THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS AND CHALLENGES OF ADOLESCENT GIRLS AND YOUNG WOMEN IN HUMANITARIAN SETTINGS IN NIGERIA AND UGANDA: A QUANTITATIVE REPORT

ICRW INTERNATIONAL CENTER FOR RESEARCH ON WOMEN
Action Health Incorporated
RESPONDING TO THE NEEDS OF NIGERIA'S YOUNG PEOPLE
UGANDA RED CROSS SOCIETY

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Acronyms

GBV	Gender-based violence
IDP	Internally displaced person
IDRC	International Development Research Centre
IPV	Intimate partner violence
LAM	Lactation Amenorrhea Method
mCPR	Modern contraceptive prevalence rate
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
VIP	Ventilated Improved Pit

EXECUTIVE SUMMARY

Introduction

Globally, 89 million people were displaced at the end of 2021.[1] Many of these are women, girls, and young people who are particularly vulnerable in times of displacement and humanitarian crisis. These vulnerabilities include unmet needs related to sexual and reproductive health and rights (SRHR) and gender-based violence (GBV). Access to care while displaced is often limited in availability and quality, leading to poor health outcomes. Research is needed to understand the needs and experiences of displaced women and girls related to SRHR and GBV in order to better serve them and improve quality access.

Methods

We implemented a cross-sectional survey with adolescent girls and young women between the ages of 15 and 24 in two sites: the Muna El Badawe Internally Displaced Persons (IDP) camp in Maiduguri, Nigeria and the Nakivale Refugee Settlement Camp in Isingiro, Uganda. Using a multi-stage non-proportional cluster sampling design, 480 women in Nigeria and 461 in Uganda were identified for participation. Data were collected in August 2021 and April 2022 in Nigeria and Uganda, respectively. All participants gave informed consent or assent to participate. Parents of non-emancipated minors also provided parental consent. Interviews were conducted in English and Hausa in Nigeria and in English and Swahili in Uganda.

Results

Demographics: The majority of participants were between the ages of 15 and 19, had achieved less than secondary education, and were not currently in school. Almost all women in Nigeria were Muslim, and almost all those in Uganda were Christian. About half of women in Nigeria and 70 percent in Uganda were single. Almost all women in Nigeria were Nigerian, but the majority of those in Uganda had come from Democratic Republic of Congo, Rwanda, and Burundi.

Living conditions: Housing conditions in the camps were generally poor. In Nigeria, the majority of participants lived in makeshift or thatch-grass shelters. Nearly half of those in Uganda had permanent shelters. Almost all participants used pit latrines, and the majority reported feeling unsafe visiting the toilet at night. The most common water sources were boreholes in Nigeria and water taps in Uganda. In Nigeria, one-third reported that there was a water source within 2-4 minutes' walk and all reported traveling no more than 15 minutes, but nearly half in Uganda reported walking more than 15 minutes to access water. Ninety percent of all participants reported that they did not have sufficient food; while 54 percent reported receiving a food ration, 84 percent of those said that the food ration was not sufficient. Twenty-eight percent reported that they earned an income.

Contraceptives, pregnancy, and abortion: Self-reported awareness of contraceptives was higher in Uganda (56%) than in Nigeria (34%), but the most common methods overall women were aware of were injectables, daily pills, and male condoms. Though 41 percent of all women interviewed reported that they were currently sexually active, only about one-quarter of sexually active women were currently using a method of contraception. However, this was much higher in Uganda (63%) than in Nigeria (8.5%). The most common reasons for non-use in both countries were desire for more children and lack of information. Women who were not currently sexually active were much more likely to know where to access contraception should they want it in Uganda than in Nigeria. About three-quarters of participants who had ever had sex reported ever having been pregnant. Though of these only about one percent overall reported that they had induced an abortion, 19 percent of women who reported experiencing delayed menstruation said they had done something to resume menstruation.

1 UNHCR USA. (2022). "Global Trends: Forced Displacement in 2021." UNHCR.

Use of SRHR services: Thirty-one percent of women reported using SRHR services in the camp, primarily pregnancy care, contraceptive care, and sexually transmitted infection care. Six percent reported receiving post-abortion care. The majority of those who had accessed any kind of service were happy with the care they received. Of the two-thirds who had not accessed any care, 15 percent reported not needing them, 14 percent were not aware of them, and 12 percent reported being "too young" for SRHR care.

Intimate partner violence (IPV): Most partnered participants reported experiencing at least one form of IPV. Emotional abuse was the most common form of abuse, experienced by 88 percent of those currently in partnerships (55% of the full sample). The most common forms of emotional abuse were partner getting jealous if they talked with another man (72%) followed by their partner insisting on knowing where they were at all times (63%). Physical abuse was experienced by 34 percent of those in relationships, with the most common form being partner slapping them (22%). Sexual abuse was 24 percent and financial abuse was 14 percent. Forty-three percent reported being afraid of their partner at least sometimes.

Gender-based violence (GBV): More women in Uganda (26%) than in Nigeria (10%) reported experiencing physical assault in the camp, of which 39 percent was perpetrated by strangers. Women in Nigeria were more likely to report assault by policemen or soldiers. Sexual harassment, sexual assault, and rape were all more common in Uganda, but in both countries sexual abuse was less common than physical abuse. Thirty-four percent of participants in Uganda and seven percent in Nigeria reported that they had sought support inside the camp after experiencing some form of GBV, most often from family members, social service organizations, neighbors, and friends. Just seven percent had sought support outside the camp, from similar sources.

Limitations

Some respondents who had been selected were not able to communicate in the languages used by the field researchers and therefore had to be replaced in the study. Some data collection methods differed between countries for specific variables, limiting the ease of direct comparison in those cases. These are noted in the report.

Conclusion and Recommendations

This study revealed that contraception uptake is quite low, particularly in Nigeria, where only 9 percent of sexually active young women are using a method. Likewise, SRHR services were used by only about one-third of women, and this was largely for pregnancy care services. Evidence suggests that low decision-making power, stigma, and lack of awareness may explain the non-use of SRHR services.

Based on evidence from this study, we suggest the following recommendations:

1. Conduct additional research with stakeholders, such as service providers, NGOs, and family members.
2. Provide gender norms training and SRHR education, particularly to men and elders, to decrease stigma and social barriers.
3. Investigate core confidentiality concerns and address gaps.
4. Increase awareness of service availability.
5. Introduce preventive measures to screen for IPV and GBV in existing SRHR services.

INTRODUCTION

By the end of 2021, the global population of forcibly displaced peoples was over 89 million, most of them being internally displaced persons (IDP) and refugees.[2] One-fifth of all refugees worldwide are in sub-Saharan Africa, with Uganda hosting the most in the region at 1.5 million, 81% of whom are women and children.[3][4] In north-east Nigeria, around 2.2 million people – half of which are women or girls – are currently displaced, largely due to the Boko Haram insurgency.[5] Young people and adolescents represent a significant portion of the population, with over half of those displaced aged less than 18 years old.[6]

Due to the critical development stages occurring for 15-24 year olds and their unique health needs, humanitarian settings place additional strains on young people.[7] There is increased risk of sexual and reproductive health and rights (SRHR) vulnerabilities and gender-based violence (GBV) for young women and girls, who additionally tend to have worse health outcomes compared to host-country populations.[8] Their vulnerabilities often include unsafe abortion, high maternal mortality, early and forced marriage, early and unintended childbearing, trafficking, intimate partner violence (IPV), and sexual exploitation, among others.[9]

Despite the knowledge of the adverse health outcomes and SRHR vulnerabilities affecting women and adolescent girls in humanitarian settings, access to quality care remains limited, particularly for young people.[10][11] While greater attention has been placed on the health needs of this group in the past two decades, they remain an under served population when it comes to adequate SRHR care.[12] Services are often available in some capacity, but may be limited in what they offer, provide a low quality of care, or have little recognition in the setting.[13]

In order to better address SRHR care access needs for young women and adolescent girls in humanitarian settings, greater insight is required on the needs and experiences of this population.[14] Focusing on young women and adolescent girls in an IDP camp in Maiduguri, Nigeria and a refugee camp in Isingiro, Uganda, this report provides greater insight into their sexual and reproductive health needs and challenges. It specifically focuses on living conditions in the camp; contraceptives, pregnancy, and abortion; use of sexual and reproductive health services; intimate partner violence; and gender-based violence. The report is part of a larger project to generate evidence to improve the design and delivery of SRHR services to girls and young women in humanitarian contexts.

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12 Ivanova, O., Rai, M., and Kemigisha, E. (2018). "A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa." International Journal of Environmental Research and Public Health, 15(8).

13 Ibid.

14 Ibid.

METHODS

A cross-sectional survey of adolescent girls and young women ages 15 to 24 years was used at the Muna El Badawe IDP Camp in Maiduguri, Nigeria and Nakivale Refugee Settlement Camp in Isingiro, Uganda. In both locations, survey respondents were selected through a multi-stage non proportional cluster sampling design.

In Nigeria, the Muna El Badawe camp accommodates about 50,000 IDPs and is organized into six subdivisions called zones.[15] First, each zone in the camp was treated as a cluster. Following an enumeration of households within each cluster, 80 households were randomly selected per cluster. In each sampled household, one participant was selected and interviewed among all eligible young women and girls (15-24 years). The required sample size of 480 was calculated based on the modern contraceptive prevalence rate (mCPR) of 10% for young women of reproductive age (ages 15-24 years old) in Northern Nigerian states.[16] Interviews were conducted in English and Hausa, depending on the language preference of the interviewee.

