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Northeast Nigeria – Borno, Adamawa and Yobe States

Rapid Gender Analysis

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Abbreviations

ANC	Ante-Natal Care.
AYDI	Halliru Memorial Youth Development and Empowerment Initiative.
CJTF	Civilian Joint Task Force.
GBV	Gender Based Violence.
HIV	Human Immunodeficiency Virus.
IGA	Income Generating Activities.
NE	Northeast
OAG	Organized Armed Group
PNC	Post-natal Care.
RGA	Rapid Gender Analysis.
SRHR	Sexual Reproductive Health and Rights.
TEGA	Technology Enabled Girls' Ambassador.

Executive Summary

The combined effects of the ongoing insurgency, the COVID pandemic, and a looming food crisis are severely affecting men, women, boys, and girls in Borno, Adamawa and Yobe states in Northeast Nigeria. Women, girls, and at-risk and vulnerable groups are disproportionately affected by these combined crises. CARE and Plan International led this Rapid Gender Analysis (RGA) to update the needs of women and girls from those identified by the 2020 joint RGA between CARE, UN WOMEN and OXFAM. Given the evolving factors and context of the overlapping crises (Food insecurity and COVID-19), This RGA includes the additional dimension of analysis to more significantly include the experience and perspectives of adolescent boys and girls in this complex crisis.

In addition to a desk review, the RGA also analyzed data collected via individual interviews and group discussions with 1,133 women and men, 42% of which were adolescent girls and boys.

Among other findings, the analyses shed light on the differential impacts of the complex crisis on women, men, adolescent boys, and adolescent girls. The analyses also particularly highlighted the specific situation young married girls face in terms of restrictions on their mobility, their domestic and care burden, and the weight of social norms and expectations that limit their access to health (especially SRHR and protection services). General findings and specific gender and adolescent findings are in the box.

Key findings

- There is a balanced share of unpaid activities between male and female: Male involvement in homestead activities has increased from 20% before 2020 to 50% now and a reduction of women domestic tasks from 80% to 50%.
- As a results of the crisis and impact on livelihoods, adolescents are faced with an increased burden to take on domestic duties (particularly for girls) and to contribute to the household income.
- Most of students who did not resume school since covid closure are girls due to domestic burden and food survival struggle. Some small IGA activities girls invest in (street sale via hawking, domestic worker) increase their risks to exploitation and abuse.
- Although girls have much limited capacity and business opportunities than boys, they are much more keen to invest all their earning in their family (69%) than boys (31%).
- Up to 2/3 of respondent of all ages report reducing the number of meals, limiting meal portion and eating less preferred/less expensive food during the last 7 days.
- Gender and social norms combined with the crisis result in limited access to family planning and high rates of risky adolescent pregnancy and the need for cesarean sections and life-saving services for treating other complications in pregnancy.
- Married adolescent girls face severe constraints and mobility restriction as they need husband approval and accompaniment to seek SRH services and to leave the home, they also face time poverty and limited opportunities to build skills and get support in case of security concerns, nevertheless they are seen by the unmarried adolescents as having more decision-making power in the home.
- Protection concerns for girls this includes sexual violence and abuse (including in the home), lack of safe spaces in the community and family pressure to engage in early marriage.
- Despite their interest, adolescents, particularly adolescent girls have limited opportunities and face overlapping barriers for meaningful participation and contribution to decision-making to support their communities.
- Despite impacts of the crisis on availability of and access to health services, improvements in access has been made since the peak of COVID due to the sustained efforts of NGOs. Deteriorating funding levels in NE Nigeria alongside SRHR being perceived as a women's issue must be highlighted
- Lack of trust in the health system and other misconceptions and rumors fuel low uptake of the COVID vaccine, especially among groups that need it the most (elderly, pregnant women, etc.)
- Despite women's leadership in serving their communities during COVID, women's participation in decision-making is half of that of men.

Key recommendations

The recommendations listed below include solutions stratified by key stakeholders including donors, implementing agencies (local partners and INGOs) and government/policymakers and by key sectors.

Livelihoods and Food

Implementing Agencies

- Review current targeting criteria and implementation modalities for livelihood and food programming (including for cash-based transfers) to ensure that nutrition priorities sufficiently meet the needs of the most vulnerable (such as pregnant women, girls of reproductive age and adolescents).
- Invest in the integration of psychosocial support services in parallel to food and livelihood programs and services, ensuring that all staff are skilled and informed of up-to-date resources around GBV services and referrals.
- Undertake a gender and age-sensitive market assessment and develop opportunities for vocational trainings with a special attention to agriculture and agribusiness initiatives and strengthening adaptive entrepreneurial skills, especially for women and young people.

Government and Policy Makers

- Create pathways for temporary employment and economic relief through subsidies and small grant programs to mitigate negative coping strategies, especially targeting women entrepreneurs and leaders.
- Invest in expanding programs that build from existing interest and engagement of adolescents, especially as it relates to initiatives that strengthen local food production.

Donors

- Establish monitoring mechanisms to hold implementing agencies accountable to collect and apply more gender-responsive approaches that responds to sex and age differentiated needs and interests.
- Support funding that allows for the sufficient integration of professional GBV staff in across livelihood and food portfolios to ensure appropriate risk mitigation standards are upheld.

SRHR and other health services

Implementing Agencies

- Connect female frontline workers including community health workers to market-based approaches to ensure their economic resilience during crises and support diverse incentivization programs for their continued growth, advancement, and learning, particularly in areas related to pregnancy and maternal health and nutrition.
- Collaborate with local civil society organizations, religious leaders, and respected community leaders to develop innovative approaches and spaces for safe dialogue around SRHR issues, concerns and misconceptions including on methods of modern contraception, healthy timing and spacing of pregnancies, specifically targeting men and boys.
- Invest in the integration of psychosocial support services in parallel and integrated into to existing health and SRHR services with a focus on adolescent girls and boys, with a focus on strengthening referral pathways for specialized and age-appropriate care (including for GBV).
- Integrate two-way dialogue through risk communication and community engagement approaches to listen to concerns, myths and rumors and share localized, accurate information on disease prevention and hygiene promotion leveraging community networks including women and youth-led groups.
- Replicate successful pilots and programs tailored to and responsive of the unique needs of adolescents, such as utilizing CARE & UNFPA's [AMAL Initiative](#) for pregnant adolescents and first-time mothers, and Plan International's Adolescent Programming Toolkit.

Government and Policy Makers

- Advocate for the appointment, training, recognition and compensation of women leaders at the last mile (police, health workers, social workers), particularly frontline health workers to improve access of adolescent girls and women to quality GBV/SRHR services including during future disease outbreaks or other crises.
- Improve accountability and trust in health systems by regularly facilitating feedback forums and providing other platforms where communities (inclusive of adolescent groups) and health providers can discuss barriers and needs related to private and public health and SRHR services.

Donors

- Continue to raise awareness for the need for critical investments in local professionals and health facilities (specifically those providing SRHR, mental health and psychosocial services), including specialized services for adolescent girls and boys.
- Replicate and support successful pilots and programs tailored to and responsive of the unique needs of adolescents, such as utilizing CARE & UNFPA's [AMAL Initiative](#) for pregnant adolescents and first-time mothers, and Plan International's Adolescent Programming Toolkit.

Education

Implementing Agencies

- Girls in particular prioritised education as a key gap for them, although this was true for both boys and girls. Ensure that gendered or other barriers to education are addressed in programming using community awareness sessions, cash distribution for education purposes, school meals, and safety audits to assess what more can be done to ease children's access to schooling.
- If access to schooling is addressed, also plan for retention of students. Gender sensitive wash in schools, transportation assistance, and women teachers/teaching assistants as well as child protection focal points could be potential solutions.
- Investigate further why education is not being provided in Lamurde in Adamawa.

Government and Policy Makers

- Advocate for more funding and attention to education in emergencies as a lifesaving activity.
- Advocate for teacher training, especially for female staff.

Donors

- Provide education in emergencies funding and ensure that access for both girls and boys is eased, particularly targeted in the areas mentioned above where education is not being provided.
- Ensure all education programming is based on a thorough gender analysis that can identify and address barriers to schooling.

Cross-Cutting Recommendations

Implementing agencies

- Foster greater sensitization around discriminatory social and gender norms, inclusive of engaging adolescent girls and boys in identifying pathways and opportunities for shifting power dynamics and adapting programming to accommodate more inclusive feedback processes.
- Apply learnings from effective methodologies that promote inclusive and participatory design and programming models such as [CARE's Women Lead in Emergencies](#) or [Plan's Adolescents in Emergencies Toolkit](#).
- Ensure that the most up-to-date referral pathways are made available to all program teams and that staff are equipped with the core competencies in GBV risk mitigating as an integral part of program operations. Additionally, ensure that professional and specialized staff are available to support and provide guidance on GBV related issues, including on adolescents.

Government and Policy Makers

- Support revisiting of community level decision-making structures to more meaningfully ensure leadership of women and adolescents in emergency preparedness, response and ongoing recovery efforts.
- Advocate for a prioritization of resources that strengthen youth participation and civil society networks through peer-to-peer groups, adolescent/youth clubs, community and women and girls' safe spaces and other platforms that support marginalized voices to gain confidence and raise their voices in community-level processes and decisions.

Donors

- Require program design and decision-making to be based on updated RGA recommendations and analysis for more effective response and resilience building programming.
- Ensure continued investment in gender-transformative research and programming including multi-year, multi-sectoral funding for men, women, adolescent boys and girls affected by crisis in NE Nigeria.

Introduction

Background

The conflict stemming from the insurgency of organized armed groups (OAGs) in Northeast Nigeria continues as intensely as ever. The attacks and insecurity have displaced millions of people, devastated agricultural production and other livelihoods, cut off and limited essential services, and caused a crisis around safety and protection.

The impacts of COVID-19, combined with a complex humanitarian context, presents an unprecedented global crisis with unique challenges for humanitarian and development actors in Northeast Nigeria. Even before the crisis, approximately 4 in 10 Nigerians were living below the national poverty line and millions more were living on the cusp of the poverty line, making them vulnerable to falling back into poverty when shocks occur.¹ Moreover, almost 13 million people are projected to face food insecurity during the lean season,² which is a 48 percent increase from 2020.³

In the Northeast states of Borno, Adamawa and Yobe (BAY states), about 8.4 million people will need humanitarian aid in 2022. Of these, 2.2 million are internally displaced, 1.5 million are returnees, and 3.9 million are members of host communities. The population needing humanitarian aid in the BAY states also includes the majority (an estimated 733,000) of the 1 million people in areas currently inaccessible to humanitarian actors.

This complex situation has disproportionately affected women and adolescent girls, as well as at-risk and vulnerable groups that include but not limited to children, elderly, pregnant and lactating women, people living with chronic diseases and/or disabilities, etc. The results of an RGA conducted by CARE, UN WOMEN and OXFAM in 2020 revealed the striking impact of COVID-19 on Nigeria's economy and highlighted the critical need for up-to-date information on access to services particularly for displaced women and girls. Given the rise in insecurity, alarming rates of food insecurity, and compounding impacts of COVID-19, CARE and Plan International undertook this RGA to not only update the needs of women and girls based on the evolving realities of the compounding crisis (food insecurity and COVID-19), but also to conduct a deeper analysis on the impact of this complex crisis from the perspective of adolescent boys and girls.

Rapid Gender Analysis Objectives

The RGA explores and assesses the differentiated impacts of COVID-19 and the food insecurity crisis on women, men, adolescent girls, and adolescent boys both in humanitarian and development settings to provide recommendations for program adaptations and/or provide the foundation for new interventions.

Specifically, this RGA will:

- Identify how the crisis has influenced the gendered division of labor, meaningful participation in decision making, and control and access to resources, with a specific focus on the inclusion of adolescents.⁴
- Identify the barriers, risks, and opportunities for accessing public spaces and services, with a focus on food security, health, markets, legal, financial, and extension services.
- Identify sources of increased safety and protection risks, with a focus on gender-based violence.
- Determine the level of access to information about the pandemic, health and markets services across diverse population groups, including adolescent girls and boys and other vulnerable populations.

