Integrated GBV prevention and response to the emergency needs of newly displaced women, men, girls, and boys in Borno State, North-East Nigeria

BASELINE REPORT

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The project, funded by EU humanitarian aid, supports 7,894 newly displaced women, men, girls and boys in Borno state, Northeast Nigeria

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Abbreviation

AOG	Arm Opposition Group
LGA	Local Government Areas
IOM	International Organization for Migration
DTM	Displacement Tracking Matrix
GBV	Gender-Based Violence
CARE	Cooperative for Assistance and Relief Everywhere
IDP	Internal Displaced Persons
FGD	Focus Group Discussion
KII	Key Informant Interview
SEA	Sexual Exploitation and Abuse
ECHO	European Commission Civil Protection and Humanitarian Aid
UNFPA	United Nation Population Fund
SRH	Sexual Reproductive Health
FGM	Female Genital Mutilation
MSF	Médecins Sans Frontières
FHI360	Family Health International
UNICEF	United Nation International Children Emergency Fund
WFP	World Food Programme
UNHCR	United Nation High Commissioner for Refugee
SIF	Secours Islamique France
WHO	World Health Organization
NFI	Non-Food Item

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1. Executive Summary

To ensure the efficiency and effectiveness of the project, CARE pays specific attention to the changes to be made, effects and impacts of the intervention for displaced populations, and hosts affected within Borno State. It therefore appears necessary to define the baseline situation in order to have information that can provide precise indicators on the sector concerned by the assistance, and to develop a monitoring and evaluation system for the continuous updating of the changes and facilitate the analysis of the transformations induced at the end of the project.

A total of 3 IDP camps (Arabic camp and International Secondary School of in Ngala and Government Secondary School GSS camp in Bama LGA) and 4 host communities (Ngala, Gambaru A and B in Ngala and Bama town in Bama LGA) were covered by the baseline, within the two targeted LGAs. Taking 5% of each population, 5,009 respondents in Bama and 2,054 respondents in Ngala were surveyed. The analysis of the information collected during the baseline helped to develop the baseline situation of the project and gives us the main following data:

- Household profile: 45% of the respondents are IDPs and 33% returnees; 67% of the total number of respondents interviewed; most of the respondent are married; most of the respondents received some education, mainly through Islamic schools, 34,5 of the women and 17% of the men; 64,39% of household have an average size of 0-1 members.
- In both Bama and Ngala, women and girls are seen to be responsible for domestic work (cooking, caring and house chores). Men, on the other hand, are primarily considered the head of the family, decision maker and economic provider.
- Rape is the most mentioned form of GBV in the community (Bama and Ngala) with 25%, followed by spouse beating 16%, verbal abuse 15% and physical violence 13%. There is much shame and social stigma associated with women and girls' virginity and upholding traditional gender roles. In many cases of violence, even when families recognize that the act is non-consensual, the blame is placed on the shoulders of the victim.
- Sex for survival and transactional sex were mentioned as coping strategies like alternative means of livelihood.
- The fear of sexual violence, often associated with abduction, is a concern raised by women and girls, contributing to psychosocial stress and further limitation of their movements. The restriction on freedom of movement of women and girls also inhibits their access to services, humanitarian aid and ultimately their rights. The shame and stigma surrounding sexual violence contributes to survivors not talking about violence when it happens. Women and girls also fear honor killing as a result of sexual violence. Families arrange marriages for girls, believing it will protect them and ease the financial burden on the family. Girls are reportedly being married younger. The socio-economic situation, lack of livelihood opportunities, and increased poverty is ultimately leading more women to resort to negative coping mechanisms such as survival sex.
- Humanitarian actors are already present in the area. But GBV services access and quality are quite poor. The findings show also that the humanitarian assistance should be improved regarding respect of safety and dignity of the communities.

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Key recommendations

- Strong GBV awareness is needed to engage communities and change social norms (stigmatization).
- To encourage existing positive coping mechanisms
- To strongly reinforce the knowledge on the accessible and available GBV services and encourage coordination between the actors.
- Vigilance on the safety, accessibility and participatory approach while delivering the activities expected in the project
- Community-based mitigation plans to be supported within the budget possibilities

2. Introduction

2.1 Context of the Project

Now in its tenth year, the crisis in North-East Nigeria remains one of the most severe in the world. Some 1.8 million people are internally displaced and human rights violations continue to be reported in the three worst affected states of Borno, Adamawa and Yobe (BAY). Over 80 per cent of IDPs are in Borno State, the epicenter of the crisis, and over 60 per cent are living in host communities, exerting pressure on the already-stretched resources of these communities. An increased number of displacements and new arrivals continue to be recorded largely coming from hard-to-reach areas for reasons related to insecurity and military operations, the return of Nigerian refugees from Niger to Damasak Local Government Area (LGA), family reunification in Banki and Gwoza, secondary displacements caused by poor living conditions of IDPs in Pulka, as well as active conflict that forced many to flee to Monguno. From November 2017 to mid-August 2018, Borno and Adamawa states have seen the movement of nearly 190,000 individuals (153,000 IDP new arrivals and 36,000 returnees). This further compounded a fragile setting where vulnerabilities are already intensifying as a result of the rainy season from June to September and where resources are already overstretched. Currently, 41 sites across 11 LGAs in Borno are in 'high congestion' status with 285,000 individuals above camp capacity resulting in the majority of individuals having no access to shelter and being forced to sleep in overcrowded shelters or outside. The provision of life-saving assistance to the most vulnerable persons of concern is hampered by a continuous unfavorable environment marked by conflict-induced insecurity and protracted displacement. Limited access to adequate services, particularly in newly accessible areas, continues to exacerbate protection risks to the affected population

Since the conflict between Nigerian security forces and armed opposition groups (AOGs) escalated in 2013, more than two million individuals have been displaced. Most of them have been displaced within Borno State, particularly to urban centers across all accessible Local Government Areas (LGA). The humanitarian response is challenged by many information gaps, including the security environment, access to services and areas of vulnerability. Local authorities have instituted a curfew from 6pm to 6am, during which civilian movement within the town is prohibited. Movement into and out of the town is only permitted with a military escort due to security concerns. These escorted movements take place mostly at least twice a week on both main routes out of town, the Maiduguri-Ngala route and the Ngala-Kala-Balge route while Bama is about 60 km, the terrain is flat, the road is tarmac though with a lot of potholes. According to the International Organization for Migration's Displacement Tracking Matrix (IOM DTM), Bama is home to 20,683 households while Ngala is 13,844 in the camp, with influx of new arrivals into the camp daily.

