SOMALIA
gender-based violence working group

2014 – 2016
STRATEGY

Contents

Executive Summary *5*

Situational Analysis *6*

Gap analysis *9*

The Three-Year Strategy *11*

Guiding Principles *15*

Definition of concepts *16*

Results Framework *17*

Key Result Area 1: Prevention *18*

Outcome 1: Communities empowered to be agents of change to prevent GBV 18

Implementation Strategy 20

Priority Interventions 21

Key Result Area 2: Service Provision and Response *22*

Outcome 2.1: Improved access for survivors to clinical care 22

Implementation Strategy 23

Priority Interventions 24

Outcome 2.2: Improved access to quality case management and PSS 25

Implementation strategy 26

Priority interventions 27

Outcome 2.3: Improved post-incident referrals and safety response for GBV survivors 28

Implementation Strategy 28

Priority interventions 28

Key Result/Priority Area 3: Access to Justice and Rule of Law *29*

Outcome 3.1: Adoption of laws, policies and international instruments 29

Implementation Strategy 30

Priority Interventions 30

Outcome 3.2: Formal and informal justice systems are equipped to uphold human rights of GBV survivors 31

Implementation Strategy 32
Priority Interventions 32
Outcome 3.3: Security and humanitarian actors empowered 33
Implementation Strategy 33
Priority interventions 34
Key Result/Priority Area 4: Coordination 35
Outcome 4.1: Strengthened coordination of prevention and response programmes 35
Implementation strategy 36
Priority Interventions 37
Outcome 4.2: Enhanced collaboration with other actors 38
Implementation Strategy 39
Priority interventions 39

Acronyms

AMISOM	African Union Mission in Somalia
BCC	Behaviour Change Communication
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
CP IMS	Child Protection Information Management System
CRC	Convention on the Rights of the Child
CMR	Clinical Management of Rape
CHWs	Community Health Workers
CPWG	Child Protection Working Group
FGM/C	Female Genital Mutilation/ Cutting
GBV	Gender-Based Violence
GBV AoR	Gender-Based Violence Area of Responsibility
GBV IMS	Gender-based Violence Information Management System
GBV WG	Gender-Based Violence Working Group
HCT	Humanitarian Country Team
IASC	Inter-Agency Standing Committee
IDPs	Internally Displaced Persons
IEC	Information Education Communication
IM	Information Management
IPV	Intimate Partner Violence
ISP	Information Sharing Protocol
M&E	Monitoring and Evaluation
MCH	Mother and Child Health Centre
MHPSS	Mental Health and Psychosocial Support
MHPSS WG	Mental Health and Psychosocial Support Working Group
MoHDPS	Ministry of Human Development and Public Services (Federal Government of Somalia)
MOSLA	Ministry of Labour and Social Affairs (Somaliland)
MOWFSA	Ministry of Women, Family and Social Affairs (Puntland)
NGOs	Non-Governmental Organisations
PSG	Peace and State building Goals
PSEA	Protection from Sexual Exploitation and Abuse
PSS	Psychosocial Support Services
UNSCR	United Nations Security Council Resolution
SNAF	Somali National Armed Forces
FGS	Federal Government of Somalia
UN	United Nations
UNSCR	United Nations Security Council Resolution
UNFPA	United Nations Population Fund

Executive Summary

Gender-Based Violence (GBV) is widespread in Somalia. Despite uncertain statistics and data about the scope of the violence, the Federal Government of Somalia (FGS), the local authorities in Somaliland and Puntland, and the international community all agree that GBV exists at unacceptable levels and must be curbed.

Decades of conflict, insecurity, environmental shocks, and the widespread use of harmful traditional practices put women and girls in particular at risk of GBV in Somalia. This is particularly true for Internally Displaced Persons (IDPs) who are at risk of GBV and sexual exploitation due to limited security in the IDP settlements, general poor living conditions, the requirement to undertake risky livelihood practices to survive, and limited clan protection. Among the IDP population women and girls are at greater risk, especially those from minority clans and female-headed households, and female elderly persons.

GBV data from Banadir, Middle and Lower Shabelle, and Bari[1] regions indicate that the majority of cases reported were rape (41 per cent) followed by physical assault (39 per cent), sexual assault (11 per cent), denial of resources (four per cent), psychological abuse (three per cent), and forced marriage (two per cent). Data from Somaliland shows a particularly disturbing increase in the number of reported gang rapes in the region in 2013[2]. Although conflict is at the core of GBV, deep-rooted cultural beliefs create persistent inequalities between men and women and place women at particular risk of being victimized. Accepted cultural practices such as FGM/C, forced and early marriage and intimate partner violence are prevalent throughout the country and are generally underreported.

The predominant perpetrators of sexual violence and exploitation vary by region (Somaliland, Puntland, and south and central Somalia). Given the conflict in the south and central of Somalia, violence and exploitation perpetrated by 'men in uniform' is more prevalent than in Puntland and Somaliland where such acts are, more often than not, perpetrated by men in civilian clothes. Commonalities exist in all three regions when it comes to other forms of GBV, such as domestic violence, FGM/C, and early marriages as well as with regard to responses to these incidents. Rather than using the formal judicial system to address a GBV incident, elders and district authorities prefer to turn to either Shari'a Law or *Xeer* (customary law), even in regions where formal judicial systems are in place. In these systems, justice is delivered by agreement between the perpetrator's and survivor's male heads of household.

The availability of medical services is largely dependent on the international community especially in terms of service delivery, necessary trainings, drugs, supplies and equipment resulting in limited access to these services by the Somali population. Medical personnel are

[1] GBVIMS – June 2012-July 2013
[2] Ministry of Labour and Social Affairs (MOLSA) Puntland and UNFPA, "Key results of SGBV activities implemented by MOLSA (April – June 2013)

neither trained in Clinical Management of Rape (CMR) nor the provision of post-rape treatment drugs. Psychosocial support services (PSS) are under-resourced and psychosocial support personnel do not have access to professional education, resulting in a highly inadequate psychosocial work force in Somalia.

The continued emphasis on governance and on the adherence to the rule of law by the Somaliland and Puntland authorities, coupled with the FGS' commitment through the Joint Communiqué[3] to address sexual violence in conflict and post-conflict was the catalyst for the development of a GBV strategy. At the request of the Resident and Humanitarian Coordinator for Somalia and the Humanitarian Country Team, the GBV Working Group as the main humanitarian body coordinating GBV interventions for the United Nations, spearheaded the drafting of this Strategy.

A three-year (2014 to 2016) Strategy was developed with the main goal to help Somalis reduce GBV through preventive measures and the provision of quality and timely multi-sectoral services to survivors. Within this goal, four categories were developed: (1) prevention; (2) response; (3) access to justice and rule of law; and (4) coordination. The Strategy has a slightly stronger focus on objectives one and two, simply because the bulk of the GBV WG members are humanitarian actors. Nevertheless, the Strategy recognizes that a critical component to reducing GBV is to ensure that access to justice and rule of law and coordination amongst the stakeholders responsible to prevent GBV is a key priority grounded in objectives three and four. This translates into a strategy that ensures continued and improved delivery of response services to GBV survivors while at the same time making working with development and political stakeholders on an effective rule of law framework, and genuine mechanisms for equal access to justice a priority. Justice and rule of law related activities will take time to implement as those stakeholders best placed to address prevention are either historically not part of the GBV WG or are newly established bodies such as the United Nation's Rule of Law and Security Institutions Group.

A cornerstone of the prevention side of the Strategy is not only key provisions in the New Deal Compact (Peace and State building Goal 3 "Justice", priorities 1, 3, and 5), but also aspects of the Joint Communiqué, which contain concise commitments that are highly relevant to reforming the security sector and rule of law institutions. It is on the mechanisms of these two documents that the GBV Strategy will base its preventative activities. The Consolidated Appeal Process (CAP) is the anchor for humanitarian interventions with regard to GBV. The cost to implement the Strategy stands at US$15.5 million for all three regions of Somalia for three years.