Methodology

Rapid Gender Analysis (RGA) provides information about the different needs, capacities and coping strategies of women, men, boys and girls in a crisis. Rapid Gender Analysis is built up progressively using a range of primary and secondary information to understand gender roles and relations and how they may change during a crisis. It provides practical programming and operational recommendations to meet the different needs of women, men, boys and girls and to ensure we 'do no harm'. Rapid Gender Analysis uses the tools and approaches of the Gender Analysis Frameworks, and adapts them to the tight time-frames, rapidly changing contexts, and insecure environments that often characterize humanitarian interventions.

¹ *Monitoring COVID-19 Impact on Nigerian Households*. World Bank. <https://www.worldbank.org/en/country/nigeria/brief/monitoring-covid-19-impact-on-nigerian-households>.

² Period from May to August where households have exhausted their food stocks, with less pasture for livestock, and households typically depend on different types of coping strategies to meet their food needs

³ *Food Security Highlights (West Africa June-August 2021)*. World Food Programme. https://fscluster.org/sites/default/files/documents/wfp_food_security_highlights_issue_2_june_2021.pdf.

⁴ The age bracket considered in this RGA as adolescents is 15-19 years as agreed by Plan and CARE

The field phase of research for this RGA was undertaken from February 14th, 2022, to March 16th, 2022. Primary data collection was conducted in 20 communities within 10 LGAs, 5 in Borno state (Bama, Dikwa, Maiduguri, Damboa and Ngala); 3 in Yobe (Damaturu, Nguru and Bade) and 2 in Adamawa (Girei and Mubi South).

For this RGA, CARE and Plan International partnered with two regional organizations that were able to assist with data collection, analysis, and reporting: the RGA Cooperative and its own local partner the Technology Enabled Girl Ambassador (TEGA) program. The RGA Cooperative is an independent network of gender experts, consultants, and feminists who come together to offer quality and localized services at scale in the topic area of gender in emergencies, with a focus on Rapid Gender Analyses. Piloted in West Africa, this initiative mobilizes a group of 16 experts under the lead of Cabinet Nitsouwa.⁵ The Technology Enabled Girl Ambassador (TEGA) program is a dismemberment of the Girls Effects Initiative in Nigeria. This program invests in adolescent girls ages 16-24 and trains them to carry out surveys with young adolescents, families, community members, and other stakeholders using technology (a TEGA App) within and outside Kano State, Nigeria for different research projects.

Secondary Data Review

A desk review was conducted by three RGA Cooperative members, and consisted of collecting and analyzing existing information including COVID-19 data, gender and food security assessments reports, and other relevant publications including humanitarian situation reports in Northeast Nigeria and more globally.

Primary Data Collection

Primary data collection was conducted by a total of 37 enumerators (20 female and 17 male) and 3 field supervisors (one for each state) provided by CARE and Plan International. Four TEGAs also contributed to data collection and utilized their experience and practice in the areas of adolescent girls' social mobilization and engagement. Consent was obtained from all research participants (including adults, parents/caregivers, and adolescents) using the Informed Consent tool prior to data collection.

Before entering the field, the team received three days of training on gender, protection, safeguarding, safety and security, RGA data collection principles, and RGA methods and tools. Additionally, enumerators engaged in a pilot tools testing to be more aware of and comfortable with administering data collection tools. The following methods were used as part of primary data collection:

- **Focus Group Discussion (FGD):** 60 FGDs were conducted with separate groups of women, older adolescent (15-19 years) girls, and older adolescent boys. 3 FGDs (composed of 6-12 people each) were conducted per location. The standard CARE RGA toolkit FGD discussion guide was adapted and applied to both adolescents and adults.
 - Plan International's Preference Ranking tool and A Day in the Life of a Young Person tool were also administered to adolescent groups to gather their perspectives on concerns, priorities, and specific vulnerabilities faced by sub-groups of adolescent boys and girls.⁶
- **Key Informant Interview (KII):** 64 key informants were selected from among respected community leaders, religious leaders, and services providers (health, child protection, and GBV), and were interviewed with CARE's adapted KII tool.
- **Individual Survey:** A quantitative survey was conducted using an adapted version of the RGA toolkit household survey tool. The Kobo Collect platform was utilized for mobile data collection.
 - The sample for the quantitative survey was calculated randomly using the probabilistic formula $n = \frac{t^2 \cdot p(1-p)}{e^2}$, with the probability of occurrence of the event (p) at 50%, a confidence level (t) of 95%, and a margin of error (e) of 5%. The equation produced a sample size of 406, and after adjustments to balance the weight of certain communities and to cover for non-valid data, the final survey sample was set at 531. The proportion and number of adolescent boys, girls, men and women in each community are listed in Annex 1, Table 1.

Quantitative data was analyzed using Kobo Collect, SPSS and Excel, while qualitative data was analyzed manually. Debriefing and validation sessions were organized to share and discuss key findings (especially in regards to the adolescent findings and the SRHR component), to review the draft report, and to approve the final report.

The following **limitations** were identified:

- Limited capacity among data collection team regarding qualitative data collection and understanding of adolescent engagement tools like A Day in the Life of a Young Person, especially in areas where CARE had no prior presence (Damboa).
- Adaptation and harmonization of adolescent engagement tools was ongoing throughout the entire data collection period.

⁵ from Niger, Burkina Faso, Senegal and Nigeria

⁶ Two adolescent profiles were studied: A 17 years in-school boy from a vulnerable family and 16 years married girl, a first-time mother, out of school, displaced due to crisis

The above limits do not affect the quality and validity of the data and related analyses. In addition to the reported limitations, it is important to note that the wide scope of this RGA (BAY states) cannot do justice to the richness of geographical specificities or the differences between rural and urban areas within and across states and LGAs. The report emphasis, therefore, is on analyzing gender gaps with specific focus on adolescents, while highlighting state-level differences.

Findings and Analysis

Demographic Profile

An estimated 13 million people currently live in the BAY states. The population is predominantly Muslim and comprised of individuals from the Kanuri, Fulani and Hausa ethnic groups. The ongoing conflict, combined with the COVID pandemic and looming food insecurity, has placed up to 8.4 million people in need of humanitarian aid in 2022 (table 1). Of these 8.4 million people, 2.2 million are internally displaced persons, 1.5 million are returnees who lack essential services and livelihoods, and 3.9 million are members of communities affected by their hosting of internally displaced people. Women, girls, and boys constitute over 80% of the people in need of humanitarian aid.⁷

Gender roles and responsibilities

Despite their complaints about domestic tasks; adolescent boys, especially in Yobe, recognize that girls are much busier with domestic tasks than boys, and that this affects their school attendance.

Table 1: People in need by sex, Nigeria HRP 2022

	People in Need (Million)	People targeted (Million)	% Targeted
Adol. Boys	2.3	1.6	70%
Adol. Girls	2.6	1.8	69%
Men	1.6	1	63%
Women	1.8	1.2	67%
Total	8.3	5.6	100

A total of 1133 individuals (62% female) participated in at least one method of primary data collection, and were spread between the Borno (59%), Yobe (35%), and Adamawa (31%) states. Participant details are further explained in Annex 1, Table 2 and Table 3.

Gender Roles and Responsibilities

Division of (domestic) labor

Qualitative discussions and secondary data both showed that family units in the BAY states operate with the traditional gender division of labor.⁸ Men act as the main provider for the family and are expected to partake in income generating activities while women generally stay home to handle domestic unpaid tasks. Adolescent girls and boys are expected to partake in domestic tasks, attend school, and work on family farms, with adolescent girls taking on a heavier share of domestic tasks and boys spending more time farming.

Gender roles and expectations have changed since the insurgency due to unprecedented security issues and population displacement that has led to the death, separation, or injury for many of the male heads of households.⁹ The family breadwinner role has shifted to women or is at least more equally shared with women. Boys and girls spend more of their time participating in income earning activities. Many men have lost their livelihoods due to destruction of irrigation and farming facilities, the loss of livestock, and reduced access to fishing grounds, and as a result they have taken on a larger share of domestic tasks (such as collecting firewood and water and cleaning).¹⁰

The combined effects of the COVID pandemic and growing food insecurity have deepened the changes in gender roles and expectations. Without the possibility of earning an income, men’s status in the household is threatened as they are no longer

⁷ Nigeria Humanitarian Needs Overview 2022 (February 2022). OCHA. <https://reliefweb.int/report/nigeria/nigeria-humanitarian-needs-overview-2022-february-2022>.

⁸ Rapid Gender Analysis of Affected Population in Borno, Adamawa and Yobe States: Main Findings (December 2017 to August 2018). FAO. <https://reliefweb.int/report/nigeria/rapid-gender-analysis-affected-population-borno-adamawa-and-yobe-states-main-findings>.

⁹ Since 2009 the beginning of the insurgency

¹⁰ Rapid Gender Analysis of Affected Population in Borno, Adamawa and Yobe States: Main Findings (December 2017 to August 2018). FAO.

able to provide as breadwinners.¹¹ At this time, adolescent girls and boys also report having increased responsibility placed on them to help out with domestic tasks and manual jobs to earn money. According to adolescent boys, the way they spend their time has changed greatly since the start of the pandemic as a result of additional chores. For example, boys reported that they were now expected to fetch water and collect firewood before going out for school or business. Both girls' and boys' groups also mentioned the imbalance in the split of domestic tasks between them. Adolescent girls' groups in MMC Bulabulin reported that "girls are the only one carrying out domestic tasks such as cooking while boys go out and play and do other things". Despite their complaints about increased domestic tasks, boys (especially in Yobe) recognize that girls are much busier with domestic tasks than they are, and that this affects girls' school attendance. Young married girls in particular are especially overburdened with domestic tasks, as they have to balance them with their additional caregiving and spousal responsibilities.

During focus group discussions, women, adolescent boys, and adolescent girls in Borno also all mentioned that the crisis has caused a shift in their daily timetable. A typical day's activities used to start as early as 6 am with firewood and water collection, but now can only begin at 9 am because of security concerns. This has made attending school in mornings challenging for some adolescents. Furthermore, some students, especially girls from vulnerable families, have permanently dropped out of school after initially being sent home due to COVID-induced school closures. According to UNESCO, among the 36.4 million students affected by COVID-induced school closures across Nigeria, very few (mostly from privileged families) were able to access quality remote or alternative learning.¹² In the BAY states, the closure of schools affected 4.2 million students, with up to 400,000 being IDP children from vulnerable families.¹³

Earning income

According to both quantitative and qualitative data, before 2020 both men and women took part in productive and income-earning opportunities. For individuals living in host communities, this includes activities such as farming, herding, fishing and running small businesses. Income-earning activities for IDPs aimed at supplementing the humanitarian assistance they were already receiving. This includes working for small retailers or as manual laborers for men, and handmade trading activities mostly for women. Adolescent boys and girls, mostly from vulnerable families, practice small income-generating activities and menial work to complement their parents' income.

COVID-19 prevention measures have negatively impacted the ability of both men and women to earn income. There are reduced economic opportunities, fewer employment opportunities and IGAs (mostly in the formal and male dominated sphere outside of the home) leading to loss of livelihoods, and businesses are closing down.¹⁴ Loss of earning potential makes coping with the looming food insecurity crisis and increased prices for food and other amenities even more difficult. In April 2022, the cost of food in Nigeria was 18.37% more than it had been in the same month in 2021.¹⁵ In order to overcome the multiple hardships, it has become critical for all members of the household (including men, women, and adolescent boys and girls) to partake in income-generating activities. Adolescent girls earn income by taking part in handwork (cap knitting, tailoring, making hygienic products including soaps and traditional perfumes, etc.), street selling and hawking foodstuff, and paid domestic work (cleaning and cooking). Adolescent boys take part in income-generating activities at a higher rate than girls, and partake in cap making, tailoring, carpentry, making shoes, welding, selling water and vegetables etc. Adolescents' earned income can be saved for personal expenses but is often used to complement family resources. Adolescent girls and adult women are twice more likely to share all their income earnings (Figure 1) with their family members (69.2% and 63.2% respectively) than men and adolescent boys (36.8% and 30.8% respectively).

