RESEARCH FOR CHANGE

Assessing Responses to the Needs of Survivors of Sexual Violence in Humanitarian Settings

Findings from Borno State, Nigeria

Save the Children

KIT Royal Tropical Institute

Funded by European Union Humanitarian Aid

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EXECUTIVE SUMMARY

Introduction

Almost thirteen years have passed since the conflict in northeast Nigeria erupted into violence, killing 41,596 people,[1] displacing 1.7 million, contributing to 5.1 million at risk of being critically food insecure, and putting 8.7 million in need of urgent assistance.[2] The conflict has had significant gendered effects, including in terms of a rise in sexual violence. Part of a multi-country study covering northern Nigeria and Southern Yemen, this study aimed to generate evidence around how sexual violence manifests in humanitarian settings, identify and assess service provision and its gaps, provide evidence-informed recommendations and good practices, and disseminate these lessons to relevant community members and actors in Nigeria.

Methods

This study used a mixed methods approach, drawing on data collected via assessments of six health facilities, focus group discussions with women, and in-depth interviews, including those who had experienced sexual violence (survivors). Interviews were held with health workers, service providers, local government officials, and NGOs. Tools were translated into Hausa and Kanuri and pre-tested. The health facility assessment (HFA) included a survey and an observation checklist. A team of qualified researchers conducted the HFA and interviews to ensure participants felt comfortable given the sensitivity of the topic. Research locations were Damboa, Gwoza and Jere Local Government Authorities (LGAs), chosen based on access, security, and the presence of state and programmatic interventions by Save the Children and its partners. Sampling ensured diversity by age and displaced/host community status, alongside inclusion of women with disabilities. Two health facilities (one public and the other non-governmental) were chosen per LGA. The study findings are not meant to be representative of Borno State but provide a snapshot as to sexual violence provision and related gaps in the state.

Findings

Sexual Violence

The study found that sexual violence, ranging from early and forced marriage to sexual exploitation and rape, was prevalent. Perpetrators commonly included family members, armed actors (members of armed opposition groups - AOGs, community militia, and security forces), and community members. In particular, responses of AOG fighters when encountering civilians was influenced by

1. Nigeria Security Tracker, available at https://www.cfr.org/nigeria/nigeria-security-tracker/p29483, last updated 25.08.2021, last visited 20.01.2022.
2. United Nations Office for the Coordination of Humanitarian Affairs, 'Nigeria Situation Report,' available at: https://reports.unocha.org/en/country/nigeria, last updated 31.12.2022, last visited 20.01.2022.

civilians' gender and age. The likelihood of boys being forcefully recruited meant women would often go to the farms for livelihood activities where they risked being sexually assaulted and abducted. Dynamics around early or forced marriage and the denial of contraceptives by husbands were, to some extent, motivated by norms around masculinity and men's perceptions that children were needed to repopulate the community since so many men had been killed by violence. Meanwhile, the kunya[3] experienced by survivors was high. Participants said 'forced sex within marriage' was not recognised as rape while street sexual harassment was normalised even though young women in focus groups were outspoken about the detrimental impacts it had on their lives. Although there was some understanding of the reasons why women and girls would engage in survival and transactional sex, doing so attracted significant stigma. There were high levels of victim-blaming in general with some women reporting that it was common to use allegations of rape as a cover for consensual sex. Perpetrators (often with more power) rarely faced any consequences while survivors and their families were shamed and stigmatised, due to which fear of reporting was high.

Service Provision and Support Structures

The study findings give a snapshot of the different types of services available for survivors. Medical services, including psychosocial services and case management were relatively more widely available than legal services and food, shelter and livelihoods (FSL). Public health facilities usually offered referrals which were implemented by international agencies. Some health workers mentioned that survivors prioritised FSL needs as opposed to health needs due to poverty, and lack of economic security and that there was very low demand for legal services. Protocols were best developed and standardised for abductees as opposed to other survivors.

There were considerable challenges in service provision and uptake. Security concerns and lack of funds hindered service availability and accessibility. While there were no legal reporting mandates or documentation required, lack of infrastructure, particularly to accommodate the needs of people with disabilities, was raised as a concern. Stock-outs such as of HIV-related supplies compromised time-sensitive interventions. Lack of capacity of health workers and service providers, particularly around counselling and communication (including language) skills were raised by many participants. The health facility assessment revealed that while five out of six health facilities had protocols on privacy and confidentiality and four out of six documented referrals, five out of six health facilities did not have any written guidelines. Only one facility followed international guidelines and there were no specific protocols for people with disabilities in place in any of the health facilities.

3. A Hausa term often translated as shyness but having more of a connotation of being ashamed, embarrassed, or under a taboo not to speak in this context.

A few participants linked sexual exploitation in particular with phasing out of humanitarian aid. This withdrawal had broader impacts, adversely affecting girls' education and economic empowerment activities. The limited food distribution activities and the politics of eligibility such as the exclusion of female-headed households also limited access for certain groups.

Alongside formal services, there were a variety of informal and community-led structures in place. These structures included groups of aunties who rallied around sexual violence, pro-active bulamas[4] and other community leaders, and general support from community members. This support encouraged help-seeking behaviour, increased sensitisation around sexual violence and was slowly encouraging reporting. The findings suggest that limited prevention work was taking place but there was more need for efforts to change the knowledge, attitudes, and practices, in particular of men, as emphasised by participants.

Conclusions

Changes in sexual violence and its incidence in Borno were linked to changes in gender realities brought about by the conflict. This study showed that related economic hardship could be linked to changes in incidence of some forms of violence, such as sexual exploitation, early and forced marriage, and marital rape. As community safety nets disappeared, there was less support from family and neighbours, and increased financial precarity. These dynamics were further exacerbated in situations of displacement which were linked to higher sexual violence incidence and intensified scrutiny of women and girls, who bore the brunt of moral panics. The findings also indicated that knowledge about services and their implementation may be higher in Internally-Displaced Person (IDP) camps where a variety of organisations operated, unlike in host communities where interventions could be more fragmented. However, due to the work of women's rights activists in Borno as well as outreach, sensitisation and service provision, survivors in some locations were now likely to come forward to seek help. This reporting was most likely when survivors were children and a culture of silence for adults still persisted.

Some organisations were trying to overcome the gaps in service provision, for example by providing training to the police for better communication with survivors. But in general, there was over-reliance on NGOs, particularly international ones to provide a more comprehensive set of services to survivors. Finally, NGOs played a significant role in funding and implementing gender-based violence work. Phasing out of services by these organisations meant they left behind key gaps. Moreover, withdrawal of humanitarian aid meant an increase in survival sex in particular, calling attention to needed mitigation in planning and delivery of changes to humanitarian assistance as well as increased

4. A bulama is the village head, part of the system of designated community leadership which cascades from bulama to lawan (ward head) to the haikimi (district head) to the emir.

sustainability of services. Yet, significant progress had been made over the past five years with Nigeria's Road Map in response to the Global Call to Action improving GBV coordination and response and setting a clear direction of travel.

With this in mind, recommendations stemming from research findings and validation processes aimed at deepening this progress are as follows:

For service providers, INGOs and UN agencies who support them, donors, and the Ministry of Health, Ministry of Women's Affairs and Ministry of Humanitarian Affairs

1) Improve service provision by:

A) Strengthening referral systems

- Continuing to strengthen, update, and socialise referral pathways to facilitate multi-sectoral collaboration
- Strengthening documentation of referrals to improve survivor follow-up
- Further supporting and publicising hotlines to link survivors to timely care[5]
- Training key community members, particularly women and girl leaders including those from excluded groups, on how to care for survivors and refer to services.

B) Inclusion of marginalised groups

- Improving disability inclusion through outreach, making services more accessible, and building service provider capacity[6]
- Developing strategies to better support and reach out to (adult) male survivors, based on proper documentation and understanding of the violence they face and barriers to accessing services including criminalisation of and attitudes around homosexuality.[7]

C) Improving the quality of health services

- Allocating separate safe spaces in health facilities to improve confidentiality and privacy
- Supporting health workers to develop and implement self and collective care strategies
- Supporting health facilities to adapt and embed global standards and practices on sexual violence service provision[8]
- Training and retraining health workers to adopt more survivor centred approaches including via health training institutes and continuous professional development
- Focusing efforts at strengthening health system capacity, particularly at primary healthcare level, to ensure government leadership and future sustainability[9]

5. Research findings indicated that hotlines serve as immediate response pathways for survivors.
6. This study found a significant gap in service utilisation despite this group being highly susceptible to sexual violence.
7. As described in the methodology section, this study was not able to uncover these dynamics but identified a need for evidence based programming in this regard.
8. A significant gap in almost all the health facilities surveyed as part of the HFA.

- Further strengthening data collection, reporting, and documentation and building mechanisms where this analysis informs learning and adaptation by service providers.

D) Strengthening accountability mechanisms

- Explore complementary means of accountability for perpetrators, for example through increasing community censure and transformative justice approaches[10] given most survivors do not want to use legal processes and the lack of survivor centred approaches and risk of re-victimisation in the criminal justice system.

For civil society, community based groups, community leaders, INGOs and UN agencies, donors, and the National Orientation Agency

2) Counter stigma, victim blaming, and otherwise encourage help-seeking[11] by:

- Funding women's rights groups to do sustained community engagement
- Working with existing community structures to carry out campaigns
- Strengthening capacities of and recruiting people from different ethnic and linguistic groups to conduct outreach, support sexual violence survivors, and advocate against stigma
- Raising awareness of all types of sexual violence including that which is less visible such as intimate partner violence, early and forced marriage, and sexual harassment[12]
- Developing strategies to engage and reach out to women and girls who face further marginalisation, such as those with disabilities
- Changing social norms through approaches that are peer to peer (e.g. among adolescent girls, men who attend majalisa, or grandmothers), intergenerational, and within families.

9. This research study found that more efforts needed to be made in strengthening health systems around sexual violence service provision, particularly outside Maiduguri.
10. Transformative justice is a series of practices that create change in social systems and serve as alternatives to criminal justice processes in cases of interpersonal violence or in societies transitioning from violent conflict or repression. Transformative justice responds to immediate needs, cultivates what is needed for violence prevention (such as healing, accountability, resilience, and safety), is aimed at breaking (generational) cycles of violence, and ensures perpetrators are held accountable. Most transformative justice interventions involve a community accountability process where a few members of the community work directly with the person who committed harm so they understand the impact of their actions on survivors and others, apologise, make amends, and repair the damage caused, and work to change their behaviour - in line with what many survivors want.
11. This study identified stigmatisation and victim blaming as both the primary consequence of sexual violence to survivors as well as the greatest barrier to seeking help.
12. While abductions and sexual violence against children tend to be the types of violence that gain most attention, concern, reporting, and service provision, intimate partner violence, early and forced marriage, and sexual harassment are much less visible.

For all sectors working groups of the humanitarian response, civil society, INGOs and UN agencies working on development and peace-building, donors, and the Ministry of Reconstruction, Rehabilitation, and Resettlement

3) Better integrate mitigation of and response to sexual violence into the humanitarian response and development and peace-building programming by:

- Integrating GBV analyses, response, mitigation, and prevention in sector strategies and plans e.g. looking at how food distribution modalities intersect with GBV dynamics[13]
- Continuing to train people working in other sectors on GBV
- Expanding the access of women to economic empowerment and livelihoods programming to counter sexual exploitation with a focus on women who are single parents, survivors, have husbands in military detention, or who are disabled
- Developing strategies to mitigate GBV, particularly sexual exploitation and abuse, when planning withdrawal or making changes to humanitarian assistance.[14]

For organisations conducting research, the Protection Sector Working Group, donors, and Ministry of Women's Affairs and Ministry of Humanitarian Affairs

4) Build the knowledge base for evidence informed programming, particularly on prevention, by:

- Learning from global good practices on what works to prevent gender-based violence[15] and piloting evidence based strategies and programmes
- Learning from experiences challenging stigmatisation of survivors of abductions to inform anti-stigma programming for other types of sexual violence[16]
- Filling existing knowledge gaps, for example on female genital mutilation/ cutting, forced and unsafe abortion, and consequences for LGBTQI survivors
- Establishing a community of practice to bring uniformity in the response to SGBV in Borno State, coordinated by the protection sector (with input from its GBV and child protection sub-sector working groups), with organisations across different to develop, socialise, and learn from evidence.

13. This study several areas, from food distribution to WASH interventions, where this GBV integration needed to be improved.
14. Withdrawal of aid was flagged by participants working to support survivors as a key causal factor of SEA.
15. For example the UK FCDO funds a What Works to Prevent Violence Against Women and Girls programme aimed at gathering research and evidence through pilot programmes: https://www.whatworks.co.za/
16. This study found that significant progress had been made on challenging the stigma to which abductees are subjected due to efforts by individuals and groups in communities, government actors, and development, humanitarian, and peace-building agencies.

ACRONYMS

AHI	Action Health Incorporated
AOG	Armed Opposition Groups
CAAFAG	Children Associated With Armed Forces And Armed Groups
CJTF	Civilian Joint Task Force
CWC	Comprehensive Women's Centre
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FIDA	International Federation of Women Lawyers
GBV	Gender-Based Violence
GBV IMS	GBV Information Management System
GEPADC	Gender Equality, Peace and Development Centre
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
ICRC	International Committee of the Red Cross
IDI	In-Depth Interview
IDP	Internally-Displaced Person
IOM	International Organisation for Migration
IMC	International Medical Corps
IRC	International Rescue Committee
LGA	Local Government Area
LGBTQI	Lesbian, Gay, Bisexual, Trans, Queer, And Intersex
MDM	Médecins du Monde
MHGAP	Mental Health Gap Action programme
MOH	Ministry of Health
MOJ	Ministry of Justice
MOWA	Ministry of Women Affairs
MMC	Maiduguri Metropolitan Council
MSF	Médecins sans Frontières
MVA	Manual Vacuum Aspiration
NCA	Norwegian Church Aid
NGO	Non-Governmental Organisation
NHRC	National Human Rights Commission
PAC	Post Abortion Care
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PSS	Psychosocial Support
PSWG	Protection Sector Working Group
SARC	Sexual Assault Referral Centre
SGBV	Sexual and Gender based Violence
SRHR	Sexual and Reproductive Health and Rights
UNFPA	United Nations Population Fund
VAPP Act	Violence Against Persons (Prohibition) Act 2015
VVF	Vesicovaginal Fistula
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme

1. INTRODUCTION

Almost thirteen years have passed since the conflict in northeast Nigeria erupted into violence, killing 41,596 people (23), displacing 1.7 million, contributing to 5.1 million at risk of being critically food insecure, and putting 8.7 million in need of urgent assistance (1). The conflict has had significantly gendered effects, with numerous men arbitrarily arrested, subjected to long periods of detention without trial, and extra judicially killed (2–4). Meanwhile, many women have been left behind to negotiate with armed actors and strategise the protection and survival of themselves and their families (5). Concurrently, northeast Nigeria sees high incidence of all forms of gender-based violence (GBV).

Part of a multi-country study covering northern Nigeria and Southern Yemen, this research study aimed to generate evidence, identify good practices, disseminate lessons, and provide evidence-informed recommendations when it comes to current dynamics around sexual violence in Borno State in northeast Nigeria. It does so, situating this violence against a backdrop of other kinds of GBV present in the conflict.

After presenting the methods used, this report discusses the study's main findings. It starts by examining sexual violence in Borno, looking at the forms and types of violence, the context in which it occurs, its consequences, and dynamics around help-seeking behaviour. It then focuses on the types of existing services available, challenges in service provision and use, and the establishment and implementation of protocols, standards and guidelines. The study continues on to analyse these findings and ends with conclusions and recommendations for action.

1.1 Background

Violent conflict intensifies pre-existing types as well as manifests new forms of GBV in a patriarchal context with widespread gender inequality. Indeed, the National Demographic and Health Surveys of 2008, 2013 and 2018 show significant increase in levels of sexual exploitation and abuse (SEA) in particular, from 8.6 percent in 2008 to 15.6 percent in 2018 (6–8). Government officials working in internally displaced person (IDP) camps, military personnel, and members of civilian militias have perpetrated GBV, with women particularly vulnerable due to inability to procure food and work for an income (9). Moreover, sexual violence perpetrated in an intimate partner setting is significant: the 2018 National Demographic and Health Survey stated that 64.8 percent of sexual violence survivors reported perpetrators being their current husband or partner (8).

Nationwide, at least one in four girls and one in ten boys under 18 years old experience sexual violence (10). Early and forced marriage is prevalent in some regions (67.6 percent of girls in the north west and 56.6 percent of girls in the

north east are married before 18 years) (11) while female genital mutilation/ cutting (FGM/C) is common in others (49 percent in the south east and 47.5 percent in the south west of girls and women aged 15-49 years have experienced (FGM/C))(7). Violence continues in adulthood: 17.4 percent of girls and women aged 15-49 have experienced physical and/or sexual violence from their intimate partners at least once in their lives.

The work of the Protection Sector Working Group (PSWG) and its GBV and child protection sub-working groups as well as Nigeria's launch of its first 2018-2019 Road Map in response to the Global Call to Action have improved GBV coordination and response. However, significant gaps remain with, for example, access to 'livelihoods' and 'safe house/shelter' the most needed but unavailable services according to 2018 data from the GBV Information Management System (12).

1.2 Research Objectives

This qualitative multi-country research had the overall objective to explore the needs and experiences of survivors of sexual violence, and assess the availability, quality and accessibility of health, psychosocial and protection services and the functioning of referral systems in Northeast Nigeria to inform service providers, humanitarian actors and policy makers. This study focused on sexual violence but included references to other forms of GBV where relevant. Its overall aim was to provide evidence-informed recommendations to contribute towards increasing the capacity of humanitarian actors, for them to adequately identify and respond to the needs and rights of groups affected by sexual violence, and to ensure the availability of services for survivors.

Specific objectives included:
1. To explore how sexual violence in humanitarian settings affects women, girls, boys and men:

- To describe the types of sexual violence occurring
- To identify most vulnerable groups affected by the various types of sexual violence in humanitarian settings
- To describe the circumstances within which different types of sexual violence occur
- To identify the overall consequences/effects of sexual violence on individuals, families and communities.

2. To assess what medical and psychosocial assistance survivors have access to, and identify gaps in protection, in particular with regards to gender:

- To explore specific service needs, use and gaps experienced by persons at high risk of sexual violence, including among others, elderly people with disabilities, adolescents, children, LGBTIQ persons, and people on the move

- To explore demand and supply factors influencing access to and use of medical and psychosocial assistance for different sexual violence high risk groups
- To assess the level of sexual violence responses integration in existing local health system(s)
- To explore how multi-sectoral referral pathways are functioning between the medical and psychosocial services, legal-, and protection services.

3. To assess whether relevant international standards on medical and psychosocial services, international World Health Organisation protocols, as well as international humanitarian law (where applicable) and international human rights law, are adhered to:
   - To identify the standards being used and to explore to what extent the programme/project complies to international standards and guidelines
   - To explore the social, legal, cultural and economic factors influencing the compliance to international standards and international law.

4. To explore existing good practices in the context of Nigeria
   - To identify evidence informed practices on prevention of and responses to sexual violence, in the context of Nigeria and Yemen.

2. METHODS

This study used a mixed methods approach, drawing on data collected via assessments of health facilities, in-depth interviews (IDIs), and focus group discussions (FGDs) as shown in Table 1.

2.1 Orientation of the Research Team

After an initial desk review, the team came together in a one day research workshop to ensure common understanding of the study, research ethics, and security procedures, to revise and agree on research tools, and discuss the sampling strategy before data collection. Research assistants, transcribers, Save the Children staff, and the lead researchers attended this workshop. Drawing on tools used for the study in Yemen, tools were developed for the Nigerian context. Participants in the research workshop discussed translation of tools (into Hausa and Kanuri) and interpretation of tricky terms and phrases in particular.

2.2 Selection of Study Sites and Sampling

The research locations were Damboa, Gwoza and Jere Local Government Authorities (LGAs), chosen based on access, security, and the presence of programmatic interventions by Save the Children and its partners, as well as the state level. Unfortunately, the team was unable to ensure geographical coverage of all areas of the state with data collected only in central and southern Borno. Monguno, a Northern Borno LGA, which was initially chosen, had to be dropped for security reasons which also affected other locations in Northern Borno.

Save the Children partner organisations working on GBV assisted in the recruitment of participants. Selection was influenced by the research objectives, the findings from the desk review and the ability of the research team to access certain groups. Women identifying as survivors of sexual violence were interviewed as were women non-survivors. Attention was paid to diversity with regards to age, disability status, ethnicity, religion, type of violence experienced, and across the displaced/host community spectrum in order to elicit different perspectives on sexual violence, help seeking and access to services. Although sexual violence against men, adolescents, and LGBTQI people was specifically explored in the desk review, these groups were not included among participants as they required specific approaches, more time, and/or had particular risks. FGDs were segmented by age to ensure younger people were not constrained from speaking by the presence of older people, a risk, given existing cultural norms and age hierarchies. They were drawn from either internally displaced people (IDP) or host communities to mitigate power dynamics between IDPs and host community members.

