



Meeting women and girls' health and safety needs in Chad, Nigeria, Pakistan, South Sudan, Ethiopia, and DRC during COVID-19

Learning brief

International Rescue Committee | February 2022

List of Acronyms

CCSAS	Clinical Care of Sexual Assault Survivors
GAC	Global Affairs Canada
GBV	Gender-Based violence
IGA	Income Generating Activities
IRC	International Rescue Committee
M&E	Monitoring & Evaluation
PM	Programme Manager
SOP	Standard Operating Procedure
SRH (R)	Sexual and Reproductive Health (and Rights)
TA	Technical Advisor
VAWG	Violence Against Women and Girls
WGSS	Women and Girls' Safe Spaces
WPE	Women's Protection and Empowerment
WASH	Water, Sanitation and Hygiene

When integrated with health, Women and Girls' Safe Spaces (WGSS) are called different things depending on location. They are also known as Women and Girls' Wellness Centres, Comprehensive Women's Centres and Integrated Women's Centres. For clarity, this report uses only the term WGSS.

This assessment report is written in British English.

Image on cover page – South Sudan Global Affairs Canada Programme.
Adrienne Surprenant.

This assessment was funded through IRC's partnership with Global Affairs Canada (GAC), through the project, Women and girls' health and safety needs in Chad, Nigeria, Pakistan, South Sudan, Ethiopia, and DRC are addressed and met during COVID-19 in 2021/22.

Global Affairs Canada does not necessarily share the views expressed in this material. Responsibility for its contents rests entirely with the author.

Meeting women and girls' health and safety needs in Chad, Nigeria, Pakistan, South Sudan, Ethiopia, and DRC during COVID-19

Learning brief

1. Introduction and setting the scene	2
2. Considerations on gender transformative approaches to programming	4
3. A Harm Reduction Approach to Addressing Unsafe Abortion	8
4. How did COVID-19 affect women and girls' sexual and reproductive health and safety outcomes in North-East Nigeria?	12
5. Our lives are integrated, our needs are integrated, our program and work should be integrated	16
6. Conclusions and next steps	20
7. References & Endnotes	22

1. Introduction and setting the scene

All over the world women and girls (W&Gs) have borne the burden of the COVID-19 Pandemic¹. The effects of COVID-19 and of ensuing containment measures have been particularly pronounced in countries grappling with ongoing humanitarian crises. In 2019, the International Rescue Committee (IRC) published a report on the impact of the Ebola Virus Disease (EVD) in West Africa drawing attention to the effects that public health emergencies have on access to life-saving SRH services for W&Gs². In a similar manner, in March 2020, at the onset of the COVID-19 pandemic, a report published by Care International predicted that the epidemic would disproportionately affect W&Gs in terms of health, protection, economic empowerment and wellbeing, education, water, sanitation and hygiene (WASH), shelter, food security and nutrition with heightened repercussions in humanitarian settings³. Drawing on their prior experiences dealing with other public health emergencies such as the Ebola outbreak and the Zika virus, IRC and CARE were quick to anticipate the gender-specific effects of COVID-19.

Accordingly, data collected in the early phases of the pandemic in low and middle-income countries shows two parallel trends: a soar in cases of gender-based violence (GBV) and a concurrent reduction in W&G's access to sexual and reproductive health (SRH) and GBV services in the pandemic's acute phases, when strict containment measures were in place⁴. SRH and GBV are deeply intertwined – GBV influences negative SRH outcomes for W&Gs, such as pain during intercourse⁵, sexually transmitted infections (STIs)⁶, HIV⁷ and unintended pregnancies⁸, potentially leading to unsafe abortions. Moreover, lack of access to both GBV and SRH services is rooted in patriarchal structures and norms.

The COVID-19 Pandemic has accentuated overlapping SRH (and rights) and GBV needs in humanitarian settings. Due to COVID restrictions, W&Gs were often confined to their homes, tasked with looking after children or other family members, and attending to household chores. Encumbered by unpaid care work, they were generally unable to access income-generating activities. They thus faced financial challenges and lost touch from their social networks. Girls could not attend school⁹. The resultant social and economic isolation facilitated the surge of GBV in the form of intimate partner violence (IPV), sexual violence and transactional sex, alongside unintended pregnancies, STIs, HIV and other sexual health complications.¹⁰ This occurred at a time when SRH and comprehensive GBV services were curtailed because perceived as “not essential”, funding allocated to GBV prevention, risk mitigation and response was reduced, and fears of contracting COVID-19 prevented many W&Gs from accessing services¹¹. The absence of or disruptions to lifesaving services for W&Gs, including emergency obstetric and newborn care, contraception, GBV case management, management of abortion complications, psychosocial support (PSS) for W&Gs, and clinical care for sexual assault survivors (CCSAS) have led to poor health and safety outcomes for W&Gs, including spikes in maternal mortality in the initial phase of the epidemic.

As the COVID-19 pandemic unravelled, the chasm between needs and service provision became more and more striking. Concurrently, the necessity of promoting W&G's empowerment to support them in making informed decisions regarding their SRH, rights, wellbeing and access to services, as well as influence overall programming, asserted itself as urgent. To address these gaps, with the financial support of Global Affairs Canada (GAC), the IRC launched the **“Women and girls' health and safety needs in Chad, Nigeria, Pakistan, South Sudan, Ethiopia, and DRC are addressed and met during COVID-19 in 2021/22” Project**, a multi-country initiative focusing on integrated SRH and WPE (women's protection and empowerment) services. This learning brief draws on the experience of IRC integrated interventions in humanitarian settings, with a specific focus on the GAC project implementation during COVID-19. **The overarching objective is to identify key takeaways and lessons learned to guide and improve integrated SRH and WPE programming in crisis-affected areas, particularly as concerns service delivery during COVID-19 and in its aftermath.**



South Sudan Global Affairs Canada Programme. *Adrienne Surprenant.*

THE GAC PROJECT AT A GLANCE

Ultimate goal: to ensure that women and girls are healthy and safe and influence their communities during and post the COVID-19 pandemic.

Intermediate objective: to ensure that women and girls are protected from and treated for the consequences of GBV and achieve their sexual and reproductive health and rights during the COVID-19 pandemic.

3 pathways to get there:

- Providing accessible, safe and quality SRH/GBV services for W&Gs during COVID-19
- Socially support W&Gs to have the information, power and resources to decide if they wish to seek SRH/GBV services during COVID 19
- Increase the demonstrative capacity in participation of women and girls in COVID-19 GBV/SRH programming.

Duration: 12 months (April 2021-March 2022)

Location(s) of the intervention: Chad, the DRC, Ethiopia, Nigeria, Pakistan and South Sudan, countries grappling with a range of challenges, including displacement, conflict, natural disasters and widespread protection issues for W&Gs.

Activities: a) remote training and supervision for the Minimum Initial Service Package (MISP), CCSAS and GBV case management; b) continued delivery of MISP, including SRHR in emergencies and comprehensive abortion care; c) skills development and integration workshops for staff; d) provision of personal protective equipment (PPE) for all service points and Infection Prevention and Control (IPC) improvements in services for W&Gs; e) women's empowerment to conduct risk analysis, remote safety audits and identify barriers to accessing support for W&Gs; f) joint awareness-raising campaigns; g) creation of Women and Girls' Safe Spaces (WGSS); i) outreach involving men and boys modelled on W&G's input.

