Adaptations to family planning and reproductive health services in humanitarian settings in Nigeria during the COVID-19 pandemic

DATA DOCUMENTATION

1. Introduction

Provision of family planning and reproductive health (FP/RH) services in humanitarian settings is a complex but necessary endeavor [1]. A humanitarian setting is one in which an event or series of events has resulted in a critical threat to the health, safety, security and well-being of a community or other large group of people [2]. In these settings, access to RH services often decreases [3] while RH needs increase [4]. Women and girls in humanitarian settings are particularly vulnerable with many losing livelihoods, education opportunities, and family, social and structural support systems, placing them at increased risk of unwanted pregnancy, unsafe abortion, sexually transmitted infections (STIs) including HIV, and maternal illness and death [5]. Comprehensive FP/RH services, including FP services, antenatal (ANC) and postnatal care (PNC), post-abortion care, STI testing and treatment, and gender-based violence (GBV) prevention and response, are critical to meeting the health needs and rights of women and girls in humanitarian areas.

The COVID-19 pandemic exacerbated the FP/RH needs of women and girls in humanitarian settings. FP/RH services in humanitarian areas suffered significant disruptions given their modes of delivery which often include community meetings, outreach activities, and peer support groups [6]. The COVID-19 pandemic has been linked to decreased access to and use of sexual and reproductive health services among women and girls [7] largely due to disruptions in supplies of contraceptives [8] and a limited health workforce and resources [9]. Fear of contracting COVID-19 in health facilities could further limit access to services [10].
The first confirmed case of COVID-19 in Nigeria was reported on February 27, 2020. As of June 13th, 2022 there had been 256,352 confirmed cases and 3144 confirmed deaths [11]. In March 2020, the Presidential Taskforce for COVID-19 was commissioned, travel bans were implemented for some states, and some states restricted the size of gatherings [12]. A national lockdown was ordered on March 30, 2020, with additional states declaring lockdowns during April 2020 [13]. An initial lockdown period of two weeks was then extended by an additional three weeks [14]. From February to early May 2020, Nigeria saw only 2950 cases with a positivity rate of 1/43 per 100,000 people and few confirmed cases in humanitarian settings in the country's northern region [15]. But this quickly changed and by July 2021 Nigeria was the 4th most affected country in Africa with a case fatality rate of 1.3% [16].

The on-going insurgency in North-East Nigeria has lasted for more than a decade and has put up an estimated 8.7 million people in need of humanitarian aid [17]. Additionally, conflict between armed separatist and government forces which began in Cameroon in 2017 has led to a rapid influx of Cameroon refugees in the South-South, North-Central and North-East Nigeria with up to 77, 000 refugees currently residing in Nigeria [18]. In the Northeast states affected by the Cameroon refugee situation, especially Borno and Cross River, Taraba and Benue states, COVID-

19 is a crisis within a crisis. In these areas the pandemic has further strained an already weakened health system deeply affected by humanitarian needs and insecurity. Stay-at-home orders, border closures, and other movement restrictions, along with the preexisting situation of poor health seeking behavior, stigma, and low socio-economic status created a fragile economic situation and delays in accessing healthcare.

To date only a few studies [10, 19] document the extent to which travel and gathering restrictions and service shut-downs related to COVID-19 affected FP/RH services in the country. Adelekan et al. assessed the provision of reproductive, maternal, and child health (RMNCH) services before, during and after COVID-19 lockdowns finding both a modest reduction in service delivery as well as stockouts, transportation challenges and harassment of health providers by law enforcement agents [10]. Balogun et. at found that despite challenges such as drug and contraceptive stock-outs, limited personal protective equipment and transportation difficulties, the large proportion of primary health centers that continued to provide RMNCH services demonstrated resilience [20]. However, data specific to RMNCH care in humanitarian settings in Nigeria, during COVID are limited.

2. Study Goal and Objectives

The overall goal of this activity is to document project adaptations to ensure continuity of FP/RH services for women living in humanitarian settings in Nigeria during the COVID-19 pandemic and to provide insight into challenges and facilitators of providing continuous FP/RH services in these settings and to synthesize the learning to guide future adaptations to FP/RH services.

