CARE Rapid Gender Analysis
Northeast Nigeria – Borno

Peninah Kimiri
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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 the United States Government/any other partners.

Cover page photo: VSLA women attending their weekly meeting in NE Nigeria.

Image: Habeeb Sulaiman/CARE
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Abbreviations

BAY          Borno, Adamawa and Yobe
CCCM         Camp Coordination and Camp Management
GAM          Global Acute Malnutrition
GBV          Gender Based Violence
IDP          Internally Displaced Person
KII          Key Informant Interview
LGA          Local Government Area
NCD          Non-Communicable Disease
NCDC         Nigeria Centre for Disease Control
NFI          Non-Food Items
OAG          Organised Armed Group
PSHEA        Prevention of Sexual Harassment Exploitation and Abuse
RGA          Rapid Gender Analysis
SEMA         State Emergency Management Agency
SRH          Sexual Reproductive Health
VSLA         Village Savings and Loans
Executive Summary

Borno is a state in northeast Nigeria. Borno has been the epicentre of the Organized A since it began its insurgency in 2009. Records of Boko Haram operations show that thousands of people have either been murdered or kidnapped as a result of the group’s activities from July 27, 2009, through late 2019. According to Nigeria’s National Emergency Management Agency (NEMA), as of January 1, 2020, Borno had recorded a total number of 32 internally displaced persons (IDPs) camps as a result of OAG. Even as the IDPs contend with this crisis, there are also host communities, including nomadic and isolated sedentary villages who have also suffered raids on their property and persons.

As the crisis has progressed, 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 now provide for their family, thus expanding their decision-making power. However, women’s decision-making power has not increased significantly enough over time to create a critical mass to shift the pervasive patriarchal which grants men power and control over women and supports unequal power relationships, access and control over resources for women and men.

For Borno, COVID-19 is a “crisis within a crisis” and presents a range of challenges in a context with limited resources. In most localities (named local government areas or LGAs), access to quality health services, including intensive care, is limited. Non-Communicable Diseases (NCDs) e.g. malaria, water borne illnesses (including cholera) and malnutrition represent the main cause of premature mortality in the state. In addition, food security and livelihoods are particularly precarious due to semi-subsistence lifestyles and heavy dependence on the informal sector for income.

Because Borno has been in a protracted crisis since 2009, gender has been a key consideration in the response. However, an outbreak of COVID-19 in Borno continues to disproportionately affect women and girls in a number of ways, as women are more likely to stay home to help with the increased domestic tasks. With the fear of contracting COVID-19, permission granted by men to access health services is decreasing which is negatively affecting women and girls’ access to maternal, sexual and reproductive health services. In addition, Gender Based Violence (GBV) service providers in Borno have reported a heightened risk of increased domestic violence in areas where pre-existing rates of violence against women in IDP camps are already very high. Additionally, with the recent loss of livelihoods, strained humanitarian interventions and inadequate field feedback handling mechanisms, Prevention of Sexual Harassment Exploitation and Abuse (PSHEA) and mitigation is a pressing concern as people in need are left vulnerable in the face of insufficient food and resources.

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Key findings

- Because of the pervasive patriarchal context of Borno, men’s incomes have been especially hit hard as they were primary bread winners. Additionally, because of women needing permission from men to go out, those with businesses have also taken a hit as fears of contracting the virus coupled with increased domestic work has negatively affected women’s income generating activities.
- Access to services, particularly health services for both men and women have been negatively affected due to COVID-19 mobility restrictions. Women are doubly affected as they also experience limited access to sexual reproductive health (SRH) services.
- Because of previously existing educational and digital literacy gaps, women and girls have less access to mobile phones and internet, hampering their access to accurate and timely information on COVID-19.
- Although civil society successfully lobbied for Gender Based Violence (GBV) services to be classified as essential services, stigma, coupled with the fear of contracting COVID-19, is still a major impediment in accessing timely GBV services.

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1 CARE Borno State RGA, 2018
As the reported cases of COVID-19 are slightly more for men than women, men's gender roles and norms need to be taken into account to ensure that men are properly targeted to help reduce their vulnerability to the disease and to take advantage of their roles as leaders and decision-makers in the home and community to help prevent the spread of the disease.

This Rapid Gender Analysis (RGA) used a mixed method approach of primary qualitative data collection in the form of KIIs with community members, NGO, INGO, UN agencies and local government. Because the data collection was done through the piloting of a VoiceApp (a voice-to-text application), it was adapted to the local context through the use of trained enumerators. Testimonies from the KIIs were complemented by a secondary data review for quantitative data. Although this RGA was an incremental step in diving deeper in the findings of Borno, Adamawa and Yobe States (BAY States) in May 2020, the findings are still significant as they give a fuller picture on some of the nuanced needs within Borno State. This RGA also gives insight on how communities are adapting to living with COVID-19 and some of the continuing pressing issues.

