Share-Net
International
The Knowledge Platform on
Sexual and Reproductive Health & Rights

KNOWLEDGE PRODUCT (TOOLKIT) FOR MANAGING AND IMPROVING QUALITY OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS SERVICES IN FRAGILE AND HUMANITARIAN SETTINGS DURING COVID-19 AND FUTURE EPIDEMICS

COMMISSIONED BY SHARE-NET INTERNATIONAL THROUGH SUPPORT TO BALANCED STEWARDSHIP DEVELOPMENT ASSOCIATION (BALSDA) AND ORGANISATION FOR HEALTH IN SUSTAINABLE DEVELOPMENT (OHISD)

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Source: Women's UN Report Network

Commissioned by Share-Net International through support to Balanced Stewardship Development Association (BALSDA) and Organization for Health in Sustainable Development (OHISD)

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Finally, we are convinced that this valuable knowledge product will provide useful information to improve SRHR in the context under review in Nigeria, Cameroon and beyond.

ACRONYMS AND ABBREVIATIONS

Acronym	Meaning
AIDS	Acquired Immunodeficiency Syndrome
ACT	Artemisinin Combination Therapy
ANC	Antenatal Care
ART	Anti Retroviral Therapy
AYFSRHR	Adolescent and Youth Friendly Sexual and Reproductive Health
BALSDA	Balanced Stewardship Development Association
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHEW	Community Health Extension Workers
CHW	Community Health Workers
CORPs	Community Oriented Resource Persons
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
DHIS	District Health-management Information Software
EmOC	Emmergency Obstetric Care
FGM	Female Genital Mutilation
FMOH	Federal Ministry of Health
GBV	Gender Based Violence
GHSC	Global Health Supply Chain
HBC	Home Based Care
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IDP	Internally Displaced Person

IEC	Information, Education and Communication
IMAI	Integrated Management of Adolescent and Adult Illness
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IPV	Intimate Partner Violence
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual
LMIC	Low and Middle Income Countries
MDG	Millenium Development Goals
MM	Maternal Mortality
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MVA	Manual Vacuum Aspiration
NACA	National Agency for the Control of AIDS
NARHS	National Reproductive Health Survey
NPC	National Population Commission
NDHS	National Demographic Health Survey
NPHCDA	National Primary Healthcare Development Agency
OHISD	Organization for Health in Sustainable Development
OOP	Out Of pocket
NPC	National Population Commission
PHC	Primary Health Care
PMTCT	Prevention of Mother To Child Transmission of HIV
PPE	Personal Protective Equipment
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goals
SDH	Social Determinants of Health

SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
UNSCR	United Nations Security Council Resolution
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WFH	Women For Health
WHO	World Health Organization

ABOUT THIS TOOLKIT

This knowledge product (toolkit) uses information synthesized from research to provide programmatic guidance to help provide, improve on and maintain essential preventive, promoting and curative sexual and reproductive health and rights (SRHR) information and services in fragile/humanitarian settings during the COVID-19 pandemic outbreak period, as well as other epidemics in the future. The toolkit helps identifying population vulnerabilities, peculiarities of the target population, identified program gaps, and showcases research evidence for best practices, lessons learnt from other pandemics and general guidance for the continuation of sexual and reproductive health (SRH) services, information and infection prevention and control.

WHO THIS TOOLKIT IS MEANT FOR

This toolkit is meant for all stakeholders working in fragile countries that require humanitarian assisstance. It cuts across funding and donor organizations, multinational organizations, philantropists and all organizations who fund and support programs among these communities. It is also useful for SRHR program planners, implementers, aid and humanitarian program managers as well as health workers working among women and young people in these environments. It is also useful to governments at Federal, State and Local government levels as well as all the Ministries, Departments and Agencies that cut across Maternal, Neonatal, Newborn and Child health in low and middle income countries (LMICs). The National Centers for Disease Control and Ministries of Health at all levels will benefit from its guidance for infection control and SRH service delivery among these special communities. Civil Society Organizations (CSOs), Researchers, Community Resource Persons and community leaders will find it a useful resource before, during and after pandemics.

BACKGROUND

The SRHR parameters in Nigeria and Cameroon show room for improvement and neither of the two countries were able to meet the Millennium Development Goals (MDGs) due to multiplicity of health systems, political and systemic challenges (Sachs et al, 2005). Both Nigeria and Cameroon have been affected by

the Boko Haram insurgency that started in 2009, but have as well experienced civil unrests and internal crises that have disrupted the lives and well-being of their citizens, leaving behind internally displaced persons, fragile systems and societies needing humanitarian support. In Nigeria, the Northwest is most affected, while the North is affected in Cameroon. The other parts of Nigeria and Cameroon that are considered as fragile and humanitarian communities are found in the South-South and parts of the North Central (OCHA, 2019).

The implications of the COVID-19 pandemic and the prevention of COVID-19 infections in the background of fragile systems puts heavy barriers to the already challenged access to SRHR in these humanitarian settings.

METHODOLOGY

This toolkit was an outcome of an extensive desk review that was set out to research the field of SRHR services in fragile communities requiring humanitarian assistance in Nigeria and Cameroon, by collecting, organizing and synthesizing available information to gain understanding of the contextual challenges, SRHR trends, gaps in coverage, access to and uptake of SRHR services in fragile communities. The Balanced Stewardship Development Association (BALSDA) team provided leadership, and a stakeholders meeting was convened. This meeting was joined by government ministries, departments and agencies that are involved in humanitarian work, SRH service delivery and matters concerning the fragile systems in Nigeria and Cameroon. Other actors in humanitarian work including multinationals, implementers of humanitarian programs, funding agencies, coordinating institutions, SRHR implementing organizations, other NGOs, CSOs and faith-based organizations that are providing services to the target population.

The meeting was virtual to respect the COVID-19 control measures and allow as many stakeholders as possible to participate. The agenda was set and deliberations made to address the emerging challenges of the COVID-19 pandemic. The team deliberated on the expanded and layered implications of the disease, its prevention strategies as well as how these reinforce the existing challenges and barriers to access of SRHR among already vulnerable persons living in fragile communities. The implications of the pandemic especially on girls and

women were deliberated and highlighted to be a vicious cycle that increased the needs for SRHR information and services and restricted access to these services in the communities.

The need to search out strategies that yielded good outcomes from other global pandemics was critical. The desk review gathered scientific evidence that would inform the team about the challenges that occurred in past epidemics especially in fragile settings, and studied the strategies previously utilized to surmount the epidemics. The findings were utilized to provide guidance for the development of this toolkit that speaks to addressing the SRHR needs of persons in challenged communities.

A Critical Interpretative Synthesis (CIS) was applied by analyzing quantitative and qualitative data. There was a broad initial literature search identifying the scope of the review and current evidence around SRHR in fragile and humanitarian contexts during the COVID-19 pandemic. Key experts shared relevant documents, reports and their expertise and knowledge about issues regarding coverage, access and uptake of quality SRHR for people affected by crisis and fragility and targeted searches supplemented the literature review. Grey literature, peer reviewed articles, qualitative and quantitative studies were included in the review. They were identified using search engines including Google and Google Scholar, as well as PubMed and Medline databases. References in the reviewed articles were reviewed.