2. Considerations on gender transformative approaches to programming

A Gender Analysis of Sexual Reproductive Health and Family Planning Use Among Displaced Populations

KEY TAKEAWAYS

Challenges of implementing SRH and FP services:

- A range of social norms, economic factors and attitudes from service providers inhibit FP
- Young age negatively impacts W&Gs' access to SRH services
- Gender-based violence affects SRH and FP
- Displacement can enhance GBV

Opportunities for gender transformative programming:

- Displacement can facilitate access to SRH services
- INGOs and supportive religious leaders can promote access to and overall acceptance of family planning
- Engaging men is crucial and requires a strategic approach
- Displacement can help leverage positive masculinities
- Youth-friendly services can enhance the quality and reach of service provision
- Greater representation of young females among community health workers (CHW) and IRC staff is needed

Gender transformative programming in humanitarian settings, namely programming that “addresses the causes of gender-based inequalities and works to transform harmful gender roles, norms and power relations”¹² comes with numerous challenges, as well as opportunities. This section delves deeper into the IRC’s experience implementing SRH/FP programs in Ethiopia (Fafan Zone and Somali Region) and South Sudan (Jamjang County), two countries involved in the GAC project. While the analysis does not focus on program implementation during COVID-19, the insights gleaned can orient future SRH/FP programs in the Horn of Africa and in other humanitarian settings, during and beyond public health emergencies.

CHALLENGES OF IMPLEMENTING SRH AND FP SERVICES

Social norms, economic factors and attitudes from service providers inhibit FP

A range of factors impede access to FP for W&Gs in Ethiopia and South Sudan. These include widespread social norms, economic factors and attitudes from service providers, which jointly affect W&G’s perceptions and understandings of FP, as well as their ability to access support.

Social norms acting as hurdles for W&G stem from the following beliefs:

- Men with larger families are more respected
- Women who use family planning are prostitutes / Wives who use family planning will become sexually promiscuous
- Religion does not allow the use of modern family planning
- Repopulating the clan is the man’s duty
- Newly married women must start having children in the first year of marriage to prove their/their husband’s fertility
- A woman who does not have children will be divorced, or her husband will take another wife

Factors of economic nature inhibiting FP include the notion that having a larger family increases household access to food rations. In South Sudan this is compounded by the conviction that a larger family helps families spread risk.

Attitudes from service providers that affect access to support include the belief that adolescent married girls should not access FP altogether, or that they may do so *only* if their parents consent to it. In South Sudan, service providers contend that women should not access FP without their husband’s permission.

Young age negatively impacts W&G's access to SRH/FP services

Adolescent girls and young women in Ethiopia and South Sudan struggle to access SRH and FP services. Barriers manifest themselves at the individual level in the form of lack of confidence and difficulty negotiating SHR and FP options with their partners, particularly in cases of low literacy; at the social level, chiefly as pressure to prove fertility within their marriage; and as service barriers in cases where providers dissuade adolescent girls and young girls from using FP services.

Gender-based violence affects SRH and FP

Rates of GBV in Ethiopia and South Sudan are high¹³ and deeply interconnected with FP. Many W&Gs reached via IRC programs disclosed experiences of intimate partner violence (IPV) in the form of economic violence (e.g. resources being taken away from them by their partners) and physical violence (e.g. being pushed or shoved). GBV is often related to fertility, with many adolescent girls reporting being pressured into demonstrating that they can have children and being mistreated by the husband's family or facing the threat of divorce when failing to do so. Seeking FP services without the partner's consent often results in violent reprisals. There is evidence from South Sudan that husbands have taken to forcibly removing family planning devices from their wives. Adolescent girls in South Sudan shared how accessing family planning without their husband's consent could lead to violent outcomes if he found out. More generally, if women and girls do not feel safe in their relationships, they are less likely to speak up and talk about FP with their husband or partner. There is a clear link between women's agency (e.g. their voice in the home), their experience of GBV and their ability to access FP.

Displacement can fuel GBV

Frustrated masculinities are often a cause of GBV, with many men taking their anger out on their partners when they feel that they have failed at fulfilling their prescribed gender roles¹⁴. Programs should be mindful of the pressures of displacement on both women and men and strive to prevent negative outcomes, particularly in the shape of IPV against W&Gs.

OPPORTUNITIES FOR GENDER TRANSFORMATIVE PROGRAMMING

Displacement can facilitate access to family planning

In the areas of Ethiopia and South Sudan where the IRC is active, a large share of both male and female unmarried clients view access to FP as comparatively easier than prior to displacement. From a service delivery perspective, there are more agencies providing a wider range of SRH/FP services than in clients' place of origin. A greater concentration of International Non-Governmental Organizations (INGOs), United Nations (UN) agencies, government services and Community Health Workers (CHWs) has contributed to greater access to services. This represents an opportunity to reach out to W&Gs who previously were unable to enjoy this form of support.

INGOs and supportive religious leaders can promote access to and overall acceptance of SRH and family planning

Family planning has become more accepted and accessible in the areas where the IRC is operational. This is largely due to the growing influence of INGOs. However, although the role of religious leaders may have partly dwindled, they still have an important part to play in promoting access to SRH & FP services. Given that religion remains an important factor preventing refugees and IDPs from using SRH services, FP or practicing birth spacing, raising awareness about the importance of SRH and FP among religious leaders remains a key priority. Bolstering alliances with religious officials who are supportive of the IRC's interventions can aid in breaking down barriers to W&Gs' access to assistance.

Engaging men is crucial and requires a strategic approach

Evidence gathered by the IRC in target areas in Ethiopia and South Sudan points to the fact that it is still common for men to make the final decision on whether a woman can access SRH services, use FP or engage in birth spacing. In many cases, women are timorous of raising the issue of FP for fear of being misunderstood or of violent reactions by male partners. This makes it difficult for couples to communicate about W&G's SRH needs. Engaging men is necessary to debunk misguided beliefs about SRH and FP and ensure access to services for W&Gs. Through the global evidence-based 'Engaging Men in Accountable Practices' (EMAP) approach, the IRC involves men in a transformative individual behavioural change to end violence against women, guided by inputs from women. In the Horn of Africa, the IRC has made strides forward on male engagement work through Men-to-Men groups, EMAP and the Equal Partners curriculum, a transformative couple's intervention promoting modern family planning methods, positive communication skills, shared decision-making, and gender equality.



Although the EMAP curriculum has been implemented in different contexts for a number of years, the approach is not systematically built into programs with an SRH/FP focus. Moreover, as highlighted by a World Bank study, while EMAP contributes to attitudes changing, behaviors are more resistant to change¹⁵. Future SRH/FP programs should therefore factor in the time commitment that is required to shift behaviors.

More generally, a strategic approach to EMAP should consider:

- the need for integrated interventions, where SRH/FP are embedded in WPE and conducive to improved equality between men and women
- the time, money, and reflection to change required to shift deep-rooted and complex social norms among men and communities
- implementing long-term interventions promising better value for money
- addressing the systemic cross-sectoral barriers that W&Gs face in accessing services and support through collaboration between SRH/FP, GBV, gender equality and economic recovery and development (ERD) programs.
- carrying out rapid, effective, and insightful evaluations, providing staff with actionable tips that can be easily implemented.
- working with men in ways that are accountable to women through Women's Rights Organisations (WROs), local women leaders or specialist staff from IRC's Gender Equality (GE) and WPE teams.

Applying EMAP to future interventions becomes even more pertinent in the context of COVID-19, in light of the fact that across East Africa, IRC humanitarian staff report an increased risk of GBV for W&Gs¹⁶.

Displacement can help leverage positive masculinities

While displacement comes with enhanced risks of GBV, it also represents a chance to reset gender relations and renegotiate new, more positive social norms (e.g., better communication between couples, more shared decision-making on SRH/FP, and a more even distribution of labor within the household). Engaging men in displaced settings is thus all the more urgent and needed, as it can go a long way in preventing violence and promoting gender equality.

Youth-friendly services can enhance the quality and reach of service provision

For services to comprehensively address the needs of W&Gs, including adolescent girls, it is vital to contribute to strengthening young people's ability to negotiate about FP. In order to ensure easy and swift access to services for young clients, it is advisable to engage schools, whilst also consulting youth on preferred times and locations for service delivery. Female youth steering groups can help improve

service quality and lend further legitimacy to the service, as can the recruitment of young female and male community health workers. Eliciting feedback from young people can act as a building block for service improvement – for instance female users of Women and girl Safe Spaces (WGSS) should be engaged in deciding what services should be offered to them in such spaces. Youth may also be involved as researchers in program evaluation. Ongoing supervision, mentorship, and support to CHWs is needed to ensure that they can continue to deliver quality services for young female clients.

