Addressing GBV & SRHR Challenges in Bama and Dikwa LGAs in Borno State, Northeast Nigeria

Project Baseline Report

CARE International in Nigeria

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Executive Summary

Borno state in Northeast Nigeria has been under frequent attacks in the past decade, which has left several million people insecure, homeless, and without any means of livelihood. Hence, the rate of Gender-based Violence (GBV) continues to increase coupled with lack of awareness and basic infrastructure for promoting Sexual and Reproductive Health and Rights (SRHR). To alleviate the challenges faced by several inhabitants of these conflict-affected communities, CARE is implementing a SRHR and GBV project to reach 47,000 vulnerable boys, girls, men and women, living in Internally Displaced Person (IDP) camps and host communities in Bama and Dikwa Local Government Areas (LGAs) in Borno State. This report highlights the current gaps in GBV and SRHR in Bama and Dikwa LGAs to serve as benchmark for measuring progress and guide implementation of the right intervention mix.

In October – November 2019, CARE Nigeria conducted a baseline survey for the project. The study involved administration of Knowledge Attitude and Practice (KAP) questionnaires as well as Focus Group Discussions (FGD) and Key Informant Interviews (KII) covering SRHR and GBV to randomly selected men, women, boys and girls in the project communities. Among the interviewed were; community members, representatives of security agencies, camp coordinator and health facility staffs respectively, in Dikwa and Bama LGAs in Borno State. A total of 79 FGDs and 46 KIIs were conducted, in addition to the quantitative survey involving 3,112 participants. In comparison, there was 43.5% males, 56.4% females and 0.1% respondent who preferred not to disclose their sex respectively. 40% of the respondents interviewed were from Bama LGA while 60% were from Dikwa LGA. Furthermore, the distribution of residential status also differs by sex of respondents. Results showed that the proportion of female respondents interviewed from both host communities and IDP camps were 56% more as can be seen in comparison with respective male respondents 44%.

It would be observed that throughout the survey, respondents in Bama were more confident and aware of services and information regarding SRHR and GBV than Dikwa. This is mostly due to the impact of humanitarian actors currently implementing GBV and SRHR in Bama, coupled with a well-structured and coordinated health system that includes working LGA-based health administration supported by both humanitarian organizations and the Government. Also, CARE has an ECHO-funded sister project implementing a stand-alone GBV response, with improved feeling of safety as well as protection mainstreaming as a key outcome indicator of the project. In addition, as at the time of the survey, Bama had access to radio broadcast coverage, which makes the inhabitants benefit from messages on GBV and SRH from diverse sources. The impact of various implementing partners can be seen from the responses from Bama, which is not the case for Dikwa, where GBV programming has little to no humanitarian representation. Bama shares border to the right with Cameroon and this exposes residents to development and economic stability more than residents in Dikwa who rely on spills from Bama or Maiduguri.

Baseline Indicators

While the baseline study also aims, secondarily, to provide vital KABP information on the nature of SRHR and GBV in the project location and Northeast at large, its primary aim was to provide baseline results to the key outcome indicators of the project. These outcome indicators include:

- % of targeted population (m/f) reporting feeling safer following the implementation of GBV and SRHR interventions
- % targeted people (m/f) who report increased ability to meet their basic needs

- Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
- % of people (m/f) who report increased awareness of how to access GBV services

All indicators had predefined guidelines governing both their collection and analysis.

% of targeted population (m/f) reporting feeling safer following the implementation of GBV and SRHR interventions

To meet the criteria for this indicator, respondents had to report feeling safe or very safe in three situations: 1) going out alone; 2) inside the household; 3) undertaking a job outside the HH. The results showed that currently 38% of the targeted population feel safe, while the results were slightly higher for men at 42% compared to 34% for women. The results showed that 66% of respondents feel safe at home with little variation between men and women. More men than women feel safe to undertake a job outside the household at 60% for men compared to 46% for women. Overall 52% of respondents feel safe to go out alone with men feeling slightly safer than women – 54% compared to 50% respectively.

% of targeted people (m/f) who report increased ability to meet their basic needs

When it comes to basic needs, to meet this indicator, respondents had to agree to be able to satisfy the basic level of need you have to survive in terms of food, water, sanitation, hygiene, shelter, healthcare. At the time of the survey, basic need was defined as what each person/household primarily needs to sustain life. The result showed that currently 54% of people are able to meet their basic needs. The result can be seen to be slightly higher for women at 55% compared to men at 52%. The results varied slightly between LGAs with 60% able to meet their basic needs in Bama compared to 50% in Dikwa.

Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

The baseline study showed that currently 13% of women aged 15-49 made their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. This varies by LGA, with a higher proportion of 22% reporting making their informed decisions in Bama compared to Dikwa where only 7% reported the same. To meet the criteria for this indicator, respondent had to correctly to answer 5 out of 7 questions.

% of people (m/f) who report increased awareness of how to access GBV services

The result shows that 59% (60%f, 57%m) report increased awareness on how to access GBV services. It will be important to note that some of the respondents who knew how to access services in the right place also thought they could access in other places (e.g. church, mosque, and police station) which is unlikely. This would be a critical focus for the midline survey to access the change in perception among respondents who chose church, mosque and police station as areas to access GBV services.

The discrepancies in data between Bama and Dikwa is due to the fact that Bama, being a safe haven for most internally displaced persons from other LGAs, with an increased humanitarian burden of SRH and GBV, has in recent times, attracted more humanitarian actors. As a result of this, the population has been able to access information from diverse sources, thus increasing their knowledge about SRH and GBV. Also, Bama has benefitted from the implementation of the CARE ECHO-funded GBV project that is specifically focused on GBV & protection.

Over the past 15 months, this project has set up several structures and undertaken awareness raising drives focused on GBV. The proximity of Bama to Maiduguri also makes it easier for them to access radio information from diverse humanitarian actors, unlike Dikwa, where there is no radio coverage.

Knowledge and Prevalence of Gender Based Violence in the Community

Knowledge of several forms of GBV was higher amongst respondents from Bama compared to respondents from Dikwa, with 72.9% of respondents from Bama identifying marital rape as a form of GBV. About 36.7% of the respondents from Bama LGA believed that GBV is common in their area compared with 13.4% from Dikwa LGA. Overall, 22.8% of respondents from both LGAs reported that GBV is common in their community. Furthermore, 42.8% of respondents from Bama LGA and 8.5% of respondents from Dikwa had at some point, experienced GBV. Hence, 22.3% of respondents from both LGAs have experienced GBV. On existing services for survivors of GBV, 48.4% of respondents from Bama and 13.9% of respondents from Dikwa mentioned Women & Girls Friendly Spaces respectively, while 69% of respondents from Bama and 30.8% of respondents from Dikwa LGA mentioned health facility.

Access to Services

Overall, more than 27% of respondents from both LGAs have received information on at least one health issue. In addition to receiving information on pregnancy complications, 32.4% of respondents from Bama LGA and 67.6% of respondents from Dikwa LGA received delivery kits. Overall, 28.8% of respondents from both LGAs received delivery kits. Knowledge of all different listed methods of contraception was higher in Bama than in Dikwa LGA. About 43% of respondents in both LGAs already belonged to a Sexual and Reproductive Health (SRH)- related community based group across both LGAs. More respondents from Bama LGA (62%) were members of an existing SRH group compared with 30.4% of respondents from Dikwa LGA. Overall, 77.5% of respondents in both LGAs reported access to food, 75.3% reported access to water, 70.1% reported access to health facility while 52.1% reported access to shelter. About 48.8% of male respondents and 50.8% of female respondents reported being able to satisfy basic needs. In addition, 59.9% of respondents from Bama reported ability to satisfy basic needs, higher than the 43.2% of respondents in Dikwa, who provided similar response. Access to food was higher for females in Bama (40.2%) and Dikwa (49.1%) than males in Bama (26.4%) and Dikwa (35.8%). With similar recorded for access to Water, health facilities, Shelter and education.

About 64.6% of respondents from Bama LGA believed going out alone is safe. For Dikwa, 43.6% believed going out alone is safe. Overall, 54.2% of male respondents believed going out alone is safe compared with 49.9% of females. About 69.4% of respondents from Bama LGA and 64.4% of respondents from Dikwa LGA believed households are safe. Similar trend was observed about perception of respondents about taking a job outside the home.

Societal and Gender Norms Influencing GBV

Findings from qualitative studies among community members and health facility workers further corroborated the result of data analysis. The study revealed that Men were perceived as decision makers and expected to take decisions concerning contraceptive use and health-seeking as well. Abortion was considered morally and religiously forbidden. Gender based violence was frowned at, but has not received the right attention by community leadership who are well respected and listened to by members of the community and the law enforcement agencies. The general opinion was that contraceptive is for married women only, and not for single

women and/ girls. Health facilities have competent staffs with capacity to provide family planning services, post abortion care and HIV testing and treatment services, as well as meet the clinical needs of GBV survivors, but are often faced with stock -out of major health & Family Planning commodities.

In conclusion, summary of baseline findings for the project indicators are as follows:

- 34.4% of females and 42.1% of male respondents reported feeling safe
- 50.8% of female respondents and 48.8% of male respondents reported being able to meet their basic needs, while 39.5% of female respondents take decisions about contraception.

Essentially, the target populations in both Bama and Dikwa LGA will benefit from the implementation of the GAC-funded integrated SRH and GBV response interventions and findings from this baseline survey will significantly help inform and guide the program implementation.

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Introduction

Gender-based violence (GBV) is defined as any harmful act that is perpetrated against a person's will and that is based on socially-ascribed (i.e. gender) differences between males and females[1]. It occurs in various forms. According to the Syria Crisis Hub of United Nations Population Fund Report in 2016, there are five categories of gender-based violence and they are: sexual violence (rape, sexual assault), physical violence (slapping, beating), emotional violence, (denial of resources), harmful traditional practices (early child marriages, female genital mutilation (FGM)) and socio-economic violence (denial of opportunities and services). Factors responsible for increased rate of GBV in the society are alcohol, drug abuse, impunity, war, poverty, lack of belief in equality of human rights for all.

In every conflict and humanitarian emergencies, there is an increased rate of GBV. Women and girls are often targeted for special forms of violence by men as a way of attacking the morale of the enemy. This always has double effect on women, first through the initial experience of violence and its aftermath and secondly through the reactions of their families to their status as survivors of sexual crime. Globally, at least one in every three women has been beaten, coerced into sex, or otherwise abused by a man in her lifetime. More than 20% of women are reported to have been abused by men with whom they live with. Over 90 million African women and girls have been victims of FGM. In Nigeria, six in ten women have experienced some form of GBV in Northeast (NE) Nigeria[2]. Prior to the crisis in the NE, GBV prevalence was 30% compared to 28% at the national level. Similarly, sexual violence prevalence was 16% in the NE compared to 7% nationally[3]. In Northeast Nigeria, sexual violence prevalence has increased by 7.7% since the insurgency began in 2009[1].

According to the World Health Organization (WHO), sexual reproductive health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled[4].A person's sexuality encompasses of sex, gender, identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. It can be expressed in a person's desires, beliefs, attitudes, values, behaviors, thoughts, fantasies, practices, roles and relationships, however, not all these forms are expressed. It can also be influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors[4].

Furthermore, in 2016, the United Nations (UN) Committee on Economic, Social and Cultural Rights (CESCR) defined the right to sexual and reproductive health (SRH) as an "integral part of the right to health". Such rights that are fundamental to the realization of sexual health as iterated by WHO include; the rights to equality and non-discrimination, the right to be free from torture or to cruel, inhumane or degrading treatment or punishment, the right to privacy, the rights to the highest attainable standard of health (including sexual health) and social security, the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage, the right to decide the number and

[1] Inter-Agency Standing Committee Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action 2015

[2] *Center for Population and Reproductive Health Ibadan, Nigeria September, 2016; Sexual and Gender Based Violence Assessment in North East Nigeria*

[3] Nigeria Demographic Health Survey, 2013

[4] WHO. The WHO Reproductive Health Library No.9. Oxford: Update Software, 2006. www.rhlibrary.com

spacing of one's children, the rights to information, as well as education, the rights to freedom of opinion and expression, and the right to an effective remedy for violations of fundamental rights[4].

In every humanitarian emergency, the potential for SRHR violation is on the rise. A panel discussion during the 61st session of the commission on the status of women in March 2017, hosted by International Rescue Committee, World Health Organization, Women's Refugee Commission and Columbia University, reports that 65.4 million people are living in fragile settings, displaced from their homes by conflict or persecution, of which an estimated 26 million are women and girls of reproductive age. In such crisis settings, women and girls experience increased levels of exploitation, sexual violence (including rape as a weapon of war) and transactional sex, which can and often does, lead to unwanted pregnancy. To this end, SRHR programs are requisite in curbing its societal menace and Center for Health and Gender Equity (CHANGE) iterates three essential components of sexual and reproductive health care are family planning, sexual health, and maternal health.

To alleviate the challenges faced by several inhabitants of these conflict affected communities in the North-east, CARE and several other humanitarian organizations have been helping to improve access to water, nutrition, and critical lifesaving sexual reproductive health and Gender Based Violence services, among other interventions, with support from local and international donor agencies. CARE International is a global leader within a worldwide movement dedicated to saving lives and ending poverty. CARE is in the process of commencing a Sexual and reproductive Health and Rights and Gender Based Violence project to reach 47,000 vulnerable boys, girls, men and women, living in IDP camps and host communities in Bama and Dikwa LGAs in Borno State.

Through the SRHR component, the project will seek to increase access to lifesaving sexual reproductive health services through strengthening health care facilities and by training health care service providers. The CARE GAC-GBV/SRHR project is a 24- month SRH and GBV prevention /response intervention for crisis-affected women, men, boys and girls in the North-east; with location in Bama and Dikwa LGAs. A baseline survey was commissioned to determine current situation of GBV and SRHR related knowledge, attitude and practices, that will serve as benchmark for measuring project achievement. Findings from the baseline survey are provided in this report.

Purpose of the Evaluation

The baseline survey is aimed at generating insights about the current situation of SRHR and GBV in Bama and Dikwa LGAs to guide program design, implementation and generate empirical data for project monitoring and evaluation and serve as basis measurement of project impact when the phases out.

Specific objectives of the baseline are to determine:

1. knowledge and perception of target respondent on SRHR and GBV
2. proportion of target population who have experienced GBV disaggregated by sub groups
3. availability and distribution of GBV and SRHR services in target communities
4. motivators and barriers of accessing GBV and SRHR services
5. availability of enabling environment to foster reporting of GBV and SRHR violations
6. coverage, functionality and effectiveness of existing GBV and SRHR services

Methodology

This study involved the administration of KAP questionnaire covering SRHR and GBV to randomly selected men, women, boys and girls in project communities in Dikwa and Bama LGAs in Borno State. Focus Group Discussions (FGD) were conducted with girls, boys, men and women groups. Key Informant Interviews (KII) were conducted with community members, representatives of security agencies, camp coordinators and health facility staff.

