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Original Article

Displaced Women and Sexual and Reproductive Health Services: Exploring Challenges Women With Sexual and Reproductive Health Face in Displaced Camps of Nigeria

Atenchong Ngwibete[1*], Olayinka Oladunjoye Ogunbode[2], Mobhe Agbada Mangalu[3], Akinyinka Omigbodun[2]

[1]Pan African University Life and Earth Sciences Institute (including Health and Agriculture), PAULESI, University of Ibadan, Ibadan, Niger

[2]Department of Obstetrics & Gynaecology, College of Medicine, University of Ibadan, Ibadan, Nigeria

[3]Département des Sciences de la Population et du Développement, Faculté des Sciences Economiques et de Gestion, Université de Kinshasa, Kinshasa, Congo

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***Corresponding author:**
Atenchong Ngwibete,
Email: atenchongngwi@gmail.com

Abstract

Background: Displaced women are affected by sexual and reproductive health (SRH) challenges, often exacerbated by poor living conditions, limited access to healthcare, and cultural norms. The aim of this study was to explore SRH issues, the effects of displacement into camps on women's SRH, and challenges with accessing and utilizing SRH services among women in camps for the displaced in Benue State, Nigeria.

Methods: A qualitative phenomenological approach was employed to gain an in-depth understanding of the women's SRH challenges, based on 12 focus group discussions between women of different age groups and eight in-depth interviews. The data were collected using tape recorders and notes. Data analysis followed a thematic approach. Ethical approval and appropriate consent were obtained for the study.

Results: The majority of research participants stated that sexually transmitted disease/*human immunodeficiency virus* was the most serious SRH issue in the camp. Their stay in camp enhanced the women's vulnerability and exposed them to sex in exchange for basic needs/palliatives, increasing their SRH challenges. Access to and use of SRH services were impacted by their migratory lifestyle, cultural and religious views, lack of SRH knowledge, and other difficulties. Short-term approaches to intervention, health providers' poor communication, and attitudes were reported to affect SRH service use.

Conclusion: There is an urgent need for comprehensive interventions to address SRH challenges among women in displaced settings, including proper coordination of humanitarian services, education on transactional sex, encouragement of men to participate in SRH initiatives, and expansion of access to services, as well as the training and hiring of culturally competent healthcare providers.

Keywords: Reproductive health, Health services accessibility, Internally displaced persons, Humanitarian challenges

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Introduction

Nigeria has been noted as one of the many African countries most affected by displacement (1). The country records about 3.6 million displaced persons, with about 18 000 living in Benue State (2). Women have been reported to be disproportionately affected by displacement and its countless challenges, including those associated with access to and utilization of sexual and reproductive health (SRH) services (3,4). SRH and rights (SRHR) are fundamental to a person's well-being and directly affect the social and economic development of an individual and society at large (4). For this reason, access to SRHR services is a necessity, especially among populations at risk of SRH issues, such as internally displaced women. However, access to and utilization of these services often become compromised in displaced settings.

Internally displaced persons (IDPs), most especially women, generally have a difficult time gaining access to SRH services (5,6). These difficulties can be made even more challenging by incidents of insecurity that disrupt health systems, displacement to unfamiliar settlements, and the vulnerabilities that come along with being displaced (7). In Nigeria, as in many other African nations, cultural, religious, and socioeconomic factors

typically intersect to influence SRH service utilization and access, making the situation more challenging (8). Although there is growing recognition of these challenges, no documentation is available regarding exploring the internally displaced women's own ideas and perceptions about their challenges and experiences with SRH in camps in Nigeria. However, understanding the reproductive health needs of refugees and displaced populations has repeatedly been identified as a global priority (5). In 2022, we performed qualitative research to explore the unique factors that affect SRH health among women in internally displaced camps in Benue State. We hope that documentation of their reproductive health experiences and opinions of the challenges they face will inform SRH-implementing programs and policies affecting this population. This manuscript focuses specifically on exploring challenges with *human immunodeficiency virus/* acquired immunodeficiency syndrome *(*HIV/AIDS), contraception, and cervical cancer screening services.

Materials and Methods

This research was part of a larger study, conducted between April and November 2022 in the Guma Local Government Area in Benue State, Nigeria, that focused on an intervention to improve the SRH of women in four selected camps in Benue State. Since the study sought to describe and explain respondents' lived experiences about the topic, it used a phenomenological qualitative study design. Specifically, the research assessed the challenges with HIV/AIDS, contraception, and cervical cancer screening services. The study took place in four purposively selected camps using 24 focused group discussions (FGDs) and 8 interviews. The interview and FGD guide were constructed to cover topics such as SRH issues faced in the camp, the effects of the camp situation on SRH, and challenges with access to SRH and use of SRH services. The intervention used FGDs and key stakeholder interviews to collect data that described the challenges associated with the services of interest. In each camp, three FGDs took place among younger girls (15–24 years), middle-aged participants (25–34 years), and much older women (35–49 years). This was to ensure that participants in the FGD spoke freely among their peers and that the researcher could explore the perspective across each age group. An interview was conducted with selected stakeholders who had lived or served in the camp for 6 months or longer.