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Nigerian Northeast society is ruled by a pervasive patriarchal system, which grants men power and control over women and supports unequal power relationships, access and control over resources for women and men1. The humanitarian crises and its unprecedented protection implications has challenged traditional gender roles and relationships. Men have experienced their livelihood activities seriously disrupted, broken or made impossible due to insecurity; they are obliged to rely on humanitarian assistance. At the same time a significant number of women have become single heads of family due to family separation or the result of mass killings. Women therefore have been faced with filling this vacuum and provide for their family, thus expanding their decision-making power. Factors contributing to Gender-Based Violence GBV include; initiation ceremonies, women's economic dependence on men, socialization of boys and girls at home and in school, inadequate laws on GBV and domestic violence, lack of law enforcement, and intimate partner violence

2.2 Project Overview

To respond to these challenges, CARE international in Nigeria is implementing a year and half (01/11/2018-30/04/2020) project: "Integrated GBV prevention and response to the emergency needs of newly displaced women, men, girls, and boys in Borno State, North-East Nigeria" European Commission Civil Protection and Humanitarian Aid (ECHO).

The European Union and its Member States are a leading global donor of humanitarian aid. Through the European Commission's Civil Protection and Humanitarian Aid department (ECHO), the EU helps over 120 million victims of conflict and disasters every year. With headquarters in Brussels and a global network of field offices, ECHO provides assistance to the most vulnerable people solely on the basis of humanitarian needs, without discrimination of race, ethnic group, religion, gender, age, nationality or political affiliation.

The goal of the project is to contribute to the protection of the lives of vulnerable women, men, girls, and boys most affected by the crisis in North-eastern Nigeria.

The project will be implemented in 4 wards: Bama, Ngala, Gambaru A and B in both Bama and Ngala LGAs.

The specific objective: **To enhance the access of newly displaced, vulnerable women, men, girls, and boys to life-saving GBV prevention and response services through coordinated, principled humanitarian support and community-based prevention activities** will support the overall goal of the project. CARE intends to use the survivors centered approach for the response in line with international best practices;

- CARE will deliver integrated GBV services and through a participative approach combining community based prevention and specialized services of GBV response, including case management, psychosocial support, and material support delivered based on needs assessed on a case-by-case-basis, and linked to SRH services already provided in the area of operation with UNFPA funding.
- The Action will be promoting coordination with other actors though safe, confidential, and effective referral pathways
- The Action will contribute to improving the quality of service delivery while reducing risks emanating from insufficient awareness and knowledge about humanitarian principles among humanitarian staff, volunteers and security actors, as well as lack of effective systems to provide accountability to affected populations and prevent and address SEA by humanitarian teams and members of the security forces working in camps and other affected areas.

These objectives have the following expected results:

R1: GBV prevention, care, and response services available and accessible to newly displaced individuals and vulnerable host community members at risk of or affected by GBV.
R2: Awareness, knowledge and application of humanitarian principles and SEA prevention and response principles improved among humanitarian actors and security forces.

2.3 Project Activities

The project objectives are supported by the following set of activities:

A.1.1 Protection Risk and Market Analysis baseline and monitoring.
A.1.2 Link into existing referral systems, ensuring clearly defined, safe and confidential referral pathway, for GBV cases.
A.1.3 Provide training on case management for CARE staff.
A.1.4 Provide case management services to GBV survivors and their family members.
A.1.5 Establish and operate Safe Spaces.
A.1.5 Provide psycho-social support to GBV survivors and their families.
A.1.7 Provide survivors with in-kind material support, depending on individual needs.
A.1.8 Set-up and train community GBV Vigilant Committees for community-based GBV prevention
A.1.9 Mobilize and train "GBV Champions" for community based GBV prevention.
A.1.10 Conduct community awareness raising on GBV.
A.1.11 Support to women solidarity groups.
A.1.12 Monitor GBV risks and incidences and report to relevant coordination bodies.
A.2.1 Establish CARE accountability mechanisms in all project locations and train staff on them, in particular on receiving, handling and using feedback and complaints.
A.2.2 Develop training curricula and IEC materials on humanitarian principles and standards as well as SEA prevention/response, adapted to the local context in Borno State, audiences, and operational conditions.
A.2.3 Conduct training on humanitarian principles and standards for CARE teams and other humanitarian staff and volunteers.
A.2.4 Conduct training on SEA prevention and response for CARE teams, and staff and volunteers from peer organizations.
A.2.5 Support humanitarian responders to strengthen/develop internal SEA prevention/response policies and mechanisms.
A.2.6 Conduct awareness raising sessions on humanitarian principles and SEA prevention and response for members of the security forces.

3. Objectives of the baseline

The baseline study is the point of reference from which the expected results of the project will be measured, at the mid-term review and at the time of the final evaluation.

1 - Main objective

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The overall objective of this study is to establish a detailed baseline of the various qualitative and quantitative indicators of the project in the targeted areas so that the information obtained can inform the implementation of project activities.

2 - Specific objectives

More specifically, the study aims at:

- Collecting information to define the baseline situation of households and facilitate projections (recognition) of changes during the life cycle of the project.
- Collecting the indicators defined in order to obtain their baseline level at the start of this phase of the project;
- Measuring baseline values of key indicators of GBV/Protection;
- Obtaining basic information for monitoring GBV/Protection;
- Collecting qualitative data to help project staff define effective approaches
- Defining recommendations for a better orientation of the various activities.

4. Methodology

The methodology used was both qualitative and quantitative data collection. This includes a mini-survey, FGD and KII. The questions deployed was centered around the baseline indicators. A total of 3 IDP camps (Arabic camp and International Secondary School of in Ngala and Government Secondary School GSS camp in Bama LGA) and 4 host communities (Ngala, Gambaru A and B in Ngala and Bama town in Bama LGA) were covered, within the two LGAs. Data collection lasted for 12 days (2nd January – 2nd February, 2019).

1. Tools

Survey

The questionnaire was developed after review by leads of the projects. A pilot questionnaire was tested and reviewed to improve the survey process. The finalized questionnaire was programmed into Kobotoolbox[1] application system to facilitate electronic data collection using hand-held electronic devices. The survey was supported by android operating smartphone devices. The use of mobile technology eliminated the need for data entry, which drastically saved on time and reduced error associated with pen and paper data collection. The questionnaires were administered in two LGAs, resulting in 5009 questionnaires entry in Bama, 2054 questionnaires entry in Ngala and a total of 7063 for both LGAs. individual interviews were conducted with a sample of women, men, boys and girls including IDPs, members of host communities, returnees, married/single, women headed/child headed families.

Key informant Interviews (KIIs)

[1] https://kobo.humanitarianresponse.info

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KIIs were carried out with community leaders, camp management, safety and security personnel and health workers in both LGAs. A total of 80 KIIs were administered. KIIs were employed using open ended question as well as close ended, which targeted camp managements, security personnel, health service providers and community leaders.

Focus Group Discussions (FGDs)

FGDs were carried out in both LGAs with community member. FGD targeted men, women and youth across the two LGAs. Four FGD were held in Bama while in Ngala 5, a total of nine FGD for the LGAs.