Sampling Technique and Sample Size

The study was conducted in all the project communities/Camps in Bama and Dikwa LGAs. The stratified random sampling method was employed for sampling of respondents. Stratified random sampling is the technique of breaking the population of interest into groups and then selecting a random sample from within each of these groups. Stratifying the population helps ensure a representative mix from all groups and ensure that enough sample is allocated to all groups. In this case, the project participant for this project were broken down by age (5-18; 19-49 and greater than 50 years). Sample size was obtained using the standard formula for sample size n,

$$n = \frac{\frac{z^2 \times p(1-p)}{e^2}}{1 + (\frac{z^2 \times p(1-p)}{e^2 N})}$$

Where:
Z = Z value is 1.96 at 95% confidence level
e = margin of error, describing the acceptable error rate: 2%,
p = standard of deviation: 50%
N = Population size of the project's project participants: 170,763

Replacing the variable placeholder with numerical values as it applies to this study, a total of 2,368 samples was determined as the sample size for the study. The sample was distributed using probability proportion to size for different age group and sex of respondents.

Data Collection

Service Providers and other staff working with the Implementing Partners constituting 15 females and 9 males served as Enumerators for the baseline survey. In locations where the number of enumerators was not sufficient, volunteers were recruited to meet up the number of enumerators. The enumerators worked under the direct supervision of the CARE M&E team and were responsible for administering the quantitative questionnaires to IDPs, host community members and returnees in Bama and Dikwa, as well as providing important feedback on fieldwork. Enumerators received a one-day orientation prior to the commencement of filed data collection exercise, and data collection was completed in 14 days using open data kit, (ODK) programmed on tablets. Qualitative data collection through administering FGDs, and KIIs, were administered majorly by the CARE mobile clinic service providers who had gone through rigorous training on how to facilitate a focus group discusssion/key informant interview.

Limitations

Shortly before the commencement of the field data collection, a major security incident took place from Armed Opposition Groups(AOGs). This incident negatively impacted the data collection process: it forced the team to re-plan the data collection period. Few days (two days) into the data collection, other humanitarian organizations

implementing food security and nutrition, started distribution activities which distracted participants, who had earlier on given their consent for the duration of the interview, as they did not want to miss out on the monthly food distribution activity. This, to a certain extent, inadvertently, affected the quality of information given by the respondents, especially the qualitative interviews.
Information can also be seen to have socially desirable bias.

Due to time constraints, some questions, especially on contraception and contraceptive methods sought response from women alone, and not men. This was an editing flaw while the questionnaire was being coded into the mobile collection platform; hence there are no comparisons between males and females for contraceptive methods.

Result

Section 1: Socio demographic characteristics of respondents

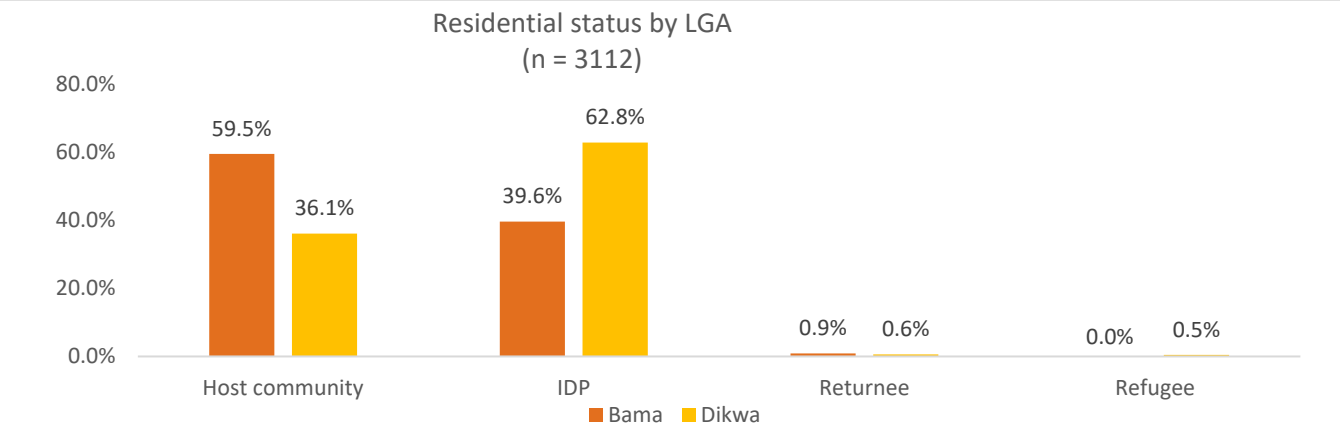
A baseline evaluation of sexual and reproductive health and right and gender-based violence was carried out in Bama and Dikwa LGAs in Borno State. A total of 3112 respondents were interviewed during the study, comprising 43.5% males, 56.4% females and three respondents (0.1%) who preferred not to disclose their sex. About 40% of the respondents were interviewed from Bama LGA, while the remaining 60% were interviewed from Dikwa LGA. Table 1 presents the distribution of respondents by LGA and sex.

Table 1: Number of respondents by LGA and Sex

LGA/Sex	Bama		Dikwa		Total	
	n	%	n	%	n	%
Male	535	42.80	820	44.04	1355	43.54
Female	715	57.20	1039	55.80	1754	56.36
Not disclosed	0	0	3	0.16	3	0.10
Total	1250	100	1862	100	3112	100

Of the 3112 respondents, 45.5% were resident in host communities, 53.5% were resident in IDP camp, 0.7% were returnees while 0.3% were refugees. When residential status was analyzed by LGA, about 60% of respondents interviewed in Bama were residents in host communities, while 39.6% were resident in IDP camps. For Dikwa, 36.1% of respondents were residents in host communities, while 62.8% were resident in IDP camps. Comparing the residential status of respondents by LGA, more respondents were interviewed from IDP camps in Dikwa than Bama, while Bama had more respondents from host communities. In general, 53.5% of respondents were from IDP camps while 45.5% were from host communities. Table 2 provide distribution of respondent by residential status and LGA.

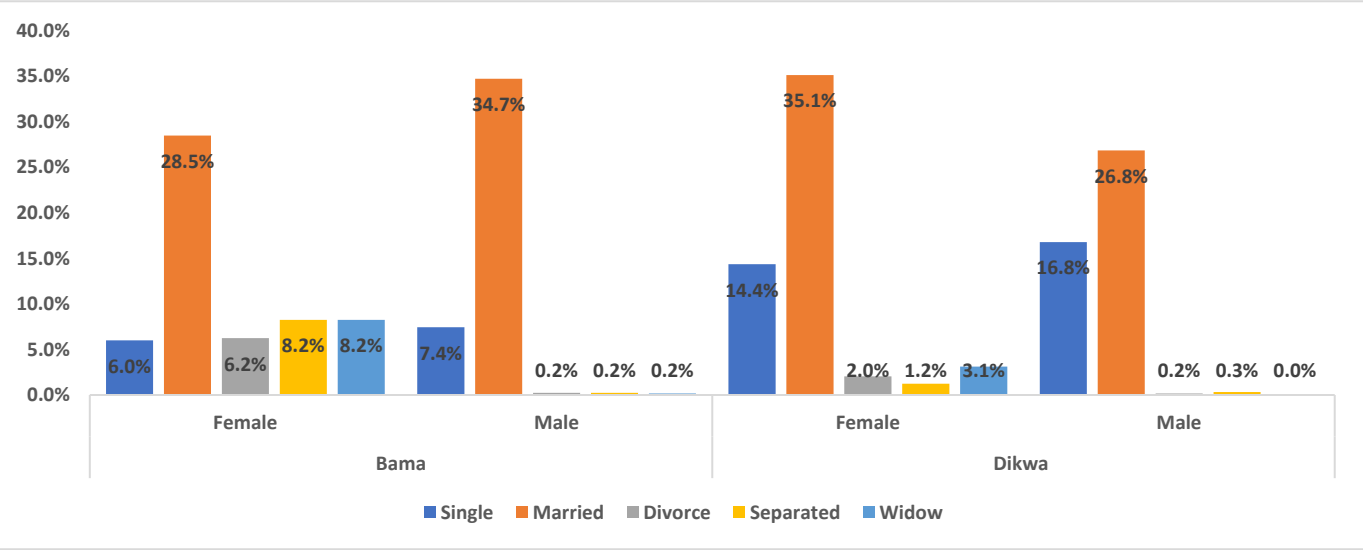
Figure 1: Residential status by LGA



Furthermore, the distribution of residential status also differs by sex of respondents. Results showed that the proportion of female respondents interviewed from IDP camps were about two times (66.7%) more than those interviewed from host communities (33.3%). For males, the difference in number interviewed from IDP camps and

host communities was about 8%, with more males sampled from the IDP camps (53.1%) than host communities (45.3%). Table 3 presents the distribution of residential status by sex.

Figure 2: Marital Status by Sex and LGA



Proportion of respondents (male and female) from both Bama and Dikwa LGAs that were married at the time of the study were males 34.7%, females 28.5% and 26.8%, 35.1% respectively. While 7.4% and 6.0% of both male and female respondents from Bama and 16.8%, 14.4% of both male and female respondents in Dikwa were single. In General, 62.5% of respondents were married and 24.0% were single at the time of data collection. A smaller proportion of the respondents were divorced (3.9%), separated (4.3%) and widowed (5.2%) at the time of the study. Figure 2 present marital status by sex and LGA, more males were married in Dikwa than Bama while more female were married in Bama than male. Table 2 presents the distribution of respondents' marital status by LGA. The distribution of respondents' marital status is similar for both Bama and Dikwa LGAs.

Table 2: Marital status by LGA

Marital status	Bama		Dikwa		Total	
	N	%	n	%	n	%
Single	168	13.44	581	31.20	749	24.07
Married	790	63.20	1,153	61.92	1,943	62.44
Divorce	81	6.48	41	2.20	122	3.92
Separated	106	8.48	29	1.56	135	4.34
Widow	105	8.40	58	3.11	163	5.24

About 26.4% of respondents younger than 18 from Bama were married compared with 73.6% of same age in Dikwa.

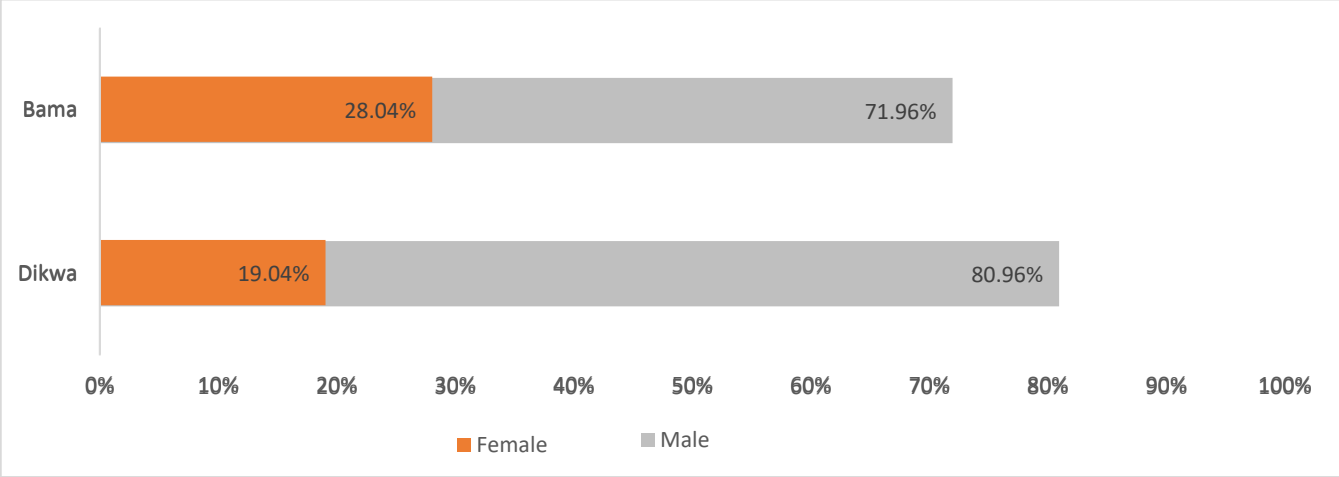
Overall, 55.4% of respondents were head of households. Of these, 65% were from Bama LGA while 49% was from Dikwa LGA as displayed in table 3.

Table 3: Is Respondent head of household

LGA	Yes		No		Total	
	n	%	n	%	n	%
Dikwa	912	49.01%	818	43.95%	1,861	100%
Bama	814	65.12%	912	49.01%	1,250	100%
Total	1,726	55.48%	1,245	40.02%	3,11	100%

Table 5b present household head by sex. Result showed that there were more female headed households in Bama than in Dikwa LGA.

Figure 3: Head of household by sex



In Bama and Dikwa LGAs, the average number of individuals living in a household was 5.7 and 5.1 with a standard deviation of 3.5 and 3.2 respectively. Overall, the average number of persons in a household was 5.3 with a standard deviation of 3.4 as displayed in table 6. The minimum number of persons per household was one (1) while the maximum number was 36 for Bama and 66 for Dikwa. It can be noted that the maximum number in a household is high, this is mainly due to frequent migration into the project location, migrants coming from the same location and are seen as extended family members tend to stay with relative in new locations, while others who do not have relatives are combined mostly in camps due to insufficient shelter aid.

A household[4] is defined as a person or a group of persons, related or unrelated, who live together in the same dwelling unit, who make common provisions for food and regularly take their food from the same pot or share the same grain store, or who pool their income for the purpose of purchasing food.

[4] Definition of household was gotten from The Demographic and Health Survey (DHS).

Table 4: Average Number of individuals living in the household

LGA	Average Number of individuals living in the household	Standard deviation
Bama	5.7	3.5
Dikwa	5.1	3.2
Average	5.3	3.4

More respondents had primary-level education in both Bama (37%) and Dikwa (42.9%) than secondary and tertiary education. Also, more male respondents had primary-level education (23%) than female (14%) while in Dikwa, a reverse can be seen where more female respondents had primary-level education (23%) than male (19.9%). For secondary education, while Bama had equal proportion of male and female respondents with secondary-level education (18%), for Dikwa, male respondents had slightly more secondary-level education (13%) than females (11%); the same can be seen across tertiary-level education with male respondents having more education than females. (Bama females 4%, males 8%, and Dikwa 1% females and 2% males). It should be noted that out of total respondents, more respondents in Dikwa (54%) had education than Bama (46%), which is a clear indication that the selection process was done randomly without bias.