Participant Selection and Data Collection

The study took place in November 2022 in the Guma Local Government Area of Benue State, Nigeria, within purposively selected IDP camps. Out of the four camps, two had a health facility that implemented some SRH services (Daudu 1 and Daudu 3), while the other two had no facility (Ortese and Abagena). Participants were purposively selected for the FGD and interviews. The woman leader in the camp assisted in selecting participants for the FGD, considering that she knew the women better. Women who could speak freely among their peers and consented to participate in the study were given priority. A total of 24 participants participated in FGD in each camp, while eight (8) personnel were interviewed. Focus group discussions and interviews were concluded once reaching data saturation. Participants in the camps with health facilities were exposed to a health educational intervention through face-to-face contact or mHealth by community-based reproductive health-trained personnel. The FGD/interview took place after exposure to the mentioned intervention. Parental/significant other assent was obtained for much younger participants. The other considerations included willingness to participate, educational level, marital status, and occupation. Interviewees included camp leaders, woman leaders, healthcare providers, and representatives from non-governmental organizations (NGOs).

Each FGD and interview was guided by an FGD or interview guide that was pretested and modified to suit the study. After the researcher identified interview participants, he/she was contacted by phone or in his/her office. The participant was informed about the study and asked for consent to participate in the interview. Then, interview dates and times that were convenient for the participants were set, and all interviews were conducted at the camp in the participants' office. Before each interview, the researcher fostered a connection with the subjects that enabled candid responses. Participants gathered in a camp hall for discussion sessions. FGD was in pidgin and the local language, "TIV". The researcher used two research assistants to facilitate the process; one acted as a moderator and translator, while the other took notes. A tape recorder was utilized to record the discussion. Prior to beginning the interview, respondents were given numeric codes. Coding was performed using the camp name (D1, D3, A1, and O1 for Daudu Camp 1, Daudu Camp 3, Abagena, and Ortese, respectively), group number, and participant number in each group. Participants' numbers ranged from 1 to 8. Participants in the age ranges of 15–24, 25–34, and 35–49 were labeled as groups 1 (G1), 2 (G2), and 3 (G3), respectively. Interviewees were given the code I and a number. The average length of the FGD was 70 minutes, while the average length of the interview was 45 minutes.

Data Analysis

The note-taker transcribed and translated all FGD and interview discussions. The data were analyzed by the researcher and two other qualitative experts. First, the researchers read the entire manuscript individually to familiarize themselves with it. Then, the transcript was reviewed carefully by all researchers to identify text that described challenges with SRH access and use. While focusing on the research objectives, the data analysts identified major and minor themes. Each theme was given a color code, and codes for each theme were extracted as they read along. Where there was disagreement on where to categorize a code or subtheme, the analyst debated to come to an agreement. A total of 6 major themes emerged from the transcript, including a lack of male involvement, shame, fear, and stigma, healthcare-related

factors, religious/cultural issues, migration, and political/government-related challenges. The researcher also enumerated the number of times each theme emerged in the transcript.

Data Rigor

The researcher ensured that data accuracy and reliability were maintained during the study by using a standardized instrument for data collection, providing intensive training on qualitative data collection, and using the same sampling criteria to select participants for the study. The researcher also kept a clear record of participant responses, including transcripts, notes, and audio recordings. During data analysis, the researchers approached the data with a neutral and open mindset to ensure the research results were as objective as possible. To ensure that the data aligned with the participants' perspectives, the researcher presented the findings of the data analysis to respondents, allowing for feedback and corrections.

Results

Socio-demographic Characteristics

Among the interviewed participants, the mean age was 39.0 and 38.5 years among women from IDP camps with SRH service facilities and those from camps without SRH facilities, respectively. The other socio-demographic characteristics are summarized in Table 1.