DESK REVIEW METHODS
The research question was set - Closing SRHR gaps in fragile settings during the COVID -19 pandemic
Where to search online – websites, databases, Cochrane reviews of humanitarian organizations, aid funders and implementers
Offline literature were defined to include newspapers, books, contacting experts for materials
List of key search words – reproductive health, COVID-19, sexual health, fragile, humanitarian, adolescent SRHR, Nigeria, Cameroon, Boko Haram, Zika, Ebola, Influenza, HIV
Construct, run and re-run search using different combinations of key words
Download the results for analysis
Apply inclusion and exclusion criteria and evaluate methodological quality
Data extraction and Analysis
Identify themes and their conclusions
Discussions and recommendations

INTRODUCTION

The global COVID-19 pandemic has significantly affected all aspects of humanity including education, livelihoods, health, and governance in all contexts of the world. The implications are worst in communities affected by conflict where health systems, social security and governance are weak. The COVID-19 pandemic and control measures have layered implications especially on internally displaced persons (IDPs) and refugees. People whose human rights are least protected are likely to experience unique difficulties. These include women, girls, and marginalized groups, IDPs and refugees who carry heavier burdens of economic and social consequences (McGinn, 2000). An SRHR and justice framework which centers on human rights acknowledges intersecting injustices, recognizes power structures and unites across identities is essential for addressing the inequitable gender, health, and social effects of COVID-19 (Wenham et al, 2000).

In fragile communities, many women and girls have fled their homes due to persecution, conflict, violence and human rights violations. They are more likely to have poor health outcomes, including SRHR, due to disrupted services, lack of health supplies, scarcity of trained health workers and increased risk of sexual violence. During conflict and natural disasters, access to health services often decreases while reproductive health needs increase and now with COVID-19, it is a double jeopardy on SRHR in fragile and humanitarian settings. In the face of the COVID-19 pandemic all women and girls, especially vulnerable ones in fragile settings, are at risk of unwanted pregnancy, unsafe abortion, sexual violence and increased morbidity and mortality due to poor access to critical SRHR services. Old SRHR policies need to be reviewed to ensure that their implementation speaks to attainment of good outcomes in fragile and humanitarian settings during the COVID-19 pandemic.

Comprehensive Sexual and Reproductive Health and Rights

Comprehensive SRHR entails the “access to information and counselling and comprehensive sexuality education; information, counselling, and care related to sexual function and satisfaction; prevention, detection, and management of sexual and gender-based violence and coercion; a choice of safe and effective contraceptive methods; safe and effective antenatal, childbirth, and postnatal care; safe and effective abortion services and care; prevention, management, and treatment of infertility; prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and prevention, detection, and treatment of reproductive cancers.

This also means that all people have the right to have their bodily integrity, privacy, and personal autonomy respected. All people are free to define their own sexuality, including sexual orientation and gender identity and expression; decide

whether and when to be sexually active; choose their sexual partners and have safe and pleasurable sexual experiences. They have the freedom to decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have. All people have access across their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence." (Lancet, 2018).

Sexual Health

Sexual health is an integral part of overall health, well-being and quality of life. It is a state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled. Much remains to be done to ensure that public health policy and practices recognize and reflect this.

Reproductive Health

Reproductive health is a state of complete physical, mental and social wellbeing in all matters related to the reproductive system and its functions and processes, and not merely the absence of disease or infirmity. It addresses these issues from the 'womb to the tomb.' This includes prevention and management of female genital mutilation (FGM), adolescent health, maternal care (antenatal, intrapartum and post-partum), new-born and child health, safe abortion and post abortion care, family planning, gender, sexually transmitted disease prevention and treatment, reproductive tract cancer prevention and treatment, menopause and andropause (male menopause) related matters.

The definition for Comprehensive SRHR shows that persons living in fragile communities requiring humanitarian assistance are unlikely to be able to achieve these, in view of the constraints and challenges of the environment, as well as layered barriers to accessing SRHR information and services.

The Minimum Initial Service Package

The Minimum Initial Service Package (MISP) is recommended for emergency phases of epidemics/conflicts (UNFPA, 2015) and this is appropriate in all phases of the COVID-19 pandemic, to ensure service delivery in the midst of the constrained resources and environment, and to prevent infection with COVID-19.

The MISP is a series of crucial actions required to respond to reproductive health needs at the onset of every humanitarian crisis. It is a set of activities that must be implemented in a coordinated manner by appropriately trained staff, and not just kits of equipment and supplies.

This set of life-saving activities forms the starting point for ensuring quality reproductive health in even the worst scenarios. These actions should be sustained and expanded with comprehensive reproductive health services throughout protracted crises and recovery (UNFPA, 2015).

The five objectives of the MISP are to:

- Ensure an organization is identified to lead the implementation of the MISP;
- Prevent and manage the consequences of sexual violence;
- Reduce HIV transmission;
- Prevent maternal and newborn death and illness;
- Plan for comprehensive SRH care, integrated into primary health care, as the situation permits.

OVERVIEW OF GLOBAL SRHR IN CRISIS AND FRAGILE SETTINGS

- Research showed SRHR services (beyond antenatal and delivery care) were rarely included in the health services available to refugees or IDPs (Wulf, 1994).
- Natural disasters, violence and population movement have affected lives of IDPs and host communities, disrupting daily routines, livelihoods and social structures.
- Inadequate and poor quality of SRHR services abound, and these are majorly paid for as Out of Pocket (OOP) expenses.
- The worsening poverty rates and the crises have led to higher rates of transactional sex, sexual violence, unplanned sex, undesired pregnancies among others.

- Access to health services and Water, Sanitation and Hygiene (WASH) is limited, with <40% of health facilities operational in the conflict-stricken region, adversely affecting SRHR of women and girls (NDHS, 2018).
- Researchers have cautioned that in conflict, refugees in stable camp settings are most often studied, a consideration for emergency/recovery phase programs for IDPs and other war-affected groups (McGinn, 2000).
- The terrains, access and available infrastructure also need to inform and influence SRHR service delivery models.
- Frameworks should be developed to access how interactions of a population's pre- and post-conflict characteristics influence how SRHR needs are affected by conflict.
- This however does not suffice to address other needs of women and girls that will arise from the disease on the other hand, including its mitigation efforts.

Gender Dimensions in Emergencies

- Ebola outbreak revealed that gender issues and women's SRHR were not included in international responses, and this reinforced health inequities.
- Data show that pandemics exacerbate pre-existing vulnerabilities especially for women and girls. They are more at risk of gender-based violence (GBV), sexual exploitation and abuse at this time.
- Their role as caregivers and increased needs of visiting hospitals puts them at risk of contracting infections.
- Social roles disrupt livelihoods and education and predispose women and girls to abduction as sex slaves, transactional sex and unplanned pregnancies.
- The sociocultural barriers to accessing SRHR and Maternal, Newborn and Child Health (MNCH) services include interplay of religion, tradition, cultural acceptability, power differences and gender inequities reinforce themselves in crises and pandemics (HPI, 2016).
- SRHR interventions/programs do not consider the patriarchal nature of Nigerian and Cameroonian society and barriers to access for women and girls.

- Women have aversions to male birth attendants but find female traditional birth attendants (TBAs) more culturally acceptable. The exclusion of Community Oriented Resource Persons (CORPs) perpetuates maternal deaths (HPI, 2015).
- While women and girls are disproportionately impacted by disasters and by GBV, men and boys can also be survivors/victims, as some are sexually assaulted by militarized masculinities in conflict.
- Gender analysis is also required to inform understanding of the context and the capacities, strengths, needs and concerns of the women, girls, boys and men in the population.

Pre COVID-19 SRHR Gaps in Fragile Countries

- Financing is key in ensuring access to quality SRHR for people affected by crisis and fragility, and governments and humanitarian support organizations should collaborate to ensure adequate budgets.
- Evidence shows that there is generally an underfunding for SRHR in fragile and humanitarian settings especially contraception, safe abortion and post rape (WHO, 2017).
- As highlighted by a key informant, <1% of total funding for UN humanitarian plans is allocated to sexual and gender-based violence (SGBV) prevention and support programs.
- The appeal for funding is also low, demonstrating lack of interest, political will or commitment by organizations and governments to prioritize SGBV programs especially among fragile communities.
- Currently the total amount spent on contraceptive supplies in LMICs alone is $3.33 billion, but there are huge gaps, as >80% comes from individuals buying supplies from private sectors.
- In Nigeria and Cameroon, where health insurance is poor, many people have to buy SRHR commodities and pay for services including MNCH as OOP expenses.
- The 2019 Commodity Gap Analysis projects a funding gap of $178 million in 2020, reaching $266 million in 2025 with the cumulative gap over 2021–2025 reaching $1.17 billion for contraceptives supplies alone (Reproductive Health Supplies Coalition, 2019).