Figure 4: Bama- level of education by sex

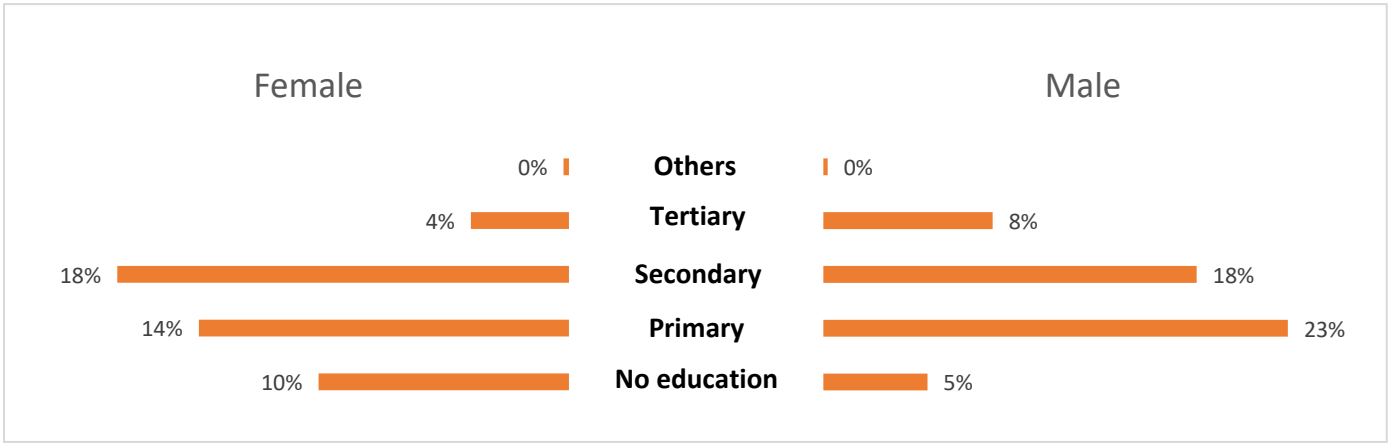
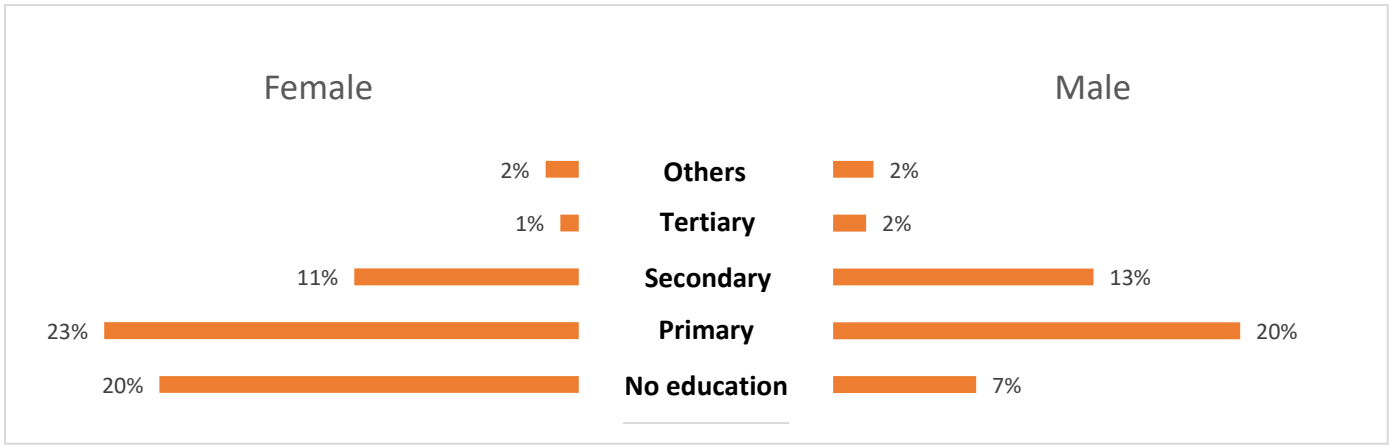


Figure 5: Dikwa- level of education by sex



Similarly, ability to read and write vary by LGA. About 67.5% in Bama and 79.7% in Dikwa could neither read nor write at the time of the study, while 21% of respondents in Bama and 10.7% of respondent in Dikwa could read and write. Others could read only. Overall, about 75% of all the respondents interviewed could neither read nor write, 10.3% could read only while only 14.9% could both read and write as displayed in table 8.

Result showed that 80.4% of female respondents could neither read nor write, 9.3% could only read, while 10.3% could read and write. However, about 20.8% of male respondents could read and write compared with 10.3% of female, while 11.7% of males could only read, and 67.5% could neither read nor write, as displayed in table 8. Of the three respondents who did not disclose their sex, one could read and write while two could neither read nor write.

Table 5: Ability to read and write by LGA and Sex

Ability to read and write	**Bama**		**Dikwa**		**Total**	
	Female (%)	Male (%)	Female (%)	Male (%)	Number	%
Neither read nor write	545 (76%)	299 (56%)	866 (83%)	616 (75%)	2,326	75%
Read only	73 (10%)	70 (13%)	90 (9%)	88 (11%)	321	10%
Read and write	97 (14%)	166 (31%)	83 (8%)	116 (14%)	462	15%

Access to basic food and Non Food Items (NFI) differ by item, as well as by respondent in LGAs. For instance, 84.9% of the respondents in Dikwa reported access to food compared with 66.6% in Bama, while 79.5% of respondents from Bama LGA reported access to water compared with 72.4% in Dikwa. About 80% of respondents in Bama LGA reported access to health facilities compared with 63.2% in Dikwa. Access to shelter in Bama (52.8%) is similar to the Dikwa (51.6%). Access to education was higher in Bama (72.4%) compared with Dikwa (54.3%). Overall, 77.5% respondents in both LGAs reported access to food, 75.3% reported access to water, 70.1% reported access to health services, while 52.1% reported access to shelter as displayed in table 9.

When access to basic food and NFI was compared by sex, more females reported access to food (80.7%), water (80.2%), health services (74.1%), and education (62.5%) compared with male respondents. While access to shelter is almost the same for males (53%) and females (51.3%). Of the three respondents who did not disclose their sex, two had access to most of the food and NFIs while one did not.

Key Outcome Indicator (KOI)

While the baseline study also aims, secondarily, to provide vital KABP information on the nature of SRHR and GBV in the project location and Northeast at large, its primary aim was to provide baseline results to the key outcome indicators of the project. These outcome indicators include:

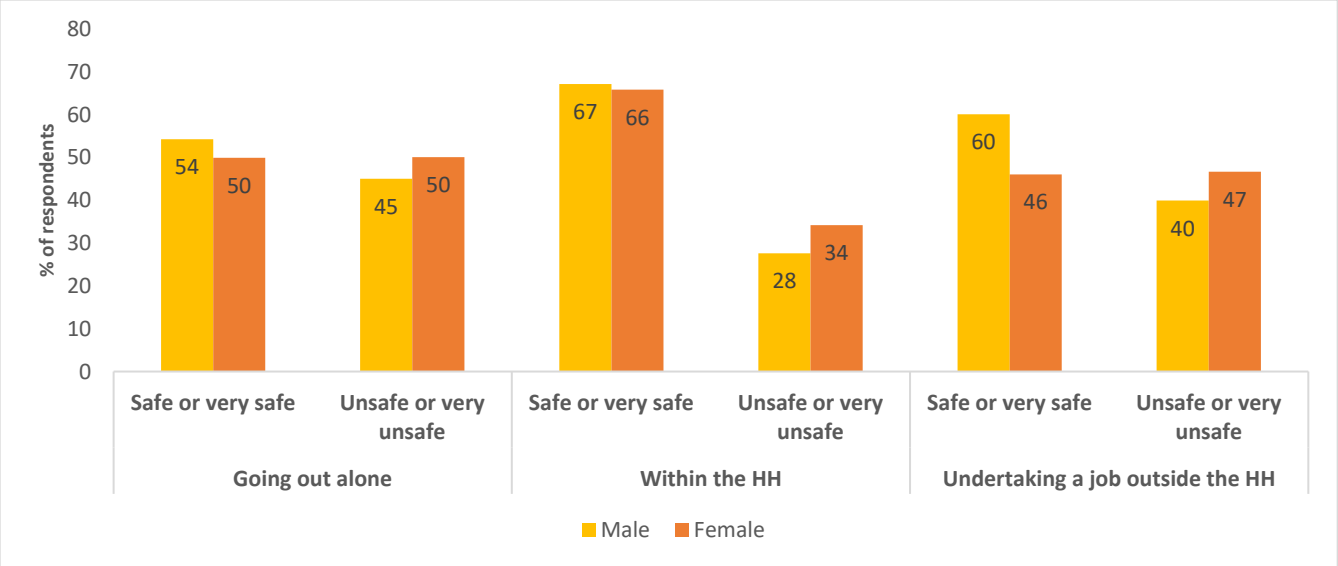
- % of targeted population (m/f) reporting feeling safer following the implementation of GBV and SRHR interventions
- % targeted people (m/f) who report increased ability to meet their basic needs
- Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
- % of people (m/f) who report increased awareness of how to access GBV services

All indicators had predefined guidelines governing both their collection and analysis.

% of targeted population (m/f) reporting feeling safer following the implementation of GBV and SRHR interventions

To meet the criteria for this indicator, respondents had to report feeling safe or very safe in three situations: 1) going out alone; 2) inside the household; 3) undertaking a job outside the HH. The results showed that currently 38% of the targeted population feel safe; the results were slightly higher for men at 42% compared to 34% for women. The results showed that 66% of respondents feel safe at home with little variation between men and women. More men than women feel safe to undertake a job outside the household at 60% for men compared to 46% for women. Overall 52% of respondents feel safe to go out alone with men feeling slightly safer than women – 54% compared to 50% respectively.

Figure 6: KOI-1 Respondent feeling safety

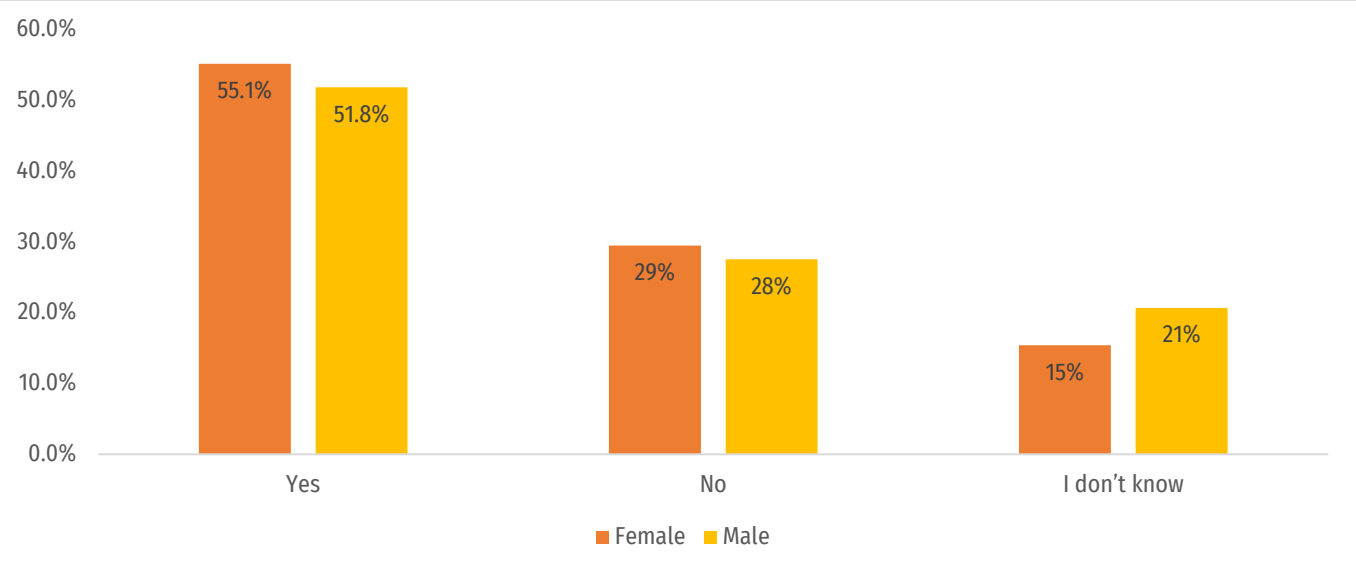


% of targeted people (m/f) who report increased ability to meet their basic needs

When it comes to basic needs, to meet this indicator, respondents had to agree to be able to satisfy the basic level of need you have to survive in terms of food, water, sanitation, hygiene, shelter, healthcare. At the time of the survey, basic need was defined as 'what each person/household primarily needs to sustain a life'. The result showed that currently 54% of people are able to meet their basic needs; the result can be seen to be slightly

higher for women at 55% compared to men at 52%. The results vary slightly between LGAs with 60% able to meet their basic needs in Bama compared to 50% in Dikwa.

Figure 7: KOI-2: Respondent Ability to Meet Basic Need (Food, Water, Sanitation, Hygiene, Shelter, Healthcare and Education)



Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

The baseline study showed that currently only 13% of women aged 15-49 make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. This varies by LGA with a higher proportion of 22% reported to be making their informed decisions in Bama compared to Dikwa where only 7% report the same. To meet the criteria for this indicator, respondents had to correctly answer 5 out of 7 questions. While the outcome on this indicator is low, the project intends to work assiduously to make some significant impact on this aspect.

% of people (m/f) who report increased awareness of how to access GBV services

The result shows that 59% (60%f, 57%m) have knowledge on how to access GBV services. It can also be seen that more respondents in Bama (84%) indicated awareness on how to report GBV than in Dikwa (42%). The discrepancies in data between Bama and Dikwa is due to the fact Bama, being a safe haven for most internally displaced persons from other LGAs, with an increased humanitarian burden of SRH and GBV, has in recent times attracted more humanitarian actors. Because of this, the population has been able to access information from diverse sources, thus increasing their knowledge about SRH and GBV. Also Bama has benefitted from the implementation of the CARE ECHO-funded GBV project that is specifically focused on GBV & protection. Over the past 15 months, this project has set up several structures and undertaken awareness raising drives focused on GBV. The proximity of Bama to Maiduguri also makes it easier for them to access radio information from diverse humanitarian actors, which is not the same in Dikwa, where there is no radio coverage.

Surprisingly, 2% of the respondents also mentioned "church, mosque, and police station" as places that provided GBV services, this is mostly due to the referral mechanism and channels of reporting mostly used.

Section 2: Reproductive Health Services in the Community

The survey elicited information on maternal status from women of childbearing age (15 – 49 years). Result obtained was similar for both LGAs. For instance, 25.3% of the respondents from Bama LGA and 27.7% of respondents from Dikwa LGA in this category had biological children who were not breastfeeding at the time of data collection. Similarly, 14.7% and 20.7% of respondents in Bama and Dikwa LGAs respectively were lactating mothers, while 21.8% and 14.4% of respondents from Bama and Dikwa respectively were pregnant. Overall, for both LGAs, 26.7% had children who were not breastfeeding, 18.3% were lactating mothers, 37.7% were neither pregnant nor lactating while 17.4% were pregnant at the time of the study. The distribution of maternal status is displayed in table 6.

Table 6: Fertility Status by Age Group

Fertility Status	Bama				Dikwa			
	Age Category				Age Category			
	<18	19-37	38-56	57-75	<18	19-37	38-56	57-75
Has biological children but not breastfeeding	7 (35%)	99 (42.86%)	71 (34%)	5 (21%)	13 (65%)	132 (57%)	136 (66%)	19 (79%)
Lactating mother	2 (20%)	80 (31%)	23 (39%)	0	8 (80%)	179 (69%)	36 (61%)	2
Neither pregnant nor lactating	36 (14%)	143 (66%)	87 (54%)	7 (17%)	217 (86%)	74 (34%)	75 (46%)	34 (83%)
Pregnant	17 (45%)	123 (53%)	18 (43%)	0	21 (55%)	110 (47%)	24 (57%)	2

For respondents who were pregnant or ever had a child, the study elicited information on antenatal care. Most of the respondents from Bama who met someone for ANC services met either a doctor (22.7%) or a nurse/midwife (72%). In Dikwa, 48.7% met with a Doctor while 39.3% met a nurse or midwife. Overall, for both LGAs 34.1% of respondents met a doctor while 57.7% met a nurse or midwife, as displayed in table 7.