[3] The Joint Communiqué was signed on 07 May 2013 in London between the Federal Republic of Somalia and the United Nations on the Prevention of Sexual Violence. Specifically it was signed by SRSG Bangura on behalf of the UN and Somali Minister of Foreign Affairs on behalf of the FGS

Situational Analysis

Decades of conflict, insecurity, environmental shocks, and the widespread use of harmful traditional practices put women and girls in particular at risk of GBV in Somalia. This is particularly true for IDPs who are at risk of GBV and sexual exploitation due to a limited security environment in most of the IDP settlements throughout the country, generally poor living conditions, the requirement to undertake risky livelihood practices to survive, and limited clan protection. The IDP population in Somalia is estimated at 1.1 million, of which 52 per cent are women and girls who are more at risk of GBV, especially those from minority clans and female-headed households or female elderly persons. The majority of IDPs are concentrated in south and central Somalia where humanitarian needs remain high and where most of the humanitarian interventions have taken place over the years. However, IDPs are not the only ones affected and GBV is not limited to south and central Somalia. Both displaced populations and the host communities in the more stable areas of Somaliland and Puntland also face high levels of GBV.

Regional disparities

The absence of central governance during the civil war has seen the northern part of the country split into autonomous and semi-autonomous regions: the internationally unrecognized autonomous state of Somaliland and the semi-autonomous state of Puntland. The area south of these two regions is commonly referred to as south and central Somalia where the Federal Government has varying degrees of control. Somaliland and Puntland have been relatively stable over the last decade, thereby allowing for a stronger emphasis on building governance and rule of law. Access to rural and non-FGS controlled areas in south and central Somalia has proven to be more challenging, with limited humanitarian interventions and nearly no sustained development activities taking place.

To date, no GBV analysis that focuses on the specific differences between the three zones of Somalia exists and this is a recognized gap in the evidentiary knowledge base. The characteristics of sexual violence and exploitation incidents and predominant perpetrators vary by regions. For example, given the active conflict in south and central Somalia and the high number of security forces operating in the area, sexual violence by 'men in uniform', is a more frequent allegation than in Somaliland and Puntland.

Whereas allegations of sexual and gender-based violence perpetrated by security forces constitute a large problem in the south and central parts of Somalia, these incidents do not play a predominant role in Somaliland and Puntland. However, the deep-rooted cultural beliefs existent throughout the country come to the forefront in these more stable areas. Many women endure domestic violence, including physical and sexual assault and often remain with their husband as a result of cultural beliefs that dictate submissive behaviour of women. Loss of their children in case of a divorce might also play an important role in this decision.

Although legislative progress such as the endorsement of the National Gender Policy in 2008 (Somaliland) and the recognition of women in the Puntland Constitution has been made in recent years, there has been little tangible impact on the ground. Key concepts such as 'Gender

mainstreaming' and 'human rights observance' are theoretic in nature only and GBV practically remains under the jurisdiction of Shari'a and customary law. GBV cases under either system tend to be judged without taking the rights of the survivor into consideration. Restitution is paid to the survivor's family instead of directly to the survivor, or if unmarried, the survivor can be forced to marry the perpetrator.

Other forms of GBV, such as domestic violence, FGM/C, and early marriage are prevalent in all three regions and there tends to be a common response to such violence. Elders and district authorities prefer using either Shari'a Law or *Xeer* (customary law) rather than the formal judicial system to address GBV incidents, even in zones where a formal judicial system is in place. As a result, justice is delivered by agreement between the perpetrator's and survivor's male head of household. In IDP settlements where elders may have less authority even customary systems may not be available to seek protection and recourse

History of GBV interventions in Somalia

Efforts addressing GBV have primarily focused on the provision of humanitarian multi-sectoral response services such as medical, psychosocial, and legal services. The success of the multi-sectoral approach is mixed and varies depending on the region. Where political stability is greater, there are more opportunities to access the populations in need and to set up proper structures to address the needs of survivors. Lack of consistent funding coupled with funding for specific areas of the country only, has often led to haphazard implementation of GBV programmes without sustainability. Consequently, GBV activities focused on response efforts in a humanitarian emergency context rather than a broader strategic response around prevention and access to justice and rule of law. In an effort to mitigate GBV, the only preventative activities undertaken within the humanitarian sphere have been the provision of street lighting, fuel efficient stoves and lockable doors in IDP settlements. While such interventions are important, they focus on contributing factors to GBV but not on the cause of GBV. The latter is evidenced by the fact that criminal prosecutions are negligible, as is the willingness of survivors to access the legal justice system.

Gap analysis

Though there are differences in the concentration of the types of GBV occurring in the three zones, there are a number of common challenges in responding to the needs of survivors. It is generally recognized that the services provided rarely meet international standards. Furthermore, there is a major gap throughout the country in the provision of safe spaces/shelters for GBV survivors and their families.

Health

Health providers struggle to have appropriate training and supplies to care for GBV survivors. Health facilities often lack Clinical Management of Rape protocols and health practitioners do not know how to properly treat GBV survivors. As a result, survivors are potentially put even more at risk. Many health centres do not have the necessary equipment and drugs to treat survivors. Another key challenge is the lack of confidential spaces in which to examine and counsel survivors. In addition, hospitals and health centres are generally only found in larger cities and are therefore difficult to access for many survivors especially from rural areas where the humanitarian community has no access.

Psychosocial support

Psychosocial support services (PSS) are an integral part of a multi-sectoral approach to survivor care. However, human resource capacity and coverage of these services in Somalia is low and nearly non-existent in rural and areas inaccessible to humanitarian workers. GBV service providers have indicated that their staff that undertakes PSS (e.g. community support workers, social workers, case workers, counselors) have limited skill-sets compared to international standards, and also have limited opportunities to improve their skills. Specialized PSS service providers are almost non-existent.

Legal services

There is no one legal system that addresses GBV in Somalia and this constitutes a particular challenge. Different legal systems operate alongside each other, with none of the systems (common law, customary law, and/or Shari 'a Law) providing sufficient legal redress for survivors. Although the 2012 Provisional Constitution of Somalia prohibits all forms of violence against women and the 2001 Constitution of the Republic of Somaliland and the 2008 Constitution of the Puntland State of Somalia recognize the "rights of women", there is a discrepancy between commitments made and the reality on the ground.
The lack of a functional formal judicial system and rule of law in many areas often means that the likelihood of legal redress in favour of the survivor is extremely low. Not surprisingly, survivors' confidence in the formal justice system is nearly non-existent. Only roughly one per cent of

survivors of GBV in Banadir, Lower and Middle Shabelle regions decided to draw on legal services between July and December 2012. Anecdotal evidence suggests that survivors seek redress through the traditional justice systems which regularly fail to take their human rights into account.

The security sector and most importantly the Somali police have a very limited capacity to guarantee the safety of the civilian population. Most survivors turn to traditional clan protection mechanisms for their security. Neither the police nor any traditional mechanism recognizes the specific needs or legal rights of individual GBV survivors. Many of the perpetrators in south and central Somalia are armed men in uniform including government security forces, militias, private security and AMISOM forces. Uniforms are widely available on the local market. This makes it difficult to know whether the perpetrator really was a security official and does not help to build confidence in security forces in the first place.

Although efforts have been made by the international community to improve the security situation for women by training police officers on gender and SGBV and encouraging the recruitment of female police officers, much work still needs to be done. There is no mechanism to protect witnesses in cases forwarded for legal redress nor is there a mechanism to protect the GBV service providers who often operate at their own risk.

Livelihoods

The number of organizations providing livelihood support to survivors of GBV is extremely low. This is a critical gap as survivors are often socially outcast and required to fend for themselves and their children. Many survivors are therefore in an extremely marginalized position following the incident which puts them at high risk of further victimization.

The Three-Year Strategy

Despite uncertain statistics and limited availability of data on GBV, all stakeholders including the Federal Government of Somalia, local authorities, and the international community acknowledge that GBV is pervasive throughout Somalia. In contrast, services to survivors are only available in very limited areas and criminal prosecutions remain negligible. This situation coupled with the continued emphasis of governance and adherence to the rule of law by the Somaliland and Puntland authorities and the FGS' commitment[4] to address sexual violence in conflict and post-conflict contexts was the catalyst for the development of a GBV strategy. In an effort to capitalize on this momentum, the United Nations in 2013 declared GBV a priority focus area that requires attention and both short and long-term intervention strategies. In response, this Strategy was developed.