Greater representation of young females among community health workers (CHW) and IRC staff is needed

Recruiting young female community health workers, to whom adolescent girls and young women may relate with greater ease, can support increased access to services for younger age groups. To achieve this, the IRC can work to identify and address barriers to recruitment and retention of women/youth, as well as ensure that younger women are also included as IRC staff. Connecting women with female and male mentors, implementing flexible work schedules, job sharing schemes, and asking teams to set recruitment targets are examples of proven strategies for raising the number of women in employment.

In the light of the identified challenges and opportunities, two key strategies should guide the IRC's gender transformative programming in Ethiopia, South Sudan and other humanitarian contexts:

Strategy 1: Engage men, improve communication in the home and build equal partnerships to improve women and girls' access to family planning. This means working in partnership with Male Change Agents (MGAs), women rights' organisations (WROs) and the wider community to build, test and roll out curriculum that is locally appropriate, and adapted from IRC's existing male engagement work in the DRC, and globally through EMAP.

Strategy 2: Support positive shifts in the belief systems and attitudes of CHWs. Create regular and continued mentorship, and peer-to-peer support for CHWs, recruit equal teams of male and female CHWs and hire younger CHWs. Only with an attitude shift will CHWs be able to deliver an effective, unbiased service to all clients.

3. A Harm Reduction Approach to Addressing Unsafe Abortion

Case studies from Nigeria, Pakistan and the DRC

Unsafe abortions account for approximately 4.7–13.2% of maternal morbidity and mortality worldwide¹⁷. Data shows that abortion restrictions do not reduce the incidence of abortion: countries where abortion is prohibited or allowed only to save the woman's life show higher rates of abortion than countries that provide abortions on request (37 abortions vs. 34 abortions per 1000 women aged 15–44, respectively). However, abortion restrictions do increase the proportion of abortions that are unsafe: countries with the least restrictive legal parameters surrounding abortion count less than 1% of “least safe”¹⁸ abortions where countries with restrictive legal parameters count 31%¹⁹. The IRC is committed to enhancing the safety of pregnancy and childbirth in crisis-affected countries. In the past few years, it has provided safe abortion care (SAC) in the DRC (North Kivu, South Kivu and Tanganyika), Nigeria (Borno state) and Pakistan (Khyber Pakhtunkhwa province – KPK). All target areas are characterised by high rates of unsafe abortions, as a result of difficulties obtaining contraception, deep-rooted cultural or religious beliefs and barriers to accessing health services.

In Northeast Nigeria, the Boko Haram insurgency has caused large-scale displacement resulting in many W&Gs experiencing rape, sexual assault, IPV and early and forced marriage, often leading to unwanted pregnancies²⁰. It is estimated that in 2018 there were 45.8 abortions per 1000 women of reproductive age, out of which approximately two-thirds were unsafe²¹. Unsafe abortions are particularly widespread among young women living in rural areas.

For the past few decades, the DRC has been affected by conflict, unrest, and displacement, exacerbated by the Ebola outbreak, affecting W&Gs' SRH and experiences of GBV in distinct ways²². A recent study estimating the incidence of abortion in the capital city of Kinshasa found that in 2016 146,700 abortions took place, equivalent to 56 terminations per 1,000 women aged 15–49. Out of these, 61% were thought to be unintended²³. According to the DRC National Strategic Plan for Family Planning (DRC-NSFPF) 80% of pregnancies among women who are married or have stable partners are considered at risk²⁴. Access to safe abortion is a priority in light of the high rates of maternal mortality registered in the DRC. Based on data gathered in 2017, it is estimated that for every 100,000 live births, 473 women die from pregnancy-related causes, a higher rate than the regional average of 445²⁵.

Pakistan hosts approximately 3 million Afghani undocumented migrants and refugees²⁶, many of whom are living in the Khyber Pakhtunkhwa province, where the IRC has been present and active since 2016. Access to health in Pakistan is far from straightforward – Pakistan devotes 0.9 percent of

its GDP in public spending to health, with many individuals and families having to cater for health expenditures via out-of-pocket spending²⁷. Hampered access to health is particularly pronounced among displaced people, especially when it comes to W&Gs, who face specific SRH and GBV challenges. The most recent data estimates for Pakistan record an abortion rate of 50 per 1000 women²⁸. Many health professionals still engage in harmful practices, which include dilatation and curettage (D&C). In rural areas, abortions are often performed by untrained professionals under problematic safety and hygiene conditions²⁹.

Thanks to the GAC Project the IRC has been able to offer ongoing access to SAC services for W&Gs in target areas during COVID-19. All SAC interventions are informed by a harm reduction perspective. The aim of harm reduction is to decrease the incidence and the consequences of unsafe abortion by providing correct information on safe abortion procedures to women and girls with unintended pregnancies. The three core principles of harm reduction are:

- **Pragmatism:** many women will resort to unsafe abortion if they are not offered a safe method of abortion.
- **Neutrality:** health care providers are meant to provide necessary health care absent of any moral judgment. Harm reduction focuses on reducing risk associated with abortion, not judging whether abortion itself is right or wrong.
- **Humanism:** all women have a right to having their health needs met, regardless of whether those needs align with religious and social norms or laws.

The legal frameworks governing abortion in the three target countries differ in important ways, calling for tailor-made approaches and solutions. In the **DRC**, since the approval of the Maputo Protocol in 2018, abortion has been possible in cases of sexual assault, rape or incest and/or when the mental or physical health of the mother or the life of the woman or fetus is at risk. Moreover, offering information on self-management of abortion is permissible by law.

In **Nigeria**, abortion is only permitted “in good faith for the purpose of saving the life of the woman”. However, access to safe abortion care is limited and while it does exist in Borno State, the quality of service varies and is often poor.

In **Pakistan** abortion is permitted if it is performed “in good faith, for the purpose of saving the life of the woman or providing necessary treatment to her.” Performing abortions for physical and physiological well-being is permitted within the interpretation of the law, whereas abortion in cases of incest and rape is considered on a circumstantial basis. Third party authorization is not required to perform an abortion, with the 1984 Federal Shariat Court declaring that the state holds the “burden of proving an illegal abortion was provided.” However, religious bodies are not typically supportive of SAC after 120 days, which coincides with “ensoulment” as part of Islamic teaching. Spousal consent or parental consent for minors is not legally required for to receive an abortion, though in practice providers may ask for the husband’s or parents’ consent.

Program specifics

In light of the differing scenarios, the IRC has adjusted its programs to the needs and possibilities of each country and specific target area.

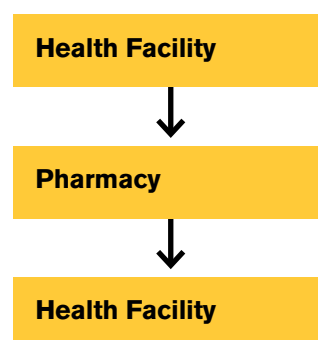
DRC

The IRC has worked in DRC since 1996 and is now operational in three provinces: North Kivu, South Kivu and Tanganyika. The program includes health, women’s protection and empowerment (WPE), child protection, WASH and livelihoods. The sexual and reproductive health (SRH) program started in 2006 with a comprehensive RH program under RAISE and continued as a FP and PAC in emergency program (FP- PACE) from 2011, both funded by a large anonymous donor. The latter program focused first on expanding access to and institutionalizing family planning (FP) and post-abortion care (PAC), and eventually, by 2019, introduced safe abortion care (SAC) and the harm reduction approach. The program currently supports 29 state health facilities with drugs, supplies and materials, financial support for stipends and operating costs, trainings and supervisions. The DRC’s ratification of the Maputo protocol in 2018 created a window of opportunity for the IRC to introduce SAC services into its pre-existing FP and PAC program operating in 29 Ministry of Health (MOH) facilities. The IRC DRC team designed a rights-based, dual-pronged program model that ensured all W&Gs in need of services were able to access them.

