Access to Reproductive Health Care for Internally Displaced Women in Northern Nigeria: A Critical Ethnography

By

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Abstract

In Nigeria, Boko Haram terrorists and Herdsmen have forcibly displaced over one million women from their homes. These women are living in precarious circumstances with limited access to essential services. Grey literature shows that displaced women are predisposed to rape and unintended pregnancies. Little is known about how these women access reproductive healthcare. My doctoral research addresses this gap in knowledge. Using a critical ethnography research design founded on feminist intersectionality theory, my doctoral dissertation examines access to reproductive healthcare for internally displaced women living in a relief settlement in Northern Nigeria. Thirty-nine participants including women, health service providers and policy makers were recruited for the study. Imperative reproductive health concerns identified among women include widespread urogenital infection symptoms and noticeable high rate of childbearing associated with a need to replace children lost to terrorist attacks. There were limited health care resources and services at the available health centers reflecting broader structural challenges in the health sector. Women navigated this limitation by seeking care with local midwives and a patent medicine vendor. The Nigerian government is overly reliant on aid agencies to support displaced women's health needs. As funding to humanitarian agencies is scaled back, displaced women are left to depend on grossly inefficient primary health care facilities. The findings of this research are invaluable to Ministries and institutions on the need to develop appropriate policies and guidelines to address the reproductive health needs of internally displaced women. My work is aligned with the United Nations Sustainability Development's broad goal "to leave no one behind" by prioritizing issues affecting the health and wellbeing of the most marginalized persons around the world.

Preface

This thesis is an original work of Oluwakemi Amodu. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name "Reproductive Healthcare Access for Internally Displaced Women in Nigeria: A Critical Ethnography Study", No. Pro00089091, May 6, 2019. Furthermore, approval was obtained from the National Social Investment office, Nigeria. The three manuscripts contained herein were prepared by Oluwakemi Amodu and at this time, the first paper is published (Chapter 2), Chapter 3 is under peer review for publication and Chapter 4 has been accepted for publication, with my supervisory committee members as co-authors.

Dedication

This dissertation is dedicated to all women who have been displaced from their homes because of terrorist attacks particularly those who shared their stories with me.

Acknowledgments

I have had the privilege of being supported by many great persons, erudite scholars and dedicated family and friends as I went through academic life at the University of Alberta. Accomplishing this PhD will not have been possible without your support therefore; I would like to recognize your immense contributions to my success. To begin, I want to thank God for giving me sufficient grace to complete my studies. I would like to express my unreserved appreciation to my wonderful supervisors, Dr. Bukola Salami and Dr. Solina Richter for their selfless support and mentorship that aided my academic growth. I cannot count all the ways you helped in this journey. I am grateful that you believed in me and were patient. I am grateful for your compassionate supervision, for listening to my questions and providing me with opportunities to work with you and with other members in your research network. Thank you specifically for teaching me the value of hard work and dedication. Thank you for your attention to my personal and professional development at all my milestones which helped me to thrive in my career progression. I am very grateful to you.

I would like to express a special appreciation to Prof. Philomina Okeke-Ihejirika, who is a member of my PhD committee. I am humbled and grateful to have had the opportunity to learn from you and to gain a broader perspective on women's research. Your critical feedback has enriched my thinking and allowed me to reason outside the immediate scientific horizons of my work. Thank you for stirring my passion to complete this dissertation. Your valuable contributions have enhanced my scholarly development in every way.

I want to especially thank the 29 women who participated in my study, and trusted me with their stories and gave me the consent to write about their experiences. Your stories bring to life the experiences of many other women who may not have survived the terrorist crisis or may

not have the opportunity to share their stories. Thanks to the camp leaders and women leaders who gave me access to their community and homes to experience significant parts of their daily realities with them. I consider this an unusual privilege. I appreciate the valuable support of stakeholders in Nigeria including Prof. Oladosu Ojengbede and Dr. Kayode Afolabi and others who connected me with needed resource persons in Nigeria and helped me navigate the terrain. I appreciate your insights, and support throughout my field research in Nigeria.

I want to acknowledge mom, Modupe Henrietta Amodu, who has been an inspiration to me in my nursing career, my forever-supportive dad, my older siblings Jumoke, Toyin, and Rotimi, for their love and prayers throughout my graduate program. I cannot neglect to mention my younger sister Ife, my cheerleader, and personal financial advisor, helping me negotiate prices of things in Nigeria when I was completing my fieldwork. Thank you to my very good friends, who encouraged me to keep going. There are many amazing individuals whose contributions have helped me forge ahead in this journey but who I do not have space to mention. Thank you so much for being there.

Finally, I want to acknowledge the funding support of the Women and Children's Health Research Institute, through the Royal Alexandra Hospital, Canada, and the International Development Research Center, Canada and other internal awards received from the Faculty of Nursing, the University of Alberta that enabled me to complete my research and thesis writing.

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Chapter 1: Introduction

> "*IDPs stay within their own country and remain under the protection of their government, even if that government is the reason for their displacement. They often move to areas where it is difficult for us to deliver humanitarian assistance and as a result, these people are among the most vulnerable in the world."*
>
> – *United Nations High Commissioner for Refugees [UNHCR], (2020a)*

Nigeria is a resource-rich, ethnically diverse country with over 200 million people and 250 identifiable ethnic groups (National Population Commission [NPC] & Inner City Fund [ICF], 2009; World Bank, 2019). One in every five Africans is a Nigerian (Organisation for Economic Co-operation and Development [OECD], 2012). Boko Haram[1] terrorist crisis escalated in Northern Nigeria because of the political divisiveness and religious extremism pervading the region. In 2014, at the peak of this crisis, the infamous Chibok abduction of school girls took place alongside mass displacement of people from their homes across other states in Nigeria. Boko Haram began with an ideological movement against girl child education and then deteriorated into a terrorist insurgency in the Northeast with targeted bombings of religious institutions, abductions, and the massacre of people in their homes. This led to the displacement of over two million people as of 2020 (United Nations High Commissioner for Refugees [UNHCR], 2020b). Some schools of thought have implicated political elites for mobilizing the group to ruffle incumbent governments to gain an advantage during general elections (Iyekekpolo, 2018). In other parts of the North, farmer-herder clashes have also ensued

[1] "Boko Haram" comes from the Hausa word 'Boko' which means "Animist, western or non-Islamic education" and the Arabic word 'haram' figuratively means "sin".

between nomads and natives, exacerbating ethnoreligious hostilities (Okoli & Atelhe, 2014). As a result of interethnic conflict and terrorist-induced displacement, Nigeria has one of the worst humanitarian crises in the world, and women and children are the larger proportion of those affected (UNHCR, 2020b). The literature identifies that women who were displaced by insurgencies in Nigeria experience sexual violation at the hands of officials and military personnel who should protect them (Dumbili & Nnanwube, 2019; United Nations [UN], 2016). Displaced persons across Nigeria live in precarious circumstances whether they are in relief camps or in host communities (Alobo & Obaji, 2016; Dumbili & Nnanwube, 2019). Women especially have an unequal access to social services and are often compelled to trade sex for food, money, and other necessities of life (UN, 2016). Moreover, traditional community structures of protection, extended family support networks, and livelihoods for women are dismantled by insurgencies further exposing women to gender-based violations, unplanned pregnancies and sexually transmitted infections (Oladeji et al., 2018; UN, 2016).

This dissertation focuses on the intersecting factors influencing displaced women's access to reproductive health in Nigeria. It delves into the issues in the context of the broader literature on conflict-induced displacement and in light of applicable socio-political perspectives on reproductive health access in Nigeria. My fieldwork took place in Northern Nigeria between May 2019 and September 2019. I completed critical ethnographic fieldwork in a displacement camp with terrorism-affected women to shed light on their experiences of access to reproductive health. My interest in reproductive health originates from my professional experiences as a nurse in Nigeria. Specifically, my focus on displaced women's reproductive health is inspired partly by a shared identity between these affected women and myself by being a Nigerian female myself, although I hail from the southern region. I am from Southwest Nigeria and recognize that I do

not have a similar cultural background or common experience of displacement with the women in this study. However, I locate my interest in this population within a feminist intersectionality perspective. Feminist intersectionality recognises that marginal experiences are dependent on an interaction between various identity categories (e.g. gender, race, class, ethnicity, religion, etc.) that have to be interrogated holistically and thoughtfully (Hankivsky, 2012). These social categories interact in a complex fashion to produce both commonalities and specificities in my participants' experiences. The enormous unaddressed humanitarian concerns of affected women living in relief settlements, my knowledge in women's health, and the potential to improve the lives of the most vulnerable women in my home country of Nigeria ultimately, encouraged me to pursue this area of research.

I was born and raised in Nigeria. I completed my nursing bachelor's program in Nigeria before moving to Canada in 2014. While practicing in Nigeria, I learned that women from Northern Nigeria experienced health issues during pregnancy and childbirth because patriarchal systems preclude them from autonomous decision making about their health. I recall a northern woman walking into the antenatal clinic weeks after the doctor had told her that her fetus was dead in utero and that the baby needed to be medically removed for her safety. She objected, saying that her husband would not support removing the baby from her body. She left the clinic and continued to go about her regular daily activities at home. A few weeks later, she developed life-threatening sepsis from carrying the dead fetus inside her. This experience (and many others like it) was shocking to me and made me begin to think about how women's lack of voice and agency over their bodies—over their reproductive and sexual rights—negatively influences their health. My work and academic experiences reflect a profound interest in women's health and reproductive rights. My master's thesis focused on women's experiences of obstetrical fistula in

Nigeria, a vaginal injury predominant among women in Northern Nigeria associated with childbearing at a young age. I conducted a critical discourse analysis of reproductive health and social policy to reveal the broader structural factors underlying the prevalence of obstetrical fistula among Nigerian women. My thesis demonstrated that although the Nigerian constitution supposedly provides a foundation of social justice and equity to eliminate maternal morbidities, activists and political observers alike have questioned the constitution's commitment to social justice for women in Northern Nigeria (Amodu, Salami, & Richter, 2018).

This PhD dissertation builds upon my master's work focusing on access to reproductive health for women displaced by terrorism in Nigeria. The realization of the topical and critical nature of the problem of internal displacement at the time of admission to the PhD program in nursing inspired this focus. I aimed to explore access to reproductive health care for women internally displaced by Boko Haram and Herdsmen in Northern Nigeria, West Africa. This dissertation includes an introductory chapter and three manuscripts prepared according to journal standards, followed by a conclusion chapter. The introductory chapter is the first chapter and provides a brief overview of the literature on displacement in Nigeria and the significance of examining the reproductive health access of displaced women in particular. This first chapter also includes the purpose, research question and objectives of my research, the theoretical and methodological approaches used, and the ethical considerations in the study. The manuscripts follow from Chapter 2 to Chapter 4, Chapter 2 being "a scoping review on the health of conflict-induced internally displaced women in Africa", which is published. Chapter 3 is a paper focused on the analysis of findings on access to reproductive health from an intersectionality perspective and Chapter 4 is focused on structural perspectives and systemic factors associated with access to reproductive health among internally displaced women in Nigeria. This manuscript has been

accepted for publication. A conclusion chapter follows the three manuscripts presented. The concluding Chapter 5 summarizes the thesis findings, study limitations, and provides recommendations for policy, research and practice pertaining to strengthening health systems and improving the health and wellbeing of women affected by conflict and displacement in Nigeria.

Significance

My project keys into the Nigerian humanitarian response plan (January 2019 - December 2021) supported by the Ministry of Budget and National Planning, which is an innovative and bold initiative aimed at transitioning all program interventions from a humanitarian perspective to a recovery and development perspective (United Nations Office for the Coordination of Humanitarian Affairs [UNOCHA], 2019).The findings of this research will be informative to global humanitarian agencies, the Ministry of Health, and governments on developing appropriate responses to the reproductive health challenges associated with terrorism and the mass displacement of persons in Nigeria. I presented my study results at the National Reproductive Health Technical Working Group meeting in Abuja, Nigeria in March, 2020. At this meeting, sponsored by the Federal Ministry of Health in Nigeria, recommendations for planning reproductive health initiatives across the country were developed and proposed to the Honorable Minster of Health. Through this presentation, a conversation has begun with policymakers in Nigeria on how to improve the distribution of health human resources to primary health care centres and improve reproductive health services in the region of insurgencies as well as for other vulnerable communities in Nigeria. This research advances the field of nursing by contributing relevant evidence for the formulation of culturally appropriate

guidelines and policies to guide the practice of nurses and midwives who provide reproductive health services to displaced women in Northern Nigeria. The theoretical application of intersectionality presented in Chapter 3 of this dissertation supports the paradigm shift towards a feminist standpoint epistemology in nursing research and practice, giving justification to other aspiring nursing scholars who may passionately pursue women's research across cultures and in marginalized communities. This knowledge provides additional perspectives to the existing literature on the benefits of intersectionality to explaining African displaced women's health experiences with particular emphasis on the social determinants patterning unequal access to healthcare.

This project aligns with the UN-Women's global mandate to explore women's reproductive and social wellbeing in conflict settings (United Nations Security Council, 2014). My research purpose and objectives specifically aligns with the UN's Sustainable Development Goal 5, aimed at addressing gender-based inequality through the advancement of sexual and reproductive health rights for women and girls globally by 2030 (United Nations [UN], 2020). The findings of this research will heighten the global understanding of the reproductive health experiences of displaced women in Nigeria. Finally, my work is perfectly congruent with the United Nations Sustainability Development's broad goal "to leave no one behind" by prioritizing issues affecting the most marginalized people (UN, 2020).

Background

This section provides a background to my research study on reproductive health access for internally displaced women in Nigeria. First, I describe internal displacement and make a distinction between internal displacement and cross border movement in terms of human rights

protection and global visibility. This is followed by a description of the gender dimensions of displacement, particularly conflict-induced displacement. I elaborate on the context of displacement and reproductive health in Africa. I further integrate the history of political divisions that have pervaded African societies from the 1950s until now. I describe how in the last two decades, armed conflict and terrorist crisis has risen in Africa and displaced many persons. I bring into focus, the issue of Boko Haram and Herdsmen terrorism and its significant role in increasing the number of displaced persons in West Africa, predominantly in Nigeria. It has been reported that during displacement, women disproportionately suffer sexual exploitation, have huge caregiver burden, and experience limited access to basic services. The focus on Nigeria is justified through an account of the health situation in the country as well as the disparities in reproductive health access between the northern and southern regions. I specifically highlight evidence which shows that there is widespread incidences of sexual exploitation among displaced women in Northern Nigeria. Additionally, there are reports of deaths from unattended childbirths in displacement camps. Yet, there is no study that explores the reproductive health access for affected women in Nigeria. I outline the specific purpose of my study, my research questions and objectives. Following this, I delve into a detailed description of my methodology of critical ethnography used for this study. I also describe my theoretical framework of intersectionality and applicable concepts. Further, I give a description of the setting of my study, safety measures, phases of data collection, data management and analysis, ethical considerations and results dissemination. To conclude, the organization of my dissertation chapters and a summary statement about this chapter is provided.

Internal Displacement

Escalating conflict, terrorism, and human rights violations have increased the global displacement of persons (Internal Displacement Monitoring Centre [IDMC], 2015). Nearly 80 million people are forcibly displaced around the world, 80 percent of whom are women and children (UNHCR, 2019). Of this population of forcibly displaced persons, 41.3 million are internally displaced persons (IDPs) (IDMC, 2019). An IDP is a person who is forcibly displaced but who remains within the country's borders (IDMC, 2016). IDPs have been described as "the invisible majority" because even though they outweigh international asylum seekers and refugees by 50%, they have relatively limited global visibility and legal protection/aid when compared with refugees (Norwegian Refugee Council [NRC] & Internal Displacement Monitoring Centre [IDMC], 2017; UNHCR, 2016). While there is a relationship between internal and cross-border movement, both in terms of flight and return, its nature and extent need to be better understood. For instance, both IDPs and refugees have the right enshrined in international law to a solution, whether through voluntary return and reintegration, local integration, or relocation (UNHCR, 2016). However, IDPs are more likely than refugees to still live within fragile settings (NRC & IDMC, 2017). Therefore, the characteristics of internal displacement are uniquely distinct from cross-border migration in terms of constitutional and legal provisions for access to resources, social services, and international human rights protection (IDMC, 2017).

IDPs face protection concerns during all stages of their displacement (Cohen & Deng, 2012; IDMC 2016) and can remain within host countries for many years after the acute crisis is resolved without security, shelter, food, and water, and with numerous factors threatening their survival within the areas of their resettlement (Burton & John-Leader, 2009; International

Committee of the Red Cross [ICRC], 2009; Leaning & Guha-Sapir, 2013). Internal displacement was placed on the international agenda and recognized as an important issue of global concern in the early 1990s. The key milestone in the institutional history of internal displacement was the creation of the Guiding Principles on Internal Displacement in 1998 by the UN Commission on Human Rights. The development of this framework represented a landmark in the process of establishing a normative framework for the protection of IDPs. Since then, several further important developments have allowed the issue of internal displacement some visibility in regional and international policy dialogue (IDMC, 2013). Nonetheless, the legal protection framework for IDPs is not concrete (IDMC 2018) and their global prominence is further obscured by restrictions on international media coverage and humanitarian assistance to conflict-affected regions (Mirza, 2011; Oliver-Smith, 2009). Additionally, humanitarian workers and policymakers respond to internal displacement with desperate measures that preclude a deep analysis of the human rights aspects of the situation. At baseline, analysis of internal displacement includes two main factors: the coercive conditions causing the displacement and the fact that such movement takes place within national borders (NRC & IDMC, 2017). Furthermore, IDPs have different drives for flight and the conditions of displacement differ based on political, geographical, social, and economic factors (UN General Assembly 2015). However, literature does not always disaggregate the conditions of displaced persons based on these factors, rather it may describe them as an indiscriminate group of forced migrants with a common experience (Lischer, 2007).

It has been said that internal displacement falls in the cracks between various academic, humanitarian, and applied disciplines (Caprioli, 2005; Lischer, 2007) and the offshoot of this is disconcerted responses to the problem (Boano, Zetter & Morris, 2008). On one hand,

humanitarian agencies are diplomatically exploring human rights aspects of displacement to avoid compromising their neutrality by becoming involved in international politics (Lischer, 2007). On another hand, intergovernmental organizations deliberating peace and conflict resolution mostly work separately from forced migration experts and view displacement simply as one of many undesirable outcomes of the conflict (Boano et al., 2008; UN, 2014). These parochial responses to internal displacement jeopardize international security, hinder assistance to affected populations, and have important research and policy implications (Mooney, 2005; The Brookings institution, 2007).

Gender and Internal Displacement

In conflict-affected regions, women are overrepresented among IDPs, stateless persons, and returnees to their countries of origin (Alam, 2016; UN, 2015), yet, research and program interventions in displacement are rarely disaggregated by gender. Gender is an important intersectional social identity that defines a person's lived experience of displacement (Alobo & Obaji, 2016; UN General Assembly, 2015). Women often have a different experience of displacement when compared with men depending on the conditions surrounding their displacement and other demographic factors (International Crisis Group [ICG], 2016; UNHCR, 2016). Women are doubly vulnerable especially in the context of conflict-induced displacement because human rights protection mechanisms are broken and this aggravates existing gender-based disparities in access to social resources and health care (Human Rights Watch, 2016; IDMC, 2017). Moreover, because of gender responsibilities, women tend to face severe social exclusion in circumstances of displacement. For example, women may have limitations to social mobility and access to economic opportunities because of their domestic and reproductive roles (Cardoso et al., 2016; UN General Assembly, 2015). Where women are fleeing with family, the

burden of caring for family members and neighbours may impede caring for themselves. Unmarried women fleeing alone and those widowed by terrorism can also experience restrictions against access to aid supplies because of discriminatory social systems (ICG, 2016). In many conflict-affected societies patriarchy is the cultural order, where a woman's identity and national registration is as an ancillary to her husband or family patriarch (King & Ardis, 2015; World Bank Group, 2019). In conflict, where families become separated, many women are left without national identity; food and cash support previously channeled through a registered male head of household may be withdrawn (Brookings Institution, 2008; Human Rights Watch, 2016). In certain contexts, gendered barriers can exclude displaced women from decision making opportunities and access to humanitarian interventions within the camp they live in (Human Rights Watch, 2016). In other words, women do not participate equally with men in the administration of the camps and in the formulation and implementation of assistance programs which creates unequal access to relief materials. This predicament may compel women to engage in transactional sex and/or forced marriages for survival (Ezeamalu, 2015; Human Rights Watch, 2016).

There is a strong association between political violence, sexual violence and intimate partner abuse (Clark et al., 2010; United Nations Population Fund [UNFPA], 2018). In many conflict-affected settings, including the Middle East and Africa, women can only seek justice through customary courts where judges are not competent to rule in matters affecting women such as sexual violence (UNHCR, 2016). In Sudan, for example, customary judges criminalized victims of sexual violence by defining rape as adultery and thereby fining both the victim and the perpetrator. In other cases, the victim was compelled to marry the perpetrator (Human Rights Watch, 2008). Also, most legal systems in these affected regions do not grant men and women

equal property ownership rights. Land is held and transferred or transmitted according to traditional or customary rules that often limit the rights of women, girls, and outsiders to land ownership. In South Sudan, after the second civil war, it was reported that many widows and orphaned girls had their land taken over by family members and were excluded from inheriting land according to local tradition (IDMC & NRC, 2012). In Lebanon and Palestine, there were staggering reports of gender-based violence among women during conflict (UNFPA, 2016; UNFPA, 2017). Social attributes that intersect gender are important to acknowledge when research is carried out with displaced women because this knowledge will help in understanding the factors that drive inequalities and social marginalization among displaced communities (Cardoso et al., 2016; UN Security Council, 2000). The interplay of gender with factors such as age, group affiliation, disability, and civil or socioeconomic conditions creates peculiar human rights challenges for internally displaced women (Alam, 2016; ICG, 2016). For example, among communities affected by terrorist insurgency, the fear that some persons have been radicalized as suicide bombers may impact community's acceptance of them. This happened in Northern Nigeria where it was reported that suspected terrorist accomplices including the Chibok girls who were freed from Boko Haram captivity were confronted by serious discrimination in camp settlements (ICG, 2016). The landmark United Nations Security Council resolution on conflict and forced displacement recommends active participation of internally displaced women in the development and implementation of national and regional action plans on women, peace, and security and the integration of their diverse concerns into such plans (UN Security Council, 2000). The United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) also recognized that women often face double discrimination as IDPs and women (UN

General Assembly, 2015). This calls for a comprehensive approach to addressing women's needs in the context of conflict and displacement.

Conflict-Induced Displacement

The regions most affected by conflict-induced displacement are sub-Saharan Africa with 4.6 million new displacements and the Middle East and North Africa with 2.6 million new displacement (IDMC, 2020). Between 2014 and 2018, the majority of new displacements were the result of protracted armed conflict crises in Iraq, South Sudan, Syria, Democratic Republic of Congo (DRC), and Nigeria (UNHCR, 2018). In sub-Saharan Africa, armed conflict led to 75% of Africa's new displacements in the first half of 2017 (Iyekekpolo, 2018). In that year, the number of new internal displacements associated with conflict and violence almost doubled, from 6.8 million to 11.8 million (IDMC, 2018). DRC, Nigeria, and South Sudan are among the five countries worst affected by conflict-induced displacement in Africa contributing to the steep rise in global displacement numbers (IDMC, 2017).

The term 'conflict-induced displacement' describes situations in which people leave their homes to escape political violence or armed conflict (Adhikari, 2013; Bakewell, 2011). During armed conflict, there is violation of international humanitarian law (IHL) and fundamental human rights with attacks on civilians and civilian property, and destruction of infrastructure essential to people's welfare (Deng, 2010; Droege, 2007). The subsequent displacement crises create logistical and humanitarian concerns that threaten international security and the lives of displaced people, aid workers, and peacekeepers (Justino, 2009). Armed conflict causes millions of people to migrate yearly. Those forcibly displaced within their own country are not safe. They may experience counter insurgencies, reprisals and obstruction of humanitarian supports necessary for their survival in their new settlement which is in many cases, not distant from the

region of the insurgency (IDMC, 2017). Despite the dangers posed by conflict-induced displacement, scholars, policymakers, and international organizations usually have only a partial understanding of these crises.

Conflict and Displacement in Africa

Displacement in sub-Saharan Africa is not only a growing humanitarian crisis but also an obstacle to the region's development (IDMC, 2018). Since the 1950s and 1960s, many nations in Africa have suffered civil wars and ethnic strife that generated a large number of refugees from various nationalities and ethnic groups (Venkataswamy, 2015). The division of Africa into European colonies in 1885 created separations between newly independent nations. These artificial divisions promoted intrastate conflict and an increase in the spread of displaced populations across the African continent (Aremu, 2010). In Angola, one of the largest and deadliest civil conflicts erupted (1975–2002) shortly after independence (Pearce, 2012). By the end of the Cold War, approximately four million persons were displaced (Brinkman, 2003). In the 1970s, East African nations including Uganda implemented racist policies that targeted the Asian population of the region with subsequent racial grievances (Muhammedi, 2017). German and Belgian colonialists who ruled through the kings perpetuated a pro-Tutsi policy against which the Hutu population in Rwanda revolted in 1959 instigating genocide. During this infamous 1994 Rwanda genocide, over two million people migrated into neighbouring countries, including Zaire, now DRC (Adelman, 2003). In Nigeria and Sudan, the British divide and rule strategies created regional tension between the northern and southern areas that culminated into a large-scale armed conflict in the mid-1950s (Kebbede 1997; Prunier, 2005). These political divisions overlapped existing socioeconomic and environmental problems, particularly slow-onset hazards such as drought, coastal erosion, land degradation, diminishing grazing sites which

result to loss of livestock and loss of livelihoods. Conflict and economic hardship continue to fuel displacement in the Horn of Africa and the Sahel region. In countries like Nigeria, Congo, Somalia, Sudan, and Angola, corrupt, cynical, and exploitative governance have aided armed conflict and nationalist dispute (Tinuola & Oriola, 2016).

Displacement in Nigeria

Nigeria stands out as one of the seven countries of concern to UNHCR, accounting for over 20% of conflict-induced displacements worldwide but is yet to approve the international human rights protocol to protect displaced women (UNHCR, 2019). Corrupt opportunistic elites have assigned political relevance to terrorist groups and Islamic radicalism in the course of contesting political power, also capitalizing on ensuing poverty in the region (ICG, 2016; IDMC, 2015). In Nigeria, the Boko Haram movement, seeking to abolish the secular system of government and establish Sharia law in the country (Asfura-Heim & McQuaid, 2015), has threatened internal security and extended the crisis to bordering West African countries including Nigeria, Cameroon, Niger, and Chad (Onuoha, 2014; Fisseha, 2016). Likewise, in the northcentral region of Nigeria, violent clashes have ensued between Fulani pastoralists, Tiv, and other farmers as well as through communal and religious violence in Kaduna, Plateau, Nasarawa, and Zamfara, displacing large numbers of persons (Ladan, 2013).

Nigeria

Nigeria has a population of 200 million people, the largest in Africa, and accounts for 20% of global maternal mortality with high rates of under-five child mortality (World Health Organization [WHO], 2020). Between 2005 and 2015, it is estimated that over 600 000 maternal deaths and no less than 900 000 maternal near-miss cases occurred in the country (WHO, 2020). In spite of the poor maternal health indices, the country invests minimally in the health system,

which makes services less effective than in other African countries (Onyeji, 2018; WHO, 2011). At the African Union Summit in 2001, the Nigerian government committed to allocating 15% of the national budget to the health sector however, 10 years following this, the target was yet to be met (WHO, 2011). From 2012 to 2015, Nigeria's health spending consistently remained at around 6% of the national budget; with a decrease to 4.64% in 2016 (Dodo, 2017). The highest percentage since the declaration was in 2012 when 5.95% of the budget was allotted to health (Onyeji, 2018). On the other hand, in other African countries, significant health and economic improvements have been achieved with modest investments by countries such as Rwanda, Malawi, and Botswana, which allocated 18%, 17.1%, and 17.8% of their respective budgets to health care (Dodo, 2017). In Nigeria, the Midwives Service Scheme and the Subsidy Reinvestment and Empowerment Program (SURE-P), which was designed to improve the maternal health care service usage, had an uneven success because of a lack of understanding of the health human resource needs regionally in Nigeria (Abimbola et al., 2012; Lassi, Kumar & Bhutta, 2016). There are different sources of healthcare financing in Nigeria including, but not limited to, tax revenue, out-of-pocket payments (OOPs), donor funding, and health insurance. Emphasis on OOPs create complex challenges with universal health care coverage (Uzochukwu et al., 2015).

Twenty percent of global maternal deaths occur in Nigeria and Northern Nigeria contributes poorly to the health of the nation (WHO, 2020). Maternal Mortality Ratio in Northern Nigeria is 1271 maternal deaths per 100 000 live births comparing unequally with the national average of 512 deaths per 100 000 live births (Doctor, Findley & Afenyadu, 2012; NPC & ICF, 2019). Geographically, Northern Nigeria is home to around 85 million persons representing nearly half of the entire country's population with 19 states that are divided between

Christian and Muslim. Nigerians value large families (Adebowale, 2019; Isiugo-Abanihe, 1994). Nigeria alone accounts for around 6% of all births globally (UN, 2015), and Northern Nigeria also has the highest fertility rate and teenage pregnancies in Nigeria. The total fertility rate in Northern Nigeria in 2013 was seven children per woman, compared to the national average of five children. At ages 15-19, almost one quarter (23%) of adolescents have begun childrearing (NPC & ICF, 2014). Contraceptive utilization in 2013 was 3% and 4 % in Northeast and Northwest Nigeria with even lower figures in rural regions, while the percentage in Southeast and Southwest Nigeria was 29% and 38 % respectively (NPC & ICF, 2014).

Teenage motherhood is the most prevalent in the Northwest Zone (36%) and lowest in the Southeast and Southwest Zones (8% each). Antenatal care coverage is 41% in Northwestern Nigeria and 49% in the Northeast compared to 90% and 91% coverage in the Southwest and Southeast regions respectively (National Demographic Health Survey [NDHS], 2013). Literacy rates for women in Northern Nigeria are as low as 5% compared to a national female literacy rate of 51%. Over half (65%) of girls in Northern Nigeria are married before the age of 18 (NDHS, 2013). The low levels of literacy and education among northern women have implications for the overall health outcomes of people from this region (NPC & ICF, 2014). No area of Northern Nigeria has skilled birth attendance more than 20% whereas states in the South and Southeast Zones reach 98% coverage (Doctor & Dahiru, 2010). In Northern Nigeria, pregnant women are expected to be covert especially about their pregnancy and there is an entrenched belief that pregnancy follows a natural course and does not require special care. Traditionally, women are likely to deliver their first child in the home because some communities consider this environment safer (Doctor et al., 2012). Similarly, women are expected to show a high tolerance for pain in labour, which may mask imminent complications (Doctor et al., 2012). UNHCR has

highlighted the importance of subjective reports towards understanding the factors influencing maternal and reproductive health in the African context and the need to have an implicit understanding of regional disparities in access to healthcare (UNHCR 2014). It is clear that addressing women's health in the global displacement crisis require local insights, which may vary, across regions particularly with reference to government actors' commitment to the implementation of interventions for advancing women's health (Sinai et al., 2017; World Bank, 2019).

Displacement in Nigeria and Reproductive Health

Boko Haram's violent activities and Herdsmen extremism has led to a crisis of internal displacement in Northern Nigeria (UNHCR, 2020b). Boko Haram is internationally recognized as one of the most lethal Jihad revivalist groups employing armed conflict and sexual violation as an instrument to demonstrate opposition to western education for women and girls (ICG, 2016). The group has displaced 2.7 million persons (International Organization for Migration [IOM], 2019). Boko Haram activities have predominated in Northern Nigeria since 2002, with bombing and targeted military-style attacks on schools and health centres. This creates enormous setbacks to health care access for women in Northern Hausa[2] speaking communities in Nigeria (Ager, Bancroft, Berger & Stark, 2018). Furthermore, according to a Global Terrorism Index report, there has also been a resurgence of the pastoral conflict in Nigeria over the past years, with Herdsmen extremists[3] from the north carrying out a number of high-profile attacks between

[2] Hausa is a Chadic language spoken by the Hausa people, the largest ethnic group in sub-Saharan Africa, mainly within the territories of Southern Niger and Northern Nigeria.

[3] Cattle herders clash with farmers over access to land for grazing animals also related to climate crisis; deteriorating environmental conditions, desertification and soil degradation.

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January to September 2018 (Akpor-Robaro & Lanre-Babalola, 2018; Institute for Economics and Peace, 2018).

Health facilities have been the target of Boko Haram attacks, particularly in Borno, Adamawa and Yobe states (BAY states)[4]. Nearly half of the health facilities in this region has been destroyed. Although research about displaced women is sparse, extant studies in Northern Nigeria identify an alarming rise in maternal deaths associated with excessive bleeding during childbirth due to an apparent lack of professional personnel to manage childbirth (Ager et al., 2015; Omole, Welye, & Abimbola, 2015). In 2014, Yola the capital of Adamawa, had one-third of their health facilities providing maternal and reproductive health services; doctor-population ratio was 1 for every 54,000 people (Umar & Bawa, 2015). In Gujba, another smaller city in the same state, no doctors were available to deliver health services in the General hospital (Ager et al., 2015). The impact of this disproportion in availability of health infrastructure and services on the maternal outcomes for displaced women is understated in the literature (Tinuola & Oriola, 2016). Likewise, health human resource deficiency has been explored only peripherally including one study on health worker migration, which has arisen from the Boko Haram crisis in Yobe state (Ager et al., 2015).

It is established that women bear the emotional and physical burden of caring for close kin during displacement (Ager et al., 2015; Caprioli, 2005; Clark et al., 2010). With responsibilities toward children and family members including those living with disabilities, as well as possible safety, financial, and cultural barriers to travel without male accompaniment, access to health care can prove impossible (Human Rights Watch, 2016; ICG, 2016). Infectious

[4] BAY states are Northeastern states worst affected by the humanitarian crisis in Nigeria in 2014.

diseases are also more prevalent among displaced women because of constant contact with the sick within the community and neglect for their own self-care in the course of caring for others (Alobo & Obaji, 2016). UNFPA news report showed that in August 2017, in Maiduguri, Borno state Nigeria, there was a cholera outbreak in displacement camps among pregnant women leading to abortions, stillbirths, and a high maternal mortality during pregnancy (UNFPA, 2017). An investigation was done on the use of malaria preventive measures during pregnancy and the risk of malaria parasitaemia among parturient women in an insurgent area in Northeastern Nigeria (Muhammad et al., 2016). Displacement was associated with non-adherence to directly observed treatment (DOT) for malaria related to health worker unavailability to administer IPTp-SP. The findings showed that pregnant women had poor access to sulfadoxine-pyrimethamine for intermittent preventive treatment (IPTp-SP) and insecticide-treated nets (Muhammad et al., 2016).