Strategic Goal

The goal of the three-year Strategy is to reduce GBV in Somalia through prevention including conflict related violence, and by providing quality and timely multi-sectoral services to survivors.

Objectives of the Strategy

1. To **build community resilience** to prevent and mitigate acts of GBV and harmful traditional practices and contribute to the systemic implementation of the United Nations Security Council related Resolutions on Sexual Violence in Conflict.
2. To **improve capacity** for timely delivery of appropriate medical, psychosocial and post incident safety response for GBV survivors.
3. To **strengthen rule of law and access to justice** to reduce the vulnerability of women, men, boys and girls to GBV.
4. To **strengthen coordination of GBV prevention and response activities** among GBV WG members, other humanitarian actors, Somali civil society, UN integrated mission and government authorities.

Scope

The bulk of the technical expertise on GBV has primarily been about response services to survivors which is where the strength of the GBV Working Group. Until now, the GBV WG has only rarely engaged with security forces and other rule of law actors in Somalia. Stakeholders in the position to influence preventative mechanisms such as the judiciary and the security sector have been slow to engage with the GBV WGs and vice versa. While in some areas local authorities coordinate with the working groups, their technical capacity is exceedingly limited, and they often engage more on issues of organizational spending rather than programmatic improvements.

[4] In April, 2013 UK Foreign Secretary, William Hague, launched the *G8 Declaration on Preventing Sexual Violence:* https://www.wiltonpark.org.uk/the-g8-makes-landmark-declaration-on-preventing-sexual-violence; The SRSG for Sexual Violence in Conflict, Zeinab Hawa Bangura, was instrumental in supporting the Federal Government of Somalia (FGS) and UN to issue a *Joint Communiqué on Prevention of Sexual Violence* (visited Somalia in April, 2013): http://unpos.unmissions.org/LinkClick.aspx?fileticket=sI1uGop6Bc8%3D&tabid=11461&language=en-US.

Additionally, the GBV WG historically only included participants from the humanitarian sector and not the security or political domain. Therefore a key component of the Strategy is to improve coordination among the various stakeholders in order to ensure that decisions with significant bearing on GBV prevention and response are taken within rule of law-related fora such as the newly established Rule of Law and Security Institutions Group. The entry point for this will be the Joint Communiqué on the Prevention of Sexual Violence which contains concise commitments to reform the security sector and rule of law institutions. On the UN side, UNSOM has the main responsibility to coordinate the implementation of this Communiqué and will be supported by the GBV WG. This will require consistent participation of rule of law stakeholders, as without them the GBV WG will not be in a position to comprehensively take forward a number of the key objectives of the Strategy.

Methodology

The Strategy was developed through participatory consultations conducted with GBV WG members across the three regions. In August and September 2013, consultations were held in Somaliland (Hargeisa), Puntland (Garowe & Bossaso), south and central Somalia (Mogadishu/Banadir, Bay & Bakool, Middle & Lower Shabelle, Dhobley/Lower Juba, Belet Weyne/Hiraan) and also in Nairobi. 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 GBV WG members, with support from the Global GBV Area of Responsibility, a global level forum for coordinating prevention and response to GBV in humanitarian settings, and then validated by GBV WGs at the national and sub-national level.
For ease of reference, the Strategy is broken down by objective and sub-divided by region in order to show how each intervention will be implemented in each region, and whether the implementation strategy is different or the same. The Strategy will build upon the concept of sexual violence in conflict (SVC) as defined in the Rome Statute and other relevant international courts jurisprudence. UNSOM will take the lead in this sector and will continue to work with the UN Country Team and AMISOM as well as national counterparts to enshrine these concepts in their programmes and actions.

Cross-cutting Issues

The Strategy will adhere to the guiding principle that all action will reinforce the survivor-centred approach to service provision. Further, the Strategy will adhere to the Inter-Agency Standing Committee's five Commitments on Accountability to Affected People/Populations (CAAPs).[5] The following cross-cutting issues will receive specific attention throughout the Strategy:

- **Protection from Sexual Exploitation and Abuse (PSEA):** The GBV WG will support the PSEA Network in implementing relevant mechanisms (codes of conducts, internal and

[5] IASC Task Force on Accountability to Affected Populations http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-common-default&sb=89

external complaints mechanisms and investigation capacity). The GBV WG will also support the Network in implementing a survivor assistance strategy. The GBV WG prevention and response objectives will include references to PSEA as a cross-cutting issue.

- **Disabilities:** Women and girls with disabilities are often at greater risk of GBV, both within and outside the home, and are disproportionately affected in emergencies and conflict situations due to inaccessible evacuation, response, and recovery efforts. The Strategy will ensure that women and girls with disabilities are prioritized.

- **Advocacy:** The GBV WG will engage in advocacy at all levels within the four objectives. The group will engage in budgetary advocacy with government counterparts to ensure that the Government provides adequate funds for efforts to reduce GBV. Legislative advocacy will ensure that GBV legislation is prioritized.
  Mass media campaigns and advocacy activities will be developed and implemented to ensure that Somalis are aware of their rights and available services. This includes health advocacy to ensure that CMR is mainstreamed throughout the health sector. Political advocacy will ensure support through all levels. The SRSG and his Deputies will be counted on to lead high level policy dialogue and advocacy with government and local authorities and the international community to ensure availability of adequate and sustainable resources to strengthen the technical and infrastructural capacities and systems of government institutions including the judiciary and law enforcement.

- **Targeted Actions:** In addressing GBV, there is an understanding that different population groups need to be targeted and responded to differently. As a result, the Strategy will use different approaches to target the following key groups:

    - **Men:** Interventions focused on boys and men should not be pitted against those aimed at women and girls but rather work toward establishing programmes that engage all populations. When working specifically with men, the GBV WG will adhere to three key principles: (1) violence against women and girls is almost always more prevalent than violence against men and boys in conflict settings; (2) men and boys are part of the problem and thus must become a greater part of the solution; and, (3) sexual violence against women and girls, as well as against boys and men, stems from many of the same underlying causes and thus the solutions must be approached more holistically.[6]

    - **Women:** Keeping women motivated to address and voice their concerns, violations against women and girls, and addressing GBV through women and girls' participation and engagement is vital. Women and girls must be seen as agents of change, and as powerful actors in the fight against GBV. Inclusion of women and girls in any GBV intervention is paramount.

[6] Sexual Violence in Conflict and Post-Conflict: Engaging Men and Boys, MenEngage-UNFPA Advocacy Brief, http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Advocacy%20Brief-%20Sexual%20Violence%20FINAL.pdf

- **Elderly women:** GBV activities often focus on women and girls of reproductive age, meaning that elderly women are often left out. Elderly women are often the drivers of harmful practices, and as such they need to be targeted for direct interventions and their needs must be taken into consideration.

Guiding Principles

This strategy will reinforce the survivor-centred approach to service provision. Informed consent 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:

- **Safety/Security and Sensitivity:** Considering the vulnerability of GBV survivors, the issue of safety and security is paramount. Survivors need to be protected from the risk caused by the persistent threat or violence from the perpetrators who do not want to be held accountable for their actions. Sensitivity to the safety and security of survivors must be a priority and obligation for service providers at all times. Service providers must provide a timely response to the needs of the survivor.

- **Respect:** GBV survivors often feel degraded, suffering from feelings of low self-esteem, respect and confidence. Survivors rely on service providers to support them and restore their dignity and respect. The service providers are expected to support the survivors in regaining lost confidence and all actions taken must be guided by respect for their choices, rights and dignity.

- **Confidentiality:** GBV often results in shame and stigma and many survivors lack the feeling of trust on confidential issues. Trust must be established to help survivors acknowledge that they have been subjected to violence and that they are in need of available services. In order to provide survivors with the best possible care, service providers must respect confidentiality under all circumstances and protect the survivors' privacy. Information about the survivors must be collected, stored and transferred safely for the protection of all involved.