Because the RGA was only able to sample adults (age 20-65) in 5 different IDP camps and two host communities, the RGA is limited in providing information about those camps are is not reflective on the needs of children, including adolescents. Another key limitation to this RGA was that it did not target persons with disability in the data collection or NGOs that specifically support persons with disability. As the VoiceApp allows for an even more mobile approach to data collection, this is its next logical step to amplify persons' with disabilities voices. However, for the purposes of this RGA, the findings are regrettably not reflective of their specific needs.

Key recommendations

The COVID-19 pandemic, like any other health crisis, exposes existing inequalities and disproportionately affects populations that are already criminalized, marginalized and in a precarious situation that often do not benefit from social protection mechanisms. Thus, in response to this pandemic, communities, humanitarian organizations and governments, must take into account the following recommendations for urgent and immediate action:

- Because of the effect that COVID19 has had on businesses and employment, livelihood actors, including state ministries involved, should support women’s economic empowerment e.g. women small business owners to access markets through trade fairs and exhibitions and accessing flexible loans and grants to boost their businesses and to cushion them from the impact of the pandemic.

- Health service providers must address obstacles and barriers to accessing health care in order to enable women, girls and vulnerable people to access health care services, including SRH services and psychosocial support services, for survivors of GBV. This should be a combination of mobile care to reduce the transmission of COVID-19 and static care for critical cases, including those not COVID-19 related. Health service providers must raise awareness on continuation of services with the public and be provided proper PPE to give care.

- To bridge the information gap that women and girls experience, humanitarian organizations should ensure better access to information in rural areas by not only relying on community radio stations and SMS platforms but also in local meetings e.g. chiefs’ meetings, community dialogues and VSLA meetings where women are present to get the message across. In the longer term, governments should invest in infrastructure and adult learning to increase digital literacy of women and girls.

- To increase access to GBV services, NGOs should mobilize religious leaders (including women) to promote better understanding of the health measures put in place and engage them in raising GBV and COVID-19 awareness of populations. These efforts should be complemented by working reporting systems on PSHEA to protect community members and mitigate risks.
Introduction

Background information

Borno is one of the poorest states in Nigeria, with a poverty rate of 70.1 percent – one of the highest in the country as of 2019.2 The humanitarian situation in Borno State is characterized by pockets of severe and extreme levels of poverty in the return areas and within some urban communities hosting IDPs. People in rural areas are farmers, while widespread illiteracy, unemployment, and limited infrastructure contribute to low human capital development. Extreme poverty levels among families continue to have significant impacts on the wellbeing and development of children.

Additionally, vast and entrenched inequality in access to essential services deprives minority ethnic groups of the possibility for developing and improving their situation. There has been notable progress made towards improving access to health services, electricity, potable water, and other essential services. However, reducing ethnic inequalities in access to government services, including electrical power, remains a challenge.

While gains have been made in narrowing the gender gap in access to education, the distribution of economic goods is uneven by ethnicity. Humanitarian needs in Borno are exacerbated by poverty associated with lack of access to essential services, ethnic disparities, low economic development and protracted armed conflict. An initial analysis by WFP, indicates that about 7 million people may become food insecure in Borno, Adamawa and Yobe (BAY) states due to the potential impact of a COVID-19 on food security and livelihoods. This is almost double the 3.7 million people who were projected to be food insecure in the 2020 lean season according to the March 2020 Cadre Harmonisé (CH).

Humanitarian needs in Borno State increased marginally during the March–July 2020, mainly as a result of an upsurge in attacks by non-state armed groups (NSAG) and clashes between them and government forces displacing local populations. Movement restrictions and other impacts of the COVID-19 pandemic are also increasing risks of domestic violence and of gender-based violence including sexual violence. GBV Sub-Sector partners have developed innovative ways to adapt their response, including through new phone-in helpline services and redesigning safe and friendly spaces together with affected women.

School closures due to COVID-19 lockdowns also affected 4.2 million students across the BAY states, which led education sector partners to adapt their response by, for example, delivering radio learning programmes reaching out to 1.9 million children, including those in IDP camps and host communities.

In April, the humanitarian community mourned the death of an aid worker, who was working as a nurse in Pulka, who had contracted COVID-19. This marked the first case recorded in Borno State. Health partners are working closely with the National Center for Disease Control (NCDC), Borno State Government, the State Ministry of Health and the State Ministry of Humanitarian Affairs, Disaster Management and Social Development, to contain the spread of virus by establishing isolation centres, contact tracing, and bolstering measures to prevent the spread of the virus and protect IDPs and communities in Borno State.