For the health facility assessment (HFA), two health facilities were chosen per LGA, of which one facility was run by the LGA itself while the other was run by a humanitarian agency which integrated service provision in its work. Seeking convergence between the catchment area of these health facilities

and participants for the qualitative component as much as possible, HFA selection was determined by the existence of entry points in communities to arrange interviews and focus groups and willingness of health facility staff to participate in the assessment. It is important to note that these results are not representative of the state of all health facilities in Borno State. Moreover, many areas of the state do not have functional health facilities due to damage to buildings, insecurity, and/or insufficient numbers of health workers. In such a context, the HFA detailed in this study provides a snapshot as to sexual violence service provision and related gaps in the state.

Table 1: Overview of methods and participants

Method and type of participant	Location				Total
	Damboa	Gwoza	Jere	State level	
Health Facility Assessments (HFAs)					6
Run by LGA	1	1	1	-	2
Run by humanitarian agency	1	1	1	-	2
Interviews					33
Service providers	2	2	2	-	6
People working for NGOs on GBV	1	1	1	2	5
Women survivors				-	
- 18-24 years old	1	1	1		
- over 24 years old	1	1	2		7
Women non-survivors				-	
-18-24 years old (IDP camp)	1	1	1		
- over 24 years old (IDP camp)	1	1	1		
-18-24 years old (host community)	1	1	1		
- >24 years old (host community)	1	1	1		12
LGA officials	1	1	0[17]	-	2
State government official	-	-	-	1	1
Focus Group Discussions					6
18-24 year old women (IDP camp)		1	1	-	2
18-24 year old women (host community)	1			-	1
>24 years old women (IDP camp)	1			-	1
>24 years old women (host community)		1	1	-	2
Total	Per LGA: 2 HFAs 10 interviews 2 FGDs			At state level: 3 KIIs	Total: 6 HFAs 33 interviews 6 FGDs

17. Despite multiple efforts, it was not possible to set up a meeting with the appropriate LGA official for Jere.

2.3 Data Processing and Analysis

Data was captured in HFA forms, notes were taken contemporaneously, and transcripts of audio-recorded interviews were made. The interviews were conducted in English, Hausa and Kanuri with interpreters present. Audio recordings were transcribed and translated into English by a team of transcribers. A thematic content analysis was conducted using an initial coding framework which was based on the topic guides and literature. This framework was then adapted to include emerging themes from the data. As for the HFAs, descriptive statistics were used. Data from the HFA was manually extracted into facility specific reports and organised under key themes. Data was then arranged in tables to reflect results and observations and analysed to identify common practices and gaps within the health facility setup and service mechanisms.

Findings were presented to stakeholders for validation though a virtual session where participants working for NGOs, service providers, and government were invited and in-person for community leaders and government officials by Save the Children colleagues in Borno with virtual presence of researchers. The report was finalised to reflect feedback from the validation workshop and written comments.

2.4 Research Principles, Approach, and Ethical Considerations

Throughout the research process, conflict and gender sensitivity, and social inclusion were guiding principles. in this study. Tools were designed and delivered in ways to not only 'do no harm' but also 'do more good', for example by integrating appreciative inquiry. Debrief meetings of the research team reflected on conflict and gender dynamics in research locations. As this study took an intersectional feminist approach, integration of other axes of social exclusion also informed research methodology, sampling, and the HFA, interviews, and focus group tools.

During FGDs and IDIs, the team encouraged research participants, especially young people and others who often experienced social exclusion, to feel comfortable with the research process and be empowered to discuss sensitive issues. One method for doing so was to start the interview by asking the participants to tell their story, allowing them to begin on their own terms and discussing the issues and the extent to which they wanted to share.

In terms of research ethics, a robust approach was followed and systems put in place to ensure standards are adhered to at all times. The team discussed self and collective care during the research workshop, particularly salient given the topic at hand, and checked in with each other regularly as data collection progressed. Survivors of sexual violence interviewed were not asked to recount their experiences of violence but rather of the services received (or not).

Although this was made clear at the start of the interview, many said that they wished to share personal experiences of sexual violence regardless. Pathways were established to enable linking and referral of survivors who disclosed experiences of violence and who may have needed services.

Ethical approval was taken from the KIT Research Ethics Board in 2019 as well as local approval was taken from Nigeria from the State Ethical Approval Committee, part of the Ministry of Health, in January 2020.

2.5 Research Limitations

Research limitations include issues of security and access, for instance to hard-to-reach areas, which restricted the locations the team was able to reach. Moreover the constant changing security situation as well COVID-19 related restrictions meant data collection had to be postponed multiple times, and finally took place in 2021. Moreover, due to limitations in time and budget, particular issues such as female genital mutilation/cutting (FGM/C), forced abortions, sexual violence against men, and sexual violence against lesbian, gay, bisexual, trans, queer, and intersex (LGBTQI) people, which required specific approaches, more time, and/or had particular risks were not strongly reflected in the data. The research team made sure to practice physical distancing from research participants during data collection to mitigate COVID-19 transmission risks.

3. FINDINGS

3.1 Sexual Violence in Borno

A. Forms and Types of Sexual Violence

A.1 Abductions by Armed Opposition Groups

Women and girls were kidnapped as fighters took over villages. Participants described how they, family members and friends were abducted from their homes, schools, and other public locations. Parents were forced to consent to the marriages in exchange for a tokenistic bride price, according to interviewed participants. Survivor Testimony 1 shows that, despite being asked if they desired the marriage on occasion, the girls and women affected reflected that they had no actual consent due to the potential of violence to themselves or their family members if they refused.

Survivor Testimony 1

"My father forced me to marry someone in [the] bush in [information withheld]. My father said that I must marry that man. I told my father that I did not like that man but he said that if you did not marry him, there will be no you and no me..." – 22 year old woman, interviewed in a Gwoza IDP camp (translated from Hausa)

"Before I came to the camp, I was abducted by Boko Haram. We were living in a village called [information withheld] with my mother. Then one Boko Haram [fighter] came to my village and told my mum that if she does not give them her girls, they would kill her. So my mum handed over her girls to Boko Haram to be safe. We stayed for a year plus in the bush with the boys before coming to the town." – 25 year old woman, interviewed in a Gwoza IDP camp (translated from Hausa)

According to service providers interviewed, these abductions happened when women and girls ventured out of government-controlled areas to engage in livelihood activities, as shown by the quoted text in GBV Actor Testimony 1. They said that, where military bases existed, for example in LGA capitals and major towns, this presence only ensured limited security (attacks can still take place in these locations) within the town and a small perimeter. Outside this area, territory could be contested and could see the presence of armed opposition groups, government security forces, and community militias. However, despite risks of violence from all conflict parties, civilians still needed to access these areas and farm, gather plants, or engage in firewood collection to provide for themselves and their families. When AOG fighters came across civilians in such a context, their response depended on civilians' age and gender. Women, girls,

younger boys, and older people were sometimes threatened and warned off and other times abducted and/or sexually assaulted. Men and older boys were forcefully recruited or killed. Given this gendered pattern of attacks, a woman working on GBV response, interviewed in Gwoza, shared that women and girls are usually those who go beyond the military security perimeter, to safeguard men from being subjected to risk. She added that this risk is particularly undertaken by women subjected to poverty who have fewer alternative options including displaced women who are less likely to have farmland that is close to security force presence.

GBV Actor Testimony 1

"[There are] sometimes abductions in the bush by AOGs. If [people] go for farming, it [AOG's strategy] is to attack and take them away to the bush. Many girls fall victim. Here, mostly women go to farm to protect men from AOGs, as they will kill [them] as opposed to abducting or chasing women away. Anyone who they find, they can decide to take. We have received cases of [abducted] women from host communities and from the camps. Women from the camp fall victim more [to abduction] as they have the need to go deep into the bush to find space to farm."
– woman working for an INGO that supports GBV survivors, interviewed in Gwoza (speaking in English)

Once under AOG control, according to the accounts of several participants abducted, girls and younger women tended to be subjected to forced marriage and sexual enslavement. Older women (approximately those over the age of 40 years) were instead given tasks of cooking, cleaning, and looking after children. During their time in captivity, they were forced into marriage with their abductors if they were Muslim, to convert to Islam, or categorised as sexual slaves if they were Christians. By the time they were able to escape or were rescued by security forces and community militias, many of them had become pregnant, given birth to multiple children, and could test positive for sexually transmitted diseases (STDs) including HIV. Yet, while older women tended to be forced into childcare and housework roles, this allocation of tasks did not necessarily exempt them from sexual violence. However, as shown by the quoted text in Survivor Testimony 2, violation of group norms around whom it was permissible to rape sometimes has consequences for the perpetrators who could be punished by group leaders for their actions.

A.2 Denial of the Right to Use Contraceptives

Focus group participants who were married spoke at length about their struggles to maintain control over their reproductive lives in the face of husbands' hostility to family planning. This reluctance to use contraceptives was long-standing in Borno and, indeed, in many parts of northern Nigeria, as highlighted by GBV service providers and focus group participants themselves. This was partly due to beliefs that when and how children arrive is a divine rather than human prerogative, and that the conflict has brought about new beliefs.

GBV Actor Testimony 1

"[After attacking town and killing my husband while we were fleeing], they rounded us all up and put us inside one house… Most of us were young girls with 1-2 children or pregnant and the older ones among us were not many. On reaching the village, they married off the women who were young, sharing them among their boys. They said they would not marry me as I was old but that I would be their slave. I ground powder then cooked, washed plates, swept the compound etc. My hands were swollen because of the work I was doing…. I was there with them for 6 years. One night I was sleeping and two boys that are not [so] grown up switched the torchlight on me. I asked them [why] and they said to me, they want to have sex with me. I told them I was old enough to be their mother [and] children [were] lying next to me but they still insisted. One held my hands while the other raped me. Something was wrong with my eye as a result of crying so the leader asked what had happened to me and I told him that his boys had raped me. He took them to markas, their prison, and I don't know what happened to them… We have suffered so much. You cry, cry and there is nothing you can do. I even have [high] blood pressure as a result." - 45 year old woman interviewed in a Jere host community (translated from Hausa)

Participants working for NGOs providing GBV services spoke of how households struggled to support existing members. Women from the focus groups shared how they were burdened with more responsibilities and tasks in a difficult environment. They often relied on others such as parents to get food and other basic necessities and needed to engage in hard and sometimes dangerous labour as their husbands were unable or unwilling to provide for the family. In the words of an NGO participant, *"Households struggle to support existing members"* and women participants indicated that they wished to stop having children altogether or at least engage in child spacing so that they could concentrate on providing for current children and rest from the physical exertions of pregnancy, childbirth, and the first few years of infancy. Yet, participants said that husbands, due to ideas of masculinity being tied with

having many children and certain religious interpretations refuse to agree. Another rationale male family members of participants provided to them was the need to replace those killed by the conflict by having more children as the survivor in Women's Testimony 1 explains.

Women's Testimony 1

"There's this case of men not allowing their wives to use contraceptives and child spacing. They [cannot] provide enough to the family but still say children are a blessing so not do family planning. It is a serious case because the mothers suffer a lot… Lots of our men here don't like the idea of child spacing. If a woman said that she wants family planning, they will say that, all the men that Boko Haram have killed, you have to give birth to replace them." – woman, part of a focus group discussion for participants aged 25 years and above, held in a Jere host community (translated from Hausa)

Despite this resistance, women participants felt they had no other option but to get contraceptives from medical centres or take herbs believed to prevent pregnancy. Such attempts by women to use contraceptives or to end pregnancies, if discovered or suspected by husbands, could cause marital tensions and escalate into emotional abuse, controlling behaviour, physical violence, and divorce. Women participants shared how even miscarriages could raise distrust and beliefs that they had sought abortion, particularly if they had tried to persuade their husbands to explore family planning beforehand. This anger could manifest even if contraception was used on doctor's orders with the physical health of the woman concerned in mind as shown by Women's Testimony 2. Women could also be punished by their husbands for the number and gender of babies. For instance, participants shared how husbands they knew had become angry at women who gave birth to girls in succession, multiple sets of twins, or only boys. This hostility towards contraception could also have other effects. For example, women focus group participants discussed how some people believed that water purification tablets and vaccinations led to reduced fertility, thereby lowering their uptake. Some of these women participants expressed bitterness at this state of affairs, noting that men did not suffer and so did not know the pain of childbirth. They lamented that men did not provide for their families but wanted to continue having children, and that they prevented their children from having needed vaccinations.

Women's Testimony 2

"My elder brother had a wife… The doctors said you are having complications as you are giving birth serially so we need to turn your womb [and] then open it after 5 years. If you get pregnant again, your life and your child's life is at risk. After a year, she did not become pregnant and the husband started asking her questions… [He said] that they should go to the hospital and find out the problem. They went to the hospital in [information withheld] and he complained to the doctor who found out what had been done and said if it is not up to 5 years, her life may be at risk. [My brother] then sent [his wife] to her house without being divorced – so she has no chance to marry another person and he will not keep her in his house." – woman, part of a focus group discussion for participants aged 25 years and above, held in a Damboa IDP camp (translated from Hausa)

A.3 Early and Forced Marriage

As of 2021, the picture regarding early and forced marriage varied depending on location. Among research locations, places where there had been more interventions, specifically sensitisation and other efforts around early and forced marriage, saw lower rates, as mentioned by some participants, compared to before the conflict.

In areas of interventions by humanitarian and women's rights actors such as IDP camps in Damboa and Gwoza, women in these communities perceived that levels of early and forced marriage had fallen and the age of first marriage had risen. They said humanitarian interventions helped them to provide for their families and that sensitisation efforts persuaded parents to keep their daughters in school rather than marry them off. Many women participants had been married when they were teenagers themselves, some as young as 13 years in age. A 35 year old woman, interviewed in an IDP camp in Jere, described how girls would be married by the age of 10 years in her village. She elaborated that it was considered to be bad luck if they started menstruating in their father's house and people worried she would get pregnant before being married. She went on to say that this state of affairs was no longer the case in the IDP camp with marriages more likely to be consensual nowadays. As a woman working for an INGO that supports GBV survivors, interviewed in Damboa, said, *"We have girls in the camp living with VVF (vesicovaginal fistula), divorce, and with health and social consequences [of early marriage] so people [are now] afraid to allow early and forced marriage due to the consequences. It may have increased in the early years of the conflict but now, as they see the consequences, due to sensitisation, as parents are more exposed and get information about [its] consequences, and [because of] support from community leaders, it has decreased"* (speaking in English).

Survivor Testimony 3

"Most of our people marry daughters at an early age. I was married out at an early age which caused me VVF. I spent almost a year not being able to control my urine. My elder sister got married before she started menstruation. She in her husband's house then got pregnant. When they took her for delivery, they had to do episiotomy – tear the vagina before the baby came out"- woman, part of a focus group for participants aged 25 years and above, held in a Damboa IDP camp (translated from Kanuri)

However, several women participants, also living in IDP camps said that the age of marriage had dropped compared to before displacement: while girls would be married between 17 years and 20 years in their hometowns, in the IDP camp, girls started to be seen as old from the age of 14 or 15 years onwards. As one 18 year old woman, interviewed in a Jere IDP camp said, *"We are not married and society sees us as old and grown up already. People are talking about us not having been married"* (translated from Kanuri).

These marriages did not always last. Once girls and women were divorced, their former husbands often no longer supported them or their children and they lived precarious lives, particularly if their parents were in another location, estranged, or living in poverty themselves. Service providers spoke of girls as young as 16 or 17 years old who had been divorced asking for help to terminate pregnancies as they would not be able to look after these babies when born and their former husband would not be financially contributing.

Early and forced marriage continued, particularly in areas of little or no interventions and where there was economic hardship, according to some women participants and attested to by those working on GBV. Participants spoke of how parents married their daughters from age 13 years onwards, not because they wanted to do so, but as they were unable to take care of them. Often, these marriages were contracted without the consent of the girl concerned. Reasons given included the bride price paid by prospective husbands, the belief that girls should marry early as they would be considered unmarriageable after a certain age, and to prevent the social shame if the community suspected that the girl was engaging in pre-marital sex.

However, participants described how some girls and young women resisted these pressures from their families and communities to marry. If they refused to agree to the marriage, their families could stop providing them with food and other support. Conversely, there had been cases where girls had persuaded their parents who, as a result, had agreed that they could choose their husbands for themselves. GBV service providers said that, often, mothers who saw the need

for education and self-sufficiency and knew that being married did not equal financial security, could be girls' allies. They also said that, in some communities, women with influence, male community leaders, women activists, or humanitarian actors working on GBV could intercede successfully, with parents.

A.4 Female Genital Mutilation/Cutting

As presented in the introduction above, FGM/C was one of the least reported forms of violence in northeast Nigeria which has the lowest prevalence (6 percent compared to a national average of 20 percent and 35 percent in the southeast)) of women aged 15-49 years being subjected to FGM/C in the country (8). FGM/C in Borno State had not been the focus of either research or programmatic interventions. Yet, while overall rates were low, it continued to be practiced among certain ethno-linguistic communities, particularly the Shuwa,[18] according to women in a focus group discussion in Damboa. Government officials spoke about how such cases were rarely reported to them and how any outreach they did to Shuwa communities tended to focus on the health consequences of these acts due to the culturally-sensitive nature of such discussions. Participants who lived in IDP camps and host communities, including those who were Shuwa themselves, understood the rationale of conducting FGM/C to reduce feelings of sexual desire among unmarried girls and women and thereby prevent them from engaging in sex outside of marriage.

In comparison to other forms of sexual violence, relatively little is known about the dynamics surrounding FGM/C and how these dynamics are affected by the current conflict and humanitarian situation. Although participants working on GBV service provision said FGM/C continued to be practiced, including on girls as young as seven years old, there were few programmatic interventions to provide services, ensure increased awareness, and to prevent these acts.

GBV Actor Testimony 2

"Once in a while, we get such cases… I try to work on the health [argument] and tell them it is wrong as it is part of a woman's reproductive rights and she should decide what to do with her own body… We all have our culture but some of the culture goes against natural justice. [But] we have not got many cases of FGM."
– woman working for a government agency that supports GBV survivors, interviewed in Maiduguri (speaking in English)

18. The Shuwa (also known as the Shuwa Arab) are one of the ethno-linguistic groups present in Borno State and the rest of the Lake Chad region. As with other communities, Shuwa people have been subjected to violence, displacement, loss of livelihoods, and gender-based violence as a result of the conflict in the region.

A.5 Forced Abortion or Sterilisation

Participants were more likely to talk about denial of access to safe abortion rather than forced abortion or sterilisation. However, there were some indications that forced abortion may be taking place. A participant in a focus group discussion for women aged 25 years and above in a Jere host community talked about how the mother of a teenage girl who had become pregnant outside marriage had insisted that she abort the pregnancy before community members could intervene and report her. Although it was unclear whether the girl herself wanted the abortion, the community perceived abortion as sinful and hence were motivated to act. Moreover, given dynamics around children born to women and girls abducted by AOGs examined in the analysis in Section 3.3 below, there was a risk of forced and unsafe abortions in this context.

A.6 Rape and Sexual Assault

While rape and sexual assault took different forms, participants spoke of how people, girls and women in particular across a range of ages, disabilities, ethno-linguistic and religious backgrounds, geographical locations, marital status, and other identities and characteristics, were subjected to this violence. Those who faced intersecting and overlapping axes of exclusion such as women and girls who had disabilities, were displaced, or engaged in sex work were more likely to be subjected to violence. For example, a (female) GBV service provider, interviewed in Jere LGA, said that women and girls with intellectual disabilities had added vulnerabilities to violence and could be specifically chosen by perpetrators as they would not be able to identify them or to recall what had happened. Further, a former (female) sex worker, interviewed in Maiduguri, (identifying details withheld) described how she used to live in an area with other sex workers, some as young as 10 years old, that was frequented by clients, especially soldiers. These soldiers would refuse to provide the payment agreed after sex and become violent. They refused to have sex with them, for example without a condom.

As shown by statistics from the N3alewa Centre, Borno's only Sexual Assault Referral Centre in Table 2, the majority of reported sexual violence tended to be perpetrated against children and adolescents of all genders but mostly girls. However, participants reflected that barriers to reporting are higher for other age groups and in cases of certain types of violence. As noted by a (female) GBV service provider, interviewed in Jere LGA, marital rape in particular was normalised and not covered by Nigerian criminal law, despite suggestions for its inclusion by women's rights activists including those in government and civil society. Kunya, a Hausa term often translated as shyness but having more of a connotation of being ashamed, embarrassed, or under a taboo not to speak in this context, could be particularly strong as shown by the experience narrated

in Survivor Testimony 4. Moreover, as detailed below, cultural mechanisms for dealing with mistreatment within marriage have been affected by the conflict and related displacement.