W&Gs who sought pregnancy termination and met the Maputo protocol criteria (cases of sexual assault, rape or incest and/or when the mental or physical health of the mother or the life of the woman or fetus was at risk) were able to access safe abortion care services at an IRC-supported health facility. The IRC recognized that it was important to also meet the needs of clients desiring a pregnancy termination who did not meet the Maputo protocol criteria. Therefore, it supported healthcare workers to offer these clients counseling on safe self-management of abortion, permissible under law. The misoprostol drug necessary for medication abortions is often available at local pharmacies; thus, the IRC partnered with local pharmacies to ensure the availability of quality misoprostol in the community. Importantly, self-management of abortion was made available to all women seeking abortion. The client was able to choose to self-manage her abortion using misoprostol at a pharmacy site because ineligible for SAC at the health facility under the Maputo protocol, because she preferred self-management of abortion and did not wish to access clinical services at the facility. This made several access pathways possible, depending on W&G’s point of entry:

HARM REDUCTION CLIENT PATHWAYS

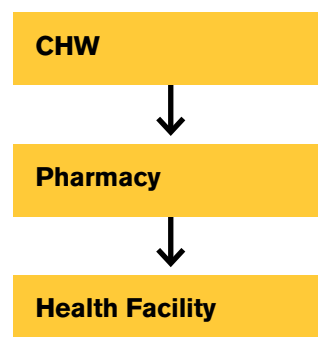
Pathway 1



Pathway 2



Pathway 3



Nigeria

In Nigeria, the IRC has provided comprehensive reproductive health services to W&Gs in the Borno State through various Ministry of Health facilities, an IRC Reproductive Health (RH) clinic in Bakassi IDP camp in MMC/Jere Local Government Areas (LGAs), six Comprehensive Women's Centers (CWC) and through roving support in other IRC outpost stations such as Nutrition and Primary Health centers. The CWCs centers offer women and girls from displaced and host communities a safe space where they can receive integrated SRH services and WPE services, helping them to heal and recover from some of the hardships they have faced since the onset of the crisis. Services provided in these centers include: family planning (FP), Sexually Transmitted Infections (STIs) prevention and treatment, post-abortion care (PAC), antenatal care, post-natal care and safe deliveries, clinical care for sexual assault survivors and community sensitization. These services are also provided to and tailored for adolescent girls. The WPE services include case management of GBV, psychosocial support activities, and Girl Shine adolescent life-skills and empowerment activities. In Gwoza, the IRC works alongside Médecins Sans Frontières (MSF), who runs the town's secondary hospital, which also offers comprehensive SRH services and acts as the referral facility for both CWCs.

The program model differs slightly between urban and rural areas, due to differing availability of SAC services. In Gwoza, midwives offer information on the use of Misoprostol and/or refer the client to MSF who offer medical or surgical SAC services for women with pregnancies up to 22 weeks. Women then have the option to access their own misoprostol from local pharmacies, or to access SAC services at the MSF hospital. MSF receive all women requesting this service in a separate room to the maternity to maintain confidentiality and privacy. The IRC and MSF meet on a monthly basis to discuss this referral process, iron out any challenges and compare the number of referrals made by the IRC and the number received by MSF. In Maiduguri, no referral pathway has been established with an organization or facility that provides SAC. For this reason, during counseling, IRC midwives offer information on how to self-managed an abortion by buying misoprostol over the counter or where to access SAC services from private clinics identified in the SAC assessment mentioned above.

HARM REDUCTION MODEL IN GWOZA

Pathway 1

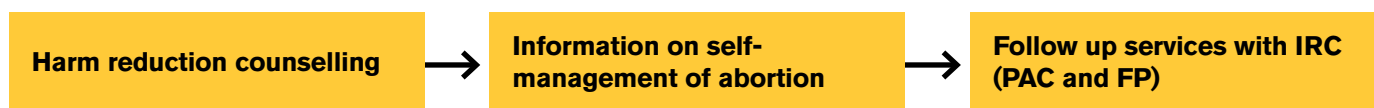


Pathway 2

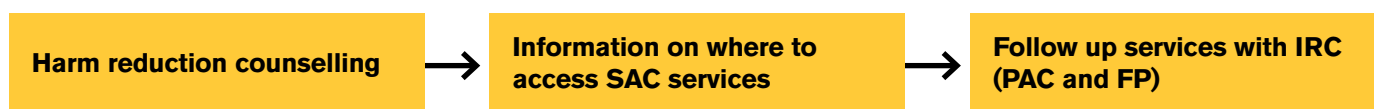


HARM REDUCTION MODEL IN MAIDUGURI

Pathway 1



Pathway 2



Pakistan

IRC Pakistan began implementing Family Planning and Post-Abortion Care in Emergencies (FP-PACE) in 2011 to increase access to and quality of family planning and post-abortion care to conflict-affected and displaced women and girls in Khyber Pakhtunkhwa (KPK) Province in Pakistan. Key program activities include competency-based training for health care providers, supportive supervision, provision of supplies and equipment, monitoring and evaluation and community outreach. The program initially focused only on delivering family planning and post-abortion care (PAC) government health facilities but began efforts to increase access to safe abortion care (SAC) in 2016. The program was renamed Contraception and Comprehensive Abortion Care in Emergencies (ConCACE) in 2018 to reflect the broader focus of the program.

Results

The IRC's harm reduction programs in the DRC, Nigeria, and Pakistan led to remarkable results, testifying to the immense benefits of investing in safe abortion interventions for W&Gs.

- In the **DRC** 4,388 women and girls received SAC services through IRC supported services between January 2019 and November 2020. Of these, 31% (1,377) received direct SAC services at an IRC-supported MOH facility and 69% (3,011) were referred to self-manage their abortion and purchase misoprostol at an IRC-supported pharmacy. Of these harm reduction clients, 78% (2,360) followed up to receive an FP method at a health facility. All three provinces showed a sharp increase of harm reduction clients in the early months of 2020. In North and South Kivu, this is likely influenced by the addition of 33 new pharmacies in the harm reduction approach. However, the fact that this trend is also observed in Tanganyika suggest that this might also be correlated with the appearance of the Covid-19 crisis which may have increased women and girls' real or perceived barriers to accessing services in health facilities, and thus encouraged them to seek abortion services in pharmacies instead. However, the direct service delivery data does not show an expected decrease.
- In **Nigeria**, between September 2019 and November 2020, 384 women and girls received harm reduction counseling: 204 in Maiduguri and 180 in Gwoza. Of these, 13% or 49 women returned for PAC services (44 in Maiduguri and 5 in Gwoza – the difference is due to the fact that most women received full SAC and follow up care from MSF in Gwoza); and in Gwoza, 58 women and girls followed up on their referral to receive SAC services from MSF between January and November 2020.
- In **Pakistan**, 365 women received SAC through IRC supported health facilities in KPK. Of those women and girls who received services from July 2017–December 2018, 19% accepted a FP method before discharge and 61% accepted a FP method within two weeks after discharge. However, no SAC data were reported

from January 2018 to June 2018 due to the absence of formal support and documentation for SAC during the period. Most SAC cases were reported from government facilities and relatively few came from private providers. From April to September 2019, 141 clients received SAC in newly supported health facilities and 30% accepted contraception before discharge. Fifty-eight percent were treated with misoprostol, 41% were treated with manual vacuum aspiration and 1% were treated with D&C. Providers are often more comfortable with the administration of misoprostol, being that it requires less skill than MVA. Many women and girls also prefer misoprostol due to the option of at-home self-administration. In May of 2019, one D&C treatment was administered, accounting for less than 1% of SAC evacuation methods. SAC data disaggregated by method of uterine evacuation were not available until 2019.