There is evidence of an increase in new HIV infections disproportionately affecting women due to exposure to sexual exploitation and violence in IDP camps (Owoaje, Uchendu, Ajayi & Cadmus, 2016). Anecdotal reports have identified that displaced women in Nigeria experience sexual exploitation in exchange for food, clothing, conditional privileges such as freedom to parole, to receive assistance from relatives and to access needed emergency services (Human Rights Watch, 2016; UN News Centre, 2016). Unplanned pregnancies are consequently multiplying in displacement camps. In 2015, according to the UNFPA country representative in Nigeria, about 60,000 births were expected in displacement camps (Ezeamalu, 2015). Little is known about the reproductive health experiences of women displaced by terrorism in Nigeria. As part of the post-2015 Sustainable Development Agenda, the UN Secretary-General on women, peace and security called for global studies scholars to explore the extent to which nation-states

have upheld the mandate to protect women's reproductive health in conflict settings (UN Security Council, 2014). The UN-Women global mandate has been overlooked in Nigeria: no systematic research has examined women's reproductive health concerns as they navigate the traumatic experiences of displacement.

Purpose of the Study

The purpose of my research is to examine access to reproductive health care for internally displaced women in Nigeria.

Research Questions

My research made the following specific inquiries:

1. How do internally displaced women in Nigeria negotiate access to care in the midst of other challenges?
2. What factors influence reproductive health care access for them?
3. What are the gaps in health service provision for internally displaced women in Nigeria?

Research Objectives

My research objectives are to:

1. Identify how internally displaced women access reproductive health care in Nigeria;
2. Identify and explain the factors influencing reproductive health care access for internally displaced women in Nigeria; and
3. Develop policy and service recommendations for addressing gaps in reproductive health care for internally displaced women in Nigeria.

Methodology: Critical Ethnography

My doctoral research used a critical ethnography methodology. Ethnography is one of the oldest forms of qualitative social research, dating back more than 100 years (Hodgson, 1999; Thomas 1993). Its origin lies in anthropology (Thomas, 1993). Ethnography focuses on describing and exploring the meanings of a group's culture, including values, beliefs and behavior (Harrowing et al., 2010). The ethnographer's strategy is to attain full immersion of self in a culture in order to explore the interrelationship between people, their environment and societal structures (Cruz & Higginbottom, 2013). The ethnographer supports the development of a descriptive story of a culture using varying methods of data collection including interviews, observations, focus groups and/or documents reviews. The ethnographer strives to explore "what is" (Thomas, 1993). There are different forms of ethnography including critical ethnography, feminist ethnography, autoethnography, focused ethnography, historical ethnography and institutional ethnography (Van Maanen, 1988). These ethnographies vary by their philosophical underpinnings that pertain specifically to the construction of meaning.

I employed critical ethnography methodology for my study. Critical ethnography is distinct from all other ethnographic methods because this approach provides opportunity for the researcher to embrace their own vulnerabilities in the research process through self-reflexive strategies. Simultaneously, this approach permits the researcher to consider the political implications of their work. Displacement predisposes women to various human rights violations and social injustices (Dumbili & Nnanwube, 2019). Studies done in other African countries demonstrate that displaced women are vulnerable to different forms of gender based violence because of their precarious status as displaced persons (Ager et al., 2018; Cardoso et al., 2016). Moreover, the restricted mobility imposed on women in the relief camps can further hamper

accessibility to basic survival commodities and thereby worsen women's vulnerability to exploitation (Human Rights Watch, 2016). My previous graduate work has noted that women in Northern Nigeria experience gender based inequalities. In order to explicate gender specific challenges as it relates to healthcare access, an approach best suited must be sensitive to these known realities as they shape the participants' experiences. The methodology of critical ethnography was useful for building new narratives on how gender and culture interacted with health access for displaced women while living in precarious circumstances. This approach enabled me to consider systemic processes imbued in prevailing socio-political and health system conditions in Nigeria that shaped displaced women's experiences of access to reproductive health services. In the following section, I provide more justification for my choice of critical ethnography.

Philosophical Underpinning

Unlike traditional ethnography that focus on pure description of culture (Van Maanen, 1988), critical ethnography includes a sociopolitical analysis of factors underlying communal experiences (Thomas, 1993). Critical ethnography is founded on relativist ontology, which is concerned with subjective experience of reality and multiple truths. Critical ethnography methodology is based on the notion that reality is multiple. Also, experience and meaning are constituted by the relational experiences between people and social institutions (Guba & Lincoln, 1994). The epistemology of critical ethnography is rooted in this idea that knowledge is co-created. There are power relations existing in the research context, and research is a naturalistic process that includes both personal and reflective components.

Within this paradigm, truth is an embedded reality and therefore, research data has nuanced meaning requiring contextual interpretation. Internally displaced people have been

described as the "invisible majority" a representation which connotes perpetual victimhood (NRC & IDMC, 2017; UNHCR, 2016). In my study, I explored women's marginal experiences in the context of displacement. I extended by analysis beyond the mainstream narrative of victimhood towards participants' personhood and lived experiences. I then contextualize participants' experiences of accessing care within the social and cultural factors defining their health beliefs and practices. My work highlights the ways in which displaced women navigate and challenge the barriers to their reproductive health access through power, agency and collective action. Self-reflexivity was possible through a critical ethnography approach as I was able to see how the ethnographic encounter had implications not just for my participants, but also for me as the researcher. As described by Pacheco-Vega and Parizeau (2018), conducting research in the Global South raises important issues of researcher positionality[5], more so where it concerns vulnerable persons. Throughout my fieldwork, I was self-critical of my positionality and how I perceived women's stories, as well as about interpretive decisions I made while representing women's experiences through writing. The data collection process was iterative and I was proactive in communicating any challenges with my supervisors. I sought to remain open to new ideas and suggestions about my research, but at the same time critical enough to change my strategies for recruitment, data collection and ethical decision making. According to Thomas (1993), the critical ethnographer has both an insider and outsider stance when it comes to the research community because the researcher is both a participant within the community and an external observer at the same time. To navigate the shifting dynamics of insider/outsider locations, I gave credence to the multiplicity of both myself and my participants' identities,

[5] Positionality refers to the stance or positioning of the researcher in relation to the social and political context of the study—the community, the organization or research community.

particularly seeing that I myself hail from Nigeria but do not share similar ethnic background with the participants in my study. My participants were of diverse ethnic and religious backgrounds. As well, participants had both shared and divergent experiences of conflict and displacement. This brought to bear the heterogeneity of my "insider" and "outsider" status not just broadly, but in specific moments with specific participants during one on one interactions.

Critical ethnography research is designed to benefit the socially disadvantaged by creating awareness of "what should be" as an equitable replacement to "what is", with the intent of raising critical consciousness (Baumbusch, 2011; Thomas, 1993). Consciousness raising is focused on rousing participant's awareness to present and non-present opportunities for emancipation, which can result in action and decisions aimed towards attaining social equality. According to Merriam et al. (2001), it is necessary to pay attention to power differences inherent in relationships with respondents; particularly as it relates to the ways researchers choose to represent people in writing. This awareness enabled me to vividly recognize lines of difference between myself as a novice researcher and the members of the research community and to act on any concerns related to these differences. Such responsiveness was necessary to ensure the safety of myself and of the participants and for the correct application of research principles. For example, I was able to bridge language barriers effectively by employing a well-versed interpreter who also served as a transcriptionist. We worked together during data collection, and engaged in not just linear interpretations of ideas, but also the intersubjective dialogue, constantly navigating and deconstructing pluralistic meanings. Initially, I was doubtful about my own safety and the safety of participants in this crisis environment in Northern Nigeria. I was also concerned about the challenges of accessing the sample required for this design to achieve data saturation or adequate data (Sandelowski, 1995). During my independent study on critical

ethnography with Dr. Solina Richter, I learned the value in developing partnerships and connections early with relevant stakeholders that will assist with accessing participants, conducting data collection and data analysis. I began to do this a year prior to field work and this facilitated my acceptance into the setting by gate keepers of the displacement camp in Nigeria. With supervisory and stakeholder support, I was able to creatively deploy impromptu fieldwork strategies to manage power and my social identity. I became a critical participant in the challenging process of co-creating knowledge from both a subjective culturally nuanced view of experiences and from an objective standpoint at the same time.

Prolonged engagement is an essential characteristic of critical ethnography. Prolonged engagement can be defined as a full immersion into the research field (Thomas, 1993; Van Maanen, 1998). Prolonged engagement allowed me to gain trust of my participants and to access the community in a respectful and authentic way. The women in my study shared personal distressing stories of their displacement. For example, participants discussed losing their loved ones and all they had in their source villages to terrorist attacks. Women had experiences of serial displacement and utterly traumatic trajectories; hiding in the mountains without food for days and trekking long distances across state borders. Practicing prolonged engagement enabled me to explore different ways of managing the research relationship, including the physical and emotional demands of undertaking ethnographic field research in this remote community with displaced persons, and gave me enough time to execute a healthy exit strategy from the field.

Intersectionality

I used an intersectionality theoretical perspective. Intersectionality is a theoretical perspective developed by American critical legal race scholar Kimberlé Williams Crenshaw in

1989, to explore the impact of simultaneous intertwining of diverse aspects of social identity, location and systems of oppression on human experience (Crenshaw, 1989). Intersectionality is used to explore privilege and oppression as an embodied phenomenon acting upon and reconstituting one another. Any agenda for freedom and justice for the oppressed is thus contingent on an understanding of the socio historic and political aspects that reproduce privilege and oppression. Intersectionality recognizes how power and power relations across intersecting locations shape vulnerability, privilege, and marginal experiences, and operate in a dialectic and intersubjective system. Intersectionality has featured in post-colonial feminists, African feminists and anti- racist dialogues before the term was officially coined (Hankivsky, 2012).

Intersectionality extends and complicates the analytical boundaries of traditional feminism by questioning the dominant understanding of marginality, as well as racial and gendered inequalities. This theory has quickly gained ground among scholars investigating health inequities among marginalized populations particularly, indigenous and black women (Hankivsky et al., 2010; Hankivsky, 2012). Intersectionality has utility for health research with marginalized communities because it draws attention to relations of power, class, gender, race, sexuality and multiple forms of oppression as they operate along different axes — constantly shaping health outcomes for the minority (Collins, 2015). Rather than dwell on the symptoms of the problem, intersectionality allows the researcher to dig deeper into the underlying causes of social inequalities in their complexity. Informed by this theory, my research employed an iterative set of processes that recognized broader socio-cultural influences in the experience of, and access to, reproductive health for IDP women in Nigeria. Intersectionality-based critical ethnography was appropriate for this research because it gave me the opportunity to engage in a progressive non-conventional approach to developing knowledge about healthcare access for

internally displaced women. Members of my supervisory committee provided insightful feedback as critical feminist scholars with expertise in marginality and health access. Concepts that were applied specifically in my research are self-awareness and reflexivity.

Self-Awareness

At the initial stages, I was seen as the researcher who sought data, but as the research progressed, my position changed. My presence (along with my research assistant) became consistent and recognized in the community. A school of thought recommends bracketing in order minimize researcher's influence on the results in qualitative research (Tufford & Newman, 2012). It was impossible to completely bracket my assumptions, knowledge and identity as a qualitative researcher with a nursing background but, reflexivity helped me to become self-aware and cognizant of how my insider and outsider positions changed during the research process (Baumbusch, 2011; Thomas, 1993).

Self-awareness is especially important when conducting research with ethnically diverse persons. It has been suggested that feminist researchers need to be thoughtful when conducting cross cultural research to ensure that research does not become a form of voyeurism and exploitation that further re inscribes privilege and marginalization (Hankivsky et al., 2010; Roper & Shapira, 2000). Privilege here for the researcher and marginalization becomes the ascribed identity of the research subject. During my fieldwork in Nigeria, I engaged in a continuous self-evaluative process giving consideration to the social location of my research participants, and the context within which their experiences were situated. Specifically, I paid attention to the cultural perspectives constituting health for women. I hired a research assistant who was culturally knowledgeable, born and raised in Northern Nigeria, with more than 5 years of experience conducting research on reproductive health among this population. She was able to provide

suggestions on how to best approach women and how to greet in the local language and use humor to help women feel at ease by our presence, thereby facilitating positive engagement in the field. As well, I became close with some of the participants who spoke English including the camp co-coordinator, the community women leader and other women who provided necessary support with entry and recruitment. Even if I did not need to do an interview, I would occasionally stop by a few houses to say hello. This kind of insider support and relationship has been widely recommended for health research with people of a different culture (Berger, 2015; Ogilvie et al., 2008). Likewise, it is agreed that the researchers' position in terms of ethnic orientation can affect access to the 'field' because respondents may be more willing to share their experiences with a researcher whom they perceive as sympathetic to their situation (Ganga & Scott, 2006). This was the case with my research, as women told me traumatic stories alongside their difficult experiences of accessing care. There was often an expectation for expressing sympathy in between interviews. Where women did not speak in English, I was able to provide reassurance to them in Hausa language through my interpreter. This was often necessary as women frequently reported experiences of trauma or loss, and this fostered trust and willingness to discuss their experiences in greater detail. Through reflexive journaling and memo writing, I documented my emerging awareness and relations in the field, which helped me to be cognizant of any power disparities between participants and myself and to make adjustments for more just relationships.

Voice and agency

Intersectionality recognizes the need to create space for the voices and agency of the marginalized in research (Hankivsky et al., 2010). I provided a background that established that the status of displaced women and their health seeking practices are shaped by existing cultural

norms, gender and social location in conflict-affected African societies (Ager, Bancroft, Berger & Stark, 2018; Kizza et al., 2012). The issue of voice and agency of women in this study was particularly considered in this study. I applied my prior knowledge and experience of navigating consent and cross-cultural literacy while working with marginalized populations as a nurse in Nigeria. Using an ethnographic approach for this study was beneficial to developing close cross-cultural engagement with women and enabling women to articulate culturally rich stories pertaining to their health. Nevertheless, this also came with its challenges, especially, with navigating cultural and ethical norms within an inter-dependent familial context. Again, on this matter, I was intentional in scheduling interview times with women and choosing more suitable locations such as participants' homes. This allowed women to engage intermittently with domestic activities where needed. The cautious representation of displaced women's agency and voice through this research has implications for reframing displaced women's social narrative through inclusion of these women as equal partakers in health development research. My research methods were gender and culturally responsive. Sitting with participants in their homes, I tried to ensure that women had the privacy needed to express themselves. At times, women preferred to be in the company of other women and their babies. This choice was respected as well. Using an open-ended questioning approach, the reproductive health dimensions of women's experiences was understood from a personalized viewpoint. Although sometimes women tended to overshadow this perspective with the stories of conflict and displacement, which was understandably more real to them. I guided the inquiry carefully to enable women to see their perceived role in redefining their own narratives by also being able to share those issues that concern them in the present, especially health care access. This aligns with the goal of critical consciousness raising (Thomas 1993). Women were therefore able to contribute to

suggesting recommendations for developing initiatives to advance reproductive health in the context of displacement, which is included in the manuscripts herewith. All recommendations proposed through this project, stated in the papers and presented to policy makers, are originally based on women's experience and identifiable needs as well as stakeholder perspectives. The technique of "data verification", whereby emerging interpretations are reviewed by participants for confirmation of consonance was a major strategy of giving respect to women's voices and meanings derived from the data. Intersectionality framework has therefore helped me to position displaced women's perspectives on reproductive health access at the center of a broader analytical work pertinent for understanding the broader issues associated with reproductive health access.

Methods

This study was conducted in a purposively selected camp in Northern Nigeria. The selection of this camp was based on consultations with stakeholders in Nigeria and recommendations by International Development Research Center, Canada as well as the members of my supervisory committee. The following sections provide a description of the study site, the shelter type where internally displaced persons live, and the community's access to basic services. I further discuss the safety measures I adhered to throughout the process of data collection and my data collection steps.

Study Site

I chose to focus my research activities within Abuja, Nigeria as the safest site to access the participants for the study. I was in contact with the International Development Research Center (IDRC) program officer and it was based on our discussion and informed by the Canada's Travel Advice and Advisories (Government of Canada, 2018), along with a complete assessment

by members of my supervisory committee, that a decision was made on the site for my study. My chosen research site was a camp located in FCT Abuja—one of the safer regions of Nigeria recommended for cautionary travels by Canada Travel Advisory (Government of Canada, 2018). The camp is remotely situated 25 to 35 km from the central business district depending on the route taken. The camp holds 5,000 people of 900 households. Charity agencies and NGOs tend to visit camps closer to the central area, therefore humanitarian support to my selected camp is very limited.

Shelter type

The camp is an abandoned federal government housing estate, leased to IDPs by original owners as a temporary residence when they migrated from the northeastern side of Nigeria in the wake of crisis in 2014. Although it was originally built as residences for indigenes to the community, known as the "Gbagyi" people, the Gbagyi rejected the houses because the construction was not finished. IDPs live in the houses by allocation upon arrival from Borno and other parts of the north. They pay a deposit to live there on arrival. The living units are crowded. Each housing unit has one to three bedrooms, having one to six households sharing cramped housing spaces. Residents use mats for sleeping on the floor. A few use mattresses placed on the floor but most people use mats. The bathrooms have unfinished floors with sand while some have been laid with ceramic slab. IDPs allow their bath water and sewage to drain through the sand, contributing to the poor hygiene. Some bathrooms have taps but no water flows through. There is no flushing system for the toilet.

On arrival, IDPs pay a one-time rent to the contractor security personnel - ranging from 30,000 to 50,000 naira (USD$70 to 130) depending on the house size. Some residents have previously reported concerns about eviction when custodians issued eviction notices to IDPs due

to non-payment of rent (United Nations High Commissioner for Refugees, National Human Rights Commission, & Federal Emergency Management Agency [UNHCR, NHRC & FEMA], 2015). The IDP settlement keeps expanding with influx of newcomers including those who previously fled to other areas of Nigeria. The buildings have no doors and building windows are covered with sacks, clothes, and pieces of zinc. There is no government electricity (power) supply to the camp but a local merchant supplies the market shops close to camp clinic with electricity at a cost. Individuals own up to 20 small generators.

IDPs use the small generators to power household equipment such as blending machine- which the women leader uses for business. Typically, generators are put on at night in Nigeria for power outages. There is central church which also has a generator stowed by the camp chairman. Very few houses have televisions and some people use mobile phones. The phones work with recharge cards for making regular calls. There is no Wi-Fi in the area. There is a television viewing center owned by one IDP located closer to the clinic around the market area usually open at night. This shop is where IDPs watch football (some people call it a DStv shop). The shop has 3 TVs. IDPs go to the shop for recreation at night especially men. The generator that powers the shop is a 3.0 voltage generator. There are local police officers and community vigilante present for security. Around 70% of the IDPs at the camp are unemployed. Some of the IDPs were borrowed plots of land by locals and have been farming.

Access to Basic Services

There is a central clinic in the camp as well as a community pharmacy shop. IDPs can walk into these facilities to seek care for basic illnesses. Sanitary facilities are poor; there is a shortage of clean drinking water in the camp. There are streams from where IDPs fetch water for use, but this stream is distantly located from where the IDPs live. IDPs drink water from the

local stream, which is also used for cooking, bathing, and washing. Four boreholes are located in the camp that often do not function because of a lack of power supply. The boreholes are occasionally powered by a generator. When the boreholes functions, IDPs have to pay ₦50 (USD$0.1) per gallon of water. The improvised method for maintaining sanitation of toilet facilities is to flush toilets manually. That is, fetching water with buckets from the borehole or stream, and using buckets of water for running water down to flush. This is common practice (fairly normal for a lot of people) in public facilities in Nigeria that have run down sanitary systems. There are structures made with raffia and wood where men and children bath outside. Open defecation in the bush is a common practice. There is no garbage management system. IDPs also dispose garbage in the bush. No one enforces proper garbage disposal. There is a problem of distribution of relief materials between IDPs from different regions. Children are receiving some form of education in a public school in the settlement but there are limited seats and insufficient teachers, mostly children sit on the ground. Many IDP children stop education at primary school level because parents cannot afford secondary school registration fees.

Safety Measures

My research site was located centrally within the fragile area of Northern Nigeria and this necessitated a safety plan for research data collection with internally displaced women. I collaborated with the special advisor to the vice president on IDP matters who manages stakeholders and liaises with relevant agencies in charge of the welfare of IDPs. A letter of support was given to me by the National Social Investment Office (Appendix K). I was at the camp during the day from 10 am to 5 pm and did not go out after dark. I went around the community in the company of my interpreter and/or NEMA representative. I travelled with caution while conducting my fieldwork. I did not go to any area north of Abuja and did not go to

any area that the travel advisory stated “to avoid all travels”. On one occasion, I received an advisory from Risk Management, University of Alberta International that the Government of Canada had issued a situation update on monkey pox in Nigeria on May 17. I ensured that I avoided contact with animals during this period. In one of the weeks in July, I could not complete field activities because of reports of clashes between the police and protesters near the vicinity of the Federal Secretariat in the city centre. The police were using forcible measures, including tear gas and live fire, to disperse supporters of the Shia Muslim Islamic Movement in Nigeria (IMN) who were demanding the release of the group's imprisoned leader Ibrahim el-Zakzaky. The second conflict-related advisory was to avoid the vicinity of Banex Plaza in Wuse 2 area due to ongoing clashes between police and protesters. I continued to monitor travel advisories and stayed informed of local news. I also complied with the Hausa custom around dressing with legs covered and was guided by the local advisors about safety. I was mindful of cultural norms. Additionally, I travelled with minimal cash at hand on every trip for data collection. I avoided all non-essential travels within Nigeria. My supervisors supported me to make informed decisions regarding travel safely while I was collecting data.

Data Collection Methods

The three phases of data collection are described in the following sections. Phase 1 involved participant observation; Phase 2 involved interviews with women. I also describe the sample and recruitment process in this phase; Phase 3 involved interviews with health service providers and policy stakeholders. The primary methods used in my study include participant observation and interviews; actual sample size was 39: women (n=29), stakeholders [service providers and policymakers] (n=10). This section provides a detailed description of how

observations were conducted, the processes of interviewing women, health service providers' and policy stakeholders in the research field.

Phase 1: Participant Observation

Observation is simply the use of the senses including hearing, sight, and touch to assess the way people move, dress, interact, and use space within a research setting. There are two ways of conducting observation: structured and unstructured methods. The choice of observation method depended on my starting research question and the paradigm underlying the study (Mulhall, 2003). Quantitative research uses structured observation while naturalistic research often uses unstructured observation (Bowen, 2008). It is recommended in structured observation that the researcher should have a checklist to help remember what is meant to be observed. The categories of information that were observed included individuals' general appearance, verbal and physical behaviours, personal space, human traffic at the clinics, and people who stand out (Chesebro & Borisoff, 2007; Mack, Woodsong, MacQueen, Guest & Namey, 2005). Unstructured observation is used to understand cultural behaviour. The researcher needs no discreet plan on what to observe (Mulhall, 2003; Sofaer, 1999). Participant observation is one type of unstructured method of observation typically used in qualitative research and ethnography to gain familiarity with a specified community and their practices through an intensive involvement with people in their cultural environment, usually over an extended period of time. In participant observation the investigator observes and obtains information on the social setting and situation of the community of research (Jorgensen, 2015; Wolf, 2007). My observations occurred at any time I was moving about the community and interacting with people. For example, I discussed with women while they were busy with their meal preparation and while sewing clothes. It is also suggested that researchers observe the same population in

several different locations and at different times (Musante & DeWalt, 2010). I observed women in their household, at the marketplace, and in groups chatting with other women and their children. I also observed women while waiting in the camp clinic or the local health facility. In my study, I used an unstructured participant observation method for my field research because of my chosen methodology of critical ethnography. My participation in the field began in the first month of the fieldwork during which I developed relationships with gatekeepers and government officials.

There are two main women leaders for IDPs displaced by Boko Haram in the camp. There is another women leader for women who were displaced by Herdsmen. These women leaders are often earliest migrants, the more educated or vocationally skilled and may be more financially buoyant. For example, one of the women leaders has tailoring machines and trains younger women in tailoring. The other women leader has grinding machine for food blending as commercial business. Another woman is an advocate for those Herdsmen victims considered minority IDPs to allow them access to resources and aid. They participate in decision making with other members of the village committee. They have information on new comers. They work closely with other women to know of their maternity issues and help them access help. They also facilitate recruitment during research and or during interventions planning and participate in aid allocation to households. Women leaders can interpret for researchers in the privacy of their homes. Additionally, women leaders may also represent women when they have to meet with government agencies on housing and for discussions concerning development plans. Women leaders can work directly with women empowerment agencies and co-jointly implement work with or for other women. An NGO recently opened a bank account for women to receive income for which women leaders made collective decisions about how to budget for the household;

although this created tension with some husbands. They go to the farm and engage in other income-generating activities.

The observational activities included establishing rapport with community members through initial visits to the field of study with the NEMA representative, engaging in activities with the locals, sitting in the clinic and observing consultations taking place, writing reflexive notes, and constructing a coherent story of the data gathered. While not a standardized activity, field observation was useful to validate and challenge data gathered while conducting interviews. I conducted observations concurrently with interviews to obtain insight into the nature of interactions among women. Observation is an ongoing dynamic activity that is more likely than interviews to provide evidence for the behaviours that are in process, continually moving and evolving (Blomberg Giacomi, Mosher & Swenton-Wall, 1993; Spradley, 1980). It is recommended that the researcher have some pre-developed questions in mind before beginning participant observation. The focus of my observation was the activities women engage in related to reproductive health as identified in my interview guide (Appendix A). It is recommended that the researcher should focus directly on observing behaviours and other factors that are most relevant to the research problem. In this respect, I observed the shelters where the women reside and the sanitary conditions of the environment; the hygiene and sanitary practices of the women in the camps; daily activities of the women; daily interactions between the women and men; where the women go to access medications and sanitary supplies; and the women's daily dietary intake. The primary health care (PHC) facility was located 8 km from the camp. There were women in line waiting in the clinics for antenatal assessments. Women are provided routine physical examination and counselling and are referred for scanning at the Asokoro General hospital when there are complications. Women depend on farming for most of their livelihoods

and during pregnancy, these earnings decline even further. My field notes described the context and daily activities related to accessing care and health-related activities of the women to provide additional knowledge for verifying the data reported by participants during interviews. The process of writing field notes depends on the researcher's worldview. Ongoing analysis was conducted with field notes and interview data integrated as complete data. I have included an observation tool in Appendix A.

Phase 2: Interviews with Women

Interviews are a critical, dialogical, and reflective approach to pursue in-depth information around an experience beyond the prevalent view (Mann, 2010; Thomas, 1993). The qualitative research interview is focused on obtaining descriptive knowledge on central aspects of a particular experience. The main responsibility of the researcher in interviewing is to understand the meaning of what the interviewees say (Gill, Stewart, Treasure & Chadwick, 2008; Weng & Spaulding-Givens, 2017). Critical ethnography upholds prolonged engagement as a technique that allows the researcher to gain the trust of participants and to access the community in a respectful way. Women displaced by conflict in my study, for example, have had traumatic experiences from conflict and displacement. If a displaced woman is pregnant, her pregnancy may have resulted from sexual exploitation or may be unplanned. It was therefore important for women to describe their lived experiences pertaining to their access to health care.

Interviews took place over a four-month period. I employed the strategy of prolonged engagement. I had an extended stay in the field in order to obtain detailed information on how women access reproductive health care. The general process of the interview included choosing a setting with little distraction and explaining the purpose of the interview; introducing the research support personnel to my participants including their role and their background;

addressing terms of confidentiality; explaining the type of interview; and answering any questions posed by participants. The settings of interviews were mostly at home, in the compound, and at the clinic. I informed each participant prior to the interview how long the interview was expected to take and provided my contact details for participants to ask any follow-up questions related to the interviews. Due to the discreet nature of the culture of Nigerians, I conducted interviews one-on-one to foster privacy. The choice of location for the interviews was discussed with each participant and was comfortable and convenient. Interviews were conducted by me in English and interpreted by a bilingual interpreter on site. The interpreter's reflections and opinions about the research were considered. The literature suggests that interpreters must go beyond mere language interpretation and incorporate an interpretation of the cultural aspects of the interview situation (Squires, 2009; Wallin & Ahlström, 2006). In my study, the interpreter acted as a collaborator who is knowledgeable about the research process. The interpreter also acted as a conduit and could influence the research by providing perspectives during interviews. Therefore, the language interpreter was asked to sign a confidentiality agreement before every interview (Appendix F). It is recommended that the interpreter should be someone with well-established links to the ethnic group involved in the study who is respected and trusted by them (Baker 1981; Hennings et al., 1996). In addition, the interpreter needs some knowledge of the principles of qualitative research methods and ethics. I, therefore, engaged an interpreter who fluently spoke the local language and was familiar with the district of my study and I provided training as needed.

I used a semi-structured interview guide (Appendix C) because this is preferable for conducting a qualitative study on health issues (Corbin & Morse, 2003). Semi-structured interviews are those in-depth interviews where the respondents answer pre-set open-ended

questions (Corbin & Strauss, 2008) and typically last a duration of 30 minutes to a little over an hour (Dicicco-Bloom & Crabtree, 2006). In my study, interview time lasted between 20 minutes and 120 minutes. All interviews were audio-recorded. Well-designed questionnaires produce data of immense value to health research, and this value could be further enhanced by their fruitful use (Adamson, Gooberman-Hill, Woolhead & Donovan, 2004).

It is recommended that the questions in the interview guide should comprise of the core question and many associated questions related to the central question (Creswell, 1998). I developed a semi-structured interview guide for my study based on my research questions. The purpose of an interview guide is to keep the interviews focused and to manage the interview time more efficiently (Corbin & Strauss, 2008). Within a qualitative framework, the guide was structured to elicit information from three categories of respondents including women, health service providers, and policymakers related to reproductive health for internally displaced women. The question guide for women was developed to include questions related to general health and reproductive health access including 1) Family-planning use; 2) Education and services for prenatal care, safe delivery, and postnatal care; 3) Management of the consequences of abortion and; 4) Treatment of reproductive tract infections. The major research questions that were answered through the interviews with women include 1) How do internally displaced women negotiate access to care in the midst of other challenges?; 2) What barriers do they face and how do they overcome them? These interview questions were progressively modified based on the findings of each day's interview with women (Spradley, 1980) in order to broadly cover all the areas of reproductive health access (DiCicco-Bloom & Crabtree, 2006). Topics such as experiences of urogenital infections and community alternatives for health care access were included in the inquiry. The interview also reflected participants' experiences with health care

use and their decisions to seek or not seek health care. The interviews moved from broad questions to specific topics in proceeding from their current experience with health access, followed by deeper conversations pertaining to reproductive health access. Further inquiry was made on recommendations for the role of women in improving reproductive health. By using open-ended questions and probes, participants were provided room to give detailed answers to these questions, hence, deeper insights and contextual representations were drawn. The inclusion and exclusion criteria for selection of women in my study is described below.

Inclusion Criteria

- Women age ≥18 years and have been internally displaced.
- Women who can provide oral consent (oral consent is chosen because of low literacy)
- Women displaced by conflict
- Women must be a Nigerian citizen by descent

Exclusion Criteria

- Women who speak neither English nor Hausa
- Women with a cognitive or developmental deficit

Sample and Recruitment

In both quantitative and qualitative research, sampling decisions and specifications, sample composition, and access to the sample are important for determining the applicability of research findings (Ogilvie et al., 2008). It is suggested that researchers who engage in transcultural research should engage research assistants from the ethno-cultural region of the participants to assist with recruitment even if it requires training. Recruitment was done with the support of community women leaders who approached potential participants and introduced the study. Health workers in the camp clinic also provided referral support during recruitment and

interviews. Critical ethnography permits me as the researcher to explore different ways of managing the research relationship to foster trust- building and a nonthreatening environment through local stakeholder support. It is recommended that the researcher should be visible in the target community (Arcury & Quandt, 1999; Ogilvie et al., 2008). As I became more familiar with the IDPs, I directly solicited participation wherever the opportunity presented itself. I was well received in the community because of the support I received from the community leaders. Participants were recruited through purposive sampling to ensure a selection of participants that could provide rich information to answer the research questions (Higginbottom, Pillay, & Boadu, 2013). Purposive sampling is a non-probability sampling method that involves sampling based on pre-determined inclusion criteria and lived experience of the phenomenon of interest (Higginbottom et al., 2013; Oliver & Jupp, 2006). Purposive sampling is often used when small samples are studied using intense, focused methods such as in-depth interviews (Curtis et al 2000). In my study, potential participants who were approached were those meeting the study criteria in terms of age, language comprehension, and willingness to provide information about their reproductive health experiences. Participants were selected based on oral skills, ability to describe and reflect upon aspects of their lives, and experience of health access in the camp. Critical ethnography incorporates a notion of cultural safety of all participants in the context of research (Higginbottom et al., 2016; Stout & Downey, 2006). Because of the risks involved in public advertisements for women living in these circumstances, word of mouth was the chosen strategy for the recruitment of participants in my study.

After indicating interest to voluntarily participate in my study, I approached potential participants and provided further details about the study at which time an interview was arranged if there was an agreement to participate. Interviews were scheduled at a location of the

participant's choice, which was usually at the clinic or the participant's home or work place (Gledhill, Abbey & Schweitzer, 2008). In qualitative research, the characteristics of the sample will reflect the goals of the research and the population to which the researcher intends to generalize. Specifying sample characteristics helps to set the boundaries of the sample, restricting it, for example, by demographic characteristics (e.g., gender or age), sociocultural factors (e.g., ethnicity, education, or area of residence) or employment characteristics (e.g., working, retired, or unemployed) (Arcury & Quandt, 1999). Sample size is determined based on research design, population, and anticipated willingness of persons to participate in research (Ogilvie et al., 2008). The political, societal, historical, and social context of the participants are important considerations when estimating a sample in qualitative research because this context influences the research process in terms of how participants respond to the research. Sandelowski (1995) suggests a sample size of 30 to 60 for critical ethnography. Absolute sample size used for this study was determined at the time when an in-depth and rich understanding of the phenomena had been reached. My total sample size was 39 including internally displaced women (n=29), service providers (n=5) and policy stakeholders (n=5).