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In March and April, the hot and dry season in Nigeria led to a series of fire outbreaks in camps for internally displaced people. In one of the most severe fire outbreaks which happened in International Secondary School IDP Camp in Ngala, Borno State, on 16 April, fourteen people lost their lives and 300 shelters were damaged. By mid-April, some 15 fire outbreaks had been recorded since the beginning of the year affecting more than 15,000 people. Overcrowding in IDP camps across the BAY states, with shelters being built in close proximity to one another, exacerbates the risk of fire outbreaks, as well as disease outbreaks. These series of incidents, coupled with the risk of COVID-19 and other diseases spreading across IDP camps, highlights the urgent need for decongestion and expansion of camps.

The Rapid Gender Analysis (RGA) objectives

Rapid Gender and GBV assessments provide information about the different GBV risks, needs, capacities and coping strategies of women, men, boys and girls during crisis. The global objective of this assessment is to improve the quality and effectiveness of CARE and partner’s response to the crisis in Northeast Nigeria.

Specific Objectives:

1. Understand gender roles, power dynamics and social norms and practices with regard to food security and livelihoods, sexual and reproductive health (SRH) and GBV among women and men of all ages within IDP and host communities.

2. Understand the main risks of GBV for women, men, boys and girls of IDP and host communities and map GBV services providers and their capacity, including community-based GBV prevention and response systems.

3. Provide practical recommendations to CARE and other humanitarian actors to improve gender integration and quality of GBV prevention and services in their response.

The following report presents the findings and recommendations for Dikwa and Bama LGAs in Borno State.

Methodology

Rapid Gender Analysis 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 Gender Analysis Frameworks and adapts them to the tight time-frames, rapidly changing contexts, and insecure environments that often characterise humanitarian interventions.

The research has been undertaken from August 10, 2020 to August 14, 2020. Research is still continuing and the RGA will be updated appropriately when new findings and recommendations are produced. Research method's included:

- **Key Informant Interviews (KII)** with 142 people (87 women and 55 men) piloting CARE’s VoiceApp.
- **Secondary Data Review**

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3 The VoiceApp is a mobile phone application, currently under development by CARE, which uses speech-to-text technology to reduce the burden of qualitative data collection efforts during RGAs by automating the transcription of interview responses, collating answers and centralizing data export functions to assist in more rapid analysis of findings.
The RGA had several limitations:

- The RGA only sampled 5 out of the 32 IDP camps in Borno State and did not include children, including adolescents. It also did not reach persons with disabilities or organizations that specifically working with them.

- During the KIIs, humanitarian workers did not always have time to fully answer the interview questions, resulting in some incomplete interviews and disparate numbers of response sample sizes.

- In the 1:1 interviews with community members, some did not complete the interviews, indicating a lack of clarity around what benefits they would see from their participation.

- Specific to the piloting of the VoiceApp, it was at times difficult to find a quiet place to use the speech-to-text function of the application, as most female interviewees did not want to be alone when responding to the questions. Instead, they preferred to be with their peers, which resulted in conducting interviews in noisier environments.

Demographic profile

Sex and Age Disaggregated Data

Across Northeast Nigeria State, 10.6 million people need humanitarian assistance in 2020⁴, including a 2.8 million increase due to the COVID-19 outbreak. Overall, the people in need of humanitarian assistance has increased in and since 2019, resulting mainly from rising violence and insecurity, poverty and lack of access to services and the impact of the COVID-19 pandemic. A breakdown by population groups indicated the highest proportion of households with severe needs are in the host communities.

Demographic analysis

Sex- and age-disaggregated data for COVID-19 is unavailable for Borno, but as of July 19, 2020, the Nigeria Centre for Disease Control (NCDC) had confirmed a total of 536 cases of COVID-19, which had resulted in 35 deaths in the state, which is the highest among the three most conflict-affected states. Evidence from other global health pandemics such as the Ebola outbreak suggests that women and girls often suffer from secondary implications – such as GBV and loss of income – during health crises more than men. Available national statistics from NCDC indicate that 68 percent of the national cases are men, while 32 percent are female, with the age range of 31–40 years being the most affected. This is in line with emerging global data that suggests that men are more at risk compared to women.