2. *Sample size*

The sample size was determined by compiling population data for both Ngala and Bama LGAs, taking 5% of each population data. The intention was to get a reasonable number that would represent the community. The survey used simple random sampling techniques to identify households to be sampled in the sub- location. The number of households to be sampled was determined by the total number of households in the Sub-location. CARE has considered the displaced population as a homogeneous population that allows us to define the representativity of the sample on all displaced populations and the host population as another homogeneous population as well. Thus, each element of this sample had the same probability of being chosen as all other elements of the mother population (displaced, host).

The survey targeted 7,063 respondents in all: 5,009 respondents in Bama and 2,054 respondents in Ngala respectively. Analysis of responses received was done separately for the two LGAs (Bama and Ngala).

3. *Team for data collection and analysis*

The assessment was led by the CARE Nigeria MEAL officer with support from the respective project managers and a team of 29 comprising of 24 (8 females and 16 male) enumerators distributed evenly; 12 in Bama and 12 in Ngala and 2 females and 3 male CARE Staff and who are experienced in data collection and surveys, and have the appropriate languages skills. Five CARE staff oversaw the data collection and data analysis (3 in Ngala and 2 in Bama) under the leadership of the Gender and Protection Advisor.

The assessment was administered using an electronic mobile data collection system called Kobotoolbox, which was synchronized to a cloud server and later downloaded on excel spread sheet. The team was orientated through a two- day training workshop on the methodology, data collection tools and approach for administering the questionnaires. A field pre-test of the survey tools was first done as part of the training, following which the tools were finalized. The training platform was also used to address the potential challenges the data collection might encounter. A team Leader was assigned to each of the survey teams. After each day's data collection, under the guidance of the respective team leaders, meetings were held with the enumerators, in an effort to assure quality and covered sharing discussions around key challenges faced in the process and recommendations on how to address future challenges. Data cleaning to address mainly spelling, duplication, wrong or empty cells was done after the completion of the fieldwork. Each enumerator was assigned a tablet and an identification number that was used to crosscheck entries while survey was ongoing and assess the assimilation of the training on how to administer the form. The empty entries/duplication were sorted and cleaned out.

4. *Limitations*

- Language barriers. The tools had to be translated in local language by focal points from communities.

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- Efforts were made to ensure a gender balance when conducting the assessments. Data collectors were trained to seek out female respondents when possible using best practices that were culturally sensitive and relevant for the method used. Despite these efforts, the overall percentage of female enumerators and female key informants remained low in the quantitative assessments.
- Due to time constraints, FGDs were conducted for men and boys together as well as women and girls. There was no separated FGD conducted separately for adolescents and youth which limitated the understanding of the adolescent and youth whom were mostly over voiced by the adults in the FGD.
- KIIs were not made totally qualitative. This was due to the fact that it will require more time to fill for each individual KII sample representative. Furthermore, the budget allocated to the activity was not adequate enough to hire more hands/enumerators to conduct this so that it can be completed within reckon time.

5. Expected results

The study will look at questions, in order to:

- Understand gender roles, power dynamics and social norms and practices with regards to GBV and protection issues among women and men of all ages within IDPs and host communities.
- Understand the main risks of GBV for women, men, boys and girls of IDP and host communities and map GBV service providers and their capacity, including community-based GBV prevention and response systems.
- Provide practical recommendations to CARE and other humanitarian actors to improve gender integration and quality of GBV prevention and services in their response.
- Collect the baseline value for the key indicators.

6. Key findings

6.1 Households profile

The survey targeted 7,063 respondents. Women and girls had a significant place in this study because they massively answered the questionnaire and they represent 67% of the total number of respondents interviewed.

Chart 1: Respondent by age group

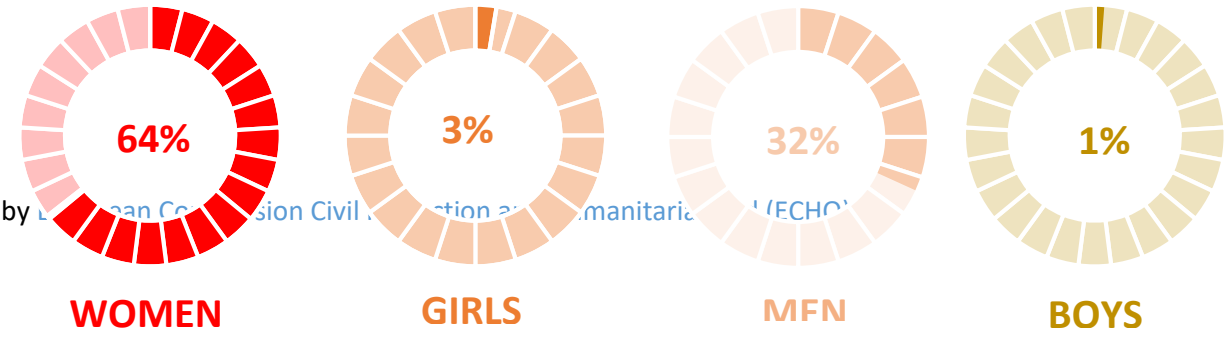
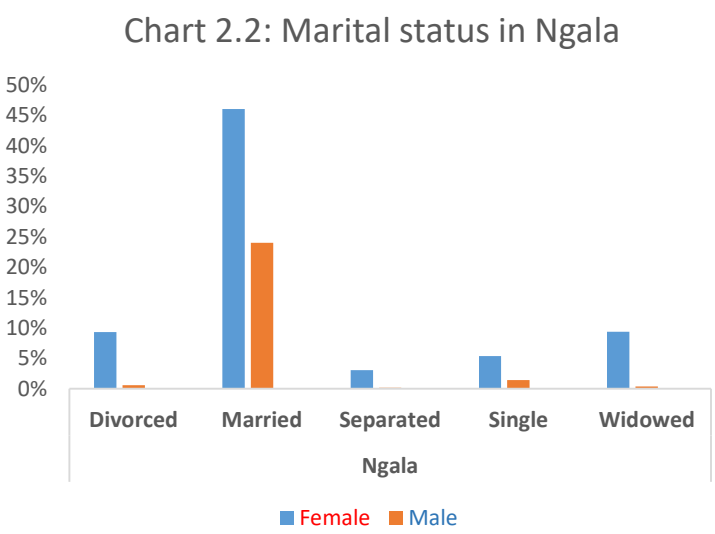
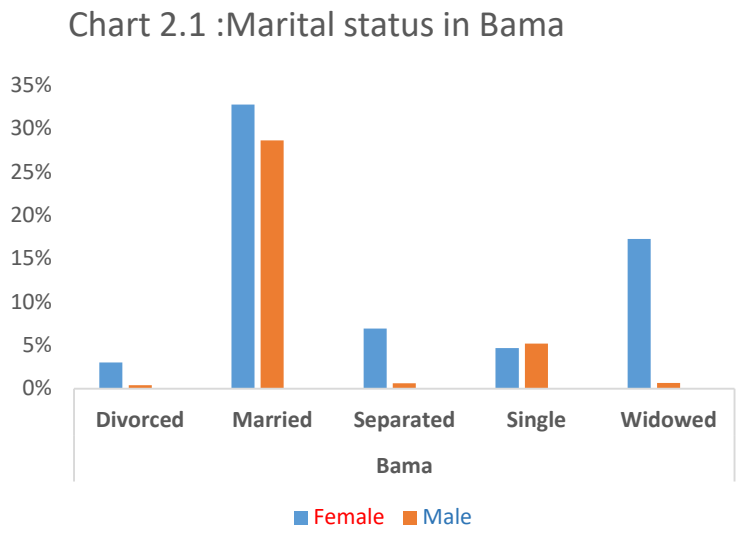