Phase 3: Interviews with health service providers and policy stakeholders

This phase involved interviews of service providers providing services to IDPs, including health and humanitarian services as well as with policy stakeholders in government. Inclusion criteria for participation was: health service provider involved in IDP women's care, health related co-ordination and/or management and, stakeholders who were involved in or had knowledge of interventions for IDP women's health. These stakeholders provided information specific to access to care barriers and the context of the IDP health situation in Nigeria from a systemic standpoint. I conducted interviews with 5 service providers and 5 policy makers to

address the question 3 of my research: what are the gaps in health service provision for women? (Interview Guide-Appendix D & E). Service providers were identified to be both informal and formal; working in both government-owned facilities and independently run health units such as in a local pharmacy shop. The first service providers interviewed included the representative of the National Emergency Management Agency (NEMA). This NEMA representative supported me with access to gate keepers in the community including the camp chairman, secretary and women leaders. I had a series of consultations with the camp chairman and women leaders. I explained the purpose of my study to them and they gave recommendations on the range of service providers in the community that worked directly with IDP women and could provide relevant information. Through the help of these gate keepers, I was able to access health service providers. I conducted interviews with the camp clinic health provider, the camp clinic health volunteer, and one health worker in the primary health care centre serving both IDPs and the host community. Through the help of community members, I was able to recruit the local caregiver, a patent medicine vendor, for interviews related to the services being provided to the community. I collected information about the main health problems affecting women within this camp, the health facility response strategies to general issues or health complaints from women, challenges women face with navigating access to health services and the role of institutions for improving services for women (Interview Guide-Appendix D).

Policy stakeholders provided information necessary for understanding the regional and national jurisdiction pertaining to delivery of humanitarian and health services to IDPs. Intersectionality research aims to interrogate tacit dynamics that influence institutions and people in order to challenge the status quo and instigate social change (Hankivsky, 2012). An understanding of the social determinants of health provides insights on the wider context

surrounding health inequities and is an essential element to resolving public health problems (Dunn, 1981; Reutter & Kushner, 2010). Policymakers and service providers were knowledgeable or directly involved in leadership and management of internal displacement issues at both local and regional levels. Inclusion in the study was based on availability to provide information related to displaced women's health access. Critical ethnography approach allowed me to examine the inequities in health service access for IDPs from a governance perspective. The interview arrangements with policy makers began through the Presidential Committee on Northeast Initiatives (PCNI) established by President Muhammadu Buhari to serve as the primary national strategy, coordination and advisory body for all humanitarian interventions, transformational and developmental efforts in the Northeastern region of Nigeria. In the initial period, I met with stakeholders to debrief on the project plan, recruitment, and result dissemination. I made confirmation of interview appointments with service providers and policy makers. I interviewed policymakers including representatives from the National Assembly, the National Social Investment Office (NSIO), the Ministry of Health, and the Local Government. Interviews with policymakers were held and were contingent on their availability to be interviewed within a safe location in FCT, Abuja.

The inquiry with policy stakeholders was focused on identifying institutional and governmental roles in service provision for IDPs and particularly for IDP women's health. I also investigated specific health funding schemes that are in place for the reproductive health of women in IDP camps in Nigeria. This phase also enabled the identification of the primary stakeholders involved in the implementation of health care services for internally displaced women and the sources of funding that local institutions can access from the government for reproductive health responses. Additional queries included the kinds of consultations that were

being arranged on the issues of women and reproductive health, the strategies being used to prevent maternal and newborn mortality in IDP camps, and the plans being made for integrating comprehensive reproductive health solutions into primary health programs in the region where IDPs are located. The policy stakeholder analysis yielded results to inform practitioners and public health experts on strategies to improve health services to IDP women.

Data Management

All personal identifying information was removed from every transcribed ethnographic record and all field records. Numerical codes and pseudonyms replaced the participants' actual names. Data was only shared with the members of the research team after removing all identifiers (Lahman et al., 2015). All digitally recorded data, field notes, and transcripts were saved in encrypted and password-protected files on my research computer on a password-protected secure shared drive, i.e., Dropbox®. I also had a backup storage of data on an external hard drive, which was also password-protected and stored in my home office in a locked cabinet. Only the researcher, members of my supervisory committee, and the transcriptionist have been given access to the audio-recordings. The digitally transcribed data was stored on my research computer while using a FileVault key and password to encrypt my entire start-up drive. This data will be kept for a minimum of five years. Hard copy data will be destroyed in September of 2024 after 5 years of my study. My analysis was completed with the NVivo 12 software program. This helped to maintain a systematic record of the data and to support data management and analysis. The advantages of using a computerized data management system rather than a paper-based one included its capacity to assist the researcher to record, store, index, edit, sort, browse, code, and link study documents digitally. For example, this software enabled the efficient aggregation of

data as well as keyword searching (i.e., word frequency queries). Word frequency queries list the most frequently occurring words or concepts in the source document.

Data Analysis

Ethnographic analysis uses an iterative process in which cultural aspects of the research data that the researcher collates in the field are represented in the analysis. The analysis entailed a form of horizontal interpretation of data whereby common themes were selected and sorted out from pieces of data to produce thematic categorizations, search for inconsistencies and contradictions, and generate conclusions about the phenomena under study. The Inter-Agency Working Group on Reproductive Health Crises (2017) recommends that observational data be recorded in a field notebook and any anecdotal information provided by stakeholders be matched against the interview data that has been collected. Data collection and analysis occurred concurrently. The observational field notes complemented interview data (Higginbottom, Pillay, & Boadu, 2013; Roper & Shapira, 2000). A professional transcriptionist was hired to transcribe the English version of recorded data after each day of interviewing. The transcriptionist had no political affiliation in the region of the study as recommended by key informants. The interpreter who assisted during interviews also transcribed the data separately. Both transcripts were compared. As expected, both transcripts were similar, however, the interpreter provided transcripts with richer details and more cultural depth. The interpreter's copy was used for the analysis. Expert opinion recommends that interpreters are the best personnel to transcribe interviews because of their participation in the research process (Squires, 2009). Specific quotes were back-translated by a knowledgeable Hausa speaker who verified correctness. During the analysis of data, pseudonyms were substituted for the real names of the participants in order to

ensure confidentiality. I began the initial analysis after conducting the first five interviews and I sent emerging themes to my supervisors for review.

The sub-steps in data analysis included an intersectional analysis of the observational data and descriptive data obtained during the women's interviews; an analysis of the wider socio-cultural context of reproductive health access and integration with stakeholder perspectives; and integration of critical aspects of the data collection. To do an intersectional analysis of observational data and descriptive data, I organized each data set including field notes and interview transcripts according to categories for interpretive purposes based on findings related to the general health access of the women and the four aspects of reproductive health access. This included family planning information and services; education and services for prenatal care, safe delivery, and postnatal care; the management of abortion; and treatment of reproductive tract infections. During coding, I identified common patterns and themes across the data and integrated stakeholder perspectives. This dialectical relationship between stakeholder interview data and women's responses demonstrated the structural associations between multiple levels of factors determining health access. During the integration of critical aspects of the data, I outlined the underlying relationships between complementary data informing access to reproductive health and integrated additional insights derived from observations, reflections, cultural interpretation, and data verification. This process of iterative analysis began during the first month of fieldwork and was completed with the writing of International Development Research Canada (IDRC) reports, three manuscripts, and the dissemination of findings at the National Reproductive Health Technical Working Group meeting in March 2020 in Abuja, Nigeria. The synthesis of the data was based on the three research questions identified.

Ethics Considerations

Ethics approval was obtained from the Human Research Ethics Review Board (Pro00089091) at the University of Alberta, Canada. Local consent and confirmation of support for this study were granted through the National Social Investment Office of the Vice-President's Office State House, Abuja, Nigeria (Appendix K). All methods used in the design of the study were based on existing literature and expert opinion from my supervisory committee. Prior to each interview, informed consent was obtained, which included a request to audio-record the interview and to return for verification of summary findings. While obtaining informed consent, I ensured that potential participants fully understood the purpose of the research, procedures, and potential impact to allow them to make a voluntary decision to participate in this study. Participants had the option to withdraw at any time during the course of the study. It was explained that at the time of withdrawal, all information provided by the participants would be deleted. My experience of living and working as a nurse and midwife in Nigeria fostered cultural sensitivity for rapport and referral of women to available support services in case of emotional distress which may arise during interviews. There was specific consideration for psychological distress in women during interviews. I had the support of health workers for necessary referrals and care. The consent forms were read in the local language of participants for verbal consent. This verbal consent was audio-recorded and the date and time of the consent were documented. This record was stored in a secured cabinet.

The study also had gender implications in terms of the local culture and ethics. Privacy and confidentiality have an arguably different cultural meaning within Northern Nigerian cultures. With support from a female cultural broker (Hausa speaking interpreter) who is indigene to the community and learned in the research process, local cultural values were

incorporated into the application of ethical principles. My cultural knowledge of the community was continuously refined by being self-conscious and aware of my social positioning in relation to my research context and by clarifying cultural aspects of the research process. My dressing and conduct were culturally informed. My work was in conformity with local participants' values on individuality, privacy, confidentiality, and autonomy including respecting participants' agency in deciding to participate or to withdraw, to the extent that I was not in breach of the Tri-Council Research Ethics Policy (Government of Canada, 2020). Each participant received an incentive in the form of an appreciation package, which included consumables and food items costing $5 CDN as appreciation for their participation.

Rigour

Reliability and validity in critical ethnography research is demonstrated through rigour, otherwise called trustworthiness (Lincoln & Guba, 1985), a process of ensuring that the methods used were systematic and sufficiently rigorous. This includes the strategies that were used to maintain the credibility of the research process. Trustworthiness for my research was assessed based on the following criteria: theoretical perspectives, researcher credibility, adequate data and dependability.

Theoretical Perspectives

Feminist intersectionality stems from an agenda to emancipate women by transforming one-sided narratives about how their identity and experiences have been shaped (Crenshaw, 1989). Thus, by engaging marginalized women in the creation of knowledge about their experiences, subjugated perspectives can be brought to the surface to inform a more holistic interpretation of their situation. In keeping with tenets of feminist intersectionality philosophy

(Hunting, 2014) which undergirded this study, I paid attention to the issue of voice and agency. While completing data collection and in patterning of the data, I was cognizant of broader dimensions within women's narratives pertaining to sensitive and personal social challenges with their health. This included aspects not directly related to reproductive health per se. I privileged the stories of women and emerging knowledge related to cultural and religious factors that intersect to define women's individual meaning of health and reproductive wellbeing. To explicate the unique ways intersectionality impacted my research, I articulated nuanced expressions of women using direct quotes and conceptualized the social determinants of health with reference to the dominant cultural influences. The use of a semi-structured interview method allowed inquiries to be tailored based on the participants' responses to general questions about health and reproductive wellbeing. Through iterative data interpretation and reflexive writing, I documented the evolving process of my awareness in the field and my relationship with the observed reality. I made notes of the changes in my personal feelings and preconceptions as I progressed in the fieldwork and recognized how this impacted my results.

Researcher Credibility

The methods undertaken and findings of qualitative research are intrinsically connected with the researcher's philosophical position, experiences and perspectives (Higginbottom et al., 2016; Ogilvie et al., 2008). I was committed to systematic implementation of the methodological procedures of this research. I employed prolonged engagement in the field. Through prolonged engagement in the field (up to four months), participants became comfortable with my presence in their natural setting, like an insider, and this enabled me to identify all the subtle and everyday practices among women related to health access. During my field experience, I reassessed my personal perspectives and predispositions as I became acquainted with the setting of the study. I

developed skill in qualitative research including qualitative data analysis and use of NVivo software for coding and interpretation of data while working as a research assistant in Canada. I also took an independent study course on critical ethnography and learned about the techniques of this methodology and potential challenges to anticipate. The precision in which the findings reflect the data is dependent on the integrity and application of the methods (Adamson et al., 2004; Rashid, Caine & Goez, 2015). The effective application of critical ethnography approach necessities that the investigator immerses themselves into the culture that is being studied and constantly reflect on the process of observation, data collection, analysis, data interpretation, and production. My research design included in-depth one-on-one interviews with open-ended questions planned for a period of up to 90 minutes to facilitate dialogue and awareness raising with my participants as they reported on their experiences and their challenges related to reproductive health care access. The interview time varied depending on the extent of the participant's willingness to share their experiences. Using the open-ended approach helped the women to think about how they might be disenfranchised in terms of health access and health program development without imposing my own perspectives onto theirs. Ongoing methodological decisions and emerging themes from the findings were discussed with my supervisors and their critical feedback enriched the interpretation of my findings and helped to maintain cohesion between my study's objectives and my research design.

Adequate Data

The choice of my sample size was informed by the literature, and the minimum size that had been used for critical ethnography in similar studies (Morse et al., 2002; Sandelowski, 1995). I also consulted with my supervisors who are experienced in using ethnographic design. For my research, I pursued data collection until sufficient data was obtained to meet my research

objectives. The use of multiple sources of data including observations and interviews with different stakeholders helped me to identify the variations or ambiguities in data that could be attributed to level of researcher awareness, participant's descriptions or data misinterpretation. Thick description, which is a richly descriptive account of experiences (Bitsch, 2005), was used. This technique was important for the credibility of my research report and deliverables from this work. The research personnel who assisted with data interpretation was involved during the preliminary phases of analysis to ensure that I was able to include all the contextual details and culturally salient meanings of the data. When there were doubts, I returned to the participants for follow-up interviews to clarify the data to avoid overgeneralizing deductions and to better address the complexities of the health and social issues affecting displaced women.

Dependability

Dependability involves verifying that the inquiry was consistent and stable (Creswell, 1998; Morse, Barrett, Mayan, Olsen & Spiers, 2002). I kept a decision tracking record to confirm that the process followed a consistent pattern and all decisions were documented, including language choices, research personnel contributions, and a justification of any changes to the field activity schedule. The continuous supervisor support and feedback with debriefing meetings helped to keep the overall consistency of this work (Boswell & Cannon, 2014; Morse et al., 2002). Following presentation of the work to policymakers and development partners in Abuja, I received feedback, which helped to further corroborate data.

I was attentive to issues of voice of the women I interviewed. I provided them with a channel to verify emerging interpretations from the interview data after I had read the interview transcripts. This also provided an opportunity to expand on specific areas related to the subject of reproductive health where necessary. On the one hand, having participants verify the meaning of

the data fulfilled my aim of keeping the women's voices represented in the data and ensuring their interests were preserved when the data was disseminated. On another hand, reserving some influence over the research data analysis allowed me to take initiative to broaden the interpretation of data by including a sociopolitical analysis of upstream determinants that interacted with the social conditions of women beyond the views of women themselves. The shared power of critical ethnography methods allowed for a fair and complete representation of the phenomena of access to reproductive health care for displaced women in Nigeria. As well, the identity of all informants was protected during knowledge dissemination. This means that identifying details relating to the interview material were kept confidential and real names were replaced with fake names. The location of the camp was also kept confidential at all stages of knowledge mobilization.

Dissemination of Findings

The uniqueness of this work and the potential implications merited dissemination. A report was presented on my findings to IDRC in January 2020. Findings were also presented at the Women and Children's Health Research Institute (WCHRI) Research Day, Edmonton, Canada on November 6, 2019. I presented a poster on the preliminary findings; the barriers and facilitators of access to care for internally displaced women. These factors include a preference for home birthing assistance, the ethnicity of the service provider, financial factors, literacy, the distance to the health centre, and trust of the service provider. I made a second oral presentation of my findings at the Edmonton Public library (EPL) on the Edge Speaker Series on the topic "Access to reproductive health care for displaced women in Nigeria" in Strathcona Library in Edmonton, Alberta on November 20, 2019. An interdisciplinary audience from the community attended this presentation in Edmonton. At this talk, I presented on access to care for women,

highlighting the experience of implementing critical ethnography research and policy implications. I also made a presentation to the junior high (Grade 8) students of Highlands school on December 3, 2019. I spoke to the students on the topic, "Nursing research in a Nigerian relief camp", explaining my motivation for this work, my professional experiences, the fieldwork experience, and how I was positioned to conduct this research socially and educationally. Students had a class exercise on completing social research. They practiced doing an interview, simulating experience in a relief camp and they described health needs they could imagine. Each group presented their findings with sticky notes. This provided an example to the students on the importance of community-grounded research that takes place outside of laboratories.

The final presentation was made to the National Reproductive Health Technical Working Group (NRHTWG), which engaged practitioners from development agencies and representatives from the Ministry of Health including the Director for Reproductive Health. The NRHTWG is the forum established by the Federal Ministry of Health to appraise the implementation of reproductive health and family planning (RH/FP) interventions and to document lessons learnt as well as strategic direction for the RH/FP program. The program was held in Rock View Royale Ademola Adetokunbo Crescent, Wuse II, Abuja, Nigeria.

Through these aforementioned avenues, I have raised awareness at the federal government of Nigeria and among a cross-disciplinary and academic audience in Canada about the research findings on reproductive health access for internally displaced women in Nigeria. For academic dissemination, each paper in this dissertation has been written for a specific journal; the first manuscript (Chapter 2) has been published in the International Journal of Environmental Research and Public Health, the second paper (Chapter 3) has been submitted to Refugee Survey Quarterly (reviewer changes received, revised and resubmitted), and the third

manuscript (Chapter 4) has been accepted for publication in Global Public Health. Executive summary reports will be presented to the Reproductive Health Department, Federal Ministry of Health, Abuja and to the National Social Investment Office, Office of the Vice President.

Organization of Dissertation Chapters

The dissertation is organized sequentially comprising of an introductory chapter, three papers written for publication that address the three research objectives, and a concluding chapter. I wrote the first draft of all papers and made revisions based on supervisory and peer review feedback. The three papers are co-authored with members of my supervisory committee, who provided critical feedback and contributed to the development and revisions of the manuscripts. The members of my supervisory committee provided perspectives and thoughts on the findings and theoretical perspectives. The first manuscript is a review of existing literature on the health of conflict-affected women in Africa. This paper outlined the scope of peer-reviewed studies that have been conducted in the area of health of conflict-affected, displaced women in African countries including Nigeria. I explored in this paper violence, mental health, sexual and reproductive health, and malaria as key health concerns among displaced women in Africa. Much of the literature on health care access for women in Nigeria is focused on sexuality, sexual violence, and sexual health although grey literature suggests that displaced women in Nigeria experience reproductive health challenges in addition to sexual health issues.

The second paper presents the broader reproductive health challenges affecting women of childbearing age in a displacement camp in Nigeria, addressing the first research objective and moving on to address the second objective from a sociocultural perspective. The paper casts a lens of intersectionality on the findings to show interlocking factors influencing health decisions

and patterns of health access among this population. According to Hankivsky (2012), these intersecting factors are not simply gender related but also traverse broader social-cultural realities. In this manuscript, I contextualized displaced women's experiences with access to care at the intersections of gender, normative beliefs and knowledge, traditional and religious value systems as well as socioeconomic status.

In the third manuscript, I present an analysis of structural perspectives on access to reproductive health for internally displaced women. This paper responds to the second research objective: identify and explain the factors influencing reproductive health care access for internally displaced women in Nigeria from a structural standpoint and findings based on stakeholder perspectives. It also addresses the third objective to provide policy and service recommendations for addressing gaps in reproductive health care for internally displaced women in Nigeria. I identified that a specific policy framework for IDP women is yet to be articulated in Nigeria. Gaps exist within the primary health care sector in the provision of reproductive health care for IDP women. The world's only legally binding regional instrument on internal displacement, the African Union's Kampala Convention (2009) encourages more countries to domesticate their provisions for displaced women into national laws and policies. Nigeria ratified the African Union Convention for the Protection and Assistance of Internally Displaced Persons (IDPs) in Africa in May 2012 but failed to domesticate the revised national IDP policy. With no policy in place, there are also no real guidelines to coordinate the efforts of the various implementation partners in the IDP crisis. There is poor governance by the Federal Capital Development Agency (FCDA) and Local Government (LG) of the primary health care activities. Outcomes of state and local government-run activities related to IDPs are also constrained by the credibility of civil servants in charge of specific departments assigned to implement specific

health programs. The institutional and political shortcomings identified in the third manuscript have implications for policy development and reproductive health implementation agenda of the Ministry of Health in Nigeria. The concluding chapter of this dissertation includes a summary of the findings of the manuscripts written out of this research including health of conflict-induced displaced women in Africa; intersectionality and access to reproductive health for IDP women; and structural perspectives on access to care for IDP women. This summary is followed by recommendations for policy, research and practice. In light of the reviewed literature and the results of this study, I present strategies to improve the reproductive health outcomes for IDP women and to address human resource shortages through improved budgetary allocation to the primary healthcare sector. Finally, I present the limitations of the study and conclude the dissertation with some important closing statements.

Conclusion

In this first chapter of my dissertation, I have provided a background on my topic of internal displacement and access to reproductive health for women from a broad perspective. The chapter began with a description of the country of study, Nigeria, and the conflict situation that has led to the displacement of persons. I provided a general justification for this research including a reflection on my position and experiences as a southern Nigerian with a nursing background and I explain how my previous work experience and research trajectory has inspired my focus on women's health in the context of conflict and displacement. I further present the significance of this project and its innovativeness with respect to the UN-Women's global mandate to explore women's reproductive rights in conflict settings. I further engage in a discussion about internal displacement and the seriousness of the problem globally including the gender aspects of the problem. I provide a description of conflict-induced displacement in

Africa. I present a discussion on Nigeria, as a nation among 7 main countries of concern to UN Refugee Agency. I provide a backdrop on the reproductive and maternal health situation in Nigeria and the ways that health services are affected by Boko Haram crisis in particular. In justifying my focus on Northern Nigeria, I provide an insight on the precarious conditions of women living in displacement camps as identified in grey literature. I proceed to expatiate on my methodology of critical ethnography which is chosen for this study. I provide a description of the research process including an anonymized description of the study site. I describe the safety measures I followed while conducting this study, my sampling methods, ethical considerations and rigor principles applied. Lastly, I presented the organization of the chapters in this dissertation in the following order: the background chapter, the three middle chapters which are submitted manuscripts co-authored by members of my supervisory committee and the final recommendations chapter.

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Chapter 2: Paper 1-A Scoping Review of the Health of Conflict-Induced Internally Displaced Women in Africa

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Abstract

Armed conflict and internal displacement of persons create new health challenges for women in Africa. To outline the research literature on this population, we conducted a review of studies exploring the health of internally displaced persons (IDP) women in Africa. In collaboration with a health research librarian and a review team, a search strategy was designed that identified 31 primary research studies with relevant evidence. Studies on the health of displaced women have been conducted in South- Central Africa, including Democratic Republic of Congo (DRC); and in Eastern, East central Africa, and Western Africa, including Eritrea, Uganda, and Sudan, Côte d'Ivoire, and Nigeria. We identified violence, mental health, sexual and reproductive health, and malaria and as key health areas to explore, and observed that socioeconomic power shifts play a crucial role in predisposing women to challenges in all four categories. Access to reproductive health services was influenced by knowledge, geographical proximity to health services, spousal consent, and affordability of care. As well, numerous factors affect the mental health of internally displaced women in Africa: excessive care-giving responsibilities, lack of financial and family support to help them cope, sustained experiences of violence, psychological distress, family dysfunction, and men's chronic alcoholism. National and regional governments must recommit to institutional restructuring and improved funding allocation to culturally appropriate health interventions for displaced women.

Keywords: internally displaced women; scoping review; women's health; Africa; health

Introduction

Conflict and internal displacement are underexplored issues, but they are the significant social determinants of health for persons around the world (Internal Displacement Monitoring Centre [IDMC], 2019). It is estimated that 60% of preventable maternal deaths, 53% of under-five deaths, and 45% of neo-natal deaths take place in settings of conflict and displacement (World Health Organization [WHO], 2010). Women and children make up around 80% of internally displaced populations, and international humanitarian agencies have recognized the special needs of women who are fleeing with children (Brookings Institution, 2014). Displaced women face special challenges in accessing healthcare, which is linked to rising death rates from maternal complications of unplanned pregnancies and unattended childbirth in the displacement settlements where they have sought refuge (Brookings Institution, 2014; Mulugeta Abebe, 2010). International agreements exist that afford international migrants and refugees' special protection and entitlements, but unfortunately, they do not provide the same protections to all internally displaced persons (IDPs) (WHO, 2020). Global attention to the health needs of IDPs has similar gaps. International policy frameworks have been disproportionately centered on health for migrants and refugees to developed countries, since richer destination countries are increasingly mandated to recognize their ethical responsibility towards health and human rights protection for immigrants and refugees (Matlin et al., 2018). IDPs, however, have not crossed international borders; therefore, since they remain within the binding institutions of their home counties, their health access is subject to the provisions made by the presiding government, which is often still in the throes of sustained political unrest (United Nations High Commissioner for Refugees [UNHCR], 2020).

Notably, Africa hosts one-third of the world's forcibly displaced persons (United Nations High Commissioner for Refugees [UNHCR], 2017). UN peace-keeping and the UN Commission for Humanitarian Affairs have played an active and important role in maintaining security in war-torn African states, restoring political order, and addressing the acute hunger and shelter needs of those displaced people (UNHCR, 2017; United Nations [UN], 2017c). Yet, these interventions have downstream effects; further, they do not address the long-term needs for empowering communities to manage the social and economic consequences of the conflict and displacement (UN, 2017).

The United Nations Population Fund identifies that displacement is a gender issue: the face of displacement is female (UNFPA, 2018). The grey literature and academic literature both agree that women are disproportionately affected by the negative consequences of conflict-induced displacement, yet little is known about its long-term impact on them and their health (International Organization for Migration [IOM], 2014; UN, 2019; UNFPA, 2018; UNHCR, 2020). Similarly, women's health issues in the context of displacement in Africa have been underexplored likely related to the fact that no human rights protocols exist to protect these women's rights to access health care (Jesuthasan, Witte & Oertelt-Prigione, 2019; Mulugeta Abebe, 2010; Oloka-Onyango, 1995). Research in the field of displacement has skewed toward sexual violence and prevention of unplanned pregnancies, a result of the gender-based violence women experience. Conflict-related sexual violence is a well-established tactic of terrorism in many African countries and around the world (Olu et al., 2015). Moreover, most displacement crises in Africa happen in environments with significant power differentials and deep-rooted inequality, in which the conditions are already unfavorable to women and girls' sexual freedoms (WHO, 2018b). An example is the well-known 2014 Chibok abduction and subsequent sexual

violations of schoolgirls in Nigeria, an apparent strategy to vehemently oppose western education for girls (International Crisis Group [ICG], 2016).

Over the last decade, through cluster interventions, the UN has made remarkable inroads in addressing basic humanitarian needs and ameliorating the protection and assistance gaps for IDPs (UNHCR, 2020). Nevertheless, Olajumoke Yacob-Haliso has critiqued the United Nations High Commissioner for Refugees on their approach to forced displacement in Africa, describing it as a blanket approach that obscures African women's unique marginal experiences in various refugee settings (Yacob-Haliso, 2016). In particular, displaced women carry an unequal burden of care because of a gendered responsibility toward caring for children and the elderly. In circumstances of conflict, women often are the last to flee, are usually fleeing with children, and may have to undertake in transactional sex to provide food for themselves and their children. This increases the chances of exposure to physical and mental health problems, infectious diseases, and to sexual violation (Brookings Institution, 2014; IDMC, 2019).

Grey literature reports and research provide evidence that women are affected negatively by conflict-induced displacement, but no peer review study has reviewed the existing evidence on health problems affecting women who are internally displaced, even though this population remain one of the most vulnerable groups of migrants. The International Organization for Migration has identified that attaining the United Nations Sustainable Development Goal "to leave no one behind," ultimately entails creating a more inclusive and equitable society: this suggests that marginalized and disempowered persons should be the center of development activities which would certainly include internally displaced women (UN, 2020). Planning effective programs to address their needs is necessary, but such efforts must depend on evidence-based understandings. The current review discusses all the studies related to the health of

internally displaced women in Africa to identify research gaps and areas where policy interventions should be focused.

Materials and Methods

A comprehensive literature search was performed using the keywords internal* AND displace* AND Africa* in major health databases. Specifically, with the support of a librarian, we reviewed and retrieved peer-reviewed articles written in English from these databases: CINAHL (n = 347), Ovid MEDLINE (n = 112), EMBASE (n = 334), PsycINFO (n = 138), and Global Health (n = 247). The search was updated between 2017 and 2020, when five additional studies were identified.

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)

The review process was guided by the PRISMA guidelines for systematic reviews (Moher et al., 2009). Two reviewers screened the papers. The most experienced researcher gave feedback about the discrepancies between the reviewers' approaches. The first database search was completed in March of 2017, with the results updated in January of 2020. There were no date limits. The PRISMA flow diagram of the review search is shown in Figure 1; a total of 1179 records were retrieved from the database search. After duplicates were deleted, 991 articles remained. Article screening was performed using RefWorks Citation Manager, with the following inclusion criteria: research articles published in English that focus on the health of internally displaced women in Africa. Articles with any of the following exclusion criteria were not reviewed:

- A focus on women who migrated outside of their country's borders, who were displaced by a natural disaster, or who are economic migrants;

- A focus on instrument testing or the piloting of questionnaires;
- Lacking a methodology;
- Merely literature reviews or discussion papers;
- Grey literature, reports, websites, and graduate theses;
- Published in a language other than English.

A two-step process was followed for study screening: the first step involved screening by title and abstract; the second step involved screening by an initial read of the full text. Titles and abstracts were screened against the inclusion criteria. After the title and abstract screening, 324 were identified, which was further reduced to 212 after the initial reading. Then, after the final assessment for eligibility by all members of the team, 26 articles, with an added 5 updated retrievals, were included in the extraction table. (See Figure 1).

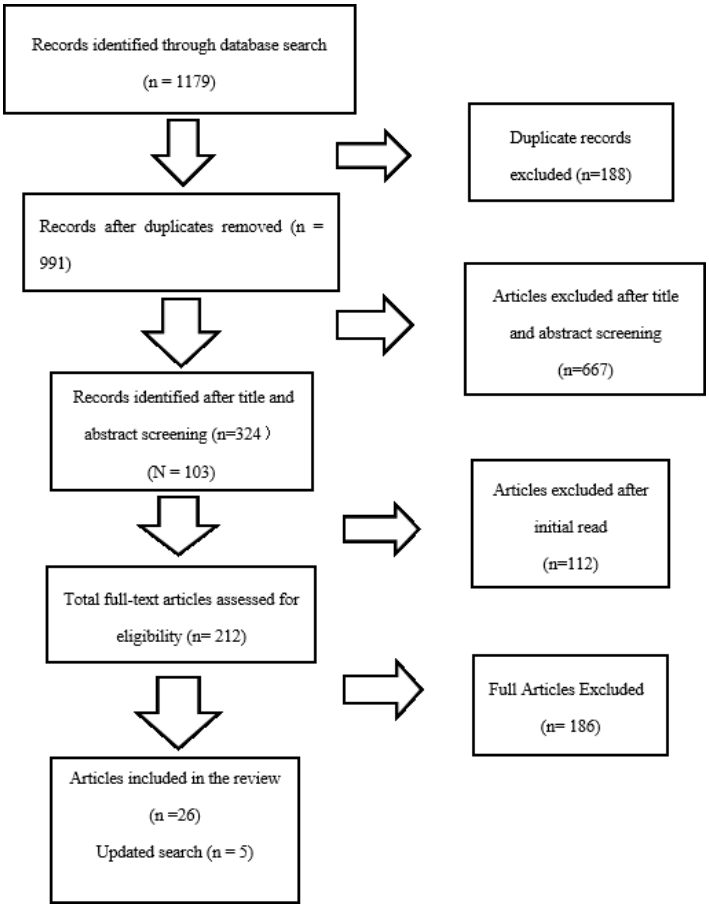

Figure 2. 1 PRISMA Flow Diagram

Results

The 31 articles were charted in Microsoft Word using the study characteristics of author, purpose of study, design, country/setting of research, sample size, and study results (see Table 1). The locations of these studies were Sudan (n = 7), Uganda (n = 11), Eritrea (n = 2), Cote d'Ivoire (n = 1), Angola (n = 1), Democratic Republic of Congo (DRC) (n = 3), Sudan and DRC (n = 1), Sudan, Uganda, and DRC (n = 1), Burundi and Uganda (n = 1), and Nigeria (n = 3). The methodology used in the studies varied, but many included quantitative surveys (n = 15). The studies did not hinge on any theoretical standpoint. Diverse methods were used in the studies, as follows: cross-sectional survey (n = 15), mixed methods (n = 5), focus group(s) (n = 2), semi-

structured interviews (n = 4), qualitative psychological autopsy method (n = 2), neighborhood methodology (n = 1), descriptive method comprising a focus group and semi-structured interviews (n = 1), and a clinic record review (n = 1). We categorized results according to several subtopics related to aspects of the health of internally displaced women, as follows: violence (n = 7), mental health (n = 10), sexual and reproductive health outcomes (n = 9), and malaria (n = 5).

Violence

Our review shows that violence against displaced women by intimate partners and by others is a socially and psychologically damaging practice in conflict-affected communities in Africa. In countries like Northern Uganda, Ethiopia, and DRC, over two decades of conflict and gender-based violations have served to reinforce a culture of disregard, and thus impunity, for diverse forms of violence (Ager, Bancroft, Berger & Stark, 2018; Stark et al., 2010; Stark et al., 2017). Prolonged displacement brings about community apathy, because social cohesion and trust are eroded by war (Cardoso et al., 2016); additionally, domestic violence becomes normalized, families live in chaotic, overcrowded settlements without any form of privacy. In other words, private incidents of violence become known to neighbors and, being a frequent occurrence, the community becomes numb. This applies, for example, to the issue of marital rape—even when this has happened and neighbors know of it, they no longer intervene (Ager et al., 2018). The practice of domestic violence affects the mental health of women, children's orientation to sexuality, and the value of parental authority. Marital rape also results in children having premature sexual awareness, contributing to girls losing interest in education because of early sexual engagements with the opposite sex (Ager et al., 2018; Aham-Chiabuotu, Abel, & Thompson, 2019). Gender role dysfunctions, threats to masculinity, and women's non-

conformity to the expected subordinate roles were significant factors making them more vulnerable to domestic violence (Stark, et al., 2010; Stark et al., 2017).

Eight studies explored domestic violence, in which marital rape had variable meanings. In Northern Uganda, Stark et al. (2010) explored violence among 204 households and identified that about 50% of respondents had experienced intimate partner violence in their marriages. Cardoso et al.'s work expanded on the causes of marital rape, associating its prevalence with social and structural changes to the environment of the displaced (Cardoso et al., 2016). The study, conducted in Cote d'Ivoire in West Africa, identifies that urban poverty—with its high male unemployment, food insecurity, financial stress, and cramped housing— played a role in women's experiences with intimate partner violence. Women talked about their own stress and anxiety over financial constraints, as well as losing interest in being sexually intimate with their husbands (Cardoso et al., 2016). A cross-sectional study, conducted in Kampala, Uganda, found that 53% of women reported experiencing violence in Kampala's urban settlement, with married participants having higher odds of intimate partner violence than single ones (Logie et al., 2019).