Table 2 lists the socio-demographic characteristics

Table 1. Sociodemographic Characteristics of Interviewed Participants

Variable	Sub-category	Camps With SRH Service Facility No. (%)	Camps With No SRH Facility No. (%)
Gender	Male	1 (25.0)	2 (50.0)
	Female	3 (75.0)	2 (50.0)
Marital status	Single	1 (25.0)	0 (0.0)
	Married	3 (75.0)	4 (100.0)
Religion	Christianity	4 (100.0)	4 (100.0)
	Islam	0 (0.0)	0 (0.0)
Highest level of education	None	1 (25.0)	1 (25.0)
	Primary	0 (0.0)	0 (0.0)
	Secondary	1 (25.0)	1 (25.0)
	Tertiary	2 (50.0)	2 (50.0)
Occupation	Health worker	1 (25.0)	2 (50.0)
	Camp captain	1 (25.0)	1 (25.0)
	Women leader	1 (25.0)	1 (25.0)
	INGO representative (Counselor)	1 (25.0)	0 (0.0)
Number of years stayed/ worked for the camp	≤1	1 (25.0)	2 (50.0)
	>2	3 (75.0)	2 (50.0)

Table 2. Sociodemographic Characteristics of FGD Participants

Variable	Sub-category	Camps With SRH Service Facility No. (%)	Camps With No SRH Facility No. (%)
Age (y)	15-24	16 (33.33)	16 (33.33)
	25-34	16 (33.33)	16 (33.33)
	≥35	16 (33.33)	16 (33.33)
Marital status	Single	3 (6.3)	7 (14.9)
	Married/cohabiting	42 (87.5)	40 (83.3)
	Widowed	3 (4.2)	1 (2.1)
Religion	Christianity	48 (100)	48 (100)
	Islam	0 (0.0)	0 (0.0)
Highest level of education	None	37 (77.3)	43 (89.6)
	Primary	10 (20.8)	4 (8.3)
	Secondary	3 (6.3)	1 (2.1)
	Tertiary	0 (0.0)	0 (0.0)
Occupation	Farming	41 (85.4)	42 (87.5)
	Others*	6 (12.5)	5 (10.4)
	None	1 (2.1)	1 (2.1)

Note. SRH: Sexual and reproductive health; FGD: Focused group discussions.
* Others include schooling, tailoring, and teaching.

of those participating in the FGDs. The mean age was 29.25 ± 8.56 and 29.44 ± 8.73 among the IDP camps with and without SRH service facilities, respectively.

Emerging Themes and Number of Quotations (n) by Camp and Age Group

Tables 3 and 4 provide data regarding the emerging themes for each team and the number of quotations (n) by camp and age group. Healthcare-related factors had the most quotations among the respondents.

SRH Issues Faced in the Camp

The most prevalent quotation for SRH issues faced by women was vaginal infections or sexually transmitted infections (STIs), commonly called "*infection*". Women identified that most women had vaginal discharge, itching, fowl/fishy smelly vaginas, and sometimes abdominal pain. The majority of the quotes emerged from women in camps with no facilities and within the ages of 25–34 years (11/28). One woman in a camp with no health facilities indicated, "*It's the biggest problem we have. I have had an infection in my vagina for 2 years now. If I take treatment, it will stop and come back*" (G2OP4, 30 years).

Unwanted pregnancies and HIV/AIDS also had frequent quotations. According to a health worker, "*The majority of the women present with PID and STI, including*

Table 3. Quantitative Representation of Emerging Themes During the Focus Group Discussion and Interviews and the Number of Quotations (n) by Camps Among the Study Participants

Theme/Sub-theme	Camps With SRH Service Facility (n)	Camps With No SRH Facility (n)	Interviewed Participants (n)	Total (N)
SRH issues faced in the camp				
Vaginal infections/STIs	13	15	4	32
HIV/AIDS	10	11	4	25
Unwanted pregnancy	13	8	4	25
Stay in camp and SRH				
Increase incidence of SRH issues (HIV/AIDS, unwanted pregnancy, lack of money, food, and shelter)	8	9	4	21
Increased vulnerability of women (lack of money, food, and shelter)	11	9	6	26
Better access to SRH service interventions	12	5	4	21
Challenges associated with access and utilization of SRH services				
Male involvement				
Partner support/approval to take up services	11	10	3	24
Lack of trust in relationships	6	9	0	15
Shame, fear, and stigma				
Fear of being seen with another person's partner, rape, and shame of being pregnant	8	5	1	14
Stigma related to diseases/use of service	11	7	3	21
Healthcare-related factors				
Poor knowledge about the SRHR services	8	8	2	18
Distance to facility	3	13	4	20
Unavailability of SRHR services/commodities in camps	5	14	5	24
Communication gaps	10	5	0	15
Healthcare workers' attitude	9	3	0	12
Insufficiency in time spent with healthcare worker	6	1	0	7
Lack of finance	11	15	3	29
Distance to facility	1	12	5	18
Religious/cultural				
Availability of alternative healing option	10	7	3	20
The desire of many children	9	5	2	16
Influence of pastors and native doctors	6	3	5	14
Migration				
Search for farming/other opportunities	3	1	4	8
Political/government/NGO interventions				
Timing of interventions	3	3	5	11
Short-term service provisions	1	0	3	4

Note. SRH: Sexual and reproductive health; STI: Sexually transmitted infection; HIV/AIDS: Human immunodeficiency virus/acquired immunodeficiency syndrome; SRHR: Sexual and reproductive health and rights; NGO: Non-governmental organization.

