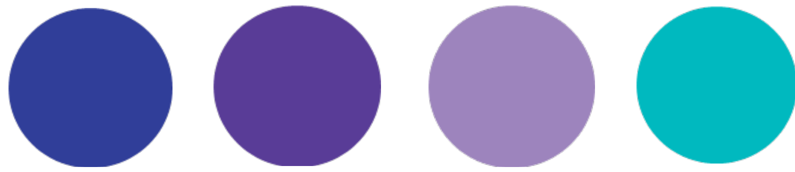

SOMALIA
National GBV Strategy
2018 - 2020

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Introduction

Somalia is experiencing a large-scale humanitarian crisis due to the compounding effects of protracted conflict and drought. Gender inequality exacerbated by poverty, environmental shocks, decades of conflict and weak rule of law have undermined individuals', families' and communities' abilities to cope. Approximately half the population – 6.2 million people – need humanitarian assistance to meet basic needs and protect their most fundamental rights.[1]

The number of people displaced has increased significantly since the onset of the drought in 2015. There are now 2.1 million people across Somalia displaced from their homes.[2] The majority of those displaced are women and children who have migrated to urban centers in search of food, water and economic opportunities.[3] They are now living in formal and informal settlements for internally displaced persons (IDPs) that are largely managed by private land owners or "gatekeepers" who often take advantage of their vulnerable status by charging exorbitant prices for basic necessities, and providing very little in the way of personal protection.[4] Lack of purchasing power coupled with exposed living conditions make these women and child-led households extremely vulnerable to exploitation and other forms of abuse. GBV data indicates that 74% of survivors who accessed services in 2016 were IDPs; 99% of whom were female.[5]

It is in this context that members of the Somalia Gender-Based Violence (GBV) Sub-cluster developed this three-year strategy to guide advocacy and programming efforts in the three regions of Somalia. This strategy was developed to complement existing humanitarian and development processes such as the National Development Plan (NDP), the Drought Impact Needs Assessment (DINA) and resultant Recovery and Resilience Framework (RRF), the Humanitarian Response Plan (HRP) and the HCT-led Centrality of Protection Strategy (COP).

After a lengthy consultative process, stakeholders identified the following three strategic priorities as the basis for interventions:

1. **Strengthening GBV service provision and service provider capacity through enhanced coordination**
2. **Data management and evidence-based advocacy**
3. **Positive gender and social norm change around GBV**

The strategy attempts to bridge the gap between humanitarian (direct service provision) and development (social norm change) interventions by emphasizing the importance of using an evidence-based approach.

The priorities along with outcomes and outputs are presented in a logframe at the end of the document. The members of the Sub-cluster provided strategic actions that they will implement throughout 2018, given adequate funding. The Strategy will guide partners through 2020, but the logframe will be reviewed, and revised if necessary, on a yearly basis to ensure it is meeting real-time needs.

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[1] Humanitarian Needs Overview, 2018
[2] Ibid
[3] Ibid
[4] Engaging the Gatekeepers: Using informal governance resources in Mogadishu
[5] Somalia GBV Sub-cluster Annual Report, 2016

The Federal Government of Somalia (FGS), the local authorities in Puntland and Somaliland and the international community all agree that mitigating and preventing GBV is a priority.[6] The Sub-cluster, chaired by UNFPA and Ministerial counterparts across the three regions, is comprised of more than 40 members; most of whom are national and local organizations providing direct services to survivors of GBV. Members will be engaging in a series of activities over the next three years in coordination with the Government to build a society that promotes the human rights of all individuals through preventing GBV and providing quality, multi-sectoral services to survivors.

Young women fighting GBV through the Y-Peer. ©UNFPA Somalia

Situational Analysis

Scope of GBV

Somalia is a patriarchal society with firmly entrenched gender roles that often subjugate women and girls. Gender-based violence (GBV) is pervasive, particularly female genital mutilation/cutting (FGM/C), early marriage and psychological abuse. Physical violence perpetrated by an intimate partner is the most *reported* type of GBV across the three regions of Somalia. [7] Implementing activities that support positive behavior change among men and boys are a priority.