Marital rape and abuse were weapons for men to enact masculinity and familial control; they were sometimes portrayed by men as signifying "commitment." In Uganda, men pointed to the ubiquity of violence and its approval by religious leaders, thereby justifying the act and capitalizing on the victim-shaming culture to perpetuate marital abuse (Ager et al., 2018). Women reported that their husbands publicly boasted about the rape, talking about it at drinking places (Ager et al., 2018). Excessive social drinking practices pervade masculine culture in Uganda and Nigeria, as a masculine coping strategy for war-related distress, which only exacerbates familial tensions (Aham-Chiabuotu et al., 2019). A study conducted in Nigeria on social constructions of sexuality and pleasure in displacement settings also affirmed acceptance

of sexual violence. Women did not perceive their sexually aggressive husbands as violent, but rather used words like “shameless” and “impatient” to describe this behavior (Aham-Chiabuotu et al., 2019). Women in the study placed more emphasis on the moral impact the sexual violence would have on their children’s sexuality. Also, children in these crowded living conditions may see their parents having sex, which happens more openly in such contexts. The concern here is with the unhealthy sexualization of IDP children because of the lack of sexual privacy and their parents’ loss of authority, leading to moral decadence among youths.

Stark et al. (2017) conducted a study with a large sample size of over 1788 young women, identifying that in DRC and Ethiopia, violence against displaced women was perpetrated in public spaces, such as at water collection points, sports fields, forests, schools, markets, and roads—by military soldiers and police, as well as the host community. Oladeji et al. (2018) also identified sexual violence-related pregnancies among women who have been freed from insurgencies and were now living in conflict-affected Northeast Nigeria. Of the sexual violence cases that were identified, 0.6% resulted in pregnancies. All women who attended the health clinic at the camp requested to terminate these pregnancies at the initial contact; service providers suspected they moved out of the camps into host communities to achieve this outcome (Oladeji et al., 2018).

Economic difficulty leads married and single women to engage in transactional sexual practices. Financial insecurity and unemployment of spouses, for example, as well as a lack of social support led some women to have random sexual engagements to get access to money to provide for their families (Ager et al., 2018; Cardoso et al., 2016). This behavior has an impact on the sexual and reproductive health outcomes for displaced women.

Table 2. 1 Research articles on the health care of internally displaced women in Africa.

Author	Purpose of Study	Design	Country/Setting of Research	Study Results
Ager et al. (2018)	To elicit local descriptions of gender-based violence experienced by women in camp	Participatory ranking method	Northern Uganda	Rape and intimate partner violence were of greatest concern. Normalization of violence within the home, where abusive actions were considered normal.
Stark et al. (2010)	To establish incidence rates for gender-based violence in IDP camps in Northern Uganda.	Interviews: a neighborhood methodology	Northern Uganda	Gender-based violence—particularly intimate partner violence—is commonplace in post-conflict Uganda
Stark et al. (2017)	To identify discrepancies in the conceptualization and reporting on inter- personal violence in humanitarian settings.	Mixed method	DRC and Sudan	Group-based qualitative method elicited narratives of violence focusing on events perpetrated by strangers or members of the community more distantly connected to girls.
Cardoso et al. (2016)	To understand the factors in the urban environment contributing to intimate partner violence experiences of women	Focus group	Cote d'Ivoire	Extreme financial insecurity and lack of social support predispose women to sexual exploitation when they try to access resources to provide for their families. The risk is higher for women without partners.
Aham-Chaibuotu et al. (2019)	To examine the influence of conflict and displacement on	Focus group discussions and in-depth interviews	Northern Nigeria	Sexuality and procreation needed to be understood in

	gender relations, sexuality, and natality of internally displaced women in Nigeria			the context of cultural values. The popular idea of sexual violence from a theoretical standpoint did not hold true for the examined population.
Logie et al. (2019)	To explore factors associated with intimate partner violence and young adulthood violence among forcibly displaced young women	Cross-sectional survey	Kampala, Uganda	Sexual relationship was associated with decreased odds of poly-victimization. Normal activities of daily living put young women at risk for sexual violation.
Oladeji et al. (2018)	To report the disclosure and outcomes of sexual violence-related pregnancies (SVRP) among rescued female victims of Boko Haram insurgencies	Clinic records review	Borno state, Nigeria	The mean age of women with SVRP was 15 years. All concerned women desired to terminate their pregnancies but did not have access to abortion at the clinic because of the country's abortion laws. Some were thought to have travelled outside the camp to have the abortion done.
Almedom et al. (2005)	To assess the impact of prolonged displacement on the resilience of Eritrean mothers	Mixed methods	Eritrea	Women in camps had lower scores on Sense of Coherence compared with men.
Almedom et al. (2007)	To identify the determinants of sense of coherence (resilience) in displaced Eritrean persons	Quantitative questionnaire approach: Sense of Coherence scale assessment	Eritrea: Northeast Africa	Displacement had a significantly negative effect on women compared with men. Hamboka women had the lowest Sense of Coherence score

				because of their experience of serial displacement.
Hamid et al. (2010)	To investigate the effects of the Darfur crisis on the mental health of internally displaced women	Mixed methods	Darfur, Sudan	72% of the participants were classified as nonpsychotic psychiatric cases. Living conditions and security inside camps need improvement.
Kinyanda et al. (2010)	To examine the long-term health consequences of war-related sexual violence among rural women living in camps	Purposive cross-sectional study design: structured interview	Northern Uganda	Age group of less than or equal to 44 years, being Catholic, and having at least one gynecologic complaint was connected with war-related sexual violence.
Olanrewaju et al. (2018)	To explain the challenges of displacement and the coping strategies of internally displaced women in Nigeria	Qualitative approach with a descriptive survey	Yola and Abuja, Northern Nigeria	Lack of social and financial support was a major challenge for women. Access to economic opportunities would affect coping.
Corbin et al. (2018)	To explore resilience among internally displaced women in norther Uganda	Qualitative study	Nwoya and Gulu district, Northern Uganda	Resilience was located in the women's coping and maintenance of family and social relationships
Kim et al. (2007)	To assess basic health, women's health, and mental health among Sudanese IDPs in South Darfur	Questionnaire survey	Nyala Province, South Darfur, Sudan	Birth control use among IDP women was low and half of the population had experienced an unattended birth. The prevalence of major depression was 31%.

Kizza et al. (2012)	To examine the role of alcohol in suicides	Qualitative psychological autopsy method	Northern Uganda	Economic disempowerment aggravated alcohol abuse in men, which had an effect on women's mental health and suicide rates.
Kizza et al. (2012)	To investigate suicide among women in a post-conflict context	Qualitative psychological autopsy interviews	Northern Uganda	The decision to choose suicide is linked to a pattern of unpleasant experiences that prevailed in the three months prior to the suicide.
Roberts et al. (2009)	To measure the rates of post-traumatic stress disorder (PTSD) and depression among IDPs, and investigate associated demographic and trauma-exposure risk factors	Cross-sectional survey	Northern Uganda	18% of women and 8% of men had been raped or sexually abused. Gender was a determinant of mental distress, with women twice as likely as men to exhibit symptoms of PTSD and over four times as likely as men to exhibit symptoms of depression
Kisindja et al. (2017)	To describe family planning awareness and needs among internally displaced women	Cross-sectional survey	DRC	Contraceptive knowledge among female camp residents was moderate, actual usage was low, and a considerable proportion reported a history of induced abortion, including self-induced abortion.
Ali et al. (2013)	To investigate the unmet need for family planning	Community-based cross-sectional	Eastern Sudan	Age, age at marriage, number of children, residence, and

	and associated factors, and total demand for family planning	household survey		experience of child death were not associated with total unmet need for family planning. Housewives, and women with less than secondary education had higher total unmet need for family planning.
Decker et al. (2011)	To assess the factors that influence the use of contraception among women in post-war Angola	Semi-structured interviews	Angola	Internally displaced women described difficulty paying for services, the lack of nearby services, and limited knowledge about contraceptive choices.
McGinn et al. (2011)	To document and disseminate data on family planning knowledge, attitudes, and practices among displaced women	Population-based household surveys and health facility assessments	Sudan, Uganda, and the DRC	Use of modern contraceptive methods among women was under 4% in four program areas: West and South Darfur, Southern Sudan and Eastern Congo.
Orach et al. (2009)	To explore female and male IDPs' perceptions of their access to information about rights, access to health services, and experiences of gender-based violence	Cross-sectional study	Northern Uganda	Most women perceive gender-based violence as common in these settings. The main interventions include treatment of physical injuries, testing, treatment for STIs, and counselling.
Adam (2015)	To determine the association between the place of delivery for maternal health education and	Cross-sectional study	Darfur-Sudan	Having home visits for maternal health education is associated with a 43% reduction in odds of giving birth

	home visits, and women's socio-demographic characteristics			at home, compared to not receiving home visits. The level of women's education and the camp of residence predict home births.
Adam et al. (2015)	To examine women's awareness and use of reproductive health care services in emergency settings	Cross-sectional surveys	Darfur-Sudan	37% reported home-birth; 63% reported a facility-based delivery.
Chi et al. (2015)	To explore perceptions of the effects of armed conflict on maternal and reproductive health services (MRH) and outcomes	Descriptive qualitative study	Burundi and Northern Uganda	The perceived effects of the conflict on MRH outcomes include increased maternal and newborn morbidity and mortality; high prevalence of HIV/AIDS and SGBV; increased levels of prostitution, teenage pregnancy and clandestine abortion; and high fertility levels.
Kim et al. (2009)	To analyze HIV, STI, and sexual risk as part of a larger reproductive health assessment of females in IDP camps	Two-stage random sample household survey	DRC	Sexually transmitted infection symptoms in the past 12 months and a history of sexual violence during the conflict were linked with HIV infection in the IDP population.
Obol et al. (2011)	To assess the level of knowledge and misconception about malaria among pregnant women in post-conflict IDP camps	Cross-sectional study using a semi-structured questionnaire	Northern Uganda	Most pregnant women in the post-conflict IDP camps had knowledge about malaria symptoms but maintained misconceptions

				about the transmission and consequences.
Dræbel et al. (2013)	To assess aspects of malaria infection, prevention, and treatment in a population of resettled pregnant women.	Cross-sectional study	South Sudan	Primary school attendance was a stronger predictor for use of malaria risk reduction measures than any of the other selected background characteristics.
Draebel et al. (2014)	To explore lay perceptions of malaria and therapeutic process among 30 resettled pregnant women	Semi-structured interviews	South Sudan	Women relied on homemade remedies and concoctions, traditional healers' cures, magical rituals, and private formal and informal medicine vendors at the local market before seeking a malaria diagnosis and treatment at the health center.
Obol et al. (2013)	To establish the prevalence and factors associated with insecticide-treated net (ITN) use among pregnant women in IDP camps	Cross-sectional study	Northern Uganda	Factors that hinder ITN utilization were the hours taken to reach a health centre and being unmarried.
Brooks et al. (2017)	To explore the factors influencing bednet ownership and use in an IDP camp with free bednet distribution	Mixed methods	Eastern Democratic Republic of Congo (DRC)	Health information on bednets was routinely provided in the camp, as noted by respondents. Some women who receive bednets resell them for money to purchase food items for their families.

Mental Health

Mental health was explored in ten studies (Almedom et al., 2005; Almedom et al., 2007; Corbin & Hall, 2019; Hamid & Musa, 2010; Kim, Torbay & Lawry; 2007; Kinyanda et al., 2010; Olanrewaju, Omotoso & Alabi, 2018; Kizza, Hjelmeland, Kinyanda & Knizek, 2012; Kizza, Knizek, Kinyanda & Hjelmeland, 2012; Roberts, Ocaka, Browne, Oyok & Sondorp, 2008) which revealed that violence and mental health were intricately linked. Suicide and its precipitating circumstances were explored in two qualitative psychological autopsy interviews in Northern Uganda among women in a post-conflict context (Kizza et al., 2012; Kizza et al., 2012). The traumatizing effects of prolonged conflict, post-conflict gender role shifts, loss of traditional systems of social support, and socioeconomic challenges associated with displacement converged to create mental health problems for displaced persons (Almedom et al., 2007). In South Darfur, six registered IDP camps were surveyed in Nyala District. The study identified a 31% prevalence of major depression among women (Kim, Torbay & Lawry, 2007). In Northeast Africa, research showed that displacement had significantly more negative effects on women compared to men. Women in IDP camps had lower scores on sense of coherence scales, and scores worsened with the experience of serial displacement (Almedom et al., 2005; Almedom et al., 2007).

Almedom et al. found that the cultural and economic context of communities affected women's ability to adapt to the psychological effect of displacement, including outcomes for sense of coherence. For example, certain communities in Eritrea that had been used to transhumance herdsmen in subsistence farming had a better sense of coherence than those communities of a different occupation (Almedom et al., 2007). Another study by Roberts et al. measured rates of post-traumatic stress disorder (PTSD) and depression among IDPs,

investigating the associated demographic and trauma exposure risk factors through a cross-sectional survey conducted in Northern Uganda (Roberts, Ocaka, Browne, Oyok & Sondorp, 2008). This study showed that while men reported higher exposure to traumatic events than women, men reported lower levels of mental distress (Roberts et al., 2008). For instance, 49% of women compared with 71% of men had experienced eight or more traumatic events. Yet, women were twice as likely as men to exhibit symptoms of PTSD and over four times as likely as men to exhibit symptoms of depression (Roberts et al., 2008). This study also noted that women exhibited emotional symptoms, not psychotic ones. Hamid and Musa (2010) investigated the effects of the Darfur crisis on the mental health of internally displaced women—in particular, the traumatic events and resulting living conditions inside camps for IDPs in Darfur, Sudan. Results showed that 72% of the participants were classified as having PTSD and symptoms of general distress, such as anxiety and hyper-arousal.

Women's mental health was affected in diverse ways for many reasons. Women in Africa are traditionally committed to caring for their children, but keeping the marital union intact is also primarily seen as the woman's responsibility, and thus it is a priority. Men, on another hand, feel responsible for financial security of the household (Almedom et al., 2007). Internally displaced women experience a shift in gender roles creates psychosomatic distress in women because of the added financial responsibility to provide shelter, food, and security (Roberts et al., 2008). Married participants were more distressed and more anxious—with each person's psychological health issues being a direct reflection of their partner's social dysfunction (Hamid & Musa, 2010; Kizza et al., 2012). Following conflict and displacement, women bear the responsibility for the family's livelihood, in addition to their reproductive role—for example, in cases where the men's movements outside the camps were restricted and the external food aid

was limited (Cardoso et al., 2016), or when men had lost their jobs, which was a common occurrence (Logie et al., 2019; Stark et al., 2010). Despite the changed reproductive roles, husbands wanted to remain in control of the family's resources and expected the same sexual dominance and authority over their wives. However, the women were not prepared to take on the role of primary breadwinner but remain the subordinate partner. As a result, fights could ensue as women tried to restrict or control their husbands' expenditures (Kizza et al., 2012; Kizza et al., 2012). Men's quest to re-establish their masculinity, in the face of its perceived loss, led to them spending resources on alcohol, leisure activities, and extramarital affairs (Kizza et al., 2012).

Women's attempts to fight for their rights—mainly through resisting sexual advances, which is perceived as a cultural transgression resulted in men seeking to marry new wives. This added to the women's experiences of being abandoned. Worse still, while married to new wives, some men continued to be abusive to their first wife, acts which triggered suicide attempts for these first wives. Traditionally, these cultures are polygamous, and mothers-in-law would be supportive in cases where a man takes on a new wife; she would orient the new wife to the responsibilities of the home. In one of the cases, the mother-in-law had died, so that the senior wives were forced to take on the role of teaching the junior wife, which creates further stressors (Kizza et al, 2012).

These unconventional stressful experiences were summarized into two broad ideas, identified in two studies: no control in life and no care from family (Corbin & Hall, 2019; Kizza et. al., 2012). Another study categorized these stressors into three groups: (1) the individual or psych emotional factors, such as deaths of partners and children, and hardships of life in the camp; (2) the meso-system level risk, resulting from the husband's decreased participation in family responsibilities, such as farming, caring for children, and financial contributions, with

additional stressors at this level being limited access to social and community supports system; and (3) the exo-system level stressors, including decreasing community safety, increased gender-based violence and decreased respect from children (Corbin & Hall, 2019; Olanrewaju, 2018).

Sexual and Reproductive Health

Nine studies explored reproductive health as their key focus, with five focused on family planning (Ali & Okud, 2013; Decker & Constantine, 2011; Kisindja et al., 2017; McGinn et al., 2011; Orach et al., 2009), two focused on the impact of education on the use of reproductive health services (Adam, 2015; Adam et al., 2015), one concentrated on the effect of armed conflict on access to health services, access to rights, and women's perceptions of sexual and reproductive health with research conducted in Burundi and Northern Uganda (Chi, Bulage, Urdal & Sundby, 2015), and one explored HIV infection among displaced women (Kim et al., 2009). Kinyinda et al., (2010) and Kim et al. (2012), who primarily focused on mental health, also looked at the effect of reproductive health issues on the mental health of displaced women.

Chi et al.'s (2015) descriptive and explanatory qualitative study explored the perceptions of displaced women in Northern Uganda about the effects of armed conflict on maternal and reproductive health services and outcomes. Their findings reveal that the main mechanisms through which conflict led to poor access and quality of maternal and reproductive health services varied across the IDP sites. Attacks on health facilities and looting of medical supplies in both IDP sites was one reason. As well, other factors intervened: the targeted killing of health personnel, favoritism in the provision of health care in Burundi, and abduction of health providers in Northern Uganda (Chi et al., 2015).

Sexual exploitation in IDP camps predisposes women to sexually transmitted infections including HIV (Kim et al., 2009; Kinyanda et al., 2010). Women living in IDP camps in DRC

were shown to have twice the rates of HIV compared to host populations, which is associated with conflict-related sexual violence, and unprotected sex between displaced and non-displaced persons (Kim et al., 2009). Women's limited access to sexual and reproductive health rights was influenced by several factors, including low income status, cultural views, and spousal disapproval (Kizza et al., 2012). Women's access to rights also relied on their knowledge and understanding of their rights. For instance, many women did not consider that they had any rights to refuse sex, or to not be physically battered by their husbands (Kizza et al., 2012). Of 1240 women surveyed, 70% stated that in their marriages, non-consensual sexual intercourse was a normal occurrence, and contraceptive use was disapproved of by their husbands (Kizza et al., 2012).

Adam (2015) and Adam et al. (2015) conducted research at the same site in Sudan. They explored the impact that home visits/interpersonal communication for maternal education made on Sudanese displaced women's decisions about where to give birth. They were able to provide this education to 87% of women in their study, linking this to a greater preference for a medical facility for their deliveries (versus choosing a home birth). Those who choose home-births, despite the education, did so for several reasons, such as traditional significance around a home-birth, grandmothers' advice, husbands' preferences, and fear of doctors, avoiding surgical intervention, and not having enough time to go to a facility (Adam, 2015). Maternal health education at home was associated with a 43% reduction in home-based delivery performed by traditional birth attendants in the conflict-affected setting of Darfur, Sudan (Adam, 2015; Adam et al., 2015). Adam et al. found that providing a woman with education and free services are two important predictors of facility births and use of reproductive health services, including antenatal and postnatal services (Adam et al., 2015). Among all women investigated, hospital delivery

improved from 25.9% to 63.1% following a mass education campaign. There were also significant associations between receiving home visits and awareness of tetanus vaccinations and postnatal care visits in the follow-up phases. Interpersonal communication and mass education campaigns where community health workers disseminated information by home/shelter visits, clinic sessions, and public meetings improved the uptake of reproductive health services (Adam et al., 2015).

Unmet needs for contraceptives was another area of reproductive health explored in three studies. A study examining family planning knowledge and use among women in camps in DRC identified that 65 out of 155 women surveyed reported having an unintended pregnancy mostly because of extramarital affairs or casual sexual relationships (Kisindja et al., 2017). Most women reported that they had received information on contraception and had a moderate knowledge of modern contraceptive methods. Among Congolese IDP women, 84% reported having information on contraception, of whom 50% received information during antenatal care. Of this number, only a few women had used contraceptives. Contraceptive knowledge among female camp residents was moderate, however actual usage was low, predominantly for lack of interest, although additional reason given were insufficient knowledge, religious reasons, and partner refusal (Kisindja et al., 2017). More than 40% of women had experienced an unplanned pregnancy, with a history of abortion associated with non-use of contraceptives (Kisindja et al., 2017).

One study in Kassala, Eastern Sudan between July 1, 2012 and July 31, 2012 explored the unmet need for contraceptives. Among 812 married women surveyed, the total demand for contraceptives was 71%. The rates of unwanted and unplanned pregnancies and births were 13% and 16% respectively (Ali & Okud, 2013). A mixed methods study conducted in Angola between

April and October 2001 with 7090 among women aged 15 to 49 years of age showed that economic status was a major barrier to accessing a health clinic for health care services (Decker & Constantine, 2011). In Sudan, Uganda, and the DRC, current use of modern contraceptive methods among women was less than 4% in four program areas: West and South Darfur, Southern Sudan, and Eastern Congo. Oral contraceptive pills were the most widely used method in every site except Eastern Congo, where condoms were most popular (McGinn et al., 2011). Where health centers offered oral contraceptives, facilities were ill equipped to offer all the mandated methods of family planning because of a lack of funding for such programming (McGinn et al., 2011). Some women also felt that there was unfairness in facility services, in that they were being provided with contraceptives but not with reproductive and maternal health services.

Malaria

The high burden of malaria was a health concern identified in four studies, for which there are limited interventions and controls. Obol et al. conducted a study exploring misconceptions about malaria treatment among internally displaced pregnant women (Obol, Lagoro & Garimoi, 2011). They found that the role of vector transmission of malaria was poorly understood by women in Northern Uganda. Some women thought that cold food, playing in the rain, cold weather, and eating mangos could cause malaria (Obol et al., 2011).

Dræbel, Kueil and Meyrowitsch (2013) identified Plamodium falciparum to be the most common parasite species detected among Nuer Sudanese displaced women. In this malaria study, conducted in 2013, Dræbel et al. identified that primary school attendance was a stronger predictor for use of malaria risk reduction measures than any of the other selected background characteristics. This signifies that an individual's educational level need not be very advanced to

affect their practices of malaria prevention and treatment. School attendance was also significantly associated with insecticide-treated net ownership (Dræbel et al., 2013). For fever caused by malaria in pregnancy, about 65% of displaced women sought treatment within the first 24 hours. In South Sudan, Dræbel and Gueth Kueil's (2014) study also found that health centers were a last resort for treatment for malaria. They carried out a qualitative study to explore lay perceptions of malaria and process of treatment among 30 resettled pregnant women. The women preferred to pursue treatments in the following order: home remedies, traditional healers, and self-medication with medicines from vendors or supernatural healers (Dræbel & Gueth Kueil, 2014). The women did not clearly link fever as a symptom of malaria; rather, illness is considered to potentially be malaria when it is accompanied by other signs like neurosis and dizziness.

Obol, Ononge and Orach (2013) conducted a cross-sectional study in Northern Uganda in 2013 to establish the prevalence of, and factors associated with, insecticide-treated net (ITN) use among pregnant women in post-conflict IDP camps of the Gulu district. ITN usage was low (35%) among pregnant women; factors that promoted such usage included antenatal visits, ITN awareness, and a willingness to purchase ITNs. Factors that impeded its usage included the hours of travel necessary to reach a health center and being single, widowed, or divorced (Obol et al., 2013). Brooks et al., (2017) identified that women in DRC rarely complied with ITN use to prevent malaria except where it concerned their fetuses; thus, presenting information at antenatal health centers about ITNs and their use in preventing malaria was an effective way to increase compliance. Women who did not attend antenatal visits would not have knowledge about the usefulness of bed nets, since they would not be exposed to the routine information sessions held at these sites (Brooks et al., 2017). Another factor that made use of bed nets difficult was the

space constraints in camp tents, where IDPs slept on mats, making it impossible to tuck away the bed nets. Further, the muddy environment easily soiled bed nets, but washing them also posed a challenge given the shortage of water in the camps. Food insecurity compelled some women to sell their nets to the host communities (Brooks et al., 2017).

Discussion

As noted, we categorized the studies into four subtopics: violence, mental health, sexual and reproductive health, and malaria. Seven studies had findings centered on violence perpetrated by both intimate partners, armed forces, and the general community, ten studies explored mental health, and nine studies explored reproductive health. Violence in post-conflict Africa took different forms depending on the context of the settlement—in particular, whether it was rural or urban. Intimate partner violence was a major finding of this review, including aggressive sexual expectations from men, and dysfunctional masculinity related to progressively being relocated from one region to another without gainful employment opportunities (Almedom et al., 2007; Kizza et al., 2012)

Gendered power differences shifted constantly; women's new roles as economic providers seemed to especially threaten masculine authority. The loss of community and extended family supports served to strain marital relations further, so that domestic violence and other types of violence were connected, and divisions between public and private life in camps blurred (Corbin & Hall, 2019; Kim et al., 2009). The privacy of the marital environment was non-existent because of the overcrowded tent housing systems. Neighboring families could see and hear what was going on in other people's home. Violence in intimate spaces was therefore not really private, but rather, public—exacerbated by widespread communal violence that served

to sanction it (Ager et al., 2018; Aham-Chiabuotu et al., 2019). The normalization of violence against women in public spaces was facilitated by public shaming, and further institutionalized because security forces and police forces were also seen to openly violate women. Finally, pastors—who women might have reasonably seen as supportive figures or public figures they could turn to for help—were also documented to be abusive to their own spouses (Ager et al., 2018).

The lack of sexual inhibition on the part of men, associated with their traditional masculine feelings of entitlements, along with chronic alcoholism, led to open sexual relations between couples (Kim et al., 2009; Kinyanda et al., 2010; Kizza et al., 2012). Children became exposed to these kinds of adult interactions, contributing to diminishing respect for parental authority. As a result, children of the displaced begin to inappropriately imitate adult sexual behaviors at an early age, leading to the degeneration of societal mores and sexual decency. Young people are participating in a sexual economy as a means of survival and married women are turning to sexual labor in a desperate effort to meet the needs of food security for their families. Transactional sex has hence become a norm in post-conflict societies in Africa.

Mental health was explored in ten studies, especially as it pertains to the emotion-centered burden of care and family responsibilities that women shoulder, which led them experience the brunt of family disintegration in a more severe way (Almedom et al., 2005; Almedom et al., 2007; Corbin & Hall, 2019; Hamid & Musa, 2010; Kim et al., 2007; Kinyanda et al., 2010; Kizza et al., 2012; Kizza et al., 2012; Olanrewaju et al., 2018; Roberts et al., 2008). The psychological impact of sustained trauma from within the home and from outsiders, the persistent fear of the unknown, the loss of loved ones and livelihoods, housing issues, and lack of family support or community connection created a serious strain on women's mental health.

Further, when familial support systems become eroded during times of social conflict, post-partum stress can take a particular toll and advance to become full blown depression.

Obviously, mental health is increasingly becoming an issue of concern among African's forcibly displaced people (Idemudia, William, Boehnke & Wyatt, 2013). War and conflict have eroded collective resilience in African communities, which is the main strength of African societies. But gender differences are an important consideration here also, and understanding gender-specific aspects of displacement and health can inform effective long-term mental health service programs to alleviate traumatic disorders (Hamid & Musa, 2010; Morina, Akhtar, Barth & Schnyder, 2018). For example, a study in Ethiopia evaluated gender as a category that influences coping with trauma, finding that men reported a significantly different experience of traumatic life events related to displacement and perceived social support, when compared to women (Araya, Chotai, Komproe & de Jong, 2007). In this study, women reported higher emotion-oriented coping whereas men reported higher task-oriented coping. This supports findings from a study among displaced Zimbabweans in South Africa, which identified that pre- and post-migration stress, as well as poor mental health, are related to PTSD for women but not for men. Women's traumas were more attributable to higher incidences of harassment from the police during the pre-displacement period, while men reported threat-to-life, being hungry, and not having a place to live as their key concerns after displacement (Koegler & Kennedy, 2018).

With respect to reproductive health, poor awareness of relevant information was not only found among women; health providers are also inadequately knowledgeable about the guidelines for reproductive health interventions in displacement (Adam, 2015; Adam et al., 2015). Religious, cultural, and financial factors also play a role in attitudes toward contraceptive usage among African women (Ali & Okud, 2013; Decker & Constantine, 2011; Kisindja et al., 2017;

McGinn et al., 2011; Orach et al., 2009). Existing studies conducted among displaced adolescents in Africa support this, demonstrating that misconceptions about contraceptives cause adolescents to refrain from using them (Ivanova, Rai & Kemigisha, 2018). Additionally, the culture of home delivery is a common practice in traditional Africa which may also indirectly affect utilization of contraception. The review showed that home visitation and education had a huge impact on encouraging more women to choose a hospital-based delivery, and many women obtain knowledge about contraceptives from antenatal care associated with this birth choice.

However, in general, women have a fair knowledge of contraceptives irrespective of education levels. The challenge with actual uptake relates to cultural norms and expectation for women to have multiple births. The husband's educational status and position on family planning are also very significant factors determining uptake of reproductive health services. Another aspect of reproductive health is HIV prevalence. Studies examined this issue as it related to sexual violence and casual sex, observing that treatment was difficult to access for displaced people in rural settings. Armed conflict has been shown to expose women to both sexual violations and HIV (Chi et al., 2015; Kim et al., 2009).

We identified that malaria in pregnancy was a common illness among displaced women because of the open shelter housing. Moreover, this review showed that many women had misconceptions about malaria management and the effect of malaria on the growing fetus (Obol et al., 2011). In managing fever, women sought traditional healers as the first line of treatment. While insecticide-treated nets are being distributed by aid agencies, some women had to sell them in order to provide food for their household (Brooks et al., 2017). Primitive knowledge on how malaria can be controlled, such as beliefs in herbal treatments and self-medication, were found to be issues preventing prompt treatment (Brooks et al., 2017).

Treatment was usually sought upon the recognition of fever ("loup" in Nuer, which translates to "hotness"); however, the link between fever and malaria, ("juay lieth pouny" in Nuer or "illness of heated/perspiring body") was not always instantly recognized. Two women (2/30: 7%) identified malarial fever by its cyclical characteristics, but they also stated that only fever accompanied by signs and symptoms of complicated malaria—described as "confusion," "madness" or "dizziness"—could be identified as malaria (Dræbel & Gueth Kueil, 2014). Pregnant women understood the risk differently, with some misconceptions. They expressed phrases like a malaria infection could cause the fetus to "suffer," become "uncomfortable," "restless," or "irritable," or could cause the fetus to become "anemic." They also made statements such as "the child is born with spots"; "the mother's womb will swell up"; or "the child does not move for two to three months" (Dræbel & Gueth Kueil, 2014). This suggests that self-diagnosis is a common practice among displaced women, and further suggests that other infectious diseases and HIV, which may present with cyclical fever or malaria-like symptoms, may be wrongly diagnosed as malaria. About 24% of women waited for two to three days before seeking treatment.

The 2030 Agenda for Sustainable Development contains a number of targets related to reproductive health. Specifically, target 3.7 calls for ensuring universal access to sexual and reproductive health care services, including family planning, information, and education, and the integration of reproductive health into national strategies and programs by 2030 (United Nations, 2020). These interventions—in addition to the prevention of mother-to-child transmission (PMTCT), treatment for sexually transmitted infections, vaginal injuries, and fistula management, post-abortion care, safe abortions, interventions for the prevention of sexual violence, and comprehensive clinical management of rape—all need to be explored as equally

important components of reproductive health in displacement as outlined in the Minimum Initial Service Package MISP (WHO, 2010). This review showed that research has been done on the health of displaced women in parts of Africa. Nevertheless, sex-disaggregated information on internal migration in Africa as it pertains to women's health is scarce (Ivanova, Rai & Kemigisha, 2018).

Seven studies employed a qualitative approach, with single methods such as focus group discussion and semi-structured interviews, to explore aspects of the health of displaced women. The drawback of the study methodologies includes a lack of in-depth theoretical analysis of the descriptive accounts of the women. As well, the studies tended to use a qualitative method for data collection but then applied a quantitative method of analysis. This has implications for the kinds of hypothetical associations that can be drawn from most studies, as well as on the causal relationships that can be discerned, particularly with single-method studies.

Most studies were not grounded in any theoretical assumption related to women's cultural environment, language, and social vulnerability. This was the case with studies examining the unmet needs for contraceptives, which were poorly estimated because of language barriers (Decker & Constantine, 2011). As well, a theoretical framework was absent in studies that used surveys to explore women's STIs, sexual behavior, and gender-based violence, with the conceivable inaccuracy of self-reports of STI symptoms (Kim et al., 2009). Shortcomings of findings drawn from self-reporting is related to the inability to validate actual incidence with any clinic information, since health clinics did not have activity logs of clinic visits and kept poor kept health care records and had no antenatal records or vaccination cards (Logie et al., 2019).

A methodological mismatch was found with studies exploring topics like domestic violence through focus group discussion (Aham-Chaibuotu et al., 2019; Cardoso et al., 2016).

Domestic violence is a serious problem affecting displaced women, yet cultural beliefs in many African societies and patriarchal culture influence women's ability to report being violated. Thus, focus group and verbally administered survey methods used to explore topics like intimate partner violence among displaced women may have been subject to social desirability bias (Cardoso et al., 2016). Given the stigmatization of intimate partner violence in the context of African culture, there is no guarantee that participants being asked to speak in a group would be able to give a true account of their experience as survivors or as perpetrators of violence or to share their personal opinion on the matter. This casts the conclusions of these study in some doubt—at least in terms of the reported amount and degree of incidents, even if the qualitative data of the women's lived experiences and interpretations remain meaningful.

Studies that explored maternal health access often looked at intervention methods, such as studying the impact of home visits on the awareness and uptake of maternal and reproductive health services (Adam, 2015; Kim et al., 2009). These studies had no control groups, and therefore it is impossible to theorize the causal relationship between the interventions and changes in the measured outcome indicators in the follow-up survey. One study used a purely qualitative approach (including a descriptive and explanatory qualitative study with semi-structured in-depth interviews and focus group discussions) to explore perceptions of the effects of armed conflict on maternal and reproductive health services and outcomes (Chi et al., 2015). The target group was NGOs and local health service providers. The affected displaced women were not interviewed on their reproductive health access.

Another concern in several studies was the researchers' inadequate consideration for the impact trauma has on the cognitive abilities of displaced women and how this affected the data on management of related mental health issues. Considering that displaced women have been

through trauma at different points in the past, their ability to recall previous experiences can be distorted, especially when the current experience is being reported through a structured survey with closed-ended questions. Gender considerations also need to be accounted for in trauma-related studies because women may withhold certain sensitive traumatic events in their past because of the interviewer's gender (that is, they may find it too hard to share their details with a male interviewer, for example among Hausa communities of Northern Nigeria where women cannot share reproductive health information with men) (Oladeji et al., 2018).

Conclusions

This scoping review identified major health concerns among internally displaced women in Africa. Evidently, the available studies on this subject are heterogeneous, yet rich in the description about the various health concerns affecting these women. From the review, it is clear that health issues related to intimate partner abuse, poor access to contraceptives and professional birthing support, and a prevalence of malaria are priority concerns. These concerns can all be linked one way or another with the socioeconomic impact of war, and the changes in gender role expectations between husbands and wives. This is further complicated by the overall fragility of these regions and the attending precarity and housing problems. These African communities are also in need of health facilities, which depends in part on the needed humanitarian aid to rebuild health facilities that have been destroyed during conflicts in the various regions. Our review also identified the gap in research on abortion care, and post-natal outcomes for women who choose to have home- births versus those who access hospital settings for delivery.