Table 4. Quantitative Representation of Emerging Themes Among the Women by Age Group During the Focus Group Discussion and the Number of Quotations (n) by Age Group

Theme/Sub-theme	15–24 Years (n)	25–34 Years (n)	≥35 Years (n)	Total (N)
SRH issues faced in the camp				
Vaginal infections/STIs	4	13	11	28
HIV/AIDS	7	8	6	21
Unwanted pregnancy	6	8	7	21
Stay in camp and SRH				
Increased incidence of SRH issues (HIV/AIDS, unwanted pregnancy (lack of money, food, and shelter)	2	7	8	17
Increased vulnerability of women ((lack of money, food, and shelter)	6	7	7	20
Better access to SRH services interventions	4	7	6	17
Challenges associated with access and utilization of SRH services				
Male involvement				
Partner support/approval to take up services	5	7	8	21
Lack of trust in relationships	9	5	3	15
Shame, fear, and stigma				
Fear of being seen with another person's partner, rape, and shame of being pregnant	8	4	2	13
Stigma related to diseases/use of service	7	5	8	18
Healthcare-related factors				
Poor knowledge about the SRHR services	5	6	7	16
Distance to facility	3	8	6	16
Unavailability of SRHR services/commodities in camp	4	8	7	19
Communication gaps	6	5	6	15
Healthcare workers' attitude	8	3	3	12
Insufficiency in time spent with healthcare worker	4	2	3	7
Lack of finance	7	9	10	26
Distance to facility	4	4	5	13
Religious/cultural				
Availability of alternative healing option	1	7	8	17
The desire of many children	0	6	7	14
Influence of pastors and native doctors	1	3	4	9
Migration				
Search for farming/other opportunities	0	1	2	4
Political/government/NGO interventions				
Timing of interventions	0	4	2	6
Short-term service provisions	0	1	1	1

Note. SRH: Sexual and reproductive health; STI: Sexually transmitted infection; HIV/AIDS: Human immunodeficiency virus/acquired immunodeficiency syndrome; SRHR: Sexual and reproductive health and rights; NGO: Non-governmental organization.

HIV. They don't protect themselves. There are also instances of unwanted pregnancies. It's also common to see aborted fetuses in camps" (IP4 Health Worker, Daudu Camp 3).

Stay in Camp and SRH Issues

According to the women, their stay in the camp increased the incidence of SRH issues, their vulnerability, and the incidence of SRH issues; however, many quotations acknowledged better SRH access to camps with health facilities. One respondent mentioned, "*When we were in our community, we hardly needed to visit the clinic because of infections or other women's problems*" (G2Ap8, 28 years). Another respondent stated, "*At least, here we have hospitals close to us, which is an advantage because some services are free*" (D3G2p1, 25 years). Their increased vulnerability was likened to a lack of food and other necessities.

For the women, interventions to relieve hunger also increased their vulnerability, as men promised palliatives in exchange for sex. "*We do not have money or even food. If they don't give us food, we won't eat. Some women here offer themselves and their children's bodies to men in exchange for food or money*" (G3D3P2, 45 years).

Another woman in the camp with a facility declared, "*When they want to share "Nkwanbe"* (cards for palliative food*), they will come and tell us to sleep with them so we can have one. It's a once-in-a-while opportunity. Some women fall for it, although we have been warned not to listen to such people*" (G2D1P7, 34 years).

Challenges Associated With Access and Utilization of SRH Services

Lack of Finance

According to Table 1, the most significant barrier to using and gaining access to SRH services was a lack of finance (n = 26). Based on the findings (Table 2), this theme was more prevalent among those living in camps without facilities (15/29) and women over the age of 35 (10/26). According to a respondent in Abagena, *"If you have a problem or are diagnosed with one, they sometimes will tell us to go and pay and buy drugs. Where do we get the money from?"* (A1G2p8, 28 years).

Lack of Partner Support

Lack of partner support (n=24) was cited more frequently by respondents who lived in camps with facilities (11/24) and women aged 25 and older (15/19). This affected the uptake of services where sexual contact was requested. The women also mentioned that their husbands needed to give them authority to use or access services. One woman stated, "*Most times we are asked to come along with our partners/ husbands for treatment. I am not sure of how my partner will react if I tell him that I have an infection or that we are needed at the facility for treatment*" (D3G2p1, aged 25).