- **Non-discrimination**: Service providers must not discriminate against survivors, based on sex, gender, sexual orientation, clan, age, social status, nationality, or religion.

- **Human rights:** This Strategy follows a Human Rights Based Approach (HRBA) making the respect of human rights of all parties involved one of its guiding principles.

Definition of concepts

Throughout this strategy different GBV-related terms are used (see below and 'Annex II Glossary of Terms' on GBV terms). The perceived meaning of these terms often varies based on the cultural and social norms of a particular context. The GBV WG uses the global, human rights based, definitions found below:

TYPE OF GBV	DEFINITION/DESCRIPTION*
Rape	Non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object. Rape includes marital rape and anal rape/forced sodomy.
Sexual Assault	Any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks.
Physical Assault	An act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.
Forced Marriage & Early Marriage	The marriage of an individual against her or his will. Early marriage (marriage under the age of legal consent) is a form of forced marriage as the girls are not legally competent to agree to such unions).[7]
Psychological/ Emotional Abuse	Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, social exclusion, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc. "Sexual harassment" is included in this category of GBV.
Denial of Resources, Opportunities or Services	Denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. "Economic abuse" is included in this category. Some acts of confinement may also fall under this category.
Contextualised types of GBV	
Sexual Exploitation	The term "sexual exploitation" means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of "forced prostitution" can also fall under this category. [8]
Sexual Abuse	The term **"**sexual abuse**"** means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. [9]
Domestic Violence/ Intimate Partner Violence	Violence that takes place between intimate partners (spouses, boyfriend/girlfriend) as well as between other family members. This type of violence may include physical, sexual and/or psychological abuse, as well as the denial of resources, opportunities or services.[10]
Harmful Traditional Practices	Cultural, social and religious customs and traditions that can be harmful to a person's mental or physical health. It is often used in the context of female genital circumcision/mutilation or early/forced marriage. Other harmful traditional practices affecting children include binding, scarring, burning, branding, violent initiation rites, fattening, forced marriage, so-called "honour" crimes and dowry-related violence, exorcism, or "witchcraft".[11]
**Please note: the definitions provided here refer to commonly accepted international standards. Local and national legal systems may define these terms differently and/or may have other legally-recognized forms of GBV that are not universally accepted as GBV.*	

[7] Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, (UNHCR, 2003).
[8] UN Secretary General's Bulletin on Protection for Sexual Exploitation and Abuse (ST/SGB/2003/13).
[9] *ibid.*
[10] GBVIMS User Guide (2010).
[11] "Rights of the Child" Note by the Secretary-General. 29 August 2006. http://www.unicef.org/violencestudy/reports/SG_violencestudy_en.pdf

Results Framework

Goal, Objectives, Outcomes, Outputs and Strategic Actions

GOAL

The goal of the three-year Strategy is to reduce GBV in Somalia through prevention including conflict related violence and by providing quality and timely multi-sectoral services to survivors.

Key Result Area 1: Prevention

Objective: To build community resilience to prevent and mitigate acts of GBV and harmful traditional practices and contribute to the systemic implementation of the United Nations Security Council related Resolutions on Sexual Violence in Conflict

Outcome 1: Communities empowered to be agents of change to prevent GBV

Outcome	Output	Strategic Actions		
		2014	2015	2016
Outcome 1: Communities empowered to be agents of change to prevent GBV	**Output 1.1.1:** • Community-based structures capacitated on GBV prevention • Social norms guidance notes and implementation tools, training package, and monitoring tools designed and disseminated	• Review of primary prevention programmes in the country to address immediate needs of the population; • Facilitate round-table discussions with the heads of security institutions on PSEA; • Hold dialogue sessions with gatekeepers at the IDP camps on GBV prevention; • Train GBV WG members, government and other GBV actors and service providers on the application and use of the GBV guidance notes and implementation tools; • Adapt existing training packages to suit the cultural context of the country and roll out trainings in the communities and among GBV actors/service providers; • Conduct strategic outreach activities targeted at local authorities, social and health workers, teachers, traditional and religious leaders, children/youth, women's groups, and community gatekeepers; • Conduct specific pilot trainings for clan elders and dialogue sessions on GBV prevention; • Provide financial support to female	• Hold dialogue sessions with gatekeepers at the IDP camps on GBV prevention; • Conduct strategic outreach activities targeted at local authorities, social and health workers, teachers, traditional and religious leaders, children/youth, women's groups, and community gatekeepers; • Hold conferences with religious leaders from the three zones to discuss the implications of GBV on the general development of the communities; • Provide trainings and financial support to the established male and youth Networks to engage on community sensitizations, policy dialogues and mobilization against GBV;	• Conduct strategic outreach activities targeted at local authorities, social and health workers, teachers, traditional and religious leaders, children/youth, women's groups, and community gatekeepers;

		lawyers to conduct legal rights education in preventing GBV; • Support provision of lighting, fencing, lockable doors, fuel efficient stoves for IDPs; • Develop and support the implementation of specific community education programmes on UN Security Council Resolutions 1325, 1820, 1960, and 2106 among others. • Develop culturally sensitive harmonized GBV guidance notes and implementation tools; • Establish zonal community-based male engagement Networks to lead advocacy against all types and forms of GBV; • Provide trainings and financial support to the established Male and Youth Networks to engage on community sensitizations, policy dialogues and mobilization against GBV;		
	Output 1.1.2 Participatory community-based prevention IEC/BCC materials available and standard guidance notes on how to use them	• Promote use of a culturally sensitive approach in working with communities and local leaders with primary concentration of resources on IDP camps and settlements; • Strengthen education and awareness-raising on the implications of GBV to the wellbeing, human rights and development of men, women and children using community dialogue, theatre, art and radio; • Develop harmonised GBV prevention IEC materials and promote community-led campaigns; • Sensitize the general public on GBV as a security and violation of rights issue;	• Promote the use of multi-sectoral and holistic communication campaigns targeting men and women;	• Develop community specific advocacy plans, awareness-raising on causes and contributing factors to GBV;
	Output 1.1.3 Evidence-based community mitigation and safety	• Develop guidance note/methodology for evidence-based community engagement prevention programmes	• Document lessons learned on effective community-based strategies for protection and mitigation, including	

	mechanisms guidance and tools developed and disseminated	and community security programmes based on the specific issues and needs identified from the three zones of the country;	effective infrastructure and other support (lighting, fencing, lockable doors, fuel efficient stoves etc.);	
	Output 1.1.4 Community and policy engagement and dialogues on FGM/C total abandonment enhanced	• Develop evidence-based community engagement prevention programmes based on the specific issues and needs from the three zones of country; • Engag young men to learn about their attitudes toward GBV, including those around marriage expectations related to FGM/C; • Strengthen community protection mechanisms by advocating with custodians of traditions and religions to abolish harmful traditional practices such as FGM/C and promote use of reproductive health services;	• Advocate with custodians of traditions and religions to abolish harmful traditional practices such as FGM/C and promote use of reproductive health services; • Advocate for the implementation and enforcement of total abandonment of FGM/C policies, legislations, 'Fatwas' and declarations;	• Advocate for the implementation and enforcement of total abandonment of FGM/C policies, legislations, 'Fatwas' and declarations;
Total cost for outcome 1: US$ 4,500,000 (Four million five hundred thousand US Dollars)				

Implementation Strategy

In order to facilitate a swift implementation of the Strategy, focus should be put on strengthening the involvement of all key community structures to take leadership in community education on human rights treaties and their application to GBV prevention, development of consolidated guidance notes, tools, packages and advocacy materials on GBV prevention, mainstreaming and cooperation with Somali civil society in all three zones. Prevention in Somaliland and Puntland is particularly important within the context of relative stability and greater access to rural communities. Most of the GBV interventions are currently focused on urban areas particularly in south and central Somalia.