- These projections were made before the emergence of the Corona virus and the COVID-19 pandemic, which has increased the SRHR needs for many especially those in crises areas.
- The gaps do not reflect other critical aspects of SRHR commodities and services like maternity care, care for SGBV survivors, post abortion care and care for persons living with HIV/AIDS.
- Hand washing with soap and water rates in Nigeria are low. The national average for homes with soap for hand washing is 38%, while that of water is 63%. The rates in the North East of Nigeria are 12% and 24% respectively, which is grossly inadequate for the hand washing prevention strategy for the COVID-19 Pandemic.

Vulnerability and SRHR Needs of Adolescent Girls in Fragile Settings

- Increasing numbers of out-of-school children especially in communities hosting IDPs.
- Many schools were converted to IDP camps while functional ones are overcrowded and unable to accommodate newcomers.
- School curricula are a major source of SRHR information and education and being out of school for COVID-19 control in fragility constitutes a major knowledge gap.
- Adolescent girls in conflict and displacement settings are at high risk of violence, because of destruction of social protective structures and economic isolation.
- They are vulnerable to exploitation, abuse, sexual violence, neglected health needs, and take on greater roles and responsibilities associated with adulthood.
- Since 2014, over 2,000 women and girls have been abducted in North East Nigeria, including 276 Chibok schoolgirls. The abductees experienced physical, emotional and sexual abuse and forced marriage.
- Specifically, greater quantity/quality of evidence on programmatic implementation is needed, especially for comprehensive abortion care, Prevention of Mother To Child Transmission of HIV (PMTCT), urogenital fistulae, FGM, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual (LGBTQIA) populations and persons with disabilities.
- SRHR evidence from previous outbreaks shows that the COVID-19 crisis could exact a massive toll on women and girls in various ways.

- Women are disproportionally represented in the health and social services sectors, increasing their risk of exposure to the disease (UNFPA, 2020).
- There are more women as health care workers than men, and women are more commonly care providers of ill relations.
- The stress, limited mobility and livelihood disruptions of the COVID-19 pandemic and its interventions also increase women's and girls' vulnerability.
- COVID-19 lockdowns put women and girls in the same spaces with perpetrators of GBV, with resultant higher need for SRHR services.
- Efforts to contain the pandemic have skewed finance, human resources for health (HRH) and focus to COVID-19 at the detriment of SRHR services, thus further compromising women's access to critical SRHR services (Guttmacher Institute, 2020).
- This intersection of fragility and disease will reinforce poor health outcomes due to disrupted services, lack of health supplies, HRH scarcity and increased risk of sexual violence.

Vulnerability and SRHR Needs of Adolescent Boys in Fragile Settings

- Young men are targeted for recruitment by military actors, putting them at high risk of brutalization (NSRP, 2015).
- They are expected to adhere to culturally dominant and patriarchal forms of masculinity, which sanctions violence, including sexual violence.
- Poverty, challenges of livelihoods and frustrations are linked to increased violence at home/communities, including sexual violence.
- SRHR interventions for young people show insufficient details of specific intervention components and outcome measurements to adequately map them.
- Efforts to address this key population's SRHR needs and evaluate effective implementation modalities require urgent attention.

SRHR Challenges in Nigeria and Cameroon

- Since mid-2014, the Boko Haram crises created a major humanitarian crisis with over 2.4 million displaced persons, over 1.6 million returnees in Nigeria, and about 1.7 million of these IDPs are women and girls of reproductive age.

- The number of people in need of urgent assistance in North-East Nigeria rose from 7.9 million at the beginning of 2020 to 10.6 million since the onset of COVID-19 Pandemic (OCHA, 2020).
- Food insecurity has risen from pre-COVID-19 figures of 3.7 million to 7 million since the COVID-19 epidemic. The states affected in Nigeria are majorly Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe .
- An estimated 1.2 million are living in areas not accessible by humanitarian workers.
- These conditions increase vulnerabilities like transactional sex, rape and adolescent pregnancies (Reliefweb, 2020).
- The crises also extend to Logone, Chari and Mayo Sava divisions of Northern Cameroon, which already had the highest poverty rate, lowest school enrolment rate before the war.
- These have led to an influx of 65,000 Nigerian refugees and internal displacement of over 93,000 people (International Crises Group, 2016).
- Currently, Borno, Adamawa and Yobe states have recorded COVID-19 cases in IDP camps, and Aid Organizations have set up hand washing stations, quarantine shelters and introduced physical distancing during distributions.
- SRHR service coverage is low, and 36 percent of births in Nigeria are delivered in a health facility with marked regional inequities. Some states in Northern Nigeria have rates as low as 4 percent (NPC, 2014).
- Nigeria Health Systems Assessment (2008) document consistent healthcare services disruption from incessant industrial action by all cadres of healthcare providers in public facilities affecting SRHR and services.
- Many private facilities lack skilled birth attendants (SBAs) and Emergency Obstetric Care (EmOC) services because of limited facility monitoring and absence of regulatory frameworks (FMOH, 2008).
- Studies of rural primary health care (PHC) centers indicate that 44% did not provide full EmOC, 11% conduct vacuum extraction and 36.8% provided post abortion care services (Okoli *et al.,* 2015).
- Health care worker attitudes to clients are a barrier to access of SRH care, as some reflect unchallenged cultural norms that discriminate girls and women (FMOH, 2016).
- Humanitarian workers and SRH service providers are targets and victims of attack and killing by armed militants, and not less than 9 workers from different organizations and government officials have been killed in Borno. The Governor was attacked while visiting IDP camps in July 2020.

KNOWLEDGE GAPS IN ACCESS TO QUALITY SRHR FOR PEOPLE AFFECTED BY CRISIS AND FRAGILITY

Lessons from other Pandemics - SRH Gaps seen during Ebola, Zika and other pandemics

- Past epidemics show that lack of access to essential health services and shut down of services unrelated to the epidemic response resulted in more deaths than those caused by the epidemic.
- Multiple studies reveal detrimental effects of outbreaks on public health and health systems in West Africa.
- Deterioration in the quality of HIV/AIDS care and a four-fold increase in avoidable all-cause mortality are reported.
- The effect of the Ebola outbreak was particularly detrimental to SRHR services with reports of declines in antenatal care (ANC), family planning visits and institutional deliveries.
- Decline in MNCH services due to disrupted services and fear of seeking treatment during the outbreak contributed to an estimated 3,600 maternal deaths, neonatal deaths and stillbirths.
- Sharp declines in contraceptive use and family planning visits occurred in Guinea, Liberia and Sierra Leone during the Ebola pandemic.
- Low rates of family planning, ANC and institutional deliveries occur during pandemics.

Global Pandemics and the SRHR Challenges – High rates of Teenage Pregnancy during Ebola, Zika and other pandemics

‘‘Prostitution is rampant, girls don’t eat unless they sleep with older men for money…Now, we girls have sex with our father’s age group, because we need money and men don’t give money for nothing’’.

- Hospital delays increased as care shifted from SRHR to Ebola patients, and became a barrier to access.
- Additional delays in care for women experiencing pregnancy complications from financial and structural barriers.
- Fear of contracting disease was a barrier especially to women in labor.
- Concerns that fearful health workers lack adequate protection and training in infection prevention control and Ebola case management.
- Socio-cultural norms of unpaid care dictate that women take care of sick family members, nurse children, and work as traditional healers and health care assistants. As a result, women are at a high risk of infection.
- Research shows reproductive health services (beyond antenatal and delivery care) were rarely included in the health services available to refugees or displaced people (Wulf, 1994).
- Atrocities like sexual violence, committed during conflicts are not addressed among reproductive health issues.
- An estimated 2.64 million people, of which the great majority women and girls, are affected by SGBV in the region.