The specific objectives of this activity are to:

- Document the programmatic adaptations to FP/RH project components made in response to COVID-19 by project between April 2020 and October 2020;
- Identify successes, challenges and opportunities from FP/RH adaptation experiences for each project;
- Synthesize and share learnings to inform FP/RH projects in humanitarian settings to improve continuous implementation and project adaptation during disease outbreaks.

3. Study Design

Two projects supporting FP/RH services for women in humanitarian settings in Nigeria in the time of COVID-19 were part of this study. The IHANN II (Integrated Humanitarian Assistance to Northeast Nigeria, April 2019 – December 2020) project is a multisectoral humanitarian response in Borno State that provides FP, RH and maternal, newborn and child health services to conflict-affected and displaced Nigerians. IHANN II works primarily in camps for internally displaced people (IDP) but also targets host communities with interventions. The UNHCR-SS-HNIR (United Nations High Commissioner for Refugees South-South Health and Nutrition

Intervention, April 2019 – December 2020) project operated in Cross River State and provided essential services including FP, ANC and PNC to Cameroonian refugees living in settlements and host communities. (UNHCR SS-HNIR also operated in Benue State, but that site was not included in this study. The activity ended in December 2020).

We conducted a mixed methods study to identify adaptations made to FP/RH services during the COVID-19 pandemic and quantify the impact of COVID-19 on key FP/RH indicators. Data were collected through: 1) Review of policy and recommendation documents, 2) Analysis of trends in FP/RH data routinely collected service statistics by projects, from January 2020 (4 months prior to lockdown in Nigeria) through December 2020 and 3) Key informant interviews with project staff including: clinical health care providers, programmatic staff and outreach workers.

This document includes only information related to the quantitative data and does not include any information about the review of policy and recommendation documents or the key informant interviews.

4. Data Collection

The study team analyzed routine programmatic monitoring data from the two projects to describe monthly trends in the provision of FP/RH services during COVID-19 from January 2020 through December 2020. IHANN II data represents nine (9) primary health facilities across four Local Government areas (LGA)s in Borno State and UNHCR-SS-HNIR-SS-HNIR data represents ten (10) primary health facilities across six LGAs in Cross River state. Monthly numbers of clients for each of these services were collected for each facility: ANC attendees, deliveries attended by skilled personnel, women receiving FP services, individuals reached with RH community outreach, children receiving oral polio vaccines (OPV) 1 and 3, and pregnant women who received HIV counselling and testing. Service utilization data was collated from project registers as a part of projects' routine monitoring system. Data collected in health facilities is then validated by project monitoring and evaluation staff during field visits and sent to project offices for compilation. Data was then cleaned to identify any outliers or inaccuracies using Microsoft Excel. The projects provided the retrospective aggregated data to the researchers for analysis.

Ethical approval for this study was granted by FHI 360's Office of International Research Ethics as well as by Nigerian State level Ethical Review Boards in Borno and Cross River states.

5. Data Management

Analysis was conducted using Excel to identify changes by month and compare four months prior to March 2020 when COVID was declared a global pandemic by the WHO and restrictions

and closures were instituted in Nigeria. All analyses were descriptive using frequencies, means and descriptive trend analyses through graphical presentation.

Study data are contained in two datasets:

- IHANN II data.csv
- UHCR data.csv

6. Limitations

As quantitative data came from physical project registers, it was difficult to obtain and verify data located within humanitarian settings experiencing conflict. UNHCR-SS-HNIR data was unavailable for family planning and children receiving the third oral polio vaccination in both November and December and months with incomplete data could not be assessed as travel to sites was limited due to security issues and pandemic travel restrictions. Quantitative programmatic data was limited to 2020 and analyses were descriptive, so results do not account for any potentially confounding factors such as seasonality of service delivery or uptake. Additionally, as the quantitative analysis is cross-sectional it is not possible to determine whether the adaptations described were the cause of the changes in programmatic outcomes. It should also be noted that we were not able to obtain the client perspective on the adequacy of services due to challenges in remote data collection during COVID-19; this is a vital perspective on accessibility and acceptability of health services that should be explored.

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