Table 2: Reporting to the N3alewa Centre (reported 6 months prior to the HFA)

Age	Number of Survivors Seen
< 5 years	13
5 – 9 years	33
11 – 19 years	104
20– 50 years	16
> 50 years	1
Total	167

As a result, few women and girls would report such incidents or even characterise them as rape. Participants, asked to instead reflect on 'forced sex' within marriage, spoke of their own experiences of this 'forced sex' and that of others that they know, calling this form of violence 'rampant.' They said that the conflict's economic impact had left many women juggling increased responsibilities of housework, childcare, engaging in income-generating activities, and strategising ways to access humanitarian assistance. As this state of affairs had strained marital relationships and women were exhausted from this additional labour and unhappy at their husband's inability and unwillingness to provide, they could be more likely to refuse sex when their husband approached them than prior to the conflict. However, attitudes were changing to a limited extent in some locations due to outreach and sensitisation. According to a woman working for an INGO that supports GBV survivors, interviewed in Damboa, *"Due to sensitisation of the community, men know there is something called marital rape. When we spoke with community leaders last time, they all agreed there is such a thing as marital rape. People are being exposed slowly, due to the actions of all those working on GBV"* (speaking in English).

Survivor Testimony 4

"I faced intimate partner violence – he forced me. I have never spoken with anyone about this, not even my older sister who is from the same mother. I feel kunya telling her what is happening to me. I had to endure and stay with what was happening to me. Not because he is my husband and he can do what he wants but because I am shy to tell. Before, he was demanding even anal sex. I was complaining to him but not telling anyone. He stopped after some time [but] before, even if I said no, he would force me." – 27 year old woman, interviewed in a Damboa host community (translated from Hausa)

Outside marriage too, participants including GBV actors, spoke about how boyfriends engaged in rape. An example provided was that of boyfriends luring girls and women into secluded areas on the pretext of being able to spend time together but then raping them. This violence could take place as a form of revenge. For example, a participant in a focus group discussion for women aged 18 to 24 years in a Gwoza host community spoke of how, if her parents refused permission for marriage, men have been known to invite their girlfriends to a quiet place and say,*"Since your parents will not allow me to marry you, I will have to do something you and your parents regret"* before raping her. Other women also spoke about this form of revenge rape, for example an over 25 year old woman (exact age unclear) interviewed in a Jere host community described how someone she knew was raped by her boyfriend as her parents had decided to marry her to a richer man.

Women had also been raped by men of their own or neighbouring communities who were not intimate partners. In Damboa, participants said men entered tents at night, particularly of those whose husbands were known to have been detained by the military to rape women and girls while they slept. Some women participants said that the incidence of such violence had been high when people were first displaced, around six years ago, and had since reduced. However this violence was still continuing during the period of data collection. A 19-year-old woman, interviewed in a Damboa IDP camp, shared that someone came into her tent and raped her a few months prior to the interview and another participant spoke of another similar case that happened in recent weeks. Another site of violence mentioned, including by the woman quoted in the text in GBV Actor Testimony 3, was camp toilets with men lurking around them, waiting for women and girls to enter them in the middle of the night after which they would follow them inside in order to sexually assault and rape them.

GBV Actor Testimony 3

"Toilets are not close to tents so, mostly in the night, there is no light in the camp and they go alone and [men] follow them and touch them when they are in the toilet. The girls feel very bad about it. They will say it is elderly men in the camp who follow them into the toilet and touch their private parts or breasts."
– woman working for an INGO that supports GBV survivors, interviewed in Damboa (speaking in English)

Other perpetrators included armed actors that comprised not only AOG fighters whose violence was detailed above but also community militia members and security force actors. Participants identified members of the Civilian Joint Task Force (CJTF - a community militia formed to work with security forces against

AOGs) as raping women and girls with little impunity due to their power and lack of recourse. Moreover, in one study site, participants spoke about how, during a time where all government officials or community leaders had fled, soldiers would enter people's homes to take women away or rape them then and there. Civilians were unable to raise these violations with military leaders due to lack of access and fear of reprisals (location and identifying details about participants withheld to protect participants). This finding of security force abuse was in line with what other research revealed, for example investigations showed sexual violence to have taken place against girls, boys, and women by security agents and inmates alike in Maiduguri Maximum Security Prison and Giwa Barracks (24).

A.7 Sexual Exploitation

Sexual exploitation was one of the first forms of sexual violence mentioned by many participants (this did not necessarily denote that it was the most common type of sexual violence). In a conflict affected environment such as Borno, the lines between sex work, survival sex, and sexual exploitation could be blurred. Several GBV actors said many women and girls in situations of financial precarity, due to their socio-economic status, displacement, loss of family members, and lack of livelihood options, had little choice but to exchange sex for money, food, shelter, protection, and humanitarian assistance. They said unaccompanied children and teenagers who have lost family members faced particular hardship and resulting vulnerability. Participants spoke of girls as young as 10-years-old engaging in sex work to sustain themselves.

Survivors could include adolescent girls, including those with disabilities, whose parents were struggling financially. They received financial, protection, and security gains from these relationships and passed on their benefits to their families. In some of these cases, GBV actors said parents could be aware that daughters bring back money and food gained in this manner, for example if they go out to hawk goods worth N500 but return with N1,500, and sometimes even pushed them to engage in transactional sex as there was no other option for family survival. Other people at particular risk of sexual exploitation included women and girls with disabilities who had even lesser access to resources, social networks, and livelihood options and could face particular challenges receiving humanitarian assistance linked to the ableism, stigmatisation, and social exclusion they faced, as shown by the quoted text in GBV Actor Testimony 4 and Survivor Testimony 5 and elaborated on in subsection 3.2 B.2.

GBV Actor Testimony 4

"Women and girls with disabilities face sexual violence [at higher rates] due to their vulnerability. People violate them. Also [they experience] exploitation. Sometimes having access to services may be difficult for [women with disabilities] due to their disability. Sometimes, she cannot pay for transport. For example, now there is ongoing distribution in a certain place and to go there to get card, it will be difficult [for her] so [she] may not get support." – woman working for an INGO that supports GBV survivors, interviewed in Gwoza (speaking in English)

Several participants working on GBV also said that perpetrators of sexual exploitation tended to be men with higher relative wealth and power whether they be fellow community members, government officials and politicians, humanitarian workers, or security agents. As discussed in the services section below, they included men who had the power to include people on humanitarian distribution lists such as government officials, politicians, people linked to community leaders who compiled these lists, and humanitarian workers. Community militia members also used their power and the money and access to resources that comes along with it to perpetrate sexual exploitation.

Survivor Testimony 5

"As of then, I had a 10 year girl and 14 year old boy. The girl would do labour in people's farms near Sambisa, harvesting crops in exchange for money. The boy could not go to the farm as it is far and Boko Haram may kill or abduct him because they do this to boys. The girl would go and get chased away by Boko Haram then go back. If I stop my girl from going, she will say, 'If I stop, who will assist us and you have only one hand so nobody will hire you' so she will insist and go. Some of the farmers would not even say the farm is far away but when she followed them, she would discover that she is going far away from [the] farm. One day, my daughter said she was going to the mountain to get firewood and she joined a group of children who were doing this. On reaching there, they collected firewood and soldiers beat them so much that her hand was swollen, then [they] sent them home. It happened twice. I used Tiger balm [an ointment] to rub on her hand. That day, I cried seriously about what soldiers had done to my daughter. I tried to stop her from going to the mountain but she replied that, 'If I did not go, who would buy firewood for us?' [This situation is] what brought about me having [high] blood pressure [and] I had to start doing what I did not want to do. I did what is not expected of me as a mother to support myself and my children..... When I discovered I was pregnant, I thought maybe that is how God wanted it to happen. The man did not force me into it but I willingly accepted [in exchange for the food he would provide] then became pregnant. I didn't do anything about it. The pregnancy got aborted by itself at 7 months." – 35 year old woman, interviewed in a Gwoza IDP camp (translated from Hausa)

Many participants, including the woman quoted in Women's Testimony 3, specifically mentioned soldiers as forming friendships with women and girls to lure them into having sex with them in exchange for needed goods. There have been cases documented of soldiers marrying women for the time they are deployed to a locality with the aim of divorcing and abandoning them and any children born to them on redeployment (5). While community members were unhappy about these actions, there was often little they could do as they feared reprisal action, particularly as many interlocutors with power and influence had left communities due to violence. GBV actors also discussed that cases wherein perpetrators were linked to the military were particularly difficult to provide holistic and effective response. As discussed below, some military commanders proactively attempted to prevent such actions from happening and ensured investigation and punishment of allegations but it still proved difficult for people to come forward to report, not least because the soldiers concerned often hid their identities.

Service providers said that incidence of sexual exploitation was heightened due to lack of livelihood options and diverted, erratic, and sporadic humanitarian assistance which meant assistance did not reach those most in need. In such circumstances, women and girls either engaged in farming and firewood collection, knowing this puts them at risk of abductions and suspicion by security forces and community militias of passing information on to AOGs as outlined above, or were sexually exploited. As will be discussed below, although this risk was particularly salient given current changes to humanitarian aid and had been raised by GBV actors, little was being done to mitigate it.

Women's Testimony 3

"This conflict has really contributed to sexual violence. Before, people were migrating, they had cattle and houses and they could sell cattle to pay for [their] needs but now they are in someone [else]'s community and it increases the chances of women being violated more than before... There is increased rate of sexual exploitation. It is mostly the military men who do this. They are here to protect us but they are also spoiling us as they have money. So if a woman meets a soldier to say what she needs, he gives her [money] which is a huge amount and she doesn't have a choice. And if she refuses, they force her." – 21 year old woman, interviewed in a Damboa host community (translated from Hausa)

A.8 Sexual Harassment

Street sexual harassment was viewed by participants as widespread for adolescent girls and young women but was often not reported. As a woman working for an INGO that supports GBV survivors said, *"Sexual harassment happens but is seen as normal since they did not rape me. They do not report. It is only when discussing with girls that they mention it. They say that since it is only verbal harassment or touching, it is normal"* (speaking in English). While this harassment may be normalised, it greatly affects those subjected to it. It takes the form of verbal comments, unwanted touching, and community gossip. It can also lead to physical violence if the girl or woman concerned is not receptive to these attentions as stated by the woman quoted in Women's Testimony 4. Nearly all the women asked about harassment recounted their own experiences of it, with older women talking about how it tailored off as they grew older and were no longer seen as easy targets. They spoke of how lines between sexual harassment and assault blurred and gave examples of men who had engaged in sexual assault progressing into rape. As a 35 year old woman, interviewed in a Jere IDP camp, said, *"If men see girls anywhere, they touch them on the chest and if the girl does not run and stop, they will have sex with her so girls have to run"* (translated from Hausa).

Women's Testimony 4

"[It happens to] those girls who are becoming matured with development of breasts. Boys from 15 – 20 years are mostly the ones touching these girls. If the girls are around 20, it is not boys from 15-20 [years] who touch them as they feel the girls can retaliate. [It is older men who touch them] A boy of 16 years old raped a small girl of 4 years old. She could talk and the boy was in the compound so she came back home and was able to say something so people know it was the boy. Most of the boys who touch women can go on to rape them. I see a link between touching of girls and women and raping them... Most of the boys are until 30 years but some who really like another person's wife are even more than 30. They mostly do it to age mates. Those more vulnerable to sexual harassment are women whose husbands have travelled to Lagos, Taraba or women whose husbands are not there with them. They are also the ones who are mostly raped." – Woman, part of a focus group discussion for participants aged 18 to 24 years, held in a Damboa host community (translated from Hausa)

Young men were largely perceived to be the perpetrators of unwanted touching but perpetrators can also be (male) soldiers, for example at checkpoints, as discussed above.

Moreover, people of all ages engaged in some form of gossip. Majalisa, a practice of sitting together in a group under a tree or some other shade and passing the time in conversation, is common in Borno. While this practice had been the site of sexual harassment of girls and women walking by even before the conflict, such sexual harassment seemed to have increased. Women participants, including those quoted in Survivor Testimony 6, described how they became the target of sexualised gossip if they had bathed, dressed nicely or were wearing makeup, with rumours spreading that they had done so to meet men.

Survivor Testimony 6

- *"There is a group of people in our community that comprises men and women who sit under a particular tree and all they do is to gossip – we call them [doing] 'condolence without dead body'."*
- *"Now, the gossip has increased unlike before. Now, as a girl if you take your bath, dress nicely and go out, people will be pointing you out and saying see this girl, who knows where she is going."*
- *"If I dress nicely and walk in the community, I cannot pass the majalisa comfortably as I know they will be talking about me and saying I am doing shekara [showing off] and am feeling too high. Sometimes, you even lose balance while walking if you want to pass in front of a majalisa."*
- *"It is as a result of the displacement as [now] people are gathering under a tree and doing nothing unlike before [when people were busy at work]"*

- Participants in a focus group discussion for women aged 18 to 24 years, held in a Gwoza host community (all quotes translated from Hausa)

Sexual harassment could limit access to education and employment also, a dynamic for which it was not possible to ascertain changes as a result of the conflict. A participant in a focus group discussion for women aged 25 years and above in a Jere host community recounted how, on two separate occasions, boys had tried to touch her daughter's breasts when she was walking home from school and when she refused and tried to run, they caught and beat her badly. She said that this sexual assault on the way to and from school was a common occurrence for many girls who attended her daughter's school and was one of the barriers to their continued attendance.

Even in the humanitarian sector, colleagues can engage in inappropriate comments and touching. A (female) GBV service provider, interviewed in Damboa LGA, said, *"[Sexual harassment] sometimes happened to me in the office. I am the smallest [in my office] so before I got married, people would tap me and say, 'with my tiny body,' make comments about my body, and touch my bum. It was only after [information withheld] that I recognised that I have rights on my body… I told them they were sexually harassing me and they apologised… Now you have increased sensitisation, they have responded and strictly adhere to principles."*

In response, girls and women had taken actions to protect themselves and others. Mothers spoke about the need for constant vigilance in order to protect their daughters, such as arranging for other siblings to escort girls who wished to go out at night, for example to use the toilet. Participants in a focus group discussion for women aged 25 years and above in a Damboa IDP camp gave the example of women leaders passing out torches for women and girls to use if they want to go to the toilet at night as this is a site where sexual harassment and assault happen. These torches were meant to be used by girls and women to know they are safe and nobody is lurking or following them and to raise the alarm. Girls and women also fought back physically, sometimes successfully, as recounted by the woman quoted in Survivor Testimony 7.

Survivor Testimony 7

"At night, it happened to me and my sister. When we were walking, a group of boys followed and started touching me. Where they did this was near to a welding shop so I took one iron and started chasing [one of them] and he ran away. The boys are our age mates - I knew him as we went to primary school together. We were about 15 years old when this happened." - 26 year old woman, interviewed in a Damboa host community (translated from Hausa and Kanuri)

B. The Context in Which Sexual Violence Occurs

B.1 Long-standing Patriarchal Power Relations and Gender Inequalities

Many of the ethno-linguistic groups present in Borno have a history of women's political leadership, religious scholarship, variation in gender norms, power sharing across genders, and some acceptance of gender fluidity (25-27). However, discriminatory and misogynistic gender norms have become entrenched in the region, influenced by British colonisation, conservativism from Saudi Arabia, Iran and the USA, religious fundamentalism and intolerance, increased inequality and poverty, changing economic fortunes, and other factors (13). Many participants shared their pre-conflict experiences of sexual violence, indicating that Borno saw high incidence particularly when it came to denial of the right to use contraceptives, early and forced marriage, FGM/C, sexual harassment, and sexual assault. However, according to GBV actors in Borno State including the woman quoted in GBV Actor Testimony 5, factors that made it difficult to quantify incidence included: a strong culture of silence; lack of systems to collect data; few mechanisms to report violence and seek help; low levels of awareness around rights to bodily autonomy and freedom from violence; victim blaming; and gender norms that promote the idea that women's bodies are seen as sites of reproduction and entertainment while men are posited as breadwinners and protectors. They stated that, particularly in areas with humanitarian presence and strong GBV sensitisation and programming

there were higher levels of awareness on GBV which may have led to reduction in some forms of violence such as early and forced marriage. Yet, at the same time, there was also backlash against the increased decision-making power, freedoms, and roles played by women and girls.

GBV Actor Testimony 5

"It was very rare [to hear stories of GBV before the conflict] which could be due to ignorance and me not being well trained enough to identify GBV and not too exposed to know what was happening in the community. We only knew that rape was not good. We did not know about early and forced marriage – it was even happening to us and we didn't know about it. GBV happens all the time. Due to conflict, the reports are high. It was very rare to hear [about this] before the conflict [but] as humanitarians are here to provide services and sensitisation, people are more likely to report [now]." – woman working for an INGO that supports GBV survivors, interviewed in Damboa (speaking in English)

However, while Nigeria had ratified international and regional human rights treaties and policies,[19] their implementation was uneven across the country. In Borno, the Child Rights Act 2003 and Violence Against Persons (Prohibition) (VAPP) Act 2015 were domesticated in the state after the period of data collection and Borno was the first state in Nigeria to have a State Action Plan on Women, Peace and Security. Yet, implementation of laws and policies was often missing. The State Action Plan on Women, Peace and Security continued to be underfunded with its implementation and revision dependent on donor support rather than political will. Indeed, according to those working on women's rights interviewed, women, peace and security, gender analysis, and GBV were side-lined in decision making and seen as the preserve of the Ministry of Women's Affairs, which was chronically underfunded, rather than integrated into policy and programming across the board.

B.2 The Conflict and Humanitarian Situation

The current crisis had seen an increase in all forms of gendered violence aside from sexual violence. Men of fighting age (approximately 15 to 60 years) bore the brunt of focus by all conflict parties. They were deliberately targeted and killed by AOGs, viewed with suspicion, arrested, detained, and killed by security agencies, and often forced to fight (3).[20] Conversely, women and girls had seen a rise in levels of emotional, psychological, physical abuse and controlling behaviour from

19. Including the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of Persons with Disabilities, and the Convention on the Rights of the Child.
20. As of 2015, Amnesty International estimated that Nigerian security forces had extra judicially executed over 1,200 people, arbitrarily arrested at least 2,000 people, mostly young men and boys, and that more than 7,000 men and boys had died in detention since March 2011 due to starvation, thirst, severe overcrowding leading to spread of diseases, torture, lack of medical attention and the use of fumigation chemicals in unventilated cells.

husbands and other intimate partners. As a (female) GBV service provider said, *"We see IPV – physical assault for example hitting, choking, and pinching. There are cases where women are at the point of losing lives, sparked by something minor and men transferring their aggression when they come home to women. If [women] make any comments, [men] transfer all aggression on her and beat [them]. It has been like this since 2017 and is linked to the conflict and humanitarian situation and power imbalance [and] men wanting to assert masculinity"* (speaking in English).

In addition, there was an increased population density in many areas, including camps and host communities, due to displacement into government controlled areas. This population density had both increased levels of awareness of violence that took place and frayed social cohesion and community mechanisms used to mitigate violence. Many participants talked about how people living more (physically) separated and busier lives previously which meant that news of sexual violence was less likely to travel as opposed to the cramped conditions and increased tendency to gossip of today. They said living alongside people from different locations with whom one had no prior connection or social networks built over generations led to reduced community feeling and solidarity, the tendency for individuals to take advantage of the situation with impunity, increased possibilities for sexual harassment, and the withering of community norms that prevented certain types of violence.

Moreover, certain cultural mechanisms were no longer as functional as before. For example, among Muslims, an alwali (guardian) is appointed upon marriage, charged with intervening if there is marital discord or any other marital problems. GBV actors said that, prior to the conflict, some of these alwali would encourage women and girls to speak out if they were in trouble and would intervene if they were being mistreated. They said that this system did not operate perfectly as the alwali determined what fair treatment in marriage meant. For example, they could believe that men should abide by women's wishes in refusing sex if they were not well but otherwise had a right to sex with their wives as they wished. However, it did serve as some recourse for women and girls and if the alwali appointed was absent or had died, another one would be appointed to his role. Yet, due to current conflict-related displacement, many women and girls lived in locations far away from their alwali or had seen him killed and a replacement not appointed. Even if a successor is in place, they may find him not approachable, be unable to share delicate and sensitive matters with him or feel that he is not looking after their interests.

Furthermore, despite these dynamics and the urgent need for service provision and prevention work, there continued to be limited prioritisation and mainstreaming of protection work in general and sexual violence in particular in both humanitarian response and government policy and practice. As will be discussed below, although survivor service provision had drastically improved

compared with the situation in 2014, service availability and quality was inconsistent around the state and non-existent outside areas with humanitarian presence.

B.3 Incomplete Knowledge and Myths

Several GBV actors said that the actions of women activists, civil society leaders, and humanitarian actors in the past six to seven years have led to increased levels of awareness of sexual violence, the right to bodily autonomy and freedom from violence, and some debunking of common myths in some areas. Women participants were, more or less, able to talk freely about the different types of violence they saw in their communities and the needs of survivors ranging from medical care and psychosocial support. They spoke of how they would support any friend who came to them telling of the violence they had experienced. They said they would support them to go to hospital, keep this confidence and not spread rumours in the community, offer love, care and understanding, and be sure not to stigmatise.