In Uganda, Nakivale Refugee Settlement Camp has a total population of almost 146,000 from nearly 40,000 households.[17] The camp is divided into zones with a number of villages in each zone. The three most populous zones have 74 villages, all of which were treated as clusters. Fifteen clusters were randomly selected from the 74, five from each zone. The second stage involved the enumeration of households within each cluster, randomly selecting 30 households per cluster. In the third stage, one participant among all eligible young women and girls (15-24 years) was randomly selected from the household. The required sample size was calculated based on the mCPR of 8.7% for young women in northern Uganda and increased to 450 for ease of allocation slots to three zones.[18] Due to an anticipated non-response, participants were oversampled and the final sample was 461. Interviews were conducted in English and Swahili depending on the preference of the interviewee.

The survey was administered by trained female data collectors using a structured questionnaire deployed through the KoboToolbox platform. Data collection occurred in Nigeria in August 2021 and in Uganda in April 2022.

ETHICAL CONSIDERATIONS

Informed consent was sought and obtained from participants aged 18 years or older, emancipated minors (i.e., girls between 15-17 years who were married or living independently as heads of households), and from the parents of non-emancipated minors (15-17 years). In addition, assent was obtained from non-emancipated minors, and they were included in the survey, only if they gave assent, their parents' consent notwithstanding. The study also adhered strictly to the principles of confidentiality, anonymity, respect for participants and ensured that participants were not exposed to any form of harm. The respective study protocol, research tools and informed consent/assent forms were approved by Nigeria's National Health Research Ethics Committee and the Makerere University School of Public Health Institutional Review Board in Uganda. Both protocols were accepted by the Institutional Review Board of the International Center for Research on Women.

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17 UNHCR. (2022). "Uganda – Refugee Statistic June 2022 – Nakivale." UNHCR.

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RESULTS

Socio-Demographic Characteristics

As Table 1 illustrates, the majority (61%) of respondents across countries were between 15 and 19 years old. The average age overall was 18.6 years (standard deviation=2.92). Overall, participants had low levels of formal education, including 40 percent with no formal education and 41 percent who had attained only primary schooling. However, participants in Uganda tended to be more highly educated than those in Nigeria (p=0.000) – 21 percent compared to 59 percent had no education and 13 percent compared to 5 percent had attained secondary education. However, some of those reporting "no formal education" may in fact have different levels of Arabic literacy or Islamic education, particularly in Nigeria, which may not be captured here. Similarly, more participants in Uganda compared to Nigeria were currently in school (p=0.003). Across both countries, most (67%) of the 243 in-school participants were enrolled in primary school.

TABLE 1: BACKGROUND CHARACTERISTICS OF RESPONDENTS

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
AGE:				0.076
15-19 YEARS	279 (58.13%)	294 (63.77%)	573 (60.89%)	
20-24 YEARS	201 (41.88%)	167 (36.23%)	368 (36.23%)	
EDUCATION:				0.000
NO FORMAL SCHOOLING	284 (59.17%)	97 (21.04%)	381 (40.49%)	
PRIMARY/ELEMENTARY	109 (22.71%)	275 (59.65%)	384 (40.81%)	
MIDDLE OR SECONDARY SCHOOL	62 (12.92%)	81 (17.57%)	143 (15.20%)	
OTHERS	25 (5.21%)	8 (1.74%)	33 (3.51%)	
CURRENT SCHOOLING STATUS:				0.000
NOT SCHOOLING	409 (85.21%)	289 (62.69%)	698 (74.18%)	
IN SCHOOL	71 (14.79%)	172 (37.31%)	243 (37.37%)	
LEVEL IN SCHOOL:	N=71	N=172	N=243	0.003
PRIMARY/ELEMENTARY	38 (53.52%)	125 (72.67%)	163 (67.08%)	
MIDDLE OR SECONDARY SCHOOL	31 (43.66%)	38 (22.09%)	69 (28.40%)	
OTHER	2 (2.82%)	6 (3.49%)	11 (4.53%)	
RELIGION:				0.000
CHRISTIAN	1 (0.21%)	441 (95.66%)	442 (46.97%)	
MUSLIM	478 (99.58%)	15 (3.25%)	493 (52.39%)	
TRADITIONAL	0 (0.00%)	3 (0.65%)	3 (0.32%)	
NO RELIGIOUS AFFILIATION	1 (0.21%)	2 (0.43%)	3 (0.32%)	
MARITAL STATUS:				0.000
SINGLE	230 (47.92%)	325 (70.50%)	555 (58.98%)	
MARRIED	223 (46.46%)	85 (18.44%)	308 (32.73%)	
PARTNERED	1 (0.21%)	20 (4.34%)	21 (2.23%)	
DIVORCED	14 (2.92%)	2 (0.43%)	16 (1.70%)	
SEPARATED	2 (0.42%)	19 (4.12%)	21 (2.23%)	
WIDOWED	10 (2.08%)	10 (2.17%)	20 (2.13%)	
PERSON WHO MADE THE DECISION ABOUT RESPONDENT'S MARRIAGE (OF THOSE MARRIED):	N=223	N=85	N=308	0.000
MYSELF	62 (27.80%)	63 (74.12%)	125 (40.58%)	
MYSELF AND MY PARENTS	95 (42.60%)	10 (11.76%)	105 (34.09%)	
FATHER ALONE	23 (10.31%)	0 (0.00%)	23 (7.47%)	
MOTHER ALONE	8 (8.59%)	2 (2.35%)	10 (3.25%)	
FATHER AND MOTHER	21 (9.42%)	4 (4.71%)	25 (8.12%)	
OTHER	14 (6.28%)	6 (7.06%)	20 (6.49%)	

Overall, most (59%) respondents were single, but more participants in Nigeria were married than in Uganda (p=0.000). Most of the married respondents reported that they were solely involved in decision-making about their marriage (41%) or together with their parents (34%). However, 25 percent were not involved in decision-making about their marriage, particularly in Nigeria.

In Nigeria, where data collection took place in an IDP camp, the overwhelming majority (99%) were Nigerian by nationality, while only 8 total respondents reported other nationalities. In Uganda, data collection took place in a refugee camp and as a result participants were more varied by nationality. Just 4 percent were Ugandan, while more than half (55%) were from Democratic Republic of Congo (see Table 2).

Most respondents resided in the camp with one or both parents, particularly in Uganda. In Nigeria, more respondents reported residing with their partner or husband compared to Uganda.[19]

TABLE 2: NATIONALITY AND LIVING ARRANGEMENTS

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
NATIONALITY (NIGERIA):				
NIGERIA	473 (98.54%)			
OTHER	7 (1.46 %)			
NATIONALITY (UGANDA):				
UGANDA		20 (4.34%)		
BURUNDI		84 (18.22%)		
DEMOCRATIC REPUBLIC OF CONGO		252 (54.66%)		
RWANDA		103 (22.34%)		
OTHER		2 (0.43%)		
LIVING ARRANGEMENT:				
MOTHER	136 (28.33%)	275 (59.65%)		
FATHER	46 (9.58%)	182 (39.48%)		
SISTER	7 (1.46%)	186 (40.35%)		
PARTNER OR HUSBAND	218 (45.42%)	77 (16.70%)		
ALONE	24 (5.00%)	29 (6.29%)		
OTHER	49 (10.21%)	71 (15.40%)		
LIVING PARENTS:				
MOTHER ALIVE	404 (84.17%)	371 (80.48%)	775 (82.36%)	0.138
FATHER ALIVE	310 (64.58%)	269 (58.35%)	579 (61.53%)	0.050

Living Conditions and Access to Resources

Housing conditions in the camps were generally poor. As described in Table 3, the most common shelters were made of grass (37%) and tarpaulin (36%). However, this varied greatly between camp types. In Uganda, where the study was conducted in a long-existing refugee camp, nearly half (47%) lived in permanent shelters constructed with iron sheets. But in Nigeria, where the study site was a transient camp for displaced people, no participants reported permanent shelter.

19 Note that in data collection in Nigeria, participants were prompted to indicate the head of the household and allowed to select only one option. In Uganda, participants could select multiple options. Therefore, the authors advise caution in interpretation when comparing the results between countries.

Nearly all respondents (99%) reported using a pit latrine. In Uganda, a small number of participants reported using a portable toilet or a ventilated improved pit (VIP) latrine. Travel time to toilets averaged 4.6 minutes in Nigeria and 3.1 minutes in Uganda (p=0.000). Fifty-eight percent of respondents reported not feeling safe to visit the toilet at night. Sources of water also varied widely between countries: the most common source of water in Nigeria was a borehole (79%), which was used by only 6 percent of respondents in Uganda. The most common source in Uganda was a water tap (67%), which were not used at all in Nigeria. Less than a third (31%) of participants reported traveling under 5 minutes to access water, particularly in Uganda. Close to half (46%) of those in Uganda traveled over 15 minutes to access water; no participants in Nigeria reported a trip of over 15 minutes.

Use of disposable menstrual pads to manage menstruation was reported by 45 percent of the participants. This was more common in Nigeria (50%) than in Uganda (40%). Far more respondents in Uganda used reusable pads compared to Nigeria (45% versus 27%), while used clothes were more common in Nigeria than in Uganda (22% compared with 12%).