GBV is known to be under-reported in Somalia due to stigma and fear of retaliation from a survivor's own family members and/or perpetrators. Communities often shun sexual assault survivors in particular under the misguided belief that they are somehow tainted and unmarriageable. Most GBV cases in rural areas are heard before the customary courts (Xeer), which rarely act in the best interest of women and girls.[8]

More than half of the population in Somalia needs assistance.[9] Protracted conflict coupled with an elevated risk of famine due to cyclical below average rains have created overlapping protection concerns that disproportionately affect the safety of women and girls. GBV is widespread especially

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[6] Federal Government of Somalia National Development Plan, 2017-2019
[7] Guidance Note on Gender-based Violence (GBV) Response to the current Drought Situation in Somalia, 2017
[8] Legal Aid Providers Supporting Survivors of Gender Based Violence in Somalia, 2014
[9] Somalia Operational Plan for Famine Prevention, Jan-Jun 2017

among women and girls who are internally displaced. According to the GBV Information Management System (IMS) 99% of survivors who accessed services in 2016 were female; 76% of whom were IDPs.[10]

GBVIMS data further indicates that women and girls are attacked while in transit to IDP sites (specifically while crossing illegal checkpoints) and further exposed once they are settled inside. Outsiders, including uniformed/armed personnel, easily enter IDP sites and perpetrate crimes such as theft and sexual assault. Findings from safety audits conducted across 38 IDP sites revealed that less than 10% of sites have any type of protective barriers around their perimeters and 34% reported the presence of armed actors.[11] These armed actors sometimes serve as protection forces for settlements while at the same time they have been known to sexually assault female residents and take part in forced recruitment of minors.

The shelters, tents/buuls, are made of simple materials that do not offer any type of physical protection. Perpetrators specifically target female and child-led households because they lack male "protectors."[12] Males often leave their families behind while they travel to find work or with their livestock to find fertile grazing land.

A circumciser who is now advocating against FGM. ©UNFPA Somalia

Near-total crop failures have caused families to adopt negative coping strategies such as skipping meals and reducing portion sizes. The most vulnerable households are now consuming one meal a day that often lacks any nutritional value. Rates of malnutrition are steadily increasing among children and women, specifically those who are pregnant or lactating.[13] Evidence suggests that food insecurity is linked to an increase in child marriage.[14] Female heads of households are forcing their daughters to marry because they can no longer afford to feed them, and in some instances, cannot adequately protect them from sexual assault. Food insecurity may also lead to conflict over scarce resources and generate violence, including GBV.

Women and girls must travel long distances to fetch water in all of the drought-affected areas. Some women and girls in the Sanaag region of Somalia are travelling up to 120km roundtrip to fetch water for their families.[15] Travelling these long distances creates overlapping protection concerns. Girls are leaving their homes late at night to arrive at water points early in the morning. Participants in focus

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[10] Somalia GBV Sub-Cluster Annual Report, 2016
[11] IDP Sites – Safety Audits, Sept – Oct 2017, UNICEF, UNFPA and GBV Working Group (Draft Report)
[12] Famine-Affected Countries Gender-Based Violence and Protection Concerns, 2017, InterAction Protection Working Group
[13] Somalia Initial Rapid Needs Assessment, May 2016, http://www.reachresourcecentre.info/system/files/resource-documents/reach_som_sirna_somaliland_puntland_drought_executive_summary_may_2016.pdf
[14] Role of Socio-Economic Factors on Early Marriage Practices in Garowe District, Dec 2016, http://www.ejbss.com/Data/Sites/1/vol5no09december2016/ejbss-1826-16-roleofsocioeconomicfactors.pdf
[15] Rapid Drought Assessment in Sanaag Region, CARE, www.somaliangoconsortium.org/download/5820690e2d109/

group discussions held in Somaliland revealed that their girl children travel at night so that they avoid the long lines at the water points. Fights at water points are becoming more and more frequent due to the long wait times and the availability of water.[16] Anecdotal evidence suggests that while these late night treks for water might reduce protection risks at water points they are increasing women and girls exposure to gender-based violence (GBV) along the route.