Chart 2: Marital status of respondent by LGAs





The above graph shows the respondent of the survey disaggregated by marital status. From the table, it can be seen that most of the respondents are married: 32.7% females and 28.6 males in Bama and 46.1% females and 24.1% males in Ngala respectively.

The table below shows the percentage total of respondent and household size for this survey, the household size has been categorized and it shows that 64.39% of the respondent have and average household size of 0 – 5 members followed by 5 – 10 members with 30.19%. Further analysis shows that 1 out of every 14 household interviewed has a disabled member.

Table 3: Respondent by household size

Household Size	Bama						Ngala					Total
	Female			Male			Female			Male		
	5-18 years	19-59 years	>60 years	5-18 years	19-59 years	>60 years	5-18 years	19-59 years	>60 years	19-59 years	>60 years	
0 - 5	1.71 %	26.32%	2.25 %	0.79 %	13.97%	2.02%	0.30%	13.01%	0.64%	3.07 %	0.30 %	64.39 %
5 - 10	0.21 %	12.97%	0.86 %	0.14 %	5.76%	0.88%	0.06%	5.13%	0.88%	2.72 %	0.58 %	30.19 %
10 - 15	0.03 %	1.02%	0.07 %	0.00 %	0.96%	0.34%	0.00%	0.41%	0.64%	0.55 %	0.10 %	4.12%
15 - 20	0.01 %	0.16%	0.01 %	0.00 %	0.08%	0.11%	0.00%	0.03%	0.11%	0.16 %	0.16 %	0.84%
20 - 25	0.00 %	0.06%	0.00 %	0.00 %	0.01%	0.03%	0.00%	0.07%	0.01%	0.01 %	0.01 %	0.21%
25 - 30	0.00 %	0.01%	0.00 %	0.00 %	0.00%	0.00%	0.00%	0.01%	0.00%	0.04 %	0.01 %	0.08%
30 - 35	0.00 %	0.00%	0.00 %	0.00 %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00 %	0.01 %	0.01%
>35	0.00 %	0.08%	0.00 %	0.00 %	0.01%	0.00%	0.00%	0.01%	0.01%	0.03 %	0.00 %	0.16%

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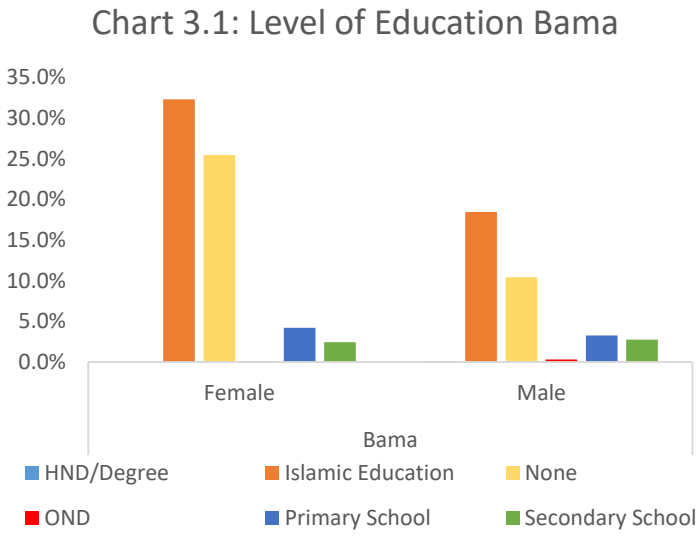
Further preliminary information was gathered from the respondent relating to the level of education. It was observed that majority of respondent have (32.3% female and 18.5% male in Bama and 36.8% female and 14.9% male) Islamic education, followed by primary school education in Bama 3.3% male and 4.2% female while Ngala was followed by secondary school education with 13.6% female and 4% male. It can be noticed also that women interviewed were more educated in numbers than men.

Chart 3: Level of Education of Respondent



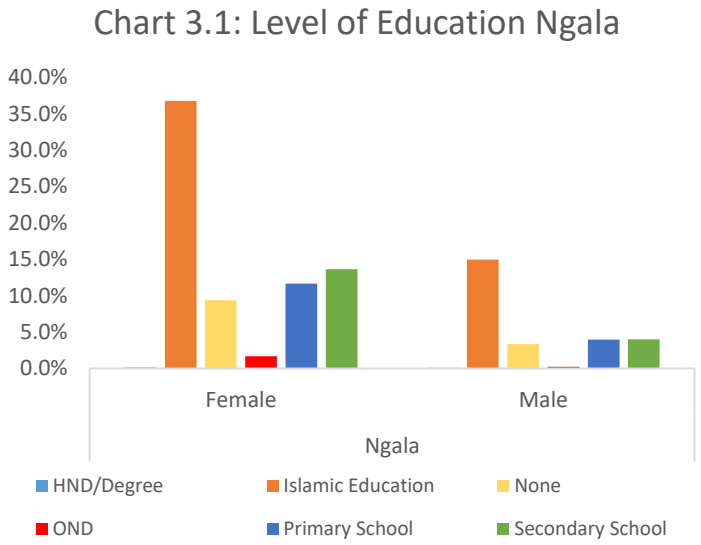


Table 4: Household status

	What Is Your Residential Status?				Total
	Host	IDP	Refugee	Returnee	
Bama	472	2202	81	2254	5009
Ngala	945	1019	4	86	2054
Total	1417	3221	85	2340	7063

The interviewed households are divided into 4 types of population, including returnees, refugee, displaced persons and the host population. 45% of the households surveyed are displaced followed by returnees who represent 33% , host population 20% and the refugees 2%.

6.2 Distribution of Gender Roles and Responsibilities

In both Bama and Ngala, women and girls are seen to be responsible for domestic work (cooking, caring and house chores). Men, on the other hand, are primarily considered the head of the family; they provide for the family and are as well in the

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position of control and authority in their respective households. Men also engage in economic activities like small business, firewood fetching and animal rearing to cover their family needs. Men do not perform domestic activities apart from fetching firewood and water for their family consumption or to sell. Women and girls also take part in fetching water and firewood due to its scarcity and huge demand. Access to firewood resources is however, been controlled by the military and Civilian Joint Task Force (CJTF). According to respondents, sexual violence mostly takes place during water and firewood collection points.