This review has useful implications. Building of health facilities, treatment of malaria, and provision of HIV diagnosis and treatments, which the UNHCR cluster strategies already

advocates for is an urgent need in African IDP camps. However, the responsibility to bring long-lasting recovery and health access to these populations remains the responsibility of governments in Africa. For decades now, African states have struggled with the issue of internal displacement and the need to advance the rights and healthcare access for displaced women through implementing the Kampala convention (Jesuthasan et al., 2019; Kampala Convention, 2009). The Kampala policy has, in itself, no specific guidelines on how institutions should implement IDP policies. However, international humanitarian actors must proceed carefully if they want to bring about real changes in conflict-affected countries and thereby improving the lives of internally displaced women. They have an obligation to respect the sovereignty of these African nations, even while they seek to implement policies that will have positive health outcomes. Moreover, Africa cannot continue to depend on these international policy instruments and depleting UN humanitarian aid to transform the status quo in Africa.

African governments need a renewed commitment towards internally displaced persons. Constitutional amendments, especially, must incorporate the health service needs of displaced people, given the many vulnerable people in this population in need of services. However, to be sustainable, health interventions must be low cost and community-based. For example, medicine vendors and midwives, as well as women, could be trained to attend births and to provide basic care like malaria treatment and couples counselling. Pastors seem to play a central role in shaping the perceptions of communities about domestic violence, and thus, interventions to mitigate this social injustice against women should engage religious leaders and community elders to change the public view about this violence. They could also be involved in promoting mental health and suicide prevention awareness. Other factors are also at play here as the prevalence of mental health issues, suicides, poverty, high birth rates, and housing issues are

important psychosocial issues that worsen health outcomes for displaced women. Most of the problems of displacement, including violence against women in the home, malaria, HIV, and transactional sex, as well as a mental health crisis are all connected directly with income. Given this association, the economic empowerment of displaced communities should be of paramount concern at this time. Governments need to direct resources toward this aspect, recognizing that psychosocial health cannot respond easily to medical interventions if the socioeconomic causes of the health issues remains unaddressed. The unfortunate reality, however, is that the humanitarian need for health services far outweighs the available funding.

The results of this review suggest that policy interventions should focus on developing incentive-based home health intervention programs to significantly improve the knowledge, perception, and willingness of displaced women to take up available services. These include malaria prevention and care, mental health services, and hospital-based childbirth services. Mental health studies should also be merged with awareness and critical consciousness raising intervention activities. Comprehensive reproductive and sexual health services are also urgently needed.

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Chapter 3: Paper 2- Reproductive Health Access for Conflict-Affected Displaced Women in Nigeria: An Intersectionality-Based Critical Ethnography Study

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Abstract

Nigeria is a significant contributor to the growing global forcibly displaced population. The forced displacement is related to Boko Haram and Herdsmen attacks in Northern Nigeria. Existing research has tended to focus on issues of sexual violence and unwanted pregnancies associated with conflict and displacement. We aimed to examine intersecting factors shaping the reproductive health experiences of women internally displaced by the Boko Haram and Herdsmen crisis in Northern Nigeria. We completed a critical ethnography study involving in-depth interviews with twenty-nine internally displaced women and five service providers in Northern Nigeria. Data were collected from May to September 2019. Four major subjects pertained to women's reproductive health access. The categories are: 1) decision on birthplace and number of births, 2) normative beliefs and access to urogenital infection treatment 3) income, health resources and accessibility to care, and 4) mental wellness, childbearing and gender. Genital infections were widespread among women. The number of childbirths per woman was determined by both personal and social expectations for childbirth and the sex of a child. The poor state of available health facilities precipitated the use of traditional reproductive and maternal health care services. In the absence of quality maternity services, birth attendance was sought at a chemist (pharmacy) and with local midwives. This study demonstrated the interrelatedness of economic, sociocultural, and religious factors in contributing to reproductive health outcomes for IDP women. Knowledge of the intersecting health needs of IDP women is crucial to developing appropriate interventions for the population.

Keywords: Boko Haram, Critical ethnography, internally displaced, Intersectionality, Nigeria, Reproductive health

Background

In the last 20 years, global forced displacement has doubled (United Nations High Commissioner for Refugees [UNHCR], 2019). There are 70 million children, women, and men displaced around the world (UNHCR, 2020). Almost two-thirds of those forcibly uprooted from their homes are internally displaced people (IDPs), who have not left their country (UNHCR, 2019). An IDP is a person who is forcibly displaced but remains within the country's borders (Internal Displacement Monitoring Centre [IDMC], 2016). IDPs have been described as "the invisible majority" because even though they outweigh international asylum seekers and refugees by 50%, they have relatively limited global visibility and legal protection/aid when compared with refugees (Norwegian Refugee Council [NRC] & IDMC, 2017; UNHCR, 2016; United Nations Office for the Coordination of Humanitarian Affairs [UNOCHA], 2020). While refugees have legal protection within international law, e.g. the Global Compact framework approved by the UN General Assembly in December 2018 for international cooperation to support refugees (UN News, 2018), IDPs do not have a legal status and are still under the jurisdiction of their own government. Hence, they depend mostly on humanitarian agencies for aid.

Africa has contributed two-thirds to the number of displaced persons around the world in the past five years (UNHCR 2020). In sub-Saharan Africa, the proportion of men and women affected by conflict-induced displacement is nearly equal; however, gender-specific risks exist that make women more vulnerable than men in the context of displacement (Amodu, Richter & Salami, 2020). These vulnerabilities relate to traditional gendered role expectations such as the superfluous expectation for domestic work, childcare, elder care, and financial responsibilities towards children—responsibilities that strain women emotionally and predispose women to

sexual exploitation when they try to access resources to provide for their families (Cardoso et al., 2016). The Humanitarian Report 2020 indicates that Nigeria has up to 5.3 million people in need of health care in the humanitarian settings and about 2 million of them are internally displaced persons in 16 states of Northern Nigeria and the Federal Capital Territory, Abuja (UNOCHA, 2020). About 80% of those displaced are women and children (UNHCR, 2020; UNOCHA, 2020). The Boko Haram crisis and Herdsmen violence have driven many people out of their homes within Nigeria and across the country's borders to Cameroon, Chad, and Niger State. Due to the peculiarity of how the Boko Haram conflict ensued in Nigeria, early international humanitarian efforts to intervene in the insurgencies following the Chibok incident have focused on mediation for security assistance, in particular, for adolescent victims. A scoping review conducted by Amodu et al. (2020) identified nine studies that explored access to reproductive health for internally displaced women in Africa. Access to reproductive health services was influenced by women's knowledge of their rights, cultural norms, availability, and affordability of care (Amodu et al., 2020). Available studies have explored family planning, the impact of education on reproductive health decisions, the impact of conflict on access to services, and prevalence of HIV infection associated with conflict-related sexual violence (Amodu et al., 2020; UN, 2016). Findings show a high incidence of sexual exploitation, unmet need for contraceptives, and unplanned pregnancy. Overall, cultural norms and expectations of the IDP communities in Africa influenced women's access to reproductive health services such as contraceptives and hospital-based birthing services.

Studies on Boko Haram and Herdsmen victims in Nigeria have centred on sexual and reproductive health including issues of gender-based violence, forced marriage, HIV/AIDs, and prevention of unwanted pregnancies, particularly among adolescents. For example, Okanlawon

et al., explored contraceptive use and unintended pregnancies among refugee girls in Nigeria (Okanlawon, Reeves & Agbaje, 2010). Durosaro and Ajiboye (2011) examined problems and coping strategies of internally displaced adolescents in Jos Metropolis. Oladejo et al. (2018) explored sexual violence-related pregnancy among internally displaced women in an IDP camp in Northeast Nigeria with a sample skewed towards girls aged 10 to 19 years. In Northeastern Nigeria, several programs have also focused on girls' safety. For instance, UNFPA's safe spaces initiatives have established young girls' access to sexual health services and recreation (UNFPA, 2016). Onuegbu and Salami (2017) also studied reproductive health information access for adolescents in camps in Nigeria. Research on broader reproductive health outcomes for affected women of reproductive age in Nigeria is particularly overlooked. Women of reproductive age who have migrated with children from the Boko Haram and Herdsmen crisis have made significant geographical shifts, moving across many states to reach their destination. Only one peer-reviewed study has explored reproductive health issues among women of all reproductive ages; it focused on sexuality, pleasure, and marital rape in displacement camps among IDP women (Aham-Chiabuotu, Abel, Thompson, 2019). Little is known about women's access to comprehensive reproductive health services in IDP camps in Nigeria. The purpose of this critical ethnographic study was to explore the factors that influence the reproductive health of IDP women of childbearing age living in a camp in Northern Nigeria.

Theoretical Framework: Intersectionality

Intersectionality is a theoretical perspective developed by American critical legal race scholar Kimberlé Williams Crenshaw in 1989 to explore how identity markers such as race, ethnicity, gender, religion and class can simultaneously constitute sources of oppression and

disadvantage for black women (Crenshaw, 1989). Intersectionality suggests ways to explore the structural and political aspects contributing to marginal experiences thereby helping to better conceptualize social problems. Evidence based on the intersectionality approach can inform public policy through in-depth knowledge that can lead to women gaining autonomy over their experiences and needs (UNHCR Global Protection Cluster, 2018). Intersectionality as a paradigm of thought does not prescribe specific indicators or methods to draw upon to assess health disparities or health interventions or describe how to translate theory into methods. Certainly, the use of intersectionality for understanding displaced women's health is a new landscape of scholarship. However, Hankivsky (2012) has functionally applied the theory to refugee women's health and proposes ways intersectionality can help us conduct research in this field. In short, Hankivsky et al., (2010) summarized intersectionality's role in women's health thus: "to produce knowledge that promotes action on the variety of factors that affect women's lives and their health" (p.1). According to this philosophy, these factors are not simply gender related but broadly include social identity and location-related factors that can influence study participants, the researchers' position, and identifiable challenges in the research context.

It can be said that development agencies and humanitarian agencies often use a Western model for examining the health challenges of forced migrants (Porterfield et al., 2010; Siriwardhana & Stewart, 2013). Olajumoke Yacob-Haliso stated that a blanket approach to humanitarian interventions for refugee women in Africa minimizes the gender sensitivity of the problem and excludes the unique social, cultural, and political contexts of female migration, health and rights in Africa. This argument is supported by an existing study from Nigeria and Uganda which showed that displaced women and their communities were not psychosocially sensitive to sexual aggression from spouses to the degree that is expected by gender analysts

(Ager et al., 2018; Aham-Chiabuotu, Abel & Thompson, 2019). Olajumoke described a concept called the "intersectionality of disadvantage" as the multiplicity of factors that aggravate African refugee women's disadvantages in accessing and experiencing solutions (Yacob-Haliso, 2016). The use of general survey methods to explore humanitarian problems produces evidence that is insufficient to inform policymakers and practitioners on the gendered and culturally determined lived experiences and needs of affected persons (Amodu et al., 2020). There is wide-reaching critique by Native and Indigenous scholars of Western anthropology that employs research methods that further alienate and exoticize marginalized persons and are intrusive to them. Smith (1999) in a book on decolonizing methodologies, criticized research methods that accentuate an assumption that research is culture free and that researchers have some kind of moral advantage that authorizes them to observe their subjects and make biased judgements about them. Overall, researchers are prompted to reflect on, and be critical of, their own values and assumptions and to acknowledge that these are not the norm across other cultures. The existing literature on conflict-affected displaced women in Africa establishes that displaced women experience marginality in a culture of patriarchy and economic subordination (Ager et al., 2018; Kizza, Knizek, Kinyanda & Hjelmeland, 2012). This knowledge and our prior experiences with cross-cultural research enabled us to utilize intersectionality based methods while attending to the issue of women's agency and voice.

Study Methodology

The current study is an ethnography study based on feminist intersectionality analysis of the reproductive health challenges of conflict-affected IDP women in Nigeria. This study involved self-identifying IDP women in a camp in Nigeria. We conducted a critical ethnography

study to examine various aspects of these women's social lives and access to reproductive health. Participant observations and in-depth qualitative interviews were completed based on a semi-structured interview guide.

Study location and ethical considerations

Our study site camp was located in FCT Abuja—one of the safer regions of Nigeria and recommended for cautionary travels by the Government of Canada Travel Advice and Advisories (Government of Canada, 2018). The IDP camp holds 5000 people in 900 households. There were about 2000 women including 300 pregnant and lactating women, three health workers in the camp, and no major security issues. There were 10 local police officers as well as lay community peace officers present. The shelter type was a government-abandoned housing estate. The camp had one central clinic run by one male service provider paid by the government and two female volunteers. The camp clinic had a shortage of medical supplies. There was a self-owned community chemist across the camp where IDPs also obtain care. Ethical approval for the study was obtained from the Ethics Review Board (Pro00089091) at the [University of Alberta] along with an approval letter from the National Social Investment Office (NSIO) in Nigeria. A National Emergency Management Agency (NEMA) representative provided feedback on progress throughout interviews. The population setting was selected because it was among the least visited by humanitarian agencies and was recommended by NEMA for the study. For the purposes of confidentiality, the exact name of this camp will not be disclosed.

Participant recruitment

Initial contact was made with the NSIO Office of the Vice President and the NEMA representative who was working with the displaced and who provided links to the camp leaders through whom access was gained to recruit participants for research. As well, we obtained

recommendations from the NSIO office on other relevant service providers to interview. Participants were purposively sampled by inclusion characteristics of age (at least 18 years to 45 years), gender (female), citizenship (Nigerian), and displacement by Boko Haram terrorists or herdsmen. Service providers who have jurisdiction for management of displacement issues were contacted for interviews. The camp coordinator, camp clinic female volunteers, and women leaders served as key recruitment support persons. We explained the purposes of the work to the camp chairperson and the women leader and obtained consent to conduct research in the setting. Snowball sampling was done through well-regarded women in the community who had good relationships with other women. All participants received a clear explanation of the study and the goals and provided either written or oral consent to participate in the study and to be audiotaped during interviews. Reimbursement for time spent was provided to the women after the interview was completed. A bilingual interpreter was present during all interviews with the women.

Interviews

The subtopics of the interview guide were informed by the study objectives, a review of the literature on conducting reproductive health assessments in humanitarian settings, and the displaced women's health needs and experiences. We completed 27 interviews in the first three months (May 2019 to July 2019) ranging from 30 minutes to two hours. By the third month of the study (July 2019), only slightly new variations in migration stories were identified, but there was no new information related to reproductive health. Interviews with five service providers took place concurrently. The inquiry continued to evolve as more data were obtained to focus questions on specific areas. Interviews were conducted in the Hausa language of the participants with the help of a bilingual interpreter who also was the research assistant. While some women

spoke in English, which is an official language in Nigeria, generally reproductive health concepts could be best understood when discussed in the participants' local language. The interpreter was involved in both cross-cultural interpretation and technical translation. We tried to assume neutrality towards the participant's stories and to openly negotiate meaning with participants, the interpreter and co-researchers as a way of sharing power. We explicitly clarified all ideas and subtle meanings that might cause misunderstandings. Where meanings were debatable, we analyzed and negotiated interpretations with participants. We noted our personal assumptions and acknowledged the limitations of our biomedical knowledge. The initial descriptive codes to summarize the basic subtopics emerging through the data were categorized and discussed with co-researchers.

Analysis

Data were transcribed verbatim into English by two bilingual transcriptionists, one of whom was present during the interviews. Both transcripts were found to be similar. The copy provided by the interpreter had more contextual details because of her presence during interviews. Another competent speaker evaluated the quality and accuracy of the translation by back translating specific quotes and illustrations. Data were analyzed using Carspeken's first three stages of critical qualitative research method involving three iterative steps: reflection on data and the research process from an outsider point; dialectic analysis of research data; and dialogical data presentation (Carspeken, 1996).

The reflection phase involved frequent debriefing sessions with all authors to discuss emerging ideas from the data, contrasts and similarities between information, and creative categorization of the data. In particular, we paid particular attention to the contextual

interpretation of data. This meets the criteria for accountability in ethnographic research as recommended by Hankivsky et al. (2010) and Jacobs-Heuey (2002). Observations of the cultural context and social interactions among participants were noted. The hired research assistant was culturally knowledgeable, was born and raised in Northern Nigeria, and had more than five years of experience conducting research on reproductive health among this population. The research assistant provided suggestions on how to best approach the women, the most appropriate location for interviews (the home), how to greet in the local language, and how to use humor to help women feel at ease with the interview process. Observation and deep immersion in the field took place including observation of the women's residences, the sanitary conditions of the environment, daily activities of the women, and activities within health centers. On-site data verification and interpretation facilitated positive engagement in the field and sustained an iterative exploratory inquiry process. Through reflexive journaling and memo writing, the lead researcher documented emerging awareness and relations in the field, which helped us to be cognizant of any power disparities between the participants and the research personnel to make modifications for more just relationships. OC led the analysis. NVivo 12 software was used to import transcripts and to begin data categorization. The initial descriptive codes pertaining to reproductive health encompassed complaints about vaginal infection, finances being a major barrier to access health care, a high number of births, and a desire for more children.

Dialectic analysis of the research data involved thinking over emerging concepts to identify recurrent themes relating to reproductive health. We probed further using newer tactics of engagement of an interactive nature to identify underlying factors influencing care access. Factors that shape women's decisions to seek health care based on previous life circumstances, knowledge, experiences, and cultural stances were identified. Interactive data collection methods

included visiting women's homes to conduct interviews instead of at the clinic, managing proximity and distance in research relations, and verifying emerging findings repeatedly with women and service providers (Georgiou & Carspecken, 1996). We performed thematic analysis, generating an outline of the underlying relationships between complementary data including observations, field notes, and interview data. We returned to participants with variant responses to confirm their experiences in comparison with the general results. In the fourth month, data saturation was reached for the aforementioned cases.

Dialogical analysis implies meaning analysis, thematic interpretation, and intersecting implications (Carspecken, 1996; Sullivan 2011). To add perspective, we meshed personal reflections on intersectionality with references to underlying structures of influence on reproductive health. Because experience can have several interpretations depending on who, why, and under what circumstances, the discussion entailed critical intersectional analysis of the data, e.g., observing patterns suggestive of social inequality, underlying truths that are not at the surface, and recognizing otherness in the fabric of talk. This step also involved thinking about different aspects of identity such as gender, ethnicity, literacy, and religion as characterizations of the data, social location, and culture as reflected in women's responses. We engaged in a continuous self-evaluative process considering the social location of research participants and the context within which their experiences are situated. Using the theoretical knowledge of intersectionality, a coding framework was developed with robust inclusion of factors that have shaped reproductive health access for women. The use of multiple sources of data, prolonged engagement in the field, and member checking through data verification helped to ensure rigour.

Results

We recruited and interviewed 29 displaced women on their experience of accessing care in camps. Morse (1994) recommends a minimum of 30 to 60 participants for ethnographic studies. Additionally, we completed interviews with five service providers to understand the systemic practices influencing reproductive health access. Women who were interviewed were internally displaced women living in an IDP camp in Northern Nigeria. Except for one participant who had been displaced from Sokoto State, the source villages for the women in my study were under Gwoza, the local government in Maiduguri, Borno State. The women were displaced between 2013 and 2017. Taraba, Adamawa, Damaturu, Madagali, and Cameroon were interim settlements for many women before reaching Abuja. Participants ranged in age from 18 to 42. All the women were married except for two women. Occupations ranged from farming to sewing, knitting, and selling provisions and soup items. While most women could not total their income, estimated earning was between 5,000 to 15,000 Naira a month (USD$14 to USD$40).

The service providers who were interviewed included three primary health care service providers (two government workers and one health volunteer), one chemist vendor (patent and proprietary medicine vendor), and a representative of the National Emergency Management Agency (NEMA). We additionally had informal conversations with the IDP camp chairman. The migration of women from their source villages to the camp means transitioning from known to unknown places. The women desired to recreate similar conditions to what they had in their homelands, but this proved to be challenging. The women narrated traumatic experiences of being attacked and chased by Boko Haram. There were also multiple attacks in countries they fled to before reaching the camp site.

With respect to reproductive health findings, four themes precipitated from our analysis including 1) Decision on birthplace and number of births, 2) Normative beliefs and access to urogenital infection treatment 3) Income, health resources and accessibility to care, and 4) Mental wellness, childbearing and gender.

Table 3. 1 Participant Demographic

IDP Women	**N**
Tribe	
Chinene	4
Maffa	2
Mandara	9
Hausa	11
Glavda	3
Religion	
Christian	17
Muslim	12
Education	
Secondary school	6
Primary school	6
No schooling	13
Nigeria Certificate in Education (NCE education)	2
Arabic school	2

Decision on Birthplace and Number of Births

This study showed that sociocultural values shape IDP women's choices on family size and birthplace although not independently of socioeconomic status. Intersectionality stresses that the creation of agency is a dynamic process (Creek & Dunn, 2011). Women abandoned the health centers and engaged in traditional home birth practices, supporting one another with childbirth. Senior wives or elderly women also regularly performed deliveries for women in their homes and trained younger women to attend births. Maryam, an IDP woman, described her experience of childbirth:

"The delivery was done in the home on a mat. The umbilical cord is cut with a heated razor and the placenta is taken away by the midwife to be buried in an unknown place."

-Maryam, IDP woman

Local midwives also provided home birth support to women. There were two well-known midwives living in the camp who frequently provided birthing support to women. By doing this, women drew on their community strength and knowledge to defy structural adversities in the health system. According to Creek and Dunn (2011) who studied common sense assumptions about violence victims, intersectionality provides a platform for analyzing how women resist, cope with, and survive adverse experiences. There was a general reluctance to provide direction to the homes of these local midwives for interviews. The women leader reported that one of the midwife's clients had recently died from uncontrolled bleeding postpartum around the period this field study began (May 2019). The local midwives' identities were thus kept private. As our ethnographic interviews progressed, we also identified that many women described the experience of getting childbirth support on credit from a *"chemist doctor"* who was well known by this community:

"Yes, I went for antenatal care and I delivered my baby at a chemist around here. We did not pay because we had a personal relationship with him."

-Rakiya, IDP woman

In Nigeria, a "chemist" is a small pharmacy shop where drugs are sold over the counter (OTC) in small amounts. In formal terms, people who manage chemists are known as patent and proprietary medicine vendors (PPMVs) (Beyeler, Liu & Sieverding, 2015). We located the *chemist doctor* and found that he was an IDP himself who had been displaced from Gwoza to Abuja. The chemist care provider told us that he had delivered about 100 babies since

2014 and he is available to IDP families 24 hours a day. We arranged for an interview with the chemist care provider (patent medicine vendor) at his chemist shop. Observational data showed that the self-owned chemist shop had an embedded patient room (locked) in a private section of the shop. This appeared to be an admission room managed by the chemist care provider. This was likely a room where women with complicated childbirth cases were managed. He however informed us that most of the births he assisted were in women's home:

> *"Most cases of the labour, I used to attend mostly—is not even most, I may say all, I used to attend the labour at home. I used to follow them at times if I see the condition and how the woman is in labour, is in need of my presence at times. I even lock the shop, wait and stay together with them, wait and wait to see how the condition is…at least within a period from that 2014 to today I may say something like 100 at least I attend just this camp that you are seeing. What have I told you? Most of women that we came together with them here from 2014 till now, most of them two, three, two, three children. Due to my exposure in this field, I can render so many services at least that to my best. We are quack doctors you know, we either kill or we succeed to get life, but we are trusting God. Since I started opening or working with the people here, I don't think I am having a record of any person that died at the process of giving birth."*
>
> *-Chemist care provider*

Parity was largely determined by sociocultural norms and religious belief systems surrounding childbearing. While women in this study were knowledgeable about family planning, the decision to uptake it was culturally determined. A woman's decision to have multiple children was not only based upon her personal perception of her own gendered reproductive role but also on the social expectations for family size. Intersectionality

acknowledges that gender can interact with other social identities to shape perceptions and behaviour in complex ways (Crenshaw, 1989). Although a few women had identified poverty as a motivation for family planning use, most women maintained that they wanted more children. For example, a participant named Aisha made comparisons with other women in the community when she described her decision to have more children and her concerns about the sex identity of her children:

> *"All my mates have five children each, but I have three. So, I want more. Besides, all my children are females. I want male children… I do not discriminate. All children are from God. The problem is my in-law who wants me to have male children."*
>
> *- Aisha, IDP woman*

The expectation for the sex of a child is a factor influencing decisions on family planning. Large family size was culturally valued in this community of displaced women and, in particular, having a male child was culturally preferred. A female child, on the other hand, is valued differently, as described by another IDP woman named Fatimah. Fatimah expressed that having many female children was a reason she chose to use family planning because she now needs to consider the cost of paying for their marriage rites in the future. Fatimah, who had eleven children and lost two children along the process of displacement, stated this regarding her family planning decision:

> *"I choose to do family planning because I am tired. Almost all my children are females, so I am thinking of how to raise money to prepare for their weddings. Let God just bless the ones I have. This idea of family planning is not new to me but the decision to take it was here in Abuja. I have become more exposed. If I had used it, I will not have had so many kids to the extent of even forgetting some at home when we were running. So, for*

women around here, they use it a lot. I use the one they fix under the skin and now my blood is normal."

- Fatima, IDP woman

Observation in the community revealed that community belonging was crucial and was linked with demonstrating fertility as a woman and having children to be surrounded by, which also had implications for cultural acceptance. Therefore, in spite of the difficult economic conditions, many women did not practice child spacing, as explained by the chemist care provider:

"Mostly, some Muslim women even if you tell them to at least space their birth they will not agree: they say is against the law of religion, so they will continue giving birth. At least from 2014 to today, many women at least bear three, two children just within a period of four or five years, see how we're multiplying."

-Chemist care provider

Many women in the camp hinged on their religion and belief in God when they discussed factors influencing decision on child spacing. Illuminating this religious standpoint, one woman with eight children in our study asserted that God's desire is for people to procreate and only God would decide when childbearing stops*:*

"I even have a newborn baby as we speak so I have never stopped becoming pregnant, he just clocked one month last Saturday…God knows how to stop them from coming and I am even ready for the ninth child if God gives me."

-Joy, IDP woman

Women who use family planning may be perceived as violating their religion as described here by another woman named Kubra: *"Some persons criticize you if you plan by saying that you don't respect God who gives children.* *-Kubra, IDP woman*

Concerning voluntary termination of pregnancy, many women refuted ever attempting to have an abortion. One participant, however, alluded to the idea that the practice was likely taking place covertly among younger girls. The chemist care provider expressed reservations when he was asked a question related to abortion services. Our interview with him showed that the loss of a baby by abortion is seen as a taboo practice and this was highlighted in the response by the chemist care provider who frowned on the idea of providing abortion services to women or girls:

> *"The cases of miscarriage I used to hear is from women but the issue of criminal abortion, that one mostly in young women, I do not even attend to such kind of thing. It is something I cannot force myself to learn but I know it happens. Some of them come and tell you that they want to terminate their pregnancy mostly young girls and spinsters. I do not attend to them. Once people know you are not into those things they do not come to you anymore"*
>
> *-Chemist care provider*

Normative Beliefs and Access to Urogenital Infection treatment

A major finding of our study was complaints from women about experiencing recurrent symptoms suggestive of urogenital infections. Symptoms women reported mostly included itchiness, copious vaginal discharge usually aggravated during pregnancy, and lower pelvic pain. Women also identified the infection as a known cause of secondary infertility within the community. Women and local service providers generally attributed the infection to the poor sanitation of the toilet facility; hence, locals described the infection as *"toilet infection"*.

"We have water shortage now. The borehole here is not working well. We buy 30 litres of water for ₦ 50 (USD$0.1). We also need a clinic here. A lot of women here complain of toilet infections. It is mostly caused by the use of dirty toilets."

-Kubra, IDP woman

One woman named Amina recounted how her husband had separated from her and married another woman because of her recurrent symptoms of urogenital infections, which she described as *"catarrh-like discharges"*, and secondary infertility. She reported using unorthodox medicine such as herbs and local douching concoctions in the treatment of the genital infections in Abuja:

"While I was in Maiduguri [Northeast] in the camp, I was experiencing malaria, typhoid and toilet infection [pain during urination]. I got drugs from the camp and I was well. I contacted the infection at the camp because we were sharing toilet. On getting to Abuja, we lived first at one camp where we had about 30 people in one house with women, their husbands and children. The single ladies were renting personal apartments for themselves. That was where I took in for my first baby, and after my baby, I couldn't take in again because of the infection. That was what I was told at the clinic [primary health center]. I started to take herbs, my husband started having issues with me because of the infection. He went ahead to marry another woman. Now he lives with the second wife in Adamawa, so I don't know if we are still married or not. He actually told me to join him but I told him I had already planted and yet to harvest, he left me telling me he was going to Cameroon to visit his parents, meanwhile he went to marry another wife, came back after two weeks and we were quarrelling within that period not having sexual intercourse, now I have only one child..."

-Amina, IDP woman

The camp community leader also described the toilet infection in relation to poor environmental sanitation and the shortage of water, as he specifies in this statement:

"We are five thousand one hundred and twenty-one here. That make us the largest IDP camp in FCT and we have problem with water. We already have, like, four boreholes but no light. We need generator. Because of this, most of our women go to the stream to get water. Because of water our women are suffering from toilet infection."

-IDP camp Chairperson

The chemist care provider gave additional perspectives on why urogenital infections were widespread among women. He explained that women mostly obtained treatment without their partner's involvement. However, women in our interviews did not openly associate the symptoms they were experiencing with sexual contact: only one woman, Elizabeth, alluded to the possibility that the symptoms she experienced were STI related and could possibly have been transmitted from her husband, although she refrained from attributing the blame directly to him:

"The issue of men, we can't trust them if they go out now and see more beautiful women, he can decide to sleep with them thereby contacting something that he will bring into my body, but I am not saying that this is what my husband is doing. He has never had an STI, I only assume that such things [sexual advances to other women] may happen."

-Elizabeth, IDP woman

Elizabeth's hesitation to ascribe her STI symptoms to her partner's infidelity may be related to patriarchal hegemony that constrains some women in Hausa-speaking cultures from openly asserting that a spouse is engaged in extramarital sexual activity. The chemist care

provider further described the issue of lack of knowledge about the need for spouses to obtain infection treatment together. Apparently, men would ignore physical symptoms because they are not as obvious as with women and can take a slower time to lead up to a complication than for women, as he described in the following narrative:

> *"Mostly, women of this community are having the problem of infection mostly. Out of 10 hardly for you to get two that are free from these conditions. Therefore, the problem is that even if you tell their husbands to be treated, but hardly for them to agree. They will say just "a ba ta ci gaba da magani": let her go off on drugs, let her be treated. I am a man. Some are ignorant about it, some it's due to their affordability and capability to treat the whole family. So, at least the problem will not go even if you treating the woman for a while. Still, the condition will still come back again. Therefore, the woman will begin to complain 'my private part is itching, I'm having an abdominal pain or a watery thing is coming out of my private part which is of a …has an offensive odour', or any other things, that's how most of them are coming so the women are having that issue seriously. It is hard for you to get a man that will accept to be treated together with his family. Some are aware of it but since the problem of infection will not reflect as in women, that is why some are just taking it for granted. Some men will just ignore it as if nothing is happening."*
>
> *-Chemist care provider*

Income, Health Resources and Accessibility to Care

We identified that income was a major factor influencing the utilization of available reproductive health services. Intersectionality recognizes that economic status has a strong link with power and access to social privileges (Dhamoon & Hankivsky, 2011). Therefore,

socioeconomic status is an important social category intersecting with other factors of marginality for vulnerable people. Socioeconomic inequalities are established from our literature review as a cause of poor health access for women who are displaced (Amodu et al., 2020). Women have to manage the stressful transition from a more home-centred lifestyle in their source villages to taking on the combined responsibilities of mothering, domestic work, and contributing financially to support themselves and their children. Women earned mostly from farming and other trade such as the sale of provisions and sewing of men's clothes and caps, etc. Several women discussed the need for bigger land portions to farm more and hoped for a higher income to pay for health care. While urogenital infections were widespread in the camp, many women could not afford the care of these infections.

> *"Yes. I was diagnosed with toilet infection. I visited the doctor and he demanded for ₦ 8,000 (USD$ 20). My husband and I don't have the money so I utilize herbal medicine which I purchased for ₦ 100 (USD$0.2). It is a powder which I dissolve in water and drink…many women including myself have toilet infection and don't have money to access healthcare. So I need financial assistance for treatment. I also need money for my children's school fees. Most importantly, we want the government to chase away Boko Haram from our community so that we can return home."*
>
> *-Halima, IDP woman*

Many women in our study stated that their husbands did not earn enough money to adequately support the family. When inquiry was made about general concerns with access to reproductive health, one women expressed her challenges with getting genital infection treatment and also not being able to access antenatal care because her husband could not afford the registration cost. This was articulated by the participant thus:

"I have back pains now and toilet infection. I had 3 kids at home in Gwoza and now I am pregnant for the fourth. I don't go for antenatal because my husband does not have money now and they charge ₦1500 (USD$4) to register."

-Sara, IDP woman

In the case of family planning, our study showed that low income was a motivating factor for some women to uptake contraceptives. Prior to displacement, abundant lands for farming were easily accessible in source villages to grow crops, hence, women gave birth to many children because they could afford to care for them. Family members were also available as a support system to take care of children and, therefore, contraception was not as popular. Displacement, poverty, and the harsh conditions of the camp led some women to rethink and make a decision to use family planning. Hafsat explained how the bills and the poor living conditions caused her to refrain from having many children and to use contraceptives:

"…God has said we should marry and have as many children as we want to, but looking at the living condition and the bills we have to pay it is wiser to go and do it [family planning]. If I am found robbing and stealing, that will not be a better option. And if I am killed while doing that, it will not be good. My children might also go into such vices which is bad. But if I am done training them, I can have more children."

-Hafsat, IDP woman

Our study showed that lack of access to quality health facilities impeded institutional births for women. A primary health care centre was located 8 km from the camp, providing maternity services. Women could not access this facility because of the distance and transportation cost. Maryam, a woman who had given birth to two children in the camp,

explained that high delivery fees and the distance to the facility were her reasons for not obtaining institutional childbirth support.

> *"...I have had two pregnancies, gave birth to the babies at home and I do not go for antenatal [care] because I do not have money; that's why I follow this pattern of not going to get care. The delivery fees here is too much, the hospital is in town, I have never gone. When I was at Gwoza, treatment was free and very close to our house."*
>
> *-Maryam, IDP woman*

In an interview with the primary health care (PHC) service provider, she explained that women abandoned clinic services because of the cost. The women depend on farming for most of their livelihoods and when women are pregnant these earnings decline even further.