¹¹ *Rapid Gender Analysis, North East Region, Nigeria (July 2020)*. CARE, Oxfam, UN Women. <https://www.careevaluations.org/wp-content/uploads/NE-Nigeria-RGA-final-2020.pdf>.

¹² *COVID-19 Educational Disruption and Response*. UNESCO. <https://en.unesco.org/news/covid-19-educational-disruption-and-response>.

¹³ *Nigeria Education Sector 2020: COVID 19 Response Strategy in North East*. https://resourcecentre.savethechildren.net/pdf/nigeria_education_sector_covid-19_response_strategy_north_east_.pdf/.

¹⁴ *How livelihoods deteriorated in Sub-Saharan Africa due to COVID-19* (Jan 2021). World Bank, <https://blogs.worldbank.org/african/how-livelihoods-deteriorated-sub-saharan-africa-due-covid-19>.

¹⁵ *CPI and Inflation Report May 2022*. National Bureau of Statistics, Nigeria. <https://nigerianstat.gov.ng/elibrary/read/1241183>.

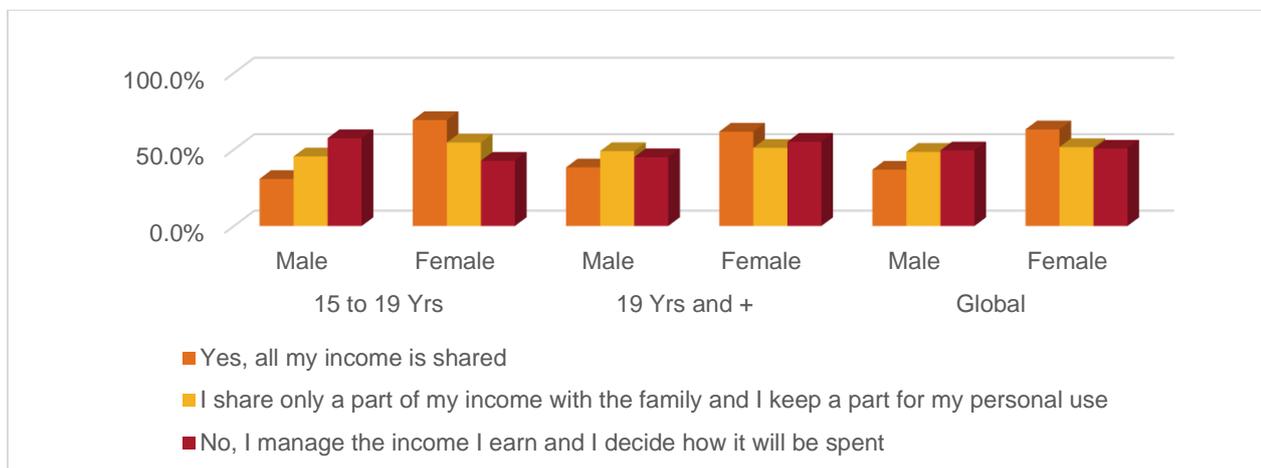


Figure 1 - Do you share your income with your husband/wife/parents or family members?

Other issues affecting income-earning activities for individuals living in the BAY states include insecurity, lack of capital, and lack of equipment and skills. Lack of business equipment (like sewing machines), and skills particularly adolescent girls, as they have more domestic chores than boys, meaning they have less freedom to go outdoors where they can develop additional skills. Married girls with children face additional burdens and limited opportunities to develop their skills mainly due to time poverty, and restricted mobility.

Control of resources

Before the insurgency, women had little access and control over family resources including food, clothing, and water. As the head of the family, men largely had control over family resources and made decisions on how resources would be shared within their families.¹⁶ As reported by boys in Adamawa, “*men go out to purchase the food items, measure the right quantity and give to the women to cook*”. Girls and boys don’t have control of family resources and are dependent on their fathers and mothers. With the insurgency and the increasing number of women becoming heads of their families and/or direct recipients of humanitarian assistance, women have gained more control over resources (both food and non-food items). Adolescent boys and girls also now have more opportunity to control resources through the income they earn from their business and menial work activities. While responsibility for family resources has become more evenly dispersed, access to the resources themselves has rapidly declined due to the COVID-19 pandemic, food insecurity, and the rising cost of living. Adolescent girls in Adamawa report that “*food and non-food items that were accessible initially because it does not cost much but now due to inflation, we hardly can afford it*”.

Decision making within the household

Due to the patriarchal structure of the BAY societies, women usually hold a subordinate position to men, with reports that “...even young boys are normally seen as being the ‘second in command’ after their father and can overrule adult women”.¹⁷ Within the family, men take decisions on assets and resources, and control decisions on how family income will be spent, including income earned by women.¹⁸ Although women participants in focus group discussions in Borno affirmed that women did not participate in decision making before 2020, CARE and FAO studies revealed that pre-COVID, women were able to make decisions on aspects such as day-to-day cash expenditure, children’s education, and family events (wedding or naming ceremonies).¹⁹ While men made the final strategic decisions, women did have significant influence on men in their households.

¹⁶ *Rapid Gender Analysis of Affected Population in Borno, Adamawa and Yobe States: Main Findings (December 2017 to August 2018)*. FAO. <https://reliefweb.int/report/nigeria/rapid-gender-analysis-affected-population-borno-adamawa-and-yobe-states-main-findings>.

¹⁷ *Rapid Gender and GBV Assessment in MMC and Jere Local Governments – Borno State*. CARE <https://careevaluations.org/evaluation/rapid-gender-and-gbv-assessment-in-mmc-and-jere-local-governments-borno-state/>.

¹⁸ *Rapid Gender Analysis of Affected Population in Borno, Adamawa and Yobe States: Main Findings (December 2017 to August 2018)*. FAO.

¹⁹ *Rapid Gender Analysis of Affected Population in Borno, Adamawa and Yobe States: Main Findings (December 2017 to August 2018)*. FAO.

87.5% of respondents to CARE’s RGA conducted in 2018 reported that women are involved in decision making in the family.²⁰ Female heads of families have been making all family-related decisions since before the pandemic.^{21,22}

According to the quantitative survey, 55.5% of males versus 44.5% of females reported that husbands decide on how money is spent in the family. Discussions with adolescent boys and girls, revealed that young people in general do not take part in decision making at home because of their age. They are under the responsibility of their parents who are the decision makers at home. Adolescent boys and girls can be involved in decision making for specific issues affecting their life including healthcare, school attendance. They also have more decision-making power in regard to how money is spent because of their increasing contribution to their family expenses. 62% of adolescent boys and 38% of adolescent girls responding to the quantitative survey affirmed that they have money of their own for which they can decide alone on its use. 8 of 19 adolescent groups also reported that a married girl can take some decision in her own family due to her new responsibilities, but she still does not have decision-making power over aspects such as mobility and family planning.

Capacity and Coping Mechanisms

Livelihoods

Even prior to the COVID pandemic, individuals living in the BAY states were struggling to maintain their livelihoods activities because of disruptions caused by the insurgency. For example, the agriculture sector, which used to provide livelihoods for about 90% of the rural population of NE Nigeria has been devastated by the insurgency (destruction of farming facilities, destruction of irrigation and livestock, reduced access to farmlands and fishing grounds, etc.).²³ The conflict had already had an estimated USD 3.7 billion impact on agriculture by 2015, and this damage has only worsened over time.²⁴ As a result, there has been a drastic reduction in the number of people depending on agriculture as their primary source of income, and an increase in the number of people depending on humanitarian assistance and other sources of income such as casual labor.²⁵

According to the quantitative survey, 18% of males and 82% of females did not partake in paid activities before 2020 (Figure 2). Since 2020, the COVID-19 pandemic has disrupted income-generation activities and livelihoods, and further widened the gender gap in employment and business earnings. Globally, women workers’ likelihood of losing their job between April and June 2020 was 36% compared to 28% among men.²⁶ Additionally, while all firms in Nigeria have experienced a drastic decline in sales, women-owned businesses have registered higher shares of closures of business.²⁷

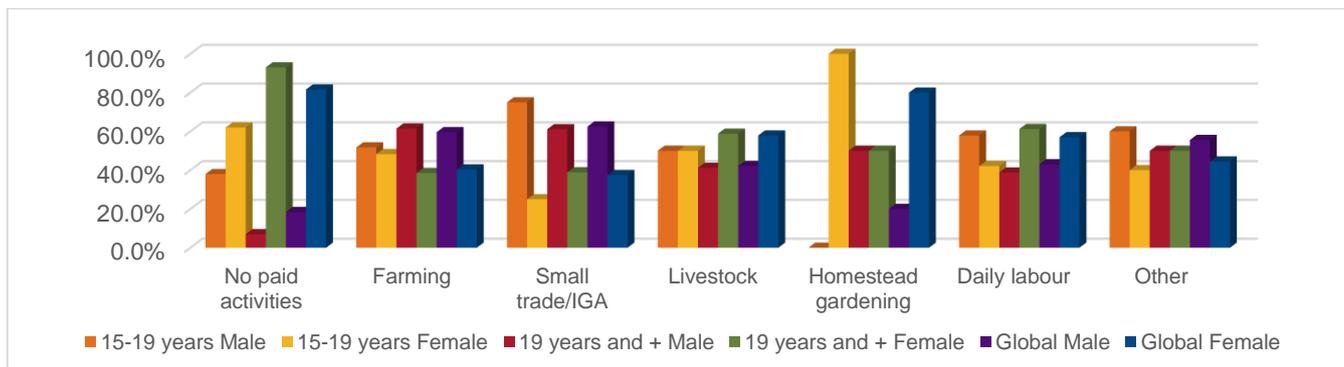


Figure 2: Main activities before 2020 by sex and age groups

The stress of the COVID pandemic, compounded with the already-present food and labor insecurity has prompted women, men, adolescent boys, and adolescent girls to practice various coping mechanisms including engaging in new business

²⁰ Rapid Gender and GBV Assessment in MMC and Jere Local Governments – Borno State. CARE

<https://careevaluations.org/evaluation/rapid-gender-and-gbv-assessment-in-mmc-and-jere-local-governments-borno-state/>.

²¹ Rapid Gender Analysis of Affected Population in Borno, Adamawa and Yobe States: Main Findings (December 2017 to August 2018). FAO.

<https://reliefweb.int/report/nigeria/rapid-gender-analysis-affected-population-borno-adamawa-and-yobe-states-main-findings>.

²² Nigeria: 2021 Humanitarian Response Plan (February 2021). OCHA, <https://reliefweb.int/report/nigeria/nigeria-2021-humanitarian-response-plan-february-2021>.

²³ FAO’s Nine-month Action Plan: Mitigating the impact of the conflict on livelihoods (2017). FAO,

<https://www.fao.org/3/i6328e/i6328e.pdf>.

²⁴ Rapid Gender Analysis of Affected Population in Borno, Adamawa and Yobe States: Main Findings (December 2017 to August 2018). FAO.

²⁵ Food security and livelihood assessment report, North East Nigeria, April 2018. ADRA, <https://reliefweb.int/report/nigeria/food-security-livelihood-assessment-report-north-east-nigeria-april-2018>.

²⁶ Gender and COVID-19, What have we learnt, one year later? (June 2021). World Bank, Poverty and Equity Global Practice.

<https://openknowledge.worldbank.org/handle/10986/35829>.

