



## Why gender and age matter in emergency health and nutrition interventions

According to assessments conducted by protection actors in 2016, internally displaced women and children are disproportionately vulnerable to sexual and gender based violence (SGBV). Unaccompanied girls and adolescent boys, single heads of households, child mothers, child spouses, and those living with disability are most at risk. This reality relates to myriad of factors including separation from families, limited access to support and economic opportunities, and overcrowding in IDP settlements which offer minimal privacy and security. Most women, girls and boys formerly abducted by Boko Haram face stigma and family rejection. The lack of adequate reintegration services and worsening economic situations of most internally displaced persons expose them to vulnerable environments making them susceptible to abuse, violence and exploitation. In order to address and mitigate protection challenges faced by the women, girls, boys and men, all humanitarian actors must ensure that their services are tailored to suit the specific needs of the different groups based on age, gender and diversity perspectives.

## Gender, age and diversity demographics and dynamics relative to emergency health and nutrition programming

The ongoing crisis in North East (NE), Nigeria has resulted in profound negative impact on women, girls, men and boys. Most IDPs are experiencing a range of protection risks and challenges. Their vulnerability is multidimensional including severe damage of social fabrics and safety nets, destruction of property and infrastructure in areas of origin.

- Women and children make up 79 per cent of the IDP population in NE, Nigeria with 35 per cent of the IDP population being children under 18 years (30%F and 25%M)<sup>1</sup>
- 25 per cent of Households (HH) have children with protection needs including unaccompanied minors and separated children.<sup>2</sup>
- 7 per cent of the IDPs are older persons with protections needs<sup>3</sup> (UNHCR Vulnerability Screening Round III, 2016)
- In Adamawa, Borno, Gombe and Yobe States, an average of one in ten households has a family member with disability (mental or physical)
- Overcrowding in IDP settlements and lack of privacy in shared accommodation and limited WASH facilities place women and girls at heightened risk of SGBV and denies them of their dignity.
- Due to culture, some families practice “tenet of *kulle*” which prevents women from leaving their homes thus, impeding their freedom of movement including access to humanitarian assistance and health services.
- Poor water and sanitation conditions at IDP sites and in crowded host communities have a large bearing on health. Of 106 sites assessed for the IOM DTM (30 June 2016):
- 44 per cent (i.e. 47 sites) have separated toilets for males and females and anecdotal reports suggest that the disaggregation is not always respected, leading many to continue to defecate in the open.
- 60 per cent (i.e. 64 sites) of the toilets have doors with no fitted locks.
- 97 per cent of sites have handwashing stations but only 56 per cent have soap or water. At the majority of sites there was no evidence of handwashing practices.
- At 70 per cent or 74 sites, there was evidence of open field defecation.
- 61 per cent of households do not have access to improved water and 55 per cent of households do not have access to proper sanitation.

<sup>1</sup> DTM Round X111, Dec 2016

<sup>2</sup> UNHCR Vulnerability Screening Round III, Dec 2016

<sup>3</sup> UNHCR Vulnerability Screening Round III, Dec 2016



- Where latrines are available, there is no lighting in the settlements at night, IDPs often continue to defecate in the open at night as latrines are dark and they are unfamiliar with them.

The sources of all data and information are included in the OCHA Gender and SGBV Analysis 22 July 2016 (available on request).



## COMMUNITY ENGAGEMENT

- Share information on entitlements to distributions, services and facilities and free access to all humanitarian services.
- Monitor vulnerable women, children, older people and people with disabilities continuously to ensure receipt of entitlements without exploitation and abuse.
- Mainstream messages on GBV prevention and response and child protection during distributions.
- Priorities women and child mothers in protection and community activities to ensure active engagement and participation
- Ensure that community programmes address the specific reproductive needs of women and adolescent girls
- Ensure that women and men participate in decision-making related to the humanitarian response
- Ensure that all humanitarian staff and volunteers sign a Code of Conduct and Child Protection Policy and receive training on child protection and the prevention of sexual exploitation and abuse (PSEA).
- Establish a complaints and feedback mechanism in each IDP location that includes feedback on the appropriateness of programme design and impact.

## MINIMUM STANDARDS

- Collect, analyse, use and report sex and age-disaggregated data, including vulnerabilities, of all health and nutrition programming to inform design and implementation. Pay special attention to older persons and persons with disabilities.
- Provide sex-disaggregated data on health workers trained in community management of acute malnutrition (CMAM) programming and, if necessary, take steps to train the under-represented sex. In consultation with the appropriate local and national authorities, consider the availability of female health workers in the area.
- Target and routinely include sex- and age-disaggregated data on nutritional activities for under 5s.
- Target pregnant and lactating women directly for food distributions.
- Separate consulting rooms/space and toilets for females and males in order to provide privacy and dignity.
- If the context requires, female health personnel must be available to attend to female patients or, at the very minimum, to accompany them in the presence of a male health worker.
- In response to the low rate of success on the Humanitarian Response Plan target for reaching PLW, consider reaching out to older women who may then influence PLW.
- Ensure that the health facility meets the 'minimum initial service package' (MISP) for reproductive health in crisis situations (i.e. referral to health, psychological and social support systems, post-exposure prophylaxis (PEP) kits, antibiotics to prevent and treat STIs, Tetanus toxoid/ Tetanus immunoglobulin, Hepatitis B vaccine, emergency contraception (where legal and appropriate))
- Ensure that health facilities and services target people with disabilities and chronic illness and have special provisions to support their distinct health and nutrition needs