in preventing unwanted pregnancies.
- The low awareness could also be influenced by cultural factors, where conversations about pregnancy and contraception may be stigmatized or considered taboo for boys. Overcoming these cultural barriers is essential for effective education.

Awareness of Health Problems Resulting from Unwanted or Unprotected Sexual Activity



Recommendations

The statistics above underscores the need for comprehensive SRH education that covers not only STIs but also explicitly addresses HIV transmission and prevention., unwanted pregnancies, mental health, and the long-term consequences of unprotected sex. Programs targeting adolescent boys should focus on increasing awareness and understanding of STIs and other related risks to encourage responsible sexual behavior and reduce the incidence of STIs among this demographic. Programs should focus specifically on educating adolescent boys about HIV, how it is transmitted, and how it can be prevented. This could involve school-based education, community outreach, and media campaigns tailored to this age group. The low percentage of awareness might also reflect social and cultural barriers that prevent open discussions about HIV and sexual health. Understanding and addressing these barriers is essential for effective communication and education.

CHAPTER 4: BARRIERS TO ADOLESCENT INCLUSION

1. **Lack of Confidential Services and Information**
   Several locations report a significant issue with the lack of confidential services and insufficient information available to adolescents. In Gwoza, Pulka Primary Health Care, Zulum Primary Health Care, Transit, and Damara Camp, there is a consistent problem with the lack of separate, confidential service provision rooms and a shortage of supplies and commodities. Similarly, Monguno's General Hospital, Ajari Clinic, Gana Ali PHCC, ALGON PHCC, and Waterboard PHCC all face challenges related to inadequate confidentiality and supply issues. Jere's Integrated Health Facilities, Mairi Clinic, Galwas Clinical and Diagnosis Center, and Amanah-Healthcare Clinic also report similar difficulties. In Damboa, facilities such as Rukayya Modu, Magaji Kolo, Yarima Haji, and Amina Mustapha face barriers related to the lack of available adolescent-specific services.
2. **Stigmatization and Fear of Exposure**
   Stigmatization and fear of exposure are major barriers affecting adolescents in multiple regions. In Ngala, facilities like PHC Ajari report that stigma and fear of community judgment prevent adolescents from accessing contraceptives. Bama faces similar issues with its RHHF One Stop Center, and Ex-Bording Health Centre. Potiskum's One Stop Center, P.H.C.C. Tudun Wada, P.H.C.C. Yarimaram, P.H.C.C. Yindiski, P.H.C.C. Dogon Zare, and other facilities also cite stigmatization as a key barrier. Dikwa's General Hospital, PHC Rabiri, and Primary Health Care Dikwa facilities report similar challenges related to fear of exposure.
3. **Parental Consent and Legal Barriers**
   Parental consent requirements and legal barriers significantly impact adolescents' access to health services. Bama's Nguro Soye Primary Health Centre and Askira/Uba's General Hospital and Rumirgo Model Primary Health Care are examples where legal restrictions and the need for parental consent create barriers. Monguno's Family Support Clinic and PHC Damara also face challenges due to similar legal constraints.