Geographical Area	Prevention	Engaging government and civil society
Somaliland	Somaliland is relatively stable and programmes are designed within a development context. The scope of community education activities on FGM/C needs to be scaled-up and broadened to GBV prevention. The high-level policy dialogues on integrated approaches to GBV prevention need to be strengthened.	Hold participatory and consultative discussions on having coordinated and harmonised prevention programmes and initiatives;
Puntland	The prevention programme has widely covered the major towns along tarmac roads. However, there is a need to move to rural areas engaging communities including women, youth members and religious leaders. A need to develop a GBV BCC strategy that guides the GBV prevention programme has been identified. At the higher level, there is a need to advocate and facilitate policy dialogue targeting senior	Engagement with government counterparts and civil society must be prioritised.

	legislative bodies (parliament), to reform legislations including penal code and criminal procedures. Specific focus on capacity building among various actors and service providers including law enforcement bodies is essential to comprehensive GBV prevention.	
South and central Somalia	GBV interventions in south and central Somalia have been focused on response as opposed to prevention. The Strategy will therefore focus on initiating prevention programmes at all levels, including dialogue with policy makers, legislators, community and local authorities, opinion leaders and women's groups.	Build the capacity of local civil society and government on application of prevention guidance would be prioritised.

Priority Interventions

The GBV WGs in all three zones will be capacitated to collaborate with Governments and communities to engage in GBV prevention programmes and initiatives at all levels within both humanitarian and development contexts.

Geographical Area	Key issues among IDP populations	Key issues among host communities
Somaliland	Sexual violence, particularly gang rape is on an alarming rise and early marriage and FGM/C issues are prominent.	IPV, gang rape, early marriage and FGM/C
Puntland	Sexual violence and early marriage (as children are married off early for families to profit from dowry driven by poverty) are prominent.	IPV, early marriage and FGM/C
South and central Somalia	Sexual violence and early marriage (as children are married off early for families to profit from dowry driven by poverty) are prominent.	Sexual violence, PSEA, IPV, early marriage and FGM/C

Alignment with New Deal

This objective focuses on mainstreaming GBV interventions and interventions will therefore be aligned with **PSGs 2 (Security), 3 (Justice), 4 (Economic Foundations), and 5 (Revenue and services)** as well as the cross-cutting issue of **capacity development**.

Key Result Area 2: Service Provision and Response

Objective: To improve capacity for timely delivery of appropriate medical, psychosocial and post incident safety response for GBV survivors

Outcome 2.1: Improved access for survivors to competent, confidential and compassionate clinical care

Outcome	Output	Strategic Actions		
		2014	2015	2016
Outcome 2.1: Improved access for survivors to competent, confidential and compassionate clinical care	**Output 2.1.1:** Protocols and technical guidelines for clinical response to sexual assault survivors developed and implemented	• Develop Somali-specific CMR protocols for a) diseases treatment/prevention and b) for documenting and collecting forensic evidence; • Advocate for the endorsement of the CMR protocol by national authorities; • Work with the health system to incorporate management of GBV case information within the health care system;	• Develop effective M&E systems for service provision; and document and share best practices and tools for CMR;	
	Output 2.1.2: Improved technical capacity of health workers to provide efficient and effective responses to GBV survivors	• Collaborate with the Health Cluster to provide technical and operational guidance on implementing CMR in health facilities; • Advocate for the inclusion of CMR, emotional support and basic GBV guiding principles and concepts in the curriculum of nursing and midwifery and for other relevant categories of health staff; • Initiate advocacy for the recruitment and training of female health workers, particularly midwives and nurses, with government bodies, Health Cluster and Health Sector; • Create a cadre of trainers to roll-out trainings on CMR, emotional support and GBV guiding principles; • Provide trainings on CMR and GBV guiding principles for health	• Hold joint supportive supervision of health workers in this section; • Advocate for the motivation of health workers working on CMR; • Advocate for the recruitment and training of female health workers, particularly midwives and nurses, with government bodies, Health Cluster and Health Sector; • Provide refresher training of laboratory technicians as a cadre of health personnel who have an important role to play in taking and preserving specimens for eventual legal actions;	

		workers, including female health workers; • Produce harmonised-culturally appropriate IEC materials for use by Community Health Workers (CHWs); • Investigate the formal process for issuing medical certificate and advocate for the availability of forensic doctors; • Train laboratory technicians as a cadre of health personnel who have an important role to play in taking and preserving specimens for eventual legal actions;		
	Outcome 2.1.3: Improved physical infrastructure, equipment and supplies for the effective and ethical treatment of GBV survivors	• Ensure availability and usage of post-rape treatment drugs and equipment supplies to health facilities, including forensic equipment; • Advocate with government bodies, Health Sector and Health Cluster regarding establishment of confidential rooms ("family rooms") and separate lockable filing cabinets in all static health facilities; • Advocate with government bodies, Health Sector and Health Cluster for the availability of forensic equipment for proper treatment and collection of forensic evidence;		
Total cost for outcome 2.1: US$ 3,350,000 (Three million three hundred and fifty thousand US Dollars)				

Implementation Strategy

This Strategy recognizes the importance of improving access to services by building competent, confidential and compassionate care through MCHs as well as providing higher-level care at regional hospitals. MCHs provide free care and are often the most accessible health facilities for women and girls, especially in rural areas. However, capacity and availability of female staff, drugs and infrastructure at the MCH level is low. Also, prevailing cultural attitudes among health workers limit the ability to provide compassionate and ethical care based on GBV guiding principles. There is a need to collaborate with the Health Cluster and Health Sector, including the Department of Health and Ministry of Health in each area of authority through the Clinical Management of Rape (CMR) Task Force to

coordinate efforts and address the significant gaps. For health facilities in both government and non-government controlled areas careful assessment of the security context for providing CMR services should be conducted, and appropriate strategies defined with support from the GBV WG, if required.

Priority Interventions

Rape and sexual assault are priorities for medical response interventions. Building capacity to effectively and compassionately treat all GBV survivors accessing health facilities is a priority, including survivors of intimate partner violence and FGM/C.

Alignment with New Deal

Outcome 2.1 is aligned with **PSG 5 Revenue & Services**. It contributes to the strategic objective to increase the delivery of equitable, affordable, and sustainable services that promote national peace and reconciliation amongst Somalia's regions and citizens.

Outcome 2.2: Improved access to quality case management and psychosocial support services for GBV survivors

Outcome	Output	Strategic Actions		
		2014	2015	2016
Outcome 2.2: Improved access to quality case management and psychosocial support services for GBV survivors	**Output 2.2.1:** Strengthened identification, reporting and referral pathways	• Support the development of referral pathways at regional and district levels; • Develop protocol and conduct training for stakeholders to activate safe referral based on GBV guiding principles; • Develop harmonised, culturally appropriate IEC materials and methodologies on PSS and available services; • Collaborate with the CPWG on the use and integration of community-based mechanisms for referral;	• Review and identify lessons learned from existing identification mechanisms and existing referral pathways to improve implementation; • Collaborate with the CPWG on the use and integration of community-based mechanisms for referral;	• Collaborate with the CPWG on the use and integration of community-based mechanisms for referral;
	Output 2.2.2: Standardised case management system which takes into account data management and accountability	• Support the implementation of the standardized case management protocol; • Support the finalisation/adaption of global GBV case management guidelines; • Create an accountability system and protocols based on informed consent and GBV guiding principles, particularly for dealing with high risk cases;		
	Output 2.2.3: Improved human resources capacity of staff involved in GBV case management	• Support the roll-out of case management trainings and guidelines; • Support roll-out of the MHPSS minimum standards for service providers training; • Advocate for and support initiation of a school for social workers in each zone; • Conduct GBV IMS/ CP IMS training		

		and refresher courses for GBV service providers;		
	Output 2.2.4: Improved guidance and capacity of staff involved in GBV psychosocial support	• Advocate for the roll-out of standards of care and levels of care in line with international standards (in cooperation with MHPSS WG); • Training package available for each level of care in line with international standards (in cooperation with MHPSS WG); • Support evidence based provision of material assistance to the GBV Survivors in Somalia;	• Develop Somali-specific guidelines; and advocate for availability and linkages with other services.	
	Output 2.2.5: Improved technical guidance on alternative livelihoods for GBV survivors	• Support alternative livelihoods projects for GBV Survivors;	• Develop tools to enable members to conduct participatory analysis of sustainable and safe livelihood strategies for GBV survivors and their families;	
	Output 2.2.6: An operational joint community-based complaints mechanism (including victim assistance and related activities)	• Support local and INGOs to initiate consultation with beneficiaries in communities to identify culturally adapted complaints mechanisms, and available referral systems (survivor assistance based on CBCM procedure document, draft Memorandum of Understanding (MOU) and ensure sign on by participating agency:	• Support local and INGOs to initiate consultations with beneficiaries in communities to identify) culturally adapted complaints mechanisms and available referral systems (survivor assistance).	
Total estimated cost for outcome 2.2: US$ 1,530,000 (One million five hundred and thirty thousand US Dollars)				