However, a number of women participants spoke of survivors needing hot water and salt to wash their genital area. They were unaware of the benefits of accessing immediate care in terms of prevention of HIV, STDs and pregnancy, or of other services provided at medical facilities for survivors. While some participants were aware of sources of help, others, particularly those living in host communities where there were less outreach efforts, had no idea of services available and suggested taking survivors to the police station (see section 3.2 below for more details). Some participants insisted that sexual violence did not take place in their communities despite going on to detail sexual violence and the consequences faced by survivors at length. This denial could be linked to stigmatisation of women and girls from locations where cases of sexual violence become known, as will be discussed below, with this denial functioning as a protective mechanism.

Participants living in both IDP camps and host communities also spoke of not believing survivors except in specific cases or if they had taken certain steps. For example, a participant in Gwoza said she would advise survivors to keep quiet about what had happened to them as speaking up and reporting would lead to stigmatisation and damage marriage prospects. In the next breath, she said that if someone did not go to hospital for assistance, she would doubt whether they had been raped or sexually assaulted and believe they were covering up for consensual sex after it was discovered. This idea of girls and women using rape allegations to cover for consensual sex outside marriage if it led to discovery including through pregnancy was mentioned by a number of women participants including the one quoted in Women's Testimony 5. Others said only children could be raped as older adolescent girls and women were able to fight off their

attacker, that only those who had not had sex before could be raped, and that children were affected by rape but that older people were not. Another common myth was that a person could only be raped or sexually assaulted once, so if they reported this violence more than once, they were lying.

Women's Testimony 5

"Men are the perpetrators of sexual violence against women, mostly young girls. But some of [these girls and women] do it willingly but will say it was by force, especially those who are not married... They are trying to shift the blame on the man's side as, if people find out she is pregnant, camp leaders may send her out of the camp. If she says it is rape by the man, the blame shifts on him... [In such cases] people think that she is trying to shift the blame and do not believe her when she says she is being raped. Some people may believe she was raped but others say no, [she] is just covering her shame... There was an instance where girls got pregnant and [the] camp leader took them out of the camp. The girls reported it to organisations who asked the camp leader why he did that and he said their presence is a bad influence. Some of them returned while others refused to come." – 20 year old woman, interviewed in a Gwoza IDP camp (translated from Hausa)

Many of these participants also blamed survivors, stating that sexual harassment and assault happened due to the negligence of girls who mixed with boys or if girls dismissed boys when they tried to chat them up. They blamed them for what they were wearing or that they had otherwise somehow aroused the men or led them on by their behaviour. Several of them criticised girls who planned to meet boys for raising the alarm and claiming they had been sexually assaulted if they touched them against their will, not recognising that deciding to meet someone did not equate to consent to all sexual acts. In other cases, despite understanding and even sympathising with the economic necessity that drove some women to engage in transactional sex, they still took moralistic positions and stigmatised those who did so.

C. Consequences of Sexual Violence

C.1 For Survivors

According to women participants, including survivors of violence, survivors faced physical health consequences, including but not limited to bruises and cuts during the course of sexual violence, VVF linked to early and forced marriage and rape of minors, pregnancy, high blood pressure caused by stress and trauma, and STDs including HIV. The medical care they required included post exposure prophylaxis, emergency contraception, surgery, and post abortion care given

their lack of access to safe abortion. Indeed, some service providers said that a key demand of many survivors was for abortion, that if this was not provided they could use unsafe means such as using herbal medicine, chemical drugs, bleach, or implements to end the pregnancy, and that many of the patients coming for post abortion care were GBV survivors. Participants also reported how on a number of occasions, foetuses and new-born babies were found in the pit latrines of IDP camps or in the bush. In some of these cases, girls and women had been arrested, tried, and returned to their communities where they continue to face stigma and discrimination from others.

Survivors, non-survivors, and service providers alike, also spoke of psychological consequences manifesting in post-traumatic stress disorder, depression, withdrawal from society, and ideation and attempts to commit suicide. It was not only the sexual violence but also stigmatisation by the family and community that could have these impacts. Indeed, participants spoke about the kunya or shame they internalised for having been subjected to sexual violence. A 35 year old woman who had engaged in transactional sex in exchange for food, interviewed in a Gwoza IDP camp, said, *"After I realised I was pregnant, it gave me kunya and I was ashamed of myself. [Sex outside of marriage] was something I did not do when I was a child and it was [when I was] grown up and had children that I did. It disturbed me and day and night I could not sleep thinking about how I had done this at my age"* (translated from Hausa).

Moreover, survivors faced stigma and other socio-cultural consequences, from both their families and communities. They were the focus of gossip with people coming to look at survivors, even those who were children, and sharing what happened to them. If survivors who were known to be pregnant miscarried or saw their baby die after childbirth, they were suspected of having sought an abortion or committed infanticide and were sometimes handed over to the police for investigation despite lack of evidence.

Furthermore, the marital prospects of survivors of both rape and sexual harassment were seen to be affected. Men would either not be interested in offering marriage or be discouraged from doing so by others. As a 20 year old woman, interviewed in a Gwoza host community, said of a 14 year old girl raped by a 50 year old man in whose house she sewed clothes, *"People are looking at her somehow even though they know it is not her fault and so do not blame her"* (translated from Hausa). Many participants, survivors and non-survivors alike, were unhappy about this stigmatisation and contrasted this treatment with that of the male perpetrators concerned who often experienced very little social consequences. Yet, this stigmatisation was not consistent for all types of sexual violence. Continued outreach and sensitisation efforts around women and girls abducted by AOGs had led to a lessening in the condemnation they experienced. This change showed that social norm change was possible.

Finally, the commission and/or threat of sexual violence increased the risks of more violence. Parents married off their daughters at younger ages to prevent them engaging in transactional sex and being sexually exploited - and the resulting moral vilification. Some of those who resisted were disowned by parents who stopped providing them with food, shelter, and other assistance, leaving them vulnerable to sexual exploitation. Girls and women were married off by parents to protect them from being abducted, forcibly married, and raped by fighters. Some participants who had been abducted by AOGs said they had no other choice but to engage in transactional sex to support themselves as they were not considered divorced and hence, could not marry again. A 22 year old woman, interviewed in a Gwoza IDP camp, shared how she was forced to marry a fighter who was subsequently captured by soldiers. Despite being separated from him for six years, she was stopped from marrying a man of her choice by the actions of his relatives who said this would be bigamy while, at the same time, refusing to help her. As she had nobody to push her case with his relatives, she was unable to get married and said she would have to engage in transactional sex to support herself.

C.2 For Survivors' Families

The families of survivors also suffered as they blamed themselves or each other. Community members blamed mothers, seen as responsible for instilling moral upbringing and for their children's physical security, for sexual violence perpetrated on their daughters. Some participants spoke of how fathers faulted mothers for the violence and linked it to alleged lack of care, even threatening divorce for this perceived failure. As a result, mothers could hide what has taken place to protect their daughters and also themselves. A divergence in opinion of

Women's Testimony 6

"[After] my daughter was sexually [and physically] harassed on her way [home] from school, when I reported the case to my husband, instead of him to taking action, he was blaming my daughter that why did she go out at the first place. I said, 'Can't you see she is wearing a uniform, does that mean she can't go to school again?' and he said, 'Okay if that is the case, she has to change the road she follows.' I then reported it and after police have arrested the [boy concerned], his father then [came] to my house [to intercede so that his son would be let go]. I carried a stick and hit him on the head and he started bleeding. Then my husband came shouting, 'Why will you do such [a thing], so you want kill someone in my house?' I then said, 'Since you refused to act like a man, I have done it my own way.' It has now caused a misunderstanding between me and my husband."
– woman, part of a focus group discussion for participants aged 25 years and above, held in a Jere host community (translated from Hausa)

how to respond, for example if the mother wished to seek help and the father wanted to keep quiet, could also lead to marital discord as shown by the text in Women's Testimony 6.

Interview and focus group participants also said that being linked to a survivor of sexual violence could lead to shame and loss of community respect for the whole family. As a result, they could not speak in gatherings, even among friends. The sisters of survivors were stigmatised and had their marriage prospects affected if the family became known as 'having a bad record.'

C.3 For All Women and Girls

The prevalence of sexual violence in their communities had led to women and girls being fearful and restricting their freedom of movement. Many participants shared their tactics to deal with this danger. They avoided going out at night, to certain locations, or through checkpoints where they knew soldiers and community militia members were likely to harass them. They made sure they did not walk alone, thinking being in a pair or a group would protect them. In areas where toilets were a site of sexual violence at night, they waited for daybreak or for their husbands, mothers, siblings, or other family members to accompany them. They knew that, if anything happened, the first question that would be asked is why they went out alone, at that time of night or to this particular location.

Participants spoke about how these fears limited their social interactions, especially at night, one of the only times girls and women could come together to relax after a hard and busy day's work. They affected access to water, sanitation and hygiene (WASH) facilities. They also suppressed their educational, income, and livelihood opportunities as sexual harassment took place on the way to, from, and in school or work. Women and girls were prevented from engaging in night-time livelihood activities such as frying food for sale. Fathers and husbands, not wanting their daughters and wives to mix with men due to the risk of sexual harassment, could also block opportunities for women to work in host communities or for NGOs, even if these women were working before the conflict.

Moreover, if it became known that sexual violence happened, it lowered the respect with which all girls and women of that locality were treated as they were all tarred as being 'spoiled' or 'engaged in immorality,' as shown by the quoted text in Women's Testimony 7. Friendships and social networks had been broken as friends of the survivors faced stigmatisation and so retreated, often under the insistence of parents who were worried about their daughter's reputation and that the survivor was a 'bad influence.'

Women's Testimony 7

"Generally, if [sexual violence] is happening in Gwoza and someone is dating and wants to marry a girl from this community and someone [else] gets to know this, the person will say [you should] not to go and marry from this community entirely because of one act [of sexual violence]. So it becomes a stigma not only to the family but to the whole community." – 20 year old woman, interviewed in a Gwoza host community (translated from Hausa)

C.4 Perpetrators

The likelihood of perpetrators facing consequences for the actions they committed were much less compared to that of the survivors of violence, as attested to by the man quoted in GBV Actor Testimony 5. Yet, in recent years, there have been attempts to change this state of affairs. Interview and focus group participants spoke of cases where even soldiers and police officers faced investigation and punishment if they could be identified and senior officers encouraged reporting and took action. Examples of punishment given included forcing soldiers to pay a set amount from their monthly salary to take care of babies resulting from sexual exploitation and rape. Personnel could also be deployed to more dangerous areas of fighting. While these punishments was not completely satisfactory according to GBV actors interviewed, it was a change from the generalised impunity of the past. However, many cases brought to the police were dropped if officers were paid to close the case, after which perpetrators were released and free to threaten survivors. It is not surprising then that the majority of survivors were hesitant to report to the police or pursue legal routes. Overall, the numbers of sexual violence cases brought to trial and resulting in convictions continued to be very low.

Consequences outside the criminal justice process were also uneven and uncertain. In some cases, participants spoke about how people shunned perpetrators known to have raped young children, to the extent that they had to leave their communities. However, the weight of community disapproval largely fell on survivors rather than perpetrators, particularly as fear stopped many survivors from naming the perpetrators involved. Perpetrators who seemed to be most spurned were those who had raped many young children, seen as innocent, as opposed to when survivors were their wives or adult women.

GBV Actor Testimony 5

"For the perpetrator, I don't think there are any consequences. If there are any cases, we refer to the [National Human Rights Commission] who follow up, follow up, follow up. Instead of the police officers charging him, his relatives come and pay money and he will be immediately released… One [member of the Civilian Joint Task Force] in [information withheld] raped a young girl [and we] followed up so he was taken to Maiduguri in court. He spent some months there before he was released and he is back in Damboa due to the efforts of one of the politicians. Even the community members and survivors feel reluctant [to report now] instead of government structures doing something so it makes others who have intention [to commit violence] take a lesson [and stop]." – man working for a Borno-based NGO that supports GBV survivors, interviewed in Gwoza (speaking in English)

D. Help seeking behaviour

D.1 Factors that Discourage Help-seeking

Lack of Knowledge on Services Available

Women participants, including survivors, shared that lack of knowledge of services prevented them from seeking help for themselves and survivors close to them. Those interviewed in areas that had not received outreach by GBV actors and those experiencing reduced freedom of movement including women with disabilities were more likely to speak of this challenge. The research team found higher awareness about services in the IDP camp than in the host community in Gwoza. There seemed to be a mixed response from the findings where some (excluding service providers, NGO participants and state government participants) were aware of INGOs and some community members who could assist them. Yet, at the same time, there seemed to be a big group of community members who were interviewed that were not aware.

MDM, 'the hospital', NHRC, the police, Save the Children, IMC, IRC and the bulama[21] were mentioned as providers of assistance. Participants knew that, in cases of rape or sexual assault, they could approach these providers to get medication - with a few elaborating that this would be to prevent pregnancy and STDs (although one participant from Gwoza did not know that medication could be taken to prevent). However, while a few knew of these NGOs, they did not know the exact services provided, and if these were specifically for sexual violence. Lastly, awareness was needed on the different services available and that these were confidential.

21. A bulama is the village head, part of the system of designated community leadership which cascades from bulama to lawan (ward head) to haikimi (district head) to the emir.

Lack of Financial Resources and Language Barriers

A few participants were concerned that language barriers would prevent them from communicating with health workers who could only speak English or Hausa. This is further elaborated on in 3.2 B.4. Similarly, they lacked financial resources to pay for treatment, often required in facilities not run by international humanitarian agencies. A local government official in Gwoza said that the requirement for a survivor to be accompanied by the police prevented survivors from accessing healthcare. While reporting to the police was not required by legislation or policy, that a government official believed this may be indicative of wider community perceptions and, potentially, also of practice in some locations.

Fearing Perpetrators

Some participants also spoke about survivors feeling uncomfortable telling family members, having little support for help and instances where families, friends and neighbours pressured them into silence. Fear of perpetrators, especially if they have power, are rich or influential restrains their engagement, particularly in the judicial process. Government official, community leaders, rich men, soldiers, and community militia members were seen as untouchable due to their ability to either buy off key actors or act in reprisal. In such cases, survivors as well as their family and community can be cautious. This fear of perpetrators was linked to a fear of reporting, further discussed in 3.2.B.3.

Stigmatisation and Victim Blaming

Reporting about sexual violence is also not encouraged as it would expose the survivor's family. This idea of having to keep family matters secret is particularly strong when it comes to intimate partner violence. As a 26 year old woman, interviewed in a Damboa host community said, *"It is seen as secret between husband and wife. It will not be nice for her to expose the secret as if her husband comes to know, it will not be good for her. [She will be] worried about what people will be saying about her, that she cannot even hold a secret between her and her husband. They will be pointing finger at you and saying this is what she said about her family"* (translated from Hausa, Kanuri, and Margi).

Indeed, victim blaming and stigmatisation by families and communities were the most commonly mentioned factors why survivors did not seek help. Community leaders and police officials also partook in this, as expressed by the woman quoted in Women's Testimony 8. The incomplete knowledge and myths described in Section B.3 add to this dynamic, with survivors knowing the community might perceive them as covering for consensual sex. Women participants told of how even close friends may not believe survivors and spread

information, leading to widespread gossip and rumours with ramifications for the survivor and her family potentially lasting for decades. As one participant in a focus group discussion for women aged aged 18 to 24 years in a Gwoza host community said, *"Even your children will be reminded about what you have done, even after you have died as, if something happens, people will recall this is what your mother did when she was alive"* (translated from Hausa).

Women's Testimony 8

"If fire burns you on this hand, you cannot take pepper and put it on there as doing so worsens the situation. In the same way, if you report it to some people, they will add to the problems you already have. If you report to the community leader or police, for example if a mother reports that someone raped her daughter, they will ask her how it happened then after explaining, they will say your daughter gave consent - so this escalates the situation rather than solving the problem. They will blame the girl. Even if you go to report, doing so will add more problems on it. Some parents also blame their daughters which discourages them from reporting also. Mostly young girls are discouraged from going as their reputations are at stake and if they report and nothing happens, it is 2-0. They have reported and nothing is done about it. Mostly girls are discouraged from reporting when their dignity [virginity] is involved. When people know you are no longer a virgin, they look at them somehow so you lose your dignity and have less value. Imagine - you lose your virginity and nothing happens, it is 2-0." – 21-year-old woman, interviewed in a Damboa host community (translated from Hausa)

Many participants spoke about how kunya (a sense of shyness, shame, and/or taboo) would prevent survivors seeking help, particularly if services are seen as linked with sexual violence (or contraception if the survivor is unmarried). According to a woman working for a Borno-based NGO on state level protection coordination, *"The shame and labelling is one of the factors that do not permit survivors to access services. If a community knows that a safe space addresses issues to do with survivors, very few people will want to be seen around that area"* (speaking in English). For example, while the services provided in the N3alewa Centre were uniformly judged by GBV actors to be of high quality, women were viewed as being reluctant to go there due to its association with GBV. According to a woman working for a Borno-based NGO that supports GBV survivors, interviewed in Jere LGA, "*The SARC is known for providing GBV services so when people go in there, people believe they are going in for purposes of GBV [treatment]... Even if I was to go to the SARC to do work, the first thing [people would] think of is that she has problems"* (speaking in English).

Further, this idea comes into play where healthcare provision by international humanitarian actors is being phased out with plans for the government to take over services. If a clinic that would previously treat all medical conditions now only provides treatment for children, sexual violence and life threatening cases, women participants were clear that survivors would not go there to access treatment. A participant in a focus group discussion for women aged 18 to 24 years in a Gwoza IDP camp said, *"If you are going [there] now, [the community] will conclude that something has happened to you and you are going there to get help regarding sexual violence as nobody is going there except children and survivors... Before, as many women were going there, you would be there for your own problems and other women would be there for their own but now if they see you go there, they conclude you are going there for [sexual violence services]"* (translated from Hausa).

Participants were also particularly negative about the judicial process with police officers and judges seen as not knowing how to interact with survivors and reinforcing the victim blaming they already experienced and with justice being seen as for sale.

D.2 Factors that Encourage Help-seeking

Confidential Quality Services

Women participants in interviews and focus groups shared their analysis that being assured of confidentiality, having high quality services available, and outreach on the existence of these services encouraged help seeking. They spoke of how survivors who had received good quality and confidential services would be able to secretly share this information to encourage other survivors to access help. GBV actors shared this view, saying that they had seen services meeting survivors' needs in holistic ways ranging from providing health and psychosocial care to shelter and income generating activities and when referral systems to humanitarian agencies worked, it led to more survivors coming forward.

Support from family, friends and leaders

Participants also stressed the importance of having support from friends, family members, or women and men leaders. They highlighted the importance of this support also being confidential so as not to lead to stigmatisation. They said that barriers such as stigmatisation and kunya still existed but that it was relatively easier to access help in areas where women in their communities had been selected and trained to deal with GBV cases. This is further elaborated on in sub section 3.2 A.6.

Improved Access Depending on the Type of Violence

Ability to access services was not uniform, with major differences based on demographic characteristics of survivors and presence of GBV actors in communities. The ease of seeking assistance also varied greatly between type of sexual violence. For example, for abductions by AOGs, survivors often did not need to proactively seek help, as shown by the experience of the woman quoted in Survivor Testimony 8. They were identified as they come into areas of government control or when picked up by the military with all actors knowing the referral pathways and relevant services. Survivors of abductions spoke of receiving a range of services including medical care and STD checks, psychosocial support, shelter, food, clothing and other non-food items, and sometimes skills training and capital to start businesses. Not only were there clear referral pathways for abductees but there had been sustained sensitisation and behavioural change campaigns that had been somewhat successful in addressing the stigmatisation they experienced.

Survivor Testimony 8

"It was easier for me, who came from the bush after being abducted and married, to access services compared to someone who experienced sexual violence in the IDP camp or host community. The difference is that, in my own case, it is not everyone who knows me here as I am coming from the bush and, even if they know me, they know I was abducted not because I went willingly and there was no health centre in the bush. So I can confidently come to seek medical assistance. But the ones who are in the camp, if someone sees [them], they may say don't mind her, she was not raped but is trying to cover up. So they will accuse someone in the host community or camp more than someone coming from the bush… Also, [it was easier for me to access help] as there is a procedure in place for people who come from the bush… After the soldiers finish their investigation, they will take you to the sarki's [designated community leader's] palace and after meeting him, they will call the medical personnel to take it from there. So you don't even need to seek help but are taken to the places where they will help you. When we came out of the bush, after the soldiers' finished their investigation and took us to the sarki's palace, we did not sleep there. We arrived in the morning and, before evening, we were released to go home after MSF came and checked on the children, measured their upper arm circumference to check whether they are malnourished or not, gave tamuwa to malnourished children, they let us go… It was my family members who received me from the emir's palace and brought me home before I was taken for medical check-ups – my father's younger brother was the one who did this… [After that,] it was the staff of [IRC's Comprehensive Women's Centre] who encouraged me to go and look for help. They came with a form, filled it with my information and referred me to UNICEF [for medical check-up]. Nothing made it difficult for me to seek help." - 25 year old woman, interviewed in a Gwoza host community (translated from Hausa)

3.2 Existing Services

A. Types of Available Services

Service providers most frequently mentioned by participants included Médecins Sans Frontières (MSF), International Rescue Committee (IRC), Médecins du Monde (MDM), International Committee of the Red Cross (ICRC), General Hospitals, N3alewa Sexual Assault Referral Centre (SARC), International Medical Corps (IMC) and National Human Rights Commission (NHRC). Community members did not always know the exact organisation providing a specific service. Service providers from other organisations were also interviewed for this study, due to which additional information about their organisations is presented here. To better understand which health services were available to sexual violence survivors, assessments of six health facilities were conducted, as shown in Table 3 (p 56). Please note that identifying details of the facilities, including the organisations running them, have been withheld in order to preserve anonymity and confidentiality.