Gap Analysis – Service Availability

Rural and non-government controlled areas in south central Somalia are virtually inaccessible due to insecurity. Nearly all of the humanitarian response is concentrated in and around Mogadishu. Even though the regions of Somaliland and Puntland are relatively stable, both displaced and stable populations in these regions have limited access to multi-sectoral response services and effective prevention mechanisms.[17] Stakeholders are especially concerned about the availability of services in areas that have been identified as "hot spots" for drought relief. Many of these areas are inaccessible, and there is no/limited information on the situation in those areas.[18]

In Somalia there are many actors dedicated to providing support for GBV survivors in difficult and challenging conditions. Most services are provided by local and national organizations that are funded through the UN and international NGOs.

Health

Health providers across the three regions struggle to provide services that meet global standards of care. Medical personnel are not adequately trained in the provision of clinical management of rape (CMR) which can put the survivor at further risk. Many of those who have been trained (32%) are not currently providing services and of the 130 professionals who completed training, only 4 were doctors.[19] Capacity building efforts need to specifically target physicians because they are the only ones who can legally sign a medical certificate which is used as evidence in court.

Midwifery students learning to advocate against harmful practices. ©UNFPA Somalia

Hospitals and/or health centers are generally only found in larger cities and towns, and they lack the necessary drugs and equipment to treat survivors. A recent study of 779 health centers across the three regions revealed that only 25% had the necessary drugs to treat sexually transmitted infections and less

[16] Drought Needs Assessment, Somaliland, December 2015, www.actionaid.org/somaliland/publications/drought-needs-assessment-somaliland
[17] GBV Sub-cluster Mapping of Services (4Ws), 2017
[18] Clinical Management of Rape (CMR) Service Mapping Assessment Report, 2017, UNFPA
[19] Ibid

than 18% had the capacity to provide counselling and testing for HIV.[20] These are both integral components of the treatment of sexual assault survivors. Another key challenge is the lack of confidential and private spaces at facilities in which to examine and counsel survivors.

Legal

There are approximately 13 organizations providing legal aid services to survivors of GBV in Somalia. The largest concentration is in the Puntland region followed by Somaliland. There is one organization providing services in and around Mogadishu, but services are nonexistent in places such as Middle and Lower Shabelle, Middle Juba and Bakool.

Young girls against GBV. ©UNFPA Somalia

Formal legal systems in Somalia are weak and rarely accessed by GBV survivors, who tend to seek justice through the traditional clan-based Xeer system or through Sharia courts. Survivors and staff face significant challenges including high risk of reprisals and interruption of proceedings by traditional elders.[21] Customary justice systems often do not rule in the best interests of the survivor, and there is limited engagement of GBV actors within this system at present. Access to justice has been identified as a major gap; to develop evidence-based legal services, there is a need to effectively engage with the different legal systems to gain an improved understanding of the systems and any barriers to justice.

Psychosocial/Case Management

Case management including psychosocial support is integral to ensuring that survivors have access to a broad range of services. There have been improvements in the provision of case management services due to trainings that took place during the implementation of the last strategy. But, for the most part, case workers are trained on the job, and there is no consistency across organizations on the type and length of training received. Many organizations provide introductory training on basic GBV concepts but do not build staff capacity on how to deliver psychosocial support services despite that being one of their main functions.[22] Furthermore, there is a significant gap in the delivery of mental health services and staff capable of delivering higher levels of psychosocial support such as one on one counselling.