²⁷ The Global State of Small Business during COVID-19: Gender Inequalities (Sept 2020). World Bank Group,

<https://blogs.worldbank.org/developmenttalk/global-state-small-business-during-covid-19-gender-inequalities>.

activities. Quantitative survey results have shown a slight change in the proportions of people not participating in paid activities after 2020, with a reduction for females from 81.6% to 80%, and an increase for males from 18.4% to 20% (Figure 3). There has been a significant increase in the involvement of males in homestead activities, from 20% before 2020 to 50% since the start of the pandemic, and a subsequent reduction of women's domestic tasks from 80% to 50%. Despite these changes, adult women still participate in business activities at much lower rates than adult men. This is mostly because of their limited mobility and exposure outside the home. According to a previous RGA conducted in NE Nigeria, “only single women, widows, elder women or married women from vulnerable and poor families practice business outside of the family compound because they do not have any alternative options. The community perceives negatively a married woman doing business in the street or at marketplaces. With the insurgency, women and girls have more freedom of movement outside the home, especially those IDPs living in camps but generally movement outside the community is limited both for women, girls than for boys and men for security reasons”.²⁸

Adolescent boys and girls have also experienced changes in their likelihood of partaking in paid activities as a result of the pandemic. The proportion of adolescent girls participating in small trade and IGA increased from 25% to 56%, and the involvement of adolescent boys in homestead activities increased from 0% before the crisis to 50%.²⁹ Adolescent boys also reported increases in daily labor (58% to 63%), and in livestock work (50% to 100%), and the proportion of adolescent girls partaking in homestead activities reduced from 100% to 50% (See Figure 3 for details).

Adolescent boys generally have more opportunities to develop livelihood skills in comparison to adolescent girls because of the gender roles and social and traditional practices that keep girls at home and busy with domestic chores. This unequal situation was not well understood by some adolescent boys who participated in the focus groups, as they exhibited gender biases and tried to justify their increased skills with stereotypes. For example, boys from Nguru Garbi Bambari reported that “skills like cooking are specific to women, and because we believe if a man gets it (livelihood skill) he will take care of the women so boys have more opportunities.” Additionally, in Bama Shehuri, boys reported that it is not opportune for them if girls develop certain skills that are currently only held by boys.

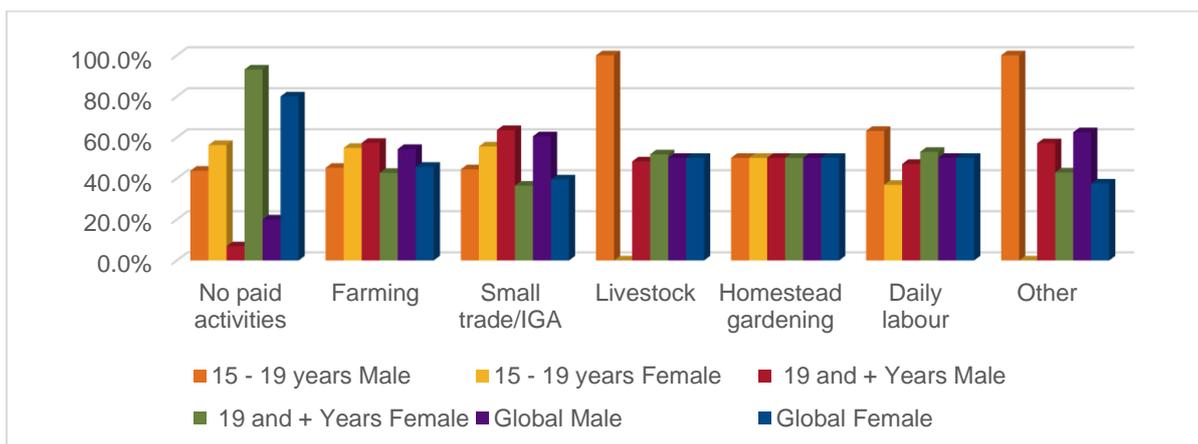


Figure 3: Main Activities per sex and age groups since 2020

Coping strategies

Women, adolescent boys, and adolescent girls all report that they have adopted various coping mechanisms as a result of the crisis. These range from normal to harmful strategies for survival. For example, as seen in the section above, women, adolescent boys, and adolescent girls have all started or increased their participation in business activities and IGA to cope with unsteady livelihoods and to earn money and meet their food and non-food items needs. Other coping strategies include relying on relatives or family members for financial support, receiving in-kind assistance from relatives, partaking in social solidarity by sharing food with those without food, relying on support or remittances from parents and friends, and relying on assistance from the government and humanitarian actors.

Because of rising food insecurity, women have also adopted more harmful strategies such as reducing the quantity and quality of food that they eat. Women in Borno reported reducing their number of daily meals, reducing the quantity of meal, reducing the diversity and quality of the ingredients used to prepare food, selling assets, and begging for food. Women in Damaru reported food abstinence when food was scarce and giving priority to feeding their children before themselves. These harmful

²⁸ Rapid Gender and GBV Assessment in MMC and Jere Local Governments – Borno State. CARE

<https://careevaluations.org/evaluation/rapid-gender-and-gbv-assessment-in-mmc-and-jere-local-governments-borno-state/>.

²⁹ Homestead activities refers to unpaid domestic activities

coping strategies have a negative impact on the nutritional status of women, and especially impact pregnant and lactating mothers who have increased nutritional needs.

Adolescent boys' and girls' harmful coping strategies include begging, dropping out of school, or low school attendance. Adolescent boys have also adopted strategies including stealing, drug abuse, and other negative behaviors. Some of the risks associated with these survival strategies include exploitation, abuse, and sexual violence (especially when engaging in sex for survival). Similarly, both adolescent boys and girls have also reported harmful strategies to cope with growing food insecurity. Adolescent quantitative survey respondents reported that in the past 7 days, they had reduced their number of meals (70%), limited meal portion size (71%), and eating less preferred/less expensive foods (78%).

According to the quantitative survey, up to 84% of adolescent respondents and 89% of adult respondents reported that they did not practice any harmful coping strategies such as stealing, begging, or engaging in sex for survival during the last 7 days, but 13% of adolescents and 10% of adults did report that they had practiced at least one of the aforementioned coping strategies at some point (Figure 4).

	0 day	1 day	2 day	3 day
15 - 19 yrs	84,2%	7,5%	6,7%	1,7%
19 years and +	89,4%	5,4%	4,2%	,7%

Figure 4: Relying on harmful coping strategies such as stealing, begging, sex for survival, etc. during the last 7 days

Access

Access refers to both the mobility and ability of individuals to procure services, and the ability of humanitarian actors to reach affected populations. In the BAY states, access has been challenging since the insurgency due to curfews, insecurity, and security measures, especially in IDP camps. Overall, access had improved significantly from the beginning of the insurgency until 2020, when the pandemic brought on new types of access limitation challenges.

Mobility Analysis

Traditionally, the movement of women, girls, and children outside the family has been controlled by men in their role as the head of the family. Women require their husbands' permission to leave the house, even for health-related issues or to pay a visit to their own family. Since 2020, COVID-19 prevention measures (social distancing, movement restrictions, etc.) have further reduced freedom of mobility for women and adolescent boys and girls. The quantitative survey also showed differential freedom of mobility based on gender. Certain respondents (mostly adult males and adolescent boys) reported having free mobility to neighborhood market shops (64%), health centers (57%), and nearby towns (48%). Women and girls reported limited movement to these same locations, except when accompanied by a child or a husband. Some of the main reasons for limitation of movement reported in the quantitative survey included the insecurity (57%), cost of transportation (38%), authorization from husbands (14%), and cultural acceptance (11%).

Adolescent boys and girls were asked about their own mobility and the mobility of two specific case-study examples during evening and nighttime as part of focus group discussions.³⁰ 21 out of 35 groups (both boys' and girls' groups) affirmed that they can go out in the evening if they return home before 10 pm, with permission from their parents, or to go to Islamic school. This varies by region, with most groups in Yobe and Adamawa reporting freedom of mobility, and most groups in Borno saying that going out at night is not possible due to safety risks and curfews. Adolescent girls face additional barriers, including having to be accompanied by a second person or a friend, but overall, also reported having some freedom mobility during evenings and nighttime. A CARE Amal situational analysis validates this finding, and reports that "girls in the community have limited mobility, needing permission to go anywhere outside of the home, usually, this was from their parents or husband. Girls are able to leave the home to run errands or for special occasions but ultimately, their mobility depended on another person".

Access to services and resources

The insurgency has had negative impacts on access to resources including farms, pastureland, rivers, water points, and credit, as well as services such as schools, markets, jobs, and leisure activities. Any resources and services accessible to individuals living in the BAY states prior to the pandemic came from humanitarian assistance (such as food, cash, non-food items, shelter, SRHR services, education, and protection,) and small businesses. A CARE assessment found that in 2019, 54% of people (55% women, 52% men) were able to meet their basic needs.³¹ Since 2020, the COVID-19 restrictive measures and the increasing inflation and related hardship have further affected the access to and control of cash, food, health, education, and economic and financial services for women and men from both IDP and host community populations.³² In addition, the closure of the

³⁰ A 17 years in-school boy from a vulnerable family and 16 years married girl, a first-time mother, out of school, displaced due to crisis

³¹ *Addressing GBV & SRHR Challenges in Bama and Dikwa LGAs in Borno State, Northeast Nigeria* (Dec 2019). CARE, <https://www.careevaluations.org/wp-content/uploads/Addressing-GBV-SRHR-Challenges-CARE-Nigeria-GAC-Baseline-report.pdf>.

³² *CPI and Inflation Report May 2022*. National Bureau of Statistics, Nigeria. <https://nigerianstat.gov.ng/elibrary/read/1241183>

camps across Maiduguri in January 2022 have further reduced access and control of resources for a majority of IDP households.³³

Food

According to OCHA, an estimated 3.5 million people living in the BAY states (1,477,620 in Borno, 1,133,211 in Yobe, and 866,345 in Adamawa) will be considered to be living in food insecurity phase 3 ('crisis') or phase 4 ('emergency') during the 2022 lean season, with the most acute humanitarian needs concentrated in areas affected by conflict or hosting large numbers of IDPs and returnees.^{34,35} An estimated 13,000 people, are also projected to be in the 'catastrophic' phase 5 at this time. Host community members make up a large proportion of the food insecure population (62%), followed by IDPs (16%), returnees (14%), and people in inaccessible or hard-to-reach areas (8%).³⁶ Additionally, adolescent girls and boys make up a larger proportion of the food insecure population (31.3% and 27.5%, respectively) in comparison to adult women and men (21.6%, 19.6%). This leads to health effect including acute malnutrition affecting adolescents at a disproportionate rate. In fact, the acute malnutrition rate for adolescent girls (ages 15-19) in the BAY states is currently a staggering 42%.

At this time, many are still feeling the after-effects of the economic recession in Nigeria because of COVID-19, which still significantly restricts households' capacity to procure essential food items. According to the National Bureau of Statistics, food prices have been on the rise for 24 consecutive months, with inflation reaching 20.75% in October 2021.³⁷

According to the HRP, across all population groups, food is the top priority need (93%), followed by livelihoods and income generation (68%) and health care (41%). When asked how people would prefer to receive aid and which type of aid, the majority also preferred food assistance (89%) in comparison to physical cash (55%), and in-kind non-food items (43%). As previously mentioned, quantitative survey results have shown reliance on harmful survival strategies by both adolescents and adults to cope with food scarcity. Inaccessibility to food was also highlighted in every qualitative group discussion conducted. Quotes from the qualitative discussions tend to show that the food insecurity seems to be most severe in Yobe state, with one adolescent girls' group in Nguru Bulabulin stating that *"things are very expensive in the market; prices keep increasing every day. Because of food insecurity most of our parents now have high blood pressure. Even youth now are suffering from it. Before we ate like three times a day; but now to eat one meal is difficult, some don't even get to eat at all"*.

Access

"Things are very expensive in the market; prices keep increasing every day. Before we ate like three times a day; but now to eat one meal is with difficulty, some don't even get at all."