An interviewed respondent added, "*I remember during one community dialogue in the chiefs' compound, the nurse was saying that women who are diagnosed with HIV don't receive care because their husbands tell them that the diagnosis is false. Some of them won't care because if they ask their husbands, they will be driven from home.*" (Ip7 INGO representative).

Unavailability of Sexual and Reproductive Health Service/ Commodity

Interviewed stakeholders cited a deficiency in SRH services and commodities as one of the most significant obstacles to the provision of services, even when they had the relevant training. This affected the provision of services, such as cervical cancer screening. According to a health worker, one of the women in the camp with a health facility indicated that the unavailability of commodities prevented them from further accessing the services, as what was needed was usually unavailable.

> "*Some services are not available; although some of us were trained on cervical cancer screening, they have not provided us with the commodities to do the screening…*" (Ip4 health worker, Daudu Camp 3).
>
> "*If you go there most times, they will say things are not available for treatment or testing. So, I would rather not go*" (D1G1 P5).

According to another woman, the unavailability of certain commodities prevented the use of other services such as condoms, "*There used to be lubricants, but they don't come again. I prefer using condoms with lubricant since they used to wound me.*" (D3G3p5, 39 years). The unavailability of condoms was also cited in the camps with no SRH facilities. One woman mentioned, "*Sometimes condoms are not available…*" (O1G1p4, 21 years).

Shame, Fear, and Stigma Related to Diseases/Use of Services

Stigma related to diseases or the use of services was a prevalent expression among respondents residing in camps with an SRH-providing facility (11/21), especially those under the age of 25 (7/18) and over the age of 35 (8/18). For younger participants, it prevented the use of HIV services.

According to a 22-year-old participant residing in one of the camps with a health facility, "*Sometimes people are sick and are afraid to get an HIV test because it is a horrible disease here*" (D1G1 P5).

This challenge was also noted by stakeholders as one that affected access and use of SRH services such as HIV post-exposure prophylaxis (PEP), contraception services, and other SRH services. According to one of the respondents, "*… some who are raped are ashamed to report, mostly because of fear and/or stigma, especially the younger victims. How will you get them to use PEP if you don't know they were raped? Also, you will hardly find these younger girls coming for family planning, but you will find them getting pregnant. I think it is probably because they feel ashamed to come for it*" (Ip7 INGO rep).

Another respondent stated, "*When some of the younger women realize they are pregnant, they won't seek medical help for abortion services, probably because they are ashamed or can't care for the child. We only know that they were pregnant if they were rushed to the facility after attempting an abortion through some funny means*" (Ip1 healthcare provider).

According to another younger lady, the stigma associated with HIV/AIDS prevented them from accessing or using HIV testing services. "*We call it "ANAKADE." If you have this disease, people will avoid you, so people prefer not to get a test or deny they may have it so they won't be stigmatized…....*" (D1G1 P5 22 years).

Cultural and Religious Challenges

The influence of native doctors and pastors was cited primarily by women over 35 (4/8) and the interviewed stakeholders (4/9). To them, the availability of alternative treatments prevented the use of SRH services, as they believed it was a more effective and safer option.

According to the NGO rep, "*There are pastors in the community who claim they can heal all diseases, including HIV. Many women have buried their ARV because the man of good said they were healed and should bury their medication*" (ARV. I10 NGO rep).

Women also seemed to believe that native medicines were better options than modern contraceptive options. A 28-year-old respondent mentioned, "*There is a native treatment that can stop a woman from getting pregnant. These are better than the ones in the hospital. Some of us are using it, and there are no side effects*" (A1G2p6 28 years).

Another cultural challenge was the desire for many children, which hindered the uptake of contraception.

According to a blockhead, "*Having children in the TIV tribe is a good thing, which is why women can give birth to as many as 12 children. If you don't give birth to children, the man will marry another wife*" (Ip4 Daudu camp, 3 blockheads).

Migratory Nature of the Respondents

The migratory nature of the respondents was primarily cited as a barrier by participants residing in camps with SRH health facilities (3/8). This was also a frequently cited phrase by interviewees (4/8). According to the respondents, their migratory nature affected their access to and uptake of SRH services. A search for farming opportunities was the primary reason for migration. One woman stated, "*We can only use the service when we are here because most of it is free; when we travel to a farm, we don't have free hospital services*" (D3G3 P2, 41 years).

For the healthcare worker, migration was seasonal and affected the use of services during the migration periods. Farming was a major occupation for the people, and most of them used their farming skills to search for jobs in neighboring states. This caused missed appointments for SRH services, including HIV services.