⁴ Nigeria Humanitarian Needs Overview, 2020
Findings and analysis

Pre-existing gender inequalities often worsen during a crisis, including public health emergencies. Recognizing the extent to which disease outbreaks affect people of different genders in specific ways is fundamental to planning effective and equitable responses. This section details:

- Pre-existing gender inequalities, and gender issues, likely affecting men, women, boys and girls,
- Specific gender issues and differences that have arisen as a result of COVID-19;
- Potential implications of both pre-existing, and COVID-19 related, gender inequalities for response policies

Gender Roles and Responsibilities

Control of resources

The armed-conflict had already interrupted access and control over most resources for all, including men who traditionally controlled them prior to the COVID-19 pandemic. Assets and resources (houses, livestock, shops) were looted or destroyed by the Organized Armed Group (OAG), farmlands and pasturelands are not accessible due to high risk of attacks, security measures and displacement. Pre-COVID-19, both women and men had access to humanitarian assistance; food, cash, non-food items (NFI), health, SRH, shelter, though women had begun to have more decision making over the use of assistance. Families living in camp or camp-like settings do not have control over most resources since all land and property is controlled and managed by the State Emergency Management Agency, in collaboration with CCCM actors and the military who allocate these (tent and houses) according to IDP needs5.

In the host communities, mostly as head of family, men usually have access and control to family resources including land, livestock, cash credit, small trade, etc., while women can access but do not control the same. boys and girls are entitled to their parents’ resources and assets. They therefore have access to them, but do not have control over them until they reach maturity and/or when their parents die. They can both inherit these assets when they lose their parents, but in practice, males always receive the lion share as they are given twice what their female counterparts receive. This dynamic has not changed with COVID-19.

Earning income

Pre-COVID-19, both men and women had begun earning income to supplement the humanitarian assistance they were receiving to meet their needs. For men, they had small businesses such as small retailers or manual labourers. Women had begun small scale trading such as knitting caps, tailoring, making mats etc.6. However, with COVID-19, this earning potential has been greatly reduced because of the lockdowns, curfews that led to a subsequent downturn in the economy and closing down of businesses. All respondents in the survey reported that there was a negative impact in earning income stating that they were unable to either sell their stock or have experienced payment/salary delays as a result of the pandemic. This, compounded with the fact that market prices have steeply

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5 CARE Gboro and Protection Risk Analysis 2018
6 NE Nigeria Rapid Gender Analysis, 2018.
increased, has added stress to families. Even for those with multiple members who have a jobs, they are still unable to contribute, as one respondent put it, “...none of the family [their] salary since COVID-19 [came]” (Female IDP, Dikwa).

**Decision making within the household**

During the acute stages of the emergency, when insurgency was the primary concern, men were usually the main decision-maker in the family in that their decision would give the ultimate direction on how property and asset management, and movement of women and girls would happen. While women were consulted on household matters (e.g. education, food or healthcare), the man would still have the final say. With the COVID-19 pandemic, not much has changed with respect to decision making, as respondents still identify that men still make decisions on behalf of the household, and particularly fathers if it is within the nuclear family. Only one male respondent pointed out an opportunity to share the load stating that even if the father makes the decisions “…the women also help in one way or the other because since the pandemic the load is too much the man can't control all” (Male community Leader – Bama). This level of self-awareness to share the burden during this “crisis within a crisis” is imperative to further the gender equality gains that have been advanced since the emergency. Additionally, thought and cultural leaders are also open about their fact that decision making being a man’s job is not necessarily a good thing as one called it “negative” and that is was the “Men controlling the family” (Imam, Dikwa).

**Capacity and Coping Mechanisms**

The increase in displacement due to the recent attacks by the AOG and the spread of COVID-19 pandemic in Borno continues to impact livelihoods negatively, and consequently on food and nutrition security. As a result of COVI19-19, Borno has experienced an increase in numbers of food insecure people, compared to the previous months. However, despite the humanitarian assistance and an increase in food crop production in the state, the COVID-19 pandemic and the pockets of hazards and vulnerabilities pose threats to food and nutrition security. Furthermore, most of the LGAs in the northern parts of the state are still facing nutritional challenges with global acute malnutrition (GAM) rates. Acute food insecurity conditions led to an increase in the proportion of households resorting to negative coping strategies compared to the previous months.

These negative coping capacities include adults not eating food so that the children can have something to eat and the selling of assets to afford food for the home. Men and women are having to find ways to keep their families fed and alive to survive the pandemic. One respondent resigned herself to the situation saying “...whatever the men bring to the house we manage, sometimes we don't even eat” (Female IDP, Dikwa). The sacrifice goes both ways as men also have to sacrifice for the children as one man stated “Sometimes we don't even eat food we are facing difficulty both financially and economically.” (37, Vigilante – IDP, Dikwa)

**Access**

The movement of women and children has been traditionally controlled by men. COVID-19 has not had a significant impact on this, as women still have to seek permission to visit a hospital, family members, or to participate in community activities. However, because of the insurgency and need to supplement income, women and girls enjoyed more freedom of movement because of the need to supplement income, and access other free services provided by humanitarian organizations, including education for children and economic empowerment activities such as VSLAs. But the freedom of movement is relative for community members and IDPs as community members,
both men and women, were still limited by security risks and curfews and IDPs could not move outside the camp. With the increased measures of COVID-19 lockdowns and curfews both affecting community members and IDPs, lack of access to cross border trade, farming, animal grazing and collection of firewood has highly affected both men and women.