BEST PRACTICES ON QUALITY SRHR SERVICES IN CRISIS AND FRAGILE SETTINGS DURING EPIDEMICS

Lessons from other pandemics – How communities maintained service delivery during Ebola crises

- Midwives who worked with humanitarian organizations indicate experiences should be considered when developing guidelines for pregnant women during outbreaks.
- They cited sufficient training, adequate equipment and access to support by colleagues as coping strategies.
- All women of reproductive age should receive information about preventive measures against pandemics irrespective of context.
- Health program managers should engage community groups in information sharing of prevention measures and to establish community member support especially for pregnant women ahead of community transmission.
- Develop birth and emergency preparedness plans and provide information about reorganization of health services.
- Prioritize safe delivery, immediate newborn care and family planning and provide 8–12 weeks stock during the pandemic.
- Role of telemedicine for SRHR information and services - WhatsApp groups, text messages
- Ndolo360, the first mobile app of its kind in Cameroon, delivers SRHR information to adolescents and young people.
- In case of community transmission, reduce ANC visits to a minimum and postpones visits of women with early low-risk pregnancies.
- Human-resource mapping should ensure community level availability of SBAs and relevant medical supplies.
- The major Ebola epidemic control measures included organization of rapid response by local health authorities.
- Majorly triage, contact tracing and quarantine, isolation, clinical management and safe burials, training and community sensitization reduced infection spread and disease impact on mothers and children, although the outbreak reduced number of patients at hospital level.
- An MISP for reproductive health is recommended for implementation in acute phases of emergencies.
- Managing pregnancy at the community and provision of home care by health workers with midwife skills will improve access and decrease contact with patients.
- Redistribution of facility-level SBA to the community, where feasible, may augment the number of community-based midwives.

Recommendations

Policy

- Policies should be formulated, and they should be informed by research findings and best practices to speak to SRH service delivery in fragile societies.
- Formative research and implementation research should be compulsory components of program planning, implementation and monitoring.
- National government should develop sound policies that speak to all the issues, with technical assistance from humanitarian organizations, as well as those working in fragile states.
- Existing policies like the task shifting and task sharing should be disseminated, supported and implemented in these settings.
- Policies including the MISP should be adopted and implemented at emergency phases of the COVID-19 pandemic in Nigeria and Cameroon.

Service delivery

(Using lessons learnt on how communities-maintained service delivery during Ebola Crises)

- Experiences should be considered when developing guidelines for pregnant women during outbreaks, as indicated by midwives who worked with humanitarian organizations.
- Sufficient training, adequate equipment and access to support by colleagues should be provided to assist midwives in coping with challenges.
- All women of reproductive age should receive information about preventive measures against pandemics irrespective of context.
- Health program managers should engage community groups in information sharing of prevention measures and to establish community member support especially for pregnant women ahead of community transmission.
- Develop birth and emergency preparedness plans and provide information about reorganization of health services.
- Prioritize safe delivery, immediate newborn care and family planning and provide 8–12 weeks stock during the pandemic.
- Explore the role of telemedicine as data shows that the number of lines exceed the number of people in Nigeria. Radios, text messages, WhatsApp

messages and SRHR app, such as the Ndolo360 app can be explored in providing SRHR messages among persons in fragile settings.

- In case of community transmission, reduce ANC visits to a minimum and postpones visits of women with early low-risk pregnancies.
- Ensure the organization of rapid responses by local health authorities.
- Organize majorly triage, contact tracing and quarantine, isolation, clinical management and safe burials, training and community sensitization to reduce infection spread and disease impact on mothers and children.
- Ensure an MISP for reproductive health is recommended during acute phases of emergencies.
- Manage pregnancy at the community and provide home care by health workers with midwife skills to improve access and decrease contact with patients.
- Human-resource mapping should ensure community level availability of SBAs and relevant medical supplies. The Northeast Nigeria has the lowest number of HCW, and some communities have no doctors but have Community Health Extension Workers (CHEWs) who conduct >90% of deliveries in PHC centers.
- Redistribute facility-level SBA to the community, where feasible, to augment the number of community-based midwives.
- Task shifting and task sharing policy to devolve skills and roles to CHEWs, with guidance and training, role clarity, supportive supervision and improved work satisfaction.
- CHEWs can deliver quality essential health services especially for MNCH, family planning, child health and adolescent reproductive health, and identify, refer, provide HIV Counselling and Testing (HCT), counsel for family planning, provide emergency contraception and dispense misoprostol in the community.
- CHEWs can provide first line measures for SGBV victims, refill ARV, identify pregnancy complications, conduct delivery, and manually remove retained placenta and other basic EmOC, new-born care and complications prevent.
- Provide immediate pregnancy and antenatal care, syndromic management of sexually transmitted infections (STIs) at communities or facility. CHEWs will thus be a very useful resource in providing SRH services in fragile communities as CORPs.

- Provide personal protective equipment (PPE), sanitizers, masks as well as COVID-19 training to TBAs, as they also have roles in SRH, based on the task shifting policy.

Supplies and Commodities

These should target hard to reach and far to reach areas during the COVID-19 pandemic.

- In order to mitigate risks, providers are advised to build inventories to reduce stock-outs ahead of pandemics, and take measures to reduce the potential impact on women and men who want and need contraception and other SRHR commodities during the pandemic: Strategies will also be required to navigate the already difficult terrains in fragile areas experiencing conflict (Purdy, 2020).
- The context of COVID-19 intensifies the need to ensure that medical supplies including SRHR medication, essential goods, and protective gear are distributed in the right quality/quantity, to the right places, and at the right time to make a critical difference. As health systems are stretched, social enterprises become a crucial partner for governments to mount an effective response.
- Collaborate with the USAID Global Health Supply Chain Program (GHSC) is a program collection of eight complementary projects who handle Nigeria's ATM supplies/drugs logistics including NE Nigeria.
- Collaborate with social enterprises: the USAID GHSC program recognized that a Coca Cola product is available almost everywhere on the continent while nearly 50% of people lack access to critical medicines especially in fragile settings. Therefore, USAID, BMGF and GFATM pioneered a 'Project Last Mile' with Coca Cola to enable medicines reach and benefit communities in Sierra Leone, Liberia, Tanzania, Ghana, Mozambique, Swaziland and Nigeria.
- Coca Cola technicians also provide repair services for refrigerators, freezers and generators for health facilities and help maintain cold chain.
- Riders for health, another 'last mile delivery' international social enterprise that collaborated with WHO in Nigeria's nationwide polio eradication program.
- Explore accredited private pharmacies, chemists and drug stores since only 3% Nigerians have health insurance and most purchasing medicines as OOP expenses including SRHR services.

Financing

- Financing is key in ensuring access to quality SRHR for people affected by crisis and fragility and governments and humanitarian support organizations should collaborate to ensure adequate budgets.
- Evidence shows that there is generally an underfunding for SRHR in fragile and humanitarian settings especially contraception, safe abortion and post rape (WHO, 2017).
- These projections were made before the emergence of the Corona virus and the COVID-19 pandemic, which has increased the SRHR needs for many especially those in crises areas.
- The gaps do not reflect other critical aspects of SRHR commodities and services like maternity care, care for SGBV survivors, post abortion care and care for persons living with HIV/AIDS.

Demand Generation

- One of their major roles is to reach hard to reach communities with essential SRH services. CHEWs have generated community awareness, countered stigma and traced contacts, which can hinder regular service delivery.
- TBAs should be engaged and motivated to refer and escort women and girls with immediate needs to health facilities.
- Community gate keepers, including men leaders, women leaders, youth leaders, peer support, CORPs, youth spaces, youth SRHR advocates, formal and informal learning spaces, girls and boys clubs leaders should all be involved and utilized.
- Social media, WhatsApp groups, text messages, radios and information, education and communication (IEC) materials in local languages can be utilized.