All six facilities included in the health facility assessment (HFA) provided some level of health services to sexual violence survivors, although with limitations. Some services were run by NGOs and government agencies while others were government facilities run by the Ministry of Health (MOH), with the sexual violence centre involving cross government collaboration between different ministries [information about which ministries were involved withheld].In each LGA, the study selected one government primary health care (PHC) and one clinic supported by INGOs. The assessment tool covered a set of health services, including medical services, psychosocial and protective services, HIV services, SRHR services, and Post Abortion Care (PAC). Other areas assessed include community engagement; accessibility for persons with disability; general infrastructure; equipment and supplies; protocols and information for survivors; referral systems and follow up of survivors; and reporting and information systems.

The Primary Health Care (PHC) in Jere LGA provided the majority of medical services evaluated in the assessment except HIV/PEP services and forensic examinations, citing lack of supplies and equipment. Similarly, psychosocial and protective services were available to survivors, with the exception of socioeconomic empowerment, shelter/safe houses, legal counselling, and group activities. Survivors were referred to the sexual violence centre for psychosocial and protective services which were not provided at the PHC. The facility offered two HIV services, including HIV counselling and HIV testing, although they did not have any test kits during the time of the assessment. Post Exposure Prophylaxis (PEP) for both adults and children and HIV testing services were offered as a referral service to the Jere sexual violence centre. In addition, sexual violence

survivors had access to a range of SRHR services including post-abortion counselling – although uptake was reported among non-survivors and only for medication (misoprostol).

The sexual violence centre in Jere LGA provided all medical services examined in the assessment. While the Centre provided psychosocial and protectives services to sexual violence survivors, Mental Health Gap Action Programme (MHGAP), psychiatric care, socio-economic empowerment, shelter/safe house, and group activities were offered as referral services. In particular, survivors were linked to the Neuro-Psychiatric Hospital for MHGAP and psychiatric care; UNFPA and Ministry of Women's Affairs (MOWA) Development Centre for socio-economic empowerment, and National Agency for the Prevention of Trafficking In Persons and MOWA for shelter/safe houses. There was no specified referral linkage for group activities. sexual violence survivors had access to all the assessed HIV/SRHR/PAC services, although the latter was limited to medication and manual vacuum aspiration (MVA). Please note that the centre is situated within a hospital so an absence of supplies did not mean they are not available for examination of patients but rather that the patient is referred to and care is given by other departments in the hospital.

The PHC in Damboa LGA offered medical care to survivors of sexual violence, but did not provide HIV and PEP services, STI treatment/prophylaxis, vaccination, emergency contraception, forensic examination, counselling, or psychological first aid. Service providers said they were not provided due to issues with staff training, supplies/equipment, and budgetary constraints. Psychosocial and protection services were offered as referral services to MDM and IMC respectively. Similarly, HIV services were not offered to survivors, with the facility noting lack of test kits since February 2021. However, the PHC facility provided referrals for HIV-related services, including adult and paediatric PEP services, to IRC or MDM. Sexual violence survivors had access to a range of SRHR services, with the exception of HIV and STI services, safe abortion, and comprehensive emergency obstetric and neonatal care. Although the facility offered PAC services, access was limited to counselling due to lack of demand by sexual violence survivors.

The IDP camp clinic in Damboa LGA provided all of the assessed medical services to survivors. Psychosocial and protection services were also available to survivors, with the exception of psychological first aid, socio-economic services, shelter/safe house, and legal services, which were offered as referral services to an unspecified health facility. The clinic provided a range of SRHR services, excluding HIV services, basic emergency obstetric and neonatal care, comprehensive emergency obstetric and neonatal care, and mobile SRHR outreach to hard-to-reach populations. PAC services were limited to counselling. There was no reason provided as to why other services were not provided and no information on referral options.

The PHC in Gwoza LGA provided all of the assessed medical services, with the exception of forensic examinations. In addition to these services, the health facility also provided hygiene and dignity kits to survivors of sexual violence. Furthermore, the PHC provided psychosocial and protection services to survivors, with the exception of a MHGAP, case management, psychiatric care, socio-economic empowerment, shelter/safe house, and legal counselling. Survivors were linked to the IDP camp clinic mentioned above for all of these services except legal counselling with no referral point mentioned for this service. Additionally, HIV services were available to survivors, although PEP for children was offered as a referral service to MSF. The PHC provided a range of SRHR services, excluding safe abortion and comprehensive emergency obstetric neonatal care. Survivors were linked to another service provider for safe abortion services permissible under Nigerian law. PAC services were available to survivors, although these were limited to counselling, medication (misoprostol), and MVA services.

The IDP camp clinic in Gwoza LGA provided all of the assessed medical services to sexual violence survivors except for vaccination services. Clients were referred to a PHC for immunisations. Although facility staff were trained to provide forensic examination, this service was not utilised by survivors due to fear of reporting to the police. In addition, the clinic provided psychosocial care and protection services to survivors, with the exception of psychiatric care, in which case survivors were referred to MSF and IOM. Shelter/safe house services were also not provided but survivors were referred to IOM. Furthermore, legal counselling, provided by the NHRC and the IRC Protection and Rule of Law team, was also provided as a referral service. Lastly, the clinic did not have a MHGAP with no indication for referrals. Similarly, protection services were provided as a referral service by MOWA and NHRC. The clinic provided HIV services, limited to weekdays. At other times, survivors could go to MSF for HIV-related services. The clinic also provided PEP for adults only. PEP for children was offered as a referral service to MSF. The clinic provided a range of SRHR services. However, it did not provide safe abortion or comprehensive emergency obstetric and neonatal care. Access to safe abortion was limited by law, a constraint raised by health workers in providing this service, but there was no highlighted reason why other services were not available to survivors. Lastly, the clinic provided PAC services to survivors, including medication and MVA, although the former was most preferred by clients citing privacy, shyness, and client perception of pain attached to surgical procedures.

Table 3: Health services surveyed in the health facility assessment (HFA)

● Available ● Referral ● Not observed ○ Not applicable

LGA	Jere		Damboa		Gwoza	
Health Facility	Sexual violence centre	PHC	IDP camp clinic	PHC	IDP camp clinic	PHC
Medical services						
Medical care	●	●	●	●	●	●
HIV and PEP services	●	●	●	●	●	●
STI treatment/prophylaxis	●	●	●	●	●	●
Vaccination	●	●	●	●	●	●
Emergency contraception	●	●	●	●	●	●
Forensic examination	●	●	●	●	●	●
Counselling	●	●	●	●	●	●
Psychosocial first aid	●	●	●	●	●	●
Psychosocial and protection services						
Psychological first aid	●	●	●	●	●	●
Problem management	●	●	●	●	●	●
Mental health gap action programme (MHGAP)	●	●	●	●	●	●
Basic emotional support	●	●	●	●	●	●
Case management	●	●	●	●	●	●
Psychosocial support	●	●	●	●	●	●
Psychiatric care	●	●	●	●	●	●
Socio-economic empowerment	●	●	●	●	●	●
Shelter/safe house	●	●	●	●	●	●
Legal counselling	●	●	●	●	●	●
Group activities	●	●	●	●	●	●
HIV Services						
HIV counselling	●	●	●	●	●	●
HIV testing	●	●	●	●	●	●
PEP drugs	●	●	●	●	●	●
PEP for children	●	●	●	●	●	●
SRHR services						
Contraception	●	●	●	●	●	●
SRHR counselling	●	●	●	●	●	●
HIV	●	●	●	●	●	●
STI	●	●	●	●	●	●
Safe abortion	●	●	●	●	●	●
Post abortion care	●	●	●	●	●	●
Ante-natal care	●	●	●	●	●	●
Postnatal care	●	●	●	●	●	●

Basic emergency obstetric and Neonatal Care	●	●	●	●	●	●
Comprehensive Emergency and Obstetric and Neonatal Care	●	●	●	●	●	●
Adolescent SRHR	●	●	●	●	●	●
Mobile outreach for SRHR to-hard-to reach populations	●	●	●	●	●	●
Post abortion care (PAC) services						
Post abortion counselling	●	●	●	●	●	●
PAC with medication (Misoprostol)	●	●	○	●	●	●
PAC with MVA	●	●	○	●	○	●
PAC with Dilation and Curettage	○	○	○	○	○	○
PAC with Dilation and Evacuation	○	○	○	○	○	○
PAC with other methods	○	○	○	○	○	○

An important element to note was the availability of referral mechanisms among facilities to support survivors. PAC services were limited to counselling, PAC with medication, and MVA with no indication of what happened if a survivor required other options. Psychosocial and protection services were equally lacking with shelter/safe house and socio-economic empowerment provided by only one facility while services like psychiatric care, MHGAP, and legal counselling provided by only two facilities. However, there were established referrals for services not provided at each facility.

Only four facilities had service data on sexual violence service uptake for the past six months. Within this cohort, forensic services were provided at only the sexual violence centre in Jere LGA while only two facilities provided police services. Generally, boys and men of all ages had not been provided sexual violence services, including boys or men with disabilities, except at the sexual violence centre in Jere LGA. Additionally, only two facilities (the sexual violence centre in Jere LGA and the IDP camp clinic in Gwoza LGA had provided services to girls less than 15 years of age. Of the four facilities with data, three facilities had provided data on survivors with disabilities although this was limited to female survivors except for the sexual violence centre in Jere LGA (see annex 2 for details).

With the exception of the IDP camp clinic in Damboa LGA, all six healthcare facilities had access to clean water for functional purposes. When it came to electricity, the PHC in Gwoza LGA and the PHC in Damboa LGA had regular power. The IDP camp clinic in Gwoza LGA only had power in certain rooms while the IDP camp clinic in Damboa LGA only had power during working hours. Due to the absence of power in Maiduguri during the period of data collection, the PHC in Jere LGA had power for only two to three hours with staff working the rest of the day without electricity. The generator was not functioning so electricity supply was reliant on solar power. Staff at the sexual violence centre in Jere LGA indicated that it had 24 hours access to power.

Researchers also conducted inventory of supplies in the space where sexual violence services were provided, noting items such as medical instruments, healthcare supplies, and medication options. Supplies like examination gloves, sharps containers, swabs, sanitary towels were widely available across all facilities at the time of the assessment. However, none of the facilities had HIV rapid test kits at the time of the assessment, the common reason being stockouts. Only three facilities had consent forms, PEP drugs, misoprostol, and hepatitis B/Tetanus vaccine (see Annex 1 for details). Only one facility (the IDP camp clinic in Gwoza LGA) had a lockable cupboard for forensic/medical legal evidence. Other least-stocked items included tranquilisers, special aids for examining children, consent forms, emergency clothes, blood tubes, and specula.

A.1 Medical Services

In Gwoza, the PHC provided a certain level of health services to survivors[22] while linking them to other facilities run by IRC and MSF. IRC linked survivors with medical service providers, including its own reproductive health team which provided medical services including ANC, PAC, and dignity kits for survivors. A woman from an IDP camp in Gwoza, when asked what survivors of sexual violence should do, said survivors could approach 'Rescue' (IRC) for treatment and referral to General Hospital if their case was complicated. MSF also provided medical support and MHPSS and was available on the weekends for PEP provision and pregnancy prevention, according to a service provider in Gwoza.

Meanwhile, women in a focus group discussion for women aged 25 years and above in a Damboa IDP camp said that the 'centre' (the women's centre in the IDP camp) and the NHRC could help with getting medical assistance with the NHRC following up to find the perpetrator in addition. A (male) local government official, interviewed in Damboa, also shared that IMC treated survivors' injuries and conducted follow up. He explained that only some health workers were trained on GBV whereas others only conducted 'light counselling'. The HFA showed that providers at the PHC (both medical and non-medical) had never received specialised training on clinical care for sexual violence survivors with no reason provided as to why these trainings had never been conducted. On the contrary, both medical and non-medical providers at the IDP camp clinic had received specialised training on clinical care for sexual violence survivors. According to the HFA, medical services were provided by the IDP camp clinic but only (emergency) 'medical care' was provided by the PHC.

22. As per a local government official in Gwoza, the PHC worked with Action Health Incorporated (AHI) to provide maternity kits and supportive kits to anyone coming from the bush, including young children. Although many of this group have been subjected to sexual violence, this support was not limited to survivors.

A.2 Counselling and Case Management

Social workers, who undertook case management, were present in almost all LGAs, as explained by a (female) state government official, interviewed in Maiduguri. She went on to say that the Child Development, Social Welfare and Women's Affairs departments worked together within the MOWA to respond to GBV. By partnering with NGOs, case workers were available in the LGA, community and the IDP camp and cases including those of mediation, abuse or child neglect were reported.

At the state level, there were some organisations and interventions working across multiple LGAs. There was a hotline that survivors could access that provided telephone counselling and referred them to services in their locality. A (male) GBV service provider, interviewed in Jere, explained that they had a hotline number, however it was not toll-free and having one number meant that access was limited. If more numbers were to be organised and calls made free for the caller, this could increase access and assure clients a more timely response. However, there was a state-wide toll free line in existence. According to a woman working for an INGO that supports GBV survivors, interviewed in Maiduguri, remote case management had improved accessibility as clients could call via toll-free lines instead of waiting for face-to-face access for help. Case workers received calls and referred clients to services in their localities as needed for livelihood, clinical management of rape and legal redress. This reporting system had been established with the Ministry of Health with Jere N3alewa SARC. She shared that clients could access information about service points at different locations but increased awareness about hotlines was needed in the form of messaging to communities that it was free, and that the survivors could not be traced. Further, according to a woman working for a Borno- based NGO on state level protection coordination, provision of safe spaces in communities where calls can be made would be helpful.

In Jere, psychosocial and support (PSS) services were provided by the MOWA with social workers often the first point of contact for the survivor. According to the HFA, both facilities surveyed in Jere provided few psychosocial and protection services. In Gwoza, case management was only done by IRC and UNICEF while GISCOR and Mercy Corps identified cases, gave referrals and conducted follow ups, according to participants. The IDP camp clinic in Gwoza LGA provided PSS, conducted case management, and provided referrals. It was accessible during the working day, according to a participant in Gwoza and confirmed by the HFA, which also found that this camp clinic provided psychosocial and protection services for clients referred by others. Meanwhile, the PHC in Gwoza LGA provided referral for all psychosocial and protection services. According to a (female) GBV service provider, the GBV response division at IRC provided

counselling, PSS through a social worker, and did case management. MDM also provided mental health and psychosocial and support services (MHPSS) services. A (male) local government official, interviewed in Damboa, shared that they would refer survivors to NGOs for PSS.

A.3 Food, Shelter and Livelihoods

In Maiduguri, there was a need to increase livelihood programs as these were not active in all locations or had limited funding, as explained by a (female) state government official, interviewed in Maiduguri. Holistic interventions were needed where survivors would be able to register and gain the relevant skills needed to run a business (including accounts etc) which went beyond soap and cap making, as elaborated on by a woman working for an INGO that supports GBV survivors, interviewed in Maiduguri. Survivors were concerned in meeting their basic needs such as food and shelter, and according to a (female) GBV service provider, interviewed in Gwoza, were not as concerned with their own health. She emphasised that every client/survivor had different needs and that while some needed counselling, others needed basic necessities such as food.

Zooming in on the three locations, the findings indicate that, in Gwoza, IMC was the only organisation providing food support via the World Food Programme (WFP) food rations to IDPs while Mercy Corps was supporting host communities. However, the provision of food was limited to those persons registered in that specific camp. On the other hand, a woman from Gwoza indicated that IRC was also giving food (including clothes and, if pregnant, delivery kits and soap). The IOM would offer support for shelter, however, according to a woman working for an INGO that supports GBV survivors, interviewed in Damboa, it was important for survivors to emphasise the skills they had to be able to sustain a livelihood, as the service was unable to provide food. With regards to livelihood support, this was done through provision of capital or materials, along with skills development by Mercy Corps, IMC, IOM,[23] and Norwegian Church Aid (NCA). A (female) GBV service provider, interviewed in Gwoza, emphasised the importance of consistent interventions. Knitting caps was a common livelihood support intervention as per the findings by NGOs and other participants alike. In Gwoza, a 25 year old survivor, interviewed in the host community, also shared that the staff of the IDP camp clinic were conducting weekly sessions to discuss body hygiene, livelihood support, and other topics which she attended regularly. Tailoring was another economic empowerment activity being provided by them and they also carried out village saving and loan activities (VSLAs) to tackle the incidence of GBV. In Damboa, IMC was appreciated for their support to income-generating activities such as tailoring and selling snacks.

23. IOM was the only organisation mentioned as providing financial capital for livelihoods. A survivor from Gwoza shared that IOM provided 45,000 Naira to support businesses.

The HFA indicated that socio-economic empowerment services were only provided by the IDP camp clinic in Gwoza LGA and that shelter/safe houses were not provided by any of the surveyed facilities and were mostly referred for. There also existed a shelter funded by the UNFPA in Maiduguri, but survivors could usually stay there only for a week. Lastly, a (female) state government official, interviewed in Maiduguri shared that there was a children's home for abandoned children which also housed child survivors there until their case was resolved. The findings indicate that there were no specific shelters/safe houses for survivors but that survivors could be referred to shelter providers e.g. in IDP camps – to varying effect with some survivors provided shelter (but not always protected from perpetrators) while others were not.

A.4 Legal Services

According to a woman working for an INGO that supports GBV survivors, interviewed in Maiduguri, *"Legal services are present but are not really accessible"* (speaking in English) because their 'rigid' (bureaucracy and formality) nature made them more inaccessible to survivors. Moreover, legal services were not frequently provided by the surveyed health facilities. Additional information about this is also addressed in the next section. However, across all locations, NHRC, often referred to as 'human rights' by survivors, was where they went for advice. A (female) GBV service provider, interviewed in Jere, explained that the NHRC worked in all LGAs (except Hawul, Kwaya Kusar and Shani) and partnered with UNDP to conduct community human rights monitoring. The MOWA would also follow up on cases from the police station to address the needs of survivors, including children associated with armed forces and armed groups (CAAFAG) and other children rescued by the military. As explained by the (female) state government official, interviewed in Maiduguri, : *"We partner with almost all the NGOs and there are case workers everywhere in the community, IDP camp, LGA etc. When there are cases of sexual violence, people report to us especially for cases that require mediation, child neglect and child abuse in the family and for survivors who need legal services. They refer to us as NGOs cannot go to the police station and to court so the MOWA follows up cases from police station to CID [criminal investigation department of the police] to court so the survivor receives what she needs. For mediation, we sit down with survivors and families, sensitise communities, trace families of survivors and CAAFAG and children rescued by the military – we do family tracing and reunification"* (speaking in English).

In Jere, legal counselling was provided by the sexual violence centre and other facilities provided referrals. The International Federation of Women Lawyers (FIDA) also had a one stop centre for legal services in Maiduguri (also covering Jere LGA), which was mentioned by several participants. However, according to a (female) GBV service provider, interviewed in Jere, police officers were not

skilled enough to communicate well with survivors. The British Council had set up gender desks to train police officers from all divisional units but, due to staff changes, teams had to be re-trained.

In Gwoza, a (male) local government official mentioned that most survivors were not keen on going to the police station due to the risk of exposure and related stigma. When asked about criminal justice processes available, a (female) GBV service provider, interviewed in Gwoza, shared that the NHRC and IRC protection and rule of law team worked on criminal justice processes. In addition, she mentioned that the National Bar Association (NBA) also visited at times. According to a woman working for an INGO that supports GBV survivors, interviewed in Gwoza, if survivors could identify the name of the perpetrator and location, the police were more likely to offer concrete support. According to her, there were particular challenges when survivors do not know the names of soldiers who perpetrate sexual violence against them. However, when survivors had been able to identify the military personnel concerned, the commander had forced them to pay 15,000 naira from their salary to take care of any resulting babies and these soldiers would be deployed to the bush.

In Damboa, a woman working for an INGO that supports GBV survivors, interviewed in Damboa, said that all other services were working well and there was an effective referral system but legal services were a major challenge. She said that it was not always possible to go to Maiduguri as the road from Damboa was not safe and that if there was a difficult case or when the survivor did not wish to go to the NHRC, the survivor was given the option to go to the District Head who would mediate the issue. Protection partners had pushed for LGA courts but these were not functional yet.