-- Girls in Nguru Bulabulin

Education

According to the quantitative survey, both adolescent boys and girls attended school before 2020 as reported by 65% of respondents. Since 2020, this situation has improved, with a higher proportion of respondents (77.4%) reporting that both boys and girls attend school (see figure 5). Although this data does not provide an explanation on this change, it can be hypothesized that respondents perceived a change in school attendance based on their memory of the pre-pandemic situation, the peak of the pandemic and school closures, and the current situation.

Qualitative discussions showed a very different situation in comparison to the survey, with frequent references made to school attendance drop-off due to COVID, food insecurity, and hardship. Adolescent FGD groups reported that attending school throughout the pandemic has been challenging. Many students dropped out of school when COVID lockdowns forced temporary closures, and some students never resumed. Those who remained in school faced additional attendance challenges: students were always or often late because they now had to split their time between school, domestic tasks, and income-earning activities.

³³ *Current developments affecting the humanitarian response, BAY states as of 31 January 2022*. OCHA, <https://www.humanitarianresponse.info/en/operations/nigeria/document/ocha-nigeria-situation-report-borno-adamawa-and-yobe-states-no-17>.

³⁴ *Nigeria Humanitarian Needs Overview 2022 (February 2022)*. OCHA, <https://reliefweb.int/report/nigeria/nigeria-humanitarian-needs-overview-2022-february-2022>.

³⁵ *Current developments affecting the humanitarian response, BAY states as of 31 January 2022*. OCHA,

³⁶ *Nigeria Humanitarian Response Plan 2022 (February 2022)*. OCHA, <https://reliefweb.int/report/nigeria/nigeria-humanitarian-response-plan-2022-february-2022>.

³⁷ *Nigeria Humanitarian Response Plan 2022 (February 2022)*. OCHA, <https://reliefweb.int/report/nigeria/nigeria-humanitarian-response-plan-2022-february-2022>.

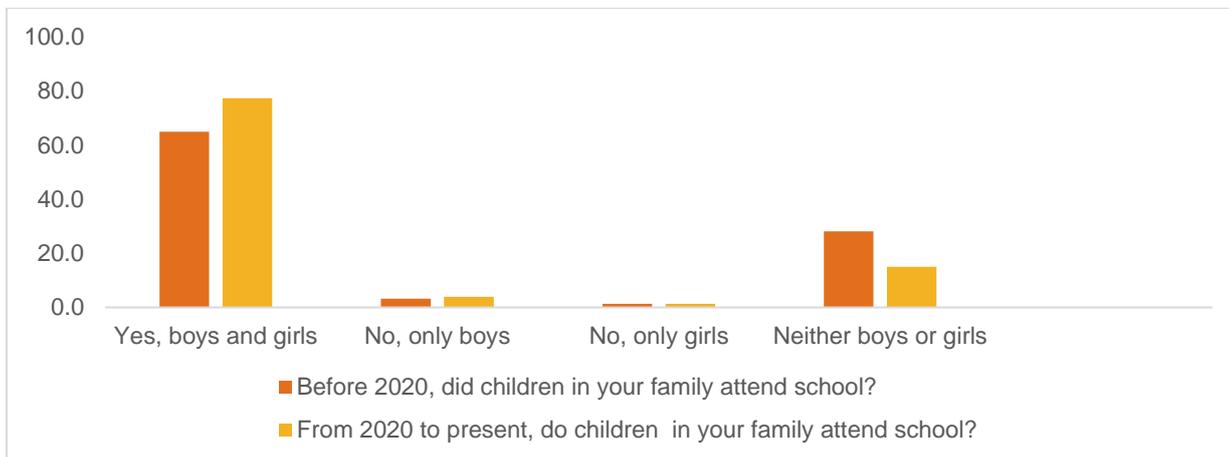


Figure 5: School attendance before the crisis and now

School attendance drop-off mostly affected students belonging to IDP populations,³⁸ and qualitative discussions showed that definitive drop-off also disproportionately affects girls regardless of status as IDPs or host community members. This is due to food insecurity, inflation, livelihood activities, increasing domestic /unpaid tasks burden, and other pressures that adolescent girls. It was also reported that parents prefer to invest in boys' educations when family resources are limited.³⁹ Adolescents in communities such as Lamurde in Adamawa did not mention school at all in their daily activities both before and after 2020. This response requires additional investigation, and any new findings should be used to more effectively create and tailor education programming for these communities.

SRHR and other health services

"There is an increasing number of women who undergo Caesarean section especially young girls". -Nguru Bulabulin girls

Even prior to recent crises, it is important to note the historic lack of health infrastructure, later exacerbated by conflict resulted in the destruction of health facilities compounded by limited access by women, girls and other marginalized groups due to gender and social norms.⁴⁰ Through the 2022 RGA, across the BAY states, women, adolescent boys, and adolescent girls all reported multiple barriers to accessing SRHR and other health services as a result of the overlapping crises impacting their communities. For example, women from Adamawa and boys from Bade and Damaturu in Yobe reported multiple barriers including a lack of medications, distance to facilities, cost of services, and general lack of trust in the health system/health providers. These barriers have caused many sick people to refuse to seek health services during the COVID pandemic due to fear of being diagnosed with or exposed to COVID-19. Despite this situation, all groups reported concerns of lack of subsequent improvement in health facilities and limited availability of quality of services offered at either private or public facilities. In Adamawa and Yobe, women, adolescent boys, and adolescent girls all reported that since the pandemic, there has been a rise in health-related diseases such as malaria, cholera, and diarrhea that mostly affect adult men and women, likely related to unsanitary practices and limited access to clean water.⁴¹

The gendered implications of health access are particularly evident by impact of SRHR. According to Nigeria 2018 DHS, half of Nigerian women ages 25-49 give birth before the age of 21. In Borno state, 10-17% of women ages 15-19 have begun childbearing in comparison to Adamawa and Yobe states, where this figure sits at 18-25%. Pregnant women and adolescent girls continue to face high risk of miscarriage in the BAY states, particularly because of the relatively early age at which they are having children.⁴² Qualitative data from the RGA confirms that gender and social norms resulting in increased rates of CEFM (see CEFM section), combined with the impacts of the insurgency and COVID-19 on access to life-saving care, have resulted in increased rates of risky adolescent pregnancies requiring cesarean sections and other life-saving interventions among young pregnant women (as reported by Nguru Bulabulin girls). Furthermore, early marriage and multiple early pregnancies further impacted by the growing food insecurity is another cause for concern that is likely to disproportionately impact already vulnerable pregnant adolescents' health outcomes.⁴³

³⁸ Nigeria Humanitarian Needs Overview 2022 (February 2022). OCHA..

³⁹ Rapid Gender and GBV Assessment in MMC and Jere Local Governments – Borno State. CARE

<https://careevaluations.org/evaluation/rapid-gender-and-gbv-assessment-in-mmc-and-jere-local-governments-borno-state/>.

⁴⁰ Humanitarian Situation Overview in Hard-to-Reach Areas: Adamawa and Yobe States | Nigeria (January 2022). REACH, <https://reliefweb.int/report/nigeria/humanitarian-situation-overview-hard-reach-areas-adamawa-and-yobe-states-nigeria>.

⁴¹ Humanitarian Situation Overview in Hard-to-Reach Areas: Adamawa and Yobe States | Nigeria (January 2022). REACH,

⁴² women who have given birth or are pregnant with their first child.

⁴³ Adolescent and young adult health (January 2021). WHO, <https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions>.

Despite the devastating impact of COVID-19 on accessing routine health services, particularly SRHR as indicated in the previous RGA of 2020, the 2022 RGA quantitative survey indicates some improvement since the peak of COVID-19 lockdowns. For example, 56% of respondents reporting having access to ANC, PNC, and safe delivery since 2020. 28% of respondents reported increased access since 2020, while 15% reported decreased access, 13% reported no change, 33% said they don't know, and a few but significant proportion (5%) reported that they did not have access prior to 2020 and still don't have access now (see figure below).

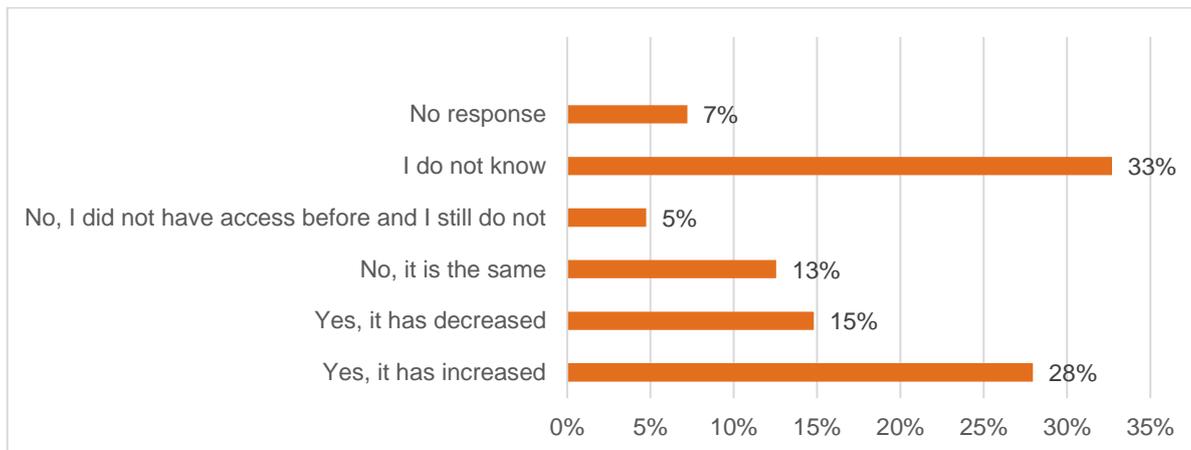


Figure 6: change in access to FP and SRHR services since 2020

Qualitative discussions with adolescents showed similar trends, with 10 out of 18 groups of adolescents reporting that family planning and SRHR services are available for them. It should be noted however, that geographical variation is important to consider. For example, CARE SRHR and GBV baseline survey led in 2021 in Dikwa and Bama, 45.4% of respondents have knowledge of FP; with large variation between geographical areas (58.1% for Bama and 32.8% for Dikwa) and gender (96.79% and 3.21% respectively for female and male respondents).⁴⁴ In addition to receiving information on pregnancy complications, 32.4% of respondents from Bama LGA and 67.6% of respondents from Dikwa LGA also received delivery kits.⁴⁵ Similarly, the RGA reveals that some respondents including adolescent girls in locations where humanitarian health actors had been present prior to COVID-19, implementing agencies were able to pivot to ensure continuity of essential services. For example, adolescent girls in Dikwa, Borno State reported improvements in SRHR including maternal health. Girls in Dikwa Ajari confirmed this, stating that “*abortions that were occurring especially in camps, have now reduced through awareness done by CARE*”. Girls in Bama Kasagula, Borno State also stated that “*We gain more knowledge about SRHR and COVID-19 where whenever we feel anything we go to the health care since medication is free which are provided by the NGOs*”. It should be noted however, that other global crises are shrinking prioritization and funding availability to continue programming in these locations. On the other hand, according to girls’ groups in Damaturu Yobe State there is also limited utilization of clean and safe delivery services with skilled attendants (which is especially important for complicated pregnancy cases).

Based on the discussions with women and adolescent boys and girls, it is clear that **SRHR is perceived as a women’s issue, largely limited to ANC and PNC and therefore, seen as a “women’s-only affair,” indicating limited male engagement and knowledge on SRHR.**⁴⁶ Furthermore, SRHR services are widely restricted to married women and married adolescent girls. However, even among this group, access to SRHR, particularly stigmatized services such as family planning, requires husband’s and sometimes in-law’s approval, especially for adolescent girls. This situation is even more dire for unmarried girls and single women, as it is not culturally and religiously accepted to have sex outside of wedlock; therefore, adolescent girls and boys are ashamed to seek these services. For example, *two* groups of boys from Yobe reported not having access to SRHR services because they are not women and so they don’t have the right to access family planning, and one group of boys reported that they had no information about it. Overall, access to family planning is still an issue for a significant number of women and men for a variety of reasons including cost, distance, social beliefs and gender norms and practices, and gender power relations. 8 adolescent groups explained how each of these barriers restricts access to family planning (see box).