EXPECTED ROLES AND RESPONSIBILITIES of SRHR STAKEHOLDERS DURING PANDEMICS

1. Government/Policy Makers (National, Sub-National and Community Level)

"My message to world leaders is simple. Put people first: their needs, their aspirations, their rights." Remarks from the United Nations Secretary-General, António Guterres, at the 2019 opening session of the United Nations General Assembly.

- Mobilize and coordinate effective principles and humanitarian actions in partnership with local actors (NGOs), International NGOs, United Nation Agencies, CSOs, development partners and other Ministries, Departments and Agencies (MDAs) that render assistance to the vulnerable population.
- Provide leadership for implementation of quality humanitarian programs with integrated SRH and COVID-19 interventions that will articulate one multipronged response, provide one coordination mechanism, and provide a monitoring and evaluation framework.
- Ensure that aid and health care workers have access to all populations in need, including across borders, manage HRH challenges and facilitate logistics of humanitarian and medical commodities for preparedness and response activities.
- Plans to ensure the continuing medical education, including remote learning or radio broadcasts.
- Ensure that all IDPs and refugees are accounted for in national surveillance, preparedness and response plans and activities.
- Ensure that any movement restrictions related to COVID-19 account for the needs of different vulnerable groups.
- Ensure that emergency preparedness and response plans are grounded in sound gender analyses, considering gendered roles, risks, responsibilities, and social norms, and focusing vulnerable populations, especially women and girls.
- Lead, fund, commit to and prioritize Health Systems Strengthening across all six building blocks.
- Develop and disseminate research informed policies.
- Provide and fund community insurance programs.
- Line Ministries must be identified- Education, Finance, Communication, Women Affairs, Youth and Sports Development, Justice.

- Improve and utilize existing research, tools, human resources, systems, infrastructure to address both SRH and COVID-19 services.
- Convene stakeholders' meetings to ensure robust review of program cycle (needs assessments, planning, program implementation, SRHR monitoring and evaluation).
- Create and strengthen policies that support the provision of comprehensive sexuality education (CSE) and create visibility and prioritization for CSE programs in these contexts.

2. Service Providers

These include Government (Primary, Secondary and Tertiary levels), faith-based facilities, private facilities, CORPs, volunteers, humanitarian organizations, NGOs and CSOs.

- Emphasis on integration into existing frameworks and mechanisms and leveraging, and avoiding effort duplication and stand-alone programs.
- Innovation including decentralization, mobile outreaches, home based care.
- Engage CORPs including TBA for delivery of approved role specific tasks.
- Provide the MISP: a series of crucial actions is required to respond to reproductive health needs at the onset of every humanitarian crisis. These should be sustained and expanded with comprehensive reproductive health services throughout protracted crises and recovery (in this case the COVID-19 and the armed conflict).
- Engage with local communities to provide access to information to all community members.
- Programs should factor in age, disability, education, gender, migration status, sexual orientation, and the existence of pre-existing health conditions of the population in their strategies.
- Train health care workers to properly identify, manage and refer cases of SGBV and intimate partner violence (IPV).
- Involve existing female health care workers and local women leaders in decision making to ensure that responses to COVID-19 outbreaks adequately address the needs of women and girls in each community.
- Ensure that menstrual hygiene, obstetric, reproductive, and other PHC commodities are well-stocked and available at health care facilities.
- Proper data capture when outbreak enters the community and disaggregate as appropriate to guide preventive measures.

- Health providers are well-positioned to support CSE by providing information about the common SRH needs of young people, sharing information and lessons learnt about the outcomes of their education strategies and by actively participating in efforts to strengthen the link between CSE and health services.

3. Community Members

- Organize the provision of transport and referral for women in need.
- Ensure observation of COVID-19 prevention measures in the community and facility.
- Set up community thrift groups to help women save and prepare for MNCH and other SRH services.
- Collaborate with security agencies and local vigilant groups to provide security, protect SRH workers and improve commodity logistics.
- Provide appropriate spaces, town halls and other spaces where SRH services can be provided as outreach or mobile stations during the pandemic.
- Discourage stigma around COVID-19 and SRH needs of girls and single women especially.
- Women groups, men groups, youth clubs and girls' clubs should be engaged to provide accurate COVID-19 and SRH information to members during meetings.
- Community leaders can pave the way for acceptance and support of CSE programs implemented in formal and non-formal settings. It is crucial to work with these stakeholders to counter inaccurate information and dispel any existing myths and misconceptions around CSE that the community might have. Community leaders can also provide support for efforts to contextualize the content of the program.
- Religious and faith-based organizations play an important role in the lives of many communities. The influence and authority that religious leaders have in communities allows them to speak from a theological foundation of respect for human dignity and wholeness (Religious Institute, 2002). It is important to keep a dialogue going with these organizations, as well as with young people of different faiths. It is only through discussion that the complex issues of the content of CSE programs can be addressed. Most religions promote building healthy and loving relationships free from coercion and abuse, and all religions

want young people to be healthy and happy. Dialogue can help find the balance between what religion teaches, what scientific evidence proves and the lived reality of local young people.

4. Civil Society Organizations

- Advocacy to all stakeholders for undisrupted service delivery.
- Form pressure groups to ensure governments provide needed leadership and resources.
- Provide demand creation to improve uptake and refer women for services.
- Organize women and young women to provide information and help improve uptake.
- Prepare for increased episodes of SGBV and IPV incidents among women, girls, LGBTQIA community, and other vulnerable populations.
- Support mobile hotlines to mitigate and respond to SGBV, MNCH and other SRH challenges where it can be done safely.
- Continue development and humanitarian service provision as much and safely as possible, accounting for the potential imposition of movement restrictions and social distancing measures. Where possible, continue GBV and psychosocial support, and WASH services along with the provision of food, nutrition, and hygiene commodities and shelter support.
- Develop community economic empowerment strategies and cash transfer programming to mitigate the impact of COVID-19 outbreaks for community and those who lost means of income.
- Work with local communities, particularly women's groups, before, during and after public health emergencies to ensure continued trust, access, and to provide the best possible services.

5. Donors

- Prioritize SRHR programs as part of humanitarian services.
- Ensure SRHR services are funded within COVID-19 appeals. The COVID-19 prevention restrictions have increased needs for SRHR services and have as well created barriers to accessing the services, so both COVID-19 and SRHR needs can be jointly funded and programed for.
- Fully fund the Global Humanitarian Response Plan for COVID-19 since the shelters, IDP camps and IDP host communities will be more at risk of COVID-19 acquisition because of overcrowding, possible WASH gaps, non-availability of sanitizers, facemasks and face shields from infection prevention.
- Provide continued and flexible funding to ensure the provision of essential and life-saving SRHR services throughout the global COVID-19 response in line with the MISP.
- Invest in supply chain and logistics for life-saving SRHR supplies.

- Donors, CSOs and local NGOs serve as a valuable resource for schools and teachers to turn to for more information or to invite as guest speakers to discuss topics that reinforce or complement the CSE curriculum. Some NGOs also have community-based CSE programs in place. They should support the dissemination and implementation of CSE.

CALL TO ACTION FOR UNINTERRUPTED ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN FRAGILE AND CRISIS SETTINGS DURING AND AFTER THE COVID-19 CRISIS

All actors across all levels should commit to proactive, early information sharing and coordination to ensure a robust global response that utilizes intersectional analyses to account for the needs of all individuals, irrespective of ethnicity, gender, nationality, or sexual orientation. These efforts should take place with the full participation of at-risk populations, particularly women and girls.