A man working for a Borno-based NGO that supports GBV survivors, interviewed in Damboa, explained that UNHCR protection and UNDP stabilisation support supported communities to identify and follow up cases of sexual violence, particularly once a referral was made. They said that, although fear of the perpetrator and lack of willingness of survivors to report were key constraints, provision of services and sensitisation by humanitarian actors meant that people were now more likely to report.

However, resources were focused increasingly towards counselling and livelihoods, as opposed to legal services. This prioritisation was in response to survivor demand for one set of services and lack of interest and uptake for the other. Lastly, a survivor-centred approach for legal services as defined by the United Nations was not always prioritised by the respective service providers with key gaps identified by participants, particularly when it came to the military, police, and judicial system. Moreover, there were other barriers to ensuring

prosecutions that were not being addressed by GBV actors. For example, for medical evidence to be admissible in sexual violence trials, a medical examination needs to have been done in a medical facility with a doctor signing the report. This effectively excludes survivors who access most health facilities from bringing cases because most PHCs – even in Maiduguri – do not have doctors and many clinics are run by INGOs and so not government facilities.

A.5 Specific Services for Abductees

The Bulumkutu Rehabilitation and Transit Centre provided specific services for abductees. It was run by MOWA as a place for survivors abducted from AOGs to be assisted. According to a (female) state government official, interviewed in Maiduguri, these women stayed for a month to up to a year and received counselling from the military, after which their families were traced in order to facilitate their community reintegration. Over time, those exiting Operation Safe Corridor came to transit through this centre also. All people in the centre were housed within one compound, with a fence in between the men on the one side and women and children on the other side. There were security personnel present but they were "not the best." According to the (female) state government official, interviewed in Maiduguri, the Bulumktu Rehabilitation and Transit Centre was initially focused on training people with disabilities, however this had been stopped due to the conflict. They indicated that there would be advocacy done towards the government to provide another space for disabled persons to get access to livelihood training.

A.6 Community-based Structures and Individual Support

There were no concrete and independent community structures for supporting survivors who relied mostly on NGOs such as IRC, MSF and IMC. According to a 19 year old survivor, interviewed in a Damboa IDP camp, no one in the community was doing prevention work. As explained by a participant in a focus group discussion for women aged 18-24 years old in a Gwoza IDP camp, "*The people in the community who are doing sensitisation are linked to NGOs. They are not people from the community but NGOs workers – unknown people, we do not know them*" (translated from Hausa).

Some community members especially women also came together to support survivors. Some of them provided help in accessing services while others supported in fetching water, cooking, and engaging in other tasks. In addition, they helped survivors go to the hospital. According to participants in a focus group discussion for women aged 18 to 24 years old in a Damboa host community, aside from seeking help from family, in cases of early marriage or any other violence, sources of support were community leaders or older women

in their community. According to a woman working for a Borno-based NGO on state level protection coordination, community-based mechanisms worked well to facilitate identification of survivors and referrals for food, livelihood, health and legal services. However, as mentioned earlier, this support could be dependent on the number of times a woman had reported sexual violence. There could be a perception that women who reported sexual violence more than once had consented to sex and were trying to cover up this fact. In Damboa LGA, if a woman explained she had had transactional sex due to lack of livelihoods and financial support, women in the community, supported by a NGO, could support her to establish sustainable livelihoods to address one of the root causes of this violence. A 25 year old woman, interviewed in a Damboa IDP camp, explained this process: *"When the woman admits it is because of food or clothes, there is an organisation called 'centre' in the camp, the women take her there and if you know how to make caps or sew, they give you all the materials to make caps or clothes. When you sell it, you bring back money which they put for you as adashe (saving and loans scheme) and you keep the profit"* (interviewed in Hausa).

Efforts by Women Leaders

"What would encourage survivors to seek help is if a women leader or community leader knows about it and connects her to an organisation that helps her. It is easy to report to the bulama or woman leader as there is a woman assigned in the community that if sexual violence happens, we should report to her and she will take it to the bulama or woman leader. Some organisations came together with people in the community to give this woman the position – handles GBV cases and if you don't have food or shelter or if you come to the community newly, you can meet her and she will link you. She is the women leader, selected by the people of the community to handle any issues like GBV, girls who got pregnant out of wedlock to be taken to the hospital, anyone with complaints goes to her." - 25 year old woman, interviewed in a Damboa IDP camp (translated from Hausa)

Key members of the community, to some extent, also act to mitigate and prevent sexual violence. Participants in a focus group discussion for women aged 25 years and above in a Damboa IDP camp described how two women leaders were trying to make the camp safer for young women especially while walking to the toilets in the night. They explained that the bulama focused more on peace than sexual violence but would act if a case of sexual violence was reported. In multiple locations, women leaders gathered community members to do anti-stigma work and they as well as the LGA chairman, camp leaders, and designated community leaders (bulama, lawan, haikimi) sensitised communities about GBV. Another

community-based mechanism initiated was of 'women protectors' that included aunties (older women in the community) against GBV. These women were part of a security-community relations committee which also included the police, military, and CJTF (as well as people with disabilities) run by GEPADC (Gender Equality, Peace and Development Centre) and supported by Global Affairs Canada.

Designated leaders could also be the voice of the community in stopping violence. For example, in one location (identifying details withheld), soldiers used to forcefully enter people's homes and rape women and girls but people had no recourse due to fear, inability to speak directly with senior military officials, and since local government officials and community leaders had fled. After his return, members of the community raised this issue with the designated community leader who then spoke with the military commander. While the incidence of such sexual violence since fell within the town, what happened outside in rural areas was unknown and there was some concern that soldiers had moved to sexually exploiting women in these areas. In fact, a participant in this location shared that since communities relied heavily on INGOs, withdrawal of their services had adversely increased transactional sex between women in the community and the soldiers. However, there tended to be few community members or specific mechanisms supporting sensitisation, prevention work or anti-stigma work according to participants in all three research locations.

Efforts to reduce GBV in the IDP camp

"NGOs are sensitising, so [SGBV] has drastically reduced now. Before, they would come and open your room at night and rape you…or people would corner you in the toilet. I have been in the camp for almost 6 years and it was when we came newly that this was happening but it has not been happening for a while. The LGA chairman and leaders in community and IDP camps would gather people in the community and tell them about these things – and say that if any man comes to rape you, you should shout and they will come and take the man to the police station. This happened and it reduced." – 25 year old woman, interviewed in a Damboa IDP camp (translated from Hausa)

Moreover, according to a woman working for an INGO that supports GBV survivors, interviewed in Maiduguri, it was important to build community mechanisms where key leaders were able to address and resolve cases without bias, with awareness raising playing a key role to enable this to happen. For example, a (male) local government official interviewed in Damboa, shared that if they had survivors coming forward, they would report this to the police or the

chairmen of camps. It was not clear if he considered the consent of the survivor in this decision and he was unaware if there was anyone in the community that helped survivors and did not know if there was anyone working on prevention.

A.7 Anti-stigma Work and Awareness-raising Activities

Survivors were greatly stigmatised by community members. Stigma was the most commonly identified consequence of sexual violence as well as the most significant barrier to reporting identified by participants. Awareness raising was a key strategy used to do anti-stigma work by civil society and government agencies. A state government official described how the MOWA was involved in conducting sensitisation via radio and in the community to reduce stigma. MOWA officials and social workers discussed stigmatisation with parents, caregivers, religious and designated community leaders. As social workers and service personnel working on case management were trained, stigmatisation had reportedly reduced to some extent as a result of their work. As per women survivors interviewed Gwoza, the IRC Protection Committee, together with other NGOs, sensitised the community to stop speaking about and stigmatising survivors who had been abducted and forcibly married or sexually enslaved. This reduced the kunya felt by survivors to seek help and hence they were more confident.

While anti-stigma work was primarily mentioned by a participant at the state level, and those from Gwoza, there was other awareness-raising work on GBV mentioned by those from Damboa. According to a 19 year old woman survivor, interviewed in a Damboa IDP camp, IMC did sensitisation work to reduce stigmatisation against woman and girls who been abducted by AOGs and forcible. They gathered women and men under the tree and informed them how to access services. According to her, these organisations told people to 'stop spoiling people's children'. They informed them that whenever a case occurred, it was important to collect injections and drugs from "demonde" (referring to MDM). According to a (female) GBV service provider, NHRC did radio programmes every Tuesday and Thursday to campaign against GBV. The HFA also found that community liaison officers and social workers attached to the Jere sexual violence centre and IDP camp clinic in Gwoza LGA worked closely with community leaders and religious leaders to conduct community engagement on sexual violence.

Women who were abducted and returned from the bush had been particularly stigmatised in the past but, as a result of focused anti-stigma work, this stigma had changed. As explained by a 45 year old woman survivor, interviewed in Jere: *"They [International Alert] also did a drama showing us how things should be done. They gave the example of two women whose daughters were abducted by [an AOG] and a man whose son impregnated a daughter who was able to escape and come*

home. One mother rejected the daughter for being pregnant for [the AOG] while the other accepted [her] as [she] said it was an increment to her family and [was] calling people to celebrate that she has a new baby in the house. The other mother, seeing this, then decided to accept her daughter back" (translated from Hausa).

There was also an increase in awareness of marital rape due to increasing sensitisation from partners. As explained by the participant from an NGO in Damboa, many reported cases were of intimate partner violence which included denial of resources, emotional abuse, and physical assault. In Damboa, according to a (female) GBV service provider, there were awareness sessions for adolescent girls to discuss GBV, after which many went on to report what had happened to them. Although the exact names of organisations were often unknown to community members, 'organisations from outside', alongside women leaders and bulamas were raising awareness about rape and other forms of GBV. Volunteers were trained by IMC on sexual exploitation and assault so they could sensitise the community, as per a woman working for an INGO that supports GBV survivors, interviewed in Damboa. The Protection Sector Working Group (PSWG) was also integrating stigma reduction in their work. However, in Gwoza LGA, the research team found that outreach had not been very successful with staff not trained well for raising awareness and not giving complete and accurate information. Moreover, in all research locations, often not all types of sexual violence were being addressed during sensitisation.

Additional work on raising awareness was also done in Gwoza. IRC carried out sensitisation on the importance of reporting within the first 72 hours (after assault) to prevent STDs and pregnancies and provided assurances of trust and privacy while reporting. Moreover, IRC also provided information on the importance of school for children, early and forced marriage, rape and violence. They informed the parents that they should not allow their children, especially girls, to go out at night if it was not necessary as they could be raped. A woman working for an INGO that supports GBV survivors, interviewed in Gwoza shared that IRC also focused on advocacy for service provision and conducted safety audits to understand the risks women and girls face.

A.8 Establishing 'Safe' Spaces

Other interventions such as women-friendly spaces in host and IDP communities were implemented by IRC in Gwoza LGA. Due to the rainy season however, these were closed, but were usually full during the dry season where awareness raising and different activities were conducted. In Maiduguri, IMC also had a safe space established. GEPADC has been running eight women-friendly spaces, child-friendly spaces, and transitional learning spaces. These spaces had women coming from the camp to have a one-on-one session with case workers. In addition, the transitional learning spaces were spaces for children on the

street to be educated and the child help desks invited any child for counselling or to discuss any problems with trained staff. A (female) GBV service provider, interviewed in Damboa, also spoke about IMC doing skill building in a safe space in the past.

Feeling comfortable with other women in the 'safe space' and having confidentiality were considered important. For instance, a woman working for an INGO that supports GBV survivors, interviewed in Damboa, shared that survivors were uncomfortable speaking with them if they saw others waiting for the services. However, organisational mandates and scope of work did not often align with community needs to solve such issues. Moreover, as per a woman working for an INGO that supports GBV survivors, interviewed in Maiduguri, there were not enough safe spaces and size affected accessibility. This was illustrated by a (female) GBV service provider, interviewed in Damboa, who worked in the IDP camp clinic there which was surveyed by the HFA: *"[The] survivor said she is not comfortable talking as [she] sees someone she knows [is] waiting for medical services. Our supervisors asked us to draft a TOR and we included a safe space [in it] but were told that [we are] a medical organisation so not possible to provide a safe space"* (speaking in English). According to the HFA, other facilities had dedicated spaces for counselling sexual violence survivors and were not subjected to waiting at the reception.

A.9 Prevention

There was very little evidence-based work being done to address forms of sexual violence. For example, while efforts to combat early and forced marriage had been somewhat successful in some areas, major gaps remained when it came to prevention of most other sexual violence. Peer-to-peer and family-based approaches such as those engaging age-mates in educational facilities (including Islamiyya schools), men sitting in majalisa, or working through groups of mothers, aunties, or grandmothers saw particular gaps. Beyond meetings with community leaders, men in particular were not always well-engaged on GBV issues. However, as said by a woman working for an INGO that supports GBV survivors, interviewed in Maiduguri, "men need to know it is wrong to rape a girl" (speaking in English). This was also emphasised by GBV service providers in all locations who discussed their work on informing men what actions they take in case of an incident and, according to woman working for an INGO that supports GBV survivors, interviewed in Damboa, there was a need to "sit with men and integrate women's voices into communications and interactions with men so they know harmful behaviours and change behaviour in household" (speaking in English).

B. Challenges in Service Provision and Use

B.1 Availability of Services

As per the previous sections, while there were a variety of services available (though referral) both according to the qualitative data as well as the health facility assessment, there was a lack of legal services. Service providers and key informants, along with users of services gave more in-depth insight and how they experienced the availability of services. As per a (female) GBV service provider in Jere, there was a lack of certain services such as obstetric scans. In Damboa, a (female) GBV service provider outlined the lack of equipment or capacity particularly for secondary healthcare which was missing in some health facilities. Lastly, a (male) GBV service provider from Jere explained the lack of DNA facilities which restricted paternity tests in the cases of rape.

The target group also seemed to influence the availability of and access to services. For example, the research team observed that more outreach and sensitisation was done in the IDP camp compared to host communities in Damboa LGA. The availability and provision of certain services at certain hours was also influenced by the provider. A key international NGO in Damboa was reportedly phasing out services according to various participants due to lack of funding so had limited service provision. For example, only women's first deliveries were being assisted and services were only available during the day. Further, abortions, provided in alignment with Nigerian law, had stopped and hence service providers noted an increase in levels of unsafe abortions. Moreover, there were no organisations providing services at night.

The changing security situation further complicated matters. A woman working for an INGO that supports GBV survivors, interviewed in Gwoza, shared that the adverse security situation, especially in camps which can be targeted for attack, prevented them from operating. Insecurity was a problem that adversely affected service provision particularly in Damasak, Dikwa, and Rann as per a woman working for an INGO that supports GBV survivors, interviewed in Maiduguri. Recently in Damasak, there had been several GBV cases but few actors and high insecurity. According to her: "When (there is an) increase in insecurity, (there is a) reduction in GBV services. We see local actors still present but humanitarian actors withdrawing key staff who really do the work which brings a gap in services. Often, places do not have one stop centre where you can go and make a call to services on the ground" (speaking in English). Conversely, there were areas of the state like Maiduguri Metropolitan Council (MMC) (which had a one stop centre), Monguno (where organisations provided livelihood and case management referrals) and Pulka, where services were more available and accessible. The HFA found that health facilities including the PHC in

Jere LGA and the IDP camp clinic in Gwoza LGA had adjusted operational hours from 24 hours to daytime only, citing security issues.

Moreover, the availability of services in the state, according to a woman working for an INGO that supports GBV survivors, interviewed in Maiduguri, was not considered to be consistent, and lacking in some areas, due to which persons had been discouraged to access services. This was particularly relevant for adolescents who were considered most vulnerable to GBV and had difficulties accessing them.

B.2 Accessibility of Services

The security situation affected the availability and accessibility of services. This was compounded by already limited visits to hard-to-reach areas. Although MDM, ICRC and UNICEF were active in research locations, in some hard-to-reach areas there was lack of accessibility, either due to illegal checkpoints controlled by AOGs or due to limited visits by health providers to those areas. This was illustrated by a man working for a Borno-based NGO that supports GBV survivors, interviewed in Damboa, who shared that, *"IMC and IOM are providing counselling services [but]there are some issues. In hard to reach areas, a case that will take a week takes only a day in Maiduguri. One of their psychiatric doctors used to come to Damboa once a month to consult on cases referred but [I have] not seen him throughout 2021."*

Other challenges around accessibility and hence quality were those related to infrastructure. A (male) GBV service provider working in the sexual violence centre in Jere LGA flagged that clients had to speak quietly in the counselling room if they did not want to be heard by others and that passing through the waiting room to go there meant one would not have anonymity and privacy. This was further complicated by a telephone counselling intervention implemented by another organisation which limited the space available to deliver services. The building in which this centre was housed was also said to not have been not designed appropriately. However, it is crucial to interpret this finding keeping in mind that this centre in Jere LGA was one of the most resourced and comprehensive service providers to survivors of sexual violence in the state.

Problems with electricity also disrupted provision of health services according to a (female) GBV service provider in the IDP camp clinic in Gwoza LGA. Shortly before data collection, AOGs had cut power lines, meaning people were reliant on solar power (not widely used) or generators (expensive). As per the research team's observation, this led to services in the counselling room being provided by torchlight and electricity was limited only to the staff room. Moreover, equipment was split up in a disorderly fashion between different rooms. Moreover, as per a (male) local government official in Gwoza, the local government also did not have

enough funds for tertiary service provision which led to stockouts for essential medicines. According to the HFA, stockout of supplies was marked as a reason for not offering onsite HIV testing services and PEP at the PHC in Jere LGA and the IDP camp clinic in Damboa LGA.

Alongside stockouts, lack of income was another barrier. Similarly, budget issues were cited during the HFA at the IDP camp clinic in Gwoza LGA as the reason why certain services were not available to survivors. The consequences of stockouts and cost as a barrier were illustrated by a testimony from a 19 year old woman survivor, interviewed in a Damboa IDP camp, who shared that, *"I don't have shelter. I was having chest pain and vomiting blood and they did not give medicine for this. They said I should go and buy it at the chemist but I was not having money so could not afford it. Before I was raped, I did not have chest pains and [was not] vomiting blood, but [this] started after the rape. When I complained [of these ailments, I was told] the medicine was out of stock so I should go to the chemist to get it"* (translated from Hausa).

In light of making services accessible, an international NGO had conducted a mapping of services through which they could provide clients different options, however the limited spread of services still meant that some had to pay or walk long distances as explained by a Maiduguri-based participant from this organisation. In Gwoza, services delivered by MSF and IRC were free with the only out-of-pocket expense for clients being transportation. However, according to a 20 year old woman, interviewed in a Gwoza IDP camp, this meant an hour-long walk or N100 by transport, with services available for 24 hours. However due to the increasingly limited services provided due to the drawdown of a key service provider, there was a gap. Lastly, the lack of certain services meant clients had to pay for that service at a referred facility. As per a (male) GBV service provider in Jere, the hospital could arrange for cost concessions to clients coming from their facility but uptake of referral was limited and the high turnover among decision-making staff such as the Commissioner of Health or hospital management board had slowed this process.

Since there was considerable stigma around sexual violence, it was important to maintain confidentiality and let community members know about that this would be guaranteed when using the services. While a few participants spoke of lack of privacy, a 19 year old woman survivor, interviewed in a Damboa IDP camp, shared that she had had a positive experience with the clinic she accessed. She appreciated the staff and outlined that although she had to wait in a queue for six hours, she got free medical treatment and did not need transportation due to the proximity of the service to her house.

IMC was catering to camps while Mercy Corps was catering to host communities in Damboa. Obstacles including inability to register for general food distribution,

few livelihood activities, and inconsistent food distribution also compromised accessibility of services. This is further elaborated on sub section B.5 which discusses integration of services with the humanitarian system. Inadequate information and awareness among caseworkers about legal services, meant there was not enough sensitisation on the services, due to which access was affected adversely.

Experience accessing services

"The challenges of accessing the clinic, sometimes there are challenges and sometimes there are not. Sometimes, you have to follow a queue before accessing services. I had to wait a long time – I went there by 7am and had to wait until 1pm to be seen [but] I did not have to pay to access treatment, medication or transportation as it is very close to the house. The staff there are very nice people: there are no problems and they will even give you good medication. There was privacy there." – 19 year old woman survivor, interviewed in a Damboa IDP camp (translated from Hausa)

"People are trying their best to be disability inclusive but sometimes if you work with community leaders… [they] are too corrupt and only want distribution for themselves and their families so will not point and show who are the people with disabilities [in their communities]. Very few of them are open and honest to support such people. This is the reason why humanitarian actors go to certain communities to do registration – but there are some PWDs who cannot even leave their house let alone go to the sensitisation area. It depends on others showing them their houses before humanitarians can access them." – woman working for an INGO that supports GBV survivors, interviewed in Gwoza (speaking in English)

Moreover, women with disabilities experienced marked challenges accessing health services, as outlined by a woman working for an INGO that supports GBV survivors, interviewed in Gwoza. This intersected with poverty and their inability to, for instance, pay for transport and hold the right documentation for access to resources. They elaborated that corruption among community leaders meant additional resources for people with disabilities were diverted for their own purposes instead. In addition, facilities had minimal explicit accessibility considerations (physical and communication) for them.