Table 7: ANC Provider

ANC provider	Bama		Dikwa		Total	
	n	%	n	%	N	%
Auxiliary Midwife	3	2.00	6	5.13	9	3.37
Community Health workers	2	1.33	6	5.13	8	3.00
Doctor	34	22.67	57	48.72	91	34.08
Nurse/Midwife	108	72.00	46	39.32	154	57.68
Traditional Birth Attendant	2	1.33	2	1.71	4	1.50
Other	1	0.67	0	0.00	1	0.37

Furthermore, for Bama, the majority of the respondents who met someone for ANC met the person at a government facility (42.3%) or at home (39.7%). For Dikwa, respondents met the ANC provider either at government health centers (28.7%), at government facilities (31.2%) and at home (21%). Overall, for both LGAs,

ANC providers were met at government health centers (21.7%). Government facility (36.7%) and at home (30.5%) as displayed in table 8. Only one respondent each, mentioned private health center and private facility respectively.

Table 8: ANC Location

ANC location	Bama		Dikwa		Total	
	n	%	n	%	n	%
Govt health center	23	14.74	45	28.66	68	21.73
Government facility	66	42.31	49	31.21	115	36.74
Home	62	39.74	33	21.02	95	30.35
Other	3	1.92	24	15.29	27	8.63

The study elicited information on age of pregnancy at first antenatal visit. Significant differences were observed between respondents from Bama and Dikwa. For Bama, most of the respondents commenced antenatal visits from three months of their pregnancy, while for Dikwa, about 34% of respondents commenced antenatal visits less than one month into their pregnancy while 5.5% commenced ANC visit in the first one month of pregnancy. Overall, for both LGAs, 22% commenced antenatal visits in the first one month, 3.6% commenced antenatal visits in the second month while the highest proportion of respondents (29.6%) commenced antenatal visits from the fourth month.

Table 9: Month of Pregnancy at first ANC visit

Month at first ANC	Bama		Dikwa		Total	
	n	%	n	%	n	%
Less than month	1	0.66	92	33.95	93	22.04
First month	0	0	15	5.54	15	3.55
Second month	5	3.31	40	14.76	45	10.66
Third month	16	10.60	52	19.19	68	16.11
Fourth month	103	68.21	22	8.12	125	29.62
Fifth month	20	13.25	24	8.86	44	10.43
Sixth month	3	1.99	20	7.38	23	5.45
Seventh month	3	1.99	3	1.11	6	1.42
Eighth month	0	0.00	2	0.74	2	0.47
Ninth month	0	0.00	1	0.37	1	0.24

On the number of antenatal (ANC) visits, about half of the respondents from Bama LGA visited clinic for ANC services about 5 times before delivery. This is different from the situation in Dikwa LGA where antenatal visits spread from once to fifteen times, with majority, 18.1% visiting antenatal clinics just twice during their pregnancy.Overall, about 25% visited antenatal clinics for at least four times. Antenatal visits ranged from one to nine visits. Table 10 shows the number of ANC visits.

Table 10: Number of ANC visits

Number of times visited ANC	Bama		Dikwa		Total	
	n	%	n	%	N	%
Once	0	0.00	29	10.70	29	6.87
Twice	3	1.99	49	18.08	52	12.32
Three time	1	0.66	34	12.55	35	8.29
Four times	88	58.28	18	6.64	106	25.12
Five times	26	17.22	16	5.90	42	9.95
More than five times	36	21.19	26	9.59	58	13.75

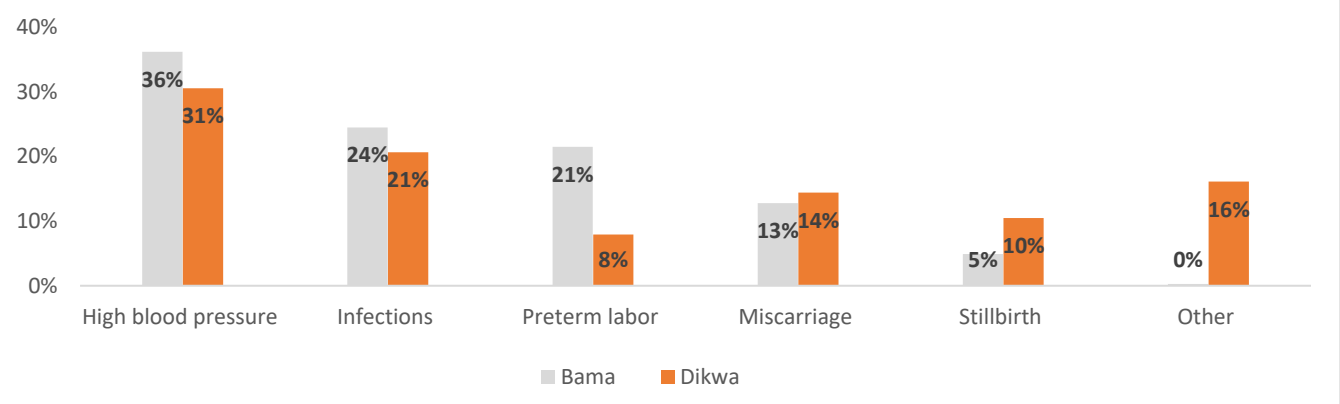
About 94.7% of respondents from Bama and 50.9% of respondents from Dikwa LGA received information about pregnancy complications during antenatal visits as displayed in table 18. Overall, 73.3% of respondents received information on pregnancy complications.

Table 11: Received information About Pregnancy Complication

LGA	Yes		No	
	n	%	N	%
Bama	143	94.70	8	5.30
Dikwa	138	50.92	81	29.89
Total	281	73.3	89	31.7

On the type of pregnancy complications informed about, 93% of respondents from Bama and 44.4% of respondents from Dikwa received information on high blood pressure. In addition, 62.9% of respondents from Bama and 30% of respondents from Dikwa, received information on Infections while 55.2% of respondents from Bama and 11.5% of respondents from Dikwa, received information on Preterm labor. This is displayed in figure 8. Overall, for both LGAs, 62.4%, 42.2% and 27.7% of respondents received information on high blood pressure, infections and preterm labor respectively.

Figure 8: Type of Pregnancy Complication Informed About



In addition to receiving information on pregnancy complications, 32.4% of respondents from Bama LGA and 67.6% of respondents from Dikwa LGA received delivery kits. Overall, 28.8% of respondents from both LGAs received delivery kits, as can be seen in table 12 below.

Table 12: Received Delivery Kit

LGA	Yes		No	
	n	%	N	%
Bama	93	32.40	194	67.60
Dikwa	166	27.04	448	72.96
Total	259	28.75	642	71.25

About 50.5% and 40.9% of respondents from Bama received delivery kits from health facilities and mobile outreach team respectively, compared with 66.7% of respondents from Dikwa who received delivery kits from health facility and only 12.5% that received delivery kits from mobile outreach team. Some respondents mentioned community health workers and traditional birth attendants as source of their delivery kits. Overall, 59.6% received delivery kits from heath facility, 24.9% received delivery kits from mobile outreach team. Details of source of delivery kits is provided in table 13.

Table 13: Where Delivery Kit was Received

Where delivery kit was received	Bama		Dikwa		Total	
	n	%	n	%	n	%
Health facility	47	50.54	80	66.67	127	59.62
Mobile outreach team	38	40.86	15	12.50	53	24.88
Community health workers	3	3.23	15	12.50	18	8.45
Traditional birth attendant	4	4.30	3	2.50	7	3.29

Home and hospital were the most reported places of delivery for the respondents in both Dikwa and Bama LGAs. In Bama LGA, about 47.7% of deliveries occurred at home, which is very similar to the report of 47.6% of home deliveries among respondents from Dikwa LGA. Also, the proportion of deliveries at government health facilities was about the same for both LGAs as provided in table 14.

Table 14: Where Did You Give Birth

Place of delivery	Bama		Dikwa		Total	
	n	%	n	%	N	%
Home	137	47.74	292	47.56	429	47.61

Govt. Facility	125	43.55	88	14.33	213	23.64
Govt. health center	74	25.78	156	25.41	230	25.53
Private hospital	29	10.10	17	2.77	46	5.11
Private medical facility	8	2.79	4	0.65	12	1.33

Among respondents from Bama LGA, 56.1% of the deliveries were assisted by a nurse/midwife, 17.4% were assisted by a medical doctor while 38.7% were assisted by a traditional birth attendant. Among respondents from Dikwa LGA, 26.2% of deliveries were assisted by traditional birth attendants, 22.6% by a medical doctor and 25.1% were assisted by nurse/midwife. Overall, 35% of deliveries were assisted by a nurse/midwife, 30.2% were assisted by a traditional birth attendant while 21% were assisted by a medical doctor. The majority of deliveries were assisted by nurse/midwife in Bama while for Dikwa, majority of the deliveries were assisted by Traditional birth attendants, while both LGAs have a similar proportion of deliveries assisted by community health workers as provided in table 15.

Table 15: Who Assisted with the Delivery

Who assisted with the delivery	Bama		Dikwa		Total	
	n	%	n	%	n	%
Doctor	50	17.42	139	22.64	189	20.98
Nurse/Midwife	161	56.10	154	25.08	315	34.96
Auxiliary Midwife	19	6.62	47	7.65	66	7.33
Traditional birth attendant	111	38.68	161	26.22	272	30.19
Community health workers	21	7.32	43	7.00	64	7.10

Among current pregnant respondents, 57.5% of respondents from Dikwa had an unwanted pregnancy. Also, the single pregnant woman in Bama LGA reported that she had an unwanted pregnancy. Overall, only 42.5% of respondents from Dikwa LGA desired the current pregnancy as described in table 16.

Table 16: Desire for Current Pregnancy

LGA	Yes		No	
	Number	Percentage	Number	Percentage
Bama	0	0.00	1	100.00
Dikwa	76	42.46	103	57.54
Total	76	42.22	104	57.78

About 58.1% of respondents from Bama and 32.8% of respondents from Dikwa had knowledge of contraception. Overall, knowledge of contraception was 45.4% among respondents from both LGAs.

Table 17: Knowledge of Contraception

LGA	Yes		No	
	Number	Percentage	Number	Percentage
Bama	416	58.10	300	41.90
Dikwa	356	32.75	731	67.25
Total	772	45.42	1031	54.58

Knowledge of contraceptive by sex is presented in table 18. Result showed that more females have knowledge of contraception than males. In Bama LGA, only one male respondent had heard of contraception, compared with 22 males in Dikwa LGA.

Table 18: Knowledge of Contraception by Sex

LGA	**Female**		**Male**	
	Number	Percentage	Number	Percentage
Bama	415	99.76	1	0.24
Dikwa	334	93.82	22	6.18

Knowledge of contraception methods varied by LGA and by methods. In Bama LGA, 56.1% of respondents knew about long-acting reversible contraception (LARC) method while about 37.8% of respondents from Dikwa LGA knew about this method. Also, about 44.8% of respondents from Bama knew about hormonal contraception method compared with 30.1% in Dikwa LGA. Overall, knowledge of all listed methods of contraception was higher in Bama than in Dikwa LGA as described in table 19.

Limitation: there was a slight design flaw of this question, it was designed to only seek out response from female participants and not male, this was due to the bulkiness of the questionnaire and an attempt to reduce to minimal or zero, respondents fatigue. Therefore, the information in this section does not have a male-female data comparison.

Table 19: Knowledge of Contraceptive Methods

contraceptive methods	Bama		Dikwa		Total	
	n	%	n	%	n	%
Long Acting Reversible Contraception (LARC) Method (e.g. implants, IUD)	270	65.06	104	37.68	374	54.12
Hormonal Contraception Method (injectables, oral and combine pills)	186	44.82	83	30.07	269	38.93
Barriers Method (condoms)	134	32.29	83	30.07	217	31.40
Permanent Contraception (Vasectomy & Tubal Ligation)	47	11.33	6	2.17	53	7.67

Emergency Contraception Methods (1-Pills, copper-bearing IUD, etc.)	61	14.70	30	10.87	91	13.17

About 49.1% of respondents from Bama had ever used modern contraceptives compared to 27.3% of respondents from Dikwa. Overall, 38.2% of respondents from both LGAs had ever used a modern contraceptive as shown in table 20.

Table 20: Ever Used Modern Contraceptive Method (Female Only)

LGA	Yes		No	
	N	%	n	%
Bama	351	49.09	364	50.91
Dikwa	248	27.28	661	72.72
Total	599	38.19	1025	61.81

On recent use of contraceptives, more respondents from Dikwa LGA reported recent use of contraceptives than their counterpart from Bama LGA. The most recent use of contraceptives was about a week, preceding the data collection. In each LGA, majority of the respondents reported use of contraceptives in four and more weeks preceding the study. Table 21 provide details of contraceptive use by LGA.

Table 21: Recent Use of Contraceptive

When last used contraceptive	Bama		Dikwa		Total	
	n	%	N	%	n	%
1 week ago	4	1.14	104	24.36	108	13.86
2 weeks ago	10	2.84	51	11.94	61	7.83
3 weeks ago	38	10.80	35	8.20	73	9.37
4 weeks (1 month) ago	95	26.99	41	9.60	136	17.46
Over 4 weeks (1 month) ago	205	58.25	196	45.9	401	51.47

About 43.2% of the respondents from Bama used Long-Acting Reversible Contraception Method as the last contraceptive method used, compared with 24.6% of respondents from Dikwa who reported the same contraception method. Barrier method was reported by 28.4% of respondents from Dikwa LGA compared with 39.3% from Dikwa LGA. Overall, the barrier method was the most last used method of contraception among respondents from both LGAs. Details of the last contraception method by LGA are provided in table 22.

Table 22: Last Method of Contraceptive Used

Contraceptive Method	Bama		Dikwa		Total	
	n	%	n	%	n	%

Long Acting Reversible Contraception (LARC) Method (e.g. implants, IUD)	152	43.18	105	24.59	257	32.99
Hormonal Contraception Method (injectable, oral and combine pills)	47	13.35	103	24.12	150	19.26
Barriers Method (condoms)	100	28.41	168	39.34	268	34.4
Permanent Contraception (Vasectomy & Tubal Ligation)	26	7.39	4	0.94	30	3.85
Emergency Contraception Methods (1-Pills, copper-bearing IUD, etc.)	27	7.67	47	11.01	74	9.50

A high proportion of respondents from both LGAs have received information about health issues in their community. However, more respondents from Bama reported ever received information on health issues than their counterparts in Dikwa LGA. Information on how HIV is contracted, transmitted and prevented was received by 64.1% of respondents from Bama LGA and 38.5% of respondents from Dikwa LGA. Other information received by LGA is provided in table 23. Overall, more than 27% of respondents from both LGAs have received information on at least one health issue. Generally, more males than females had ever received information on health issues. Table 24 presents information reach by sex.

Table 23: Ever Received Information about Health Issues by LGA

Health issues	Bama		Dikwa		Total	
	n	%	n	%	n	%
How HIV is contracted, transmitted and prevented	801	64.08	717	38.53	1,518	48.79
How other STIs/STDs (gonorrhea, Syphilis, etc.) are contracted, transmitted and prevented	689	55.12	554	29.77	1,243	39.95
How to receive various methods of modern contraceptives	634	50.72	461	24.77	1,095	35.20
Ante-natal care	627	50.16	493	26.51	1,120	36.01
Post-natal care	620	49.60	477	25.65	1,097	35.27
Post-Abortion Care	555	44.40	416	22.37	971	31.22
Clinical Management of Rape	586	46.88	275	14.78	861	27.68

Table 24: Ever Received Information about Health Issues by Sex

Health issues	Male		Female		Total	
	n	%	n	%	n	%
How HIV is contracted, transmitted and prevented	962	54.88	555	40.96	1,518	48.79
How other STIs/STDs (gonorrhea, Syphilis, etc.) are contracted, transmitted and prevented	786	44.84	456	33.65	1,242	39.95
How to receive various methods of modern contraceptives	742	42.33	353	26.05	1,095	35.20

Ante-natal care	799	45.58	321	23.71	1,120	36.01
Post-natal care	783	44.67	314	23.19	1,097	35.27
Post-abortion care	703	40.10	268	19.79	971	31.22
Clinical Management of Rape	595	33.94	266	19.65	861	27.68

Knowledge of where to access health needs was high among the respondents in Bama LGA than Dikwa LGA. For Bama LGA, a higher proportion of respondents (62.1%) know where to access HIV counseling and testing services, followed by knowledge of testing and treatment for other STIs. A similar trend was observed for Dikwa LGA. More details are available in table 35. In table 26, knowledge of access to health needs was disaggregated by sex. The result showed than more males than females have knowledge of where to access health services including access to modern family planning methods.