All these categories of actors have their various roles and responsibilities embedded in the discussions and recommendations for call to action. These categories include:

- Government/Policy Makers (National, Sub-National and Community Level)
- Service Providers
- Community Members
- Civil Society Organization
- Donors

DISCUSSION AND RECOMMENDATIONS FOR CALL TO ACTION

Accessing SRHR remains a major challenge to people affected by crisis and fragility, and this is more challenging in the face of the COVID-19 pandemic, which has reinforced the causes of increased need for SRHR services while at the same time creating additional barriers to access. These realities are more daunting for Nigeria and Cameroon, where parts of the countries markedly affected already had very poor social, medical, financial, and educational indices and poor state presence even ahead of the crises, and armed conflict poses a direct barrier to SRHR services. Crisis and fragility affect people's access to quality SRHR by exposing them to higher risk of unplanned sex, unplanned pregnancies, teenage pregnancies, STIs/HIV, poor pregnancy care and outcomes. These predispose them to SGBV, STIs, HIV, unintended pregnancy, unsafe abortion and ultimately various degrees of maternal morbidity and mortality.

The contexts of fragility, even within Nigeria and Cameroon are different, and fragility associated with armed conflict poses a more complex emergency, contrary to affected by natural disasters where challenges of accessing those communities differ from other contexts. COVID-19 contexts also differ and the risks and challenges to assessing SRHR are affected by whether there is already community transmission of the infection or if the mitigation efforts are the existing constraints. When community transmission has occurred, there are fears and risk of acquiring the infection from health facilities, and health workers who may get infected have to be quarantined. This can lead to further depletion of the already scarce HRH resources, as well as temporary closure of some of the few health facilities for fumigation. COVID-19 is also a relatively unknown emerging infectious disease and the prevention efforts, transmission routes, health implications and other public health implications differ from those of other infectious disease pandemics and research is still ongoing at this time. In view of these differences in context and the intersection of disease and other vulnerabilities, it is impossible to find solutions that can address the problems to access quality SRHR that will fit everyone.

However, we can learn from what has worked in different fragile settings and disease pandemics, and adjust interventions to the context, needs and disease mitigation efforts of specific populations.

Prong 1: Prioritizing Comprehensive Sexuality Education in Formal Spaces and Informal Settings as a Prevention and Empowerment Strategy

Every young person, including those in conflict regions affected by fragility and requiring humanitarian assistance, whether in IDP camps or in host communities, will one day have life-changing decisions to make about their SRHR. Yet research shows that the majority of adolescents lack the knowledge required to make those decisions responsibly, leaving them vulnerable to coercion, STIs and unintended pregnancy. This has been found to occur among vulnerable youths in these areas affected by conflict where the COVID-19 pandemic and its control measures have increased exposure to SGBV, unplanned and unprotected adolescent sex, transactional sex and high-risk sexual behavior.

CSE using the rights-based approach, seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality, physically and emotionally, individually and in relationships. It views sexuality holistically, as a part of young people's emotional and social

development and recognizes that information alone is insufficient, but should include opportunities to acquire essential life skills and develop positive attitudes and values. This approach recognizes and accepts all people as sexual beings and is concerned with more than just the prevention of disease or pregnancy. CSE programs should be adapted to the age and stage of development of the target group and help them to acquire accurate information on sexual and reproductive rights, dispel myths and provide references to resources and services. Also, CSE programs should support people to develop life skills including critical thinking, communication and negotiation, self-development and decision-making, goal setting, sense of self, confidence, assertiveness, ability to take responsibility, ability to ask questions and seek help and empathy. CSE programs should help them to nurture positive attitudes and values, including open-mindedness, respect for self and others, positive self-worth/esteem, comfort, non-judgmental attitude, sense of responsibility, and positive attitude toward their sexual and reproductive health.

Recommendations

Key players in CSE delivery include service providers, peer educators, parents, teachers and other educators who

- have appropriate information, training, tools, skills and qualities
- have an understanding of young people and their agenda
- have the intention of enlightening, transforming and preparing them
- be someone who creates an enabling environment that young people trust and feel comfortable with
- be someone who imparts knowledge and facilitates skill development
- be accessible and non-judgmental and have no personal agenda

Those who deliver sexuality education whether one-to-one or in groups need the necessary information, skills and attitudes in order to do so effectively. Training, ongoing support, supervision, and access to resources and materials are critical.

Recommendation	Stakeholder Responsible	Support provided
CSE should be included into existing curriculum for in-and-out of school youths. It should be provided to young people in these areas as outreach services or integrated into other modalities of community education.	Government/ Policy Makers (National, Sub-National and Community Level)	Civil Society Organization Donors
CSE should be provided in informal schooling spaces, health service settings, waiting areas like food and aid collection points, youth/adolescent clubs and spaces, religious gatherings, NURTW spaces (tricycles, buses etc.), community drama and activities and by incorporating them into community traditional rituals.	Community Members Service Providers	Civil Society Organization
Training, support and provision of materials for resource persons to deliver sexuality education, whether one-to-one or in groups.	Government/ Policy Makers (National, Sub-National and Community Level)	Donors
Develop and disseminate appropriate policies that support the provision of CSE in conflict areas, with provision of leadership, prioritization, ownership, necessary resources and enabling environment.	Government/ Policy Makers (National, Sub-National and Community Level)	Civil Society Organization
Provide advocacy for CSE programs and help demystify myths, stereotypes and beliefs, to create acceptability and support of CSE programs to be implemented in formal and non-formal community settings and contextualizing the program contents.	Community members	Community Society Organizations
Educate and address various forms of violence, substance abuse, alcohol and toxic gender stereotypes and norms, and dialogue to support inter-faith and inter-ethnic tolerance and peaceful coexistence.	Community Members (Religious leaders, Community gate keepers)	Civil Society Organizations

Provide trainings, materials and support for school teachers, CHEWS and other Community Resource Persons to be gainfully engaged in the community-based CSE programs for in-and-out of school youths to forestall the potential adverse SRH outcomes.	Civil Society Organization Community members	
Develop and disseminate context and language specific IEC materials on CSE and provide buddies within the community.	Civil Society Organization	Communit y Members
Provide and integrate the Seven essential components of CSE into existing structures and systems	Civil Society Organization	Communit y Members

Provision of the Seven Essential Components of Comprehensive Sexuality Education is critical. They are:

1. *Gender* – Educate about differences between gender and sex, perceptions of masculinity and femininity, gender roles and attributes, society's changing norms and values, manifestations and consequences of gender bias and stereotypes.
2. *Sexual and reproductive health and HIV* – Incorporate information about sexuality and the life cycle, anatomy, reproductive process and use of contraception, pregnancy information, STIs and HIV, their transmission, prevention, testing and treatment. Drug/substance use (including codeine, hemp), virginity, abstinence, faithfulness, social expectations, self-esteem, empowerment, respect for the body and myths.
3. *Sexual rights and sexual citizenship* – improve knowledge of sexuality related laws and structures, social, cultural and ethical barriers to exercising SRH rights, available services and resources and accessing them, practices and norms and different sexual identities. Others are choice, protection, negotiation skills, consent and the right to have sex only when ready.
4. *Pleasure* – Educate that sex should be enjoyable and not forced, sexuality as part of everybody's life, the biology and emotions behind the human sexual response, gender and pleasure, sexual wellbeing, safer sex practices and pleasure, masturbation, love, and relationships. Others include interpersonal communication, the first sexual experience, consent, alcohol, drugs, and the implications of their use.
5. *Violence* – Explore various types and manifestations of violence towards men and women, GBV, gender community norms, non-consensual sex, support options available and seeking help, prevention to include personal safety plans, self-defense techniques, understanding of victims and abusers, appropriate referral

mechanisms for survivors especially during the pandemic in conflict areas, preventing the victim from becoming a perpetrator and understanding men/boys as both perpetrators and allies in violence prevention, which is critical in conflict areas.