[20] Somali Service Availability and Readiness Assessment, 2016, www.humanitarianresponse.info/system/files/documents/files/somali_country_report_final_draft_30dec2016-.pdf

[21] Legal Aid Providers Supporting Gender Based Violence Survivors in Somalia: Report and Recommendations, 2014, Legal Action Worldwide

[22] GBV Capacity Development Project, Somalia Capacity Assessment: Data and Results; PPT presentation, 2015, IRC

A recent assessment of case management services revealed that program managers and caseworkers feel a main challenge is social and cultural barriers that limit survivors' ability to access service centers.[23] There are also not enough providers to meet the growing demand for case management services, particularly in drought affected communities and newly formed IDP settlements.[24] Caseworkers also cited security risks and threats as another challenge; caseworkers are often targeted by community members because of their support of survivors which is often contrary to patriarchal norms.

Security/Protection

Survivors rarely access services because of stigma, and fear of retaliation by their families and/or the perpetrators. There are very few community-based protection mechanisms in place, and there are only three states that have safe houses and only in urban centers. The police do not prioritize GBV cases, and are not well-informed about GBV-specific laws and forensic evidence collection. There is also evidence that Government backed security forces are perpetrating GBV, particularly sexual assault in and around IDP settlements.[25]

Livelihoods

Lack of livelihood opportunities for survivors and those at risk of GBV is a critical gap. There are few organizations providing these much-needed services. Women are largely responsible for household-level agricultural production and trading at markets. The drought has severely impacted their economic stability, increasing their risk of exploitation and abuse. Women are migrating with their families to urban centers due to the impact of drought. They often lack livelihood skills applicable to urban environments.

A member of the Y-Peer advocating against FGM. ©UNFPA Somalia

Strategy Development

The GBV Sub-cluster undertook a comprehensive evaluation of the previous three-year strategy which ended in 2016. Once the evaluation was completed the report was disseminated to members across the three regions in preparation for a series of consultations that took place to identify new strategic priorities based on lessons learned.

Stakeholders identified the following three strategic priorities as the basis for interventions:

1) **Strengthening GBV service provision and service provider capacity through enhanced coordination**

[23] Ibid

[24] Final Evaluation Report on the Implementation of the Somalia Gender-Based Violence Sub-Cluster Strategy 2014-2016, prepared by the Somalia Gender-based Violence Sub-cluster, 2017

[25] Hostages of the Gatekeepers: Abuses against Internally Displaced in Mogadishu, Somalia, Human Rights Watch, 2013

2) **Data management and evidence-based advocacy**
3) **Promote positive gender and social norm change around GBV**

These priorities along with outcomes and outputs are presented in a logframe at the end of the Strategy. The members of the Sub-cluster provided strategic actions that they will implement throughout 2018 given adequate funding. The Strategy will guide partners through 2020, but the logframe will be reviewed, and revised if necessary, on a yearly basis to ensure it is meeting real-time needs

Evaluation results

Despite the progress made during the implementation of the 2014-2016 National GBV Strategy, the evaluation report concludes that GBV remains a serious protection concern[26] Intimate partner violence, early marriage and FGM/C are still considered acceptable cultural and social norms and therefore widely practiced. The evaluation report highlighted that the need for education and services far outweighed the availability of service providers, particularly in communities outside of IDP settlements. This unmet need was directly linked to chronic underfunding; the newly displaced and vulnerable populations living in rural areas are especially impacted.

Circumciser advocating against FGM. ©UNFPA Somalia

The evaluation report stressed the need for members to continue to work with Government counterparts at all levels to institutionalize policies and programs designed to prevent and mitigate violence. The 2016 passage of the Sexual Offences Act in Puntland and the ongoing advocacy to pass similar Acts in Somaliland and South Central was noted as a successful example of this synergy. However, it was also acknowledged that a “weak legislative framework” and reliance on customary courts to settle GBV cases are still major constraints.[27]

The report identified some “facilitating factors” which were considered while developing this strategy. The foremost was the seemingly strong political will in all three regions to address GBV. The leadership shown by the chairs of the GBV Sub-cluster led to a greater sense of accountability among members and other humanitarian actors. The media was believed to have had a pivotal role in sharing information about GBV prevention and response services especially in hard to reach areas. Finally, the willingness of health professions to attend trainings on clinical management of rape (CMR) led to increased availability to life-saving health services.