Although this study did not quiz the respondents for the reasons behind women's loss access to information, a recently conducted study, the strategic impact inquiry (SII) on GBV and SRH, shows that men have more access and control over information than women who are usually busy taking care of and preparing the house and food.

Table 25: Knowledge of Where to Access Health Needs by LGA

Health issues	Bama		Dikwa		Total	
	n	%	n	%	n	%
Counseling and testing for HIV	776	62.08	617	33.17	1,393	44.79
Testing and treatment of other STIs/STDs	639	51.12	453	24.35	1,092	35.11
Modern contraceptives/Family Planning	504	40.32	386	20.75	890	28.62

Table 26: Knowledge of Where to Access Health Needs by Sex

Health issues	Male		Female		Total	
	n	%	n	%	n	%
Counseling and testing for HIV	872	49.74	520	38.40	1,393	44.79
Testing and treatment of other STIs/STDs	675	38.51	415	30.65	1,092	35.11
Modern contraceptives/Family Planning	625	35.65	265	19.57	890	28.62

The most reported sources of information on health services in both LGAs were health facility workers (82.5%) in Bama and 45.5% in Dikwa), followed by community health volunteers, and friends. The least reported source of information was mobile outreach (3.7%), followed by radio (3.92%) across both LGAs. The source of information on health services by LGA is provided in table 33a.

Table 27 present source of health information by sex and LGA. A high number of male and female respondents in Bama and Dikwa received information from health facility staff and community health volunteers.

Table 27: Source of Health Information by Sex and LGA

Source of health information	Bama		Dikwa		Total	
	Female (%)	Male (%)	Female (%)	Male (%)	Number	%
Through health facility staff	567 (55%)	468 (45%)	476 (56%)	369 (44%)	1,878	60.39
Through Community Health volunteers/ Workers (CHWs)	460 (67%)	228 (33%)	277 (62%)	173 (38%)	1,138	36.59
Posters and/or flyers	87 (54%)	74 (46%)	42 (56%)	33 (44%)	236	7.59
Radio	46 (51%)	44 (49%)	4 (13%)	28 (87%)	122	3.92
Relatives/ friends	40 (51%)	39 (49%)	315 (53%)	281 (47%)	676	21.74
Mobile outreach team	9 (90%)	1 (10%)	59 (56%)	46 (44%)	115	3.70

About 43% of respondents in both LGAs already belonged to a Sexual and Reproductive Health (SRH) related group across both LGAs. More respondents from Bama LGA (62% (were members of an existing SRH group compared with 30.4% of respondents from Dikwa LGA. When disaggregated by sex, male respondents who were members of an existing SRH group were about 44.8% compared with 41,6% of females. Tables 28 and 29 provide details of membership of SRH group by LGA and by Sex respectively.

Table 28: Membership of SRH-related Group by LGA

LGA	Yes		No	
	n	%	n	%
Bama	771	61.68	479	38.32
Dikwa	566	30.43	1,294	69.57
Total	1,337	42.99	1,773	57.01

Table 29: Membership of SRH-related Group by sex

Sex	Yes		No	
	n	%	n	%
Male	607	44.83	747	55.17
Female	729	41.59	1024	58.41
Total	1337	42.99	1773	57.01

About 88.3% of respondents from Bama LGA confirmed presence of humanitarian organization in their communities while 61.3% of respondents from Dikwa LGA provided similar response as displayed in table 30.

Table 30: Presence of Humanitarian Organization in Community

LGA	Yes		No	
	n	%	n	%
Bama	1,103	88.31	146	11.69
Dikwa	1,031	61.30	651	38.70
Total	797	27.19	2,134	72.81

Many respondents demonstrated knowledge of services provided by the humanitarian organizations present in communities in both LGAs. While 85.3% identified health services, 68.4% identified education services, 61.1% mentioned food services. Overall, WASH and GBV were the two services mentioned by the least number of respondents in both LGAs. A comprehensive list of services by LGA is provided in table 31. Furthermore, respondents in both LGAs were aware of a group of people who did not have access to these services. Details are provided in table 32. More respondents identified this group in Dikwa more than Bama.

Table 31: Type of Services Provided by the Humanitarian Organization

type of services	Bama		Dikwa		Total	
	n	%	n	%	N	%
Health (including SRHR)	1,104	94.84	925	76.51	1,972	85.26
Education	911	82.52	672	55.58	1,583	68.44
Food	651	58.97	763	63.11	1,414	61.13
Livelihood	362	32.79	339	28.04	701	30.31
Shelter	423	38.32	228	18.86	651	28.15
WASH	399	36.14	236	19.52	635	27.45
Protection & GBV	520	47.10	173	14.31	693	29.96

Table 32: Are there Group of People without Access to this Services

LGA	Yes		No		Total	
	n	%	n	%	n	%
Bama	139	11.12	1,111	88.88	1,250	100.00
Dikwa	561	30.16	1,299	69.84	1,860	100.00
Total	700	22.51	2410	77.49	3111	100.00

When asked about the respondent's confidant for personal problems, a similar trend was observed between male and female respondents. The most mentioned confidant was family members (57.6%), followed by friends (33.9%), before spouse (22%), while 15% reported not having any confidant. Other details are provided in table 33.

Table 33: Confidant for Personal Problems by Sex

Confidant	Male	Female	Total

	n	%	n	%	n	%
Your spouse	328	25.15	316	19.46	644	21.97
friend	465	35.66	529	32.57	994	33.91
Family member	826	61.00	964	54.99	1791	57.59
Friends or belonging religious order	139	10.27	212	12.09	351	11.29
A medical worker	127	9.38	196	11.18	323	10.39
Nobody	202	15.49	235	14.47	439	14.98

Section three: Knowledge and perception of SRHR and GBV

Knowledge of sexually transmitted infection (STI) is high among respondents in both Bama and Dikwa LGAs, with knowledge of HIV/AIDS higher than others. Knowledge of STIs is comparable among male and female respondent. Tables 34 display knowledge of different STIs by LGA and by sex. Similar trend was observed for knowledge of signs and symptoms of STIs by LGA and by sex as provided in tables 35.

Table 34: Knowledge of Sexually Transmitted Infection by LGA and sex

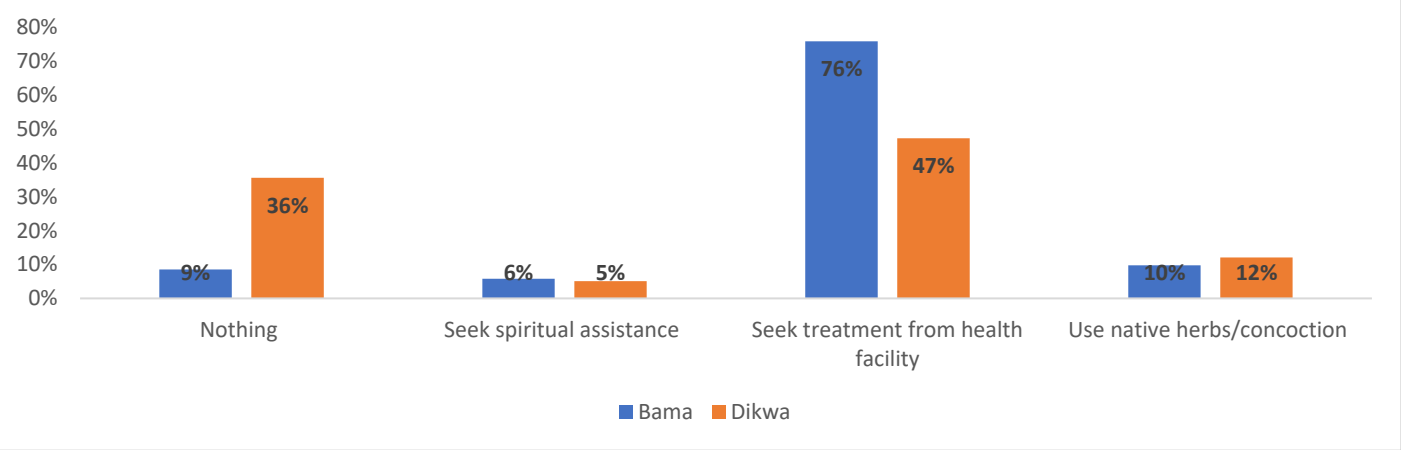
Sexually Transmitted Infection	Bama		Dikwa		Total	
	Female	Male	Female	Male		
	n (%)	n (%)	n (%)	n (%)	n	%
HIV/AIDS	534 (58%)	392 (42%)	250 (56%)	198 (44%)	1,374	42.57%
Gonorrhea	303 (56%)	238 (44%)	106 (51%)	101 (49%)	748	23.17%
Syphilis	187 (63%)	109 (37%)	62 (54%)	52 (46%)	410	12.70%
Hepatitis B	229 (53%)	202 (47%)	2 (22%)	7 (78%)	440	13.63%
Vaginitis	64 (52%)	58 (48%)	70 (52%)	64 (48%)	256	7.93%

Table 35: Knowledge of Signs or Symptoms of Sexually Transmitted Infection by LGA and Sex

signs or symptoms of sexually transmitted infection	Bama		Dikwa		Total	
	Female (%)	Male (%)	Female (%)	Male (%)	n	%
Swelling in groin region	377 (56%)	291 (44%)	102 (57%)	76 (42%)	846	48.79
Painful urination	309 (56%)	256 (45%)	163 (50%)	160 (50%)	888	51.21

Knowledge of seeking treatment for STI from health facility was higher among respondents from Bama LGA (75.9%) compared with Dikwa LGA (47.3%). Other responses are provided in figure 9.

Figure 9: What People do When They Have STI



Knowledge of HIV transmission by LGA and by Sex is provided in tables 36 and 37 respectively, with 85% of the respondents from both Bama and Dikwa LGAs identifying sexual intercourse as a source of HIV transmission while 3.7% mentioned mosquito or other insect bites.

Table 36: Knowledge HIV Transmission by LGA

HIV transmission	Bama		Dikwa		Total	
	n	%	n	%	n	%
Sexual intercourse	984	83.82	635	86.99	1619	85.03
Sharing needles/unclean medical equipment	640	54.51	340	46.58	980	51.47
Blood transfusion	703	59.88	359	49.18	1062	55.78
During pregnancy	229	19.51	36	4.93	265	13.92
Mosquito or other insect bites*	46	3.92	25	3.42	71	3.73

Table 37: Knowledge HIV Transmission by Sex

HIV transmission	Male		Female		Total	
	n	%	n	%	n	%
Sexual intercourse	736	87.83	882	82.82	1619	85.03
Sharing needles/unclean medical equipment	503	60.02	447	44.79	980	51.47
Blood transfusion	467	55.73	595	55.87	1062	55.78
During pregnancy	101	12.05	164	15.40	265	13.92
Mosquito or other insect bites[5]	28	3.34	43	4.04	71	3.73

[5]* This is not an accurate method by which HIV can be transmitted, the study will measure the change via its midline and endline survey.

Knowledge of forms of GBV was higher among respondents from Bama compared with respondents from Dikwa, with 69% female and 54% male respondents from Dikwa identified marital rape as a GBV, while 41% females and 32% males identified marital rape and child abuse (41% female and 30% male) as the highest form of GBV in the location. Other GBV mentioned are provided in figure 10 (Dikwa) and 11 (Bama).

Figure 10: Dikwa – Knowledge of Gender Based Violence

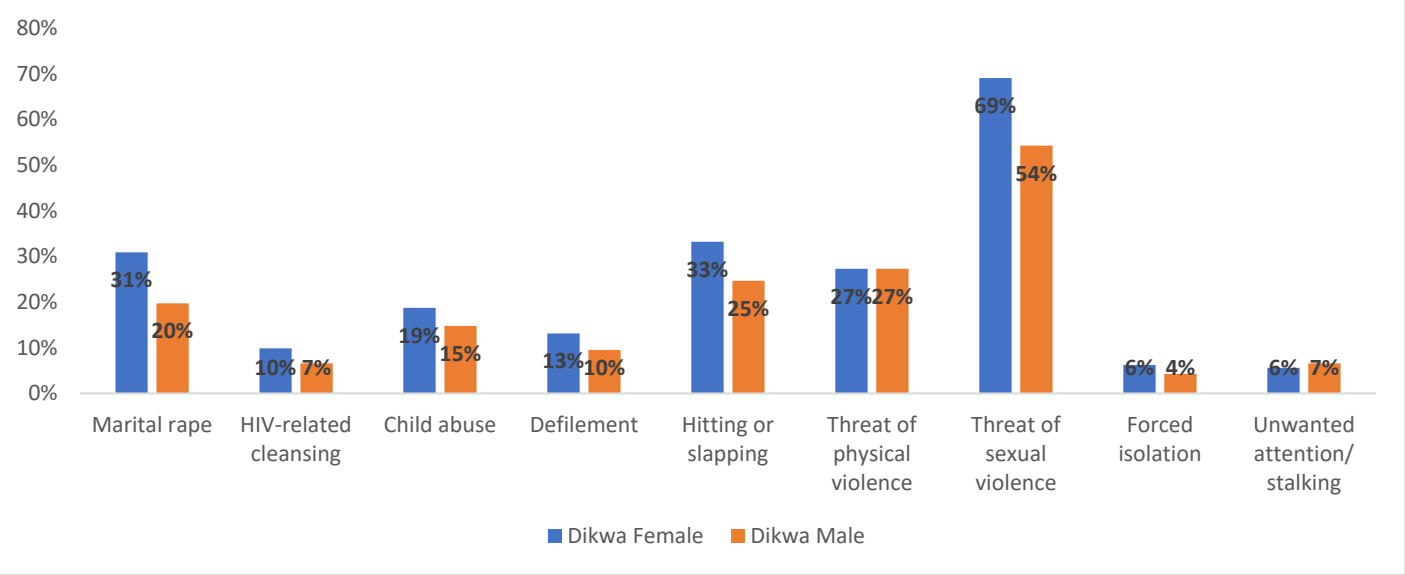
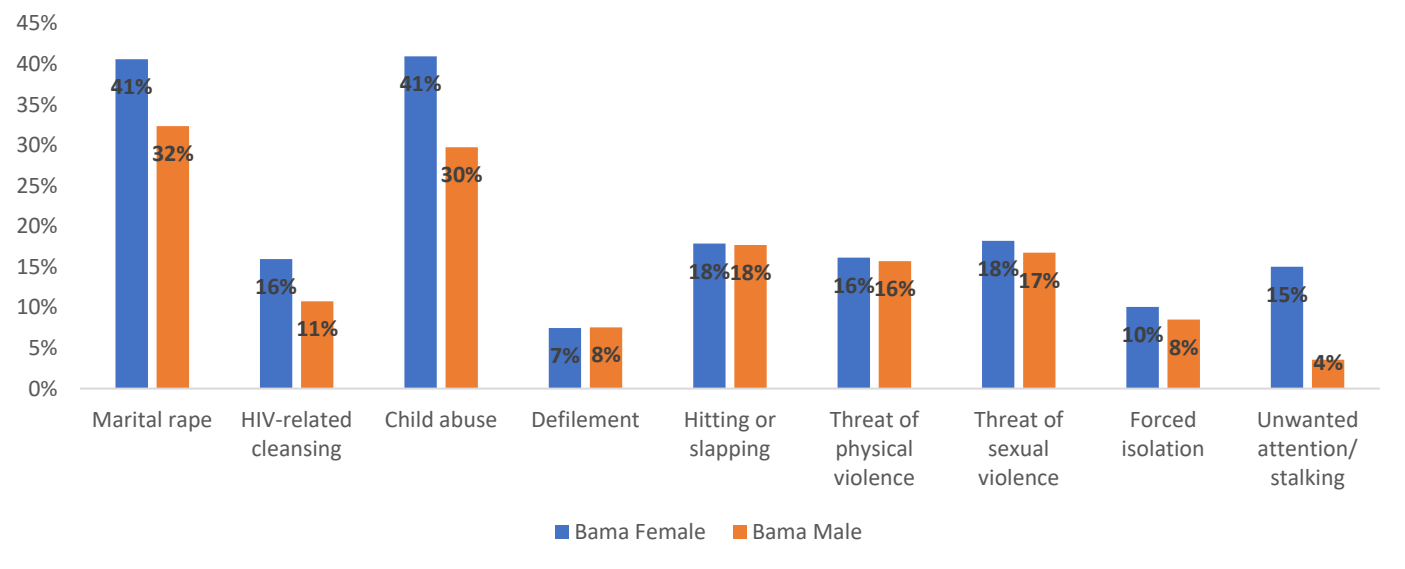


Figure 11: Bama – Knowledge of Gender Based Violence



About 36.7% of the respondents from Bama LGA believed than GBV is common in their area compared with 13.4% from Dikwa LGA. Overall, 22.8% of respondents from both LGAs reported that GBV is common in their community. Details are available in table 38.