6. *Diversity* – Uphold recognition and understanding of diversity (faith, culture, ethnicity, socio-economic status, ability/disability, HIV status and sexual orientation), recognizing discrimination, its damaging effects and handling it, believing in equality and supporting young people to move beyond just tolerance to acceptance, respect, mutual understanding to celebration of diversity. This is very critical for these young people in conflict areas.
7. *Relationships* – Provide understanding of different types of relationships (family, friends, sexual, romantic, etc.) and the constant change associated with relationships, understanding emotions, intimacy, rights and responsibilities, healthy and unhealthy or coercive relationships and communication are key. They need to be taught about trust and honesty in relationships, peer pressure and that love and sex are not the same.

Young persons in the North East who are in conflict areas and out of school on account of COVID-19 mitigation efforts are at higher risk of adverse SRH experiences and outcomes and provision of CSE is critical for them during this time and other such periods of time in their lives.

Prong 2: International and National Actors need to focus on and Invest in Building Resilient and People Centered Health Systems in Fragile Communities.

The health systems in areas affected by both man-made and natural disasters are usually negatively affected, and this is more prominent in the conflict-ridden parts of Northern Nigeria and Cameroon where the dominant terrorist group has destroyed many health facilities, disrupted logistics of medical products, killed health workers and made many to flee. Other HRH challenges include inadequate numbers of all cadres, inadequate skills levels and bad behavior and attitudes of health staff affecting SRHR service delivery and now COVID-19 infection. These are consequences of insufficient capacity-building systems, personal norms and values and lack of supportive supervision. All six pillars of the health systems in the conflict areas are affected. The challenges of data collection in these contexts, limited use of data for service delivery, planning, implementation and reporting are challenges that limit implementing agencies responses to SRHR needs. Gaps have been identified with commodities and supply chains for SRHR related services especially contraception and abortion services. Governance in crisis or fragile contexts is challenged because of destroyed institutions and systems, which has resulted into poor coordination and collaboration with the influx of aid and SRHR organizations in humanitarian contexts. The funding for SRHR is inadequate, especially for contraception and responding to the needs of survivors of SGBV. Service delivery of comprehensive SRHR services, many times, is either lacking, inappropriate or not people centered in these contexts.

Recommendations

Recommendation	Stakeholder Responsible	Support provided
The MISP should be used to deliver SRHR services from the onset of intervention in acute crisis phase and moving towards offering comprehensive SRHR services as soon as feasible in those contexts. The reproductive health units of federal and state Ministries of Health should work closely with a major SRHR implementer to implement SRHR programs in fragile and humanitarian contexts.	Service Providers	Civil Society Organization
Generate a well-motivated, equipped and supported health care workers team with SRHR and infection COVID-19 prevention training to work in these contexts and to provide quality SRHR and infection control services to all persons including adolescents and persons with disabilities. Unfriendly health worker attitudes should be addressed especially	Government/Policy Makers (National, Sub-National and Community Level)	Civil Society Organization

complaints related adolescents SRHR and women in labor.		
Appropriately compensate frontline healthcare workers and women-led and women-focused civil society organizations who are risking their lives in delivering lifesaving SRHR and COVID-19 information and services especially in conflict areas. Gender gaps in pay should be corrected and remunerations should be improved and regular.	Government/Policy Makers (National, Sub-National and Community Level)	Donors
Increase investment in COVID-19 responsive in person and remote support, training, supervision, and monitoring to maintain accessibility, availability, and quality of sexual and reproductive health services as well as safety for health workers and patients.	Government/Policy Makers (National, Sub-National and Community Level)	Donors
All government and non-government actors should invest into continuous medical education, curriculum development and training for SRHR and infection control. This should be in person and remote support, training, supervision, and monitoring to maintain accessibility, availability, and quality of SRHR services and safety for health workers and patients.	Government/Policy Makers (National, Sub-National and Community Level) Donors	
Adopt the task shifting and task sharing policies to bridge HRH services in these fragile and humanitarian contexts. The CORPs including TBAs should be supported to deliver SRHR services in approved roles, and avert complications and refer to save lives, support COVID-19 infection prevention and referral of suspected cases.	Service Providers Community Members	Civil Society Organization
Support community, telemedicine, and home-based care, according to WHO guidelines, through access to consumer products such as pregnancy tests, condoms, oral contraceptives, and HIV tests.	Civil Society Organization	Service Providers
Adopt appropriate and flexible funding models to ensure sustainable investments into comprehensive SRHR programs in fragile states. Invest into funding for Global Humanitarian Response Plan for COVID-19	Donors	Government, (National, Sub-National,

and include comprehensive and non-discriminatory SRH services.		Community)
Ensure continued and flexible funding for preparedness, early action efforts and implementation of the MISP for SRH in humanitarian crisis.	Civil Society Organization Donors	Government, (National, Sub-National, Community)
Ensure supply chains are uninterrupted and reproductive health supplies are reaching the facilities. Support pool procurement of critical SRHR and COVID-19 infection control supplies and PPE for SRHR providers, to ensure uninterrupted service delivery in these settings. Innovative and context specific strategies like social enterprises should be utilized in commodity logistics.	Government/Policy Makers (National, Sub-National and Community Level) Civil Society Organization	Service Providers
Prioritize and invest in monitoring and evaluation and data collection systems to ensure appropriate responses and evidence-based advocacy for prioritization of SRHR in these settings.	Civil Society Organization	

Prong 3: Prioritize Community Engagement, Participation and Ownership of Programs to Respond to the Dual Crises of Fragility and COVID-19 from the Onset.

It is crucial to engage communities and their key representatives and gatekeepers from the onset of interventions. This will provide information and clarity, needs assessments and generate some formative assessment about delivery models that have been successfully implemented. This is critical in conflict because the people understand the terrains, have community coping strategies, transport routes, mechanisms of obtaining information of providing community security, which can be leveraged for assessment, planning, implementation, monitoring and evaluation. This engagement should happen in all phases of acute humanitarian and fragile settings, protracted crises, recovery phases, in camps of internally displaced persons or their host communities. Affected populations should be at the center of any intervention, including the most marginalized groups, and health providers should work beyond the 'walls' of a clinic, providing outreach activities in constant dialogue with communities.

Social distancing, wearing face masks, handwashing and other COVID-19 prevention strategies should be followed and meetings should include only major representatives and other communications can be by text messages during the pandemic.

Recommendations

Recommendation	Stakeholder Responsible	Support provided
SRHR organizations and aid program implementers should engage communities and ensure participation of communities in decisions and crafting implementation strategies and programs specific to the needs and the context.	Civil Society Organization Community Members	Service Providers
Implementers need to engage community gatekeepers including community and religious leaders, youth leaders, women group leaders, men groups to address gender norms, masculinities and provide peer support. Major groups that are critical like the Nigerian Union of Road Transport Workers, vigilante groups, health workers including midwives service scheme and CHEWs, and CORPs including TBAs are also critical in view of the security challenges and COVID-19 interventions.	Civil Society Organization Community Members	
SRHR and COVID-19 programs should leverage on and be integrated into existing programs like HIV, Tuberculosis and Malaria for these challenged contexts where HRH and health facilities are inadequate and parallel programs are not resource efficient.	Civil Society Organization Government/Policy Makers (National, Sub-National and Community Level)	Donors
Prevention and behavior change programs should be implemented using local resources and strategies. Social distancing, wearing facemasks, handwashing and other COVID- 19 prevention strategies should be encouraged within communities.	Community Members	Civil Society Organization
Education and empowerment of women and girls to increase women's agency, voice and power as a strategy for SRHR services access is key.	Government/Policy Makers (National, Sub-National and Community Level)	Civil Society Organization

SRHR and COVID-19 education and information should be provided using available communication channels like radio, text messages and WhatsApp groups, and should include messages for persons with sexually diversity and people living with disabilities.	Civil Society Organization	Civil Society Organizati on

Prong 4: Increase Coverage, Improve Safe Access and Support Uptake of Comprehensive SRHR Services by Providing Information and Creating an Enabling Environment for People who Need them in Fragile Communities during the COVID-19 Pandemic.