4. **Financial Constraints**
   Financial constraints were reported as a notable barrier for adolescents in accessing health services. For example, in Potiskum, facilities such as the One Stop Center and P.H.C.C. Yarimaram reported financial issues that affect service accessibility. Bama's Ex-Boarding Health Centre and Family Support Clinic also experienced financial constraints. Maiduguri's Integrated Health Facility Center for Comprehensive Promotion and Reproductive Health and Fatima Ali Sheriff Primary Health Care also highlighted the same.
5. **Lack of Youth-Friendly Services**
   The absence of youth-friendly services has been reported a recurring issue in certain areas. Gwoza's Pulka Primary Health Care, Zulum Primary Health Care, Transit and Damara Camp were some of the examples of facilities which lacked youth-specific service provisions. Maiduguri's Integrated Health Facility Center for Comprehensive Promotion and Reproductive Health also reported similar gaps.
6. **Ignorance and Lack of Awareness**
   Ignorance and lack of awareness about available services were prevalent barriers in several locations. Bade's AFRYDEV GBV center as well as Dikwa's Primary Health Care Dikwa and Geidam's Asheikri PHCC, all report issues related to insufficient awareness and information. Gujba's CARE International and Buni Gari PHCC also highlighted these barriers.
7. **Inadequate Infrastructure and Supplies**
   There was notable shortages of essential drugs, post-abortion care kits, and contraceptives such as LARC, medications for SRH-related issues, and general medical supplies. Facilities such as Pulka Primary Health Care, Zulum Primary Health Care, Doro Camp, PHC Damara, PHC Rabiri, PHC Potiskum, PHC Bula, Gana Ali PHCC, and ALGON PHCC reported these shortages as well.
8. **Cultural and Religious Beliefs**
   Cultural and religious beliefs also play a crucial role in limiting adolescents' access to health services. Maiduguri's GTS Camp Clinic and Integrated Health Facility Center for Comprehensive Promotion and Reproductive Health, as well as Monguno's Family Support Clinic and PHC Damara, and Askira/Uba's General Hospital and Rumirgo Model Primary Health Care, all cited cultural and religious beliefs as barriers to service access.

Limitations and Challenges

1. **Data Quality issues:** There have been data quality issues which led to some discrepancies such as incomplete data, errors in data entry, duplication of data entry at the source levels – health facility and mapping. Some partners failed to meet the deadlines for submission of tools resulting in data that could have impacted the accuracy of data and information. The submissions have also been different for locations and type of tool viz-a-viz selection made during the planning meetings.
2. **Differing priorities and organizational mandates:** The assessment was led by GBV AoR, however, the clinical management of rape survivors' services is dedicated to health and sexual and reproductive health (SRH) partner**s.** Therefore, these partners have distinct mandates or organizational priorities leading to GBV and SRH teams working in parallel within the same organization. The teams who were responsible for both GBV and SRH mandates within the same organization have been observed to be more responsive in their submissions.
3. **Differing definitions of "Quality":** Partners have different definitions of what constitutes high-quality healthcare for GBV services. For example, one partner has focused on availability of clinical services like CMR, while others emphasize psychosocial support which could also be due to limited funding or funding focused only on SRH (family planning and maternal health). These varying perspectives created discrepancies and inconsistency between the health facility data and the mapping.
4. **Reliance on Self-Reporting:** The health facility Quality assessments relied on self-reported data from facility staff / partners, which has introduced biases by overstating their abilities or the quality of care they provide, especially with a perception that the assessment could influence future funding, training opportunities, or partnerships. (e.g., the number of facilities offering CMR services), partners may have focused on achieving these metrics at the expense of a more nuanced understanding of service quality, which could have led to biased reporting. This pressure led to biased reporting, especially when real challenges such as low service uptake or staff burnout, commodity stock outs exist in NE Nigeria,
5. **Conflicts of Interest:** Partners funding specific health facilities being assessed may be reluctant to report poor quality services due to conflicts of interest. For example, an NGO providing technical support to a facility might be less likely to highlight serious service gaps in order to avoid criticism of its own work.
6. Variation in Geographical focus this assessment was conducted in Borno, Adamawa and Yobe (BAY) – three different states with local variations in GBV incidents, cultural norms, and service availability. The geographical spread of partners across three states with a much focus on Borno State.
7. **Lack of Independent Verification:** GBV AoR could not independently verify the data provided by the partners, instead relied on the reports provided by the facility personnel or Managers. This lack of verification could have resulted in biased reporting.

Recommendations

GBV Area of Responsibility (AoR) would like to provide recommendations on to address the intersection of ASRH and GBV. By incorporating these recommendations, stakeholders can improve health services for adolescents and address critical issues like GBV. This will enhance the effectiveness of interventions and contribute to the overall well-being of adolescents in conflict-affected areas in BAY:

GOVERNMENT: The following recommendations focus on policy and program commitments to ensure a coordinated and effective approach by Ministry of Health (MOH), Ministry of Education (MOE), Ministry of Justice (MOJ), and Ministry of Social Welfare and Women Development (MOSWD). Each of these government authorities play a critical role in the prevention and response to GBV and in addressing the specific needs of adolescents in humanitarian settings. By working together and focusing on their respective areas of expertise, they can create a more effective and coordinated response to GBV, ensuring that adolescents receive the support and protection they need.