In addition to the numbers of W&Gs accessing harm reduction services, it should be noted that across all three countries the IRC invested in awareness-raising and training of key stakeholders, most notably IRC staff, community health workers, health providers and pharmacists via values clarification and attitude transformation (VCAT). The benefits of training and awareness-raising will outlast IRC interventions.

LESSONS LEARNED

- **Adolescents and unmarried woman face increased barriers to services**, requiring a specific strategic approach and ad-hoc awareness-raising about unsafe abortion and available SRH services
- **Guaranteeing clients' confidentiality** is paramount
- **Building strong community partnerships is critical for creating an enabling environment for SAC**
- **VCAT (values clarification and attitude transformation)** are needed to introduce taboo subjects, overcoming negative attitudes, and building acceptance of towards the intervention both internally and externally to the organization
- **In Pakistan, peer support and coaching improved clinical skills for uterine evacuation** – support was offered to providers who lacked training on MVA and misoprostol and were performing outdated or incorrect practices, like dilation and curettage
- **In Pakistan, it is best to avoid working with private providers**, as it poses challenges to ensuring the quality of care, affordability of services and consistent reporting
- **In the DRC, working with pharmacies was key** to ensuring access to misoprostol
- **In the DRC, the inclusion of Health authorities and health facilities** in set-up and implementation allowed for zonal health authorities to integrate this new approach as part of primary healthcare
- **Once you start, you cannot stop** – ensuring continuity is a priority.

4. How did COVID-19 affect women and girls' sexual and reproductive health and safety outcomes in North-East Nigeria?

An assessment of women and girls' perspectives

KEY TAKEAWAYS

- COVID-19 has exacerbated existing barriers and created novel barriers to accessing SRH and WPE services
- COVID-19 has had non-negligible financial repercussions on W&Gs.
- The pandemic has led to a rise in commercialized sexual exploitation among adolescent girls while adult women had mixed experiences of intimate partner relations during lockdown.

In Nigeria, the healthcare system has been severely challenged by COVID-19. SRH and GBV services have been largely sidelined, with the bulk of resources being diverted toward emergency response efforts. As in other places ridden by conflict or natural disasters engendering mass displacement, COVID restrictions over movement, access to education and work have fuelled GBV, and placed financial pressure on W&Gs³⁰. North-East Nigeria is not only affected by militia violence, but also dominated by patriarchal gender norms that often hinder access to SRH and GBV response services for W&Gs, making empowerment all the more needed and urgent. The recollections of the acute phase of the pandemic by women and adolescent girls in the Borno state - more specifically, in the GSS camp for internally displaced people in Gwoza and in Bakassi's host community in the Maiduguri Metropolitan Council - shed light on the challenges faced by women and adolescent girls on the ground and on the lessons learned from integrated interventions during the pandemic.

COVID-19 has had non-negligible financial repercussions on W&Gs

Prior to the pandemic, W&Gs were able to engage in a range of profitable activities that allowed them to cater to their essential needs, with some cash to spare for non-essentials. COVID-19 reduced access to income, making it increasingly difficult to meet basic needs. Women spent more time at home and changed their everyday habits, especially during the acute phase of the pandemic. At this time, education came to an abrupt halt, with many girls not being able to go to school. Some W&Gs reported positive outcomes stemming from lockdowns, such as the possibility to spend more time with their husbands or parents, and the opportunity to acquire new skills. The latter especially applied to younger girls.

The pandemic has led to a rise in IPV and commercialized sexual exploitation among W&Gs

Despite COVID-19 opening up novel opportunities for several W&Gs, confinement within the home often led to increased risks of IPV. Moreover, the rise of joblessness and hardship resulted in exacerbated commercialized sexual exploitation of adolescent girls by those who held money. The breakdown of social barriers as a result of COVID-19 restrictions meant that girls were more isolated and it was increasingly harder for them to confide in their friends.



Muna and her older sister Kumis fled their home in the Nuba mountains in 2016. Today, they attend the IRC's classes on how to prevent gender-based violence, which tends to spike during times of crisis. *Adrienne Surprenant.*

COVID-19 has exacerbated existing barriers and created novel barriers to accessing SRH and WPE services

“Even the service providers are not available. People are afraid to go to the hospital because they might be told they have Covid.” – Adult woman in North-East Nigeria

In the areas targeted by the IRC intervention in Nigeria, W&Gs face multiple barriers in accessing SRH and WPE services even in non-pandemic times. This is largely due to cultural and religious norms, as well as lack of awareness about eligibility for services. For instance, many adolescents are unaware that family planning and safe abortion care is not restricted to married women. This means that they often opt for risky alternatives in an attempt to interrupt an unwanted pregnancy. There are also widespread preoccupations surrounding providers' confidentiality and their tendency towards age-based discrimination. Young women fear being judged and looked down upon due to their age.

Against this backdrop, during the acute phase of COVID-19, women generally managed to discreetly access SRH and WPE services but weren't always able to return for follow-up appointments. This led to unplanned pregnancies and on occasion, IPV following discovery of contraceptive use by spouses. Despite access to facility delivery being relatively easy compared to other SRH services, many W&Gs ended up giving birth at home and during the night in unsafe conditions. Antenatal care was subjected to severe delays, while postnatal care was perceived generally readily available.

When it comes to more heavily stigmatised services such as post-abortion care (PAC), family planning and GBV care these were increasingly difficult to access at the peak of COVID-19, even more so in rural areas. In addition, providers ran short of contraceptives and medical supplies for STIs, with reverberations on W&G's wellbeing.



Courtesy of IRC Democratic Republic of Congo. O. Acland.

TABLE 1 – BARRIERS TO ACCESSING INTEGRATED SRH/WPE SERVICES MENTIONED BY W&GS

BARRIERS PRE COVID-19	COVID-19 SPECIFIC BARRIERS
Lack of knowledge of the benefits of family planning (exacerbated by COVID)	Travel restrictions
High levels of illiteracy amongst women and girls	Fears of contracting COVID
Lack of Money (exacerbated by COVID)	Limited support by chosen companion during facility delivery
Lack of spousal support	Fewer patients allowed in facilities at any one time.
Fear of side effects from contraceptives	Lack of availability of health workers at facilities
Health workers' attitudes	Lack of availability of SRH services (during lockdowns)
Services unavailable (exacerbated by COVID)	
24hr services not available	
Providers requesting consent forms from spouses or parents	
Fears related to abortion procedures	

LESSONS LEARNED

W&G's experiences at the height of COVID-19, in conjunction with the views of IRC staff on the ground, point to the need for greater preparedness vis-à-vis extreme pandemic conditions, in order to better cater to women's complex needs.

More specifically, future work in North-East Nigeria and in similar humanitarian settings during public health emergencies should be prioritise:

...PROVIDING

- integrated SRH and WPE community engagement to reduce stigma around services and protect women from GBV including as a consequence of accessing services.
- toll-free numbers that women can call to request SRH and GBV services and receive free advice and referrals (e.g. for GBV/ WPE services)
- 24 hour services
- home-based services relying on trained health workers to deliver SRH services to women in need
- extended prescription periods for contraceptive pills
- tricycles placed in strategic locations for women to easily reach hospitals, especially during emergencies (suggested government provision)
- personal protective equipment (PPE) for W&Gs to easily access facilities
- SRHR information to W&Gs in the course of Risk Communication and Community Engagement activities

... SUPPORTING

- socio-economic empowerment of women and girls via multipurpose cash interventions to protect them from damaging, exploitative coping strategies as a result of disrupted livelihoods

...ADVOCATING

- for facilities and woman and girl safe spaces to remain open during lockdowns in light of SRH and GBV services (not just SD, ANC and PNC) being lifesaving
- for access to contraception without the need for prescriptions or partner consent, and community-based service delivery³¹.