Implementation strategy

Across Somaliland, Puntland and south and central Somalia there will be little difference in implementation since there is a need to strengthen referral pathways at district and regional levels. There has been limited standardization in minimum standards for psychosocial support services, including the level of knowledge, skills and experience of psychosocial staff and concrete learning from PSS approaches and development of best practices in this context. Recently, efforts have been made to address these gaps including the development of minimum standards for MHPSS service providers and associated training package for the Somali context by the MHPSS working group. Guidelines on case management in child protection are being field tested. However, there is a need to adapt these to GBV cases. Personnel providing GBV case management and psychosocial support are largely concentrated in urban areas due to difficulties in access to rural areas and areas under control of non-governmental actors. An alternative livelihood strategy and programme will be adapted to rural areas. There is a need to work on methodologies and mobilize support for the extension of GBV psychosocial response and case management to these under-served areas across all zones.

Priority interventions

GBV case management and psychosocial support workers will be trained to handle all types of GBV in Somalia, including harmful traditional practices such as FGM/C, forced/early marriage and denial of resources. The frequency of different forms of GBV is affected by the context. Among IDPs and along transit routes sexual violence is common whereas in rural villages intimate partner violence, FGM/C and early marriage is widespread.

Alignment with New Deal

Outcome 2.2 is aligned with **PSG 5 Revenue & Services**. It contributes to the strategic objective to increase the delivery of equitable, affordable, and sustainable services that promote national peace and reconciliation amongst Somalia's regions and citizens.

Outcome 2.3: Improved post-incident referrals and safety response for GBV survivors

Outcome	Output	Strategic Actions		
		2014	2015	2016
Outcome 2.3: Improved post-incident referrals and safety response for GBV survivors	**Output 2.3.1:** Technical support provided to establish safe spaces for GBV survivors in need of temporary protection	• Pilot evidence based safe spaces initiatives/projects (interim care, safe houses, foster-family and other approaches); • Develop culturally sensitive SOPs for the operations of safe spaces and approaches appropriate in Somalia;	• Support evidence-based safe spaces initiatives/projects (interim care, safe houses, foster-family and other approaches);	• Support evidence-based safe spaces initiatives/projects (interim care, safe houses, foster-family and other approaches);
	Output 2.3.2: Media and other actors engaged in the importance of confidentiality for the safety of survivors and their families	• Engagement with the media on principles of survivor-centred reporting; • Training for service providers and humanitarian field staff on GBV guiding principles;	• Engagement with the media on principles of survivor-centred reporting;	
Total estimated cost for outcome 2.3: US$ 1,020,000 (One million twenty thousand US Dollars)				

Implementation Strategy

Across Somaliland, Puntland and south and central Somalia there will be little difference in implementation due to major gaps in all regions in post-incident safety response for survivors, knowledge of media, service providers and other stakeholders of the importance of confidentiality and the impact of safety for survivors, effective alternative livelihood programmes and PSEA. There is a need to tailor guidance on appropriate strategies for safe spaces to urban, rural, IDP contexts and non-government controlled areas. In addition, media engagement will be predominately concentrated in urban areas. PSEA protocols and engagement will focus on humanitarian, development and security actors.

Priority interventions

Sexual violence (including rape, child and adult sexual abuse and exploitation) and intimate partner violence will be prioritized for post-incident safety actions.

Alignment with New Deal

Outcome 2.3 is aligned with all five **PSGs as well as the cross cutting issues**. It contributes particularly to the strategic objective to increase the delivery of equitable, affordable, and sustainable services that promote national peace and reconciliation amongst Somalia's regions and citizens.

Key Result/Priority Area 3: Access to Justice and Rule of Law

Objective: To strengthen rule of law and access to justice to reduce the vulnerability of women, men, boys and girls to gender-based violence

Outcome 3.1: Adoption of laws, policies and international instruments to protect women, men, boys and girls and vulnerable groups from all forms of gender-based violence

Outcome	Output	Strategic Actions		
		2014	2015	2016
Outcome 3.1: Adoption of laws, policies and international instruments to protect women, men, boys and girls and vulnerable groups from all forms of gender-based violence	**Output 3.1.1:** Existing laws reviewed to identify gaps on the implementation of international treaties	**Immediate term action(s):** • Conduct a review of existing legislation to ascertain gaps. The analysis of findings would be used by all GBV actors as advocacy materials for GBV prevention mainstreaming in the reviewed laws; • Support specialized lawyers groups to conduct legal institutions mapping providing legal assistance to survivors of GBV and identifying the needs of and gaps of services provided;		
	Output 3.1.2: Technical assistance provided to the actors and stakeholders involved with the drafting of GBV-specific laws and policies	• Engage with legal experts tasked with drafting GBV-related laws for example assisting in the drafting of a Sexual Offences Bill; • Provide guidance to ensure proposed laws are survivor-centred and comply with international standards; • Support extensive community consultations on the process and content of drafting process;	• Engage with legal experts tasked with drafting GBV-related laws for example assisting in the drafting of a Sexual Offences Bill;	• Review the language of laws once they are in draft form;
	Output 3.1.3: Advocacy conducted for the enactment and implementation of GBV specific laws	• Organise community mobilisation activities to encourage Somali civil society to dialogue with their legislators to pass the laws;	• Advocate with policy and lawmakers to adopt GBV-specific laws and policies; • Conduct community outreach programmes and engage local and international media to raise	• Advocate with policy and lawmakers to adopt GBV-specific laws and policies;

			the profile of proposed GBV legislative processes;	
	Output 3.1.4: An improved PSEA secretariat-administered complaints mechanism	• Contribute actively in strategic forums linked to PSEA, complaints handling and investigations; • Promote awareness of the Joint complaints mechanism amongst members; • Support investigations into serious complaints; • Promote transparent reporting of complaints data;	• Contribute actively in strategic forums linked to PSEA, complaints handling and investigations; • Promote awareness of the Joint complaints mechanism amongst members; • Support investigations into serious complaints; • Promote transparent reporting of complaints data;	
Total Estimated cost for Outcome 3.1: US$ 600,000 (Six hundred thousand US Dollars)				

Implementation Strategy

The legislative system in Somalia is complex. The Constitution is still provisional and the Criminal Code has not been updated since the Italian colonial period. At the federal level, advocacy must be targeted to ensure provisional protection measures are put in place to protect women and girls from FGM/C, violence against women and gender discrimination and to encourage the Somalia Federal Parliament to update the Criminal Code as well as draft and enact laws to prevent GBV and provide a response mechanism for survivors. Recognizing the de facto autonomy of Somaliland and to a lesser degree of Puntland, separate advocacy, community mobilization and capacity building efforts will be required vis-à-vis the unique government institutions in these zones. Any effort to adopt laws must recognize that the reach of this effort will only be as far as the reach of the local authority responsible for enacting the law.

Priority Interventions

Though not all zones in Somalia may accept the Provisional Constitution, it will nevertheless become a guiding document that the FGS, government-supported regions and the international community refer to as a starting point for all legal frameworks and judicial opinions. Hence, ensuring the ratification of a document that underlines the unconstitutionality of all forms of GBV and encourages the adoption of international legal frameworks will be a critical priority. FGS endorsement of CEDAW, UNSCR 1325 and 1820, and other international frameworks on the prevention and mitigation of GBV should also be prioritized. Legislative efforts in Somaliland, Puntland and other areas of south and central Somalia should prioritize advocacy for drafting laws that protect women, men, boys and girls from GBV. It should be acknowledged that in rural or non-government controlled areas, informal and traditional justice systems are entrenched, and thus at this time cannot be prioritized for adopting formal laws, policies and international instruments.