B.3 Fear of Reporting

Fear of the perpetrator and willingness of the survivor to report were important factors in uptake of services. This was elaborated on in 3.1 D.1. However, people were more likely to report if humanitarian agencies provided services

and sensitisation. In fact, as per a (female) GBV service provider, interviewed in Damboa, initially community members were not on-board with discussions about sexual violence but now due to increased sensitisation, there has been a change and an increase in reporting cases.

Fear of reporting - service providers share their experience

"There is pressure from the community to drop cases of SGBV and we tell them it won't work. [We ask] where were you when it was happening and what steps did you take to stop it happening? We don't compromise." – (female) GBV service provider, interviewed in Jere (speaking in English)

"Persons of concerns are not willing to speak up and lay their complaints thinking that when they say it, I was raped, I would be scared of coming to the protection desk and saying what has happened to me as the perpetrator may threaten in case I say anything.....Also, they will think, why will I open up for the community to know I was raped - so there is an issue of silence." – man working for a Borno-based NGO that supports GBV survivors, interviewed in Damboa (speaking in English)

B.4 Capacity and Attitudes of Service Providers

Help seeking behaviour was encouraged when high quality services were provided and service providers were capacitated and treated survivors well (as mentioned in sub-section 3.1)When participants were asked about survivors seeking help, participants in a focus group discussion for women aged 18 to 24 years held in a Gwoza host community shared experiences which were seemingly were not only about survivors but about women generally seeking help. These alluded to the lack of prompt attention given to patients that were in a critical condition and taking women's conditions seriously. However, a participant in this focus group also praised the helpful attitude of staff at IRC and MSF providing services. She explained that, *"Staff are very polite and have good human relations – do not have any problem with how they attend to people"* (translated from Hausa).

According to a (male) GBV service provider, interviewed in Jere, the communication skills of police with survivors was of poor quality which had led the British Council to intervene and provide training. A woman working for a Borno-based NGO on state level protection coordination drew attention to the language barriers experienced by service providers when interacting with INGOs and flagged INGO's technical style of communication which consisted of jargon. Due to limited services available, there were tensions as agencies wanted to provide what they could but this did not always align with what the survivor

wanted. The participant went on to explain that, in this context, national NGOs were much more effective, understood the concerns of survivors, and would not have a large communication gap. However, a (female) GBV service provider interviewed in Gwoza provided nuance by stating that within the Nigerian context and even within Borno State itself, it was difficult to communicate due to the existence of multiple languages. Moreover, there was a lack of accurate and trustworthy interpreters.

Social welfare units were supported by NGOs, however, according to a (male) local government official in Gwoza, the PHC staff lacked adequate training. Moreover, there was a lack of staff, which meant there were no doctors and only a few nurses or midwives and community health workers. Furthermore, they were not adequately skilled and there was a lack of social workers who could attend to and provide psychosocial support. Incentives were needed such as better pay for social workers. Lastly, a (female) GBV service provider from Gwoza flagged that supervision and assessments about their performance helped them improve and they cited the example of IRC giving them the necessary training to do so.

Moreover, the ability of a health worker to make the survivor feel comfortable was an important facet. In addition, having female health workers working with survivors was important as they might not feel comfortable with a male service provider, as per a woman working for a Borno-based NGO on state level protection coordination. She said, "*If a woman goes into the safe space and meets a man, it may not be comfortable [for her] to share so staffing is important as is capacity of service providers to know how to talk with service providers so they can open up and build confidence"* (speaking in English).

B.5 Inconsistent Integration of GBV into the Humanitarian System

Withdrawal of aid in the humanitarian system had caused adverse effects and challenges, particularly outlined by informants from Damboa. Multiple NGO participants and service providers reported an increase in sexual exploitation, particularly in Damboa. Survival sex was already a challenge due to lack of livelihoods interventions and a reduction in food distribution.

There were also links between inconsistency, insufficiency, and delays in food distribution and risk of sexual violence. Moreover, limitations in terms of eligibility for food distribution left out people in need. A (female) GBV service provider in Damboa LGA described how only male-headed households with wives and children were included which left out female-headed households, unless they had no children or a husband, and meant that women were dependent on food distributed to their husbands being handed over to them. While the service provider had lobbied the only organisation providing food in

host communities to include some survivors, this assistance was short-lived and this organisation was unable to help survivors at the time of data collection. Service providers were advocating the need to fill this gap in protection meetings with other partners with a (female) GBV service provider explaining, *"I have been calling the man at [name of organisation] and it does not work out. Almost every implementing partner is also trying to include their survivors but not able to do so. Registration has stopped and they have been giving food for more than a month. I felt very bad as survivors are dying out of hunger and have no support to give them. I had put it as a success story when survivors could access food and some told me to close their case as their needs have been met but it has now gone backwards"* (speaking in English). As indicated in subsection A.3, these dynamics was linked to both sexual exploitation and risk that women and girls who went to the bush to farm or collect firewood would be killed or abducted by AOGs.

Protection and GBV specialists also noted gaps in other humanitarian sectors. For some cases, livelihood activities were delayed as survivors did not have the prerequisites needed to join or all spaces had already been filled. A (female) GBV service provider in Damboa also flagged the importance of lighting, particularly for toilets which would make it harder for men to assault women on their way there at night. Although she and others had flagged this with other water, sanitation and health (WASH) partners, and it had been discussed by the local Protection Sector Working Group, no action had been taken to mitigate this risk.

C. Protocols, Standards, and National Guidelines

Among all the six health facilities involved in the health facility assessments, only one facility (IDP camp clinic in Gwoza LGA) followed international guidelines on sexual violence service provision. This facility followed their own agency's guidelines which were in accordance with WHO guidelines. A (female) GBV service provider, interviewed in Gwoza, there indicated that supervisors came and frequently checked to ensure guidelines were implemented, supplemented by supportive supervision and checks by doctors. As per the HFA, staff from the sexual violence centre in Jere LGA noted that there was a book covering minimum standards, safeguarding, humanitarian principles, and other topics, however this book was not at the facility at the time of the assessment. Meanwhile, the IDP camp clinics in Damboa and Gwoza LGAs specified that they both had facility-specific guidelines, although these were not observed at the time of the assessments. Among the potential guidelines these facilities may have possessed, none of the guidelines were reported to address vulnerable populations. They did not integrate sexual violence service provision for people with disability. None of the facilities had special guidelines on sexual violence services provision for children. Lastly, five of the six health facilities did not have written guidelines on referral services for survivors of sexual violence (it was not clear whether the IDP camp clinics in Damboa and Gwoza LGAs possessed these

guidelines, but they were not observed at the time of the assessment). None of the facilities had child protection guidelines.

Four out of six assessed facilities had a system in place to document referral linkages for sexual violence clients to other organizations or facilities. The sexual violence centre in Jere LGA and IDP camp clinic in Gwoza LGA used referral forms to document referral linkages for sexual violence survivors while the PHC and IDP camp clinic in Damboa LGA didn't specify which systems they are using. Although four facilities reported having a client follow-up system, an active register was only observed at the sexual violence centre in Jere LGA. No evidence of survivors receiving follow-up care was observed at the IDP camp clinics in Damboa and Gwoza LGA and the PHC in Gwoza LGA. Additionally, the IDP camp clinic in Gwoza LGA used calls and home visits by caseworkers to follow up clients while the sexual violence centre used a multi-pronged approach that included contacting the focal person, the person who received the referral, and the survivor directly. The PHC in Jere LGA did not have either of the systems and no reason was provided for this gap. A (female) GBV service provider in Damboa said there was provision for internal and external referrals. For example, if a survivor agreed to see a midwife, they would accompany the client or call the midwife to come to the counselling room depending on the client's preference. For services not available at the centre like PEP, they referred the client to MSF. The client would either go with the centre's keke napep (auto rickshaw) or alone depending on individual preference. In certain cases, the service provider explained that they went on behalf of the clients and advocated for services until the client was ready.

The IDP camp clinics in Damboa and Gwoza LGAs and the sexual violence centre in Jere LGA were the only health facilities with medical records and forms completely filled out with all the relevant information. While the sexual violence centre in Jere LGA had a digital register to document and analyse trends in sexual violence data, the IDP camp clinics in Damboa and Gwoza LGAs used a separate paper-based sexual violence register. Both the IDP camp clinic in Gwoza LGA and the sexual violence centre in Jere LGA could segregate sexual violence data by age and gender. None of these three facilities could segregate data by type of violence or characteristics such as disability. Only the IDP camp clinic in Gwoza LGA used common unique identifiers to link data to other services. In particular, it was noted that identifiers depended on who saw the survivor first as midwives used numbers while case workers used codes which were then subsequently used by others. The rest of the facilities (the PHCs in Damboa and Gwoza LGAs) did not have any reporting and information systems.

Additionally, with the exception of the PHC in Damboa LGA, all health facilities had established protocols to ensure privacy and confidentiality among sexual

violence survivors during treatment. The sexual violence centre in Jere LGA noted that while confidentiality remained a priority of the facility, privacy had become constrained. Service providers in the IDP camp clinic in Gwoza LGA specifically noted that there were different routes of entry into the health facility to help protect patient privacy. Additionally, survivors didn't wait in the queue as volunteers informed the midwife at the clinic that a survivor would be coming to see her although it wasn't clear how this information was coordinated. Similarly, at the PHC in Jere LGA, survivors of sexual violence did not have to wait to be seen by a healthcare provider but were treated as emergency cases. Apart from the PHCs in Damboa and Jere LGA, the rest of the assessed health facilities had a dedicated room for sexual violence survivors. Four of the health facilities (the PHCs in Gwoza and Damboa LGAs, the IDP camp clinic in Gwoza LGA, and the sexual violence centre in Jere LGA) did not allow survivors of sexual violence to be accompanied by anyone into the room where sexual violence services were provided - unless if requested by the client. However, the sexual violence centre in Jere LGA specified that there were exceptions to this rule and people incapacitated by intellectual or learning disabilities and children three years of age and younger were allowed to be accompanied. All health facilities allowed children and adolescents the opportunity to speak with a health professional alone if they were accompanied by a parent. Only three health facilities (the PHC in Jere LGA and the IDP camp clinics in Damboa and Gwoza LGAs) had a social worker or protection worker or another nurse accompany a child during consultation when the guardian stepped out – although this would be at the clients' request. A service provider in Damboa LGA mentioned that they were not allowed to disclose any information about a survivor without their consent: a survivor would have to consent for release of information (with thumbprint on form) and could decline the service at any moment.

Among all six health facilities, there were no legal reporting mandates that providers had to follow when treating survivors of sexual violence. Also, for all the assessed facilities, survivors did not have to bring any documentation before or after sexual violence services were provided. According to a local government official in Gwoza, people filled in forms during the investigation, after which if the survivor wished for litigation, they would forward the case to the appropriate authorities and there were lawyers from the NHRC available for this purpose.

Notably, sexual violence services were free to survivors at all stages of service delivery across all assessed facilities. Apart from the PHC in Damboa LGA, all assessed facilities had trained medical and non-medical providers in specialised clinical care for sexual violence survivors. Three facilities (the sexual violence centre in Jere LGA and the IDP camp clinics in Damboa and Gwoza LGA) had trained their staff on how to approach treatment for people with disabilities. Five health facilities except the PHC in Damboa LGA had trained staff on

psychosocial care. A (female) GBV service provider at the Gwoza IDP camp clinic indicated that she had had a 5-day training on clinical care for sexual assault, how to welcome male and child survivors, and how to talk with and communicate to them. She said that *"After rendering service, a person may be happy even if you do not satisfy their needs completely - I have inner joy and motivation that I am actually helping someone"* (interviewed in English). Her agency conducted training twice or thrice yearly to keep providers up-to-date with new information. The (female) GBV service provider at the IDP camp clinic in Damboa LGA and the (male) GBV service provider at the sexual violence centre in Jere LGA indicated that they had regular training and supervision on GBV also. The training was provided by a number of different INGOs and UN agencies.

Please refer to Table 4 below for an overview of protocols, standards, and guidelines used by facilities assessed by the HFA.

Table 4: Protocols, standards, and guidelines used by sexual violence providers

🟢 Yes 🔴 No 🟠 Not observed ○ Not applicable

LGA	Jere		Damboa		Gwoza	
Health Facility	Sexual violence centre	PHC	IDP camp clinic	PHC	IDP camp clinic	PHC
Protocols and guidelines						
Do the registers clearly indicate if a survivor presents for sexual violence services?	○	🔴	🟠	🔴	🟢	🔴
Does the health facility/Ministry of Health follow any international guidelines for the provision of sexual violence?	🔴	🔴	🔴	🟠	🟢	🔴
Does the facility have a copy of the national guidelines for providing sexual violence care located in or nearby the room where medical examinations routinely take place?	🔴	🔴	🔴	🔴	🔴	🔴
Does the facility have a copy of the facility specific guidelines for providing sexual violence care located in or nearby the room where medical examinations routinely take place?	🔴	🔴	🟠	🔴	🟠	🔴
Are there special guidelines for examining and treating infants and children?	🔴	🔴	🔴	🔴	🔴	🔴
Do the protocols and guidelines used by the facility integrate disability?	○	🔴	🔴	🔴	🟠	🔴

Does the facility have written guidelines on referral of survivors to other services located in or nearby the room where medical examinations routinely take place?	●	●	●	●	●	●
Do the guidelines include phone numbers and contact people at each referral point?	○	○	●	○	●	○
Do referral guidelines explicitly address procedures for removing a child from an unsafe domestic environment?	○	○	○	○	○	●
Referral and follow-up systems						
Facility has a system in place to document referral linkage(s)	●	●	●	●	●	●
Facility has a system in place to follow up with patients	●	●	●		●	●
Reporting and information systems						
Facility has a system in place to collect and analyse trends in sexual violence data	●	●	●	●	●	●
Sexual violence service data are linked to HIV and other health services data through common unique identifiers	●	●	●		●	●
Privacy and confidentiality						
Is there a protocol and/or system to ensure privacy and confidentiality for survivors during treatment?	●	●	●	●	●	●
Is there a specific area or room dedicated for sexual violence services?	●		●	●	●	●
Is the person who accompanies the survivor allowed to be in the room where sexual violence services are provided?	●	●	●	●	●	●
Are children and adolescents given a choice to speak with the health professional alone when accompanied by a guardian?	●	●	●	●	●	●
Does the health facility have a social worker or protection worker or another nurse who can accompany a child during consultation when the guardian steps out (as per Save the Children and medical policy)?	●	●	●	●	●	●
Payment mechanisms						
Is there a user fee required for sexual violence consultation/treatment services at this health facility?	●	●	●	●	●	●

○

Documentation and reporting						
Does the survivor have to bring any documentation before services for sexual violence can be provided or initiated?	🔴	🔴	🔴	🔴	🔴	🔴
Does the survivor have to bring any documentation after services for sexual violence are provided or initiated?	🔴	🔴	🔴	🔴	🔴	🔴
Is there any legal reporting requirement for the health provider when survivors are seen at the health facility?	🔴	🔴	🔴	🔴	🔴	🔴
Capacity building						
Have the medical providers at the health facility received any specialized training on clinical care for survivors of sexual violence?	🟢	🟢	🟢	🔴	🟢	🟢
Have the non-medical providers at the health facility received any specialised training on clinical care for survivors of sexual violence?	🟢	🟢	🟢	🔴	🟢	🟢
Has the staff received training on how to approach treatment for PWDs?	🔴	🟢	🟢	🔴	🟢	🔴
Has any of the health facility staff received training on psychosocial care?	🟢	🟢	🟢	🔴	🟢	🟢

3.3. Discussion

A. Sexual Violence in Borno State

While AOG fighters abducting women and girls and subjecting them to sexual enslavement and forced marriage received national and international notice in the wake of the mass abductions from Chibok Girls Secondary School in April 2014 (2,14) and has been extensively discussed above, it is one of many types of sexual violence that occur in the Lake Chad Basin conflict. These dynamics overlay pre-existing high levels of gender-based violence and gender inequalities and mesh with nationwide realities. For example, 43 percent of girls in Nigeria (67.6 percent in the northwest and 56.6 percent in the northeast) are married before their 18th birthday (8). As shown above, the conflict has increased these pre-existing levels of human insecurity and led to new forms of violence such as abductions, forced marriages, and sexual enslavement by AOG fighters. This study's findings show that related economic hardship can be linked to changes in incidence of some forms of violence, such as sexual exploitation, early and forced marriage, and marital rape with the disappearance of the community safety nets, in terms of support from family and neighbours, as everybody now lives in financial hardship also contributing to this dynamic.

However, due to the work of women's rights activists in Borno State as well as outreach, sensitisation and service provision by humanitarian actors, survivors are now likely to come forward to seek help and, sometimes, pursue judicial processes aimed at punishing perpetrators. Yet, this reporting is most likely when survivors are children as shown by Table 2 in Section 3.1. These statistics do not mean that adult women do not experience rape and sexual assault but rather that there has been a partial breaking of the culture of silence for younger people who are both less likely to be able to hide what has happened and to be blamed for it. There are even higher barriers to reporting for adult women, adult men, and others of other genders who are more likely to be shamed for violence perpetrated against them and particularly for those who face intersecting axes of marginalisation such as people (of all genders) with disabilities. Moreover, older adolescent girls and adult women, as described below, are more likely to face disbelief and insistence that this incident was consensual sex and are likely to be subjected to victim blaming and stigmatisation. This is a powerful incentive not to report, particularly if they are raped by their boyfriends. Other research conducted sheds light on sexual violence amongst LGBTQI people, showing that they perceive rape and sexual violence against the yan daudu in particular to be common and that it is impossible for these survivors to access help due to widespread discriminatory attitudes and the risk of criminalisation, making it difficult to know the full scale of incidence (28).

Indeed, while sexual violence against boys is reported, that against men is generally not. None of the health facilities surveyed had ever received a case of sexual violence where the survivor was a man. Incidence of sexual violence against men and boys is likely to be lower than that against women and girls. For example, a nationwide survey found that at least one in four girls and one in ten boys experience sexual violence before the age of 18 (29). However, notwithstanding the reality that patriarchal and gendered power relations put women at higher risk of sexual violence, this lack of reporting does not mean that sexual violence against men does not exist in Borno State (30). Although there is not a systematic campaign of abductions and rapes of men and boys as there is for women and girls and AOGs take a strong moralistic stance against homosexuality, there is one documented instance where two young men who were abducted were assigned to different male fighters within the same group who regularly raped them (28).

Moreover, participants saw increased population density, changes in gender norms and realities and weaker social ties in situations of displacement as linked to higher sexual violence incidence. They also connected this to the intensified scrutiny of women and girls, as shown by testimonies that show how sexual harassment can take the form of gossip. Other research has shown that this gossip also targets those seen as contravening gender norms, for example by speaking in public meetings and is part of a wider backlash against the expanded roles and responsibilities thrust onto women and girls due to violence and reduced abilities of men to fulfil gender norms of being family breadwinners and protectors (5). This social loss experienced due to conflict by many displaced men in particular having vast stretches of time without tasks to do, often for the first time in their busy working lives, can lead to increased attention and policing of what is seen as immorality, whether this be women and girls contravening gender norms, people seen as engaging in same-sex relationships, or survivors of sexual violence believed to have engaged in consensual sex outside marriage, adding to the stigma, shame and victim blame to which they are subjected (30).

This research has also highlighted areas where not much is known, for example when it comes to incidence and dynamics around FGM in the Shuwa community or forced abortions. In the initial years when abducted girls and women returned to communities, many did so pregnant and/or with young children. There was widespread concern, among community members, government officials, and security agents that these women were “annoba” or epidemics who would recruit others into AOGs and their children of ‘bad blood’ who would grow up to be perpetrators of violence like their fathers (14). During this time, some people went so far as to call for abortions of all women and girls pregnant with the babies of AOG fighters and condone the infanticide of babies and young children, putting these children at risk of abandonment, discrimination,

rejection, and potential violence and the women concerned at risk of forced or coerced abortion. In response, Muslim women activists issued a statement of religious opinion stipulating that Islam requires that women abducted and any child born to them as a result of this abduction be welcomed and supported by society. Although this research has not uncovered evidence of forced abortions or sterilisation of women and girls associated with AOGs, it is likely that this violence, at least to some extent, took place amidst these dynamics.

Finally, the study has shown the need for more intersectional analysis that separates out the different types of violence, examines their contours and root causes. It is clear that some types of violence and categories of survivors receive more focus than others and that these decisions are not necessarily linked to incidence. Types of violence considered 'exceptional' or 'spectacular,' for example abductions, rape, and sexual assault tend to receive more research and programming attention despite the realities that the incidence of other violence such as the denial of the right to use contraceptives and early and forced marriage is much likely to be higher (15). Table 5 below aims to show the most likely perpetrators and survivors for each type of sexual violence in Borno.