Table 38: Perception on Prevalence of GBV: Is GBV Common in This Area

LGA	Yes		No	
	n	%	n	%
Bama	459	36.72	633	50.64
Dikwa	250	13.43	400	21.49
Total	709	22.79	1033	33.20

Furthermore, 42.8% of respondent in Bama LGA and 8.5% of respondents in Dikwa had ever experienced GBV. Overall, 22.3% of respondents from both LGAs have ever experienced GBV as provided in table 39. When disaggregated by sex, a slightly higher proportion of male respondents (24.7%) reported to have ever experienced GBV than female respondents (20.5%).

Table 39: Ever Experienced GBV by LGA

LGA	Female		Male		Total	
	n	%	n	%	N	%
Bama	277	43.21	258	50.59	535	42.80
Dikwa	82	16.57	77	23.91	159	8.54
Total	359	20.48	335	24.72	694	22.1

In addition, 30.8% of respondents from Bama LGA had witnessed violent incidence or GBV in their community in the last six months compared with 6.2% in Dikwa LGA. When disaggregated by sex, almost equal proportion of males (12.68%) and females (12.83%) had witnessed violent incidence or GBV in their community in the last six months. Further information on LGA and Sex distribution of respondents' previous witness of GBV available in table 40.

Table 40: Ever Witnessed Violent Incidence or GBV in Your Area in the Last Six-months

LGA	Female		Male		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Bama	186	29.52	199	39.80	385	30.80
Dikwa	66	13.07	50	15.48	116	6.23
Total	252	12.83	249	12.68	501	16.10

Table 41 shows opinion of respondents on the current situation of GBV in their community. About 14.5% of respondents from Bama LGA believed GBV is increasing, 57.8% believed GBV is declining while 15.4% believed the situation is staying the same.

Table 41: Opinion on status of GBV in respondents' area by sex and LGA

LGA	**Female**	**Male**

	Increasing (%)	Declining (%)	Staying the same (%)	Increasing (%)	Declining (%)	Staying the same (%)
Bama	87 (14.77)	402 (68.25)	100 (16.98)	94 (18.54)	320 (63.12)	93 (18.34)
Dikwa	93 (26.12)	159 (44.66)	104 (29.21)	93 (33.45)	89 (32.01)	96 (34.53)
Total	180 (10.40)	561 (32.43)	204 (11.79)	187 (10.81)	409 (23.64)	189 (10.92)

Several factors enabling the prevention of GBV were highlighted by respondents. About 71.7% of respondents from Bama believed than economic independence from the perpetrator will lead to the prevention of GBV. This was corroborated by 30% of respondents from Dikwa LGA. Overall, 46.1% agreed that economic independent from perpetrator will enable prevention of GBV, while 28.8% agreed that community disagreement with GBV will enhance prevention. Detail of other suggested prevention approaches is provided in table 42.

Table 42: Factors Enabling Prevention/Response to GBV

Factors aiding prevention or response to GBV	Bama		Dikwa		Total	
	Female (%)	Male (%)	Female (%)	Male (%)	Number	%
Economic independence from perpetrator	448 (50)	448 (50)	265 (49)	273 (51)	1434	38.00
Equality in decision-making in HH	227 (61)	143 (39)	102 (58)	75 (42)	547	14.49
Help from friends	173 (66)	91 (34)	58 (62)	35 (38)	357	9.46
Public services to support	243 (75)	80 (25)	114 (55)	92 (45)	529	14.02
Community disagrees with GBV	180 (65)	99 (35)	369 (60)	247 (40)	895	23.71
Distance to services (PSS, Case management and referrals) is near	0	0	0	2 (100)	2	0.05
Trust services to respond	0	1 (100)	3 (33)	6 (67)	10	0.26

Common community response to GBV are provided in table 55. About 22.6% of respondents identified community dialogue as a main community response to GBV, 17% mentioned taking the survivor to GBV response center (safe space), while 14.9% mentioned taking perpetrator to police. Details are provided in table 43.

About 59% of respondents mentioned hospital as the type of help survival of GBV seek, 47.4% mentioned community leaders while 45.7% mentioned survivor service center. Difference in opinion was observed between the two LGAs. Opinion on other types of help a survivor of GBV seek is provided in table 44.

Main community response to GBV	Bama		Dikwa		Total	
	Female	Male	Female	Male	n	%
Perpetrators taken to police	210 (65.63)	110 (34.38)	89 (61.81)	55 (38.19)	464	14.92
Cases usually not reported	91 (62.76)	54 (37.24)	121 (54.75)	100 (45.25)	366	11.77
Community dialogue	89 (66.42)	45 (33.58)	330 (58.10)	238 (41.90)	702	22.60
Taken to headman/ chief	128 (78.53)	35 (21.47)	89 (55.63)	71 (44.38)	323	10.39
Taken to local court	203 (70.98)	83 (29.02)	39 (62.90)	23 (37.10)	348	11.19
Discuss as families	113 (62.09)	69 (37.91)	68 (54.84)	56 (45.16)	306	9.84
Case taken to religious leader	123 (48.05)	133 (51.95)	50 (68.49)	23 (31.51)	329	10.58
Taken to health services	129 (50.79)	125 (49.21)	26 (44.83)	32 (55.17)	312	10.03
Taken to GBV response center	198 (50.38)	195 (49.62)	71 (53.38)	62 (46.62)	526	16.95
Other	31 (100)	0	236 (60.51)	154 (39.49)	421	12.54

Table 43: Opinion/Knowledge on Main Community Response When GBV Occurs

Table 44: Opinion/Knowledge on Type of Help Survivors of GBV Seek

Type of help	Bama		Dikwa		Total	
	n	%	n	%	n	%
Police	350	36.46	35	10.70	385	29.91
Relatives	233	24.27	39	11.93	272	21.13
Hospital	689	71.77	70	21.41	759	58.97
Place of worship	65	6.77	4	1.22	69	5.36
Hotline	44	4.58	0	0	44	3.42
Survivor service center	511	53.23	77	23.55	588	45.69
Community leaders	388	40.52	221	67.58	610	47.40
Peer Group	47	4.90	2	0.61	49	3.81
Support Group	232	24.17	3	0.92	235	18.26
Court	61	6.35	13	3.98	74	5.75
Others	0	0	1	0.31	1	0.08

Respondents identified several existing platforms for help for survivors of GBV. Hospital, survivor centers, and community leaders were the most reported existing platforms. Other platforms by LGA are provided in table 45.

Table 45: Assessing Respondents Knowledge of Existing Response Platform/Help For Survivors of GBV Seek

Type of help	Bama		Dikwa		Total	
	Female	Male	Female	Male	n	
Police	196 (56%)	154 (44%)	19 (54%)	16 (46%)	385	29.91
Relatives	136 (58%)	97 (42%)	17 (44%)	22 (56%)	272	21.13
Hospital	389 (56%)	300 (44%)	51 (73%)	19 (27%)	759	58.97
Place of worship	38 (58%)	27 (42%)	1 (25%)	3 (75%)	69	5.36
Hotline	24 (55%)	20 (45%)	0	0	44	3.42
Survivor service center	275 (54%)	236 (46%)	52 (68%)	25 (32%)	588	45.69
Community leaders	154 (40%)	235 (60%)	130 (59%)	90 (41%)	609	47.40
Peer Group	24 (51%)	23 (49%)	0	2	49	3.81
Support Group	159 (69%)	73 (31%)	2 (67%)	1 (33%)	235	18.26
Court	51 (84%)	10 (16%)	7 (54%)	6 (46%)	74	5.75

A high proportion of respondents (78.6%) from Bama LGA were aware of the existence of community support groups on GBV than respondents (17.2%) from Dikwa LGA as displayed in table 46. Most reported activities on GBV were supporting through counseling (73.8%), and awareness creation and sensitization (72.4%).

Table 46: Awareness of Existence of Community Support Group on GBV

LGA	Yes		No	
	n	%	n	%
Bama	982	78.56	132	10.56
Dikwa	320	17.20	430	23.11
Total	1302	41.85	562	18.06

When asked if respondents received any information on GBV in the past three months, 47.1% of respondents from Bama and 15.2% of respondents from Dikwa reported having received information on GBV in the past three months, as displayed in table 47. More respondents from Bama than Dikwa LGA received information on GBV in the past three months

Table 47: Received Any Information on GBV in the Past Three Months by LGA

LGA	Yes		No	
	n	%	n	%
Bama	589	47.12	519	41.52
Dikwa	283	15.21	554	29.77
Total	872	28.03	1073	34.49

*37.5% responded "I don't know"

Source of information on GBV varied across LGAs. Among respondents from Bama LGA (58.7%) reported friends as their source of information on GBV, followed by relatives (34.8%) and radio (34%). Among respondents from Dikwa LGA, 78.1% reported health workers at the clinic as their main source of information on GBV, followed by friends (28.3%) and relatives (13.4%). Other sources of information on GBV are provided in table 48.

Table 48: Main Source of Information on GBV

Type of help	Bama		Dikwa		Total	
	n	%	n	%	n	%
Radio	200	33.96	10	3.53	210	24.08
Newsletters	79	13.41	9	3.18	88	10.09
Relatives	205	34.80	38	13.43	243	27.87
Friends	346	58.74	80	28.27	426	48.85
Workmates	84	14.26	6	2.12	90	10.32
Church/place of worship	64	10.87	2	0.71	66	7.57
Peer educators	39	6.62	5	1.77	44	5.05
Health workers at the Clinic	163	27.67	221	78.09	384	44.04
Billboards	56	9.51	9	3.18	65	7.45
Leaflets	58	9.85	1	0.35	59	6.77
Posters	79	13.41	7	2.47	86	9.86

Tables 49 and 50 showed perception about safety by LGA and by sex respectively. About 64.6% of respondents from Bama LGA believed going out alone is safe. For Dikwa, 43.6% believed going out alone is safe. Overall, 54.2% of male respondents believed going out alone is safe compared with 49.9% of females.

Table 49: Perception of Safety Going Out Alone by LGA

Safety categories	Bama		Dikwa		Total	
	N	%	n	%	n	%
Safe	359	28.72	601	32.29	960	30.86
Very safe	449	35.92	212	11.39	661	21.25

Unsafe	421	33.68	624	33.53	1045	33.59
Very unsafe	21	1.68	424	22.78	445	14.30

Table 50: Perception of Safety Going Out Alone by Sex

Safety categories	Male		female		Total	
	n	%	n	%	n	%
Safe	458	33.08	501	28.58	960	30.86
Very safe	287	21.18	374	21.33	661	21.25
Unsafe	407	30.04	638	36.39	1045	33.59
Very unsafe	203	14.98	240	13.69	445	14.30

Tables 51 and 52 showed perception about safety in the household by LGA and by sex respectively. About 69.4% of respondents from Bama LGA and 64.4% of respondents from Dikwa LGA believed households are safe, while 67.1% of male respondents and 65.8% of female respondents believed households are safe. Similar trend was observed about perception of respondents about taking a job outside the home as displayed in tables 53 and 54.

Table 51: Perception of Safety within the Household by LGA

Safety categories	Bama		Dikwa		Total	
	n	%	n	%	n	%
Safe	414	33.12	850	45.67	1264	40.63
Very safe	454	36.32	348	18.70	802	25.78
Unsafe	367	29.36	522	28.05	889	28.58
Very unsafe	15	1.20	141	7.58	156	5.01

Table 52: Perception of Safety within the Household By Sex

Safety categories	Male		Female		Total	
	n	%	n	%	n	%
Safe	583	43.03	679	38.73	1264	40.63
Very safe	327	24.13	475	27.10	802	25.78
Unsafe	374	27.60	515	29.38	889	28.58
Very unsafe	71	5.24	84	4.79	156	5.01

Table 53: Perception of Safety Undertaking a Job outside the Household by LGA

Safety categories	Bama	Dikwa	Total

	n	%	n	%	n	%
Safe	383	30.64	873	46.91	1256	40.37
Very safe	277	22.16	218	11.71	495	15.91
Unsafe	520	41.60	597	32.08	1117	35.90
Very unsafe	70	5.60	173	9.30	243	7.81

Table 54: Perception of Safety Undertaking a Job outside the Household by Sex

Safety categories	Male		Female		Total	
	n	%	n	%	n	%
Safe	605	44.65	649	37.02	1256	40.37
Very safe	209	15.42	158	9.01	495	15.91
Unsafe	457	33.73	660	37.65	1117	35.90
Very unsafe	84	6.20	158	9.01	243	7.81

Ability to satisfy basic need by sex and by LGA was presented in tables 68 and 69. About 48.8% of male respondents and 50.8% of female respondents reported being able to satisfy basic need. In addition, 59.9% of respondents from Bama reported ability to satisfy basic needs, higher than the 43.2% of respondents from Dikwa who reported similar ability.

Table 55: Ability to Satisfy Basic Need by Sex

Sex	Yes		No	
	n	%	n	%
Male	661	48.78	363	26.79
Female	890	50.77	464	26.47
Total	1553	49.92	827	26.58

Table 56: Ability to Satisfy Basic Need by LGA

LGA	yes		No	
	n	%	n	%
Bama	749	59.92	369	29.52
Dikwa	804	43.20	458	24.61
Total	1553	49.92	827	26.58

About 57.2% of respondents from Bama LGA and 38.0% of respondents from Dikwa LGA reported to be responsible for making decision about personal health care as presented in table 70. While 51.9% of respondent in Bama and 46.2% of respondent in Dikwa mention their partner as the final decision maker on personal health care as

presented in table 58. Similarly, decision making about contraception and final decision maker were presented in tables 59 and 60.