Alignment with New Deal

Outcome 4.1 is aligned with **PSG 3 Justice**. It contributes to the strategic objective to establish independent, accountable and efficient justice institutions capable of addressing the justice needs of the people of Somalia by delivering justice for all.

Outcome 3.2: Formal and informal justice systems are equipped to uphold the human rights of GBV survivors

Outcome	Output	Strategic Actions		
		2014	2015	2016
Outcome 3.2: Formal and informal justice systems are equipped to uphold the human rights of GBV survivors	**Output 3.2.1:** Evidence-based approaches to improving access to justice	• Conduct participatory research on access to justice for GBV survivors (including customary, Shari'a, statutory laws and legal processes, barriers to access);	• Disseminate research on access to justice for GBV survivors (including customary, Shari'a, statutory laws and legal processes, barriers to access).	
	Output 3.2.2: Community-based and informal justice systems enhanced to better respond to the human rights of GBV survivors	• Develop a community-based legal advocacy strategy; • Support women's groups to prepare and present position papers calling for action on timely and fair legal redress in their respective communities; • Conduct trainings and hold dialogue sessions with customary courts on the promotion of human rights and referral of GBV cases to the formal court;	• Enhance coordination between community groups, legal aid providers, police, judiciary and traditional elders;	
	Output 3.2.3: Formal justice systems strengthened to improve access to justice for GBV survivors	• Train legal professionals on basic principles and facts around GBV; • Advocate for and provide technical support for the inclusion of GBV in the curriculum of Somali universities, law schools, and judges' training courses; • Train legal professionals on forensic evidence protocols (developed in output 2.1.1); • Strengthen courtroom procedures to protect survivors' safety; • Support access to justice within military courts for national and international forces;	• Advocate for and provide technical support for the inclusion of GBV in the curriculum of Somali universities, law schools, and judges' training courses; • Support access to justice within military courts for national and international forces;	• Assess the impact of interventions on the outcome;
	Output 3.2.4: Increased awareness of Protection	• Build capacity of GBV WG members and other stakeholders	• Engage and assist stakeholders in fulfilling their commitments to	

	from Sexual Exploitation and Abuse (PSEA) among aid workers	in key areas of PSEA standards implementation;	improved accountability and quality management;	
Total estimated cost for outcome 3.2: US$ 1,600,000 (One million six hundred thousand US Dollars)				

Implementation Strategy

Across Somaliland, Puntland and south and central Somalia there will be little difference in implementation since formal and informal justice institutions in all three zones face large gaps of capacity. Similar to the adoption of laws any approach to strengthen the justice institutions' capacity to uphold human rights for GBV survivors will need to be adapted to the respective zone and where necessary to the region recognizing the varying reaches of authority of informal and formal justice institutions. To achieve this outcome, unique approaches will need to be developed for urban and rural contexts. These new approaches will have to recognize that urban areas have formal justice mechanisms. Capacity-building of the court system should be prioritized taking note of the fact that elders regularly influence formal processes. In rural areas where formal courts are absent interpretations of traditional law by elders such as the Xeer system dominate the legal sector.

Priority Interventions

Evidence-based documentation of informal justice systems and frameworks as well as the barriers that survivors face when seeking redress in both urban and rural areas is incomplete. Building this knowledge base to inform WG members and other stakeholders' efforts to reform the justice system will be critical. In urban areas, a focus should be given to building the capacity of courts. Working with elders and community leaders in rural areas to shift social norms to a more survivor-centred and human rights-based approach to traditional justice systems will be critical to realizing gains across the majority of Somalia in the longer term.

Alignment with New Deal

Outcome 4.2 is aligned with **PSG 3 Justice**. It contributes to the strategic objective to establish independent, accountable and efficient justice institutions capable of addressing the justice needs of the people of Somalia by delivering justice for all.

Outcome 3.3: Security and humanitarian actors empowered to provide protection to populations vulnerable to GBV, and ensure dignity and respect for survivors and Strategic direction on Survivor assistance is defined and approved with involvement of UN, Government, AMISOM and other stakeholders.

Outcome	Output	Strategic Actions		
		2014	2015	2016
Outcome 3.3: Security and humanitarian actors empowered to provide protection to populations vulnerable to GBV and ensure dignity and respect for survivors.	**Output 3.3.1:** Strengthened capacity of security and humanitarian actors on the protection of survivors	• Develop and promote behaviour change programmes and initiatives of security forces; • Train police on improved patrolling, with sensitivity to gender-specific needs; • Train staff from UN, AMISOM, NGO as investigators for appropriate assistance and support in a timely manner;	• Document lessons learned on effective strategies to enable security forces (especially police) to improve protection for communities, specifically from threats related to GBV;	• Share best practices on key results for the interventions supported in the outcome;
	Output 3.3.2: Police capacity and protocols developed to improve GBV prevention and response	• Address barriers to reporting and processing cases by the police through research, programme development and advocacy; • Train police on GBV case handling, investigation and guiding principles of a survivor-centred approach (including protocol developed in output 2.1.1); • Support the establishment of pilot Family Support Units within the police stations that have been trained; • Conduct advocacy with police authorities to increase the number of qualified female officers;	• Support the establishment of expanded Family Support Units within the police stations that have been trained; • Conduct advocacy with police authorities to increase the number of qualified female officers;	• Support the establishment of expanded Family Support Units within the police stations that have been trained; • Conduct advocacy with police authorities to increase the number of qualified female officers;
Total estimated cost for outcome 3.3: US$ 1,800,000 (One million eight hundred thousand US Dollars)				

Implementation Strategy

There is a complex array of security and humanitarian actors operating across Somalia. Incorporating conflict analysis prior to implementation, studying the actors and their motivations that define the security and police contexts in Somaliland, Puntland and south and central Somalia will be critical. The security situation remains most volatile in south and central Somalia, particularly in urban areas with significant IDP populations. Consequently, this zone has the greatest diversity of actors to target as key stakeholders. This includes the presence of AMISOM, SNG forces and police as well as local actors such as Raskamboni, ASWJ and international security actors. In Puntland, maritime forces represent an additional stakeholder group. Somaliland benefits from a more stable security situation. This

complexity will require localized approaches that are aligned with international standards and best practices with the capacity to feed into federal institutions as they emerge and are consolidated.

Priority interventions

In 2013, gaps in police capacity and knowledge of how to appropriately provide response to incidents of GBV, particularly cases of sexual violence, became obvious. The majority of perpetrators identified by reporting survivors in Mogadishu have been men in official uniform. However, the availability of military and police uniforms in local markets makes this difficult to confirm. High profile cases of rape during which perpetrators were identified as security actors have highlighted the priority to raise awareness among security and humanitarian actors of how to correctly react to incidents of GBV and how to best protect civilians. Efforts will be made to prevent armed forces from becoming perpetrators of sexual violence themselves. Intensifying PSEA activities and building the capacity of police will be key priorities under this outcome.

Alignment with New Deal

Outcome 4.3 is aligned with **PSG 2: Security**. It contributes to the strategic objective to establish unified, capable, accountable and rights-based Somali Federal security institutions providing basic safety and security for its citizens.
It also contributes the cross-cutting issues of **capacity development** by aiming at strengthening basic sectoral and core government functions in support of the establishment of a responsive, inclusive and accountable public sector.

Key Result/Priority Area 4: Coordination

Objective: To strengthen coordination of GBV prevention and response activities among GBV WG members, other humanitarian actors, Somali civil society, UN integrated mission and government authorities.