TABLE 3: LIVING CONDITIONS AND ACCESS TO BASIC RESOURCES

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
TYPE OF SHELTER:				0.000
MAKESHIFT/PATCH GRASSES	256 (53.33%)	88 (19.09%)	344 (36.56%)	
TARPAULIN	190 (39.58%)	152 (32.97%)	342 (36.34%)	
PERMANENT (IRON SHEET)	0 (0.00%)	217 (47.07%)	217 (23.06%)	
OTHER	34 (7.08%)	4 (0.87%)	38 (4.04%)	
TYPE OF SHELTER:				0.010
PIT LATRINE	479 (99.79%)	448 (97.18%)	927 (98.51%)	
PORTABLE TOILET	0 (0.00%)	4 (0.87%)	4 (0.43%)	
VIP LATRINE	0 (0.00%)	4 (0.87%)	4 (0.43%)	
OTHER	1 (0.21%)	5 (1.08%)	6 (0.64%)	
DO YOU FEEL SAFE TO VISIT THE TOILET AT NIGHT?				0.065
NO	293 (61.04%)	254 (55.10%)	547 (58.13%)	
YES	187 (38.96%)	207 (44.90%)	394 (41.87%)	
MAIN SOURCE OF WATER:				0.000
WATER TRUCK	17 (3.54%)	6 (1.30%)	23 (2.44%)	
BOREHOLE	381 (79.38%)	28 (6.07%)	409 (43.46%)	
WELL	1 (0.21%)	50 (11.50%)	51 (5.42%)	
HANDPUMP	43 (8.96%)	16 (3.47%)	59 (6.27%)	
SOLAR BOREHOLE	38 (7.92%)	0 (0.00%)	38 (4.04%)	
WATER TAPS	0 (0.00%)	308 (66.81%)	308 (32.73%)	
OTHER	0 (0.00%)	53 (11.50%)	53 (5.63%)	
DISTANCE FROM WATER SOURCE:				0.000
LESS THAN 2 MINS	60 (12.50%)	5 (1.08%)	65 (6.91%)	
2-4 MINUTES	157 (32.71%)	65 (14.10%)	222 (23.59%)	
5-9 MINUTES	120 (25.00%)	121 (26.25%)	241 (25.61%)	
10-14 MINUTES	143 (29.79%)	60 (13.02%)	203 (21.57%)	
15 MINUTES OR MORE	0 (0.0%)	210 (45.55%)	210 (22.32%)	
MATERIAL USED FOR MENSTRUATION:				0.000
USED CLOTHES	107 (22.29%)	57 (12.26%)	164 (17.43%)	
DISPOSABLE MENSTRUAL PADS	240 (50.00%)	183 (39.70%)	423 (44.95%)	
REUSABLE PADS	130 (27.08%)	209 (45.34%)	339 (36.03%)	
OTHER	3 (0.63%)	12 (2.60%)	15 (1.59%)	

The vast majority (91%) of participants in both countries reported not having sufficient food, and there was no difference between countries (see Table 4). However, in Nigeria, participants were more likely to report receiving food rations than in Uganda (p=0.000). Of the 511 respondents receiving food rations, most (89%) received them monthly. In Nigeria, these rations largely came from sources such as the State Emergency Management Agency (47%) and the National Emergency Management Agency (47%), and in Uganda the main sources were UNHCR (45%) and WFP (51%). However, the majority (84%) reported that these rations were not sufficient for meeting their families' needs, particularly in Uganda.

TABLE 4: ACCESS TO FOOD

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
DO YOU HAVE SUFFICIENT FOOD?				0.786
NO	437 (91.04%)	422 (91.54%)	859 (91.29%)	
YES, EVERYDAY	43 (8.96%)	39 (8.46%)	82 (8.71%)	
DO YOU RECEIVE FOOD RATION?				0.000
NO	187 (38.96%)	243 (52.71%)	430 (45.70%)	
YES	293 (61.04%)	218 (47.29%)	511 (54.30%)	
FREQUENCY OF FOOD DISTRIBUTION (OF THOSE RECEIVING RATIONS):	N=293	N=218	N=511	0.000
DAILY	0 (0.00%)	1 (0.46%)	1 (0.20%)	
WEEKLY	3 (1.02%)	1 (0.46%)	4 (0.78%)	
MONTHLY	241 (82.25%)	213 (97.71%)	454 (88.85%)	
OTHER	49 (16.72%)	3 (1.28%)	52 (10.18%)	
DO FOOD RATIONS PROVIDE ENOUGH FOOD FOR YOUR HOUSEHOLD DURING THE ALLOTTED TIME? (OF THOSE RECEIVING RATIONS)	N=293	N=218	N=511	0.000
NO	222 (75.77%)	208 (95.41%)	430 (84.15%)	
YES	71 (24.23%)	10 (4.59%)	81 (15.85%)	

Only about a quarter of participants in both countries had access to income, with no difference between them (see Table 5). In Uganda, a majority of participants (53%) received money from an NGO, compared to just 2 percent in Nigeria. Other sources of money were uncommon in both countries.

TABLE 5: WORK AND ACCESS TO MONEY

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
DO YOU DO ANY WORK FOR MONEY?				0.298
NO	352 (73.33%)	324 (70.28%)	676 (71.84%)	
YES	128 (26.67%)	137 (29.72%)	265 (28.16%)	
DO YOU RECEIVE MONEY FROM THE FOLLOWING SOURCES?*				
GOVERNMENT	1 (0.21%)	18 (3.90%)	19 (2.02%)	0.000
AMILY	31 (6.46%)	37 (8.03%)	68 (7.23%)	0.353
FRIEND	10 (2.09%)	6 (1.30%)	16 (1.70%)	0.354
NGO	9 (1.88%)	246 (53.36%)	255 (27.10%)	0.000
OTHER	23 (4.79%)	9 (1.95%)	32 (3.40%)	0.016
NO, I DON'T RECEIVE MONEY FROM ANY SOURCES	406 (84.58%)	148 (32.10%)	554 (58.87%)	

**Participants can choose more than one response.*

As illustrated in Table 6, six percent of respondents reported experiencing harm or the threat of harm by others in order to take money from them. However, this was more common in Uganda than in Nigeria. Similarly, more participants in Uganda reported exchanging money, goods, or services for sex.

TABLE 6: ABUSE RELATED TO RESOURCE ACCESS

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
EXPERIENCE OF HARM/THREAT OF HARM IN ORDER TO TAKE MONEY FROM RESPONDENT:				0.000
NO	472 (98.33%)	415 (90.02%)	887 (94.26%)	
YES	8 (1.67%)	46 (9.98%)	54 (5.74%)	
EXCHANGE OF MONEY, GOODS, OR SERVICES FOR SEX:				0.002
NO	430 (89.58%)	381 (82.65%)	811 (86.18%)	
YES	50 (10.42%)	80 (17.35%)	130 (13.82%)	
DO YOU FEEL SAFE TO VISIT THE TOILET AT NIGHT?				0.065
NO	293 (61.04%)	254 (55.10%)	547 (58.13%)	
YES	187 (38.96%)	207 (44.90%)	394 (41.87%)	

**Participants can choose more than one response.*

Contraceptives, Pregnancy, and Abortion

Self-reported awareness of contraceptives was higher in Uganda than in Nigeria (p=0.000), and a total of 425 respondents across countries had heard of contraception (see Table 7). Of these, the most common methods mentioned overall were injectables (53%), daily pills (51%) and male condoms (47%). However, the most common methods differed by country: in Nigeria, the most common method mentioned was daily pills (84%), mentioned by only about one-third of participants in Uganda. In contrast, the most common method mentioned in Uganda was the male condom, mentioned by 62 percent of women in Uganda who had heard of contraception but by only 25 percent of women in Nigeria. The most common sources of contraceptives known to participants in both countries are public health centers and hospitals.

TABLE 7: AWARENESS OF CONTRACEPTIVES

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
EVER HEARD OF ANY CONTRACEPTIVES	165 (34.38%)	260 (56.40%)	425 (45.16%)	0.000
CONTRACEPTIVE METHODS EVER HEARD OF (OF THOSE WHO HAVE HEARD OF ANY METHOD)*:	N=165	N=260	N=425	
INJECTABLE	89 (53.94%)	136 (52.31%)	225 (52.94%)	0.743
DAILY PILLS	138 (83.64%)	80 (30.77%)	218 (51.29%)	0.000
MALE CONDOM	41 (24.85%)	160 (61.54%)	201 (47.29%)	0.000
IMPLANT	51 (30.91%)	42 (16.15%)	93 (21.88%)	0.000
FEMALE CONDOM	10 (6.06%)	73 (28.08%)	83 (19.53%)	0.000
WITHDRAWAL	15 (9.09%)	15 (5.77%)	30 (7.06%)	0.193
IUD	4 (2.42%)	20 (7.69%)	24 (5.65%)	0.022
BREASTFEEDING/LAM	5 (3.03%)	11 (4.23%)	16 (3.76%)	0.526
EMERGENCY CONTRACEPTION	1 (0.61%)	11 (4.23%)	12 (2.82%)	0.028
FEMALE STERILIZATION	0 (0.00%)	10 (3.85%)	10 (2.35%)	0.011
RHYTHM METHOD	0 (0.00%)	10 (3.85%)	10 (2.35%)	0.011

TABLE 7: AWARENESS OF CONTRACEPTIVES (CONT'D)