> *".... It mostly about the issue of money. Some cannot even pay ₦ 200 (USD$0.5) for drug that will help them and their unborn child. The IDPs believe that government must do everything for them free of charge… the IDP women are always pregnant and have common cases of malaria. A lot of them have energy to farm but cannot because of their situation [of pregnancy]. They always claim that they do not have money to pay for basic tests like PCV, hepatitis B, pregnancy scans even though the prices are subsidized in our facility. They prefer to have everything free of charge… Services offered here include malaria treatment, antenatal, common cold, and catarrh and how they can make their food at home. For antenatal if they come, we first ask how many children they have. We then do Malaria Parasite and HIV test for them to know their health status. We use BP machine to examine them, weight and temperature. To know whether the baby is lying flat, we also advise scanning for the pregnant women but most of them will complain of money. Scanning is usually ₦ 2000 (USD$5) so we encourage them to do it."*

- PHC Service provider

Many women receive the referral for ultrasound scan but admitted to not going for it due to financial constraints. Kafilat shared an experience of feeling dizzy during pregnancy and being referred for a scan by the primary health care center. She admitted to not going saying *"money is very difficult to come by here".* She also reported experiencing fever and heartburn in pregnancy but would self-medicate by going to the chemist and purchasing drugs. For most women, care of their children and daily needs for food preceded any other health care need.

Health resource availability also influenced accessibility to reproductive health. Although a central mobile clinic was located at the camp, IDP women did not often obtain birth support services at this available facility. Despite being the most proximally located health facility in the camp, the women generally reported not visiting the mobile clinic because it was short of birthing support supplies and there was usually no doctor present to attend to their health needs. Moreover, our health stakeholder investigation demonstrated that there was poor governance by the local government of the health facilities. For example, the health service provider worked independently of the mandate from the local and state governments by taking charge of the supply procurement within the centre and autonomously varying drug pricing to increase revenue. We conducted an interview with the said clinic service provider on his perception of why women would not obtain services at the available clinic. He ascribed the non-uptake of services to his male gender and the religion of the women.

> *"I told them not to be ashamed to tell me their problem during antenatal. But because I am a man, religion does not allow women to show men their body. Nevertheless, I told the traditional birth attendant that I have records of women I have treated at my former health facility"*

-Camp clinic service provider

By his statement above, the clinic service provider expressed a notion on why he thought women would not seek care at his clinic. This contradicted the information women gave us. His narrative rather showed a predisposition to stereotype the health behaviour of this particular ethnic group—thereby characterizing their health seeking behaviour based on known group cultural or religious attributes. Women told us they valued the services of the chemist more than the camp clinic because the chemist vendor provided services to them on credit. Joy explains here:

"He [chemist care provider] really helped me. He didn't collect the delivery fee from my husband. That is the biggest help for me. So my husband used the money he had to buy me food, tea and other things I needed after childbirth"

-Joy, IDP woman

A similar narrative was expressed by another IDP woman, Maryam:

"We keep falling ill of catarrh. I tell my husband and he takes us to the chemist based on how much he can afford. But if we go, we get the drugs on credit and pay later because the chemist is good at treating malaria and other ailments. Their treatment is very good"

-Maryam, IDP woman

Mental Wellness, Childbearing and Gender

There was a complicated interrelationship between women's emotional and psychosocial wellbeing and certain aspects of their reproductive health including childbearing. This study demonstrated that having peace with one's spouse and demonstrating fertility by having multiple births was linked to emotional and spiritual wellness and community belonging for women. The aspiration towards emotional wellness therefore intersected with childbearing decisions.

Although mental health was not an explicitly understood concept, women did allude to deriving emotional support from being around many children. This was tacitly expressed in ideas such as wanting to replace lost children or wanting to be surrounded by children to have a distraction from the hardships they were facing. Feeling good in one's mind was associated with having a good harvest from the farm and being able to feed one's children. In our study, women did not demonstrate a perception of mental health as understood from a biomedical point of view, however, participants described traumatic stories of people being chased and killed by Boko Haram. As Abigail described:

> *"A lot happened and there is a lot of difference from how we lived at home and how we are living now. We did not even know we would leave home. It was one day we were sitting down and some men in uniform came into our house, we thought they were soldiers. It happened at 3:30 pm, I was with my siblings when they came. The men were killing people, collecting their female children, and killing the men. We ran away, trekking very long distances for three months; they killed three of our male and four sisters… it was tough for us because it was only the kids that ate so I developed ulcer on the way. It was when I came here, I got drugs to take and I feel better now"*
>
> *- Abigail, IDP woman*

Women described losses such as losses of property, loved ones, and children and it could be observed that women had negative feelings about these experiences, although many did not use the term "trauma". Some women referred to "tough experiences", having high blood pressure resulting from stress, feeling down, having headaches and pain, and not being able to eat or having no appetite. Psychosocial wellness was greatly associated with peace in the home, between husband and wife, with God, and with having more children. Amina an IDP woman,

who reported having urogenital infection symptoms was observed to have experienced trauma due to the conflict between her and her husband. She had only one child and was abandoned by her husband because of this. Her husband separated from her after many disputes and married another woman as a result of her genital infection symptoms, which was associated with secondary infertility. She described being put down since her husband left because of not being able to produce more than one child. Her in-laws also emotionally abused her for not giving birth to more children:

> *"The experience puts me down because when I look back at when I was living with my in-laws in Borno, how they maltreated me, the experience makes me feel headache. It even affects my eyes and I do not want to ever go back to my husband and his people anymore. I have never lost a baby in this camp, but I am more affected by the attacks and issues with my in-laws… they [Boko Haram] burnt my foodstuffs, groundnuts, guinea corn, my husband's cows, and the properties that my mom bought for me when I was getting married. However, I thank God, I am alive today. I want to remarry and have kids in a new home, and I want to treat my infection. Even though I have taken injection and insertion cream with drugs before, I still feel the symptoms, I see discharges like catarrh-like in my vagina."*
>
> *- Amina, IDP woman*

Following this, she alluded to her spiritual health and being traumatized because of her health condition and the experience of being separated from her husband:

> *"I do not have peace in my mind, like the issues with my husband and his family affected my practice of my faith. So far, now my faith does not permit me to remarry and I am not*

living in peace with my husband, I just do not know what to do. Maybe I will experience the same thing when I remarry"

Family meant a lot to the people of this community. The IDP women were very seriously affected by the loss of loved ones or being separated from them.

"The only painful part is that we left old people and physically challenged and we keep hearing that they were burning them… We moved all our relatives. But it's other people in the community we hear about…I play music on my phone or play with my kids and it distracts me"

-Abigail, IDP woman

Replacing lost children was a salient emotional wellness factor that influenced maternal outcomes. Women expressed a feeling of needing to replace lost children—those children who had been killed by Boko Haram or who were lost as the women journeyed from their villages to the present location. The female health volunteer who worked in the camp clinic also supported the responses pertaining to family planning uptake by women who attended antenatal care, explaining that there was a widely reported need to replace those lost children and many women would not accept family planning for this reason. The camp clinic volunteer reflected:

"You know the issue of IDP here, some of them when you ask them during antenatal they will say they want to replace those that they lose. Some may accept family planning, while some will not because they want to replace the people that they lose... Some have nine, ten children. We tell them not to replace but to take care of the children. We tell them about family planning…Some do agree to do family planning but some say they want to replace"

-Camp clinic volunteer

IDP women also reported issues of relatives being kidnapped or not being able to locate where they might be. The situation of left-behind family members was observed to have a negative psychological implication for the women. Hafsat described having a miscarriage after hearing the news that her mother was kidnapped and her brother had been killed in Gwoza:

> *"For my five children I went for the antenatal, but on the sixth one I couldn't because there was no peace [in Gwoza]. Nevertheless, on the seventh one, which I had here, I had a miscarriage. This happened because I could not go for antenatal due to the news of my kidnapped mother and the death of my brother. The pregnancy was two months and some days. My husband told my neighbours to come and persuade me to go for treatment while I was bleeding. So, I accepted and went to the hospital for flushing (manual evacuation). When I got home, my mother-in-law and neighbours took care of me"*
>
> *-Aisha, IDP woman*

Discussion

Intersectionality proposes new ways of thinking about marginal experiences beyond a single perspective (Hankivsky & Christoffersen, 2008). Indeed, this study's findings demonstrate that multiple factors related to identity, social location, and structural forces converge to define the experience of reproductive health for conflict-affected women of reproductive age in Nigeria. We found that the problem of urogenital infections was endemic among IDP women and was reportedly associated with secondary infertility. Several factors arguably lead to the spread of this infection in this population. Women reported practicing herbal douching to soothe the symptoms of infection. Scientific evidence shows that douching may exacerbate the infection because it depletes the normal flora of the vagina (Zhang, Thomas & Leybovich, 1997).

Specifically, the World Health Organization warns that douching is associated with negative gynecologic outcomes, including increased risk of bacterial vaginosis (BV) and trichomoniasis. Both infections have been linked to preterm delivery and low birth weight and, when concomitantly present, they can increase both the infectiousness of and/or the susceptibility to HIV (WHO, 2007). This study found that the general displaced community believes that urogenital infection is a result of using unsanitary facilities. Although this is medically contestable, we do not discredit the participants' assertion that their infections were transmitted through the toilet. Intersectionality-based research aims to give voice to subjugated beliefs.

The literature is divided on whether or not toilets can cause a genital infection, however, generally urogenital infections are known to be transmitted sexually or iatrogenically (CDC, 2020). Research has nonetheless identified that people who use a latrine or outhouse instead of a flushing toilet are at an increased risk for contracting trichomoniasis. This is speculated because of the close proximity to the urine and feces of others sharing the facility who may have trichomoniasis, not because the infection is spread by surfaces (Etuketu et al., 2015; Whittington, 1957). The Center for Disease Control also confirms that trichomoniasis may be transmitted if the toilet seat is wet or damp, but other STIs typically cannot be transmitted this way. Vulvovaginal candidiasis may also occur concurrently with other infections (CDC, 2020). A case study conducted about a woman in Gambia identified possible transmission of trichomoniasis by a traditional healer who conducted a digital vaginal 'exam' with a damp finger from a prior examination (Peterson & Drame, 2010). The beliefs of the community about the toilet pathway of infection transmission cannot be discounted, yet, it is also important to state that sexual transmission of the infections cannot be ruled out unless further diagnostic and environmental assessments have been performed.

Another predisposing factor of concern relates to the fact that husbands rarely obtained treatment for infection with their wives and this accounted for reinfection and persistence of the disease. This issue of noncompliance of men with treatment seeking can be linked with the culture of discernible social separation of genders in homes and public spaces among women and men from the northern region of Nigeria, in which reproductive health issues are perceived as exclusively a women's issue (Kadiri, Ahmad & Mustaffa, 2014). Additionally, there was a covert reluctance of a woman to implicate her husband as a potential harbor of this infection. Intersectionality-based research approaches hold promise for future studies with IDP men on their reproductive health. A better understanding of the male identity and the social construction of acceptable masculine sexual and reproductive behaviour as constructed in the Hausa community can enable program planners to develop models of health education to facilitate uptake of treatment. Again, in order to combat the health behaviour practices that are predisposing women to urogenital infections, it is necessary to give full consideration to the women's perceptions and beliefs on herbal douching and why they perceive the herbs to be effective. These considerations can shed light on areas of tension between scientific information and cultural beliefs and can provide a baseline for agencies to drive forward behaviour modification programs and acceptable diagnostic and treatment interventions for these infections.

IDP men's understanding of their own reproductive health needs requires investigation. Men's reproductive health behaviour can contribute to poor sexual and reproductive health outcomes for women in many ways. Additionally, religious, socio-cultural, and ideological factors, such as those which sanction male infidelity in the marital union, can contribute to women's vulnerability to STI (Kadiri et al., 2014). For example, a study carried out in Nigeria on

the sexual behaviour of married men during pregnancy and after childbirth identified that men who have sexual activity during their wives' pregnancies are justified. Similar to our study findings, the study also emphasized that Nigerian men, when diagnosed positive for an STI, tended to be indifferent in their approach to its management (Aderinto et al., 2005).

Gender-based norms that hinder open communication of women with their spouses about their infection symptoms and other reproductive health matters can hinder spousal STI management. Improved interpersonal communication between partners will affect the epidemiology of urogenital infections in this community and treatment seeking. The work of improving sexual and reproductive health-related behaviours will require an intersectional behaviour change approach to simultaneously address all the factors that predispose women to infections including limited access to diagnosis and treatment and sexual risk behaviours in men.

In our study, while poverty most evidently influenced the capacity to access health services, this was not an independently acting variable of influence over access to care. We found that the cost of care and supply shortages were associated with women abandoning government-owned health service centres and seeking care with a patent medicine vendor and local midwives. Previous studies have stereotyped women from Northern Nigeria as conservative and as a thoroughly oppressed group whose interaction with the male service provider is forbidden even in a medical emergency (Tukur et al., 2010; Wall, 1998). Our study did not identify this as an absolute. Women overall articulated several factors that hindered their access to reproductive health services, but they also took corresponding agentic action to seek alternative sources of care such as home birth and over-the-counter medication. Again, the choice to have a home birth among Hausa women is not simplistically based on traditional practices alone as supported by emerging research with women from Northern Nigeria (Okeshola

& Sadiq, 2013). Women have multiple reasons which transcend culture for choosing to deliver their babies in the home. For example, in our study women expressed dissatisfaction with the services at the camp clinic including reports of health supply shortages and unavailability of service providers to manage their health concerns. The traditional value for home birth practices among Hausa communities has been reported in the literature (Aderinto et al., 2005; Amodu et al., 2020; Wall 1998), but this is fast becoming a dated practice. Home birth practices have been overgeneralized to Hausa-speaking women with an emphasis on religious and cultural factors in relation to the decision to have home births. This study, however, indicate that the practice of home birth was a circumstantial choice that women resorted to, exercising agency in the crisis of displacement and health service shortages. Women demonstrated agency by taking action to use ancestral home birth practices. This finding is in line with previous knowledge demonstrating that women from Northern Nigeria are traditionally independent in the birthing process, having the greatest pain tolerance in childbirth of the three main ethnic groups in Nigeria (Aderinto et al., 2005; Muhammed & Danlami, 2015).

It is important to highlight that women in this camp were from diverse tribes and religious backgrounds, hence, care decision making was a cumulative effect of multiple identity-related factors. As intersectionality theory rightly proposes, a single category like race or ethnicity alone cannot be used to interrogate identity. Intersectionality, therefore, categorizes a range of overlapping individual indicators including gender, education, ethnicity, and religion as constituting identity at multiple axes (Crenshaw, 1989). Identity-related factors pertaining to the local health service provider were interlaced with profound socioeconomic hardships in determining maternal choices on where to seek care. The chemist care provider was the preferred birth support person for women partly because he provided care on credit and partly because he

was from a similar tribe as many of the IDP women and had formed a genuine rapport with the women and their husbands throughout the period of displacement to the camp. Therefore, income intersected with the culture of the service provider to determine where women would go for care. Most of the time, he provided birthing support to women without requesting payment. Existing research shows that chemist vendors, also known as patent and proprietary medicine vendors (PPMVs) are widely patronized in Northern Nigeria because of the ease of accessibility to the care (Okonkwo & Okonkwo, 2010). Although the Pharmacy Council of Nigeria regulates PPMV practice with stringent limitations on their scope of services, many chemist vendors go beyond their scope of practice to render what could be described as all-inclusive health care to communities ranging from consultations, health assessments, family counselling, and family planning to childbirth attendance. The gender identity of the service provider was less important to the women in our study. Factors that concerned the women were first and foremost immediate availability, proximity to the services, affordability of the services, competence of the service provider, and possibly kinship connectedness with the provider. Adetunji (1991) pinpoints that the main benefit of chemists is the flexible pricing and personalized relationships that vendors have developed with customers. Our study's results are supported by a similar study conducted in Northcentral Nigeria on religious influences on the utilization of maternal health services among Muslim and Christian women (Al-Mujtaba et al., 2016). The study identified that the distance from the clinic and socioeconomic dependence on male partners were stronger hindrances to facility-based service uptake than religious restrictions.

High parity (number of births per woman) was another major finding of this study. A culturally-linked factor determining parity is the expectation for the sex of children. Nigerian family size is greatly influenced by the desire to have a child of a particular sex, usually a male

child. In this study, desiring a male child was a factor influencing the women's decision not to use family planning. The male child syndrome described by Nwokocha influences family size in Nigeria, as our study proved (Nwokocha, 2007). The syndrome describes a strong preference for male children. This is based on the cultural belief that "a boy belongs to us, a girl to someone else", as men are going to be the only legitimate successors of the family inheritance (Kahansim, Hadejia & Sambo, 2013). Since men influence reproductive decisions in most families, when a woman is without a child, particularly without a son, the man either will pressure the woman to have more children or consider marrying a second wife to attempt to have a son (Isiugo-Abanihe, 1994; Kahansim et al., 2013).

In order to address maternal mortality among IDPs and promote hospital births, economic vulnerability needs to be addressed together with the structural problems in the delivery of health services. As well, the values and beliefs of women and families as they pertain to childbirth, the choice of family size, and the birthplace need to be given consideration (Abubakar, Adamu, Hamza & Galadima, 2017). Service provider attitudes can create barriers to accessing certain life-saving reproductive health services, e.g., abortion services. Unwanted pregnancies are not unlikely among women and girls who live in displacement camps because women may be raped by strangers or intimate partners or compelled to not access family planning. Existing research shows that several contextual factors, e.g., geographical location, lack of information, cost, and service provider attitudes make it difficult for women and girls to access contraception to prevent unwanted pregnancies (Bankole et al., 2015). For example, a clinic record review was conducted in a humanitarian setting in Borno State where female victims of insurgencies reported sexual violence-related pregnancies (Oladeji et al., 2018). Like our study showed, requests for abortion were recorded and reportedly turned down by service providers (Oladeji et al., 2018). There is

poor knowledge on how these women have sought abortion services after being declined. The silence over abortion care needs in IDP camps, therefore, calls for attention too, especially because there is a risk that unsafe abortion methods are being carried out as an alternative. Moreover, over and above the issue of conflict-related sexual violence and pregnancies is the issue of intimate partner violence, which also tends to be overlooked in literature among displaced persons (UN 2016). It is well known that during conflict many women are stripped of the traditional support systems of their source villages and are therefore more prone to exploitation by intimate partners (Amodu et al., 2020). The precarity associated with displacement and being economically and socially vulnerable can intersect women's natural propensity to be victims of violence in the domestic sphere. It is important to specifically consider that Northern Nigerian women culturally defer decision making to male partners and have a culture of silence on issues of violence, and this may be constraining to their reproductive health decision-making capacity. Therefore, male involvement in programming activities needs to be adequately explored. Orienting IDP interventions around women's special reproductive health needs within broader socio-cultural contexts and perspectives is paramount to advancing women's health in communities of displaced people, both within camps and in host communities.

Further, our study showed that there was an unusual connection between spirituality, psycho-social health, and fertility choices. Our study showed that marital harmony and the well-being of left-behind extended family members was associated with peace with God, having more children and was a positive motivation to access reproductive health services. It is known that large families are a traditionally valued practice among Hausa-speaking cultures, however, our study pointed to the possibility that the women's decision to have more and more children was a

bid to replace the lost children. This thought is supported by a study conducted in Burundi where a high fertility rate was associated with women aiming to replace lost children and to expand their own ethnic group after the war (Chi et al., 2015). It is important not to make simple conclusions about why specific groups practice and believe in certain ways.

The literature on the mental health and psycho-social wellbeing of displaced women is few. Migration scholars have conducted several studies on refugee and migrant mental health and found that the mental health of immigrants is linked with community belonging (Correa-Velez, Gifford, & Barnett, 2010; Dennis, Merry & Gagnon, 2017; Salami, et al., 2019). Mental health was not explicitly described as a concept but there were references to experiences of trauma and the loss of loved ones. It is important to highlight that mental health as a concept has not been extensively explored among African forcibly displaced persons. Mental health issues affecting refugees and migrants in most of the literature including post-traumatic disorders and depression are conceptualized according to Western biomedical models (Nickersonet al., 2017).

Western classifications of mental illness do not always align with an African's self-perceived state of mental health or its solution. For example, a systematic review of the literature identified that African migrants tend to associate mental illness more with physical acts of aggression or acting "crazy" or use other terms such as "thinking too much". Anger is also commonly identified cross-culturally as a symptom of depression **(**Haroz et al., 2017). Yet, anger does not feature in the Diagnostic and Statistical Manual or International Classification of Disease conceptualizations of depression. Studies have shown that even among immigrants to developed countries like Canada, the cultural interpretation of mental health can differ. A study by Salami, Salma and Hegadoren (2019) demonstrated that African migrants prefer to consult spiritual leaders, family, and friends to receive support for stressful life events rather than

contacting health professionals. African migrants especially perceive the symptoms of mental illness as a spiritual crisis that may require spiritual or herbal intervention (Alaazi et al., 2017). Intersectionality challenges the mainstream conceptualization of the linkages between cultural identity, experience, and health access (Hankivsky et al., 2010). Researchers and health experts should further propose innovative ways of understanding psycho-social wellbeing, mental health symptoms and coping for conflict-affected persons. This can inform newer metrics for performing mental health assessments across health care settings. In particular, interventions for African women affected by conflict must apply within the local context because these displaced communities are not homogenous groups.

Conclusion

Community beliefs and perceptions heavily influenced individual reproductive health practices emphasizing the constitutive nature of cultural identity and experience. Our study identified that there was a high prevalence of urogenital infections and the prevailing belief that this infection is caused by the use of unsanitary toilet and pit latrines. Differentiating between pathological and non-pathological vaginal discharge will require testing and complete symptom analysis. A participatory action research (PAR) approach addressing the poor access to education and treatment services for genitourinary tract infections will be valuable. Reproductive health of men needs to be examined including the social practices surreptitiously sanctioning sexually risky behaviour among married men and how this is contributing to poor reproductive health outcomes for women. Income was a stronger influencing factor of health seeking behaviour than most other factors. Although there is an assumption that women from Hausa-speaking communities have religious and gender-based restrictions against women being attended by a

male service provider, our study disproved this. Beyond the gender of the service provider, our study showed that the reproductive health choices of displaced women were influenced by cultural connectedness with, and feelings of trust for, the service provider, which accounted for the preference for the male chemist vendor and local midwives as birth attendants.

Programs and propositions that can financially empower women such as new land allocation, gainful employment opportunities, and skill development will have an aggregate effect on household income earnings and will facilitate access to health care for women. Culturally appropriate educational interventions, particularly incentive-based interventions, can potentially address the issue of the high number of births in these camps. For instance, existing programs such as conditional cash transfer schemes and other incentive-based awareness programs can be adapted specifically for displaced women where any woman who agrees to use family planning can be incentivized with opportunities for psychosocial counselling, skills acquisition, and capital to start a business.

The poor state of the primary health care infrastructure serving IDPs calls for great concern. Budgetary allocation to primary health centers in the districts of IDPs acutely needs improvement. Qualified and well-remunerated staff should be deployed who have been trained to provide needed comprehensive reproductive health services.

The chemist vendor played a key role in caring for women in this IDP community, which cannot be overlooked. Women and other members of the displaced communities were heavily reliant on the chemist for essential treatment. The government and the health care regulatory bodies in Nigeria need to reassess the practices of these ancillary health workers and evaluate ways in which PPMV practice might be recognized, regulated, and funded to meet the health needs of displaced communities in humanitarian settings.

The evidence basis of mental health symptom conceptualizations and corresponding interventions needs to be culturally adapted to cross-cultural contexts. Future research and interventions to support IDP women should take into consideration intricate cultural-spiritual-psychosocial determinants shaping reproductive health access. These include cultural expectations for childbirth and the sex of a child.

Finally, this paper has helped to shed light on the interconnectedness between normative beliefs and economic status as well as psychosocial-spiritual wellbeing in influencing reproductive health access for conflict-affected women. Interventions to improve the reproductive health of affected women should consider an intersectional approach based on the local cultural antecedents and meanings of health and health seeking for conflict-affected women. Specifically, an intersectional approach can accommodate complex social identities, spirituality, and the behavioural and structural determinants influencing access to reproductive and maternal health for conflict-affected women.

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Chapter 4: Paper 3- Reproductive Healthcare for Women in IDP Camps in Nigeria: An Analysis of Structural Gaps

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Abstract

Health and health service access for women displaced by terrorism from Northeast Nigeria is a serious problem. Existing government and humanitarian initiatives in Northeast Nigeria focus on food, security, housing, water and sanitation to the neglect of health access needs, especially access to reproductive health. With no policy in place and very little existing research, the systemic influences surrounding IDP women's health in Nigeria are not well understood. This study aimed to identify structural gaps impacting access to reproductive health care for women displaced by terrorism in Nigeria. The findings highlight structural factors that undermine reproductive health access for IDP women: poor governance of the primary health care sector (PHC) in Nigeria and insufficient co-ordination between the federal government and implementing agencies. Results have implications for policy and administrative restructuring in the primary health sector, as well as for improved funding allocation for the provision of reproductive health services, including voluntary family planning, STI treatment and maternal health support. Strategies to ensure strong leadership and accountability by the Federal Government and all institutions managing healthcare funds should be implemented. Government co-ordination and support for the activities of development partners will eliminate duplication of interventions targeting IDP health and wellbeing.

Keywords: access; displaced women; Nigeria; primary health care; reproductive health

Introduction

Internal displacement is an emerging problem in West African countries. Nigeria, Africa's most populous country hosting 250 ethnic groups with a population of 208 million, is one of the worst affected West African countries to date (United Nations Office for the Coordination of Humanitarian Affairs [UNOCHA], 2020). Nigeria has constantly recorded interethnic tensions which have progressively worsened over the past 10 years (Displacement Tracking Matrix [DTM], Nigeria, 2019). Nigeria's conflict situation purportedly sprung up after transitioning from autocratic to democratic leadership in 1999 because of an anti-establishment sentiment to push back against systematic inequality in governance (Çancı & Odukoya, 2016). The marginalized Northern ethnic groups progressively established alliances against opposition parties in order to gain dominance in government and the community. Underlying issues of extreme poverty, widespread unemployment and illiteracy combined with radical religious enthusiasm to lay the groundwork for terrorist indoctrination in Northern Nigeria (Chothia, 2012; Uzodike & Maiangwa, 2012).

Terrorism and resulting humanitarian crisis contribute to a high maternal mortality and morbidity in Nigeria. Twenty percent of global maternal deaths occur in Nigeria and Northern Nigeria contributes to poor health of the nation (World Health Organization [WHOa], 2020). The Maternal Mortality Ratio in Northern Nigeria is 1200 to 1500 maternal deaths per 100,000 live births comparing unequally with the national average of 500 to 600 deaths per 100,000 live births (Doctor, Findley & Afenyadu, 2012; National Population Commission [NPC] & Inner City Fund [ICF], 2019). Nigerians prefer large families (Adebowale, 2019; Isiugo-Abanihe, 1994). Nigeria alone will account for around 6% of all births globally (United Nations [UN], 2015), and Northern Nigeria also has the highest fertility rate and teenage pregnancies in Nigeria. The total

fertility rate in Northwest Nigeria in 2013 was 6 to 7 children per woman. At ages, 15-19, almost one quarter (23%) of adolescents have begun childrearing (NPC & ICF, 2014). The existing health challenges of Northeastern Nigeria are aggravated by the humanitarian crisis in the region which has led to destruction of infrastructure and social amenities (UNFPA, 2016). Major security threats contributing to maternal mortality in Nigeria are the Boko Haram and Herdsmen terrorism.

Boko Haram terrorists and Herdsmen have forcibly displaced over two million persons from their homes forcing them to relief camps within Nigeria (DTM Nigeria, 2019; UNOCHA, 2020). The greater population of those displaced are women and children (80 % of internally displaced people) with several unmet needs (United Nations Office for the Coordination of Humanitarian Affairs [OCHA], 2019; Internal Displacement Monitoring Centre [IDMC], 2019). In 2009, the terrorist group Boko Haram, which started as a rebel group, began to clash with government security forces. Boko Haram's leader, Mohammed Yusuf, initiated the group as an ideologically isolated Islamic denominational movement (Chothia, 2012). The Nigerian government's lack of experience in dealing with insurgencies and IDP issues has resulted in inefficiencies and gaps in support for affected displaced populations living in relief camps (Brechenmacher, 2019). The continued unrest in the northeast of Nigeria is creating increasing populations of internal migrants; therefore, Nigeria now has one of the worst humanitarian crises in the world (UNOCHA, 2020).

A systematic review of literature on the health of conflict-affected women in Africa identified that there are several cultural, socioeconomic and gender-related factors that significantly determine health and the uptake of health interventions by the above population (Amodu et al., 2020). In one instance, aid agencies donated insecticide-treated nets to women in

the Eastern Democratic Republic of Congo (DRC) to help prevent malaria, but women reportedly sold their mosquito nets to be able to provide food for their children (Brooks et al., 2017). This review also identified that issues around sexual rights, marital abuse and abortion rights remain challenging areas in reproductive health literature on displacement in Nigeria (Amodu et al., 2020). Moreover, women who have had pregnancies resulting from sexual violence and do not desire to keep the pregnancy have not been fairly considered in intervention processes.

In Africa, displaced women may be unable to participate independently in humanitarian activities or in decision-making about their access to reproductive health and rights. As well, reproductive health matters are conservatively discussed; therefore, women's issues can be easily marginalized in program implementation (Human Rights Watch, 2016). As a result, the UNFPA affirms that displacement and humanitarian responses should be viewed as a feminist issue, that is, through a gender lens, especially within the context of provisions made by domestic governments and institutions for women's reproductive health and rights (UNFPA, 2018). In Northeast Nigeria, grey literature reports show that displaced women in IDP camps have been experiencing sexual exploitation, unplanned pregnancies and unmet needs for reproductive and maternal health, including contraceptives, antenatal care and birthing support needs (UNFPA, 2018). Conservative belief systems in Northern Nigeria have played a role in pushing issues of sexual and reproductive health to the margins (Wall, 1998). An uneven focus on food, security and shelter needs at the expense of health issues has been reported. UN agencies have been working in Nigeria and many other African countries to support accessibility to health care for female victims of conflict for decades (UNHCR, 2018). However, their interventions for sexual and reproductive health have been impeded by a lack of expertise in service delivery and

ideological controversies at the sites of intervention (Girard & Waldman, 2000; UNHCR, 2018). Data on the reproductive health of displaced people pointing to existing socio-economic limitations have been published ad-hoc in humanitarian publications, such as in UN agencies' and other NGOs' reports (McGoldrick, 2005). For instance, the United Nations Population Fund (UNFPA) noted that among Muslim IDP women in Northeast Nigeria in 2014, women who were unmarried could not access food and aid for agricultural activities because the resources were being channeled through male heads of households (OCHA, 2018).

Nigerian government interventions in the crisis have not prioritized sexual and reproductive health because of conflicting priorities. Government commitment to IDPs is obscured by other priority areas such as curbing security challenges of terrorism, intrastate conflict, abductions and the general economic and infrastructural needs in the northeast (Chothia, 2012). Regional instruments and conventions that consider gender aspects of the IDP crisis including women's health access have been overlooked in Nigeria. The Nigerian government signed the Kampala IDP Convention in October 2009 (Kampala Convention, 2009), suggesting intention to comprehensively address internal displacement issues. Furthermore, the Nigerian National Assembly was presented with a draft national policy on internal displacement aligned with the Guiding Principles from UNHCR and the Kampala Convention in 2011, but this draft policy was not approved (Akpoghome, 2015). These top-level failures of decision makers have cascaded down to the grassroots administrations and affect the institutional co-ordination capacity of subnational ministries and agencies handling IDP matters. In this paper, we examine the existing structural challenges in health administration and services in Nigeria specifically for the benefit of understanding reproductive health access limitations for IDP women. This paper

answers the question: what are the gaps in reproductive health provision for IDP women in Nigeria?

Method

The research design was a critical ethnography. Data was collected from 29 internally displaced women and 10 stakeholders, including 5 service providers providing care to IDPs in one IDP camp and 5 policy makers with jurisdiction over IDP matters. This study focuses on stakeholders who can influence the direction and outcome of health and humanitarian policy and practices. The interviews ranged in duration from 20 to 120 minutes. We audio-recorded and transcribed the interviews verbatim. We used thematic analysis of stakeholder perspectives for understanding structural influence on the delivery of healthcare to IDP women (Duncan & Reutter, 2006). We defined structural determinants as the broader factors at institutional and government levels influencing access to care for displaced women directly or indirectly. For the stakeholder analysis, we developed a coding framework in NVivo 12 to show the stakeholders' positions with respect to intersecting political and institutional factors. The initial descriptive codes summarized the basic subtopics emerging from the data. These were categorized and discussed with the research team. We identified systemic factors that influence the provision of health services and stakeholders also verified the data to ensure rigor. Analysis included examination of policy maker perspectives on the relationship between the different levels of state leadership and Federal legislature that hold primary jurisdiction over provision of health care services.

Study Location

The study was conducted in an IDP camp located 25 to 35 km from the central area in Federal Capital Territory, Abuja that hosts over 5000 displaced persons. All the women in our study except for one woman from Sokoto state was displaced from Gwoza local government in Borno state Maiduguri. Gwoza is approximately 135 kilometers southeast of Maiduguri (Nigeria) located close to the Cameroon border. Gwoza was the epicenter of the Boko Haram crisis for eight months between 2014 and early 2015. As of 2014 there were about 3,000 Gwoza residents displaced to the borders of Abuja. The camp of my study is surrounded by forests with sites where Fulani cattle herders graze their cattle. The shelters are overcrowded, with an average of eight IDPs per room. The shelter type is a government-abandoned housing estate. Camp residents live in the houses by allocation upon arrival from Borno or other source states. The houses were originally built for indigenes of the community. The buildings are uncompleted with no doors and the windows are covered with sacks, clothes, and pieces of zinc. There are structures made with raffia and wood where men and children bath outside. Open defecation in the bush is a common practice. There is no garbage management. IDPs dispose of garbage in the bush. There are four central boreholes for water supply. When it functions, IDPs have to pay ₦50 ($0.1 USD) per gallon of water.

Interviews

We completed in-depth interviews with twenty-nine internally displaced women. Women were recruited with the support of community women leaders who approached potential participants and introduced the study. Women who participated in this study represented 5 major tribes from Gwoza including Chinene (n=4), Maffa (n=2), Mandara (n= 9), Hausa (n= 11), Glavda (n= 3). Of the 29 women interviewed, 2 women had a college degree, 12 women had

education up to primary or secondary school and 2 women had Arabic education. Most of these women were farmers with a meagre income roughly estimated at 5,000 to 15,000 Naira a month ($14 USD to $40 USD).