**Access to services and resources**

Both men and women were able to identify that they could safely access food, water and NFIs such as dignity kits for women. However, there have been marked reported changes in the amount and quality of services that they receive. Women seemed to focus on the immediate needs of the family such as food, water and NFIs while men thought more holistically of the services that they received. Men pointed out that the amount of water and food they used to access has reduced as well as services such as education have been completely halted.

**Access to Health Services and SRH**

Respondents reported that their overall access to health services had declined as a result the pandemic stating reasons such as having longer wait times, sometimes not even being to get services on the same day. Before the pandemic, access to health services was consistent in that they could expect to get same-day services and admission if need be. As COVID-19 spreads, there has been a decline in admission rates, to stem the spread of the pandemic, which is a frustration for community members who feel that they or their loved ones could benefit from being nursed in the full time care of a medical professional. Additionally, the majority of respondents agree that there is less access to services for women and girls, particularly for health, SRH and GBV.

There are differences in how men and women perceive their own access challenges. Women report that priority is given to men because there are few/no female staff available to attend to them, while men feel that women are given priority as pregnant and lactating mothers are allowed to “jump the queue”. However, outside of this demographic, men do not think that women are prioritized.

Overall, both humanitarian agencies and community members report an increase in COVID-19 related services such as testing and isolation centres. However, there is still need for support from the government to support these initiatives to allow for other services to continue such as SRH. There appears to be more empowerment of older women (aged 30 and over) when it comes family planning, where they report to have decision making power by themselves or in partnership with their husbands, while younger wives (20-30) report having to do as their husbands say in matters family planning.

**Access to Technology**

Access to information and resources are limited because of a lack of outreach and translation into Indigenous languages as well as lower levels of internet and information and communication technology (ICT) access. A majority of respondents reported accessing COVID-19 related information through phones or radio. However, for women, they reported to access information through their husband’s phones which indicates a reliance on the availability of their husband’s resources and permission to access the information. In Dikwa, there are no radio stations available, so there is a heavier reliance on accessing information through men’s phones or face-to-face interaction that would put communities at greater risk for contracting COVID-19.

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9 Ibid
Measures to stop the spread of COVID-19 have accelerated the pace at which both work and education are going digital. However, this accelerated pace of migration to digital platforms runs the risk of exacerbating existing gender inequalities. While data is very limited around the intersectional gender gap in connectivity for the region, the data that does exist clearly shows that women and girls have less access to digital communications and platforms across the region compared to men. In Nigeria, women’s access to mobile phones and the internet is high. 84% of women in the country own mobile phones and there is only a 5% gender gap between men and women’s access. However, only 35% of women have access to internet as compared to 50% of men. This gap, coupled with family disapproval of women having access to a phone and internet, widens the gap in Borno. Because of the pandemic, women have begun accessing mobile phones and the internet which overall, they report to be happy with this change. However, a majority of male respondents reported this to be a negative change as they fear that it will distract women from their domestic work.

**Rumours and Harmful Beliefs**

Social media as a tool of communication provides huge information outlets to Nigerians during the pandemic. The announcement of the first COVID-19 victim was made through various social media platforms such as Twitter, Facebook, and various websites. Subsequently, health care agencies such as the NCDC updated the masses on the number of cases that have are positive, fatal or have recovered in Nigeria through these social media platforms. However, the acquisition of smartphones and data has created an opportunity for the spread of misinformation. Fraudsters have capitalized on this opportunity to take advantage with false treatments. Additionally, those not trained to discern credible news sources spread falsehood and half-truths, which cause misinformation to still predominate the social media. Trusted news and information sources such as health workers and religious leaders have largely been inaccessible to community members and thus having them rely on subpar information outlets has led to some damaging consequences.

**Traditional medicine and practices**

Pre-COVID-19, community members complemented western medicine with traditional medicine such as herbs but knowing that formal healthcare was essential to a full recovery. However, with lockdowns and long-wait times, some community members had begun to supplement hospital care with local herbs. This has had a negative impact, particularly for pregnant and lactating women and in the menstrual health of girls and women. Both men and women respondents in the survey reported that traditional medicine was the default means to supplement hospital care but was not ideal as it either did not change the patient’s health status, made the condition worse or resulted in death. However, the merits of including religious beliefs such as prayer for the patient are still revered as a holistic intervention.