Table 57: Decision making About Personal Healthcare

Decision maker	Bama		Dikwa		Total	
	n	%	n	%	n	%
Myself	715	57.20	707	38.01	1422	45.72
My partner (husband or wife)	268	21.44	379	20.38	647	20.80
Myself and my partner (husband or wife) jointly,	100	8.00	346	18.60	446	14.34
Other family member(s)	54	4.32	72	3.87	126	4.05
Myself, my partner and other family members jointly	58	4.64	265	14.25	323	10.39

Table 58: Final Decision Making About Personal Healthcare (If First Decision in Table 54 Is Made by Others)

Final Decision maker	Bama		Dikwa		Total	
	n	%	n	%	n	%
Myself	25	15.82	65	10.62	90	11.69
My partner (husband or wife)	82	51.90	283	46.24	365	47.40
Other family member(s)	51	32.28	264	43.14	315	40.91

Table 59: Decision Making About Contraception

Decision maker	Bama		Dikwa		Total	
	n	%	n	%	n	%
Myself	659	52.72	507	27.24	1166	37.48
My partner (husband or wife)	290	23.20	334	17.95	624	20.06
Myself and my partner (husband or wife) jointly,	104	8.32	347	18.65	451	14.50
Other family member(s)	53	4.24	74	3.98	127	4.08
Myself, my partner and other family members jointly	48	3.84	279	14.99	327	10.51
I don't know	96	7.68	320	17.20	416	13.37

Table 60: Final Decision making about contraception (if first decision in table 49 is made by others)

Final Decision maker	Bama		Dikwa		Total	
	n	%	n	%	n	%
Myself	21	13.82	66	10.53	87	11.17
My partner (husband or wife)	79	51.97	290	46.25	369	47.37
Myself and my partner (husband or wife) jointly,	0	0	0	0	0	0

Other family member(s)	52	34.21	271	43.22	323	41.46

The ability to refuse sex with partners by sex and by LGA is presented in tables 61 and 62 respectively. About 48.6% of male respondents believed they can say no to their partners' request for sex, compared with 38.7% of female respondents. Also, about 65.9% of respondents from Bama and 27.6% of respondents from Dikwa were able to say no to partner's request for sex. Furthermore, table 63 presents women's ability to ask a partner to use a condom for sex. 63.5% of female respondents from Bama LGA reported being able to ask a partner to use a condom for sex compared with 24.6% of female respondents from Dikwa LGA.

Table 61: Ability to Say No to Partner's Request for Sex

Sex	Yes		No	
	n	%	n	%
Male	659	48.63	233	17.20
Female	678	38.68	563	32.12
Total	1337	42.98	797	25.62

Table 62: Ability To Say No to Partner's Request for Sex

LGA	Yes		No	
	n	%	n	%
Bama	824	65.92	225	18.00
Dikwa	513	27.57	572	30.74
Total	1337	46.75	797	24.37

Table 63: Ability To Ask Partner To Use Condom For Sex: Female Only

Sex	Bama		Dikwa		Total	
	n	%	n	%	n	%
Female	454	63.50	256	24.64	710	40.48

Access to general services provided by humanitarian workers by LGA and by Sex are presented in tables 64 and 65 respectively. About 29% of respondents from Bama and 34.2% of respondents from Dikwa reported having access to services, while 31.1% of male respondents and 23.9% of female respondents reported access to services.

Table 64: Access to Services by Humanitarian Workers

LGA	Yes		No	
	n	%	n	%
Bama	362	28.96	888	71.04
Dikwa	637	34.23	1224	65.77
Total	999	32.11	2112	67.89

Table 65: Access to Services by Humanitarian Workers by Sex

Sex	Yes		No	
	n	%	n	%
Male	421	31.07	934	68.93
Female	576	23.86	1177	67.14
Total	999	32.11	2112	67.89

Expected Results	Indicators	Baseline Data	Targets
Ultimate Outcome			
1000 Lives saved, suffering alleviated and human dignity maintained through SRH and GBV interventions for crisis-affected women, men, boys and girls in Northeast Nigeria	% of targeted population (m/f) reporting feeling safer following the implementation of GBV and SRHR interventions	38% [Female 34%; Male 42%]	70% men, 70% women
	% targeted people (m/f) who report increased ability to meet their basic needs	54% [Female 55%; Male: 52%]	70% men, 70% women
Intermediate Outcomes			
1100 Increased and equitable use of gender-responsive assistance by crisis-affected people to meet basic SRH needs in Northeast Nigeria	Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	13%	65%
	% of targeted people (m/f) who report satisfaction with regards to relevance, timeliness and accountability of SRHR assistance	n/a	70% men, 70% women
1200 Increased and equitable use of gender-responsive assistance by crisis-affected people to meet basic GBV needs in Northeast Nigeria	% of people (m/f) who report increased awareness of how to access GBV services	59% [Female: 60%; Male: 57%]	70% men, 70% women
	% of targeted people (m/f) who report satisfaction with regards to relevance, timeliness and accountability of GBV assistance	n/a	70% men, 70% women
Immediate Outcomes			
1110 Increased access of women, men, boys, and girls to sexual and reproductive information and services in target areas of Northeast Nigeria	# of crises-affected persons (m/f) reached through community awareness sessions/radio programmes on SRHR/GBV	0	47,000 (17,500 men and 29,500 women)
	# of crises-affected targeted people who report that they have access to at least one SRHR service	0	30,000 (10,500 men and 19,500 women)
1210 Increased access of crisis affected population and survivors to GBV protection services in Northeast Nigeria	% of GBV committees operating and functional	0	80% of GBV committees operating and functional

	# of people who have experienced, or are at risk of, any form of SGBV that have received related services in the previous 12 months	0	5,810 (1,450 males and 4,360 females)

Table 66: Baseline Figure for Indicators

Findings from Qualitative study

Summary of findings from KII with Community Members

According to the discussion, the general opinion of GBV is a situation whereby a man rapes his wife or fights her, which is commonly linked to economic issues and low level of education, especially girls and women that are 18 years of age and above. Male and female groups included in the qualitative study agreed that females are most vulnerable to GBV. Also, women and girls mentioned that domestic violence is a main risk for girls and women before the conflict, but this has been extended to boys and men during the conflict. Women believed that, GBV is an act of injustice between the leaders of the community and other members (married, unmarried and divorcees), which is caused by alcoholism and poverty. Female respondents pointed out that the possible ways of getting GBV reported is through the family members or from the survivors. But cases are often not treated when reported to the police. Men were of the opinion that cases of gender-based violence should be reported to community leader as well as religious leader who will counsel the couple.

Both men and women in Dikwa and Bama shared a common opinion on the incidence of "gender-based violence (GBV) since the onset of the insurgency in the state. GBV was described as sexual violence characterized by beating, rape and seizing of properties and considered prevalent in their communities. While men believed the major cause of GBV is poverty, women believed men who consume too much alcohol often lack control, which may result to violence. Both men and women believed that disagreement between husband and wife and indecent dressing are contributing to the GBV in the community.

- Most of the participants from Bama were of the opinion that the incidence of GBV has increased since the insurgency while some said it had increased in the last five years. On the contrary, some participants in Dikwa believed that violence against women was decreasing because it is not permitted in Islamic religion.
- Family members were the most used channels in reporting cases of GBV. However, other means of reporting were through NGO workers, health care workers and survivors.
- Most community members in Dikwa were of the opinion that the main source of information on GBV are the NGOs, while for Bama, were mainly community members/volunteers and NGOs and these were carried through community dialogues.
- Many members of the communities in Dikwa and Bama were of the opinion that they do not have a relationship with police officers that could help in addressing GBV. Most respondents mentioned a good relationship with NGOs and community volunteers.
- The government through the police department should be more involved in supporting the victims when cases are reported.
- There should be more sensitization and awareness on the GBV cases prevalent in the community to reduce the incidence.
- There should be the empowerment of the community members to reduce poverty.

Summary of findings from KII with Camp Coordinators

Amongst the camp coordinators in Bama and Dikwa LGAs, Gender-Based Violence was described as a harmful act mainly towards the female gender and children. Harmful acts indicated are sexual assault, physical assault, domestic violence, etc. Rape cases were shown to be the most prevalent incidence of GBV. Denial of resources

was also pointed out. Some services are rendered to women, girls and survivors/victims who are involved in GBV. Summary of findings provided below:

- Family members, health care professionals and referrals were the major channels for reporting GBV in Bama and Dikwa local government.
- Camp coordinators agreed that inadequate shelter and food can drive GBV in the IDP camp.
- Poverty, lack of education/proper awareness, insecurities were pointed out by both Bama and Dikwa LGA as susceptible factors responsible for women and children's exposure to GBV.
- Livelihood support, provision of food, provision of borehole, availability of toilet and employment were pointed out by some of the respondent as important activities/actions that can help reduce women's and children's vulnerability to violence. Bama LGA complained more about the livelihood support, while Dikwa LGA were about the social amenities.
- The presence of cultural obstacles like community leaders/cultural leaders and cultural norm hinder women, girls, boys and men access to registration services in both LGAs.
- The relationship between the camp coordinators and police stations nearby is not too pleasant as many of the coordinators in in both LGAs are not too pleased with the services from the police close by.
- Both LGAs reported a positive relationship between the camp coordinators and NGO over SGBV.
- Poor awareness, insecurities and absence of social amenities is a big gap that needs to be filled in Bama and Dikwa IDP camps. Intervention for GBV control should focus on strengthening these aspects and also have representatives within for routine checks to enable a successful implementation of the program.
- Most of the IDPs need proper sensitization on the issue of GBV.
- Awareness needs to be raised to help them know what to do and who to report to.
- If possible, camp resident should be provided with social amenities and the ones already provided should be improved.
- Proper dialogue should be done with traditional/cultural leaders, to prevent them from being an obstacle to people for registration services.

Summary of findings from Focus Group Discussion with Men Group

Focus Group Discussions were conducted among 21 men groups. Of these, 18 were from Dikwa and 3 were from Bama LGA. Number of participants per group range from 8 to 12. Overall, about 210 men were included in the discussion in both Dikwa and Bama LGAs.

Participants from Dikwa and Bama shared common opinion on the perceptions and attitudes on the use of family planning, perceptions and attitudes towards abortion, social norms, power and decision relations to the community people, and lastly perceptions and attitudes on rape/incest.

- **Community Perceptions and Attitudes on the Use of Family Planning**

According to participants in Bama LGA they considered sex before marriage and sex outside marriage as unacceptable in the community and prohibited. While in Dikwa LGA they considered sex before marriage as not acceptable in their community and religion and sex outside marriage to be illegal. Suggested reasons that was responsible for such an act by the participants could be poverty and ignorance, religious beliefs, and household needs. According to respondents, teenagers and young people do find information about sex and sexuality in the

community in secondary/tertiary institutions, family members, friends and peers. Their perception of Contraceptives /Family Planning for unmarried women was that contraceptive/FP is improper for them.

According to their responses, most group participants suggested some ways to improve FP/LARC for women and girls, which are; By installing new health facilities that can be useful in the community; and creating awareness about the FP/LARC for women and girls. Based on responses from each LGA, organization/individuals that provide FP services in the communities are Private Health center, Humanitarian actors (Local NGO, INGO, UN agencies). Though some respondents mentioned that unwanted pregnancies, taboo to their tradition and religious belief are factors that can affect, women and girls from using contraceptives /FP to prevent STI/HIV, while in (Dikwa LGA), factors that can affect women and girls from using contraceptives /FP to prevent STI/HIV are health issues, poor state of the hospitals in the local government.

- **Community Perceptions and Attitudes towards Abortion**

Men from both LGAs agreed that the reason why some women and girls had an abortion was due to shyness and stigmatization, the majority of the participants in Dikwa said abortion has been discussed in the community, while few participants in Bama oppose it. Men in Bama listed types of abortion as traditional and professional, safe and unsafe, which are practiced in the community. Majority of participants in Dikwa claimed that girls and women use local herbs for abortion while some go to private health centers. While few participants in Bama LGA did not give a specific place where girls and women carry out abortion. According to their responses from both local governments, they know that death, shame, bleeding and infertility are the consequences or complications of unsafe abortions. Also, awareness on risk abortion, and visiting health centers for confirmation are what should be done to avoid complications and deaths from unsafe abortions. Participants from Bama LGA pointed out that there has not been any case of abortion in their community. While in Dikwa LGA they pointed out that there are cases of abortion in their community, but they refuse to give reasons.

- **Community Perceptions and Attitudes on Rape/incest**

From the data collected from the 21 communities in Bama and Dikwa LGAs, most of the prevalent circumstances and places where sexual violence often occur are in homes, toilets, at water points, when women/girls are on their way to/from the market and when women/girls go to collect wood outside the camp. Local vigilante and Civil Joint Task Force (CJTF) seem to be the most common type of security forces present in the camps/communities. In some communities like Masarmari and Bulabulin, volunteers who are mainly hunters also provide security services. These security operatives in the camps ensure safety for women and girls against GBV risks. There appears to be a mixed response from the communities as regards the kind of support services available for survivors of violence receive. Many of the communities recorded the absence of GBV cases, still went ahead to suggest ways in order to prevent GBV from happening in the community. There was no indication of cultural, religious and traditional practices that serve as barriers for people to readily access GBV services.

- **Social Norms, Power and Decision Relations**

Majority of the participants in Dikwa claimed that men had the final say when it came to decision making in the family, but the insurgency has changed it as both men and women are now included in the decision making process. A participant in Bama claimed that insurgency has not changed this and that the man makes the final decision in the family. According to all the participant in both LGAs claimed that everybody has equal access to resources and life opportunities (land, livestock, cash income, cash credit, seeds and other agricultural inputs, education), because they are giving everything equally. Most respondents in Dikwa and in Bama did not give a

clear response on what kind of decision women take within a family since the insurgency, even on what is the norm in their community about a couple discussing sex. Though some participants in Dikwa mentioned that women refuse sex when they are sick or during menstruation. Most participants in both local governments mentioned that community leaders and health personnel help them in resolving the issue if a man forbids his wife from using SRH services, because men believes that its illegal.

Summary of findings from Focus Group Discussion with Women Group

A total of 16 women groups participated in Dikwa LGA while three women groups participated in Bama LGA. Total number of women for all group in Dikwa LGA was 220 while the total number of women for all groups in Bama was 33.

- **Community perceptions and attitudes on the use of family planning**

In both Bama and Dikwa LGAs, most respondents agreed that having sex before marriage and outside marriage is illegal. It is against their religion. Reasons that were given for such acts include poverty, need for survival, no home training and delay in marriage. Respondents also mentioned that teenagers and young people get information about sex and sexuality from friends and peers, secondary schools and family members. For unmarried women, the perception/reaction of the community about contraceptives and family planning given by the respondent is negative. It is not allowed. Most respondents perceive it as an act of prostitution, a cause of infertility and a means of killing infants. However, for married women, the perception given by most respondents was that contraception is a normal and promoted practice. On the provision of family planning services in the community, most respondents from Dikwa mentioned that no organization is rendering such services. However other respondents mentioned that the Federal Government and humanitarian agencies provide such services, while most respondents from Bama LGA mentioned that private health services and humanitarian agencies provide such services. In both LGAs, respondents didn't know of any laws or policies that promote the provision of SRH/FP. In Dikwa, the orientation of traditional leaders, opening outreach clinic from 8 am-5 pm, creating awareness, engaging with youths were suggested ways to improve FP/LARC services for women and girls, while for Bama, creating new health facilities and more clinics were suggested as ways to improve FP/LARC services for women and girls.