South Sudan Global Affairs Canada Programme. *Adrienne Surprenant.*

5. Our lives are integrated, our needs are integrated, our program and work should be integrated

An external assessment of staff views on IRC's SRH/WPE integration programming

KEY TAKEAWAYS

- SRH/WPE integration is vital
- Successful integration efforts must be all-encompassing, multi-level and multi-stakeholder
- Community engagement is essential to success
- Although there are both barriers and enablers to integration, enablers outweigh barriers
- While COVID-19 poses unique challenges to service provision, these can be tackled via a well-structured and responsive program

SRH/WPE integration is vital

IRC staff involved in the implementation of the GAC Project saw integration as the mainstay of humanitarian work, recognising its particular salience during public health emergencies. Integration rooted in a **woman-centred approach** can help ensure **access** to lifesaving GBV and SRH services leading to an overall improvement in health and safety outcomes for W&Gs. In humanitarian settings, the IRC's SRH service is part of the health sector, while WPE services falls within the purview of Violence Prevention and Response (Protection). However, in societies where GBV is widespread due to patriarchal beliefs, inequality, and misconceptions about W&Gs' roles in society, SRH and WPE needs are inextricably linked. This means that W&Gs often require access to both SRH and WPE, and strong referral pathways need to be in place to ensure that they are adequately supported.

"Much of the consequences of GBV affect SRH... SRH education and services are a huge component of GBV prevention. In many contexts we work in, societies are more conservative or religious, where SRH information and services are stigmatised and taboo. If SRH and WPE integrate in safe spaces, where women and girls can receive different types of services, information, and activities, there is more confidentiality and protection on who is receiving/doing what at the centres (...) Furthermore, it is more effective for units to be integrated where we can work with the same target population, provide more effective referrals, use the same facility for services" – IRC staff member quoted in External Assessment of IRC's SRH/WPE Integration Programming

Successful integration efforts must be all-encompassing, multi-level and multi-stakeholder

To be truly effective, integration must span **all levels of the organisation** – including management and coordination – as well as **every phase of programming**, from the very onset of planning to fundraising activities. The GAC Project experience highlighted that key elements of success in integrated SRH/WPE programming include the provision of integrated SRH/GBV and WPE services; collaboration among trained staff; community engagement; maximisation of extant resources to avoid duplication; and collaboration with partners and donors.



Courtesy of IRC Nigeria. KC.

Community engagement is essential to success

Of the above-mentioned aspects, particular attention and effort were devoted to community sensitisation, considered essential for building trust with community leaders and potential service users. To this end, staff underscored the need of:

Engaging:

- women and men by setting up community support groups
- religious and community leaders
- women leaders
- men and boys
- teachers

Providing:

- weekly comprehensive sexuality education for W&Gs at safe spaces
- age-appropriate learning sessions for children and adolescents on SRH and GBV
- training of community groups and leaders to be advocates

Communicating:

- via local radio, social media and safe spaces

When community sensitisation hits home, community leaders themselves are proactive in insisting and enabling the organisation offering integrated programming to stay in their area and continue delivering services. This was the case for the IRC in the territories where it operated.

Although there are both barriers and enablers to integration, enablers outweigh barriers

Integration comes with immense gains, as well as challenges. In the eyes of staff working on the GAC project, barriers to integration were both internal and external, although the former were perceived as more preponderant. This should not come as a surprise, as it common to identify difficulties in one's daily working life as dominant. In particular, staff members lamented a lack of understanding and prioritisation of integration by supervisors working in Health and Protection, with both sectors tending to work in silos. A power struggle between management in the two sectors was also frequently mentioned by staff, alongside the belief that country managers do not put integration first. Resources and staff being funded by different sectors were identified as a barrier and may be part of this issue. Furthermore, logistics emerged as a problem for integration programming, giving rise to disagreements over which sector should provide which vehicles. Overall, internal tensions were seen to contribute to the lack of a universal management approach/ universal planning at all levels. Additionally, there was a sense that more staff training and skill-development would greatly benefit on-the-ground operations, alongside an increased focus on service confidentiality. Ultimately, the disproportionate attention given to shorter-term outputs, rather than longer-term outcomes was considered as detrimental to successful integration. For most of the internal barriers to integration identified by staff, enablers were also pinpointed, hinting to the fact that there are clear and pursuable pathways to address outstanding gaps.

In terms of external challenges, these coincided with government health staff lacking an in-depth understanding of integration - which often meant that it was not prioritised – as well as the skills to support it. Government policy was often described as ambiguous or lacking. In addition, the short timeframe of the GAC project was interpreted as a non-negligible hurdle. Funding is unsurprisingly seen by many staff members as essential for integration. GAC funding allowed the Technical Advisors (TAs) to focus exclusively on integration, and this is the single most significant reason that SRH/WPE teams were able to channel their expertise to deliver integration, despite more senior management often not prioritising it. GAC funding coming to an end was perceived by staff as a risk factor, which could potentially jeopardise the sustainability of integration in target areas.

As regards enablers, the sheer enthusiasm and belief in integration from staff members was key to promoting integration. As previously mentioned, ongoing support provided by TAs is conducive to project success; staff highlighted that being able to meet with TAs in person from time to time, provided that the security and health context allow for it, as well regularly talking with them via online video calls, is of great help. Additionally, shared meetings, moments of reflection and de-briefs between the Health and Protection sectors were seen as instrumental to overcoming

separateness, with overall gains for the service. The strong relationship with the community, in line with the approach previously described, was reiterated as indispensable – ruptures between the IRC and the communities where it operates would have a serious impact on the delivery of integrated services. Similarly, notwithstanding the challenges of liaising with government representatives and external organisations, collaboration remains a priority, given the challenging contexts where project implementation takes place. Successful integration has a ripple effect, as it paves the way for future integration.

Overall, staff members identified a greater number of enablers than barriers – this speaks to their positive experience working with the IRC, their confidence in the feasibility of integrated programming and their belief in the benefits of the intervention for W&Gs, as well as local communities.

While COVID-19 poses unique challenges to service provision, these can be tackled via a well-structured and responsive program

Interestingly, despite COVID-19 acting as an obvious hurdle rendering access to drugs, cash and travel more arduous, it was not perceived as the main issue by IRC staff. This may be because personnel is accustomed to working in challenging contexts and is used to advocate for the need for integrated interventions with health and local authorities, even when the bulk of resources and attention are diverted elsewhere, as has been the case during the pandemic.



IRC Pakistan.

TABLE 2 – INTEGRATION BARRIERS AND ENABLERS

ENABLERS	BARRIERS
Enthusiasm and belief in integration of staff	Integration not prioritised by senior managers in either sector
Support from Technical Advisors (or other Senior staff, as applicable)	Integration not prioritised by service providers and governments
Shared/joint meetings	Short timeframe of the GAC project
Strong relationships with the community	
Strong relationships with external organisations	
Successful integration and its outcomes	

LESSONS LEARNED

Future work in humanitarian settings should prioritise:

... SECURING

- multi-year funding to sustain and deepen integration in all areas where it has already been established

... IMPLEMENTING

- integration at all levels of hierarchy and all project stages with close reference to Theories of Change and their aligned sub-outcomes, including common woman-centered indicators throughout the project cycle.

... INCLUDING

- participatory and feminist driven approaches to program design and implementation of projects focused on women and girl outcomes
- hands-on, in-person support for Program Managers (PMs) from Technical Advisors (TAs) (Covid restrictions permitting).

