Testing effectiveness, feasibility and acceptability of the integration of gender-based violence screening and first-line response in family planning and antenatal care services in Sokoto and Ebonyi Nigeria: Early Findings

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SVRI Forum
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Summary of the MCGL Nigeria Program

GOAL
address major contributors to maternal mortality and morbidity through the prevention and mitigation of the consequences of violence against women and girls (VAW/G)

Technical priorities
• Intimate Partner Violence
• Child early and forced marriage
• Early adoption of family planning

Key Approaches
• Build capacity of host-country institutions and local organizations
• Participatory action planning and co-creation processes
• Facilitate the coordination of local actors to respond to GBV

Partners
• The Federal Ministry of Women Affairs and Social Development (FMWASD)
• The Federal Ministry of Health (FMOH)
• DOVENET
• Nana
• Helping Hands
• ECEWS
• Ruwoyd
• Essential Health Network
Background on intimate partner violence in Nigeria

- In Nigeria, 36% of women have experienced violence by their husband/partner, but 45% of these women never sought help.

- In 2021, Nigeria adapted the WHO guidelines for responding to intimate partner and sexual violence in the health setting, including guidelines on routine inquiry and first-line and clinical response.

Source: DHS, 2018
Study Aim and Objectives

**Aim**: To pilot and evaluate the integration of first-line response to gender-based violence (GBV), particularly intimate partner violence (IPV), sexual violence and reproductive coercion (RC), within family planning (FP) and antenatal care (ANC) services at public health facilities in Ebonyi (n=10) and Sokoto (n=10) states in Nigeria.

GBV first-line response in the health setting includes screening, empowerment counseling, safety planning, and support to connect to additional services needed.

**Specific Objectives:**

1. Assess effectiveness of an integrated service delivery model (integration of GBV first-line response and empowerment counseling in standard of care FP or ANC services) in reducing on-going experience of intimate partner violence (IPV) and increasing utilization of modern contraceptive methods among clients.

2. Explore factors influencing feasibility, acceptability and ability to implement GBV first-line response as part of FP and ANC services.

**Study period**: November 2021-present
GBV Screening Tools

- Direct, specific questions about experiences of violence, including psychological, physical, and sexual violence, and reproductive coercion
- Includes assessment of patient safety
- Guidance on referrals to other services
Many women experience violence in their relationships. You are not alone. We are here to help.

In this clinic, we offer confidential support for women experiencing violence in their relationships. If this may be you or any of my colleagues about you?

**Conduct GBV first-line response intervention only when you can speak to the client alone.**

**METHOD**

**PROS**

**CONS**

**DISCUSSION**

Injectable contraceptives (long-acting)

- Does not leave any marks on the skin
- Same as above and

- Injectable contraception will be safe for 72 hours
- Sanitary bleeding changes

- Are you worried that your partner may get the IUCD?
- Do you have a safe space to store this item?

Implants

- Sometimes can be felt under

- Removes bitter and

- Are you worried that your partner may have the implants?

Copper or hormonal IUD

- Copper IUD may increase menstrual flow

- Are you worried that your partner may have the copper IUD?

- Some women may be concerned if any may have an IUD?

PIH (EDCQ or FOI)

- Some women may be

- Packet of pills may be kept in

- Do you have a safe place to keep the pills?

Intrauterine Contraception Device (IUD)

- May be feasible for women

- Does your partner

- Does your partner

- May be efficient and are

- Do you have plans for

- Does your partner

- Use a condom when

- Use of new contraceptives

- You may have a plan for

- You may have a plan for

- Does your partner
Training of Services Providers on Integration of First Line Response into GBV and ANC settings

- WHO: 54 health care workers (29 Ebonyi, 25 Sokoto) trained
- WHERE: 20 intervention sites (10 sites in Ebonyi, 10 sites in Sokoto)
- WHEN: November 2021
- WHAT:
  - GBV first line support (LIVES)
    - Reproductive coercion
    - Caring for Mental Health of Survivors and Service Providers
    - Guiding principles and overview of health response to violence against women
    - Clinical care for survivors of sexual assault/rape, part 1: history-taking and examination, GBV data documentation etc.
    - Legal requirements for reporting sexual assault (FIDA)
## Mentoring and Supervision Methods

- **Monthly on-site mentoring**

- **Health facility screening and register review** (monthly from April-August 2022)

- **Supervision visits** using observation and structured skills assessment tool that is applied while observing actual or simulated screening sessions with the client (Feb, Jun, July, August 2022)

- **Interviews with providers** (August 2022)

### Monthly on-site mentoring

- Establishes a good rapport
- Asks purpose of her visit
- Allows the client to talk and listens attentively

### Health facility screening and register review (monthly from April-August 2022)

- Talks to her about Reproductive Consent (RC): ANC clients: Asks
  - Did you want this pregnancy? Or was it forced by your partner? If forced, has your current partner ever made it difficult for you to get or use family planning (e.g. destroy, take away, or hide your contraception) in the past?
  - FP clients: Asks
    - Are you currently being pressured or forced by your husband/male partner or family member to stop using family planning or to become pregnant against your will?