- **Community perceptions and attitudes towards abortion**

In Dikwa, most communities responded in the affirmative to the knowledge of abortion cases while others gave negative responses. All respondents from Bama were not aware of abortion in their community. The reasons given for abortion identified by respondents from both LGAs included avoidance of stigmatization and unwanted pregnancies. The general perception of people about abortion is that it is not allowed. It is a taboo and prohibited act, which is not discussed in the community. Respondents from Dikwa mentioned that girls go to private health centers, drug sellers to carry out abortion while respondents from Bama insisted that there are no abortions in their community. General opinion on the consequences or complication of unsafe abortion included death, infertility, anemia and womb damage. Respondent believed that to avoid complications and death from unsafe abortions, women should be educated, family planning should be promoted, and abortion should be stopped. Others mentioned avoiding pregnancy, creating awareness would prevent complications from unsafe abortion practices. Most respondents do not know laws that prohibits performance of unsafe abortion.

- **Community perceptions and attitudes on rape/incest**

Respondents from both LGAs believed that the rate of domestic violence before and after the conflict has remained the same for girls, women, boys and men. The risk of not having enough privacy at home has increased after the conflict for girls and women, but this has not affected boys and men. In Dikwa, sexual harassment/assault/rape has also increased after the conflict for girls, women and men and remained the same for boys while in Bama, the risk of being sexually harassed/assaulted has remained the same for girls, women and boys after the conflict but has decreased for men. In Dikwa, the risk of sex for survival has increased after the conflict for girls, women and remained the same for boys and men while in Bama, the risk of sex for survival has only increased for girls and women after the conflict. Furthermore, the risk of getting attacked when traveling outside the camp/community has increased for girls, boys, women, and men after the conflict but when moving within the camp, this risk has only increased after the conflict for girls and women and not for boys and men.
In Dikwa, domestic violence before and after the conflict has remained the same for girls, women, boys and men while in Bama, the risk of domestic violence has remained the same both before and after the conflict. In Dikwa, the risk of early child/forced marriage has reduced after the conflict for girls. In Dikwa, the risk of denial of access to resources or opportunities has reduced after the conflict for girls, women, boys and men while in Bama denial of access to resources marriage or opportunities has remained at same level for girls, women, boys and men. In Dikwa, the risk of traditional harmful practices has reduced after the conflict for girls, women and remained the same for boys and men while in Bama, the risk of traditional harmful practices has remained the same after the conflict for girls, women, boys and men. In Dikwa, sexual violence usually occurs at home, when women go to collect wood, distribution assistance and on their way to/from market while in Bama, sexual violence usually occurs when women go to collect wood and at the toilet/latrines.

In Dikwa and in Bama CJTF (Civilian Joint Task Force), Police, Vigilante (Hunters), Nigerian Immigration and Custom services, Civil defense are present in the communities. However, in Bama, rape was mentioned as the most prevalent incidence of violence against women and girls but now at a decreasing trend. Also, no challenge is faced when women and girls move around in the community and there are no known danger zones. In Dikwa, sexual harassment is the main challenge that women and girls face when they move around in the community and known danger zones are home and peer groups influence. In Dikwa, health services are accessed in health centers while in Bama, health services are accessed in government hospital, NGOs and mobile outreach. Respondents in Dikwa and Bama mentioned that in order to prevent GBV and improve the status of women and girls, education, sensitization and empowerment is required. In Dikwa, respondents don't know of any laws/legislation that prohibits rape or incest but in Bama, respondents are aware of such laws.

- **Social norms, power and decision relations**

In Dikwa, roles and responsibilities are shared and these have changed after the insurgency. In Dikwa, girls, women, boys and men don't have access to resources and opportunities equally while respondents from Bama mentioned that there is equal of access to resources and opportunities among girls, women, boys and men. In both LGAs, men make decisions and this has not changed. Religious (Islam) and traditional beliefs prevent women from participating in decision making. Respondents mentioned that it was normal for couple to discuss about their sex life, and some women are free to refuse when they are sick, tired or menstruating or ask for sex while some are not because it is not religiously accepted. Some communities in Dikwa LGA forbid men from reacting to their wives' use of SRH services while other communities do not interfere. In Bama, nobody in the community reacts if a man forbids his wife from using SRH.

Summary of findings from the Qualitative Studies

Factors that can affect women or girls from using contraceptives to prevent sexually transmitted infections/HIV, unwanted pregnancies and laws that promote the use of SRH services are unknown to both male and female respondents. However, female respondents have more knowledge on the use of SRH and family planning services in both LGAs than male. Both men and women agreed that they were aware of abortion in both communities but mentioned that such practices are prohibited. GBV risks are still prevalent in the LGAs and women and girls are the most vulnerable groups. Women are still restricted from making decisions and mostly traditional rulers have access to resources and opportunities.

- The perception and attitudes of the communities in Dikwa and Bama LGA on the use of family planning are comparatively similar. Most of the men interviewed do not consider it a needful or legal act to practice, while women believed it is important to prevent unwanted pregnancies. Among men, religious, and cultural leaders had inadequate knowledge about family planning, this could be seen as factors were the leading cause to this perception. As the report shows that it is only in secondary or tertiary schools that they find information about sex and sexuality.

- Although some cases of abortion were reported, communities frown at it as it is considered illegal and sinful, making those who are involved to act clandestinely and patronize dangerous local methods or unlicensed doctors (quacks). It is important to highlight the fact that both male and female respondents in the communities were aware of the risks involved in undertaking abortion.

- The case of rape is a serious issue in any community, and the communities in Dikwa and Bama LGA are no exception. The reports from these community shows that rape is an issue that is mainly peculiar to girls and women. From the reports, cases of rape occur when women and girls leave the camp to get woods/water/on their way to/from the market. The report clearly shows that there are no adequate security agencies around to ensure their safety. Inequality is also not in favor of the female gender, as most of the community reports from boys clearly show that they see girls and women as inferior to boys and men.

- Community members tend to observe the social norms of their communities. Men appear to hold more power, they are the traditional leaders, and religious leaders so they automatically become the heads of families, make decisions and set rules. The only decision made by women as pointed out in the report is that of cooking and related affairs. Even though, it was made clear that the society does not interfere with family matters, most of the families still live by societal norms.

Summary of findings from Health Facility Assessment

Key informant interviews were conducted in nine (9) health facilities, four (4) in Bama LGA and five (5) in Dikwa LGA. Health facilities assessed included GH Bama, Kilaguro Clinic, IDP Camp Clinic, GSSSS Bama IDP clinic, MCH Clinic 2, Shehu Master Clinic, MCH Clinic, WHO Clinic, Falatari Clinic. Below is the summary of findings from the Key Informant Interviews

- **Report of Sexual Violence**

Of the four health facilities in Bama, GH Bama, Kilaguro camp clinic, IDP Camp clinic confirmed receiving reports of sexual violence, while only Falatari Camp clinic in Dikwa LGA received report of sexual violence.

- **Current SRH Intervention**

In Bama LGA, one out of the four health facilities (Kilaguro camp clinic) is currently providing SRH intervention, while in Dikwa LGA, three health facilities; MCH Clinic 2, Shehu Master clinic, and Falatari clinic, is currently providing SRH intervention. For Kilaguro, intersos, FHI360 and UNICEF were the organizations supporting sexual and reproductive health programs, while MCH Clinic 2, mentioned that no organization currently support them. Other health facilities did not provide names of organizations supporting them on SRH programs. GH Bama mentioned availability of four nurses-midwife for SRH services while others did not provide response.

- **Family Planning Services**

In Bama, GH Bama, IDP Camp clinic and GSSSS Bama IDP clinic provide free FP services, while for Dikwa, only Falatari clinic was not providing free FP services and Shehu Master clinic did not provide response. For Kilaguro clinic in Bama and Falatari clinic in Dikwa who were not providing FP services, their reason was the unavailability of contraceptives. For all the facilities, with the exemption of Shehu Master clinic, a registered nurse or nurse-midwife is responsible for providing FP services. In Shehu master clinic, a "community lady worker" provides FP services. Contraceptives provided by most of the facilities included Injectable, IUD, implant and condom. However, MCH clinic provides only injectable. IUD, implant and condoms were not provided. Also, GSSSS Bama IDP clinic did not provide condoms.

- **Post Abortion Care Services**

All the facilities except Shehu master clinic were providing Post Abortion Care services. Shehu master clinic mentioned unavailability of supplies prevented them from providing this service. Only GH Bama, GSSSS Bama IDP clinic, MCH Clinic 2 and WHO clinic provide PAC with MVA. Kilaguro clinic mentioned lack of demand while MCH clinic and Shehu master clinic mentioned unavailability of MVA kit and supplies respectively, as reasons for not providing PAC with MVA. All the facilities provide PAC with misoprostol except IDP camp clinic and Kilaguro clinic. Kilaguro clinic mentioned lack of demand as reason for not providing the service. All the facilities mentioned provision of FP services as part of PAC, while GH Bama, GSSSS Bama IDP clinic, MCH clinic 2 and WHO clinic were the only facilities storing FP materials in the same room where PAC is performed. Reasons for not storing FP materials in the room where PAC is being performed, Kilaguro clinic mentioned that it is not the right thing to do, MCH clinic mentioned that the PAC room was not conductive for FP materials while Shehu master clinic mentioned that FP supplies were not available.

- **Sexual and Gender-Based Violence**

All the facilities reported provision of free services for survivors of Sexual and Gender-Based Violence (SGBV). In GH Bama, male doctors and registered nurses were responsible for managing cases of SGBV, while in Kilaguro clinic, female doctors, male doctors and registered nurse-midwives were responsible for managing cases of SGBV. For other facilities, registered nurse-midwives and community female health workers were responsible for managing cases of SGBV. All facilities provide emergency contraceptives except Kilaguro clinic who mentioned lack of demand as reason for not providing it. Only Kliaguro clinic, GSSSS Bama IDP clinic, MCH Clinic 2 and WHO clinic provide Post Exposure Prophylaxis (PEP) HIV Kit while other facilities mentioned that the PEP-HIV kits were

not available. However, all the facilities provided antibiotics. All the facilities except Kilaguro clinic provided Hepatitis B vaccine. Kilaguro clinic mentioned lack of supplies as reason for not providing the vaccine. All health facilities provided referral for SGBV, and both Kilaguro clinic and Falatari clinic mentioned Intersos safe space as their referral center.

- **HIV Testing and ARV Service Provision**

All the health facilities provide HIV testing services, only GH Bama, MCH Clinic 2, Shehu Master clinic and WHO clinic provide Anti-Retroviral (ARV) while others mentioned that ARVs were not available. GH Bama, GSSSS Bama IDP clinic, MCH Clinic 2 and WHO clinic provided condoms while other facilities mentioned condom being unavailable as the reason for not providing them to patients. Only GH Bama provide safe blood transfusion services, while other facilities mentioned lack of equipment and supplies as reasons for not providing the service.

- **IEC materials, Communication and Transportation**

All facilities surveyed had IEC materials except GH Bama, GSSS Bama IDP clinic, MCH clinic 2 and WHO clinic. Both MCH clinic 2 and WHO clinic mentioned that IEC materials were available but not in the local language. All facilities had phone network and means of transportation. Distance to referral center varied among the facilities. For GH Bama, MCH clinic 2 and WHO Clinic, the distance to their referral center was 75km, 62km and 62km respectively, requiring 2-3 hours travel time, while others were less than 5km of about 10 – 15 minutes' travel time.

Conclusion

The baseline evaluation report has highlighted some of the salient issues on GBV and SRHR in Bama and Dikwa LGAs. Overall, the study identified poor awareness among community members (men, women, boys and girls) and limited access to GBV and SRHR services as the most important factors increasing the menace of GBV and SRHR violations in the communities. The study showed unequal distribution and access to information and services between men and women, further compounded by the religious and cultural practices that put women behind men. With most critical decisions including use of contraception and number and timing of births reserved for men, women continue to suffer in silence and an intervention on SRHR and GBV has become more important in these conflicts affected communities.

The objectives and anticipated outputs of CARE's SRHR project are well positioned to address the challenges of SRHR in Bama and Dikwa LGAs. Based on the findings from this study, both LGAs require program targeting increased awareness on sexual and reproductive health and rights that will ensure increased and equitable use of gender – responsive assistance, increase access of women, men, boys and girls to sexual and reproductive information and services. These objectives may be achieved through provision of training and facilities to improve preparedness and response to GBV, as well as other SRHR services identified as very lacking in these communities. While community mobilization and awareness are very important in improving knowledge and access to services, community and religious leaders were identified from this study as major stakeholders who can drive the messages of SRHR for increased community participation and acceptance and should be included as potential priority change agents to ensure result.

A structured and sustainable approach using new and existing community structures such as support groups as identified from the study will be of more impact and will help in reaching more people with the right information on a continuous basis required for achieving behavioral change. Integration of community and religious leaders as part of the support group as well as health service providers may be one of the strategies that will enhance acceptance and behavioral sustenance among the people. The study observed limited capacity of health facilities due to unavailability of drugs and other commodities required for effective and continuous SRHR service provision. Some training gaps were also identified therefore, interventions in these areas will increase health facility attendance and uptake of services. While, use of mobile clinic may be a good strategy that brings the health services closer to the people, there is need for proper awareness and clear objective of such strategy so that community members will not misinterpret them as abortion centers. From the study, community frowns at abortion and may be aggressive towards providing such services using mobile clinics.

In addition, poverty was identified as one of the main drivers of GBV and empowering men, women, boys and girls through this program is important. However, livelihood programs should not be limited to survivors of GBV alone, but should be considered as a major preventive strategy and made available in different forms to interested community members, while prioritizing survivors of GBV. The study identified the need to further improve confidence in the security agencies such as security agency[6], to respond to reports of GBV and sexual violations. Provision of awareness and orientation programs for members of the security agencies on investigation and prosecution of perpetrators of GBV may improve their capacity to respond and increase willingness of survivors to report cases of abuse to security agencies. This will ensure sustainability and continuity when other project specific programs terminate.

[6] Original name was changed to not single out any security agency

Sexual and Reproductive Health and Rights (SRHR) is the human right approach to sexuality and reproductive health in order to eliminate the preventable mother and child death and incidence of diseases. Based on findings from the study, SRHR was understood to be the rights of girl, women, boys and men in the community to sex, ownership of resources and family planning. The guiding principle are coordination, which involves effective information sharing; quality care that is accessible, comprehensive, inclusive and address the right of individual without discrimination; communication which involves passing of information through the right channels and Human right actors that govern how state treat people under jurisdiction and advocacy that involves strategic action to ensure that laws and norms practices enable people to enjoy their right to sex and reproductive health. SRHR is important in the prevention of GBV in addition to other very important interventions. While the challenges of insurgency have increased prevalence of GBV in North-east Nigeria, the lack of government policies and supportive environment continues to increase its impact on survivors who are often at the mercy of their abusers. Result presented in this evaluation report has identified several gaps that when addressed, will improve living and livelihood for boys, girls, men and women.