Table 4. 1 Leading Interview Questions

Women

Can you share your health experience in the Abuja Camp?
So what are the things that make it difficult for you to complain about your health?
How have you been caring for yourself since you came here?
What makes it hard for you to get healthcare?
When you are pregnant, how do you deliver your baby?
What makes you choose not to go to the camp clinic?
What other challenges, besides money, affects ability to access healthcare here?
What is the main thing you need government to assist you with when it comes to your health?
What about the clinic services are you not okay with?
We are thinking in the future to do some things in this camp, what can we do for reproductive health?

Service providers

Can you tell me your experience working with IDP women?
What are the major health challenges confronting women in the IDP camp?
What is the major barrier that may keep some women away from the clinic which may also lead to complications?
Describe how the health facility here responds to issues of health?
Do you have the facility to do the testing for infections?
What are the service that are in place for the women like maternity, since there is high rate of childbearing?
Was this service originally meant to be subsidized or you charge the little amount to raise money for the staff welfare?
So when the NGO bring drugs how do they go about sharing the drugs?
So what does the clinic need to improve their services?
What are the other reasons why women don't like to come for antenatal?

Policy makers

What is your role in your current office for supporting IDPs and particularly IDP women's health?
For the Abuja camp clinic, are there any support from your office for the camp clinics in FCT?
What is going on with management of PHCs by the government? In terms of subsidies for IDP women in particular? Is the conditional cash transfer still ongoing?
What funding support has your department received for reproductive health response from the government for IDPs?
What is the role of this Local Government in IDP health issues?
How is the role of civil servants influencing IDP health services?
What do you think government can do to improve services for women?

Ethical approval for this work was obtained from the University of Alberta research ethics committee and approval was obtained from the National Social Investment Office (NSIO) in Nigeria. The interviews followed an unstructured format with the aim of eliciting from stakeholders, their perspectives related to reproductive health access of IDP women. The stakeholders interviewed were selected purposively by recommendation from the NSIO office. They included a humanitarian service provider (n=1), health workers with knowledge of primary health care (PHC) activities (n=4), a representative from the National humanitarian hub (n=1), a top official from the Ministry of Health (n=1), a special advisor from the National Assembly (n=1), a Local Government council representative (n=1) and a representative of the office of the vice president (n=1).

Findings

These findings draw on an examination of stakeholder perspectives. Analysis was performed with the aim of understanding structural gaps in reproductive health access for displaced women in Northern Nigeria. A priori themes combined statements that spoke to similar concepts and inferred context on systematic practices influencing reproductive health access. The

findings suggest that there is poor governance of primary healthcare (PHCs) sector in Nigeria and uncoordinated activities of the federal government with the agencies on the ground.

Poor Governance of the Primary Health Care (PHC) Sector in Nigeria

There is weak governance by the State Primary Health Care Development Agency (SPHCDA) and Municipal Area Council of PHC activities in affected communities of displaced persons from Northeast Nigeria. Sub-themes related to governance are categorized as: weak system of funding medicine supply (failed drug revolving fund); concerns with credibility of civil service; inadequate human resources and poor state of the PHC; and reliance on patent and proprietary medicine vendors (PPMVs).

Weak Drug Revolving Funding system

A case of poor governance of the PHC sector was identified with respect to the drug revolving fund (DRF). DRF is a drug financing scheme also known as the Bamako Initiative, which was being privately implemented in the IDP camp in this study. The initiative was designed to be a revenue-based financing system for supporting the procurement of newer supplies to keep services on-going in primary health facilities across African countries (Salako, 1991). Our study showed that the drug revolving fund initiative (clinic self-financing system) was initiated by the local government area (LGA) council in the mobile camp clinic serving IDPs. A DRF scheme ideally begins with a one-time capital investment (seed money) provided by the government, donor agencies or interested communities, which is used to purchase an original stock of essential and commonly used medicines to be dispensed at prices sufficient to replace the stock of medicines and ensure a continuous supply. It was found that the scheme was being appropriated by the service providers in charge of the mobile clinic, who now work as independent program managers because the government abandoned their responsibility for

routine financing, governance and on-going monitoring and supervision of the capabilities and logistics of the program. During the interview with the service provider in the clinic in the IDP camp, he explained that he uses personal funds to purchase medications because the government does not supply the clinic. Therefore, he makes use of the clinic revenue to pay volunteers (which he independently recruited and hired) and also to purchase new medications.

A local government official interviewed echoed this, stating that service providers in charge of PHCs across the state work like private individuals and only report economic losses on health care provided while withholding reports of any revenue from the LGA. This further weakens the funding subsidy program. He explained that service providers use their own personal funds to repair the government health facility; therefore, they have a right to work autonomously without regard for the LGA guidelines. The LGA representative stated this:

> *"The service providers in charge are doctors, but the problem is instead of working for local government, they believe the revolving fund benefit should go to them, not the LGA. Individuals felt that they have to keep the facilities running—they use their own money, they are using their own money to buy drugs and to do the repairs for the facility, hence, the benefit from drug revolving fund, benefit of incoming patients, they will remove it for themselves….the in-charge will feel like let me add 3 volunteers, he will decide on what to give volunteers. The volunteers are not being paid, they are just working to have experience for consideration by LGA for employment in future."*
>
> *- The LGA health official*

The outcomes of these self-directed decisions of service providers are counterproductive to the original intentions of drug financing, which is to ease access to clinic drugs for the more vulnerable persons like IDPs. Service providers make decisions that are in their own interest,

even if it compromises the benefits to the more vulnerable persons in need of drugs. For instance, the service provider in charge of the mobile IDP clinic in our study explained that he decided to extend the clinic services to the host community within the locality, that is, the indigenes within the community who are non-IDPs, because they were more willing to pay more for services than IDPs. Thus, he separated the drugs —NGO donated drugs and those supplied by the government. The IDPs were only allowed access to NGO donated drugs and if the stock were exhausted, IDPs would not have access to drugs. This further marginalized IDPs from any government supplies in the clinic which was originally set up primarily for their use.

> *"The work was too much for me [the service provider at the mobile clinic serving the camp community] so the office (LGA) said we should take a volunteer and they don't pay volunteer at my office. Now that they are not paying, the volunteers cannot be paid so I separated the drugs, NGO donated drugs should be given to them (IDPs) for free and the other drugs should be given for money to other Indigenes."*
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> *- Mobile IDP clinic service provider*

Perception of Credibility of Civil Servants

According to a top local government (LG) official interviewed, outcomes of state and local government initiatives are additionally constrained by the credibility of civil servants in charge of departments assigned to implement specific health programs related to IDPs. For example, there is the problem of transparency in reporting of funding needs within the community by council department heads. There are cases of some civil servants reporting an outbreak that does not exist and challenges with maintaining a legitimate account of how many service providers are assigned per primary health center. This may account for why LG officials are also tolerant of various unprofessional practices in the PHC sector. The LG representative

revealed that these department heads surreptitiously team up with service providers to carry out illegal activities.

> "*The problem with PHC is negligence. People spoil policy in times of implementation. The facilities in charge are remitting to the Head of Department illegally while some of the people in community are not benefitting from PHC activities. Blame the local government and the state. We don't do things properly."*
>
> *-LGA representative*

One woman was asked about her suggestions for future programs that may be implemented to help prevent reproductive health challenges in the community, she immediately replied by saying that the government cannot fund any programs and reproductive health is about fighting for their individual rights.

> *"When we first came to this camp, there were no doctors, only those who work by themselves [were here]. Now the main problems we have about our health is that we do not have sufficient or well-trained doctors here. When it comes sexual and reproductive health everybody should fight for their own right. The government cannot sponsor them to prevent reproductive health problems because of the corruption so everybody should fight for their own right. What you can do: you can advise them to do what is good for their own health and stop doing what can affect their future e.g. if they can contact HIV and it can affect their future."*
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> *-Sadia, IDP woman*

Inadequate Human Resources for Health and the Poor State of Primary Health Care (PHC) Centers

Our study identified that there is a shortage of human resources in PHC serving the community in the region of the IDP camp, and specifically in the clinic set up by the government

inside the camp in the study. In a separate interview carried out in the IDP camp, women also corroborated this finding.

> *"There is usually no doctor at the camp clinic, on a particular occasion, when there was an emergency; we had to take the child to Kabusa hospital (12km away). We opened card at ₦1000 (USD$3) but the treatment fee depends on what one is treating, they have doctor in the day but not at night time except we go to a private hospital which is usually more expensive, it cost ₦50 (USD$0.1) on bike to go to other hospitals outside the camp"*
>
> *-Latifah, IDP woman*

Women abandoned the IDP camp clinic because according to them, there was no services for them in the camp clinic. One woman discussed taking children to primary health centers in a distant place because the service provider in the camp clinic was not available. She describes the long distance to reaching the primary health center and that even at this location, the doctors are not always available, especially at night and they do not arrive early in the morning.

> *"Last year there were about 12 women that died in this camp as a result of giving birth. The women lost a lot of blood and that is why they died. In the night we will reach there [the PHC]. We will not see anybody. That is how women will suffer and die because there is nobody that will help them before they reach that hospital or when they reach the hospital they will not see any doctor and they will come back home or go to the chemist….. Especially in the night, we don't have a real doctor here [camp]. There are some women facing problems, like their child is weak and vomiting. You take him to the camp clinic, there is no doctor … it's better for us to carry children to the chemist. The way we see them [service provider in camp clinic], they are not qualified. Sometimes what they will do we can even do it."*

-Rakiya, IDP woman

Women received needed health care services from traditional midwives and other ancillary service providers and perceived them as more competent. The human resource allocation to primary health centers is also very poor, according to the report of the LGA representative.

> *"The health facility exists as building, not hospital, because there will not be a single doctor to attend to anybody. Meanwhile, each facility is supposed to have two or three doctors for shift. There is no light to receive a patient at night…e.g. pregnant women for delivery use lantern. These are the civil service problems."*
>
> *- LGA health representative*

The primary healthcare worker and local health service providers including clinic volunteers and the chemist vendor [known as 'doctor' by IDP women] are highly dedicated. Notwithstanding, they have poor job security and are under remunerated. Many of these workers sign up to be volunteers, working with very little incentive with the hope that they will be considered for employment by the local government if they continue to work. This practice is highly exploitative.

> *"I am the oldest volunteer. I was transferred from Walibu to this place. When you go round most of the PHCs, you see our volunteers. We have too many volunteers on ground and we are all linked with AMAC (Abuja Municipal Area Council). Our letters are from AMAC and we are hoping that they will remember us when they want to employ. Whatever the facility realises at the end of the month, they pay us. There are no permanent staff."*
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> *- PHC worker*

Patent and Proprietary Medicine Vendors (PPMVs)

Located close to the IDP camp is a drug vendor who regularly provided IDPs with health care. The drug vendors, also known as PPMVs, are a strong representative of relevant health service providers within rural communities. The PPMV within the IDP camp community in our study was an IDP himself who had been displaced in 2014 due to conflict in Gwoza. On arrival to the camp, he set up a small pharmacy shop in the community with personal funds. During an interview, the PPMV expressed his dedication to the care of the IDPs, providing services mostly on credit. The PPMV provided explicit descriptions of his services to the IDPs in the camp, expressing an age-long commitment to the health of the people of Gwoza, especially women. He had a diligently compassionate disposition towards achieving positive health outcomes for IDPs. As we conducted the interview, three people walked in to get medication without payment. The well-known PPMV stated that he had been offering free services to women for as long as he has been displaced, his practice of birth attendance began in 1999. We wanted to know how he managed to keep track and follow up on clients who come in without paying for drugs. He responded thus:

> *"To save life was my priority because even if someone doesn't have money, if the person gets his normal health at least he will go and seek money. If the person is having promise he will bring back the money. I give them drugs with or without your money. I will just give you trusting God that you will come back, and I used to tell people that to save life is far much better than money. Some are giving back the money…some may not even come back again. But I just forfeit everything, leave everything for God."*

The women also confirmed in varying instances of how the chemist supported them with treatment for common illnesses like catarrh and malaria and attended their births.

"In this Abuja camp we keep falling ill of… catarrh. I tell my husband and he takes us to the chemist based on how much he can afford. But if we go, we get the drugs on credit and pay later because the chemist is good at treating malaria and other aliments—their treatment is very good. I have had two pregnancies, gave birth to the baby at home and do not go for antenatal which has been the case right from home and it's because we do not have money… When the labor started. I was home with my husband and the doctor from the chemist, who received the baby, he cut the umbilical cord and my husband's mother buried my placenta. Then the doctor cleaned the baby, and he was paid. We are used to him receiving our pregnancies from Gwoza. Although I prefer the hospital but the opportunity is not there.

-Maryam, IDP woman

PPMVs are not expected to trade in controlled medications or provide certain interventions such as administering injections according to the Pharmacy Council of Nigeria (PCN) and the National Agency for Food & Drug Administration (NAFDAC) regulations. However, the PPMV in our study reported providing wide ranging services to women, including consultations, health assessments, family planning and counselling, childbirth attendance, sexually transmitted infections (STI) treatment and intravenous (IV) fluids. In an aspect of our conversation, he admitted to being a quack doctor, but has never recorded a death while providing childbirth support. He stated:

"We are quack doctors you know, we either kill or we succeed to get life, but we are trusting God. Since I started opening or working with the people here, I don't think I am having a record of the person that died in the process of giving birth. Since I can be able to at least to treat people at my level; there is no at least, there is no other health facility

that somebody can go without referral. If the case has gone beyond my effort, I will just refer the person. If I am suspecting any shortages of blood or any other thing, I will tell the person to run to go to where he can get help."

In terms of primary health care distribution across states in Nigeria, there is still a long way to go. Specifically, reproductive health services provided by primary health facilities and trained health staff are limited. The government is taking steps to expand reproductive health services across PHCs, as explained by a top government official from the Ministry of Health who was interviewed for this study:

"Reproductive health is already integrated in every primary health care programme in the country. The challenge we have is ensuring that substantial if not all primary health care centres in the country provide reproductive health care services. We actually started with 3,000 in 2011 providing reproductive health care services of about 34,000 health centres. So, we want to scale up to 20,000. We are already around 12,000."

- Top Ministry of Health official

Insufficient Co-ordination of Federal Government and Implementing Agencies

The co-ordination between the Federal Government of Nigeria and UN agencies is uneven. Divergent activities of government parastatals and humanitarian organizations overlap with an apparent lack of accountability in the health sector, which undermines the systems of care delivery and seriously compromise access to basic services for women in displacement camps. The problem of humanitarian agencies working vertically was a recurrent theme in the analysis. A few NGOs are aligned with government priorities; nevertheless, the government does not mainly prioritize reproductive health as a comprehensive part of humanitarian negotiations

and PHC sector programs across Nigeria. Issues described in this section include the vertical work of NGOs, poor government budget allocation to health care, and overreliance on UN aid.

Parallel Work of NGOs

NGOs working in humanitarian settings often work parallel with their own priorities that may not reflect the country's needs, especially in the area of reproductive health. More specifically, UN agencies are focused on emergency response needs, including provision of emergency contraceptive kits, as well as maternal and obstetrical care which is distributed in formal camp sites to beneficiaries. Likewise, local health infrastructure and manpower in Nigeria is lacking and poorly structured. Therefore, international NGOs prefer to rely on their familiar tactics to achieve institutional mandates which the government sees as cost ineffective.

> *"We discovered that majority of the money claimed to have been spent on IDPs by NGOs went into overhead costs with little getting to the IDPs themselves. So, we are pushing for the localization agenda which involve training the locals rather than bringing in expatriates. The conditions attached to most of the foreign funds make it impossible for local NGOs to access them. So, we need to move from internationalizing everything to localizing them so that more money will be available to serve the people in need."*
>
> *-Top government official*

The localization agenda is also very important in the context of Northern Nigeria, where several conflicting regional laws, regulatory practices and service provider cultural practices challenge reproductive and maternal health and rights access. The implementation of reproductive health interventions across different contexts needs to be interrogated with respect to different cultural, religious, institutional and constitutional realties. For instance, our study

showed a silence on the issue of safe voluntary termination of pregnancy from the government side. Analysis of the stakeholder perspectives showed that the silence mirrors the outlook of development partners in the area of sexual and reproductive health. Likewise, the issue of intimate partner violence has been underexplored in policy development on the reproductive health of IDPs. Our study showed that incidence of rape may be underreported because of the culture of silence among women as well as victim blaming. A top humanitarian agency representative reported the following:

> *"Women are disadvantaged. There have been cases of sex-for-food, which has led to many unwanted pregnancies. A sexual assault center has been set up to treat the victims. We provide ambulances to convey women to health centers. We counsel the women to speak up because most of them keep quiet for fear of victimization. This aspect is not well developed but it is evolving. We are currently trying to come up with a social protection policy in Nigeria because there is none. This will involve the conditional cash transfer where money will be paid to citizens based on the peculiar challenge in their locality."*

Development agencies have focused largely on safe spaces for adolescent victims of Boko Haram excluding women of childbearing age in the northeast. Moreover, gender-based violence within the existing IDP literature is traditionally conceptualized as sexual assault from non-intimate partners. Yet, IDP women can be exposed to violence even while living with intimate partners.

Poor Government Budget Allocation to Health Care

Economic and social policies in Nigeria do not prioritize adequate healthcare financing and this affects the delivery of services. Likewise, many IDPs do not have any health care

coverage that can enable them to access reproductive health services. IDPs, like the rest of the population, are expected to obtain services from primary health care centers within the community and the mobile camp clinic.

"We don't receive separate funds for response to people who are internally displaced. It is just a general reproductive health funding and then we leverage on funding through partners as well."

-Top Ministry of Health official

In terms of top-level administration of reproductive health care, the concerned institution is the Federal Ministry of Health, which is in charge of developing policy initiatives for IDPs including those on maternal health, reproductive health, and family planning. The government budget provisions allocate reproductive health care funding to the general population including IDPs. Budgetary allocation to health, particularly in the past 5 years, has been in the range of 4% to 7%, plummeting from 18%. As well, health governance in Nigeria is not a unitary system. Therefore, health policy formulation within state and local governments can take unique forms depending on the state's internally generated revenue. This disfavors the Northeastern states because they have limited state budgetary provisions for health care, and health infrastructure has been destroyed by terrorists. Moreover, when the budget is allocated, releasing the budget is also a problem. Funds spent on IDP-related concerns have been lower than expected and insufficient to carry out the numerous activities that implementing agencies have been saddled with.

"The funds is not always enough because most times you don't get 100% of all the money the government allocates for an organization."

- Humanitarian hub representative

Two stakeholders interviewed mentioned that the Ministry of Humanitarian Affairs and Social Investment is currently trying to implement a social protection policy in Nigeria which should involve the conditional cash transfer. The globally approved policy for IDPs known as the Kampala Bill has yet to be approved by the National Assembly. According to stakeholders, no specific bill exists for IDPs or IDP women's protection yet, but they are supposed to be covered under the social protection policy launched by the Ministry of Budget and National Planning. Upon review of the social protection policy, there was no mention of IDPs (Ministry of Budget and National Planning, 2016).

> *"We are currently trying to come up with a social protection policy in Nigeria because there is none. This will involve the conditional cash transfer where money will be paid to citizens based on the peculiar challenge in their locality."*
>
> *-Humanitarian hub official*

The conditional cash transfer policy, also known as the household uplifting program, was introduced in 2016. As part of this program, money will be paid to citizens based on the peculiar challenge in their locality, e.g. households with the highest food insecurity. It is worthy of note that the disbursement of funds in the initial stages of implementation of the scheme was described as being on a reactive basis and was highly inconsistent. Although this scheme is being considered for extension to IDP communities, there are no known timelines for progress on this and no guidelines exist specifically tailored to IDPs.

Overreliance on UN Aid

According to top officials interviewed at the Ministry of Health and the humanitarian hub, the larger pool of funds aiding IDPs comes from NGOs. These include the Global Funding Facility (GFF) and a conglomeration of other donor agency funds such as the World Bank, the

Bill and Melinda Gates Foundation, UNFPA, USAID, Norwegian Government Funds for IDPs, Global Affairs Canada funds and others. Although the federal government allocates around 40 billion naira ($100,000,000 USD) yearly to the northeast development initiatives (Presidential Initiative for the North East, 2015), the funding is mostly expended on feeding and a report has stated that this funding is inadequate to support all IDPs in the north.

> *"I am aware that nationally the government puts aside budget every year, especially for northeast interventions. I think last year (2018) was about 45 billion naira, this year again goes to northeast intervention appropriated to PCNI under different priorities."*
>
> *- Humanitarian hub official*

UNFPA has been supporting mobile health facilities predominantly in the northeast region with reproductive health supplies also known as dignity kits. There are issues arising from this dependence on a UN agency for health-related funding support. When global donor investors change their donor policies, Nigeria is one of the most heavily affected because the health economy is overly dependent on this aid. For example, in 2018, foreign NGOs lost access to U.S. funding and U.S.-donated contraceptive supplies due to Donald Trump's initiated global GAG policy against coercive abortion, involuntary sterilization and China's one-child rule (Champions of Global Reproductive Rights, 2018). When U.S. funding to overseas organizations was pulled, for example, UNFPA lost 60% of its family planning funds that year (Adepoju, 2019). Humanitarian services in Nigeria were scaled back—thereby leaving more clients to use highly inefficient public sector facilities.

Discussion

Our study identified that there is poor governance within the Local Government Areas LGAs of primary health sector activities. Obvious problems include the lack of legitimate management and accountability strategy of PHC financing systems, as well as interference of civil servants and service providers in the internal PHC revenue. The lack of credibility demonstrated in the ways that the drug revolving fund was being managed shows a pattern that aligns with previous studies. This scheme was launched in September 1987 at a regional WHO meeting by Mr. James Grant, director of UNICEF, in response to the acute economic crises facing sub-Saharan Africa. The fund addressed the negative effects of adjustment programs on health, and the reluctance of donors to continue to fund recurrent costs of primary health care programs (World Bank, 1987). The program was introduced in Nigeria by the Ministry of Health in support of four local governments in 1990 to help maintain remittances to the local government (LG) and to serve as a community-government cost sharing strategy to revitalize the PHC sector and maintain medication supplies (FMOH, 1990). In the IDP clinic in our study, this drug revolving fund was unsuccessfully administered.

Health finance analysts highlight and buttress the challenges brought forward in our study with respect to PHC sector development (Adeloye et al., 2017; Onwujekwe et al., 2019). Monopoly of government initiatives like community health insurance schemes by health management officials and illegitimate contractual agreements among administrators of health sector have been reported in the literature as well (Onwujekwe et al., 2019). The challenge is not confined to the local government sector. Governance issues in health financing are even more apparent across Nigeria's federal and state tiers of government, particularly with respect to equitable health budget disbursement, which has been implicated in the disintegrated state of

PHC. The Nigerian constitution places health on the concurrent legislative list, such that both the state and local governments have the responsibility to mobilize and deploy resources for the provision of health services within their respective jurisdictions independent of national policies. Therefore, the PHC's funding is contingent on national fiscal conditions and on the internal funds of the state. This creates uneven realities across regions with access to quality health services. In the northern region where insurgency has significantly damaged social infrastructure, revenues clearly are insufficient to sustain the PHC sector (Onwujekwe et al., 2019). There is no separate budget line for the health of IDPs in Nigeria (Budget Office of The Federation, 2020). The federal government does not equitably allocate the health budget based on demographic need and epidemiological factors, and as our study shows, there are always funding cuts. The capital investment of the government is limited to sustaining PHC in terms of staffing and health worker remuneration. The plan to address PHC shortfalls has featured in many electoral manifestoes and health agendas of political leadership aspirants in Nigeria, yet after election, promises are hardly met (Abimbola et al., 2012; Adeloye, et al., 2017). As our study proved, the IDP clinic health workers reported investing their own funds into the purchase of drug supplies, fuel for generators to run the clinic, etc. This is not necessarily a result of a lack of funds but rather, as identified by the LG representative in our study, there have been issues with trust, equity, transparency in the government and health system especially where it concerns funding management. These reports align with findings of other studies related to Local government management in the PHC sector in Nigeria (Uzochukwu et al., 2018). Conflict affected countries like Rwanda have succeeded in post-conflict development by unifying the management and accountability mechanisms of the health sector. However, Nigeria's progress is slow because of a systematically fragmented system.

Professional staffing of PHC was another challenge identified. Our study showed that volunteerism is the main system of health staffing in the PHC and health center in the camp serving IDPs. PPMVs and community midwives are admittedly the main source of care for women with reproductive and maternal health needs in the camp. PPMVs and community midwives have earned the trust of rural communities in Nigeria, particularly in the North, because of the ready availability of essential drugs and the cost effectiveness of their services; they therefore substitute the inadequate primary health care workforce (Okonkwo & Okonkwo, 2010; Barnes et al., 2008; WHO, 2016). The complementary services of PPMVs are widely reported across many African countries. A paper published in the Bulletin of the World Health Organization identifies that PPMVs (also known as drug vendors) are the first and main point of care in many communities in sub-Saharan Africa (WHO, 2016). In this report, Nigeria is cited as a prime example of a country where drug vendors supplement the health workforce and provide basic primary care to many people who currently have very limited access. Vendors working in the northern region of Nigeria tend to have more medical training than in the south (Treleaven et al., 2015). The PHC clinic volunteers and PPMV identified in our study had an enormous commitment to working in the communities but were paid very little. A systematic review on the role of PPMVs in Nigeria identified that the quality of care the PPMVs provide is poorly understood. Although they provide a number of family planning and reproductive health services beyond their legal scope of practice, evaluation of PPMVs' work in the literature is largely focused on adult malaria management (Beyeler et al., 2015).

Government stakeholders identified that there is a plan to expand PHC facilities providing reproductive health services. This plan needs to be matched with a strategy to enhance the health human resource training, supply and remuneration, as well as an investment in quality

assurance programming and research. There needs to be a plan for training and supportive supervision of health workers to be able to respond to the needs of IDPs in humanitarian settings in Nigeria. In 2018, the federal government established the Basic Health Care Provision Fund (BHCPF) appropriated by the National Assembly. These funds are expected to help revive the health sector, especially PHCs, many of which have been abandoned across the country. These funds can be used to support community health workers that supplement the workforce in humanitarian settings. These community health workers can add value to the human resources, be enrolled in competency training programs and be equipped with resources to carry out reproductive health programs for IDP women.

Evidence shows that the reproductive health program focus of many developing countries including Nigeria is dictated by the funding disposition of the international donors and the U.S. government. Nigeria has not yet developed a policy to address displaced people's health issues. The conditional cash transfer (CCT) initiative being proposed under the social protection policy by the Ministry of Humanitarian Affairs and Social Investment was originally part of the Maternal and Child Health component of the Subsidy Reinvestment and Empowerment Program (SURE-P MCH) (Baba-Ari et al., 2018); a package of interventions which included an incentive of 5000 naira (USD $32) for pregnant women to access maternity services in PHCs. The program ran from 2012 through 2014 and co-incidentally was exhausted at the peak of internal displacement in Northeast (World Bank, 2016). Under the new social protection policy and in the previous SURE-P MCH package, the CCT targets vulnerable women broadly without specific reference to IDPs. Moreover, the allocation of social assistance has been politically determined over the years, where politicians select facilities for SURE-MCH investment based on political or group interest. This begs the question of newer funding investment by the government to

address specific reproductive and maternal health needs of IDPs beyond conventional social protection.

Our critical analysis demonstrated that in lieu of the explicit antiabortion climate of the UN-funded agencies (Champions of Global Reproductive Rights, 2018), the local government and ministry representatives were found to be silent on the issue during our study. However, Nigeria's situation presents a distinctive situation from high-income countries like the U.S., calling for a requisite strategy. The rate of maternal deaths related to unsafe abortion, for example, is higher in Nigeria than in developed countries (Guttmacher Institute, 2015). Contraceptive access for many abortion-prone women including adolescents and those living in rural areas and humanitarian settings in Nigeria tends to be low. Marginalized aspects of reproductive health and rights that may not be clearly brought to the surface during policy dialogue need to be re-evaluated. These include issues on women's rights to access available family planning, rights to reproductive autonomy in the context of marital relationships and the understanding of specific conditions justifying the termination of pregnancy within the customary laws (penal code) of Northern Nigeria.

Conclusion and Recommendation

These findings have implications for policy and administrative restructuring in the primary health sector and for establishing strategies to ensure strong leadership and coordination by the federal government of Nigeria of all institutions representing IDPs. Greater funding allocation is crucial for PHCs, particularly for reproductive health supply procurement. This could be sourced from the current Basic Health Care Provision Fund. Our study highlighted the lack of accountability in the LG management of the drug revolving fund scheme in the camp

clinic, which is in itself an unfair practice in the context of IDPs who are clearly vulnerable and cannot afford health care costs. A more realistic solution is needed to meet the healthcare needs of IDPs. However, this will take a long time to accomplish given that government focus is now divided. While health care restructuring should remain in view as a longer-term target, in the meantime, these community service providers can be funded, re-trained, and regulated by the Federal Ministry of Health. They should also be issued a license to consult, seeing as many communities are heavily dependent on them for primary care already. The law regulating the practice of patent and proprietary medicine vendors and community midwives with respect to administration of contraceptive devices and invasive procedures need to be more clearly articulated. The issue of abortion rights needs to be reviewed, especially with respect to women's counseling and psychosocial support needs of those with sexual violence-related pregnancies who desire to safely terminate such pregnancies. There needs to be a clear stipulation of the procedures for medical providers on clinical diagnosis and interventions in situations of unwanted pregnancies and for legal decisions in rape cases. The state should also develop a public inventory of the kinds of facilities where quality reproductive health services can be accessed.

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Chapter 5: Access to Reproductive Health Care for Internally Displaced Women in Nigeria Recommendations for Policy Development, Research, and Practice

The focus of this dissertation was to examine access to reproductive health care for internally displaced women in Nigeria. The effects of conflict and internal displacement compromise health access for women in Northern Nigeria. My research objectives were to: (1) identify how internally displaced women access reproductive health care in Nigeria; (2) identify and explain the factors influencing reproductive health care access for internally displaced women in Nigeria; and (3) develop policy and service recommendations for addressing gaps in reproductive health care for internally displaced women in Nigeria. This section succinctly brings together the major findings of my doctoral research by summarizing the key results and conclusions of the three manuscripts prepared for publication. This is followed by recommendations for advancing policy, research, and practice related to reproductive health for internally displaced women in Northern Nigeria. In the next section, I discuss each paper's findings.

Paper 1: Health of Conflict-Induced Displaced Women in Africa

Prolonged conflict, inter-ethnic rivalry, and political upheavals have eroded the resilience of societies and health systems in Africa (Adelman, 2003; Asfura-Heim & McQuaid, 2015). Women's health inequities in Africa are worsened by conflict-induced displacement (Almedom et al., 2005; ICG, 2016). The purpose of this first paper was to outline the scope of research on the health of internally displaced women in Africa. Thirty-one peer-reviewed studies have explored the health of women displaced due to conflict in Africa. Health concerns of IDP women included violence perpetrated by intimate partners and outsiders, psychosocial issues arising from dysfunctional family living, sexual and reproductive health problems, and malaria (Amodu, Richter, Salami, 2020). The review paper on IDP women in Africa identified that violence by

intimate partners and strangers is common during displacement (Amodu, Richter & Salami, 2020). Violence, previous trauma, transactional sex experiences, and family dysfunction create poor mental and reproductive health outcomes for women. Unmet need for contraceptives, home-based deliveries, and malaria prevalence are key health issues identified in the scoping review study. This review further proved that access to health is influenced by demographic variables, cultural beliefs, distance to health facilities, and socioeconomic status. For example, knowledge was found to be a determinant of use of malaria treatment, hospital-based family planning, and maternity services for women in some African countries (Adam et al. 2015; Brooks et al. 2017; McGinn et al. 2011). Likewise, cultural perception of reproductive health and rights was an influencing factor over women's conception of violence and decision to access reproductive health services (Aham-Chiabuotu, Abel & Thompson, 2019; Oladeji et al., 2018).

Paper 2: Intersectionality and Access to Reproductive Health for IDP Women

Intersectionality proposes new ways of thinking about experiences in relation to identity and location categories such as gender, class, and ethnicity and to learn how these can further complicate marginal experiences (Crenshaw, 1989; Hankivsky et al., 2010). Intersectionality theory was applied to the analysis of the findings of women's interviews and observations and to stakeholder's perspectives to substantiate iterative conclusions connecting aspects of social, cultural, and religious concepts and determinants. Coming to the core of my research, women identified that there were challenges, a lack of access to reproductive health services such as family planning, antenatal care, and hospital birthing services. Complaints of symptoms of sexually transmitted infections were widespread and there was poor access to treatment. Women's experiences corroborated by service provider perspectives provided details on various factors that patterned the experience of access to reproductive health. The themes that were

identified were in four major categories: 1) decision on birthplace and number of births, 2) normative beliefs and access to urogenital infection treatment 3) income, health resources and accessibility to care, and 4) mental wellness, childbearing, and gender. As expected, reproductive health access was influenced by socioeconomic status. Women's sociocultural beliefs on childbirth and a preference for traditional birth attendants influenced the choice to use contraceptives and the decision to deliver in the home. Genital infections were found to be prevalent and there were profound ambiguities about the actual cause of infection. Knowledge of the social and economic factors intersecting the health needs of IDP women is important for developing effective interventions. This paper further showed that there were broader independent factors that shaped the access to care experiences of women in this study, including those related to affordability of care, proximity to care, social relatability of the care provided, and religious beliefs associated with childbirth and family planning.

Paper 3: Structural Perspectives on Access to Care for IDP Women

The third manuscript was focused on the systemic factors affecting the service provision for IDP women and the institutional processes that hinder the full realization of optimum reproductive health for women in need of services. Stakeholder perspectives demonstrated the structural barriers to health access and affirmed inadequate services provided by primary health centres, the shortage of staff, and a lack of transparency and accountability in health system management by government institutions.

The paper identifies weak health system management and limited funding of health as the foremost challenge to health service provision. There is also the issue of overlapping efforts by aid agencies. Findings of policymaker interviews showed there is poor management of the primary health care sector and dependence on NGO-driven interventions. The funding allocation

from the government to primary health care is limited and this affects the overall commitment and dependability of health care workers. Closely connected to this is the failure of the drug revolving fund scheme, which was intended to work as a revenue-based financing system for the camp clinic. The federal government's inequitable funding distribution, delays in appropriation and release of budgets, and inconsistencies in social assistance to IDPs were identified barriers to quality services. IDP women rely on patent medicine vendors and community midwives for their reproductive health needs. Over-dependence on UN aid agencies for administering reproductive health interventions subjugates sustainability by undermining local efforts to improve the health system and to investigate the needs of the most vulnerable people living in humanitarian settings in Nigeria.