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[26] Final Evaluation Report on the Implementation of the Somalia Gender-Based Violence Sub-Cluster Strategy 2014-2016, prepared by the Somalia Gender-based Violence Sub-cluster, 2017
[27] Ibid

Methodology

The strategy was developed based on participatory consultations conducted with Sub-cluster members across the three regions. Eight sub-national consultations were held with actors from Somaliland (Hargeisa), Puntland (Garowe, Bosasso) and South Central (Mogadishu/Banadir, Bay &Bakool, Middle & Lower Shabelle, Dhobley/Lower Juba, Beletweyne/ Hiraan). The consultations focused on current GBV activities and capacities, challenges and constraints, and gaps in each region. Participants then proposed concrete actions to be prioritized for the next three years. The strategy was drafted by a small team of Sub-cluster members, with support from the Global GBV Area of Responsibility, a global level forum for coordinating prevention and response to GBV in humanitarian settings. It was then validated by Sub-cluster members at the national and sub-national level.

Religious leader fighting harmful cultural practices. ©UNFPA Somalia

Strategic Priorities

Members of the Sub-cluster developed this three-year GBV strategy to guide advocacy and programming efforts in the three regions of Somalia. After a lengthy consultative process, stakeholders agreed to focus on the following three strategic priorities:

1) **Strengthening GBV service provision and service provider capacity through enhanced coordination**
GBV actors in Somalia have made progress on intra-cluster coordination over the past few years. However, there are still some crucial gaps that need to be filled, particularly in the areas of capacity building, strategic advocacy, standardisation of tools and protocols, and the establishment of consistent methods for collecting and sharing information within the working group (both at the sub-national level and between the national and sub-national level). There is also a need to develop a common understanding across all partners about what quality GBV programming entails as well to invest in training and mentoring of members who have a lower level of technical skill in certain substantive areas. All of these elements require dedicated GBV coordination staff at both the national and sub-national level.

2) **Data management and evidence-based advocacy**
The Sub-cluster needs to systematically collect and analyze GBV data to identify protection trends that can be used by providers to inform their interventions. The number of partners ethically and safely collecting data for the GBV Information Management System (IMS) in diverse geographic locations needs to be expanded to have a better understanding of national GBV trends. The data then needs to be presented to donors and key policy makers to advocate for additional funding and resources.

3) Positive gender and social norm change around GBV

The strategy will specifically focus on strengthening Somalia's legal framework on GBV and empowering communities to be agents of change for gender equality. The outcomes and outputs aim to contribute to the development and implementation of national and regional laws and targeted advocacy programmes, which seek to meaningfully engage all relevant stakeholders in preventing and reducing GBV in the country.

Midwifery tutor working to prevent FGM. ©UNFPA Somalia

Community engagement is a crucial component of successful behaviour change initiatives. With this in mind, this strategy aims to address the root cause of gender-based violence – gender inequality – through a community-based approach that will support the following:

- community conversations and engagement of traditional and religious leaders;
- a focus on developing the capacities and assets of women and girls to renounce discriminatory norms and practices
- advocate for the political participation, leadership and decision making positions for women and young people;
- utilise the knowledge and experience of local women's groups and engage men and boys as partners and change agents for the prevention of GBV all in the pursuit of positive changes in gender and social norms.

Geographic coverage

Somalia is a very unique operating environment that encompasses three distinct regions: South Central, Puntland and Somaliland. Various consultations were held with key stakeholders in each of the regions to determine if one strategy could realistically capture the gaps/challenges across these three landscapes. Based on feedback from the consultations it was recognized that although operating environments might vary, service providers across Somalia struggle with many similar issues, particularly in the areas of positive gender and social norm change, knowledge management and strengthening service provision and service provider capacity. Therefore, it was determined that the Sub-cluster would develop one strategy for all of Somalia. Partners will contextualize the overarching activities during the implementation phase.