Also, given the ongoing discussions on durable solutions by the Borno State Government, it's indeed essential to emphasize the role of the Ministries in funding Adolescent Sexual and Reproductive Health (ASRH) services. In regions like Borno, where the population—especially adolescents—faces heightened vulnerabilities due to conflict, displacement due to camp closures, and limited access to essential services, ASRH services should be a critical component of durable solutions.

Ministry of Health (MOH) should

- Commit to sustained funding for adolescent GBV prevention and response programs, ensuring that services are adequately resourced and available across the BAY states.
- Allocate resources for capacity building of service providers to improve the quality of care and support they offer to adolescent GBV survivors, including healthcare workers, social workers, and law enforcement personnel.
- Create specific laws and policies addressing GBV among adolescents, distinct from broader VAPP

Act and child protection (CP) laws, to ensure the unique needs of adolescents are adequately covered.

- Formulate policies to actively recruit and deploy female healthcare providers to government health facilities, particularly in areas with high demand for GBV and ASRH services.
- Offer incentives such as financial bonuses, housing allowances, and career development opportunities to encourage female healthcare professionals to work in underserved or conflict-affected areas
- Increase funding specifically for the procurement of medical supplies and equipment needed for GBV response and ASRH services. This includes emergency contraception, STI treatment, menstrual health products, post rape kits / PEP kits and other essential items.
- Ensure that ASRH related data from health facilities are aligned with State Primary Health Care Agency (SPHCA) health information systems and strategies to support government's durable solutions commitments. This can help with the integration of ASRH data into broader health and social services planning. (caveat: the Adolescent data was out of scope of the assessment)

Ministry of Education (MOE):

- Ensure Comprehensive SRH Education and GBV Prevention in Schools by introducing comprehensive sexuality education (CSE) in schools, which includes age-appropriate information on sexual and reproductive health, consent, gender equality, and GBV prevention. This should be part of the national curriculum and adapted to the BAY context.
- Include awareness-raising programs on GBV prevention and adolescent rights in educational settings, helping adolescents recognize abuse, seek help, and understand their rights.
- Governments should support teacher training programs on GBV prevention and intervention, ensuring educators can identify signs of GBV, provide support, and make appropriate referrals.

Ministry of Justice (MoJ) should:

- Facilitate access to legal aid and justice for Adolescent GBV Survivors by ensuring that adolescent survivors of GBV have access to free legal aid and support throughout the justice process, including legal representation, court advocacy, and support in navigating the judicial system.
- Implement specialized judicial procedures for adolescents, such as child-friendly courtrooms, to reduce re-traumatization and ensure their participation in legal proceedings is handled sensitively.
- Criminalize all forms of GBV against adolescents and ensure that perpetrators are held accountable. This should include provisions that recognize the particular risks faced by adolescent girls and boys

Ministry of Social Development and Women Affairs (MOSWD) should:

- Expand Social Protection Programs for Adolescent Survivors by providing social protection and economic empowerment programs for adolescent GBV survivors, including cash transfers, vocational training, and educational opportunities, to reduce their vulnerability and dependency.
- Create reintegration programs for adolescent survivors, helping them re-enter school or the workforce, ensuring that they can rebuild their lives after experiencing violence.
- Ensure that survivors of GBV have access to social services such as food security, housing support, and healthcare, as part of a comprehensive response to their needs.

Health Sector and Sexual and Reproductive Health Working Group:

- Address the low availability of CMR services is crucial for ensuring comprehensive care for GBV survivors. This requires increased investment by GBV partners to provide CMR supplies, adequate

training of health providers, strengthen referral linkages and community outreach to create an environment where survivors feel supported and can access the care they need.