**Protection**

**Gender Based Violence**

The threat of the spread of COVID-19 to communities affected by conflict in Northeast Nigeria is high and heightens the already existing vulnerabilities for gender-based violence. In different parts of Nigeria including in the

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10 Connected Women. The Mobile Gender Gap Report 2019
Northeast, activists and service providers are already recording increases in GBV incidents reported to them since the COVID-19 outbreak. In neighbouring Yobe, a husband chopped off his wife’s right hand because she had gone to a wedding he had not approved for her to go while the lockdown was still in effect.11

Yet reporting and seeking services remain challenging due to the lack of available, safe, ethical and quality response services as well as fears of stigmatization, reprisal, and lack of access to appropriate information on seeking help in the context of the pandemic.12

The government-imposed lockdown and movement restrictions have also greatly affected access to GBV service points for both project participants and service providers. In principal, lifesaving GBV interventions continue during this period to ensure critical GBV response services are available all the time for survivors and individuals in need. However, response modalities to COVID-19 present various levels of risks and restrictions that make some modes of GBV service delivery more possible than others. At the same time, maintaining the health and wellbeing of GBV workers is of critical concern. This therefore demands a higher level of flexibility, and a more layered approach to GBV service delivery with strategies that adapt to changes in modalities of accessing and interacting with survivors during service provision.

PSHEA

With the recent loss of livelihoods, strained humanitarian interventions and inadequate field feedback handling mechanisms, Prevention of Sexual Harassment Exploitation and Abuse and mitigation is a pressing concern on service providers. As people in need are left vulnerable in the face of insufficient food and resources, the risk increases.

Conclusions

Despite some marginal changes to women’s influence in households and revenue generation, the current insurgency in Northeast Nigeria and its unprecedented displacement of populations has greatly exacerbated existing gender inequalities and GBV in the region. Displaced women, men, girls and boys are trapped in a vicious cycle of violence including sexual and gender-based violence with related trauma and long-standing social stigma.

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. It is recommended that organisations continue to invest in gender analysis, that new reports are shared widely and that programming will be adapted to the changing needs. The next iteration of this RGA should expand to other camps, host communities in Borno and persons with disability. This should

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12 Gender Based Violence (GBV) Helpline Management. RAPID ASSESSMENT REPORT. Gender Based Violence Sub Sector; Nigeria May 2020
include insights from data gleaned from Post Distribution Monitoring reports, needs assessments, feedback mechanisms, humanitarian processes such regular cluster meetings, etc.

Overarching recommendation

Traditional gender roles have shifted and while displaced women and men are in need of basic immediate humanitarian assistance, there is also increasing need for long-term and durable solutions in gender equity. In particular, a systematic, gender and GBV focused response mechanism is needed at the community level.

Targeted recommendations

These recommendations should be considered urgent for immediate action:

- To bridge the informational gap with women and girls, all service providers (NGO and government) should adapt the messages delivered to populations at different literacy levels and of education for the different groups of the population but also at the different levels of access to the means of information and/or communication taking into account the digital gap and locations specific to the ones that women and men attend.

- Health care service providers should address obstacles and barriers to accessing health care. This should be done by using a mix of mobile and static services to make up for proximity to the community, adapting opening hours to ensure all persons can be served as per their domestic or formal work schedules, using appropriate information sharing mediums such as radio, SMS, megaphone alerts to enable women, girls and vulnerable people to access health care services, including SRH services and psychosocial support services for survivors of GBV. Additionally, provide mobile SRHR services, particularly in the nomadic and for isolated sedentary villages.

- Because women and girls experience a gap in accessing timely information, WASH, health, GBV actors and government bodies in charge of relaying COVID 18 guidelines should ensure better access to information in rural areas by not only relying on community radio stations and SMS platforms but also in local meetings e.g. chiefs’ meetings, community dialogues and VSLA meetings where women are present to get the message across. In the longer term, governments should invest in infrastructure and adult learning to increase digital literacy of women and girls.

- To increase access to GBV service, NGOs, and governments should mobilize religious leaders (including women) to promote a better understanding of the health measures put in place (but also to engage them in raising the awareness of populations). The sensitization of religious leaders must also cover aspects related to GBV referral pathways in case of disclosure.

- As teenage pregnancy and child marriage have been a consequence of previous outbreaks such as Ebola, governments and NGOs must ensure that adolescent-friendly SRH services are available in health care facilities and community distribution points for adolescents to visit.