> "*Most of the inhabitants of this camp are not stable. You will think that because they are resettled, they should be here year in and year out, but that's not the case. They usually migrate to other places to look for work. It's a seasonal kind of migration. They go to look for farm work in Kogi, Nasarawa, and other places during the planting season, which is sometimes around April or May. Another time for migration is during the harvesting season. So, if you give them an appointment during this period, they won't make it*" (Ip4 healthcare worker, Daudu Camp 3).

Lack of Trust in Sexual Relationships

This challenge primarily erupted among women under the age of 25 who reported a lack of trust in sexual relationships (9/15). Lack of trust prevented the use of services that required the women to come along with their partners. For the women, being in multiple relationships or having a partner who had another partner prevented them from seeking care, especially when the partner was also needed for treatment.

According to one young lady, "*The nurse will tell us to come with our partner/husband but we are not confident about these men dating us. Sometimes it's a secret because they tell us not to tell anybody*" (D1G1p3, 18 years).

Another respondent recounted a story. She mentioned, "*There is a story of a young girl who was sick, and her partner took her to the hospital for treatment. The wife of the man saw them and started beating her. This has made many young people hide the man they are dating. You don't know who will attack you on your way to the hospital*" (D3G1p7, 18 years).

Healthcare Worker-Related Challenges

Many more quotations arose from younger participants expressing dissatisfaction with communication patterns in which lay community workers were used as translators, along with considering the attitudes of healthcare workers and the limited amount of time they spent in consultation with the service provider. For most women, having a direct communication channel, less judgmental attitudes, and a longer time to interact with the practitioner would have been more satisfactory and would have improved their use of care services.

According to a 17-year-old resident in a camp with a health facility, "*In our facility, some of the healthcare providers do not speak our local language; they use an interpreter, who is usually one of us. Sometimes we are not comfortable sharing the problem with a third party. If you have a secret, they may go and tell the others in the camp*" (D1G1p1).

In addition, the women stated that they were sometimes blamed for having an infection, which discouraged them from seeking help if they needed it. According to a 26-year-old respondent who was unsatisfied with the healthcare workers' attitude, "*The infection we are having is not our fault, but we are blamed for always having infections because they say we don't use condoms. I went to the clinic to complain, and it was my third time. I am sure that I am getting it from the toilet. The health worker said I am always infected and am careless. I felt ashamed, and I decided not to go there again*" (D3Gp2, 26 years old).

Insufficient time between a care provider and patient was a remark that arose most frequently for women under 25 (4/7). It discouraged most of them from seeking health care. Prior to administering the treatment, they were not allowed to express themselves. According to a forty-year-old female, "*I once went to the clinic when I was sick. I had not even finished talking, and the nurse wrote my medicine. I told her I wanted to ask her something, and she said many people were waiting*" (D3G3 p8 40).

Poor Knowledge of Sexual and Reproductive Health Issues

Certain SRH concepts were insufficiently understood by women. They were unable to utilize a service due to a lack of understanding and familiarity with a specific intervention. A woman in a position of authority stated that women's reluctance to utilize services such as cancer services was due to a lack of knowledge about an SRH intervention. According to her, "*One time they came for the cervical cancer screening, they did not explain it to us as they do now. Most of us thought they could steal our wombs. Some women said they used something to remove their wombs. For this reason, we are scared of some of these people who come for some of these types of screenings*" (Ip8 Woman Leader/Block Head, Daudu Camp 1).

On some occasions, women were treated without adequate information about the treatment. This resulted in poor adherence. "*My child was raped, and they gave her plenty of medicine to take for a long time. We don't even know what it is for. I had to force her to take it every day; she kept saying she wasn't sick*" (A1Gp3, 38 years).

For services such as contraception services, poor knowledge, along with misconceptions about the services, prevented uptake. A woman expressed the view that "*What's the need to get family planning when there are lots of complaints about it? It doesn't even work well*" (D3Gp2, 26 years old).

Short-term Service Provision Due to Political/Government/ Non-governmental Organization Interventions

The majority of interviewees cited political events and short-term interventions as impediments to the continued utilization of SRHR services (3/4). Respondents interviewed for the study reported some short-term interventions that increased service utilization and diagnosis for some ailments. However, some of these ailments were not treated or referred for further treatment. "*During political events, they will do screening, and those diagnosed will be left unattended to. A woman was diagnosed with cervical cancer during a screening; sometimes no further help was given to her. Even those with lesions were not treated*" (Ip4 healthcare worker, Daudu Camp 3).