STANDARD DAYS METHOD/CYCLE BEADS	1 (0.61%)	4 (1.54%)	5 (1.18%)	0.385
MALE STERILIZATION	0 (0.00%)	4 (1.54%)	4 (0.94%)	0.109
OTHER	9 (5.45%)	4 (1.54%)	13 (3.06%)	0.022
WHERE RESPONDENTS THINK THEY CAN GET ANY CONTRACEPTIVE METHOD (OF THOSE WHO HAVE HEARD OF ANY METHOD)*:	N=165	N=260	N=425	
PUBLIC HEALTH CENTER	83 (50.30%)	97 (37.31%)	180 (42.35%)	0.008
PUBLIC HOSPITAL	79 (47.88%)	150 (57.69%)	229 (52.88%)	0.048
PUBLIC PHARMACY	22 (13.33%)	14 (5.38%)	36 (8.47%)	0.004
COMMUNITY HEALTH WORKER	12 (7.27%)	20 (7.69%)	32 (7.53%)	0.873
PRIVATE DOCTOR	2 (1.21%)	6 (2.31%)	8 (1.88%)	0.418
PRIVATE CLINIC	3 (1.82%)	21 (8.08%)	24 (5.65%)	0.006
PRIVATE HOSPITAL	2 (1.21%)	7 (2.69%)	9 (2.12%)	0.302
PRIVATE PHARMACY	2 (1.21%)	10 (3.85%)	12 (2.82%)	0.110
PRIVATE NURSE	0 (0.00%)	5 (1.92%)	5 (1.18%)	0.073
OTHER	13 (7.88%)	21 (8.08%)	34 (8.00%)	0.942

**Participants can choose more than one response.*

Just over half (53%) of the total sample had ever had sex, including 42 percent of women in Uganda and 64 percent of women in Nigeria (p=0.000; see Table 8).[20] Age at first sexual intercourse was far more likely to be earlier in Nigeria than in Uganda, with 41 percent in Nigeria 14 years old or younger compared to 15 percent in Uganda. The majority of participants, particularly in Nigeria, who had ever had sex were also currently sexually active (see Table 8). Of these, just one quarter were currently using a method of contraception, and the differences between countries were stark: just 8 percent of sexually active women in Nigeria were using contraception, compared to 63 percent in Uganda (p=0.000). As above, the most common method overall was the injectable (40%), though in Nigeria daily pills were more common (57% of women in Nigeria). Other common methods included male condoms (33%) and implants (10%). Sixty-nine percent of women in both countries who were currently using a method had obtained that method inside the camp, including 48 percent of women in Nigeria and 76 percent of women in Uganda.

Among the 291 women who reported they were currently sexually active but not using a method of contraception, the most common reason overall was that the participant desired more children (42%). This was particularly common in Nigeria (45%) but less common in Uganda (23%). Lack of information about available methods or where to obtain them was cited by 26 percent of respondents. Partner or family opposition was given as a reason by 8 percent, while the respondent's own opposition was only cited by two percent. Health concerns or fears of side effects or the insertion procedure was cited by seven percent, particularly in Uganda (16%).

TABLE 8: CURRENT CONTRACEPTIVE USE

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
EVER HAD SEX:	307 (63.96%)	195 (42.30%)	502 (53.35%)	0.000
AGE AT FIRST SEXUAL INTERCOURSE				0.000
14 YEARS OLD OR YOUNGER	125 (40.72%)	30 (15.38%)	155 (30.88%)	
15-17 YEARS OLD	126 (40.04%)	87 (44.62%)	213 (42.43%)	
18 YEARS OLD OR OLDER	56 (18.24%)	78 (40.00%)	134 (26.69%)	
OF THOSE WHO EVER HAD SEX:	N=307	N=195	N=502	
CURRENTLY SEXUALLY ACTIVE:	271 (88.27%)	117 (60.00%)	388 (77.29%)	0.000

20 This figure includes three participants in Nigeria who originally stated they had never had sex, but later stated they are currently sexually active.

TABLE 8: CURRENT CONTRACEPTIVE USE (CONT'D)

OF THOSE CURRENTLY SEXUALLY ACTIVE:	N=271	N=117	N=388	
CURRENTLY USING ANY CONTRACEPTIVES:	23 (8.49%)	74 (63.25%)	97 (25.00%)	0.000
OF THOSE CURRENTLY SEXUALLY ACTIVE AND USING CONTRACEPTION:	N=23	N=74	N=97	
CURRENT METHOD*:				
INJECTABLE	6 (26.09%)	33 (44.59%)	39 (40.21%)	0.114
MALE CONDOM	5 (21.74%)	27 (36.49%)	32 (32.99%)	0.189
DAILY PILLS	13 (56.52%)	6 (8.11%)	19 (19.59%)	0.000
IMPLANT	3 (13.04%)	7 (9.46%)	10 (10.31%)	0.622
BREASTFEEDING/LAM	0 (0.00%)	5 (6.76%)	5 (5.15%)	0.201
FEMALE CONDOM	0 (0.00%)	4 (5.41%)	4 (4.12%)	0.255
IUD	0 (0.00%)	4 (5.41%)	4 (4.12%)	0.255
EMERGENCY CONTRACEPTION	0 (0.00%)	3 (4.05%)	3 (3.09%)	0.327
WITHDRAWAL	1 (4.35%)	1 (1.35%)	2 (2.06%)	0.377
FEMALE STERILIZATION	0 (0.00%)	0 (0.00%)	0 (0.00%)	
MALE STERILIZATION	0 (0.00%)	0 (0.00%)	0 (0.00%)	
STANDARD DAYS METHOD/CYCLE BEADS	0 (0.00%)	0 (0.00%)	0 (0.00%)	
RHYTHM METHOD	0 (0.00%)	0 (0.00%)	0 (0.00%)	
OTHER	0 (0.00%)	1 (1.35%)	1 (1.03%)	0.575
GOT CONTRACEPTIVE WITHIN CAMP	11 (47.83%)	56 (75.68%)	67 (69.07%)	0.012
OF THOSE SEXUALLY ACTIVE AND NOT USING A METHOD:	N=248	N=43	N=291	
REASON FOR NOT USING CONTRACEPTIVES*:				
WANT MORE CHILDREN	111 (44.76%)	10 (23.26%)	121 (41.58%)	0.008
LACK OF INFORMATION	67 (27.02%)	10 (23.26%)	77 (26.46%)	0.606
PARTNER/FAMILY OPPOSED TO FAMILY PLANNING	21 (8.47%)	3 (6.98%)	24 (8.25%)	0.743
INCONVENIENCE OR COST	16 (6.45%)	3 (6.98%)	19 (6.53%)	0.898
HEALTH CONCERNS OR FEARS	12 (4.84%)	7 (16.28%)	19 (6.53%)	0.005
AGAINST RELIGION	7 (2.82%)	2 (4.65%)	9 (3.09%)	0.523
I AM OPPOSED TO FAMILY PLANNING	5 (2.02%)	2 (4.65%)	7 (2.41%)	0.298
DON'T LIKE EXISTING METHODS	7 (2.82%)	0 (0.00%)	7 (2.41%)	0.265
INFERTILITY/FEMALE STERILIZATION	5 (2.02%)	0 (0.00%)	5 (1.72%)	0.348
EMBARRASSED	3 (1.21%)	2 (4.65%)	5 (1.72%)	0.109
NOT EFFECTIVE	0 (0.00%)	1 (2.33%)	1 (0.34%)	0.016
OTHER	40 (16.13%)	9 (20.93%)	49 (16.84%)	0.437

**Participants can choose more than one response.*

A much larger proportion of participants in Uganda compared to Nigeria who have never had sex knew where to obtain a method within the camp (p=0.000; see Table 9). Participants in Uganda primarily responded that they would discuss options to avoid pregnancy with their family members, while participants in Nigeria were most likely to discuss this with their friends. Far more participants in Nigeria reported that they would discuss with their partners than in Uganda. Fewer than 10 percent of participants in both countries reported that they would discuss avoiding a pregnancy with a healthcare provider, including community health workers, nurses, doctors, and pharmacists.

TABLE 9: AWARENESS OF CONTRACEPTION AMONG THOSE WHO HAVE NEVER HAD SEX

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
OF THOSE WHO HAVE NEVER HAD SEX:	N=173	N=266	N=439	
KNOW WHERE TO GET CONTRACEPTIVE METHOD IN THE CAMP:	21 (12.14%)	199 (74.81%)	220 (50.11%)	0.000
WHO WOULD YOU TALK TO AVOID PREGNANCY [21]*:				
PARTNER/HUSBAND	39 (22.54%)	6 (2.26%)		
FRIEND	53 (30.64%)	69 (25.94%)		
FAMILY MEMBER	22 (12.72%)	154 (57.89%)		
FORMAL PROVIDER [22]	30 (17.34%)	35 (13.16%)		
HERBALIST	0 (0.00%)	1 (0.38%)		
RELIGIOUS LEADER	0 (0.00%)	0 (0.00%)		
TEACHER	1 (0.58%)	8 (3.01%)		
OTHER	28 (16.18%)	32 (12.03%)		

**Participants can choose more than one response.*

There was little difference between countries in experience or outcome of pregnancy, as illustrated in Table 10. Three-quarters of all women who had ever had sex reported ever being pregnant, and of women who had ever been pregnant, the mean number of pregnancies was 2.15 (standard deviation=1.29).[23] Number of pregnancies ranged between one and eight. Of the 372 women who had ever been pregnant, 14 percent had experienced one or more stillbirth, 16 percent had experienced a miscarriage, and one percent had induced an abortion. Miscarriages were somewhat more common in Nigeria (p=0.015), and no women in Nigeria reported inducing an abortion, but 5 women in Uganda did so.

One-third of women who had ever had sex had experienced delayed menstruation in the previous three years, and of these, 52 (19%) had done something to resume menstruation. Unlike reported induced abortion, resumption of menstruation did not differ significantly by country.