... HARNESSING

- the expertise of PMs and supporting them to share learning across IRC. Explore the provision of forums and opportunities for integration program staff globally to communicate with each other.
- the knowledge garnered in the field to develop a toolkit containing models of integration and case studies³²

6. Conclusions and next steps

The IRC's experience conducting SRH/WPE interventions in humanitarian settings has proved that there is a pressing need to keep promoting a gender responsive and integrated approach to programming in crisis-affected areas. The GAC Project has reiterated the importance and value of the IRC's integration model, which the organization has continued to invest in and fine-tune over the years thanks to its work in various countries around the world. COVID-19 has underscored that service providers should be prepared and ready to adapt SRH/WPE services to pandemic conditions, above all ensuring ongoing availability of and access to services at all times, including at the peak of public health emergencies. This is in line with a vision of SRH/WPE as essential and the importance of SRH/WPE services being women-centered at all times.

Finally, the GAC project has emphasized the necessity to devote more time and resources to advocacy (internal and external), staff training, knowledge-sharing and multi-level communication, as well as underlined that project sustainability should be a key priority to be accomplished via sustainable multi-year funding.

All the lessons learned via the GAC Project experience and prior programming, as presented in this learning brief, shall serve to shape more informed, evidence-based, and sustainable future interventions.



7. References & Endnotes

LINKS TO REPORTS INFORMING THIS PAPER

External parties please contact your IRC focal point for access

- [GAC Integration assessment \(French\)](#)
- [GAC Integration assessment \(English\)](#)
- [Packard COVID assessment on W&Gs \(French\)](#)
- [Packard COVID assessment on W&Gs \(English\) in PDF](#)

REFERENCES

- Alsibiani, S. A., & Rouzi, A. A. (2010). Sexual function in women with female genital mutilation. *Fertility and Sterility*, 93, 722–724.
- Anand, E., Unisa, S., & Singh, J. (2017). Intimate partner violence and unintended pregnancy among adolescent and young adult married women in South Asia. *Journal of Biosocial Science*, 49, 206–221. doi:10.1017/s0021932016000286.
- Andersson, N. et al. (2008). Gender-Based Violence and HIV: Relevance for HIV Prevention in Hyperendemic Countries of Southern Africa. *AIDS*, 22(4), 73–86. doi: 10.1097/01.aids.0000341778.73038.86.
- Banke-Thomas, A., Yaya, S. (2021). Looking ahead in the COVID-19 pandemic: emerging lessons learned for sexual and reproductive health services in low- and middle-income countries. *Reproductive Health*, 18, 248, 1-8. doi: 10.1186/s12978-021-01307-4.
- Bell, S.O., Omoluabi, E., OlaOlorun, F. et al. (2020). Inequities in the incidence and safety of abortion in Nigeria. *BMJ Global Health*, 5, 1-11. doi:e001814. doi:10.1136/ bmjgh-2019-001814.
- CARE. (2020). GENDER IMPLICATIONS OF COVID-19 OUTBREAKS IN DEVELOPMENT AND HUMANITARIAN SETTINGS. Available at: <https://bit.ly/3HZs2Wm>
- Democratic Republic of the Congo Ministry of Health. (2014). Family Planning - National Multisectoral Strategic Plan (2014-2020). Political Advocacy Committee and Permanent Multisectoral Technical Committee. Available at: http://advancefamilyplanning.org/sites/default/files/resources/PSN_PF_2014-2020_english_20140916'.pdf
- Erez, E., Adelman, M., and Gregory, C. (2009). Intersections of Immigration and Domestic Violence. *Feminist Criminology*, 4(1), 32–56. Doi: 10.1177/1557085108325413.
- Gender Innovation Lab, IRC & The World Bank.(2020). Engaging men to transform gender attitudes and prevent intimate-partner violence in the DRC. Available at: <https://bit.ly/3HxCNhC>
- Grose, R.G., Chen, J.S., Roof, K.A., Rachel, S. & Yount, K.M. (2020). Sexual and Reproductive Health Outcomes of Violence Against Women and Girls in Lower-Income Countries: A Review of Reviews. *The Journal of Sex Research*. 58:1, 1-20. doi: 10.1080/00224499.2019.1707466
- Guttmacher Institute and Population Council. (2013). Postabortion care in Pakistan: in brief. Available at: <https://bit.ly/3sA4YlX> [Accessed 14 May 2020]
- Hernández, R.L., Valladolid, U.A., Ferrero, B.O.L., Díez, S.C. Sexually transmitted infections in the context of a sexual assault. *Enferm Infecc Microbiol Clin*. 2019, 37(3): 187-194.
- IFRC.(2022). Regional Population Movement - Afghanistan: Preparedness and Response - Operation Update #2, DREF Operation n° MDRAFRPM21. Available at: <https://bit.ly/3hkbdJT>
- International Rescue Committee. (2020). What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls. Available at: <https://bit.ly/3rSwsIH>
- Lince-Deroche et al. (2019). Unintended Pregnancy and Abortion in Kinshasa, Democratic Republic of Congo: Challenges and Progress. Guttmacher Institute. Available at: <https://bit.ly/3piVNHV> [Accessed 25 February 2022]
- McKay G., Black B., Mbambu Kahamba S., Wheeler E., Mearns S., Janvrin A. (2019). Not All That Bleeds Is Ebola: How has the DRC Ebola outbreak impacted Sexual and Reproductive Health in North-Kivu? New York, USA: The International Rescue Committee.

- Sathar, Z., Singh, S., Rashida, G., Shah, Z. and Niazi, R. (2014). Induced abortions and unintended pregnancies in Pakistan. *Studies in Family Planning*, 45:(4)471-491. doi:10.1111/j.1728-4465.2014.00004.x.
- Say, L. et al. (2014). Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*, 2(6), 323-333. doi: 10.1016/S2214-109X(14)70227-X.
- Singh S., Remez L., Sedgh G., Kwok L. and Onda T. (2017). *Abortion Worldwide 2017: Uneven Progress and Unequal Access*. Guttmacher Institute. Available from: <https://bit.ly/3sovDI4>
- The World Bank. (2020). Democratic Republic of Congo, Human Capital Index 2020. Available at: <https://bit.ly/36Oe6Rn> [Accessed 23 February 2022]
- The World Bank. (2020). Pakistan, Human Capital Index 2020. Available at: <https://bit.ly/3sl3TUI> [Accessed 23 February 2020]
- Tran, N.T. et al. (2021). A Call to Safeguard Sexual and Reproductive Health Information and Services during Ebola Outbreaks. *Conflict and Health*, 15(1), 15- 57. doi: 10.1186/s13031-021-00392-3.
- UN. (2020). The impact of COVID-19 on women. Policy brief. Available at: <https://bit.ly/3gSoyZC>
- UNHCR. (2018). UNHCR Ethiopia: Sexual & Gender-Based Violence Factsheet. Available at: <https://bit.ly/3hoAfYd> [Accessed 25 February 2022]
- UNICEF. (2021). Gender Based Violence in South Sudan Briefing note. Available at: <https://uni.cf/3sqZM9N> [Accessed 25 February 2022].
- UNICEF. (2020). RESPONDING TO THE SHADOW PANDEMIC: Taking stock of gender-based violence risks and responses during COVID-19. Child Protection Learning Brief #1, available at: <https://uni.cf/3GOYsBv>
- UNICEF, UNFPA & UN Women. (2020). TECHNICAL NOTE ON GENDER-TRANSFORMATIVE APPROACHES IN THE GLOBAL PROGRAMME TO END CHILD MARRIAGE PHASE II: A SUMMARY FOR PRACTITIONERS. Available at: <https://uni.cf/3srlSb5>
- UN Women. (2020). UN Trust Fund assesses COVID-19 impact on violence against women and front line organizations. UN Women 5 October 2020. Available at: <https://bit.ly/3GOZFsx> [Accessed 15 February 2022]