Additionally, NGOs provided a few limited supplies. Consequently, there were typically periods of unavailability that impacted service utilization. "*Our major source of resources is the NGOs. The government provides certain commodities that are for reproductive health. For example, it was an NGO that used to give us HIV testing kits… Since they left, you will have to go to other facilities to test. Sometimes, it costs money. I think the government needs to put more efforts into the provision of sustainable reproductive health services and even general healthcare services at the camp*" (Ip2 camp captain Abagena).

Discussion

The purpose of the study was to evaluate SRH challenges in displaced people's settings. It investigated types of SRH issues, the effects of the women's stay in the camp on their SRH, and their difficulties in gaining access to and utilizing SRH services. The most frequently mentioned SRH concerns among women were vaginal infections and/or STIs, their vulnerability due to a lack of resources, the unavailability of SRH services, the stigma associated with SRH service use, and a lack of partner support. Numerous studies in Africa and Nigeria have found a high prevalence of STIs among displaced populations (9,10). Their high risk of STIs has been attributed to factors such as poor SRH knowledge, sexual violence, and limited access to healthcare (11). It is worth noting that the majority of quotations about this challenge came from women aged 25–34. This could be because this age group is more likely to be sexually active.

Our findings revealed that living in the camps increased SRH challenges and vulnerability. The women specifically explained that they could engage in sexual activity in order to obtain necessities such as food and shelter. Notable was the fact that palliative sharing increased their vulnerability, as some women were likely to give sex in exchange for coupons "*Nkwanbe*". This indicates that proper coordination is required in displaced settings for the provision of incentives/palliatives to minimize transactional sex. There is also a need for comprehensive sex education that advocates for "pleasure sex", which promotes sex-positive education that focuses on the joyful, pleasurable aspects of sex, such as willingly choosing to engage in sex (12,13) and not being coerced. This principle has been shown to prevent more unsafe sexual activity and may be useful if applied in this setting. Numerous studies have reported that displacement has increased the vulnerability of women due to overcrowding, poverty, a lack of privacy, and lack of social support systems (14,15). These are conditions that exist in study settings such as ours.

Along with the poor knowledge about SRH, our study identified numerous challenges impeding access to and utilization of SRH services among women. Lack of finance was a quotation that arose more than two dozen times, and more so among residents in camps with no SRH facility. Women with limited financial resources may be unable to afford transportation to health facilities, consultation fees, or essential SRH commodities (16). This barrier is more prevalent in displaced settings, especially where transportation is needed to access healthcare facilities. In most African societies, partner support is crucial to ensuring access to and use of SRH services (17). In our study, most women reported that their partners' approval was required to utilize or access services. This was a notable quote among women aged 25 and older. This can be attributed to the fact that the majority of women in this age group are in a relationship. In addition, young women acknowledge a lack of trust in relationships due to the polygamous nature of their partners. This type of relationship may be kept secret due to social and cultural norms in society (18). In a study by Casey et al (18), such relationships prevented women from seeking care when their partners were needed to accompany them. This study goes a long way toward demonstrating the impact of social and cultural norms on SRH service utilization. This barrier could be overcome by addressing gender dynamics and involving men in displaced settings in SRH education and support programs.

In addition to these factors, women and stakeholders reported that certain SRH services and products were unavailable. Women's use of essential SRH services, such as cervical cancer screening and access to condoms, can be significantly hindered by the limited availability of these services (19). Thus, there is a need to ensure a consistent and adequate supply of SRH supplies and strengthen health systems to provide comprehensive SRH services in displaced settings.

Similar to other studies conducted in Africa, adolescents and young adults are disproportionately affected by shame, fear, and stigma associated with diseases and the use of services (6,20). Shame and stigma have impeded HIV service utilization and disease denial. Studies have also

demonstrated that shame prevents women from utilizing contraception services, which can result in unintended pregnancies (21). In our study, many victims of rape did not seek care, likely due to shame; this could lead to an increase in SRH issues due to a lack of preventive services, such as PEP, emergency contraception, and STIs, including HIV. Previous research indicated that awareness of PEP and emergency contraception services is generally low in low-resource settings such as ours (22), which may be exacerbated in situations of displacement.

It has been discovered that cultural and religious influences have a significant role in shaping behavioral patterns connected to the utilization of health services (6,23). African traditional knowledge systems permit the application of conventional medical treatments (24). A culture similar to that of the study population may support the idea that women give birth to many children (25). Additionally, the impact of religious convictions on the use of SRH services such as HIV treatment and contraception services has been reported in the literature (6,26).