TABLE 10: EXPERIENCE OF PREGNANCY

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
OF THOSE WHO EVER HAD SEX:	N=307	N=195	N=502	
EVER BEEN PREGNANT:	225 (73.29%)	148 (75.90%)	373 (74.30%)	0.515
OF THOSE WHO WERE EVER PREGNANT*:	N=225	N=148	N=373	
EVER HAD A STILLBIRTH	30 (13.33%)	21 (14.19%)	51 (13.67%)	0.814
EVER HAD A MISCARRIAGE	44 (19.56%)	15 (10.14%)	59 (15.82%)	0.015
INDUCED ABORTION	0 (0.00%)	5 (3.38%)	5 (1.34%)	0.005
OF THOSE WHO EVER HAD SEX:	N=307	N=195	N=502	
MENSTRUATION WAS DELAYED IN THE LAST THREE YEARS:	102 (33.22%)	62 (31.79%)	164 (32.67%)	0.739
OF THOSE WHO EVER HAD SEX:	N=307	N=195	N=502	
DID SOMETHING TO RESUME MENSTRUATION:	26 (17.57%)	26 (20.97%)	52 (19.12%)	0.478

**Participants can choose more than one response.*

21 Note that in data collection in Nigeria, participants were allowed to select only one option, while in Uganda participants could select multiple options. Therefore, the authors advise caution in interpretation when comparing the results between countries.

22 Includes Community Health Worker, Nurse, Doctor, and Pharmacist.

23 Note that one woman did not report her number of pregnancies, she is therefore not included in this analysis.

Use of Sexual and Reproductive Health and Rights Services

Almost 31 percent of total participants reported using at least one form of SRHR service in the camp, with those in Nigeria reporting 9 percent higher than participants in Uganda (p=0.002; see Table 11). Pregnancy care was the most used service, with nearly three-quarters of participants indicating they accessed these services. Use of this service was 19 percent higher in Nigeria than Uganda (p=0.000). The second most used service in Nigeria was for sexually transmitted infections (STI), with 19 percent of respondents indicating access. In Uganda, the second most used service was contraception/family planning, with half of respondents indicating access (50%). In both countries, gender-based violence (GBV) services were the least accessed service-type, with only 1 percent using them overall.

In all services, the majority of respondents reported being satisfied with the care they received. Those in Nigeria tended to report satisfaction more than those in Uganda, where no services reached above 90 percent satisfaction. GBV services had the lowest rate of satisfaction (67%), followed by STI services (85%), and contraception/family planning (87%).

TABLE 11: USE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
USED ANY SRHR SERVICES WITHIN THE CAMP	170 (35.42%)	121 (26.25%)	291 (30.92%)	0.002
SRHR SERVICES USED*:	N=170	N=121	N=291	
PREGNANCY CARE (ANC/POST-NATAL)	138 (81.18%)	75 (61.98%)	213 (73.20%)	0.000
CONTRACEPTION/FAMILY PLANNING	6 (3.53%)	61 (50.41%)	67 (23.02%)	0.000
SEXUALLY TRANSMITTED INFECTION	33 (19.41%)	14 (11.57%)	47 (15.15%)	0.073
GENDER-BASED VIOLENCE	1 (0.59%)	2 (1.65%)	3 (1.03%)	0.376
POST ABORTION CARE	13 (7.65%)	4 (3.31%)	17 (5.84%)	0.120
OTHER	7 (4.12%)	8 (6.61%)	15 (5.15%)	0.343
CURRENTLY USING ANY CONTRACEPTIVES:	23 (8.49%)	74 (63.25%)	97 (25.00%)	0.000
HAPPY WITH THE SERVICE:				
	N =138	N=75	N=213	
PREGNANCY CARE (ANC/POST-NATAL)	134 (97.10%)	65 (86.67%)	199 (93.43%)	0.003
	N=6	N=61	N=67	
CONTRACEPTION/FAMILY PLANNING	6 (100.00%)	52 (85.25%)	58 (86.57%)	0.312
	N=33	N=14	N=47	
SEXUALLY TRANSMITTED INFECTION	31 (93.94%)	9 (64.29%)	40 (85.11%)	0.009
	N=1	N=2	N=3	
GENDER-BASED VIOLENCE	1 (100.00%)	1 (50.00%)	2 (66.67%)	0.386
	N=13	N=4	N=17	
POST ABORTION CARE	13 (100.00%)	3 (75.00%)	16 (94.12%)	0.063

**Participants can choose more than one response.*

Around two-thirds of those from both Nigeria and Uganda reported they had not used a SRHR service, totaling 69 percent overall (see Table 12). Regarding why they have not used SRHR services, reasons not listed was chosen the most (29%). The second most common response was feeling they did not need the service (15%; p=0.000), followed by a lack of awareness about the services, facilities, or uses (14%; p=0.000). Less than 1 percent of participants felt opening hours or the attitude of the service providers was a major barrier for them.

In Nigeria compared to Uganda, others seeing participants was a main reason services were not used (p=0.000). Conversely, in Uganda feeling too young to need the service or not yet being sexually active was more impactful (p=0.000).

TABLE 12: REASONS FOR NOT USING SRHR SERVICES AMONG PARTICIPANTS WHO HAVEN'T USED THEM

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
REASON FOR NOT USING SRHR SERVICES*:	N=310 (64.58%)	N=340 (73.75%)	N=650 (69.08%)	0.002
FEELS THEY HAVE NOT NEEDED THEM/NO REASON TO USE THEM**	68 (21.94%)	31 (9.12%)	99 (15.23%)	0.000
LACK OF AWARENESS**	21 (6.77%)	71 (20.88%)	92 (14.15%)	0.000
FEELS THEY ARE TOO YOUNG OR ARE NOT SEXUALLY ACTIVE**	13 (4.19%)	62 (18.24%)	75 (11.54%)	0.000
OPENING HOURS	1 (0.32%)	1 (0.29%)	2 (0.31%)	0.948
LOCATION IN THE CAMP	6 (1.94%)	11 (3.24%)	17 (2.62%)	0.300
DISTANCE	6 (1.94%)	23 (6.76%)	29 (4.46%)	0.003
COST	25 (8.06%)	34 (10.00%)	59 (9.08%)	0.391
OTHERS MIGHT SEE ME	31 (10.00%)	11 (3.24%)	42 (6.46%)	0.000
ATTITUDE OF SERVICE PROVIDER	2 (0.65%)	2 (0.59%	4 (0.62%)	0.926
PARENTS NOT SUPPORTIVE	31 (10.00%)	25 (7.35%)	56 (8.62%)	0.230
OTHERS	108 (34.84%)	81 (23.82%)	189 (29.08%)	0.002

**Participants can choose more than one response.*
***Responses were originally part of "Others." Similar responses were combined and put into a separate category due to high number of answers.*

Intimate Partner Violence

Participants currently in some form of partnership were asked about their experiences with intimate partner violence (IPV) in regards to their current partner (including husband or boyfriend). While half of total participants were currently in relationships, over two times as many in Nigeria were currently engaged in a partnership than those in Uganda (p=0.000; see Table 13).

TABLE 13: PARTICIPANTS WITH A PARTNER/HUSBAND/BOYFRIEND

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
CURRENTLY HAVE A PARTNER (INCLUDING HUSBAND OR BOYFRIEND):	359 (74.79%)	154 (33.41%)	513 (54.52%)	0.000

When asked about situations regarding emotional abuse at the hands of their partner, the vast majority stated they had experienced emotional abuse (90% in Nigeria; 82% in Uganda; see Table 14). Seventy-two percent had experienced their partner getting jealous or angry when the participant speaks to other men, a figure higher in Nigeria than Uganda (p=0.001). Over half of all those with partners also indicated their partner insisted on knowing their location at all times. In Uganda, 45 percent experienced partner accusations of being unfaithful, compared to 25 percent in Nigeria (p=0.001). Further, participants in Uganda faced higher rates of their partner attempting to humiliate them in front of others (p=0.000).

TABLE 14: EXPERIENCE OF EMOTIONAL ABUSE BY PARTNER

	NIGERIA (N=359)	UGANDA (N=154)	TOTAL (N=513)	P-VALUE
EXPERIENCED ANY FORM OF EMOTIONAL ABUSE:	322 (89.69%)	127 (82.47%)	449 (87.52%)	0.023
FORMS OF EMOTIONAL ABUSE EXPERIENCED*:				
PARTNER GETS JEALOUS OR ANGRY FROM WHEN YOU TALK TO OTHER MEN	276 (76.88%)	97 (62.99%)	373 (72.71%)	0.001
PARTNER ACCUSES YOU OF BEING UNFAITHFUL	89 (24.79%)	70 (45.45%)	159 (30.99%)	0.001
PARTNER DOES NOT PERMIT YOU TO MEET WITH YOUR FEMALE FRIENDS	131 (36.49%)	52 (33.77%)	183 (35.67%)	0.555
PARTNER TRIES TO LIMIT YOUR CONTACT WITH YOUR FAMILY	60 (16.71%)	29 (18.83%)	89 (17.35%)	0.561
PARTNER INSISTS ON KNOWING WHERE YOU ARE AT ALL TIMES	229 (63.79%)	95 (61.69%)	324 (63.16%)	0.651
PARTNER GETS JEALOUS OR ANGRY WHEN YOU RECEIVE AIDS FROM GOVERNMENT OR NGOS	22 (6.13%)	10 (6.49%)	32 (6.24%)	0.875
PARTNER SAYS OR DOES SOMETHING TO HUMILIATE YOU IN FRONT OF OTHERS	29 (8.08%)	29 (18.83%)	58 (11.31%)	0.000
PARTNER THREATENS TO HURT OR HARM YOU OR SOMEONE YOU CARE ABOUT	19 (5.29%)	21 (13.64%)	40 (7.80%)	0.001
PARTNER INSULTS YOU OR MAKES YOU FEEL BAD ABOUT YOURSELF	81 (22.56%)	46 (29.87%)	127 (24.76%)	0.079

**Participants can choose more than one response.*

Table 15 shows experiences with physical, sexual, and financial abuse. The proportions of respondents who experiences any form of physical abuse was similar in both countries at 33 percent in Nigeria and 34 percent in Uganda. Being slapped was the most common form of abuse at 22 percent. Around 24 percent had experienced at least one form of sexual abuse, with this slightly higher in Uganda (29%) compared to Nigeria (21%). In both countries, the most common form of sexual abuse was being physically forced into sex or something like sex (21% total). Financial abuse, specifically denying economic support as a form of punishment, was experienced by 14 percent of all respondents. Compared to Nigeria, those in Uganda had higher rates of every form of abuse, except for a partner forcing them to stay inside as a form of punishment.