Chart 4.1: Control over resources - Bama

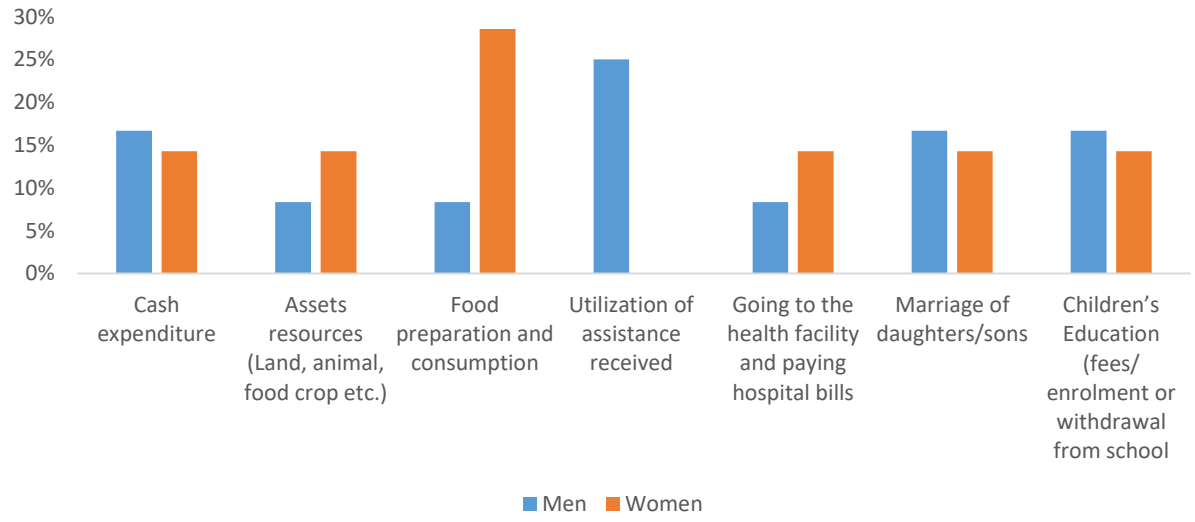
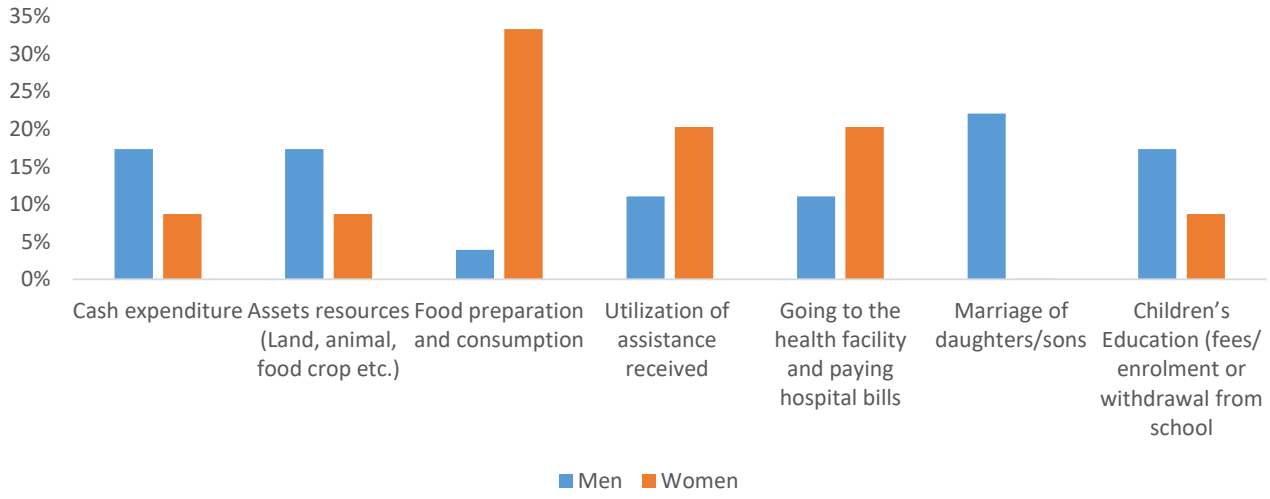


Chart 4.2: Control over resources - Ngala



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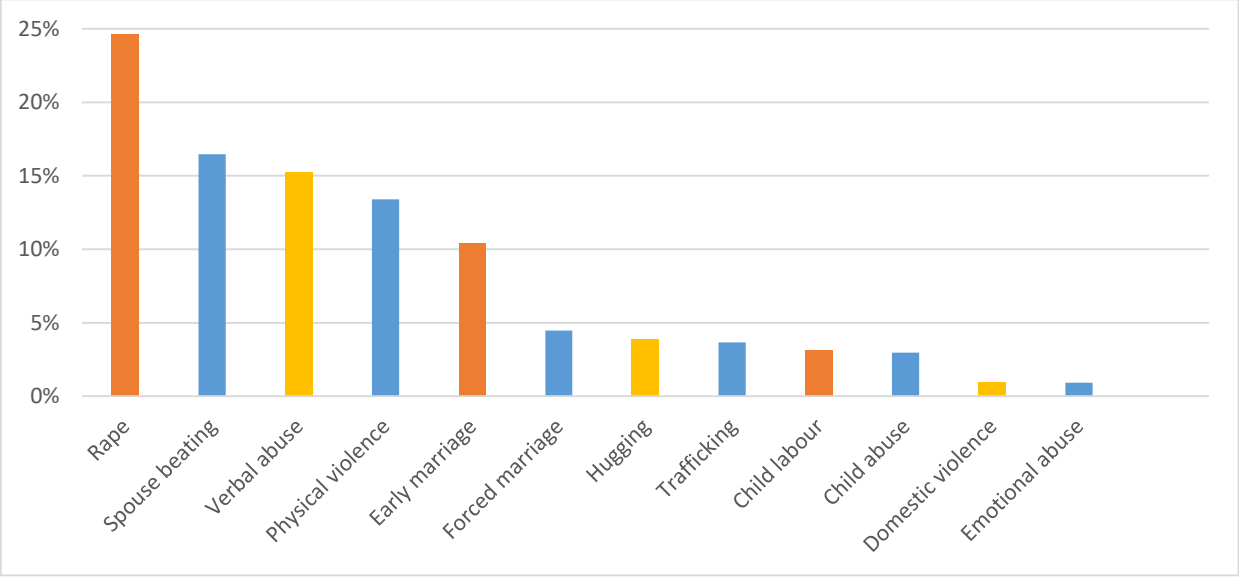
FGD shows that men are the main decision maker in the family, with control over property and assets, movement of women and girls outside the house and adding on more wives. While women control health and food utilization although still under the instruction of the husband, except if the woman is the single head of the family then the decision power is all hers. But since the insurgency, men have less decision over asset as they have loss most of their property due to migration and lands are used by the military for safe zone boundaries, while women are mostly entitled to humanitarian assistance. Humanitarian actors recognize the responsibility a woman in a family hold over a man whom is obliged to take on more wives once a not so stable feeding and livelihood opportunity is gotten. Although humanitarian assistance is tailored towards women, they still share decision on how to use any item given with their husbands.