### Supervision visits (Feb, Jun, July, August 2022)

- Helps her in getting the care and safety she needs during pregnancy and childbirth and offers postpartum contraceptive method options.
  - ANC Client: Offers full range of methods.
  - FP Clients: Supports client’s choice

### Interviews with providers (August 2022)

- Provides routine ANC and PPFP counselling
  - FP Client: Offers full range of methods.
  - ANC Client: Counsels her about methods based on her reproductive needs including methods that can be used privately if the need arises in future, and helps client choose a method of her choice.

### Observation and Total Obtained

<table>
<thead>
<tr>
<th>Action</th>
<th>Observation</th>
<th>July</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establishes a good rapport</td>
<td>Poor (0) Satisfactory (1) Good (2) Excellent (3)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Asks purpose of her visit</td>
<td>Poor (0) Satisfactory (1) Good (2) Excellent (3)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Allows the client to talk and listens attentively</td>
<td>Poor (0) Satisfactory (1) Good (2) Excellent (3)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4. Talks to her about Reproductive Consent (RC): ANC clients: Asks</td>
<td>Poor (0) Satisfactory (1) Good (2) Excellent (3)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Helps her in getting the care and safety she needs during pregnancy and childbirth and offers postpartum contraceptive method options.</td>
<td>Poor (0) Satisfactory (1) Good (2) Excellent (3)</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Provides routine ANC and FPFP counselling</td>
<td>Poor (0) Satisfactory (1) Good (2) Excellent (3)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
The chart shows general improvement across all the sites between July and August in both Sokoto and Ebonyi States with the highest recorded at Item PHC in Ebonyi and lowest at Okaria PHC.
Supportive Supervision: Qualitative Findings (Perception of Service Providers; N = 41)

<table>
<thead>
<tr>
<th>Working Well</th>
<th>Not working well</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents considered every part of the intervention to be working well in Ebonyi while Sokoto were specific concerns around screening, use of IEC materials, etc.</td>
<td>There were comments around the process of getting survivors to accept referrals as they prefer to receive only health services (this was common in both states) which is due to cultural factors, religious beliefs and fear.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Helpful</th>
<th>Not helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally, most providers find all aspects of the intervention to be very helpful for addressing GBV.</td>
<td>A provider felt asking about IPV to a married women is not helpful as it means ‘mediating in what should be internal affairs between couples’.</td>
</tr>
<tr>
<td>Some noted specifically private use of contraceptives i.e. using without your spouse being aware, amongst others</td>
<td></td>
</tr>
</tbody>
</table>
Supportive Supervision: Qualitative Findings (Perception of Service Providers; N = 41)

<table>
<thead>
<tr>
<th>Aspect of the intervention that is easier/easy to talk about</th>
<th>Difficult to talk about</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the service providers in Ebonyi find ‘talking about RC’ easier than IPV while Sokoto said both are generally difficult to talk about.</td>
<td>Referral seems to be a difficult-to-talk about/achieve in both states as clients often decline</td>
</tr>
</tbody>
</table>

Suggestions for Improvement

<table>
<thead>
<tr>
<th>How to make the intervention more helpful for Providers</th>
<th>How to make the intervention more helpful for clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human resources, incentives, re-training, learning and experience sharing forum, Resources to follow-up clients</td>
<td>Provide funds and other requirements to facilitate safety plans, economic empowerment; share promotional materials and other items like soaps etc.;</td>
</tr>
</tbody>
</table>
Lessons to Date

• Training material adaptation as we did with WHO LIVES/ARCHES is usually time consuming hence, adequate time should be considered at design stage

• Initiating GBV screening +LIVES and ARCHES interventions integrated in FP and ANC clinics were very well accepted by both providers and clients, but requires additional human and material resources
  ✓ Healthcare providers expressed the need for incentives as they see this as additional work load.
  ✓ Screens for privacy, documentation materials and job aids

• Despite established health providers' role in the prevention and response to GBV per national guidelines, majority lacked requisite skills and training to offer quality GBV care prior to intervention at the sites

• Ongoing on-site mentoring was ‘pivotal’ in resolving identified gaps in documentation and case identification/management.
Lessons to Date (contd.)

✔ Talking about IPV and RC is challenging for both provider and clients to talk about.

✔ There's hesitancy on client's part to access referrals outside the clinic (non-clinical services).

✔ Building providers confidence to do case identification and first-line response takes time; thus, rapid-scale-up should carefully considered against available resources.