ENDNOTES

1. UNICEF. (2020). RESPONDING TO THE SHADOW PANDEMIC: Taking stock of gender-based violence risks and responses during COVID-19. Child Protection Learning Brief #1, available at: <https://uni.cf/3GOYsBv>; UN Women. (2020). UN Trust Fund assesses COVID-19 impact on violence against women and front line organizations. UN Women, 5 October 2020. Available at: <https://bit.ly/3GOZFsx> [Accessed 15 February 2022]
2. McKay G., Black B., Mbambu Kahamba S., Wheeler E., Mearns S., Janvrin A. (2019). *Not All That Bleeds Is Ebola: How has the DRC Ebola outbreak impacted Sexual and Reproductive Health in North-Kivu?* New York, USA: The International Rescue Committee.
3. CARE. (2020). *GENDER IMPLICATIONS OF COVID-19 OUTBREAKS IN DEVELOPMENT AND HUMANITARIAN SETTINGS*. Available at: <https://bit.ly/3HZs2Wm>
4. Banke-Thomas, A., Yaya, S. (2021). Looking ahead in the COVID-19 pandemic: emerging lessons learned for sexual and reproductive health services in low- and middle-income countries. *Reproductive Health*, 18(248), 1-8. D oi: 10.1186/s12978-021-01307-4.
5. Alsibiani, S. A., & Rouzi, A. A. (2010). Sexual function in women with female genital mutilation. *Fertility and Sterility*, 93, 722-724.
6. Hernández, RL, Valladolid, UA, Ferrero, BOL, Díez, SC. Sexually transmitted infections in the context of a sexual assault. *Enferm Infecc Microbiol Clin*. 2019, 37(3): 187-194.
7. Andersson, N. et al. (2008). Gender-Based Violence and HIV: Relevance for HIV Prevention in Hyperendemic Countries of Southern Africa. *AIDS*, 22(4), 73-86. doi: 10.1097/01.aids.0000341778.73038.86.
8. Anand, E., Unisa, S., & Singh, J. (2017). Intimate partner violence and unintended pregnancy among adolescent and young adult married women in South Asia. *Journal of Biosocial Science*, 49, 206-221. doi:10.1017/s0021932016000286.
9. UN. (2020). The impact of COVID-19 on women. Policy brief. Available at: <https://bit.ly/3gSoyZC>
10. Ibid.
11. International Rescue Committee. (2020). *What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls*. Available at: <https://bit.ly/3rSwsIH>

12. UNICEF, UNFPA & UN Women. (2020). TECHNICAL NOTE ON GENDER-TRANSFORMATIVE APPROACHES IN THE GLOBAL PROGRAMME TO END CHILD MARRIAGE PHASE II: A SUMMARY FOR PRACTITIONERS. p. 1. Available at: <https://uni.cf/3srISb5>
13. UNHCR. (2018). UNHCR Ethiopia: Sexual & Gender-Based Violence Factsheet. Available at: <https://bit.ly/3hoAfYd> [Accessed 25 February 2022]; UNICEF. (2021). Gender Based Violence in South Sudan Briefing note. Available at: <https://uni.cf/3sqZM9N> [Accessed 25 February 2022].
14. Erez, E., Adelman, M., and Gregory, C. (2009). Intersections of Immigration and Domestic Violence. *Feminist Criminology*, 4(1), 32–56. doi:10.1177/1557085108325413
15. Gender Innovation Lab, IRC & World Bank.(2020). Engaging men to transform gender attitudes and prevent intimate-partner violence in the DRC. Available at: <https://bit.ly/3HxCNhC>
16. International Rescue Committee. (2020). What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls. Available at: <https://bit.ly/3rSwsIH>
17. Say L., Chou D., Gemmill A., Tunçalp Ö., Moller A.B., Daniels J., Gülmezoglu A.M., Temmerman M., Alkema L. (2014). Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*, 2(6), 323-333. doi:10.1016/S2214-109X(14)70227-X
18. Abortion is *safe* when done by a trained person using WHO-recommended methods, *less safe* when only one of those conditions is met and *least safe* when neither is met.
19. Singh S., Remez L., Sedgh G., Kwok L. and Onda T. (2017). Abortion Worldwide 2017: Uneven Progress and Unequal Access. Guttmacher Institute. Available at: https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf
20. International Rescue Committee. (2020). What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls. Available at: <https://bit.ly/3rSwsIH>
21. Bell, S.O., Omoluabi, E., OlaOlorun, F. et al. (2020). Inequities in the incidence and safety of abortion in Nigeria. *BMJ Global Health*, 5, 1-11. doi:e001814. doi:10.1136/bmjgh-2019-001814.
22. Tran, N.T. et al. (2021). A Call to Safeguard Sexual and Reproductive Health Information and Services during Ebola Outbreaks. *Conflict and Health*, 15(1), 15- 57. doi: 10.1186/s13031-021-00392-3.
23. Lince-Deroche et al. (2019). Unintended Pregnancy and Abortion in Kinshasa, Democratic Republic of Congo: Challenges and Progress. Guttmacher Institute. Available at: <https://bit.ly/3pjvNhV> [Accessed 25 February 2022]
24. Democratic Republic of the Congo Ministry of Health. (2014). Family Planning - National Multisectoral Strategic Plan (2014–2020), Political Advocacy Committee and Permanent Multisectoral Technical Committee. Available from: http://advancefamilyplanning.org/sites/default/files/resources/PSN_PF_2014-2020_english_20140916'.pdf.
25. The World Bank. (2020). Democratic Republic of Congo, Human Capital Index 2020. Available at: <https://bit.ly/36Oe6Rn> [Accessed 23 February 2022]
26. IFRC.(2022). Regional Population Movement - Afghanistan: Preparedness and Response – Operation Update #2, DREF Operation n° MDRAFRPM21. Available at: <https://bit.ly/3hkbdJT>
27. The World Bank. (2020). Pakistan, Human Capital Index 2020. Available at: <https://bit.ly/3sl3TUJ> [Accessed 23 February 2020]
28. Sathar, Z., Singh, S., Rashida, G., Shah, Z. and Niazi, R. (2014). Induced abortions and unintended pregnancies in Pakistan. *Studies in Family Planning*, 45:(4)471-491 doi:10.1111/j.1728-4465.2014.00004.x
29. Guttmacher Institute and Population Council. (2013). Postabortion care in Pakistan: in brief. Available at: <https://bit.ly/3sA4Ylx> [Accessed 14 May 2020]
30. International Rescue Committee. (2020). What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls. Available at: <https://bit.ly/3rSwsIH>
31. For further information on this section, please refer to: IRC. (2021). How did Covid-19 affect women and girl's Sexual and Reproductive Health and safety outcomes in North-East Nigeria?
32. For more information on this section, please refer to: IRC.2022. "OUR LIVES ARE INTEGRATED, OUR NEEDS ARE INTEGRATED OUR PROGRAM AND WORK SHOULD BE INTEGRATED." EXTERNAL ASSESSMENT OF IRC'S SRH/WPE INTEGRATION PROGRAMMING.



New York

122 East 42nd Street
New York, NY 10168-1289
USA

Amman

ABldg. 6 Khalil Dabbas Street.
P.O.Box. 850689,
Amman – Jordann

Bangkok

888/210–212 Mahatun
Plaza Bldg., 2nd Floor
Ploenchit Road
Lumpini, Pathumwan
Bangkok 10330
Thailand

Berlin

Wattstraße 11,
13355 Berlin,
Germany

Brussels

Square de Meeûs 5-6
De Meeûssquare 5-6
1000 Brussels
Belgium

Geneva

7, rue J.-A Gautier
CH-1201
Geneva
Switzerland

London

100 Wood Street,
London EC2V 7AN
England, UK

Nairobi

Galana Plaza, 4th Floor
Galana Road, Kilimani
Nairobi, Kenya

Sweden

The Park,
Magnus Ladulåsgatan 3,
118 65 Stockholm,
Sweden

Washington, D.C.

1730 M Street, NW
Suite 505
Washington, DC 20036
USA

GET INVOLVED
SPREAD THE WORD
VOLUNTEER
DONATE

RESCUE-UK.ORG
44 (0)20 7692 2764