TABLE 15: EXPERIENCE OF PHYSICAL, SEXUAL, AND FINANCIAL ABUSE BY PARTNER

	NIGERIA (N=359)	UGANDA (N=154)	TOTAL (N=513)	P-VALUE
EXPERIENCED ANY FORM OF PHYSICAL ABUSE:	120 (33.43%)	52 (33.77%)	172 (33.53%)	0.940
FORMS OF PHYSICAL ABUSE*:				
PARTNER PUSHES YOU, SHAKES YOU, OR THROWS SOMETHING AT YOU	44 (12.26%)	31 (20.13%)	74 (14.62%)	0.021
PARTNER SLAPS YOU	75 (20.89%)	38 (24.68%)	113 (22.03%)	0.343
PARTNER TWISTS YOUR ARM OR PULL YOUR HAIR	23 (6.41%)	21 (13.64%)	44 (8.58%)	0.007
PARTNER PUNCHES YOU WITH HIS FIST OR WITH SOMETHING THAT COULD HURT YOU	9 (2.51%)	24 (15.58%)	33 (6.43%)	0.000
PARTNER KICKS YOU, DRAGS YOU, OR BEATS YOU UP	39 (10.86%)	29 (18.83%)	68 (13.26%)	0.015
PARTNER TRIES TO CHOKE YOU OR BURN YOU ON PURPOSE	2 (0.56%)	7 (4.55%)	9 (1.75%)	0.002
PARTNER THREATENS TO ATTACK YOU WITH A KNIFE, GUN, OR OTHER WEAPON	2 (0.56%)	8 (5.19%)	10 (1.95%)	0.000
PARTNER FORCES YOU TO STAY INDOORS TO PUNISH YOU	61 (16.99%)	24 (15.58%)	85 (16.57%)	0.694
EXPERIENCED ANY FORM OF SEXUAL ABUSE:	76 (21.17%)	45 (29.22%)	121 (23.59%)	0.049

TABLE 15: EXPERIENCE OF PHYSICAL, SEXUAL, AND FINANCIAL ABUSE BY PARTNER (CONT'D)

FORMS OF SEXUAL ABUSE*:				
PARTNER PHYSICALLY FORCES YOU TO HAVE SEX OR SOMETHING LIKE SEX WITH HIM WHEN YOU DID NOT WANT TO	66 (18.38%)	40 (25.97%)	106 (20.66%)	0.052
PARTNER PHYSICALLY FORCES YOU TO PERFORM ANY OTHER SEXUAL ACTS YOU DID NOT WANT TO	56 (15.60%)	35 (22.73%)	91 (17.74%)	0.053
PARTNER FORCES YOU WITH THREATS OR IN ANY OTHER WAY TO PERFORM SEXUAL ACTS YOU DID NOT WANT TO	30 (8.36%)	20 (12.99%)	50 (9.75%)	0.105
EXPERIENCE OF FINANCIAL ABUSE:				
PARTNER DENIED ECONOMIC SUPPORT TO PUNISH YOU	40 (11.14%)	28 (18.18%)	68 (13.68%)	0.031

**Participants can choose more than one response.*

While overall rates were 15 percent, alcohol use by a participant's partner was notably higher in Uganda than in Nigeria, at around 4 times the rate (p=0.000; see Table 16). Further, participants in Uganda more commonly reported their partner was drunk often. Rates of overall drug use was just under half that of alcohol usage (8%). Drug use by participant's partners was higher in Nigeria, with 9 percent usage compared to 6 percent in Uganda. As was seen in alcohol use, reported frequency of getting high was greater in Uganda. For both substances, the majority of participants reported moderate frequency of their partner getting drunk or high.

TABLE 16: PARTNER USE OF ALCOHOL AND DRUGS

	NIGERIA (N=359)	UGANDA (N=154)	TOTAL (N=513)	P-VALUE
PARTNER DRINKS ALCOHOL:	26 (7.24%)	49 (31.82%)	75 (14.62%)	0.000
FREQUENCY OF GETTING DRUNK	N=26	N=49	N=75	
OFTEN	3 (11.54%)	18 (36.73%)	21 (28.00%)	
SOMETIMES	20 (76.92%)	29 (59.18%)	49 (65.33%)	
NEVER	3 (11.55%)	2 (4.08%)	5 (6.67%)	
PARTNER USES DRUGS:	33 (9.19%)	9 (5.84%)	42 (8.19%)	0.205
FREQUENCY OF GETTING HIGH	N=33	N=9	N=42	
OFTEN	4 (12.12%)	5 (55.56%)	9 (21.43%)	
SOMETIMES	27 (81.82%)	4 (44.44%)	31 (73.81%)	
NEVER	2 (6.06%)	0 (0.00%)	2 (4.76%)	

Injuries resulting from IPV were reported between 4 and 12 percent, with those in Uganda more commonly experiencing any type of injury (see Table 17). In both countries, 7 percent of participants reported being afraid of their partner most of the time and 34 percent reported they were sometimes afraid. The majority of participants reported never feeling afraid of their partner.

TABLE 17: INJURIES CAUSED BY AND FEAR OF PARTNER

	NIGERIA (N=359)	UGANDA (N=154)	TOTAL (N=513)	P-VALUE
INJURIES RESULTING FROM YOUR PARTNER*:	16 (4.46%)	19 (12.34%)	35 (6.82%)	0.001
CUTS, BRUISES, OR ACHES	11 (3.06%)	15 (9.74%)	26 (5.07%)	0.002
EYE INJURIES, SPRAINS, DISLOCATIONS, OR BURNS	3 (0.84%)	11 (7.14%)	14 (2.73%)	0.000
DEEP WOUNDS, BROKEN BONES, BROKEN TEETH, OR ANY OTHER SERIOUS INJURY	6 (1.67%)	11 (7.14%)	17 (3.31%)	0.002
ARE YOU AFRAID OF YOUR PARTNER?				0.690
MOST OF THE TIME	25 (6.96%)	10 (6.49%)	35 (6.82%)	
SOMETIMES	121 (33.70%)	58 (37.66%)	179 (34.89%)	
NEVER	213 (59.33%)	86 (55.84%)	299 (58.28%)	

**Participants can choose more than one response.*

Gender-Based Violence

All participants were asked about their experiences with GBV while they have been in the camp. In terms of physical violence – including being hit, slapped, kicked, or any other physical abuse – 18 percent of participants experienced this form of violence (see Table 18). Those in Uganda reported abuse at more than 2.5 times the amount as those in Nigeria (p=0.000). This was perpetrated largely by strangers (39%), though the overall figure is skewed by the high proportion of stranger perpetration in Uganda (52%) compared to Nigeria (6%). In Nigeria, physical abuse was most commonly perpetrated by someone's own friend or acquaintance (23%).

TABLE 18: EXPERIENCE OF PHYSICAL VIOLENCE

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
EVER BEEN PHYSICALLY ASSAULTED SINCE ARRIVAL IN THE CAMP:	48 (10.00%)	119 (25.81%)	167 (17.75%)	0.000
PERPETRATOR(S)*:	N=48	N=119	N=167	
CURRENT OR FORMER PARTNER/HUSBAND	4 (8.33%)	21 (17.65%)	25 (14.97%)	0.127
RELATIVE OR IN-LAW	6 (12.50%)	14 (11.76%)	20 (11.98%)	0.895
OWN FRIEND/ACQUAINTANCE	11 (22.92%)	10 (8.40%)	21 (12.57%)	0.010
POLICE/SOLDIER	6 (12.50%)	0 (0.00%)	6 (3.59%)	0.000
STRANGER	3 (6.25%)	62 (52.10%)	65 (38.92%)	0.000
OTHER[24]	5 (10.42%)	21 (17.65%)	26 (15.57%)	0.243
NO RESPONSE[25]	20 (41.67%)	10 (8.40%)	30 (17.96%)	0.000

**Participants can choose more than one response.*

Table 19 shows experiences of sexual abuse, including sexual harassment and perpetrated or attempted sexual assault. In sum, sexual abuse was experienced by 20 percent of all respondents. Experiences of sexual abuse were generally higher in Uganda. Twenty-nine percent of respondents in Uganda reported experiencing sexual harassment and sexual assault or attempted sexual assault compared to 11 percent in Nigeria. Sexual abuse in Nigeria happened often through the perpetrator using force (5% harassment; 5% abuse), while in Uganda, threatening physical harm to the participant or someone close to them was used most (14% harassment; 16% abuse). In both countries, strangers were the most common perpetrator of sexual abuse, followed by current or former partner. Each of these perpetrators were more common in Uganda than in Nigeria.