⁴⁴ Addressing GBV & SRHR Challenges in Bama and Dikwa LGAs in Borno State, Northeast Nigeria (Dec 2019). CARE, <https://www.careevaluations.org/wp-content/uploads/Addressing-GBV-SRHR-Challenges-CARE-Nigeria-GAC-Baseline-report.pdf>.

⁴⁵ Addressing GBV & SRHR Challenges in Bama and Dikwa LGAs in Borno State, Northeast Nigeria (Dec 2019). CARE,

⁴⁶ Humanitarian Situation Overview in Hard-to-Reach Areas: Adamawa and Yobe States | Nigeria (January 2022). REACH, <https://reliefweb.int/report/nigeria/humanitarian-situation-overview-hard-reach-areas-adamawa-and-yobe-states-nigeria>.

Distance and cost

- "There are health facilities but accessibility is very low because it is very far and going to hospital is very costly" - Boys group in Bade; Yobe
- "The use of SRHR services is limited as no one goes for it" -boys group in Kasagula
- "Access is difficult for some reasons including the need to pay for it , and requires husband permission" -girls' group in Gamboru

Social beliefs Gender norms and practices

- Family planning is not positively perceived across the 3 states because it is seen especially by husbands and other men as a way to reduce the number of children which is seen as against the religion.
- Rather than support modern contraceptive methods, communities prefer the traditional methods (such as lactation amenorrhea method) when breastfeeding (which is not as effective as modern contraception).
- Traditional gender and social norms related to SRHR and child marriage are deeply prevalent. For example, Bama Shehuri women add that "*traditionally any girl not married around 13 to 14yrs old will be perceived being at risk of prostitution*". In addition, strong societal norms and expectations for a girl to become pregnant within a year of marriage adds more pressure against use of services such as family planning.

Gender & power relations

- Even for those couples who recognize the benefit of SRHR services, the decision on whether or not to access family planning service sits with the husbands. Women access SRHR only with their husbands' permission.
- 8 out of 10 adolescent group discussions confirmed that young married girls have access to family planning and other SRH services, but this access depends *on money and husband permission*.
- A CARE baseline survey in Bama and Dikwa LGA in 2019 showed that only 13% of women aged 15-49 years make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care; with a higher proportion residing in Bama (22%) compared to Dikwa (7%) reporting the same.
- Some health workers require husband approval as a condition to provide their services as reported before the crisis in 2018 (CARE GIE SII) and in 2021. "Some health provider staff have negative perceptions of giving adolescents family planning services because they feel adolescents don't have the right to make decisions".

The above challenges and barriers leave adolescent girls and boys without adequate support and coaching, as parents, family members, and friends are all subjected to the same situation. The situation is even worse for those crisis-affected adolescents separated from their support networks. Although health is one of the top priorities expressed by adolescent boys, respondents seemed to have varied understanding of the scope and value of SRHR, demonstrating the lack of understanding of SRHR needs and gaps in their communities including: supply of essential drugs, qualified doctors, more personnel and facilities for reproductive health, warmer clothing for pregnant and lactating women, mosquito nets, mattresses, etc. More needs to be done to improve access to and understanding of SRHR services for women and girls, but also for adolescent boys and men.

In **Adamawa and Yobe**, women, adolescent boys, and adolescent girls all reported that since the pandemic, there has been a rise in health-related diseases such as malaria, cholera, and diarrhea that mostly affect adult men and women, likely related to unsanitary practices and limited access to clean water.⁴⁷

COVID-19 vaccine

Focus group discussions with women and adolescent boys and girls revealed that COVID-19 vaccines are available in all states and made freely accessible for all except pregnant women. Only one group in Damaturu reported not having access to it. Nevertheless, the acceptance of the vaccine is very low due to mistrust and misconceptions around its perceived side effects. There is a general reluctance to get the vaccine, however, youth are much more receptive to vaccine uptake than older people. The main reasons for reluctance reported by groups include beliefs that the vaccine would prevent women from conceiving, it is a conspiracy against black people, there is mistrust and suspicion regarding benefits of the vaccine, and that if the vaccines were actually beneficial, leaders would keep it for themselves. Hence the COVID-19 vaccine that is made freely available to all seems suspicious (reported by Nguru boys). According to boys in Borno, some people will want financial motivation to get the vaccine. Boys in Damaturu say they don't have access to vaccines, they just hear about it on the radio, thus have mixed feelings regarding acceptability. Sources of information about COVID-19 and the vaccine include television, radio, and health workers, but the most trusted sources of information are religious leaders, family/relatives, and community leaders.

⁴⁷ *Humanitarian Situation Overview in Hard-to-Reach Areas: Adamawa and Yobe States | Nigeria (January 2022)*. REACH, <https://reliefweb.int/report/nigeria/humanitarian-situation-overview-hard-reach-areas-adamawa-and-yobe-states-nigeria>.

Participation

Decision making about humanitarian services

According to the World Bank, the COVID-19 pandemic has globally affected women’s voices and their decision-making power despite their privileged position as agents of change due to their roles in families and communities. Women’s inclusion in decision-making around the pandemic has been challenged by a combination of their growing domestic task burden, increased instances of domestic violence, limited access to information, and social norms.⁴⁸

Participation

“Adolescent need to be heard when they voice out because they are not being heard whenever they voice out. The common challenge they face is with their parents and the society at large” (Bama Shehuri boys

In BAY States, pre-crisis investments in gender equality have demonstrated women’s ability to quickly adapt to the new COVID normal. For example, VSLA group members have been able to adapt their operating model to maintain solidarity and safety nets while respecting preventive measures by sharing information and making and selling masks and soap to curb the spread of COVID-19. Despite their ability to adapt, women’s participation in the pandemic decision-making structures, both at the community level and in high-level institutionalized decision-making processes has been limited. This lack of voice has been seen as a threat to roll back even the limited gains made around women’s participation in leadership and decision-making structures across the BAY states, and any lost progress will take years to regain.

According to the quantitative survey, community level decision making is undertaken by local government authorities, religious leaders, women and youth organizations, military authorities, and others. A majority of male responders (76%) affirm that they take part in community decision making, while only 24% of female respondents said the same. The participation of adolescent boys and girls follows this same trend with 70% and 30% of boys and girls respectively affirming participation. Women’s participation is at least twice lower than that of men and is significant only under the umbrella of women and youth organizations. Girls’ participation (30%) is also higher than adult women (23%) (see details in graphic below).

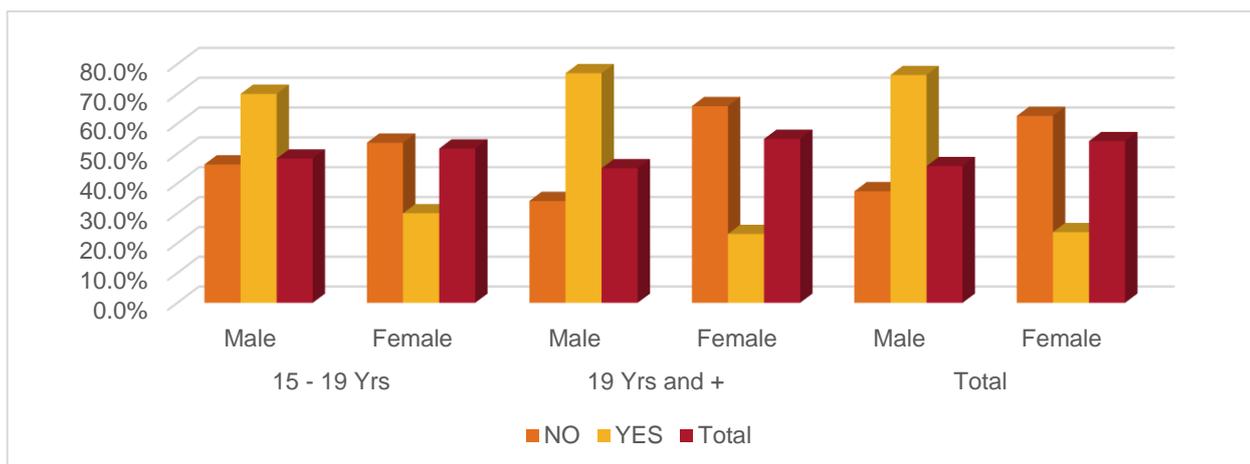


Figure 7: Do you participate in community decision making?

The qualitative data show a quite different perspective, especially regarding participation of youth. Most adolescent groups (25/35) reported that young people in general do not take part in decision making at the community level because of their younger age. Community decisions are made by community leaders. Poverty was also reported in many discussions as a reason for non-participation in decision making at the community level. Boys’ focus groups stated that “my parents never allow me to take decisions myself, they see me as a small boy for himself and for the Community, they don’t listen to us because we are poor” (Bade Dagona), and “even vulnerable parents cannot participate in community decision-making because they are poor” (Nguru Bulabulin).

Girls face additional barriers to their participation. In addition to the age factor, the fact that they are female limits their opportunities as reported by several groups. One girls’ group in Nguru Bulabulin reported that “we don’t participate in community decision-making because we are girls and we are young”. Girls’ inability to participate is linked to social norms as explained by a boys’ group in Gude (Adamawa) who said that “for cultural reasons, females are not allowed to participate in any activity or group association in the community”.

⁴⁸ Gender and COVID-19, What have we learnt, one year later? (June 2021). World Bank, Poverty and Equity Global Practice. <https://openknowledge.worldbank.org/handle/10986/35829>.

Youth organizations

Adolescents have the ability to provide input on community decisions only if they are leaders or active members of youth groups or youth-led activities, and these are roles that are very limited for girls. During FGDs, examples of youth-led activities that can create opportunity for adolescent participation in decision making included activities related to school management (prefect in the school and monitor of class) and CJTF to provide security in the community. Most adolescent boys and girls also reported that they don't participate in the youth-led activities. Some of the main reasons for lack of participation include the non-existence of the youth groups in general (Gamboru), only boys' youth groups exist in the community and there are no girls' youth groups (MMC), lack of time to engage with such activities, exclusion because existing groups have already selected participants, and lack of interest.

Overall, there is a strong interest among youth to participate in community-level decisions. From qualitative discussions with adolescent groups, it was discovered that youth feel the need to be considered by decision makers and be involved and heard. "Adolescents *need to be heard when they voice out concerns because they are not being heard whenever they voice out. The common challenge they face is with their parents and the society at large*" (Bama Shehuri boys).

Safety and Protection

Safety and protection of civilians living in the BAY states has been a critical concern for humanitarian actors since the beginning of the insurgency in 2009. Gender-based violence, child marriage, sexual abuse, child exploitation, and abuse have all become widespread during the insurgency. The crisis has also had a profound impact on the psychosocial wellbeing of children, with up to 2.1 million children (1,071,000 girls and 1,029,000 boys) in need of psychosocial support services.⁴⁹ Parents and caregivers also face high levels of violence, displacement, and a persistent lack of opportunities. This is linked in part to limited access to basic services including food, shelter, health care, education and livelihood.⁵⁰ Since 2020, the pandemic has increased the risks of violence against women, particularly intimate partner violence due to economic stress, quarantines, and social isolation.⁵¹

Protection

There is a differential perception of safety between adolescent boys and girls: as example, School is reported as unsafe area by girls because of the fear of school girls' abduction while the boys in the same community report facing no risk at all (Bade Sarkin Haoussa)

Gender Based Violence

The insurgency and its unprecedented protection implications have led to an increase in GBV in terms of both occurrence and severity. The crisis has also brought about new forms of GBV that affect mostly women and girls, and the situation has progressed significantly since the start of the COVID pandemic. In 2021, 98% of reported incidents of GBV across the BAY states were perpetrated against women, 81% of the incidents were perpetrated against adults, and 19% against adolescents under 18 years. The reported GBV incidents included physical assault (26%), denial of resources, opportunities and services (27%), rape (18%), psychological and emotional abuse (16%), forced marriage (9%) and sexual assault (4%).⁵²

43% of respondents to the quantitative survey reported that security concerns for women and girls have increased since 2020. According to adolescent girl respondents, the top three security and safety concerns they face include sexual violence and abuse (42%), violence in the home (40%), and a lack of safe places in the community (26%). Girls reported that adult women face the risk of attack when moving outside the community (29%) and within the community (24%), being asked to marry by their family (21%), and sexual violence and violence in the home (16%).