Nigeria and Cameroon still have poor SRHR indices with low coverage and uptake of SRHR services, which is even more challenged in conflict areas within the COVID-19 pandemic.

In view of the increased SRHR needs and peculiarities, an urgent need arises to improve access of the most marginalized groups, who are exceptionally affected by crisis and fragility, including LGBTQIA, people with mental or physical disability and adolescents. SRHR programs and services have to be programed to speak to the needs of these special population groups, while observing COVID-19 precautions during the pandemic.

For refugees, IDPs and migrants, who may have language differences from those of host communities or program implementers, it is paramount that SRHR services information, education materials and messages are made available and communicated in understandable local dialects. This has been identified as a barrier to accessing SRHR services when people do not know where to obtain them in new communities. Northern Nigeria and Cameroon both have a diversity of ethnic groups and besides major ones like Hausa, Fulani, French and English, many of the affected populations may speak different languages, which can differ from that of host communities and those of SRHR workers.

Recommendations

Recommendation	Stakeholder Responsible	Support provided
Aid and humanitarian organizations should prioritize and integrate SRHR and infection control programs for crisis and fragility settings since their peculiarities clearly puts them at risk. The SRHR programs to prevent and respond to SGBV, family planning and comprehensive contraception services, safe abortion care, adolescent SRHR as well as safe motherhood	Civil Society Organization	Donors

interventions are critical, but majorly under-prioritized.		
Provide basic materials like soap, sanitizers, facemasks, water purifiers, PPE and prevention messages to forestall community spread of COVID-19 among persons affected by crises, those in IDP camps and their host communities. Infection control and WASH are critical in the face of the ongoing pandemic, and should be included into the forecast and logistics for SRHR consumables since they overlap.	Civil Society Organization	Community Members
Improve access to comprehensive SRHR services including sustainable quality supply of reproductive health commodities and acceptability of services. CHEWs and CORPS including TBAs should be trained and engaged as approved by the task shifting and task sharing policy, and SRHR services should also be provided within the communities as a strategy to improve access and uptake, while as well preventing COVID-19 infection.	Civil Society Organization Government/Policy Makers (National, Sub-National and Community Level)	Donors
Decentralize SRHR service delivery to primary care level and communities (e.g. outreaches) to increase geographical access and pioneer innovative service delivery models like self-care interventions, use of telemedicine including phones and SRHR apps to access information and communicate with health provider.	Government/Policy Makers (National, Sub-National and Community Level) Civil Society Organization	
Collaborate with organizations and programs that are working in these contexts, who have achieved results with utilizing social enterprise, Coca Cola logistics and other 'last mile' innovations to ensure and maintain delivery of food, supplies and AIDS, Tuberculosis and Malaria medicines and consumables. Organizations working on SRHR should engage to leverage their competencies and networks for uninterrupted supply and delivery of SRHR and COVID-19 health products and commodities to these hard-to-reach and far-to-reach communities.	Government/Policy Makers (National, Sub-National and Community Level) Civil Society Organization	Community Members

Implement adaptive and responsive strategies to reach adolescents and young people with correct SRHR and COVID-19 related information and services, targeting in-school and especially out of school youths that are affected by the COVID-19 lockdown and conflict. This should be devoid of status including marriage, age, gender or sexual orientation.	Civil Society Organization Service Providers	Community Members
Remove barriers to access that are associated with stigma or fear by offering dedicated and integrated services to respond to the needs of women and girls who are survivors of SGBV, provide contraceptives, provide or refer for safe abortion services within the legal framework and maternity and new-born care.	Service Providers	Community Members
Offer mental health and psychosocial support in an integrated manner within SRHR services, and have referral pathways to more specialized mental health care. This is critical during the COVID-19 pandemic in the context of conflict and fragility, where mental health challenges from trauma from sexual violence, illness and loss of loved ones and other war experience affect up to 1 in 5 persons.	Service Providers	Civil Society Organization
Strengthen program linkages and referral pathways and ensure that Aid, SRHR and infection prevention responses are multisectoral and program managers and health workers should provide advocacy for reform of abortion, SGBV and LGBTQIA restrictive laws.	Civil Society Organization	Government (National, Sub-National and Community)
Invest in the Global Humanitarian Response Plan for COVID-19 and other funding mechanisms designated to respond to the pandemic, which must include funding for comprehensive and non-discriminatory SRH services.	Donors	
Donors, CSOs and local NGOs serve as a valuable resource for schools and teachers to turn to for more information, or to invite as guest speakers to discuss topics that reinforce or complement the CSE curriculum. Some NGOs also have community-based CSE programs in place. They should support the dissemination and implementation of CSE.	Civil Society Organization	Government (National and Sub-National)

Prong 5: Strengthen Multisector Partnerships, Stakeholder Collaboration and National, State and Local Accountability and Political Commitment for COVID-19 and SRHR Programs and to Transit from Humanitarian to Development Phase.

Fragile communities or states that are beneficiaries of humanitarian support have various aid organizations and implementing partners implementing varying programs. Borno state alone is said to have not less than 82 agencies/organizations working and providing various services. Most aid programs in this context are parallel to the other and to national or state programs, each with their targets, program actors and systems, and sometimes synergy, coordination and collaboration are sub-optimal and not usually cost efficient. Humanitarian and development agencies operating in all contexts in protracted crisis settings need to connect, collaborate, leverage and synergize in these contexts to deliver integrated services to the affected communities/people. Many of the COVID-19 prevention commodities are also required by the SRHR programs and can be provided together, and in settings where HRH are depleted, the organizations should work together for more efficient programming and service delivery in these contexts in COVID-19 pandemic times. Focus should be on saving lives and building resilient (health) systems in these communities.

Recommendations

Implementers of all programs including SRHR and infection control should collaborate and form partnerships to leverage and synergize each other's systems and networks. They should come under one coordination mechanism, with leadership being provided by equivalent coordinating government agency or Ministry, like the Ministry of Humanitarian Affairs as well as other government and development organizations structure like the office of the coordinator of humanitarian affairs of the United Nations.

This partnership should work towards building strong links and prioritization of one coordination mechanism, implementation of one multipronged response, and developing one monitoring and evaluation framework like the HIV program developed. These partnerships should be at national, state and local levels with regular implementation meetings and possibly development of one work plan, to include SRHR and COVID-19 mitigation efforts, into which various organizations will fit.

Partnerships should be formed between

- the development and the humanitarian actors
- the international NGOs and the local NGOs, CSOs and faith-based organizations
- the NGOs, UN agencies and the government
- the private sector actors
- the different sectors (Health, Protection, Legal, Social, Education)
- the providers of SRHR and communities

Recommendation	Stakeholder Responsible	Support provided
A national task team should be created to address all cross-cutting issues and generate one strategy, one coordinating mechanism, one implementation plan and one monitoring and evaluation framework.	Government/Policy Makers (National, Sub-National and Community Level)	All other stakeholders
State and local implementation teams should be created to reduce the number of aid workers present in conflict environments and enable coordinated, integrated and more cost-efficient responses. Programs can save funds that can be used for sustainable interventions like rebuilding health systems and facilities.	Government/Policy Makers (National, Sub-National and Community Level) Civil Society Organization	
SRHR is a cross-cutting multisector issue rather than a health sector issue, and the same is applicable to the COVID-19 crisis. The responses should be appropriate, multipronged, context specific, integrated and holistic to speak to health, social, security, protection and legal needs of the people and communities affected.	Civil Society Organization Government/Policy Makers (National, Sub-National and Community Level)	Community Members Service Providers
Accountability and regular communication and feedback should be provided to the people and project beneficiaries.	All stakeholders	Donors

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