Reports of sexual abuse were overall lower than physical abuse in both countries, with the highest rate in Nigeria at 5 percent (compare to 10% who said they had been physically abused) and the highest rate in Uganda at 14 percent (compared to 25 percent who said they had been physically abused) (see Table 18 and Table 19).

24 Excludes one person in Uganda who indicated a perpetrator but did not answer yes to any form of sexual harassment or assault.
25 Excludes two people in Uganda who indicated a perpetrator but did not answer yes to any form of sexual harassment or assault.
26 Includes teacher, employer, coworker, and staff from NGOs.
27 Note that this includes participants who were not asked about perpetrator but reported some form of abuse.

TABLE 19: EXPERIENCE OF SEXUAL ABUSE

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
PARTICIPANTS SEXUALLY HARASSED BY SOMEONE USING ANY TACTIC:	33 (6.88%)	105 (22.78%)	138 (14.67%)	0.000
TACTICS USE TO SEXUALLY HARASS*:				
TELLING LIES, THREATENING TO END THE RELATIONSHIP, THREATENING TO SPREAD RUMORS ABOUT YOU, MAKING PROMISES YOU KNEW WERE UNTRUE, OR CONTINUALLY PRESSURING YOU AFTER YOU SAID YOU DIDN'T WANT TO	3 (0.63%)	32 (6.94%)	35 (3.72%)	0.000
SHOWING DISPLEASURE, CRITICIZING YOUR APPEARANCE, GETTING ANGRY BUT NOT USING PHYSICAL FORCE, AFTER YOU SAID YOU DIDN'T WANT TO	7 (1.46%)	25 (5.42%)	32 (3.40%)	0.001
TAKING ADVANTAGE OF YOU WHEN YOU WERE TOO DRUNK OR OUT OF IT TO STOP WHAT WAS HAPPENING	0 (0.00%)	3 (0.65%)	3 (0.32%)	0.077
THREATENING TO PHYSICALLY HARM YOU OR SOMEONE CLOSE TO YOU	3 (0.63%)	66 (14.32%)	69 (7.33%)	0.000
USING FORCE, FOR EXAMPLE HOLDING YOU DOWN WITH THEIR BODY WEIGHT, PINNING YOUR ARMS, OR HAVING A WEAPON	24 (5.00%)	35 (7.59%)	59 (6.27%)	0.101
PARTICIPANTS WHO HAVE EXPERIENCED PERPETRATED OR ATTEMPTED SEXUAL ASSAULT USING ANY TACTIC:	38 (7.92%)	105 (22.78%)	143 (15.20%)	0.000
TACTICS USED TO SEXUALLY ASSAULT OR ATTEMPT TO SEXUALLY ASSAULT*:				
TELLING LIES, THREATENING TO END THE RELATIONSHIP, THREATENING TO SPREAD RUMORS ABOUT YOU, MAKING PROMISES YOU KNEW WERE UNTRUE, OR CONTINUALLY PRESSURING YOU AFTER YOU SAID YOU DIDN'T WANT TO	9 (1.88%)	27 (5.86%)	36 (3.83%)	0.001
SHOWING DISPLEASURE, CRITICIZING YOUR APPEARANCE, GETTING ANGRY BUT NOT USING PHYSICAL FORCE, AFTER YOU SAID YOU DIDN'T WANT TO	10 (2.08%)	26 (5.64%)	36 (3.83%)	0.004
TAKING ADVANTAGE OF YOU WHEN YOU WERE TOO DRUNK OR OUT OF IT TO STOP WHAT WAS HAPPENING	0 (0.00%)	3 (0.65%)	3 (0.32%)	0.077
THREATENING TO PHYSICALLY HARM YOU OR SOMEONE CLOSE TO YOU	5 (1.04%)	72 (15.62%)	77 (8.18%)	0.000
USING FORCE, FOR EXAMPLE HOLDING YOU DOWN WITH THEIR BODY WEIGHT, PINNING YOUR ARMS, OR HAVING A WEAPON	21 (4.38%)	31 (6.72%)	52 (5.53%)	0.115
PARTICIPANTS WHO HAVE EXPERIENCED SEXUAL HARASSMENT AND/OR PERPETRATED OR ATTEMPTED SEXUAL ABUSE USING ANY TACTIC:	54 (11.25%)	132 (28.63%)	186 (19.77%)	0.000
PERPETRATOR(S) OF SEXUAL HARASSMENT OR ASSAULT*:				
CURRENT OR FORMER PARTNER/HUSBAND	4 (7.41%)	19 (14.39%)	23 (12.37%)	0.189
RELATIVE OR IN-LAW	0 (0.00%)	2 (1.52%)	2 (1.08%)	0.363
OWN FRIEND/ACQUAINTANCE[26]	0 (0.00%)	6 (4.55%)	6 (3.23%)	0.111
POLICE/SOLDIER	0 (0.00%)	1 (0.76%)	1 (0.54%)	0.521
STRANGER[27]	19 (35.19%)	68 (51.52%)	87 (46.77%)	0.043
OTHER[28]	4 (7.41%)	9 (6.82%)	13 (6.99%)	0.886
NO RESPONSE[29]	32 (59.26%)	41 (31.06%)	73 (39.25%)	0.000

**Participants can choose more than one response.*

Separate from sexual abuse, participants were also asked if they had ever been raped at any point in their life, to which 12 percent indicated they had been (see Table 20). More participants in Uganda reported they had been raped (15%) compared to 9 percent in Nigeria (p=0.002).

TABLE 20: EXPERIENCE OF RAPE

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
EVER BEEN RAPED:	42 (8.75%)	70 (15.18%)	112 (11.90%)	0.002

Help-seeking for Gender-Based Violence

Participants were asked about their experiences seeking help due to any experience with GBV (see Table 21). Within the camp, participants in Uganda sought help at over 4 times the rate of those in Nigeria (34% compared to 7%; p=0.000), yet reported rates of abuse were higher in Uganda which may provide some explanation for this difference. Of those who sought help inside the camp, they most frequently approached their own family (26%) or a social service organization (24%).

Help-seeking outside of the camp was low in both countries, at 8 percent in Uganda and 5 percent in Nigeria. For both countries, it was most common to ask a family member, neighbor, or friends for support. Consulting a family member was nearly three times as common in Nigeria (p=0.000).

TABLE 21: HELP-SEEKING FOR GBV

	NIGERIA (N=480)	UGANDA (N=461)	TOTAL (N=941)	P-VALUE
TRIED TO SEEK HELP WITHIN THE CAMP*:	34 (7.08%)	157 (34.06%)	191 (20.30%)	0.000
SOUGHT HELP FROM:	N=34	N=157	N=191	
OWN FAMILY	10 (29.41%)	39 (24.84%)	49 (25.65%)	0.580
PARTNER/HUSBAND/BOYFRIEND FAMILY	1 (2.94%)	3 (1.91%)	4 (2.09%)	0.704
CURRENT PARTNER/HUSBAND/ BOYFRIEND	1 (2.94%)	2 (1.27%)	3 (1.57%)	0.478
FRIEND	6 (17.65%)	27 (17.20%)	33 (17.28%)	0.950
NEIGHBOR	6 (17.65%)	31 (19.75%)	37 (19.37%)	0.779
RELIGIOUS LEADER	0 (0.00%)	3 (1.91%)	3 (1.57%)	0.417
DOCTOR/MEDICAL PERSONNEL	2 (5.88%)	15 (9.55%)	17 (8.90%)	0.495
POLICE	0 (0.00%)	15 (9.55%)	15 (7.85%)	0.060
TEACHER	0 (0.00%)	3 (1.91%)	3 (1.57%)	0.417
LAWYER	0 (0.00%)	1 (0.64%)	1 (0.52%)	0.641
SOCIAL SERVICE ORGANIZATION	8 (23.53%)	37 (23.57%)	45 (23.56%)	0.996
OTHER	4 (11.76%)	12 (7.63%)	16 (8.38%)	0.432
TRIED TO SEEK HELP OUTSIDE THE CAMP*:	23 (4.79%)	39 (8.46%)	62 (6.59%)	0.023
SOUGHT HELP FROM:	N=23	N=39	N=62	
OWN FAMILY	19 (82.61%)	10 (25.64%)	29 (46.77%)	0.000
PARTNER/HUSBAND/BOYFRIEND FAMILY	0 (0.00%)	1 (2.56%)	1 (1.61%)	0.439
CURRENT PARTNER/HUSBAND/ BOYFRIEND	0 (0.00%)	0 (0.00%)	0 (0.00%)	
FRIEND	11 (47.83%)	11 (28.21%)	22 (35.48%)	0.119
NEIGHBOR	6 (26.09%)	11 (28.21%)	17 (27.42%)	0.857
RELIGIOUS LEADER	2 (8.70%)	2 (5.13%)	4 (6.45%)	0.581
DOCTOR/MEDICAL PERSONNEL	0 (0.00%)	1 (2.56%)	1 (1.61%)	0.439

TABLE 21: HELP-SEEKING FOR GBV (CONT'D)

POLICE	0 (0.00%)	6 (15.38%)	6 (9.68%)	0.048
TEACHER	0 (0.00%)	0 (0.00%)	0 (0.00%)	
LAWYER	0 (0.00%)	0 (0.00%)	0 (0.00%)	
SOCIAL SERVICE ORGANIZATION	1 (4.35%)	4 (10.26%)	5 (8.06%)	0.409
OTHER	1 (4.35%)	3 (7.69%)	4 (6.45%)	0.605

**Participants can choose more than one response.*

STUDY LIMITATIONS

Language barriers were a major limitation to the study. Some of the selected respondents could not communicate effectively in the primary languages field researchers could use effectively (English and Hausa in Nigeria; English and Swahili in Uganda). For this reason, some IDPs selected to participate in the study were replaced with those with whom the research team could communicate. This limited the application of the sampling technique adopted for the study. The current report is also limited to quantitative findings. However, qualitative data would have offered additional insight to illuminate the current findings. In some cases, questions were collected with different methods, for example allowing participants to choose any option that applied in a given case compared to asking them to choose one response. This led to the inability to easily compare some data points to one another. These instances are noted in the report.