The Sub-cluster is mandated to coordinate GBV activities in emergency settings. Therefore, existing and newly-identified drought and flood affected areas will be prioritized as well as areas impacted by conflict. The members will use the HRP and other national guidance to assess geographic coverage on a yearly basis.

Guiding Principles for supporting individual survivors

This strategy will reinforce the survivor-centered approach to service provision. Informed consent, which empowers beneficiaries to make their own choices, will be obtained before individuals participate

in any aspect of implementation. The specific principles that will be upheld on behalf of every individual are the following:[28]

- Non-discrimination
- Confidentiality
- Safety and security
- Respect

Guiding principles for implementation

The actions outlined in this strategy will be implemented using a rights-based approach. Community members will be engaged to examine cultural and social norms from a human rights perspective with service providers having the duty to ensure that their actions do not inadvertently violate individual rights. Increased awareness raising and on-going sensitization are expected to contribute to a positive social change across the country.

Y-Peer members strategize on the fight against harmful practices. ©UNFPA Somalia

There are opportunities throughout this strategy to engage a broad range of actors at the community level. Providers will ensure that women, men, boys and girls are included and consulted. Special measures will be taken to reach vulnerable and marginalized populations such as single-headed households, the elderly and adolescent mothers. Members recognize the need to engage men and boys as agents of change and not view them simply as potential perpetrators.

This strategy is designed around a results-based framework, which recognizes that well-informed program planning, efficient use of resources and accountability to affected populations, partners and donors are critical elements of effective humanitarian response and development assistance

Coordination and Partnership

The Ministry of Gender and Human Rights Development became co-chair (with UNFPA) of the Sub-cluster in November, 2017. The Sub-cluster must closely engage government actors at all different levels to ensure the institutionalization of GBV prevention and response measures. This engagement will ultimately lead to longer term development gains. Capacity-building is needed to ensure all relevant government actors understand their role in GBV prevention and response and that they have the skills and commitment to contribute to a coherent, collaborative effort.

[28] The Guiding Principles were taken directly from the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, 2015

Changing the structural framework that enables perpetrators to act with impunity (ie. rule of law, security sector reform) will require partners to address the issue from a development and humanitarian perspectives. This strategy was developed to complement existing humanitarian and development processes such as the National Development Plan, the Humanitarian Response Plan and the HCT-led Centrality of Protection Strategy.

The table below shows how the GBV- specific components of the two multi-year initiatives will be addressed in the strategy. Humanitarian Response Plans are developed on a yearly basis, thus the priorities encapsulated in the HRP will be incorporated into the national workplan, which will be reviewed each year.

Initiative	**GBV focused components in each of the initiatives**	**Linkages to this Strategy**
National Development Plan	• Reduce incidence of GBV by 20% by 2019 • Reduce prevalence of FGM/C to less then 70% by 2019 • Key legislation and policy frameworks enacted and popularized (CEDAW, Sexual Offences Bill, FGM Bill, FGM Policy, UNSCR, 1325, National Action Plan)	All three of the strategic priorities are designed to reduce incidents of GBV New laws, policies and rules that support the rights of survivors are enacted and promoted among law enforcement personnel Increased capacity of leaders at all levels to address GBV including negative cultural and religious practices that fuel violence against women and girls.
Centrality of Protection Strategy	• HCT to support robust referral systems being established in sites and collective centers including, development of a service map and linked to an interagency and multi sector referral pathway • Commitment to joint analysis and data-sharing. The outcome sought here is pulling together the different protection related data systems such as MRM, GBVIMS and population data systems such as PRMN and DTM, as well as other systems such FSNAU to develop a comprehensive protection picture	Functional GBV coordination mechanisms exist at national and sub-national level Increased engagement with priority clusters to promote GBV risk mitigation activities Increased availability of evidence for GBV programming and advocacy Increased awareness among donors and other key decision-makers of prevailing needs related to GBV prevention and response

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