⁴⁹ Federal Ministry of Humanitarian Affairs (Nigeria), FINAL DRAFT_BASELINE SURVEY_STRES-W2.pdf, 05/12/2019)

⁵⁰ Federal Ministry of Humanitarian Affairs (Nigeria), FINAL DRAFT_BASELINE SURVEY_STRES-W2.pdf, 05/12/2019)

⁵¹ *Gender and COVID-19, What have we learnt, one year later? (June 2021)*. World Bank, Poverty and Equity Global Practice.

<https://openknowledge.worldbank.org/handle/10986/35829>.

⁵² *Protection Sector, Northeast Nigeria 2021 annual report*. Government of Nigeria, UNHCR,

<https://reliefweb.int/report/nigeria/protection-sector-northeast-nigeria-annual-report-2021>.

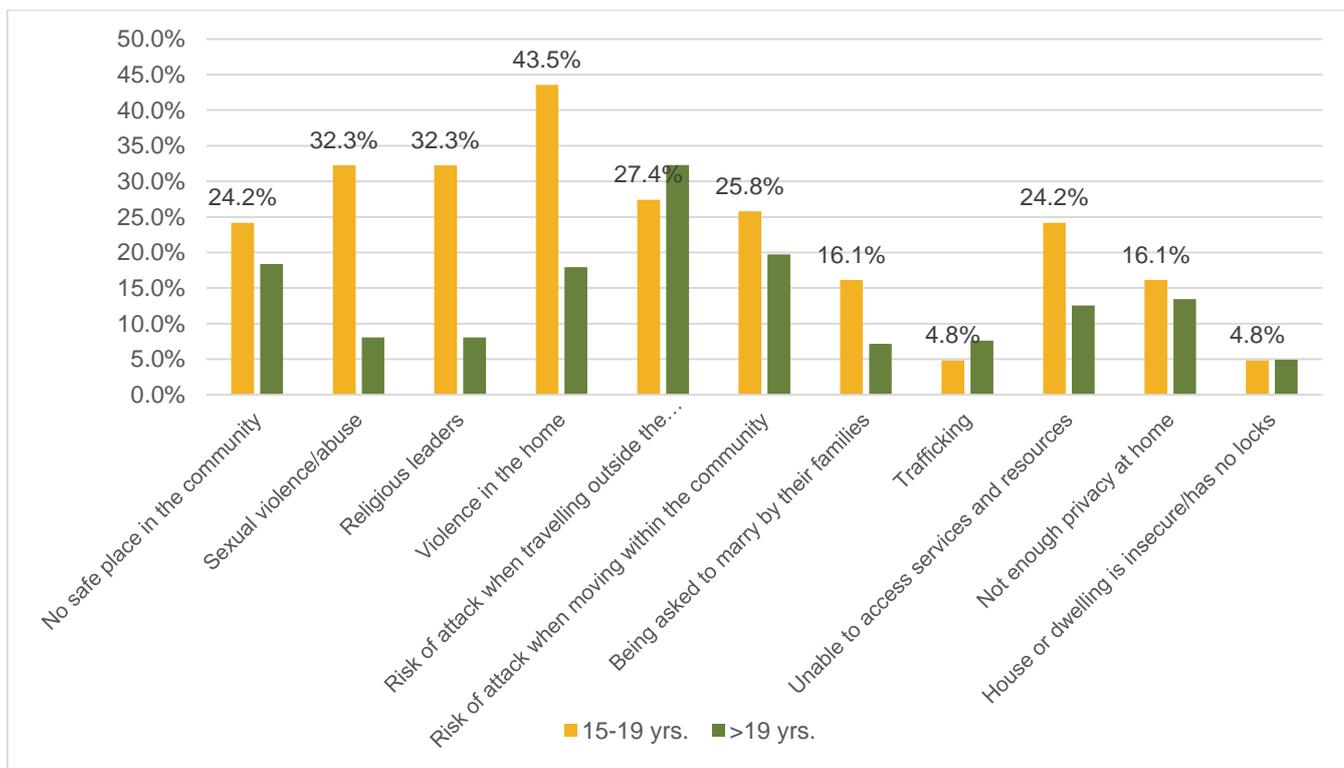


Figure 8: Specific security concerns affecting women and girls according to adolescent girls

Early and forced child marriage

Nigerian women marry much earlier than men, with the median age at first marriage for women at 19.1 years, compared to 27.7 years for men ages. Rates of CEFM vary according to location and wealth status. For example, in Northwest Nigeria women marry much earlier at 15.8 years in comparison to the rest of the country.⁵³ Across Nigeria, women from the poorest households also marry more than eight years earlier than women from the wealthiest households (15.9 years versus 24.3 years).⁵⁴ According to earlier findings from CARE, child marriage usually occurs because of traditional beliefs and practices which state that a girl's virginity is a matter of family honor.⁵⁵ Parents do not want to jeopardize this honor and so they marry their daughters off as early as possible.

The insurgency has increased child marriage in NE Nigeria. Some women reported that they had to make the decision to marry their daughters "for free" (i.e., without a dowry) in order to "protect their honor" from the increasing risk of GBV, abduction, sex slavery or rape. At global level, the pandemic and its induced economic shock to households, interruption of education, and disruption of programs and services, has prompted 10 million more girls to be at risk of early or forced marriage in childhood according to UNICEF.⁵⁶ UN Women refers further to a "shadow pandemic" of GBV, as gender discrimination along with the pandemic movement restrictions have increased the risk of girls experiencing multiple forms of violence and other harmful practices such as CEFM.⁵⁷ The prolonged closure of schools along with financial difficulties have also put girls at risk of child marriage.⁵⁸ Girls who are not in school are married off earlier, as revealed through qualitative discussions with adolescents. Quantitative survey results show that the pressure to get married is listed among the top safety and security concerns faced by girls and women living in the BAY states. The risk of being asked to marry by their own families affects 23% of adolescent girls and 21% of adult women (older than 19 years). Adult women also account for more than twice (69%) the proportion of girls (31%) who report being asked to marry by their family members.

⁵³ *Nigeria Demographic and Health Survey 2018*. National Population Commission - NPC/Nigeria and ICF, <https://dhsprogram.com/publications/publication-fr359-dhs-final-reports.cfm>.

⁵⁴ *Gender in Nigeria Report 2012: Improving the lives of girls and women in Nigeria (2012)*. British council, <https://www.britishcouncil.org/partner/track-record/gender-nigeria-report-2012>.

⁵⁵ *Rapid Gender and GBV Assessment in MMC and Jere Local Governments - Borno State*. CARE

<https://careevaluations.org/evaluation/rapid-gender-and-gbv-assessment-in-mmc-and-jere-local-governments-borno-state/>.

⁵⁶ *Gender and COVID-19, What have we learnt, one year later? (June 2021)*. World Bank, Poverty and Equity Global Practice. <https://openknowledge.worldbank.org/handle/10986/35829>.

⁵⁷ *COVID-19 and Ending Violence Against Women and Girls (2020)*. UN Women, <https://www.unwomen.org/en/digital-library/publications/2020/04/issue-brief-covid-19-and-ending-violence-against-women-and-girls>.

⁵⁸ *Rapid Gender Analysis, North East Region, Nigeria (July 2020)*. CARE, Oxfam, UN Women. <https://www.careevaluations.org/wp-content/uploads/NE-Nigeria-RGA-final-2020.pdf>.

Safety

Before the insurgency, men were solely responsible for the security of the family. Since the insurgency, this has changed and women are now very much alert to security issues (especially at home) and provide advice to their family members on security measures. More women are also now household heads, and thus they are in charge of the security of the family. Adolescent boys now assist men in providing security for their homes and the community through groups like the Civilian Joint Task Force (CJTF). Adolescents have also reported CJTF among the support systems to whom they voice safety and security concerns.

During focus group discussions, women, adolescent boys, and adolescent girls were asked about unsafe places, and their responses are in the box below.

<p>“What are some places where you feel unsafe in your community?”</p>	<p><u>Adult Women</u></p> <ul style="list-style-type: none"> • There are no unsafe places, but it is not permitted to go out at night (Adamawa) • River sides and military barracks and outposts (Bono) • At nighttime, areas outside marketplaces and motor parks
<p><u>Adolescent Boys</u></p> <ul style="list-style-type: none"> • Mountains and bush areas • Temple areas (robbery and kidnapping take place here) • Anywhere drugs are abused • Cinema houses • Dark places/motor parks and ghettos • Military locations and police barracks • River sides • NITEL area (Bama Shehuri) • GSS Dambo, Wulari, Sabon Gari camp, Aburi Karshe, Gamsiri gate and Hausari camp (Damboa Alkaleri). 	<p><u>Adolescent Girls</u></p> <ul style="list-style-type: none"> • Wells, rivers, mountains • Lonely paths on the way to hawk, and the houses of people they (girls) work for • Everywhere is not safe at night because of stealing, • Motor parks, and the outskirts of the towns (where abuse tends to take place) • In the market, as girls are sometime robbed of their items forcefully, and they occasionally experience abuse by the military personnel. (MMC Bulabulin) • Farming areas where attacks and bad people reside (Dikwa Ajari) • School, due to fear of abduction (Bade Sarkin Haoussa).

When asked about safety and protection risks during qualitative discussions, 26 groups of adolescent boys and girls from all three states reported commonly facing repercussions of the insecurity (risk of attacks by armed men, risk of being killed by armed group, abduction, explosive devices, military arrest, etc.), the risk of GBV, physical abuse, and the risks associated with food insecurity (lack of food, stealing, fighting/injuries during hawking or at school playground, prostitution, etc.).

Additional safety risks reported by adolescent girls specifically included insecurities (killing by IED) and GBV in Borno, and danger in hawking long distance; emotional stress, health and SRHR complications due to childbirth at younger age and rape sexual abuse in Adamawa, and hardship, sexual abuse, and rape in Yobe. Adolescent boys also reported safety and protect risks such as injuries during hawking or playing, attacks by herdsmen in Yobe, sickness including health and SRHR complications due to childbirth at younger age in Adamawa, and insecurities (killing by IED, abduction by AOG) physical abuse, and food insecurity in Borno.

Where to voice safety and security concerns

In cases of violence or safety issues, victims voice their concerns to community leaders (63%), police (17%), family members (15%), and humanitarian actors (4%) as reported by all respondents. During qualitative discussions, respondents suggested additional support people including CJTF, the scout (Bama Shehuri), and political leaders (Borno). There was also repeated mention that a married young woman will not tell her concerns to any man except her husband, and it was implied that married women can only talk to female family members, female community leaders, or female services providers.

Needs and Aspirations

During the focus group discussions, adolescent boys and girls analyzed the main issues and challenges they faced as a result of the combined COVID and food insecurity crisis. Results are shown in the boxes below.