- As women have maintained their social spaces in this crisis and youth have the most access to information, NGOs and governments should build women and youth capacity in risk management and resilience as they are key in reaching the community.
Gender mainstreaming recommendations

- NGOs should bring women’s, youth’s and persons with disabilities voices to traditional community decision-making structures by investing in agency-building for women (developing leadership skills), in combination with community level dialogues/advocacy for reflection and social norms change surrounding inclusive leadership.

- As cases of gender based violence are on the rise and uptake of GBV services are declining, community leaders should address issues around masculinity, gender stereotypes and GBV though community based mechanisms of self-reflection and action (e.g. Social Analysis and Action Approach).

Gender specific programming recommendations

- To address the decrease in accessing GBV services, government (Ministries of Women Affairs and Social Development) should establish state level toll-free helpline infrastructure in close collaboration and engagement with community members and NGOs.

- NGOs should construct/renovate women and girls’ safe spaces to provide GBV and protection services while allowing for social distancing measures to be observed e.g. booths for those who cannot access mobile phones for remote services.

- As women and girls report an increase in domestic work burdens, community leaders should engage men in the response at the household level by sensitizing them to the need to participate in family care and sharing of household chores.

- Humanitarian organizations should advocate for and prioritize access to sexual reproductive health services for adolescent girls and young women, including mobile responses particularly for places that remain inaccessible.

- Actors including state ministries involved, should support women small business owners to access markets through trade fairs and exhibitions and accessing flexible loans and grants to boost their businesses and to cushion them from the impact of the pandemic.

- As men contend with their loss of jobs and the slow shifting power dynamics, mental health and psychosocial should design programs to provide psychosocial support for men as deal with loss of role as primary providers.
Annexes

Annex 1: Gender in Brief

Gender in Brief

Nigeria is Africa’s most populated nation, home to a culturally diverse set of peoples – with over 250 ethnic groups, speaking over 520 different languages. Spanning across these differences, Nigeria is largely a culturally and religiously conservative nation, with a very young population - 46% of the population is under 15 years. Whist Nigeria has taken steps to eliminate gender-based discrimination and empower women; significant gender gaps persist, maintained by a traditional patriarchal view of gender roles. This is particularly evident in the northern States, in which a conservative version of Shari’a law is followed, often reinforcing discriminatory practices against women such as the right to inheritance and freedom of movement. The armed opposition group in the north-east has been carrying out increasingly sophisticated acts of violence since 2009 and serious concerns also exist in regards to human rights violations by the Nigeria security force in response to this violence.

Gender roles and responsibilities: Women’s lives in Nigeria remain governed and bound by the widely varying customary traditions of their ethnicity and region, with important differences seen across geographical regions, urban and rural areas, and levels of wealth. Additionally, the constitution protects religious freedom, which some practices reinforce gender inequality. Largely, the cultural and religious conservatism of the country is expressed in patriarchal societal structures that enforce strict and stereotypical ideas of the roles of women, men, boys, and girls. The social roles of women in Nigeria remain tied to the idea of women as homemakers and they are, therefore, responsible for child-bearing, child-care and domestic work even whilst men are unoccupied at home. Nigerian women have restricted access to land, productive resources and inheritance; and male relatives often tightly control their daily life and movements. In northern regions, many women are restricted by purdah, or female seclusion, and therefore both permission from, and accompaniment by a male relative is required to be in public. Women’s freedom to dress is also highly regulated in these areas. Whilst polygamy is forbidden in civil marriage, it is sanctioned under Islamic and customary law and high levels of polygamous marriage is evident, with 34% of women aged 15-49 years in a polygamous union.

- Population sex disaggregation: 49% male; 51% female
- Population age disaggregation: <5 years 17.1%; 5-19 years 37.4%; 20-54 years 41.4%; >64 years 4.1%
- Average household size 4.6
- Female headed households: 18.5%
- Youth literacy ages 15-24 years: male 80%, female 62.8%
- Infant mortality rates 69 per 1000 live births
- Maternal mortality rates 14 per 100,000 live births (2015)
- Rate of Domestic Violence 18% (women age 15-49 years who have experienced physical violence since age 15 years)


**Education and Economic Empowerment:** Girls and women are still lagging behind men and boys in all educational statistics including attendance and attainment. A striking variation in educational attainment is linked to wealth – with only 8% of females and 5% of males in the wealthiest households having no education, compared to 81% of females and 71% of males in the poorest households. Higher literacy rates in Nigeria are strongly linked to youth, urban living and higher wealth. Overall, men (75%) are more likely to be literate than women (53%). Women’s literacy rates differ significantly both between urban/rural: 77% of urban women are literate, as compared to 36% of rural women; and regionally: 84% of women in the southeast are literate but only 26% in the northwest.⁴