6.3 Types of violence experienced in community

*"Our children (young boys) who should be in school and furthering their career or at home resting, are now the ones that goes out in the night to secure the community – **Men FGD NGALA***

Chart 5: Type of violence in the community



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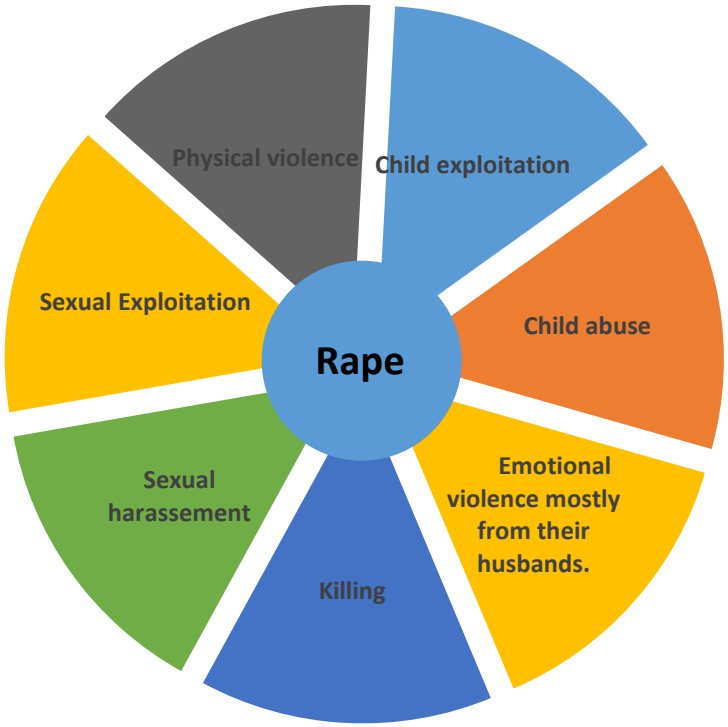
Overall, rape is the most mentioned form of GBV in the community (Bama and Ngala) with 25%, followed by spouse beating 16%, verbal abuse 15% and physical violence 13%. Early marriage 10% and force marriage 4% are predominantly among camp members whom are forced to give their children out for marriage early as they seek favor/space from new family or for themselves in the camp. FGD shows that the main cause of verbal abuse is the tension between camp and community member as regards to humanitarian assistance that is prioritized to the camp more than community member. Also, it was seen in the FGD that most survivors of sexual violence are more likely to be victimized again than speak out because of fear of community stigmatization.

> "The challenges we do face here in the community is that we usually see some army men entering houses with some of our women, which we cannot report because of the fear of reprisal, they may harm us, also the security challenge AOG." **Men FGD group – NGALA LGA**

Chart 6: identified types of violence by FGD



There were a lot of similarities between type of violence listed by mini survey with that of the qualitative FGDs (child abuse, physical violence, child exploitation/child labor) most striking mentioned in the FGD was rape, which was despicable by both men and women groups when mentioned and was also mentioned in the survey. FGD mentioned that there were known danger points where community and camp members were prone to GBV risk.

> "Torabora, Embora gate in Gambaru, Ngala." **– Men FGD group NGALA LGA**

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"Behind Shehu Kyari primary school and main market Bama." **– Women FGD BAMA LGA**

"In the community there are no known danger zones, but whenever our people move more than one kilometer away from community they get attacked and possibly killed by AOG – ***Women FGD NGALA***

Participants also noted the presence of violence in the premises where they live. This violence also affects a predominant form of livelihood – farming since community members can't move more than 1 kilometer away from the community. Therefore, cash crops farming is affected.

"Girls also get involved in such act as a result of poor guidance or lack of parenting because most of the girls whom are practicing this act are separated with their parents due to the insurgency while some are dead, nobody would care for them or provide for their needs for them, so therefore they think this is the only way out for them – ***Men FGD BAMA LGA****.*

"Some women that their husbands are in custody or separated with their husbands are involved in this act of sexual favor to meet their basic needs with their children due to poverty and life difficulties – ***Women FGD BAMA LGA.***

The fear of sexual violence, often associated with abduction, is contributing to psychosocial stress and further limitation of their movements. The restriction on freedom of movement of women and girls also inhibits their access to services, humanitarian aid and ultimately their rights.

Sex for survival and transactional sex were mentioned as coping strategies which women adopt in order to help provide for their households when there isn't any alternative means of livelihood.

Furthermore, in a KII held, health facilities confirmed that the commonest types of violence women and girls suffer from is rape and physical violence. Female Genital Mutilation (FGM) was mentioned by a few others as a type of violence women and girls had also received services for. Community leaders also highlighted, from experience, key avenues where violence often occurs to include food and non-food items distribution points, firewood collection points and schools'/training centers. Sexual violence is seen as shameful acts that dishonors the family's name. Then, young girls are pushed out to be married early mostly in the camps as the parents seek favor from new relatives and require space in the tent.

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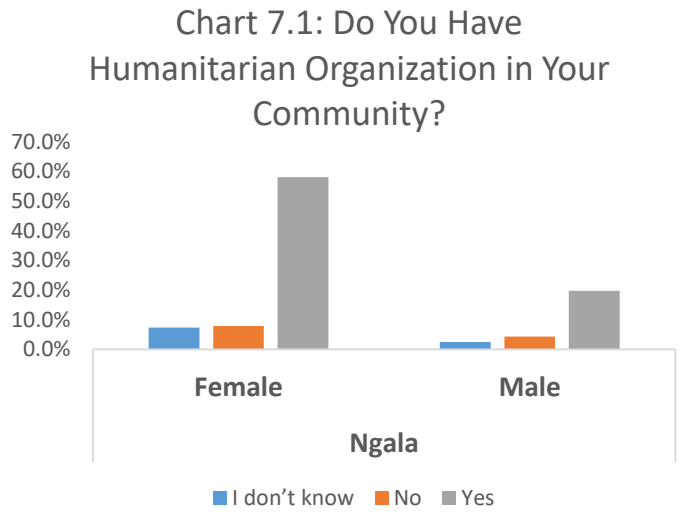
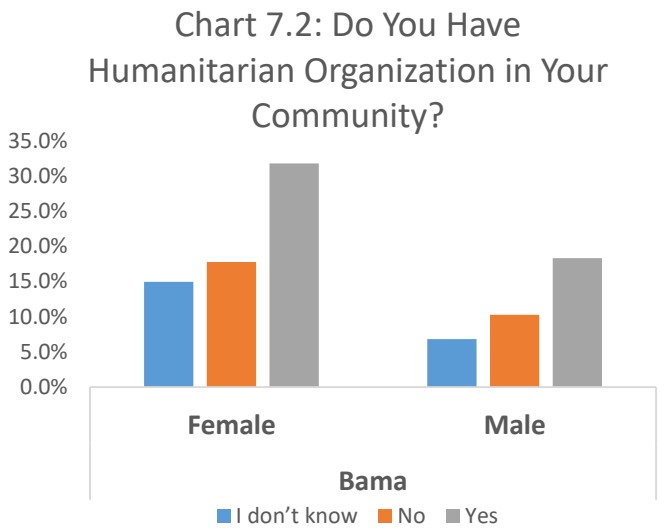
6.4 Humanitarian response and access to services