The migratory nature of the respondents affected their ability to get consistent care and the uptake of intervention within the camp. This was particularly evident during the planting and harvesting seasons, when women prioritized their farms over healthcare appointments. This finding highlights the need for programmers to adopt flexible and adaptable SRH services to accommodate mobile lifestyles while taking into consideration the unique cultural and economic factors that influence the lives of displaced persons when designing and implementing SRH interventions. The government and other stakeholders can consider providing land for "community" or "collective" farming opportunities where displaced women within the camp can come together to farm. This approach allows for shared resources, including sharing labor and knowledge, promoting cooperation and mutual support among community members, enhancing food security, promoting sustainable agriculture practices, and fostering social cohesion (27,28). This initiative can be used as a platform to sustain agricultural activities, gender equality, and education and awareness campaigns on SRH, thus promoting SRH service usage.

The findings of this study outline health worker-related challenges, such as language barriers, negative attitudes of healthcare workers, and insufficient consultation time, which have been noted in similar studies in Africa (29,30). Although the use of lay community volunteers is a common practice, some displaced populations, such as those in this study, have continued to express concerns about their trust in communicating their personal challenges through a third party (29). This study also emphasizes the importance of sufficient time allocation for patient-provider communication to address SRH concerns. Considering that the women showed poor knowledge about some SRH concepts, allocating adequate time to counseling them and using simple-to-understand language may improve SRH service uptake. The need for healthcare providers to be culturally and linguistically competent in order to effectively serve displaced populations is essential.

According to the participants, some SRH interventions were performed during political events to help diagnose women of ailment, but no treatment was provided due to the short period of the intervention. This finding suggests that there is a need for consistency and sustainability in government. It further underscores the need for consistent and sustainable government support in the provision of RH services to displaced populations. It is also necessary for implementing partners to consider a comprehensive approach when addressing various barriers to the use of RH services.

Limitations

The study used purposive sampling to select the camps and participants, which may have affected the comprehensiveness of the research and depth of the investigation considering that some participants in certain locations were not reached. This also limits the generalizability of the research. Considering that the research focused on a relatively sensitive topic, some participants did not feel comfortable sharing sensitive information. This was particularly noted among the much younger participants.

Conclusion

The findings of our study revealed the unique challenges SRH women in displaced camps in Benue State face, including STIs, increased vulnerability due to living conditions, and numerous barriers to accessing and utilizing SRH services. Based on our findings, there is an urgent need for comprehensive sex education that discourages transactional sex, improved access to SRH services, and the involvement of men in SRH health programs. It is also necessary for programmers to address cultural and religious influences, ensure a consistent and adequate supply of SRH supplies, and strengthen health systems to provide comprehensive SRH services in displaced settings. To facilitate an understanding of complex concepts, health providers in these contexts must be taught to be linguistically and culturally competent, using clear terminology and demonstration techniques for health education/communication. The study provides valuable insights that can inform the design and implementation of effective interventions to address SRH challenges in displaced settings.

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Authors' Contribution

Conceptualization: Atenchong Ngwibete, Akinyinka Omigbodun, Olayinka Oladunjoye Ogunbode.
Data curation: Atenchong Ngwibete.
Formal analysis: Atenchong Ngwibete.

Funding acquisition: Atenchong Ngwibete.
Investigation: Atenchong Ngwibete, Akinyinka Omigbodun.
Methodology: Mobhe Agbada Mangalu, Atenchong Ngwibete, Akinyinka Omigbodun, Olayinka Oladunjoye Ogunbode.
Project administration: Atenchong Ngwibete, Akinyinka Omigbodun.
Resources: Atenchong Ngwibete, Akinyinka Omigbodun.
Supervision: Mobhe Agbada Mangalu, Akinyinka Omigbodun, Olayinka Oladunjoye Ogunbode.
Validation: Mobhe Agbada Mangalu, Atenchong Ngwibete, Akinyinka Omigbodun, Olayinka Oladunjoye Ogunbode.
Visualization: Mobhe Agbada Mangalu, Atenchong Ngwibete, Akinyinka Omigbodun, Olayinka Oladunjoye Ogunbode.
Writing–original draft: Atenchong Ngwibete.
Writing–review & editing: Mobhe Agbada Mangalu, Atenchong Ngwibete, Akinyinka Omigbodun, Olayinka Oladunjoye Ogunbode.

Competing Interests

The authors have no conflict of interests associated with the material presented in this paper.

Ethical Approval

Ethical approval was obtained from the Ethics Committee of UI/UCH Ibadan (UI/EC/22/0020). Further approval to conduct the screening activity and research was obtained from the State Ministry of Health. Administrative clearance to collect data from the internally displaced in the camps was obtained from the Benue State Emergency Management Agency (BENSEMA) Office. The researcher also sought further approval from the camp captains. Each woman or interview stakeholder also consented to participate in the study. To maintain the principle of anonymity, the manuscript presents the findings of the study using participant-given codes to demonstrate findings and themes that reflect the respondents' perspectives on their challenges to the SRH concepts under investigation.

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