- Partners are suggested to look into qualitative issues like survivor satisfaction, staff attitudes, or the quality of care provided. This will avid reporting that overstates the effectiveness of the facility without addressing underlying service quality issues. Encourage staff to focus on data quality as well and not just quantity. This means ensuring the collection of accurate, reliable, and actionable data, rather than simply collecting data on supplies, medications, equipment provided. Also, to use and triangulate data sources (e.g., health facility and focus group discussions from women and adolescent girls and boys) to ensure ASRH services address the needs and priorities highlighted by this group. This will also reduce the risk of biased reporting. Promote transparency in reporting, encouraging partners to report both successes and challenges openly. Incorporate independent audits or third-party evaluations to verify reported data and assess the accuracy of self-reported information.
- Develop an action plan to fill the identified gaps and areas for improvement in service delivery for survivors and conduct regular assessments (six-monthly)
- Support the development of feedback mechanisms that allow adolescents and communities to respond to the findings of this assessments and contribute to future improvements.
- Develop IEC material and job aids for health workers, GBV case managers, and community volunteers on the specific SRH needs of adolescents. Special focus should be given to clinical management of rape (CMR) for adolescent survivors and post-exposure prophylaxis (PEP) access.
- Provide capacity building for GBV responders to ensure they understand how ASRH intersects with GBV and how to support adolescent survivors effectively.
- Use the findings from ASRH assessment to advocate for targeted funding for adolescent-specific GBV and SRH services. Data should highlight gaps in service provision, particularly around access to emergency contraception, safe abortion (where legal), and menstrual hygiene supplies.

Child Protection AoR: The unavailability of dolls in health facilities, can significantly impact the quality of care and support provided to children. Dolls are often used in therapeutic settings to help children express their feelings and experiences, particularly in cases of trauma or abuse.

- Develop Guidelines for partners and health authorities to develop guidelines that include dolls as part of essential therapeutic and diagnostic tools in health facilities, particularly those dealing with children and survivors of GBV
- Ensure that the procurement policies of health facilities explicitly include dolls and other other child-friendly materials to health facilities in their inventory for child protection and therapeutic purposes, especially in areas with high needs.
- Provide training and IEC material for health providers / partners on how to effectively use dolls in therapy and counselling with children, especially in cases of trauma or abuse.

GBV Area of Responsibility:

- Develop and include ASRH-specific indicators in existing GBV assessment tools. Indicators could cover areas such as access to contraception, sexual health services, antenatal care, and menstrual hygiene management (MHM).
- Ensure that indicators capture the unique vulnerabilities of adolescents, including barriers they face in accessing services and exposure to harmful practices like child marriage or FGM.
- Work closely with the health, education, and child protection sectors partners at state and LGA levels to ensure a multi-dimensional approach to ASRH in GBV assessments. This will help to identify gaps in services like youth-friendly health centers, psychosocial support, and safe spaces.

- Coordinate with humanitarian actors focusing on SRH, such as IRC, FHI 360, NCA, PUI, MDM, RHHF etc, to ensure alignment and comprehensive coverage of ASRH issues.
- Develop and disseminate job aids and IEC material, in collaboration with SRH and health partners on topics suggested by adolescent women, girls and boys and young people in this assessment (see previous chapters)
- Conduct GBV needs assessment in BAY

Donor Community:

- Support programmes and interventions that track changes in adolescents' sexual and reproductive health outcomes over time, rather than relying solely on data and assessments. This will provide insights into the long-term effectiveness of interventions and how adolescent needs evolve.
- Encourage partners to include follow-up mechanisms that check in with adolescents after the assessment to evaluate how they are benefiting from the services and how their sexual and reproductive health is being impacted by the interventions.
- Fund partners to assess intimate partner violence (IPV) among adolescents, as this is a critical yet often overlooked aspect of ASRH
- Ensure that partners are held accountable for the quality of their programmes and the subsequent use of the data through assessment. Require transparent reporting on the methods used, potential biases, and any limitations in the findings.

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