DISCUSSION

Access to SRHR support is a critical need of adolescent girls and young women in humanitarian settings due to their specific developmental stages occurring during this age, as well as the heightened vulnerabilities to violence, exploitation, maternal mortality, and other SRHR challenges that occur with displacement.[28] Yet in the two settings in this study – an IDP camp in Nigeria and a cross-border refugee camp in Uganda – we find that use of contraception and other SRHR services is quite low. While 63 percent of sexually active women interviewed in Uganda report using some method of contraception, just 9 percent of those in Nigeria report the same. Meanwhile, just 35 percent of those in Nigeria and 26 percent in Uganda report using SRHR services inside the camp suggesting that in Uganda, even women who do use contraception may be unable to access care inside the camp. We suggest three possible explanations for non-use of SRHR services: low decision-making power, stigma, and lack of awareness.

First, reduced decision-making power, including as an effect marriage, negatively impacts contraceptive usage. Participants from Nigeria were over 2.5 times as likely to be married than those in Uganda. Moreover, in Nigeria only 30 percent had been the sole decision-maker about their marriage, compared to 74 percent in Uganda. One reason for this may be the high rate of child marriage in Northern Nigeria, where 48 percent of girls are married by age 15 and 78 percent by age 18.[29] Data for this study were not collected from participants on age of marriage, but findings on age of first intercourse show that participants from Nigeria were four times as likely to have first intercourse prior to age 15 and 20 percent more likely before age 18, compared to those in Uganda. These findings suggest the potential for high rates of early marriage among our sample in Nigeria. Education is also connected to decision-making power, [30] and we found that 59 percent of participants in Nigeria had no formal schooling, compared to 21 percent in Uganda.

28 UNHCR USA. (2022). "Global Trends: Forced Displacement in 2021." UNHCR.

29 Save the Children. (2021). "State of the Nigerian Girl Report." Save the Children.

30 Wei, W., Sarker, T., Żukiewicz-Sobczak, W., Roy, R., Alam, G.M.M., Rabbany, M.G., Hossain, M.S., and Aziz, N. (2021). "The Influence of Women's Empowerment on Poverty Reduction in the Rural Areas of Bangladesh: Focus on Health, Education and Living Standard." International Journal of Environmental Research and Public Health, 18(13).

Reduced decision-making power is linked to girls' and women's reduced control over sexual and reproductive behaviors in the relationship, leading to lower contraceptive usage, greater risk of IPV, and reduced freedom of movement.[31] The reduced decision-making power in Nigeria therefore may have played a role in the significantly lower rates of contraceptive usage. This effect may also have been exacerbated by the humanitarian setting, where adolescent girls and young women are already at risk of lacking accessible and adequate SRHR care.[32] The relationship between reduced decision-making power as a result of lower educational attainment, early and forced marriage, and the use and/or access to SRHR in IDP settings remains understudied, though these preliminary findings are in line with emerging research and add to the growing level of information on this topic.[33]

We also suggest that stigma may play a significant role in non-use of contraception and other services, particularly in Nigeria. As those in Nigeria resided in an IDP camp, local and cultural taboos around discussions of contraceptive usage were likely more homogeneous than in a more diverse refugee camp like Uganda where norms may have greater variation and informal or formal discussions of contraceptives may be more readily accessible in comparison. Fear of being seen was a notable barrier to use of services, particularly in Nigeria. Among those who reported they had used SRHR services, by far the most common service sought in both countries was pregnancy care, but particularly in Nigeria. On the other hand, half of users in Uganda were seeking contraception, compared to just 4 percent in Nigeria.

Another indication of stigma faced in Nigeria relates to abortion. Twenty-six interviewees in Nigeria reported that they had done something to resume menstruation following menstrual delay and 8 percent of those accessing SRHR services reported that they had received post-abortion care. Yet, no one from Nigeria reported having had an abortion. Other studies on SRHR in humanitarian context correspond with these trends, noting that stigma and shame around young people's sexual activity is a barrier to SRHR services and are exacerbated in displacement contexts.[34]

Finally, we suggest that poor awareness of available services limits their use in both of these settings. Of sexually active women who were not currently using a method of contraception, lack of information was a key reason. General knowledge of contraceptive types and where to access them was lower in Nigeria, particularly among those who had never had sex. While 75 percent of these women in Uganda reported knowing where to obtain a method should they want one, only 12 percent in Nigeria did so. This suggests limited discussion with family, friends, and healthcare providers around contraceptives. At the same time, 21 percent of women in Uganda who had not accessed SRHR care inside the camp reported that this was because of a lack of information, compared to 7 percent in Nigeria. Thus, while awareness overall may be higher in Uganda, context-specific information may still be limited.

RECOMMENDATIONS FOR IMPROVED PROGRAM DESIGN AND IMPLEMENTATION

The findings presented here provide key information to help improve SRHR service quality and access for adolescent girls and young women in humanitarian settings. The following recommendations draw on findings of the study and seek to support efforts to improve the delivery of SRHR services in the study settings.

31 Save the Children. (2021). "State of the Nigerian Girl Report." Save the Children.

32 Ivanova, O., Rai, M., and Kemigisha, E. (2018). "A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa." International Journal of Environmental Research and Public Health, 15(8).

33 Hunersen, K., Attal, B., Jeffery, A., Metzler, J., Alkibsi, T., Elnakib, S., and Robinson, W. C. (2021). "Child Marriage in Yemen: A Mixed Methods Study in Ongoing Conflict and Displacement." Journal of Refugee Studies, 34(4).

34 Tirado, V., Chu, J., Hanson, C., Ekström, A.M., Kågesten, A. (2020). "Barriers and facilitators for the sexual and reproductive health and rights of young people in refugee contexts globally: A scoping review." PLoS One, 15(7).

1. **Conduct additional research with stakeholders, such as service providers, NGOs, and family members:** This survey focused specifically on adolescent girls and young women, and it shows there are gaps in awareness and effects of stigma that are central to SRHR care and access for this population. There is also need to understand the stigmas held by service providers that may limit a woman or girls' comfort in engaging with them on SRHR needs, particularly around contraception, abortion, and GBV. Future investigation should also consider how this may specifically affect unmarried women. Greater understanding of the services currently provided, awareness efforts, and stigmatizing barriers from both providers and social circles can further help to address SRHR and GBV risks and challenges faced by adolescent girls and young women in humanitarian settings.
2. **Provide gender norms training and SRHR education, particularly to men and elders, to decrease stigma and social barriers:** Respondents noted that their family and men partners were important aspects of their choices to use contraception and access SRHR services and they would most involve partners, friends, and family when learning about contraception or in help-seeking for IPV or GBV. Yet, this research found evidence that there were social barriers around discussion of SRHR that prevented adolescent girls and young women from learning about, accessing, and using contraception and SRHR services. Thus, programming should target the harmful gender norms around contraception and SRHR held those who adolescent girls and young women will turn to most when discussing these topics. By addressing stigma and misinformation held by those who are most influential in supporting adolescent girls and young women in making SRHR decisions, greater support for accessing formal SRHR services can be fostered throughout social circles and lead to heighted service usage.
3. **Investigate core confidentiality concerns and address gaps:** Greater efforts to understand confidentiality concerns that prevent some women from using SRHR services can strengthen current confidentiality measures and develop new ones to ensure adolescent girls and young women feel confident using the service. This would include addressing consent barriers where some service providers require spousal consent for girls and women to access SRHR services in the camp, forcing those whose parents or husbands are opposed to modern contraceptives to refrain from using services. Additionally, private spaces for those obtaining contraception to wait in can enhance comfort, among other confidentiality measures.
4. **Increase awareness of service availability:** Lack of knowledge of services was a major reason why they were not used. SRHR services should have outreach activities to improve awareness, including where and how to access them, as well as confidentiality policies. These campaigns should additionally continue to investigate and address issues in accessing SRHR services as awareness rises, such as ensure accessible hours and safe locations. Funding may also be allocated to providing menstrual hygiene management kits upon arrival to a humanitarian location. These kits would not only provided needed products but could be used as an avenue to inform adolescent girls and young women about the range of SRHR services available and their locations. Girls' use of SRHR services may also improve if there are peer guides that encourage them to use and help them navigate facility-based services.
5. **Introduce preventive measures to screen IPV and GBV in existing SRHR services:** The survey showed help-seeking for IPV and GBV were low and were mainly sought from withing the family or social circle. Including information and resources on IPV and GBV in other SRHR services, as well as monitoring for signs of abuse, can aid in prevention of violence and greater use of support resources.

CONCLUSION

This report shines light on the SRHR needs and challenges facing adolescent girls and young women in humanitarian settings and how these affect their ability to access quality care. Looking at two different settings – an IDP camp in Nigeria and a refugee camp in Uganda – further helps to see how these needs and challenges vary across settings. Findings on the effects of decision-making power, stigma around contraceptive use and SRHR care, and low awareness of services demonstrate gaps that can drive further research and programming to support greater SRHR access and health needs for adolescent girls and young women in humanitarian settings.

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