Recommendations

Terrorism and armed conflict in Africa have resulted in massive displacement of persons both within and outside Africa, creating a burden on an already weakened health service system. The destruction of health facilities by armed conflict groups limits health access for many displaced persons, further extending the health inequality between Africa and the rest of the world. Boko Haram terrorists and the Herdsmen crisis in Nigeria have increased the burden of displacement in Africa. My research explored the health care access dimensions of the Boko Haram and Herdsmen insurgencies in Nigeria through strategic partnerships with stakeholders. My results have implications for health policy, research, and practice in Nigeria.

Policy

Although Nigeria continues to strive to attain universal primary health care for all persons (Awosusi, Folaranmi & Yates, 2015), this goal is far from being achieved. There are existing issues with transparency and accountability in the health system, especially where it

concerns the revenue-based financing in primary health care centers. Questions have arisen on why implementation of needed social policies and health financing schemes—e.g. social protection policy, the conditional cash transfer schemes, and the Bamako Initiative—have accomplished little progress for promoting equity in health access for vulnerable persons, especially IDPs in Nigeria. The health human resource shortages and the lack of committed health service providers in primary health care centers reflect governance challenges. These health workforce shortages in the health centres contribute to limited reproductive health access for women in Northern Nigeria at large and lead to higher rates of maternal mortality (WHO, 2019). My findings showed that auxiliary health service providers such as community midwives and patent medicine vendors are the main sources of care for women as identified in the systematic review conducted by Beyeler, Liu, and Sieverding (2015). In this study, it was found that volunteers were being used to supplement the health workforce in the IDP clinic and the primary health centers serving IDPs. This suggests that there are human resource allocation challenges. These volunteers were mostly trained in community health extension and college health programs, a diploma that qualifies them to work in rural health centres. These volunteers cannot provide adequate and comprehensive reproductive health services to women in IDP camps. The government of Nigeria has the primary responsibility to provide these social services and supports. However, these supports cannot be put in place without policy and funding allocation and without the accountability mechanisms to ensure funds are expended as allocated.

The institutional and leadership shortcomings of Nigeria need to be addressed. Enduring policies are needed, as are guidelines that will ascribe responsibility to different sectors to carry out IDP health interventions. This is critical for program evaluation of progress in reproductive health service delivery to people in IDP camps. Restructuring the policy for the primary health

care sector in terms of transparency and accountability is the priority and cannot be overemphasized. There is a multiplicity of interventions and a lack of coordination of the different agencies intervening in the IDP situation. Development partners and the governments need to articulate health priority areas. Interventions should go beyond the basics of accommodation and feeding to attend to the reproductive health of IDPs including family planning, infection prevention and treatment, and hospital-based maternity services.

The nurse's role in the provision of primary health care services to IDPs in this study was understandably absent because the primary health centers were staffed by community health workers serving IDP women. This is the norm in most states, especially in the Northern parts. This is linked to the poor structuring of the health sector and limited funds to the primary health care sector and for remunerating health workers. Notwithstanding at advocacy levels, nurses have a role to play since they are at the frontlines and have a well-versed knowledge of the health disparities within the community. The Nursing and Midwifery Council of Nigeria can collaborate with the Ministry of Health to advocate for the proper staffing of rural PHCs and an increased distribution of health services to humanitarian settings. Nurses can provide outreach reproductive health services and be involved in the development of competence training manuals and the education of community health workers working in rural communities. A separate policy will be beneficial if developed specifically for the reproductive health needs of people in IDP camps rather than subsumed under other structural adjustment programs like the social protection policy or SURE-P. The specified IDP policy and guidelines must be ratified, domesticated within the states, and widely disseminated, implemented, and evaluated.

Research

Recommendations for further research need to be considered with caution. Vulnerable persons such as IDPs have often been the subject of many research studies that do not impact their circumstances. Therefore, the first recommendation is for research to focus on generating useful evidence, advocacy, and empowerment of IDP communities. Research needs to be gender and culture-sensitive and should interrogate social determinants that affect access to services for displaced women based on the context and setting of displacement. Research with displaced women needs to be empowerment-focused and should include strategies for addressing the broader social determinants of health, including skills training and education skills training and education. Gender role shifts and economic power shifts in the family are the root cause of violence in the home spheres. Economic empowerment opportunities for those displaced are necessary to help support both men and women to become gainfully employed and be able to access health care services. Research can advance the health of women displaced by terrorism specifically through the use of participatory methods that engage both men and women in the co-creation of evidence to advance women's health. Skills training and educational interventions can be embedded in such research.

The expanding population of IDPs is a cause for concern. One important factor that has led to the high birth rate identified in this study is the need to replace lost children. This may indicate unsettled grief and trauma experiences that are impacting women's fertility choices. Research needs to explore the grief and trauma experiences of affected women and the ways that the loss of loved ones may impact women's current feelings of wholeness and mental health.

Most health-related interventions for IDPs occur at primary and secondary levels of health care. An area of research to explore is the secondary level health service systems and their

experiences, responses, and challenges with managing internal displacement issues in Nigeria. In particular, the experiences and perceptions of nurses and other health care professionals can broaden insights on gaps in health care practices with respect to IDP women. Sexual violence and issues of unplanned pregnancies were not identified as a salient problem in this study. However, female youths' experiences were excluded from this study because the primary focus of the study was women of childbearing age 18 years and older. Future research can explore the experiences of unmarried women and female teenagers and youth with sexual violence, unplanned pregnancies, and access to abortion services.

Further, religion was identified in this study as an important factor influencing maternal health decisions and birth practices. Studies need to engage religious leaders in research to understand newer perspectives and belief systems that influence decisions about health and potentially engage those relevant religious leaders in developing effective behaviour change interventions.

Lastly, reports of symptoms of genitourinary tract infections among women were prevalent and associated with secondary infertility. Data on the severity and prevalence of genitourinary tract infections among both men and women is important in order to estimate the percentage of displaced persons across IDP communities that have been infected and to be able to facilitate the treatment of cases.

Practice

The population expansion among IDPs is a cause for concern. Family planning education and services need to be expanded in IDP communities. My study demonstrated that women base fertility choices on religious beliefs. Mental health is somewhat interwoven with the issue of high birth rate. The desire to replace lost children and to feel a sense of community acceptance

were reasons described by women for having many children. Although a desire for large family sizes is a traditional practice of Hausa speaking communities, behaviour modification for this community about childbirth is possible. One woman stated in our study that she changed her mind about family planning because of a realization of the benefits of education after displacement. Behaviour modification is central to family planning and population control strategies. Positive reinforcement cast in terms of 'incentives' has been effective for promoting birth planning and contraceptive use (Elder & Estey, 1992). Given the high level of unemployment reported by women, culturally appropriate educational interventions, particularly incentive-based, will address the issue of high birth rates in IDP camps. For instance, existing programs such as cash transfer schemes and other financial incentive programs in health can be adapted specifically for displaced women with a culturally applicable empowerment education component and opportunities for psychosocial counselling, skills acquisition, and capital to start a business. Issues that may arise with economic incentives for reproductive health include cultural acceptability, addressing selection bias, and maintaining intrinsic motivation for long-term behaviour change. This intervention will have a substantial impact compared with conventional economic assistance programs. Incentive-based community engagement programs can involve community leaders, religious leaders, and men in educating the public on the benefits of using family planning as a measure of improving the economic viability of families and for the reduction of maternal mortality, childhood illnesses, and deaths.

Among the population of IDP women in this study, symptoms of urogenital infections were widespread. Due to the lack of accessibility to diagnostic services, most women resorted to symptomatic treatment and use of local douching concoctions, which did not provide effective treatment and sometimes exacerbated the disease. There is a critical need for genitourinary tract

infection diagnosis, prevention, and treatment research for IDP women. Again, sexual partners also need to be engaged in such intervention's research to isolate the infection causing organisms including clinical testing to screen for common STIs, such as Trichomoniasis, Candidiasis, and Bacterial Vaginosis. Women and men also need education on the importance of having collective screening among couples in order to achieve remission of disease. Educational interventions can have a far-reaching impact on reproductive health outcomes among IDP women, as shown in prior studies. For instance, educational awareness programs can engage men and women, senior wives, religious leaders, community midwives, patent and proprietary medicine vendors and traditional birth attendants to educate them on STI causes and treatments, douching and its negative effects on genital infection symptoms, and the health importance of good hygiene practices.

Nursing Implications

This project extends the existing body of knowledge in nursing about the role of intersectionality for developing research-based evidence to understand the health problems affecting vulnerable persons. This thesis findings particularly demonstrates the relevance of critical paradigmatic perspectives to the development of nursing science. Nurses are well positioned to be at the cutting edge of development research especially for those who live in internal displacement settings (Hughes, 2016). Several intersecting factors were found to be impacting reproductive health for IDP women in this study including income, social location, educational status, beliefs and gender both directly and indirectly. The compassionate nature of nursing positions nurses to provide the kind of care that vulnerable persons require irrespective of religion, cultural background, ethnicity, gender and economic status. According to the *ICN*

Code of Ethics for Nurses, "the nurse promotes an environment in which human rights, values, customs and spiritual beliefs of the individual, family and community are respected." (ICN, 2012, p.2). Nurses can propose interventions to address these broader determinants of health including those specific to displaced persons.

The practice of nursing and the interests of nurse researchers is not limited to clinical settings alone. Nursing problems transcend the clinical setting into the community. Over the last 2 decades, it has become evident that displacement and migration are an important factor shaping health experiences globally. The goal of addressing global public health problems associated with displacement is within the purview of nursing scholars around the world. This research contributes to current scholarship on applicability of interpretive research and qualitative methodologies within cross cultural research contexts, with the simultaneous aims of instigating action, change, and empowerment of marginalized communities. As stated by Meleis (1992), concerns related to health cannot be adequately explained or addressed as individual problems but rather as a part of a broader social and political world. The complex health issues leading from globalization and increased international mobility require nurses to take leadership in creation of evidence to inform health development practices and interventions. Nurse researchers can further interrogate the underlying structures that constitute the unequal access to primary health care services for displaced populations in camps and host communities. Nurses in conflict-affected settings can extend the scope of their professional practice to include home-based maternal healthcare services for people in rural settings that lack access to hospital-based services. Innovative participatory methods can be developed to plan and test nursing interventions and community programs to address problems such as unmet family planning needs, urogenital infection and perinatal deaths among displaced persons. Global Nursing

scholars can further engage in feminist's scholarship and critical advocacy research to inform nurse-led models of care that can improve access to healthcare services and address the range of reproductive health needs of displaced women.

Limitations

The limitations to this work are those related to the choice of sample population and setting. I recruited women in a camp in Northcentral Nigeria, which is one camp out of about 15 others in the same district. Within the sample of women selected, all but one woman who was interviewed migrated from Gwoza in Borno State (Northeastern part of Nigeria) because of Boko Haram terrorism. However, this dissertation was not intended to describe the sociology of displacement and was not designed for generalizability or comparative analysis. Rather, the aim was to understand individual experiences of women's reproductive health access within a camp setting and the systemic issues related to this. Therefore, these findings are not representative of all women who were displaced by terrorism.

The grey literature is fraught with reports of sexual violence among displaced women in Nigeria. Many NGOs that work with women in displacement camps in the Northeast are focused on how to address sexual abuse and associated sexual health consequences. My interviews with women did not yield significant findings with respect to sexual or gender-based violence and abortion even though this does not undermine their importance. Deliberate consideration was given to the policymakers' perspectives, which exposed structural gaps in the views and representations of sexual violence and sexual rights by service providers and policymakers. At the initial stages of this research, there was a possibility that I was perceived as more of an outsider to the field and, therefore, intricate details with respect to sexual violations and intimate

partner violence may have been withheld. Future reproductive health research with this population of IDPs who now live in informal camps may further investigate violence and the safe management of unwanted pregnancies. Also, I initially proposed to do a policy document analysis related to IDP health in Nigeria. I found out through stakeholder consultations that there was no policy in existence related to IDP health. The existing draft policy was not approved at the National Assembly.

There were limitations due to my social location as a novice researcher who hails from southern Nigeria and was conducting an ethnography with internally displaced persons in Northern Nigeria for the first time. My prior experiences with ethnographic studies have been through working as a research assistant participating in immigrant health research projects in Canada. A practical disparity existed between my knowledge of ethnography from theory and within the context of international migration and the experiences, I had while conducting this research with internally displaced women. The application of ethical principles, trust-building process, and access to the setting in this unique context was not devoid of difficulties. My self-awareness, the application of my research knowledge, and intersectionality concepts such as power, voice, and agency evolved through the process. Feedback from my supervisors helped me to negotiate my relationships with the participants and with stakeholders, engage in a transparent process of data analysis, and adhere to my ethical responsibilities throughout the research process. Overall, the findings in this study are novel and add to existing literature suggesting the need for a women-centred approach to the study of displacement and health policy development in Nigeria.

Concluding Remarks

This research explored female victims of Boko Haram and articulates their experiences of accessing reproductive health care. For the SDGs to be attainable there needs to be health for all including health for the most vulnerable. There is need or action towards addressing the sociocultural and socio-economic factors shaping conflict affected women's lives not only in Nigeria but in Africa at large. My study demonstrated that intersectionality informed critical approaches can deconstruct hidden issues and expose systemic inequities in health service delivery in humanitarian contexts, Indeed, in order to achieve the goal of health for the most marginalized, as stipulated in the SDGs, the primary health care centres must be restored and equipped with an adequate, well remunerated, and competent health workforce and resources to serve displaced women in humanitarian settings in Nigeria. The focus on Gwoza (Northeast Nigeria) IDPs in this study is a strength that is worth highlighting. Gwoza is a ground zero region of Borno State (Nigeria) and was one of the worst affected local government's s. This thesis finding is, therefore, potentially transferrable to other female Gwoza IDPs from Borno State who happen to be among the largest population of women affected by Boko Haram. There are challenges with access to care for these IDP women that significantly extend the inequality in health access for this vulnerable group. This study showed that the challenges related to health care access are interwoven with social, cultural, religious, and institutional factors. Displaced women's experiences are, therefore, constituted by various structural influences related to the health care system governance, service provider availability, and traditional values and expectations of source villages. There is poor coordination of activities of government, health institutions, and humanitarian partners, which creates a duplication of interventions by implementing agencies and, ultimately, compromises the impact on affected women. A working

framework is needed that will guide the activities of institutions set up by the government to address displacement issues informed by research and by consultation with multidisciplinary stakeholders. Health care financing is a major challenge to accessing timely and appropriate care. Within the health sector, there has to be a creative mechanism for reducing out-of-pocket payment for vulnerable communities. Over all, internally displaced women's reproductive health concerns should be integrated into health policy and program planning at all levels of government in Nigeria.

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Appendix A: Observation Tool

Category	Includes	What to note
Appearance	Clothing, age, gender, physical appearance	Anything that might indicate membership in a culture, profession, social status, socioeconomic class, religion, or ethnicity of interest to the study
Verbal behavior and interactions	Who speaks to whom and for how long; who initiates interaction; languages or dialects spoken; tone of voice	Gender, age, ethnicity, and profession of speakers; dynamics of interaction
Physical behavior and gestures	What people do, who does what, who interacts with whom, who is not interacting	How people use their bodies and voices to communicate different emotions; what individuals' behaviors indicate about their feelings toward one another, their social rank, or their profession
Personal space	How close people stand to one another	Individuals' preferences concerning personal space and what this symbolizes within relationships
Human traffic	People who enter, leave, and spend time at the observation site	Where people enter and exit; how long they stay; who they are (ethnicity, age, gender); whether they are alone or accompanied; number of people
People who stand out	Identification of people who receive a lot of attention from others	The characteristics of these individuals; what differentiates them from others; whether people consult them or they approach other people; whether they seem to be strangers or well known by others present

Adapted from: Mack, N., Woodsong, C., MacQueen, K.M., Guest, G., Namey, E. (2005). Qualitative research methods: A data collector's field guide. Retrieved from https://goo.gl/24QdoS

Appendix B: Demographic Information Form for IDP Women

(These questions will be asked towards the end of the interview after I have built a relationship)

1. Where were you displaced from or where did you live before you were displaced for the first time? _____
2. In what year did you leave your home?
3. What other locations have you lived prior to arriving here?
4. In what year did you start to live at this camp? _____
5. To which ethnic group do you belong? _____
6. What religion do you practice? _____
7. How old are you? _____
8. What is your marital status? (single/divorced/married/widowed) _____
9. What is the total number children you have given birth to? _____
10. How many children are currently alive? _____
11. How many people currently live in your household? Exclude visitors and include elders_____
12. Who is currently the head of your household? _____
13. Who in your family usually has the final say when it comes to food distribution? _____
14. Who in your family has the final say when it comes to healthcare seeking? _____
15. What is the highest grade you completed in school? _____
16. What was your previous occupation or main source of income? _____
17. What is your current occupation or main source of income? _____
18. How much do you earn each month? _____

Appendix C: Interview Guide for internally displaced women

Participant ID number _____
Date of Interview _____
The interview will begin with general questions related to healthcare access and progressively moves to questions specific for reproductive healthcare access.

General health access questions
RQ 1: How do internally displaced women negotiate access to care in the midst of other challenges?
I will like to ask you questions in general about your health

1. Tell me about your health before you came to this camp
2. Tell me about your health after you came to this camp
3. How has been your experience getting healthcare in this camp?
   Probe:
   - Can you tell me the things that make it harder for you to get care here?
   - Can you tell me the things that make it easier for you to get care here?
4. If you are sick now that you are here, **who** will you first tell?
   Probe: How do they help you?
5. If you are sick now **where** will you go first?
   Probe: How do they help you?
6. Tell me some of the things that will make you decide not to report your health issues to a health worker or to anyone at all.
   Probe:
   - Tell me about any health problems you have had in the past that you didn't tell anyone about.
   - Why did you not tell anyone?

Reproductive health access questions
Now I will like to ask you questions about your reproductive health that is, questions specific to your health as a woman
STI

7. Tell me about illnesses of your reproductive health that you have had or currently have
   - How did you treat it?
   - Where did you get help?
   - What made it easier to get help for this issue?
   - What made it difficult to get help?

Family Planning

8. Do you try to prevent becoming pregnant?
   - How do you do it?
   - What do you know about prevention of pregnancy?

Pregnancy and Childbirth

9. Are you pregnant?
   - If yes, can you tell me how you get care during this time of pregnancy?
   - Tell me any problems you have had while trying to get help during this pregnancy?

10. Have you been pregnant in the past? Was it in this camp?
    - If yes, can you tell me how you cared for yourself during those times?

11. Have you ever had a child since you moved to this camp?
    - If yes, can you tell me where you went to deliver the baby and how it all went?
    - Tell me if you liked how they took care of you and your child

Abortion

12. Is there any time you lost a pregnancy here? Or a baby? What happened?

13. Is there a particular time you got pregnant and did not want to keep it?
    - Can you tell me what happened then? How did you go about it then?
    - Who took care of you?
    - Where did you go?

RQ2: What barriers do women face with access to care and how do they overcome them?

14. How have you been able to cover the cost associated with addressing your reproductive health?

15. What are the things that make it easier to go somewhere to complain about women's health issues that you face?

16. What are the things that make it hard for you to go somewhere to complain about women's health issues that you face?

17. Tell me about those religious/cultural traditions that you normally practice related to maintaining your health as a woman? (e. g. things that you would do during pregnancy or labor or when you have a private part disease that you will do to heal faster).
    Probe:
    - Can you give tell me some examples?
    - Tell me how you are practicing these things here in this camp

18. Please tell me the challenges related to performing your cultural/traditional rituals related to women's health that you face here.
    - What additional challenges do you face addressing your reproductive health in this place as a Hausa (or Fulani) woman that you think other cultures may not face?
    - What additional challenges do you face addressing your reproductive health as a Muslim (or Christian) woman that you think you will not face if you did not adhere to this religion?

19. Tell me what will help to improve your health and other women's health in the camp.
    - How will you like to participate?

20. Can you tell me anything that you will want the government to do to change things when it comes to the health of women in the camp?

21. We have talked about a lot today is there something more you will like to tell me?

Appendix D: Interview Guide for Health Service Providers

1	ID No	
2	Consent for interview granted	
3	Today's date (dd/mm/yyyy)	
4	Location of the interview	
5	Respondent's Gender	
6	Respondent's Ethnicity	
7	Respondent's Religion	
8	Respondent's organization/ministry	
9	Respondent's position in organization/government	
10	Respondent's no. of months in organization	
11	No. of months working in current position?	
12	Time started interview:	
13	Time ended interview:	

1) Can you briefly tell me about yourself: what is your position in this camp and how long have you served in that capacity?

2) What do you do for IDP women?
   - Tell me about your involvement with delivering care to IDP women.
   - What kind of services do you provide?

3) What are the main health problems affecting women within this camp?
   - How are these known and recorded?
   - What is/are their principal cause(s)?
   - What could be done to improve these particular issues?

4) Please describe how the health facility here responds to issues or health complaints from women?
   - What barriers do IDP women face here?
     - Particularly, what barriers do IDP women face with access to reproductive health?
   - Are services equally available to IDP women here?
   - Are health services equally available to women and men in the camp?
   - Tell me about the way health services are distributed to women here.
   - How are the services here in camp different from those provided to IDP women who live in the cities?

5) What are the facilitators (things that make it easier) for IDP women to access health services?

6) What organizations are providing health services to IDP women?
   - How far are these organizations from where IDP women live?

7) With whom could you/your organization discuss if you/your organization have unmet needs related to women/girls in this camp/area, (for example, residential block leader, camp leader, women's association, NGO, UN, etc.)?

8) What menstruation supplies, hygiene or delivery kits have been distributed to women in the camp?
   - Who did the distribution?
   - Where was it done?
   - How many times was this done in the past?
   - What did the community think about these distributions?
   - If there have been no supplies, what reasons have you heard for the lack of these supplies?

9) How have women been involved in designing or delivering services to meet their health needs in this camp?
   Probe:
   - Can displaced women be employed as health workers and their skills capitalized on?
   - How can services and policy be improved for women?

10) What do you think should be done by government to improve services for women?

11) What do you think should be done by health service providers to improve services for women?

12) What do you think should be done by IDP women to improve their own health?

13) We have discussed a lot today, what more would you like to add?

1	ID No	
2	Consent for interview granted	
3	Today's date (dd/mm/yyyy)	
4	Location of the interview	
5	Respondent's Gender	
6	Respondent's Ethnicity	
7	Respondent's Religion	
8	Respondent's organization/ministry	
9	Respondent's position in organization/government	
10	Respondent's no. of months in organization	
11	No. of months working in current position?	
12	Time started interview:	
13	Time ended interview:	

Policymaker role

1. Can you briefly tell me about yourself: what is your position in this office and how long have you served in that capacity?
   - Generally, what are your roles in this position, have you worked in any other capacity in the government?
2. What is the role of your office in creating policies for supporting IDPs and particularly for IDP women's health?

Policy formulation

3. Tell me about the policies that are in place for reproductive health of women in IDP camps in Nigeria

4. Who were the primary stakeholders in the formulation of the recently launched draft of the National IDP policy?
   - What are the gaps in this policy? Is there a consideration for women?
   - What are the main barriers to implementing policy for IDP women?
   - What are the plans in place to implement this IDP policy?
5. How will your office be participating in the implementation of this policy?

6. Could you briefly explain the processes that will be taken by your department/ministry to disseminate information regarding policies and specific guidelines on IDPs?

Funding Support

7. Please tell me what funding supports your department has received for reproductive health response from the government?
   - From which donor(s)?
8. How has this funding been used to meet your department's reproductive health program goals?

Policy Consultations

9. What kinds of consultations are being arranged on the issues of women and reproductive health?
10. In what ways are reproductive health issues being integrated into policy at government levels?
11. What plans or initiatives are there to prevent excess maternal and newborn mortality in IDP camps?
12. What is the plan for integrating comprehensive reproductive health solutions into primary health programs in the region where IDPs are located?
13. What do you think practitioners and the general public should do to improve the health of IDPs especially women?
14. We have talked about a lot of things today; can you please share your final comments?

Thanks for participating in the study.

Some questions are adapted from Inter-Agency Working Group (2017). Descriptions of MISP Process Evaluation Tools and Analysis Guidance. Retrieved from http://iawg.net/resource/misp-process-evaluation-tools-2017/

Appendix F: Confidentiality Agreement

Project Title: **Access to Reproductive Health Care for Displaced Women in Nigeria**

I, _____the _____ (specific job title, e.g., research assistant, community worker, health worker, or interpreter) have been designated to _____

I agree to:

1. keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts) with anyone other than the Researcher(s).
2. keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.
3. return all research information in any form or format (e.g., disks, tapes, transcripts) to the Researcher(s) when I have completed the research tasks.
4. after consulting with the Researcher(s), erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher(s) (e.g., information stored on computer hard drive).

I understand that all work conducted should be kept confidential and is the intellectual property of the Researcher(s).

Research Personnel _____ _____ _____

(print name) (signature) (date)

Researcher(s) _____ _____ _____

(print name) (signature) (date)

The study has been assessed by a supervisory committee and the ethics review board of University of Alberta for its adherence to ethical guidelines and approved by Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615.

Appendix G: Information letter (For displaced women)

Study Title: How displaced women access healthcare in Nigeria

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Background and Purpose

Over one million women are displaced in Nigeria. It is not understood how women who are displaced in these circumstances access healthcare. In the current study, I will address the gap in knowledge about healthcare access for displaced women in Nigeria, particularly, reproductive healthcare. My strategy is to explore the perspectives of displaced women, health service providers and relevant policy makers in Nigeria on how displaced women access healthcare in Nigeria. I also aim to understand the gaps in healthcare for displaced women. You are being approached because you are a displaced woman. You must be at or above the age of 18 years. You must also be able to read, understand and speak the English/Hausa language to participate in this study.

Study Procedures

Should you agree to participate in this study, you will attend one individual interview. If you choose to attend the interview, it will last approximately 1 hour and 30 minutes. The interview will take place at a location and time that is convenient for you, including over the telephone. During the interview, you will be asked to discuss your experience of accessing healthcare while displaced, the factors that influence displaced women's health access, the facilitators and barriers to access to health care services for displaced women in Nigeria. I will also ask you about implications for health practice, policy and research. The interview will be audio recorded. An interpreter may be present during interviews to interpret in your native language. You may be invited to verify the preliminary findings of the study at a second interview. All information will be kept confidential and only be listened to by the researchers.

Potential Benefits
There are no known direct personal benefits to participating in this study. The potential professional benefit of this study is the potential to enhance practice and policy related to providing healthcare service for displaced women. This study should provide useful evidence for service providers and policy makers on displaced women's health in Nigeria. You will receive the equivalent of a complementary $5 appreciation package at the end of the interview.

Potential Risks
There may be a risk of psychological distress associated with discussing a traumatic experience. A health worker will be available to support you and provide comfort if this happens while participating in this study.

Confidentiality
The information obtained during the interviews will be kept confidential. The information will not be available to anyone except the research team including myself and my supervisors at the University of Alberta. All information obtained in this study will be used for research purpose only. The hard copy information obtained during the interview will be kept in a locked and secured area at the University of Alberta. This information will be destroyed after 5 years. The electronic information obtained will be stored in a password protected computer with the file encrypted. Direct quotes from the interviews may be used in reports and presentations, but no identifying information will be provided with these quotes. Pseudonyms (i.e. fake names) will be used in research reports or publications. Should you wish to receive a copy of the results of the study when it is completed, you should make it known to me as well as supply your contact information.
If you will be an interpreter or interview support person, I encourage you to keep all information discussed during the interview confidential**.**

Voluntary Participation and Right to Refuse or Withdraw
Participation is strictly voluntary. You are free to refuse to answer any questions, refuse to take part in the study, or to withdraw within 14 days after the last interview without risk or penalty. In the event of withdrawing from the study, information provided will be destroyed.

Further Information
If you have any questions, you can contact Oluwakemi Amodu at 780.716.1033 or email amodu@ualberta.ca. The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of this research, contact the Research Ethics Office at (780) 492-2615. This office has no direct involvement with this project.

Appendix H: Information letter (For Stakeholders)

Study Title: Access to Reproductive HealthCare for Displaced Women in Nigeria

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University of Alberta
ECHA 5- 238
Tel: 780 4927953
solina.richter@ualberta.ca

Background and Purpose

Over one million women are displaced in Nigeria. It is not understood how women who are displaced in these circumstances access healthcare. In the current study, I will address the gap in knowledge about healthcare access for displaced women in Nigeria, particularly, reproductive healthcare. My strategy is to explore the perspectives of displaced women, health service providers and relevant policy makers in Nigeria on how displaced women access healthcare in Nigeria. I also aim to understand the gaps in healthcare for displaced women. You are being approached because you are a stakeholder, that is, a displaced person's health service provider or a policy maker in Nigeria that is knowledgeable about the situation of displaced persons in Nigeria.

Study Procedures

Should you agree to participate in this study, you will attend one individual interview. If you choose to attend the interview, it will last approximately 1 hour and 30 minutes. The interview will take place at a location and time that is convenient for you, including over the telephone. During the interview, you will be asked to discuss the factors that influence displaced women's health access, and questions related to service and policy provisions for the reproductive health of displaced persons. You may be invited to verify the preliminary findings of the study at a second interview. All information will be kept confidential and only be listened to by the researchers.

Potential Benefits

There are no known direct personal benefits to participating in this study. The potential professional benefit of this study is the potential to enhance practice and policy related to providing healthcare service for displaced women. This study should provide useful evidence for service providers and policy makers on displaced women's health in Nigeria.

Potential Risks

There are no known risk associated with your participation in this study.

Confidentiality

The information obtained during the interviews will be kept confidential. The information will not be available to anyone except the research team including myself and my supervisors at the University of Alberta. All information obtained in this study will be used for research purpose only. The hard copy information obtained during the interview will be kept in a locked and secured area at the University of Alberta. This information will be destroyed after 5 years. The electronic information obtained will be stored in a password protected computer with the file encrypted. Direct quotes from the interviews may be used in reports and presentations, but no identifying information will be provided with these quotes. Pseudonyms (i.e. fake names) will be used in research reports or publications. Should you wish to receive a copy of the results of the study when it is completed, you should make it known to me as well as supply your contact information.

If you will be an interpreter or interview support person, I encourage you to keep all information discussed during the interview confidential**.**

Voluntary Participation and Right to Refuse or Withdraw

Participation is strictly voluntary. You are free to refuse to answer any questions, refuse to take part in the study, or to withdraw within 14 days after the last interview without risk or penalty. In the event of withdrawing from the study, information provided will be destroyed.

Further Information

If you have any questions, you can contact Oluwakemi Amodu at 780.716.1033 or email amodu@ualberta.ca. The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of this research, contact the Research Ethics Office at (780) 492-2615. This office has no direct involvement with this project.

Appendix I: Consent Form

Title of Study: Access to Reproductive HealthCare for Displaced Women in Nigeria

Principal Investigator:
Oluwakemi Amodu
Phone Number: (780) 716-1033
Level 4 Edmonton Clinic Health Academy
11405 – 87 Ave
Edmonton Alberta, Canada, T6G 1C9
amodu@ualberta.ca

Co-Supervisors:
Dr. Bukola Oladunni Salami
Associate Professor, Faculty of Nursing
Level 4 ECHA, University of Alberta
780-248-1801
Bukola.Salami@ualberta.ca
Dr. Magdalena S. Richter
Professor
Associate Dean Global Health
Faculty of Nursing
University of Alberta
ECHA 5- 238
Tel: 780 4927953
Solina.Richter@ualberta.ca

To be completed by the research participants:

Question	Yes/No
Do you understand that you have been asked to be in a research study?	
Have you read and received a copy of the attached information letter?	
Do you understand the benefits and risks involved in taking part in this research study?	
Have you had an opportunity to ask questions and discuss this study?	
Do you understand that you are free to withdraw from the research study at any time, without having to give a reason and without risk and penalty?	
Has the issue of confidentiality been explained to you?	
Do you consent to be interviewed?	
Do you consent to being audio-taped?	
Do you consent to be contacted following the interview to review the transcription of your recorded interview?	

Who explained this study to you?

_____

I agree to take part in this study: YES _____ NO _____
Signature of Research Subject

_____

(Printed Name) _____

Date: _____

Signature of Witness

_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator _____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Flesch-Kincaid Grade Level: 8.6

Appendix J: Ethics Approval University of Alberta

308 Campus Tower
Edmonton, AB, Canada T6G 1K8
Tel: 780.492.0459
uab.ca/reo

Notification of Approval

Date:	May 6, 2019	
Study ID:	Pro00089091	
Principal Investigator:	Oluwakemi Amodu	
Study Supervisor:	Oladunni Salami	
Study Title:	Reproductive Healthcare Access for Displaced Women in Nigeria: A Critical Ethnography Study	
Approval Expiry Date:	May 5, 2020	
Approved Consent Form:	Approval Date	Approved Document
	5/6/2019	Information Letter_IDP women
	5/6/2019	Information Letter_Service providers_Policymakers
Sponsor/Funding Agency:	International Development Research Centre	

Thank you for submitting the above study to the Research Ethics Board 1. Your application has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Research Ethics Board does not encompass authorization to access the staff, students, facilities or resources of local institutions for the purposes of the research.

Sincerely,

Stanley Varnhangen, PhD
Chair, Research Ethics Board 1

Note: This correspondence includes an electronic signature (validation and approval via an online system).

Appendix K: Letter of Support (National Social Investment Office)

6th November 2018

Reference: **SH/OVP/IDP/MISC/VOL.II**

Carole Labrie
Center Awards
International Development Research Center (IDRC)
150 Kent Street Ottawa, ON Canada K1G 3H9

Dear Madam, 08108757387

Re: Letter of Consent and Confirmation of provision of support to Ms. Oluwakemi (Kemi) Amodu

This is to confirm that I am aware of the intention of Ms. Oluwakemi Amodu, a PhD Student of University of Alberta, Canada to visit Nigeria to conduct her research programme on Advocacy for Reproductive rights and access to healthcare for displaced women in an IDP (Internally Displaced Persons) Camp, for an estimated period of about four-six (4-6) Months.

As the Special Assistant to the President on Internally Displaced Persons in the Office of the Vice President, part of the responsibilities of my office include stakeholder management and liaising with the relevant agencies in charge of the welfare of IDPs like the National Emergency Management Agency (NEMA), the Presidential Committee on the North East Initiatives (PCNI) and the National Commission for Refugees, Migrants and Internally Displaced Persons (NCFRMI).

Ms. Amodu will be introduced to community workers and local language interpreters who are familiar with the camp environment to ensure she is in compliance with the culture within the camps and assisted with interpretation of interviews. She will also be linked to relevant stakeholders including service providers and policy makers who can assist her with her research.

Ms. Amodu will be accompanied by personnel from a private security outfit to ensure her safety while she is on field. She will additionally have access to a protected cabinet in a secure location where she can safely archive her research data. She will be able to work together with and learn from humanitarian support staff engaged in community-based work with displaced persons.

All expenses and financial costs for this project are expected to be borne by Ms. Amodu, while she will be provided with other necessary support for mobilization of her research findings which promises to be informative to developing strategic solutions to the reproductive health challenges facing internally displaced women in Nigeria.