Chart 7: Humanitarian Actors Presence in Project Location





Overall, 77.9% and 50% of respondents in Ngala and Bama respectively confirmed the presence of humanitarian response and actors. On the other hand, 12.2% and 28.1% of respondents in Ngala and Bama responded "No" to the presence of any humanitarian actors in their respective LGAs. Furthermore, 9.9% and 21.8 % respondents in Ngala and Bama tend not to even know about the presence of humanitarian actors in their locations.

On the whole, the respondents that said "Yes", listed the following humanitarian agencies; Alima, IOM, CARE[2], Danish Refugee Council, MSF, FHI360, Mercy Corp, Intersos, UNICEF, WFP, UNHCR, Red Cross, CHAD, SIF, UNFPA, WHO and Solidarites International as the organizations providing services in their LGAs. Through FGD, they also went further to mention services provided like Food distributions and NFI, Health services, Shelter, for IDPs, Psycho social support and WASH for both areas.

Table 5: Mapping of actors

Name of organization	Function/Activities	Women or Men group
FADAMA	Farming	Both
Bull	Animal rearing	Both
UNICEF	Health Services	Both
PLAN International	GBV/Livelihood	Both
International Alert	GBV Cases	Women
Girl Child Concern (GCC)	Health Services	Both
Form One	GBV Cases	Women
Mercy Corp	Distribution of food	Both
MSF	Health and Nutrition	Both
INTERSOS	Nutrition	Both

[2] CARE SRHR team implemented in both locations under the funding of UNFPA

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During the FGD session held with men and boys, the table above shows the list of organizations present and are functional in their locations. Quite a few organizations are actually providing GBV services.

The level of participation of health worker in delivering GBV responses play a striking role in a community that is infringed by male dominancy. Health facilities report rape as the most common type of violence women and girls receive services for. Abortion, Counselling, antenatal care, blood pressure, medical examination and treatment were listed as the services provided in the health facility.

Table 6: Feeling of safety and dignity by the current humanitarian assistance

Has your safety been affected by humanitarian assistance?

		Bama	Ngala	Total
Female	I don't know	16.8%	8.5%	25%
	No	46.9%	39.3%	86%
	Yes	0.9%	25.5%	26%
Male	I don't know	6.2%	3.3%	10%
	No	28.8%	13.1%	42%
	Yes	0.4%	10.3%	11%
Total		100.0%	100.0%	

Do you feel that your dignity is respected when you access a humanitarian service?

		Bama	Ngala	Total
Female	I don't know	35.3%	28.1%	63%
	No	9.9%	13.8%	24%
	Yes	19.3%	31.4%	51%
Male	I don't know	18.7%	12.6%	31%
	No	4.4%	6.1%	10%
	Yes	12.4%	8.0%	20%
Total		100%	100%	

To understand the above outcome, safety and dignity concepts need to be first defined. Regarding the global protection cluster, safety and dignity are defined as follows:

- Safety: It describes the condition of being protected against physical and psychological harm.
- Dignity: It describes the fact that people have a right to be valued, respected and receive ethical treatment. The emotional experience of a person is as important as their physical safety, and often human rights violations can be humiliating for a person, affecting their sense of self-esteem and of human dignity

At the time of this assessment, the integrated GBV project prevention and response activities had not yet started; therefore, these data inform only on the humanitarian assistance in general.

In an attempt to get a clearer understanding of the context, safety and dignity were taken as separate components, and an individual question was asked on each:

- Has your safety been affected by humanitarian assistance?
- Do you feel that your dignity is respected when you access a humanitarian service?

Both questions were closed ended question which required a "Yes", "No" or an "I don't know" response. The table below shows the finding from the survey.

Out of 7063 respondent interviewed for safety concept in humanitarian assistance, 37% responded "Yes" [broken down into each individual LGA gives; Bama 1.2%(female 0.9% and 0.4% male) and Ngala 35.8%(25.5% female and 10.3% male)] the result shows that Bama have more safety concerned than Ngala; Both LGAs have curfew at 6pm where vehicles are

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restricted from movement but trekking is still allowed to 10pm but not advised. While for dignity in humanitarian services in Bama 19.3% Female and 12.4% male while for Ngala 31.4% female and 8% male, given a total of 71% in agreement that humanitarian services encourage dignity. 29% who did not agree listed that community members are not happy with the IDP centered approach of humanitarian actors, they are kept on long queue under the sun and are afraid to go back to the camp after services because of fear of bad boys, also mentioned that some humanitarian actor staff are disrespectful and men and boys are not attended to for a long time. In total, 54,10% of the respondent agree about both feeling of safety and dignity by humanitarian intervention in general**.**

information gotten from the FGD shows that women whom go out to socialize mostly into the camps or out of the camps are prone to sexual harassment and abuse. FGDs also show that behind the secondary schools, firewood collection points are known danger zones. Very few measures are in place to increase women safety in public space such as military patrol, adequate camp security and healthcare, community engagement in humanitarian activities, awareness on Sexual Exploitation and Abuse, protection and psychosocial support.

Although the integrated GBV program at this point was not yet to start, the baseline assessed here if the general humanitarian assistance was delivered in a safe, accessible and participatory manner. The questions asked were:

- Do you feel you are able to reach and use the services provided by humanitarian workers whenever you like/choose/need it?
- Are you involved in decision making processes around the services provided in your community by humanitarian organizations?

> "Yes, all the humanitarian assistance delivered were seen as safe, accessible and participatory manner, because no one can say that is discriminated from participating, everybody is allowed to participate with equal chance given to all. Unless the program is for specific group of people for example if it is meant for men, then only men can participate and if it is meant for women, then only women can participate." **– Women FGD BAMA LGA**

Both men and women in the focus group explicitly said humanitarian activities are safe, accessible and in a participatory manner. Especially women agreed as most interventions are tailored to women in the community.