Table 5: Sexual violence in Borno

Type of violence	Most likely perpetrators	Most likely survivors
Abductions by AOGs > forced marriage/sexual enslavement	AOG fighters	Girls, young women in areas under AOG control and/or who are forced to leave government-controlled towns to pursue livelihoods due to socio-economic status, displacement, lack of access to nearby farmland
Denial of right to use contraceptives	Husbands	All married women
Early and forced marriage	Parents, husbands	Girls (more common/ younger among those displaced, of changed economic status)
Female genital mutilation	Parents, husbands	Shuwa women and girls
Forced abortion or sterilisation	-	-

Rape and sexual assault	Those known to the survivor but can be anyone particularly AOG fighters	Everyone
Sexual exploitation and abuse	Security agents, government officials, humanitarian workers, men in the community with more relative wealth and access to resources	Women and girls who are displaced, subjected to poverty, with male family members who are missing/detained/killed Unaccompanied girls Women and girls with disabilities
Sexual harassment	Men in the community Security agents	Adolescent girls Younger women Women of all ages seen as transgressing social norms

B. Existing Services

Despite the presence of NGOs in the GBV space, this research revealed major gaps in the availability of services for sexual violence survivors - a cross-cutting observation between PHC and INGO supported facilities. This was confirmed by the IRC baseline in Borno State which found limited health and psychosocial support (PSS) services, and reporting mechanisms (16).There were some services present, particularly medical and counselling-related services, but they were not easily accessible, available, and appropriate. Most of them were provided by NGOs or international organisations and public facilities provided referral to these. Moreover, stock-outs of key supplies such as HIV testing kits and PEP drugs were rampant, affecting provision of time sensitive interventions. Stockouts of specialised drugs was also found by the IRC baseline (16). While referral mechanisms seemed active between facilities, there was no clear documentation to guide follow-up of survivors. In another study on assessing GBV responses in Borno and Adamawa, the study found that referral mechanisms were not very effective and geographical limitations also were a barrier for different actors (17). Nevertheless, the adaptation of WHO guidelines to ground the provision of sexual violence services was limited, undermining the quality of care and implementation of good practices.

Further, survivors had different needs, with many requiring food, shelter and livelihood support, which seemed to be one of the least funded activities. Food distribution lists were another barrier, and in some cases, having livelihood skills were linked to better chances of organisations providing food and shelter. As

per the UNHCR Annual SGBV report in North-East Nigeria, men and boys were increasingly excluded from such lists since women were prioritised and were thereby isolated while accessing opportunities (18). However, the study also found examples of humanitarian agencies distributing food and other assistance to men, seen as heads of household, which often meant that these items did not benefit women in these households and communities. For example, a (female) GBV service provider in Damboa LGA who was from the locality discussed how her own grandmother (a widow) struggled to access humanitarian assistance and was only able to do so after influential people in the community intervened on her behalf with the relevant humanitarian agency.

Meanwhile, NHRC played an active role in providing legal-related services but long distances, the bureaucratic nature of court processes, and fear of reporting (although due to increased sensitisation, participants shared it was becoming easier to report), were barriers. In addition, health facilities usually did not provide referrals for legal services as this was not part of their training or mandate. With regards to the police, some organisations were trying to work with them by providing training for better communication with survivors but this work continued to be challenging with significant gaps remaining. Understaffing of female officers, lack of a separate space in police quarters for GBV cases were challenges found in a study assessing GBV responses in Borno and Adamawa States (17). Having a more survivor-centred approach for legal services was clearly needed as were transformative justice approaches - alternative and complementary approaches to ensuring perpetrators were held accountable, survivors felt that justice had been done, and that these processes were led by communities themselves.

Aside from NGOs who were the main service providers, several community structures and leaders (bulamas, camp leaders, women leaders, and other mechanisms such as 'aunties against GBV') played major roles in redress, providing support, and raising awareness. A similar finding emerged from IOM's assessment of GBV response mechanisms in Borno and Adamawa state, which found that community-based structures were more preferred (17). Another study conducted in Borno State similarly reported that coping mechanisms changed depending on the type of violence, and for sexual violence and abductions, the normal response was not to report or tell anyone (16).

Moreover, stigma was rampant and a huge barrier in seeking help: 45% of women and girls sampled in 2017 did not report GBV cases due to stigma (16). Hence, this was a growing focus of organisations, the government, and service providers training (for example, the MOWA was conducting radio programmes to tackle this) but anti-stigma work mostly focused on abductees and, in general, there were better standard operating procedures in place to deal with these cases.

Other issues around infrastructure, long distances, referral to private facilities, and turnover of staff in health facilities were continual challenges. Access was particularly difficult for participants with disabilities.

There was also incomplete or absence of documentation of data on sexual violence in assessed health facilities. If there was data, it was limited to gender disaggregated data. Some facilities lacked systems to collect, document, report, and analyse sexual violence data. Indeed, guidelines on documentation and reporting for sexual violence cases was a major gap across all the assessed facilities with no indication on how this data is integrated into the government reporting system.

While services did focus on issues of privacy and confidentiality, their orientation to be inclusive of groups that faced intersectional marginalisation, like women with disabilities and adolescent girls was limited, in particular when it came to basic modifications needed by people with disabilities. The quality of sexual violence-related service delivery was also influenced by the training and skills of the health providers. Similar findings emerged in other studies where a lack of empathy (perceived or real)from health providers was an issue (19) and staff were not adequately trained (16). Similarly, findings from another study in Borno State showed that language barriers which lead to the use of a translator meant that survivors were not as comfortable engaging with service providers (19).

In addition, NGOs played instrumental roles in funding and implementation of GBV work. Some INGOs and UN agencies, in particular, were very well-known and appreciated for their services which were affordable or free. However, phasing out of services by such organisations was leaving behind significant gaps. Moreover, withdrawal of humanitarian aid has meant that there has reportedly been an increase in survival sex and prospects for sustainability is not established. There is clearly an over-reliance on NGOs, particularly international ones, pointing to the need for stronger partnerships with local and state government and civil society.

Lastly, there have been several reported kidnappings of health workers by AOGs in Nigeria, with some evidence of intent, leading to executions and sexual enslavement (20). Findings from a study conducted in neighbouring Yobe state on the effects of the conflict on the health system in the state revealed that there was an increase in workload for health workers, but that health workers remained motivated and committed which helped service delivery (21). Although this was not an area specifically explored in our study, informal conversations with GBV providers after interviews were concluded revealed that prioritising physical and mentally safe working environments for health workers was crucial.

C. Good Practices and Lessons Learned

There were a few examples of good practices that emerged from the study. This included the use of hotlines. In a context where there are security concerns, long distances to reach health facilities and where some survivors and community members are unable to pay for transport, hotlines provided immediate support to sexual violence survivors. In the validation session, participants said that it was also important to limit duplication of hotlines and focus on outreach for one main hotline. Participants of the workshop further indicated that hotlines are a critical resource in situations where service providers aren't available to provide immediate care which further validates the experiences shared by study participants.

Separate safe spaces were present in four out of six of the health facilities surveyed. From the qualitative data, participants considered this important for reasons of privacy and confidentiality. These spaces also meant that survivors would not have to wait in line for help, and that these spaces often also functioned as adolescent-friendly spaces. This tallies with the documented evidence for ensuring friendly services for both adolescents and vulnerable populations where prioritisation, safe spaces to facilitate non-judgement interpersonal discussions and privacy are considered best practices during service provision (22).

From the findings, it clearly emerges that community structures were instrumental in providing support to sexual violence survivors. These included a prominent role of community leaders, women's groups that rallied together to tackle sexual violence (e.g. aunties against GBV) and women leaders. This was further articulated by participants in the validation workshop emphasising the importance of engaging and training community members to lead sensitisation and prevention initiatives as they understand the norms and practices in their communities better and are able to relay information to survivors and perpetrators in a simple and understandable language but also this has an effect on sustainability.

4. CONCLUSIONS & RECOMMENDATIONS

Changes in sexual violence and its incidence in Borno State were linked to changes in gender realities brought about by the conflict. Increasing sexual exploitation, early and forced marriage and marital rape could be linked to the disappearance of community safety nets, limited support from families, lesser social cohesion leading to economic hardship. These dynamics were further exacerbated in situations of displacement which were linked to higher sexual violence incidence and an intensified scrutiny of women and girls, who bore the brunt of moral panics. The findings also indicated that knowledge about services and their implementation may be higher in IDP camps where a variety of organisations operated, unlike in host communities where interventions could be more fragmented. However, due to the work of women's rights activists in Borno State as well as outreach, sensitisation and service provision, survivors in some locations were now likely to come forward to seek help. This reporting was most likely when survivors were children and a culture of silence as pertained to adults still persisted.

Some organisations were trying to overcome the gaps in service provision, for example by providing training to the police for better communication with survivors. But in general, there was an over-reliance on NGOs, particularly international ones to provide a more comprehensive set of services to survivors. Finally, NGOs played a significant role in funding and implementation of gender-based violence work and phasing out of services by these organisations meant they left behind key gaps. Moreover, withdrawal of humanitarian aid meant an increase in survival sex in particular as prospects for sustainability had not been established.

Yet, significant progress had been made over the past five years with Nigeria's Road Map in response to the Global Call to Action improving GBV coordination and response and setting a clear direction of travel. With this in mind, recommendations stemming from research findings and validation processes aimed at deepening this progress are as follows:

For service providers, INGOs and UN agencies who support them, donors, and the Ministry of Health, Ministry of Women's Affairs and Ministry of Humanitarian Affairs

1) Improve service provision by:

A) Strengthening referral systems

- Continuing to strengthen, update, and socialise referral pathways to facilitate multi-sectoral collaboration
- Strengthening documentation of referrals to improve survivor follow up
- Further supporting and publicising hotlines to link survivors to timely care;[27]
- Training key community members, particularly women and girl leaders including those from excluded groups, on how to care for survivors and refer to services.

B) Inclusion of marginalised groups

- Improving disability inclusion through outreach, making services more accessible, and building service provider capacity[28]
- Developing strategies to better support and reach out to (adult) male survivors, based on proper documentation and understanding of the violence they face and barriers to accessing services including criminalisation of and attitudes around homosexuality.[29]

C) Improving the quality of health services

- Allocating separate safe spaces in health facilities to improve confidentiality and privacy
- Supporting health workers to develop and implement self and collective care strategies
- Supporting health facilities to adapt and embed global standards and practices on sexual violence service provision[30]
- Training and retraining health workers to adopt more survivor centred approaches including via health training institutes and continuous professional development
- Focusing efforts at strengthening health system capacity, particularly at primary healthcare level, to ensure government leadership and future sustainability[31]
- Further strengthening data collection, reporting, and documentation and building mechanisms where this analysis informs learning and adaptation by service providers.

27. Research findings indicated that hotlines serve as immediate response pathways for survivors.
28. This study found a significant gap in service utilisation despite this group being highly susceptible to sexual violence.
29. As described in the methodology section, this study was not able to uncover these dynamics but identified a need for evidence based programming in this regard.
30. A significant gap in almost all the health facilities surveyed as part of the HFA.
31. This research study found that more efforts needed to be made in strengthening health systems around sexual violence service provision, particularly outside Maiduguri.

D) Strengthening accountability mechanisms

- Explore complementary means of accountability for perpetrators, for example through increasing community censure and transformative justice approaches[32] given most survivors do not want to use legal processes and the lack of survivor centred approaches and risk of re-victimisation in the criminal justice system.

For civil society, community based groups, community leaders, INGOs and UN agencies, donors, and the National Orientation Agency

2) Counter stigma, victim blaming, and otherwise encourage help-seeking[33] by:

- Funding women's rights groups to do sustained community engagement
- Working with existing community structures to carry out campaigns
- Strengthening capacities of and recruiting people from different ethnic and linguistic groups to conduct outreach, support sexual violence survivors, and advocate against stigma
- Raising awareness of all types of sexual violence including that which is less visible such as intimate partner violence, early and forced marriage, and sexual harassment[34]
- Developing strategies to engage and reach out to women and girls who face further marginalisation, such as those with disabilities
- Changing social norms through approaches that are peer to peer (e.g. among adolescent girls, men who attend majalisa, or grandmothers), intergenerational, and within families.

For all sectors working groups of the humanitarian response, civil society, INGOs and UN agencies working on development and peacebuilding, donors, and the Ministry of Reconstruction, Rehabilitation, and Resettlement

3) Better integrate mitigation of and response to sexual violence into the humanitarian response and development and peacebuilding programming by:

- Integrating GBV analyses, response, mitigation, and prevention in sector strategies and plans e.g. looking at how food distribution modalities intersect with GBV dynamics[35]

32. Transformative justice is a series of practices that create change in social systems and serve as alternatives to criminal justice processes in cases of interpersonal violence or in societies transitioning from violent conflict or repression. Transformative justice responds to immediate needs, cultivates what is needed for violence prevention (such as healing, accountability, resilience, and safety), is aimed at breaking (generational) cycles of violence, and ensures perpetrators are held accountable. Most transformative justice interventions involve a community accountability process where a few members of the community work directly with the person who committed harm so they understand the impact of their actions on survivors and others, apologise, make amends, and repair the damage caused, and work to change their behaviour - in line with what many survivors want.
33.This study identified stigmatisation and victim blaming as both the primary consequence of sexual violence to survivors as well as the greatest barrier to seeking help.
34. While abductions and sexual violence against children tend to be the types of violence that gain most attention, concern, reporting, and service provision, intimate partner violence, early and forced marriage, and sexual harassment are much less visible.
35. This study several areas, from food distribution to WASH interventions, where this GBV integration needed to be improved.

- Continuing to train people working in other sectors on GBV
- Expanding the access of women to economic empowerment and livelihoods programming to counter sexual exploitation with a focus on women who are single parents, survivors, have husbands in military detention, or who are disabled
- Developing strategies to mitigate GBV, particularly sexual exploitation and abuse, when planning withdrawal or making changes to humanitarian assistance.

For organisations conducting research, the Protection Sector Working Group, donors, and Ministry of Women's Affairs and Ministry of Humanitarian Affairs

4) Build the knowledge base for evidence informed programming, particularly on prevention, by:

- Learning from global good practices on what works to prevent gender-based violence and piloting evidence based strategies and programmes
- Learning from experiences challenging stigmatisation of survivors of abductions to inform anti-stigma programming for other types of sexual violence
- Filling existing knowledge gaps, for example on female genital mutilation/cutting, forced and unsafe abortion, and consequences for LGBTQI survivors
- Establishing a community of practice to bring uniformity in the response to SGBV in Borno State, coordinated by the protection sector (with input from its GBV and child protection sub-sector working groups), with organisations across different to develop, socialise, and learn from evidence.

ANNEXES

Annex 1: Equipment and supplies

Yes · No · Not observed · Not applicable

LGA	Jere		Damboa		Gwoza	
Facility	Jiddari PHC	N3alewa SARC	Hausari IDP Camp Clinic	Shuwari PHC	GSS Camp CWC	Hausari Gadamayo PHC
Place of inventory	Family planning Unit	Consultation room		Delivery room	Observation/ ANC room	MCH unit – delivery exam room
ITEM	EQUIPMENT & SUPPLIES					
Angle lamp	No	Yes	Yes	No	Yes	No
Examination couch	Yes	Yes	Yes	Yes	Yes	Yes
Speculum	Yes	Not observed	No	Not observed	Yes	Yes
Examination gloves	Yes	Not observed	No	Not observed	Yes	No
Sharps container	Yes	Not observed	Yes	Yes	Yes	Yes
Lockable cupboard for forensic/medical legal evidence	No	Not observed	No	No	Yes	No
Lockable medical supply cupboard	Yes	Yes	Yes	No	Yes	Yes
Sanitary towels	Yes	Yes	Yes	Yes	Yes	Yes
Emergency clothing	No	No	Yes	No	Yes	No
Consent forms	No	Yes	Yes	No	Yes	No
Swabs	Yes	Yes	Yes	Yes	Yes	Yes
Blood tubes	Yes	Yes	Not observed	No	No	No
Special aides for examining children	Yes	No	No	No	Yes	No
Pregnancy test kits	Yes	Yes	Yes	Not observed	Yes	Yes
Emergency contraceptive pills	No	Yes	Yes	Yes	Yes	Yes
STI prophylaxis/treatment	Yes	Yes	Yes	No	Yes	No
Analgesics	Yes	Yes	Yes	Yes	Yes	Yes
Tranquillisers	Yes	No	No	Not observed	No	No
HIV rapid test kits	No	Not observed	No	No	No	No
PEP drugs	No	Not observed	Yes	No	Yes	Yes
Misoprostol	Yes	Not observed	No	Not observed	Yes	Yes
Hepatitis B & Tetanus vaccine	Yes	Not observed	Yes	Not observed	No	Yes

Annex 2: Demographic breakdown of sexual violence survivors provided care in the past 6 months

Yes No

		Populations								
		Girls < 15	Boys < 15	Girls 15-18 years	Boys 15-18 years	Women Over 18	Men over 18	Internally Displaced Persons	Girls & Women with a disability	Boys & Men with a disability
PHC in Jere LGA										
Services Provided	Medical Care	●	●	●	●	●	●	●	●	●
	HIV & PEP services	●	●	●	●	●	●	●	●	●
	STI Treatment/ Prophylaxis	●	●	●	●	●	●	●	●	●
	Vaccination of any kind	●	●	●	●	●	●	●	●	●
	Emergency contraception	●	●	●	●	●	●	●	●	●
	Forensic examination	●	●	●	●	●	●	●	●	●
	Counselling	●	●	●	●	●	●	●	●	●
	Psychosocial First Aid	●	●	●	●	●	●	●	●	●
	Police services	●	●	●	●	●	●	●	●	●

Sexual violence Centre in Jere LGA										
Services Provided	Medical Care	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
	HIV & PEP services	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
	STI Treatment/ Prophylaxis	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
	Vaccination of any kind	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴
	Emergency contraception	🟢	🔴	🟢	🔴	🟢	🔴	🟢	🟢	🟢
	Forensic examination	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
	Counselling	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
	Psychosocial First Aid	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
	Police services	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
IDP Camp Clinic in Damboa LGA										
Services Provided	Medical Care	🔴	🔴	🟢	🔴	🟢	🔴	🟢	🔴	🔴
	HIV & PEP services	🔴	🔴	🟢	🔴	🟢	🔴	🟢	🔴	🔴
	STI Treatment/ Prophylaxis	🔴	🔴	🟢	🔴	🟢	🔴	🟢	🔴	🔴
	Vaccination of any kind	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴
	Emergency contraception	🔴	🔴	🟢	🔴	🟢	🔴	🟢	🔴	🔴
	Forensic examination	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴
	Counselling	🔴	🔴	🟢	🔴	🟢	🔴	🟢	🔴	🔴
	Psychosocial First Aid	🔴	🔴	🟢	🔴	🟢	🔴	🟢	🔴	🔴
	Police services	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴

PHC in Damboa LGA										
Services Provided	Medical Care	●	●	●	●	●	●	●	●	●
	HIV & PEP services	●	●	●	●	●	●	●	●	●
	STI Treatment/ Prophylaxis	●	●	●	●	●	●	●	●	●
	Vaccination of any kind	●	●	●	●	●	●	●	●	●
	Emergency contraception	●	●	●	●	●	●	●	●	●
	Forensic examination	●	●	●	●	●	●	●	●	●
	Counselling	●	●	●	●	●	●	●	●	●
	Psychosocial First Aid	●	●	●	●	●	●	●	●	●
	Police services	●	●	●	●	●	●	●	●	●
IDP Camp Clinic in Gwoza LGA										
Services Provided	Medical Care	●	●	●	●	●	●	●	●	●
	HIV & PEP services	●	●	●	●	●	●	●	●	●
	STI Treatment/ Prophylaxis	●	●	●	●	●	●	●	●	●
	Vaccination of any kind	●	●	●	●	●	●	●	●	●
	Emergency contraception	●	●			●	●	●	●	●
	Forensic examination	●	●	●	●	●	●	●	●	●
	Counselling	●	●	●	●	●	●	●	●	●
	Psychosocial First Aid	●	●	●	●	●	●	●	●	●
	Police services	●	●	●	●	●	●	●	●	●

PHC in Gwoza LGA										
Services Provided	Medical Care	●	●	●	●	●	●	●	●	●
	HIV & PEP services	●	●	●	●	●	●	●	●	●
	STI Treatment/ Prophylaxis	●	●	●	●	●	●	●	●	●
	Vaccination of any kind	●	●	●	●	●	●	●	●	●
	Emergency contraception	●	●	●	●	●	●	●	●	●
	Forensic examination	●	●	●	●	●	●	●	●	●
	Counselling	●	●	●	●	●	●	●	●	●
	Psychosocial First Aid	●	●	●	●	●	●	●	●	●
	Police services	●	●	●	●	●	●	●	●	●

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