The sexual division of labour is particularly evident in employment statistics - 62% of women are currently unemployed, whereas 76% of men are employed. The likelihood of a Nigerian woman working increases with education, wealth, and their relationship status: 81% of women who are separated, divorced or widowed are employed.⁵ Women produce approximately 75% of Nigeria’s food for local consumption and export, however, they are in the lowest income levels and are predominantly in the informal sector of the economy with little access to financial resources or services, often requiring a husband’s consent to access finance.⁵ In northern Nigeria, for example, a study showed that 66% of 15 to 19 year old girls participated in income-generating activities but less than 10% had a formal bank account.⁶

**Participation and Policy:** Nigeria has ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The National Gender Policy of Nigeria aims to empower women and eliminate discriminatory practices. However, the federal governing structure of Nigeria is a complicated plural legal system in which harmonisation and removal of discriminatory legal measures is particularly difficult. For example, whilst the minimum age of marriage was set at 18 years by the Child Rights Act of 2003, only 24 States have adopted it and in northern regions the legal age still ranges from 12 to 15 years. In 2016, a gender equality opportunities bill was rejected, seen as an infringement on religious belief.⁷ Domestic violence is not criminalised under national law and Nigeria’s Penal Code protects the right for husbands to beat their wives if it does not result in serious injury. However, it should be noted that some States have instituted their own laws against domestic violence.⁷ A Gender Unit has recently been created within the police, specialising in domestic violence. Whilst women have equal rights to stand for election, only 5.6% of the lower house and 6.5% of the upper house (Senate) are women.⁸

**Gender-Based Violence and Protection:** The gendered power dynamics and inequalities in Nigerian society are highly evident in the particular risk of gender-based violence that women and girls face. Widespread harmful traditional practices exist, including widow abuse, early and forced marriage and female genital mutilation/cutting (FGM/C). It is estimated that 27% of women aged 15 to 49 years have undergone some form of FGM/C, with the highest percentage of this evident in the southwest (48%) and the lowest in the northeast (3%).⁹ Domestic and sexual violence are of particular concern, with particular regional characteristics; 30% of Nigerian women and girls (age 15-49 years) have experienced some form of physical and/or sexual violence, with higher rates in the south-south zone (52%). Single women (divorced, separated or widowed) experience higher risk across all zones (44%).¹⁰ The MICS of 2011 revealed that 46% of Nigerian women believe that a husband has a right to hit or beat them for at least one reason.¹¹

Men and boys in particular are at specific risk of violence in the conflict in the north-east region of the country. Forms of violence they incur include forced abduction and recruitment, physical violence, as well as arbitrary detention by the Nigerian security forces.¹² Girls are particularly vulnerable to abduction by armed opposition groups, drafted as suicide bombers, sex slaves or domestic servants.

**Gender in Emergencies:** The insurgency by the armed opposition group in the northeast region has resulted in the death of over 27,000 people, including 37 aid workers, the abduction of over 4,000 women and girls, high levels of displacement and acute food insecurity. There are an estimated 1.8 million people internally displaced in the region and a further 187,000 seeking refuge in neighbouring countries. Of the 13 million people estimated to be in need of humanitarian assistance, 8.1 million are boys and girls.¹² The protection concerns facing the internally displaced persons are significant. Human Rights Watch has documented rape and sexual exploitation of women and girls by camp officials, policemen, soldiers, and leaders in camps; and the impunity of their actions, with little to no government response.¹³ Within the context of Nigeria, the intra-household power dynamics between the male head
of household and his wife and amongst co-wives is particularly relevant to consider within any humanitarian response.

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1 UNFPA, The State of World Population, 2016  
2 Nigeria DHS 2013  
3 Nigeria MICS, UNICEF, 2011  
4 Nigeria DHS 2013  
5 Ibid  
6 SIGI Country Profile, Nigeria, http://www.genderindex.org/country/nigeria  
7 Mercy Corps, 2013, Adolescent Girls in Northern Nigeria: Financial Inclusion and Opportunities Profile  
8 Nigerian senate votes down gender equality bill due to ‘religious beliefs’, The Independent, March 17 2016  
9 SIGI Country Profile, Nigeria, http://www.genderindex.org/country/nigeria  
10 Women in Parliament: World Classifications (as of October 2018)  
11 Nigeria MICS, UNICEF, 2011  
12 USAID Gender Analysis for Strategic Planning, July 2014  
13 Nigeria MICS, UNICEF, 2014  

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Annex 2: Tools and Resources Used

Kindly click on the link to access the tools used for the RGA.

KII for humanitarian actors

KII for community members