> "Yes, because the organization here in the camp usually come to us, seek for our consent on what we need before they provide it for us especially food item & NFI, in which we do get it in a very safe place and accessible place not far from our homes." **– Women FGD CAMP NGALA LGA**

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Table 7: Feeling of safety and dignity by the current humanitarian assistance

Do you feel you are able to reach and use the services provided by humanitarian workers whenever you like/choose/need it?

Diversity				Bama	Ngala	Total
5-18	Host	Female	No	0.3%	0.4%	1%
			Yes	0.0%	0.1%	0%
		Male	No	0.2%	0.0%	0%
	IDP	Female	No	1.2%	0.5%	2%
			Yes	0.1%	0.1%	0%
		Male	No	0.7%	0.0%	1%
	Refugee	Female	No	0.0%	0.0%	0%
	Returnee	Female	No	1.1%	0.0%	1%
			Yes	0.0%	0.0%	0%
		Male	No	0.4%	0.0%	0%
19-59	Host	Female	No	5.2%	20.4%	26%
			Yes	0.0%	6.9%	7%
		Male	No	2.7%	9.1%	12%
			Yes	0.0%	3.1%	3%
	IDP	Female	No	20.7%	30.7%	51%
			Yes	4.7%	3.8%	8%
		Male	No	10.4%	9.8%	20%
			Yes	2.6%	0.4%	3%
	Refugee	Female	No	0.7%	0.0%	1%
		Male	No	0.6%	0.0%	1%
	Returnee	Female	No	25.5%	2.3%	28%
			Yes	0.5%	0.1%	1%
		Male	No	12.7%	0.2%	13%
			Yes	0.3%	0.0%	0%
>60	Host	Female	No	0.7%	3.5%	4%
			Yes	0.0%	0.5%	1%
		Male	No	0.3%	1.5%	2%
			Yes	0.0%	0.6%	1%
	IDP	Female	No	1.1%	2.3%	3%
			Yes	0.1%	0.1%	0%
		Male	No	2.1%	1.8%	4%
			Yes	0.3%	0.0%	0%
	Refugee	Female	No	0.1%	0.1%	0%
		Male	No	0.2%	0.0%	0%
	Returnee	Female	No	2.6%	1.3%	4%
			Yes	0.0%	0.0%	0%
		Male	No	1.8%	0.1%	2%

Are you involved in decision making processes around the services provided in your community by humanitarian organizations?

Diversity				Bama	Ngala	Total
5-18	Host	Female	No	0.3%	0.4%	1%
			Yes	0.0%	0.1%	0%
		Male	No	0.2%	0.0%	0%
	IDP	Female	No	1.3%	0.6%	2%
		Male	No	0.7%	0.0%	1%
	Refugee	Female	No	0.0%	0.0%	0%
	Returnee	Female	No	1.1%	0.1%	1%
		Male	No	0.4%	0.0%	0%
19-59	Host	Female	No	5.2%	26.4%	32%
			Yes	0.0%	0.8%	1%
		Male	No	2.7%	10.7%	13%
			Yes	0.0%	1.5%	1%
	IDP	Female	No	25.1%	34.1%	59%
			Yes	0.3%	0.4%	1%
		Male	No	12.9%	9.9%	23%
			Yes	0.2%	0.3%	1%
	Refugee	Female	No	0.7%	0.0%	1%
		Male	No	0.6%	0.0%	1%
	Returnee	Female	No	25.9%	2.5%	28%
			Yes	0.1%	0.0%	0%
		Male	No	13.0%	0.1%	13%
			Yes	0.0%	0.0%	0%
>60	Host	Female	No	0.7%	3.9%	5%
			Yes	0.0%	0.1%	0%
		Male	No	0.3%	1.7%	2%
			Yes	0.0%	0.3%	0%
	IDP	Female	No	1.2%	2.5%	4%
		Male	No	2.4%	1.8%	4%
			Yes	0.0%	0.0%	0%
	Refugee	Female	No	0.1%	0.1%	0%
		Male	No	0.2%	0.0%	0%
	Returnee	Female	No	2.6%	1.3%	4%
		Male	No	1.8%	0.1%	2%
Total				100.0%	100.0%	200%

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Total	100%	100%	200%

Out of 7063 responders, 8.50% (5.3% females and 3.2% males) in Bama and 15.70 % (11.6% female and 4.1% male) in Ngala responded "Yes" that humanitarian assistance is safe and accessible. And 0.6% (0.4% females and 0.2% males) in Bama and 3.6 (1.4% females and 2.1% males) in Ngala responded that they are involved in decision making (participatory manner). In total the current humanitarian assistance is delivered in a safe, accessible and participatory manner for 14.20% of respondents.

6.5 Project indicators

At the time of the assessment, the integrated GBV project had not started therefore, all indicators figures were zero (0).

WHAT?	HOW MUCH?	
List of all project indicators	Baseline	Target
Specific Objective Indicators		
% of targeted population reporting an improved feeling of safety and dignity by the end of the intervention compared to the beginning.	0	70%
% of beneficiaries (disaggregated by sex, age and diversity) reporting that humanitarian assistance is delivered in a safe, accessible and participatory manner.	0	80%
# of surveyed communities that indicate a change in the incidence of sexual violence.	5	5
% of humanitarian staff trained and who can correctly indicate the referral pathway for GBV survivors.	0	100%
R1 Indicators		
Number of persons reached by the implementation of specific GBV prevention measures	0	7500
% of humanitarian staff trained and who can correctly indicate the referral pathway for GBV survivors.	0	32
Number of survivors who receive an appropriate response to GBV.	0	300
R2 Indicators		
Number of participants showing an increased knowledge on the protection subject in focus	0	25
% feedback/complaints received have been timely acted upon (disaggregated by sex and age).	0	85%

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7 Conclusion and Recommendations

Sexual violence is seen as a shameful act that dishonors the family's name, young girls are pushed out to be married early mostly in the camps as the parent seek favor from new relatives and require space in the tent.
Women generally are not granted a sit in decision making except for some specific issues for which women leaders are involved although, very limited or non-active in the community

GBV is pervasive in NE Nigeria society, which supports male supremacy and grants men power and control over women in both domestic and public spheres.

The conflict has also maintained a vicious cycle of GBV as women, men, girls and boys in dire situations resort to negative coping mechanisms including 'survival sex'/transactional sex, forced/early marriage. The fear, shame and stigma associated to GBV significantly weight on the mental health conditions, socio-economic situation and access to GBV services.

Humanitarian actors are already present in the area. But GBV services access and quality are quite poor. The findings show also that the humanitarian assistance should be improved regarding respect of safety and dignity of the communities.

Key recommendations

- Strong GBV awareness is needed to engage communities and change social norms (stigmatization).
- To encourage existing positive coping mechanisms
- To strongly reinforce the knowledge on the accessible and available GBV services and encourage coordination between the actors.
- Vigilance on the safety, accessibility and participatory approach while delivering the activities expected in the project
- Community-based mitigation plans to be supported within the budget possibilities

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