For adolescent girls, the main challenges faced included:

- Lack of life skills
- Inadequate access to basic quality education
- Lack of money for school fees and learning materials
- Food shortage
- Sexual violence and abuse (including in the home)
- Lack of safe spaces in the community
- Family pressure to engage in early marriage
- Lack of solidarity between rich and poor people
- Lack of participation in decision-making at community level
- No source of income
- No one to support them
- Lack of access to productive agricultural productive resources (farm land limited due to insecurity, tractors and fertilizers are unavailable)

For adolescent boys, the main challenges faced included:

- Lack of tools and the money to buy them
- Lack of available jobs
- Lack of expertise and equipment
- Skill learning is very difficult
- Insecurity and limited movement were challenging

Through the preference ranking exercise, adolescents came up with solutions to the above challenges and organized them according to their priority areas. Boys' top five priorities were Health/SRHR, Vocational training, Food, Business, and Employment. Girls' top five priorities were Agriculture, Education, Business and employment, Food, and Water.

Adolescent boys and girls identified several common challenges and solutions, but the order of their priorities varied greatly. For example, Education and Agriculture were not among boys' top five priorities, while Health/SRHR and Vocational Training were not among the top priorities of girls. The table below provides more detail.

The needs and priorities identified as part of the focus group are in line with the quantitative survey findings which also indicated that Health/SRHR, Food, Water, Livelihoods and Education are key for adolescents, and also with the 2022 Humanitarian Response Plan priority to address vulnerable people's most critical needs, such as access to food, water, and healthcare services.

Table 2: Details of adolescent priorities

Categories	Frequency (%)	
	Boys	Girls
Food (food; food security; food and cash assistance)	55	45
Water	62.5	37.5
Health (Hospital, medication,	63.6	36.4
Education (school items; school fees, school rehabilitation, teachers)	48	52
Agriculture (farmland; farming; livestock)	14.3	85.7
Participation (decision making)	0	0
Leisure (restore cultural activities;	0	100
Vocational skills (carpentering; tailoring; marketer; engineering; livelihood skills, skill learning; entrepreneurship skills)	56.2	43.8
Business and Employment (capital; business support; economic inflation; employment; design machine)	50	50
Other (shelter; road; drainage)	50	50

Recommendations

This Rapid Gender Analysis report should be updated and revised as the crisis unfolds and relief efforts continue. Up-to-date gender analysis of the shifting gender dynamics within affected communities allows for more effective and appropriate programming and will ensure humanitarian assistance is tailored to the specific and different needs of women, men, boys and girls.

The recommendations listed below include solutions stratified by key stakeholders including implementing agencies (local partners and INGOs), government/policy makers and donors by key sectors:

Livelihoods and Food

Implementing Agencies

- Examine targeting criteria and implementation modalities for livelihood and food programming (including for cash-based transfers) to ensure that nutrition priorities are sufficiently meeting the needs of the most vulnerable (such as

pregnant women, girls of reproductive age and adolescents).

- Invest in the integration of psychosocial support services in parallel to food and livelihood programs and services, ensuring that all staff are skilled and informed of up-to-date resources around GBV services and referrals.
- Undertake a gender and age-sensitive market assessment and develop opportunities for vocational trainings with a special attention to agriculture and agribusiness initiatives and strengthening adaptive entrepreneurial skills, especially for women.

Government and Policy Makers

- Create pathways for temporary employment and economic relief through subsidies and small grant programs to mitigate negative coping strategies, especially targeting women entrepreneurs and leaders.
- Invest in expanding programs that build from existing interest and engagement of adolescents, especially as it relates to initiatives that strengthen local food production.

Donors

- Establish monitoring mechanisms to hold implementing agencies accountable to collect and apply more gender-responsive approaches that responds to sex and age differentiated needs and interests.
- Support funding that allows for the sufficient integration of professional GBV staff in across livelihood and food portfolios to ensure appropriate risk mitigation standards are upheld.

SRHR and other health services

Implementing Agencies

- Connect female frontline community health workers to market-based approaches to ensure their economic resilience during crises and support diverse incentivization programs for their continued growth, advancement and learning, particularly in areas related to pregnancy and maternal health and nutrition.
- Collaborate with local civil society organizations, religious leaders and respected community leaders to develop innovative approaches and spaces for safe dialogue around SRHR issues, concerns and misconceptions, specifically targeting men and boys and methods of modern contraception.
- Invest in the integration of psychosocial support services in parallel to existing health and SRHR services with a focus on adolescent girls and boys, with a focus on strengthening referral pathways for specialized and age-appropriate care (including for GBV).

Government and Policy Makers

- Advocate for the appointment, training, recognition and compensation of women leaders at the last mile (police, health workers, social workers), particularly frontline health workers to improve access of adolescent girls and women to quality GBV/SRH services including during future disease outbreaks or other crises.
- Improve accountability and trust in the health system by regularly facilitating feedback forums and providing other platforms where communities (inclusive of adolescent groups) and health providers can discuss barriers and needs related to private and public health and SRHR services.

Donors

- Continue to raise awareness for the need of critical investments in local professionals and health facilities (specifically those providing SRHR and mental health and psychosocial services), including specialized services for adolescent girls and boys.
- Replicate and support successful pilots and programs tailored to and responsive of the unique needs of adolescents, such as utilizing CARE & UNFPA's [AMAL Initiative](#) for pregnant adolescents and first-time mothers.

Education

Implementing Agencies

- Girls in particular prioritised education as a key gap for them, although this was true for both boys and girls. Ensure that gendered or other barriers to education are addressed in programming using community awareness sessions, cash distribution for education purposes, school meals, and safety audits to assess what more can be done to ease children's access to schooling.
- If access to schooling is addressed, also plan for retention of students. Gender sensitive wash in schools, transportation assistance, and women teachers/teaching assistants as well as child protection focal points could be potential solutions.
- Investigate further why education is not being provided in Lamurde in Adamawa.

Government and Policy Makers

- Advocate for more funding and attention to education in emergencies as a lifesaving activity.
- Advocate for teacher training, especially for female staff.

Donors

- Provide education in emergencies funding and ensure that access for both girls and boys is eased, particularly targeted in the areas mentioned above where education is not being provided.
- Ensure all education programming is based on a thorough gender analysis that can identify and address barriers to schooling.

Cross-Cutting Recommendations

Implementing agencies

- Foster greater sensitization around discriminatory social and gender norms, inclusive of engaging adolescent girls and boy in identifying pathways and opportunities for shifting power dynamics and adapting programming to accommodate more inclusive feedback processes.
- Apply learning from effective methodologies that promote inclusive and participatory design and programming models such as [CARE's Women Lead in Emergencies](#) or [Plan's Adolescents in Emergencies Toolkit](#)
- Ensure that the most up-to-date referral pathways are made available to all program teams and that staff are equipped with the core competencies in GBV risk mitigating as an integral part of program operations. Additionally, ensure that professional and specialized staff are available to support and provide guidance on GBV related issues, including on adolescents.

Government and Policy Makers

- Support revisiting of community level decision-making structures to more meaningfully ensure leadership of women and adolescents in emergency preparedness, response and ongoing recovery efforts.
- Advocate for a prioritization of resources that strengthen youth participation and civil society networks through peer-to-peer groups, adolescent/youth clubs, community and women and girls' safe spaces and other platforms that support marginalized voices to gain confidence and raise their voice in community-level processes and decisions.

Donors

- Require program design and decision-making to be based on updated RGA recommendations and analysis for more effective response and resilience building programming.
- Ensure continued investment in gender-transformative research and programming including multi-year, multi-sectoral funding for men, women, adolescent boys and girls affected by crisis in NE Nigeria.

Annexes

Annex 1 : quantitative Survey sample – details

Annex 1 Table 1: Details of the quantitative survey sample

State	LGA	Community	Random sample			Adjusted sampled by sex and Age				
			Male	Female	Total	Adol. Boys	Adol. Girls	Men	Women	Total adjusted
Borno	Bama	Shehuri	41	46	87	18	19	22	28	87
		Kasugula	34	38	72	15	15	19	23	72
	Dikwa	Shuwari	2	2	4	1	1	1	1	4
		Ajari	3	3	6	1	1	2	2	6
	Maiduguri	Bulabulin	3	4	7	1	1	2	2	6
		Gamboru	8	10	18	4	4	4	6	18
	Damboa	Shuwari	45	58	103	22	22	23	36	103
		Alkaleri	11	14	25	5	5	6	9	25
	Ngala	Ngala	2	3	5	1	1	1	2	5
		Gamboru A	6	8	14	3	3	3	5	14
Adamawa	Girei	Jabi Lamba	4	4	8	2	2	2	2	8
		Girei I	6	7	13	3	3	3	5	14
	Mubi South	Gude	2	2	4	1	1	1	1	4
		Lamorde	3	3	6	1	1	1	2	5
Yoba	Damaturu	Gabir/Maduri	1	2	3	1	1	1	1	4
		Nayinawa	4	6	10	2	2	2	4	10
	Nguru	Bulabulin	1	1	2	1	1	1	1	4
		Garbi/Bambori	4	5	9	2	2	2	3	9
	Bade	Dagona	1	2	3	1	1	1	1	4
		Sarkin Hausawa	1	2	3	1	1	1	1	4
Total			182	220	402	86	87	98	135	406

Annex 1 Table 2: Characteristics of the quantitative survey sample

		15 - 19 Yrs.	19+ Yrs.	Male	Female	
Resident	#	97	324	205	216	421
	%	80,8%	79,8%	85,1%	75,8%	80,0%
Displaced in Host family/IDP living in host community	#	9	15	10	14	24
	%	7,5%	3,7%	4,14%	4,9%	4,6%
IDP in collective center/formal camp	#	4	9	7	6	13
	%	3,3%	2,2%	2,9%	2,1%	2,5%
IDP settlement/Informal camp	#	2	11	5	8	13
	%	1,7%	2,7%	2,1%	2,8%	2,5%
Returnees	#	8	47	14	41	55
	%	6,7%	11,6%	5,8%	14,4%	10,5%
Total	#	120	406	241	285	526
	%	100 %	100 %	100 %	100 %	100,0%

Annex 1 Table 3 – Total participants of the data collection per sex, tool and state

State	Quantitative Survey			FGD			Key informant	TOTAL	%
	Male	Female	Total	Adol. Girls	Adol. Boys	Adult Women			
Borno	173	199	372	94	80	92	30	668	59%
Adamawa	33	26	59	94	80	92	30	355	31%
Yobe	35	65	100	94	80	92	30	396	35%
Total General	241 (58 adol.)	290 (62 adol.)	531 (120 adol.)	179	168	191	64	1133	

Annex 2: Tools and Resources Used

- Annex 2.1: Focus Group Discussion – FGD – Adult and Adolescent
- Annex 2.2: Key informant interview tool
- Annex 2.3: Preference ranking tool
- Annex 2.4: A Day in the life of a young person tool
- Annex 2.5 : Individual Survey questionnaire, Adult and Adolescent
- Annex 2.6: Inform consent forms (Adult – Parent/caregivers and Adolescent)



CARE Gender in Emergencies

CARE works with poor communities in developing countries to end extreme poverty and injustice.

Our long-term aid programs provide food, clean water, basic healthcare and education and create opportunities for people to build a better future for themselves. We also deliver emergency aid to survivors of natural disasters and conflict, and help people rebuild their lives. We have 70 years' experience in successfully fighting poverty, and last year we helped change the lives of 65 million people around the world.

More information: emergencygender@careinternational.org

<http://gender.care2share.wikispaces.net/Gender+in+Emergencies>

Plan International

Plan International is an independent development and humanitarian organization that advances children's rights and equality for girls. We believe in the power and potential of every child. But this is often suppressed by poverty, violence, exclusion and discrimination. And it's girls who are most affected.

Working together with children, young people, our supporters and partners, we strive for a just world, tackling the root causes of the challenges facing girls and all vulnerable children. We support children's rights from birth until they reach adulthood. And we enable children to prepare for – and respond to – crises and adversity. We drive changes in practice and policy at local, national and global levels using our reach, experience and knowledge.

We have been building powerful partnerships for children for over 85 years and are now active in more than 75 countries.

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The views in this RGA are those of the author alone and do not necessarily represent those of the CARE or its programs, or other partners.

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For more information on RGA, visit: <https://insights.careinternational.org.uk/in-practice/rapid-gender-analysis>

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