Outcome 4.1: Strengthened coordination of prevention and response programmes among GBV working groups

Outcome	Output	Strategic Actions		
		2014	2015	2016
Outcome 4.1: Strengthened coordination of prevention and response programmes among GBV Working Groups	**Output 4.1.1:** Common operational procedures that maximise efficiency, harmonization and learning developed and implemented	• Create a standardised coordination toolkit (including reporting, information sharing, attendance, meeting minutes, guidance notes, procedures for data management); • Systematise information flows between the national and sub-national level coordination structures;	• Develop a mechanism for sharing best practices and lessons-learned;	
	Output 4.1.2: Harmonised systems for data management and analysis	• Build capacity on safety and ethical principles of GBV data management; • Standardise reporting formats and procedures; • Conduct focused training on data analysis, reporting and advocacy; • Write guidance on documentation and reporting of GBV data in the context of human rights monitoring and Security Council reporting;	• Engage in dialogue sessions to harmonise data systems and reporting;	
	Output 4.1.3: A network of professional, qualified and experienced staff dedicated to GBV coordination created	• Conduct comprehensive assessments of the current strengths and gaps in GBV programming; • Build capacity on GBV prevention and response (including M&E) for Working Group members; • Mobilize resources for dedicated coordination staff and recruitment of these coordination personnel;	• Mobilise resources for programme support;	
	Output 4.1.4: Strong and motivated PSEA membership	• Develop a mandatory information-sharing working group for UN, AMISOM and relevant actors; • Work with organisations to enhance	• Work with organisations to enhance accountability and quality by providing technical support and improving linkages;	

		accountability and quality by providing technical support and improving linkages;		
Total Outcome 4.1: US$ 800,000 (Eight hundred US Dollars)				

Implementation strategy

GBV coordination, information management (IM), capacity, mainstreaming and cooperation with Somali civil society differ largely based on the different areas of operationalization. Most interventions are focused on urban areas, with limited to no interventions in rural areas. Government engagement and civil society leadership are important areas to strengthen and establish to ensure appropriate coordination and response across zones.

For this Strategy, the GBV WG will focus on enhancing information management in the main cities of Somalia as follows:

Geographical Area	Coordination, Information Management and Capacity Building	Engaging government and civil society
Somaliland	Strengthening the functions of the GBV WG in Hargeisa, focusing on capacity building of the MOLSA which is currently chairing the Working Group together with UNFPA. Information management systems are only used in Hargeisa and the Information Sharing Protocol (ISP) has not been signed. Capacity building initiatives to focus on all relevant partners.	Agreement with government counterparts and cluster system must be taken to ensure the coordination mechanism functions and consolidated reports come forward. Increased cooperation with civil society must be a priority.
Puntland	GBV WG exists and functions in Bossaso, Garowe and Galkayo, however capacity building should focus on Garowe and Galkayo. Information management systems are used in Bossaso, Garowe and Galkayo, but the Information Sharing Protocol (ISP) has only been signed in Bossaso which means that this is the only place from where consolidated reports are regularly produced and shared.	Engagement with government counterparts and civil society must be prioritised in Garowe.
South-central Somalia	GBV WG exists in Dhobley, Baidoa, Afgoye and Mogadishu, but all groups have extremely limited capacity to coordinate GBV interventions. Capacity development must be a priority across all Working Groups. Information management systems are used in Mogadishu, Baidoa, Afgoye and Jowhar. However, the Information Sharing Protocol (ISP) has only been signed in Mogadishu.	Engaging government counterparts in Mogadishu is important and so is.civil society leadership across the zone. The success will directly affect the coordination mechanisms across the zone.

Priority Interventions

While the GBV WG will coordinate activities with regard to all types of GBV, sexual violence is a priority in the humanitarian setting of Somalia.

Geographical Area	Key issues among IDP populations	Key issues among host communities
Somaliland	Sexual violence and early marriage (as children are married off early for families to profit from dowry due to poverty)	IPV, early marriage and FGM/C
Puntland	Sexual violence and early marriage (as children are married off early for families to profit from dowry due to poverty)	IPV, early marriage and FGM/C
South-central Somalia	Sexual violence and early marriage (as children are married off early for families to profit from dowry due to poverty)	Sexual violence, IPV, early marriage and FGM/C

Alignment with New Deal

Outcome 4.1 focuses to a large extent on improving coordination among GBV WG members but also with other actors. To some extent, it contributes to the cross-cutting issue of **capacity development.**

Outcome 4.2: Enhanced collaboration with other actors, whilst ensuring preservation of humanitarian principles

Outcomes	Outputs	Strategic Actions		
		2014	2015	2016
Outcome 4.2: Enhanced collaboration with the other actors, whilst ensuring preservation of humanitarian principles	**Output 4.2.1:** Enhanced Policy dialogue and technical support with the government to set national standards and protocols based on GBV best practices	• Provide technical support as needed during the drafting process of national standards and information sharing protocols		
	Output 4.2.2: GBV capacity building activities conducted with representatives from key government ministries	• Engage in policy dialogue with police and military and legislators on the implementation of strategies/policies on GBV; • Train government on international standards for GBV prevention and response (including information sharing protocols);	• Train government stakeholders on international standards for GBV programming, including national standards for service provision and information sharing protocols;	
	Output 4.2.3: Framework defined and implemented outlining effective coordination within the UN integrated mission for effective GBV prevention and response	• Mapping of UN humanitarian, development and security actors, including their expertise, mandate, geographic presence and available resources (taking into account varying levels of access due to security or other practical challenges);		
	Output 4.2.4: GBV prevention and response mainstreamed across key humanitarian clusters	• Train key humanitarian clusters on GBV guiding principles and IASC GBV Guidelines; • Review other sectors' assessments and work plans to monitor the implementation of topics covered in these trainings; • Develop and support implementation of action plans on GBV mainstreaming with other humanitarian cluster and service providers; • Advocate for specific interventions in key sectors (such as CMR supplies and training with health actors and other service providers);	• Develop and support implementation of action plans on GBV mainstreaming with other humanitarian cluster and service providers;	• Develop and support implementation of action plans on GBV mainstreaming with other humanitarian cluster and service providers;

	Output 4.2.5: Somali civil society and women's groups engaged in GBV prevention and response	• Consult with Somali civil society (including women's groups) on how to improve engagement and leadership for prevention and response to GBV (including M&E)		
	Output 4.2.6: Mainstreaming PSEA within relevant clusters	• In consultation with clusters, include accountability to affected populations in their work plans in the following areas: leadership/governance; transparency; feedback and complaints; participation of affected communities and p M&E of implemented efforts; • In consultation with relevant clusters and relevant implementers, incorporate PSEA language, best practices and guidance materials where appropriate;	• In consultation with clusters, include accountability to affected populations in their work plans in the following areas: leadership/governance; transparency; feedback and complaints; participation of affected communities; and tM&E of implemented efforts.	• In consultation with clusters, include accountability to affected populations in their work plans in the following areas: leadership/governance; transparency; feedback and complaints; participation of affected communities; and M&Eof implemented efforts.
Total estimated cost for Outcome 4.2: US$ 262,500 (Two million two hundred and sixty-two US Dollars)				

Implementation Strategy

Geographical Area	Policy dialogue, technical support, capacity building	Urban, Rural, Government and Civil Society
Somaliland	No comprehensive national standards, frameworks or strategies around GBV existent, with the exception of an FGM/C decree	Focus on system-building within government, and linking civil society to government processes
Puntland	No comprehensive national standards, frameworks or strategies around GBV existent, with the exception of an FGM/C decree	Focus on system-building within government, and linking civil society to government processes
South Central Zone	No comprehensive national standards, frameworks or strategies around GBV existent	Government has expressed interest in developing a GBV Strategy and a Sexual Violence Law which should be further advocated for. In rural areas, attention has to be given to local authorities, elders, community leaders and civil society rather than a centralised government.

Priority interventions

Capacity-building interventions should focus on creating a holistic understanding of GBV, while addressing sexual violence, IPV and FGM/C.

Alignment with New Deal

This outcome aligns with **all PSGs** as it is mainstreaming of internal and external processes.

ANNEXES

Annex I	Alignment with the New Deal Compact
Annex II	Glossary of Terms
Annex III	M&E Framework
Annex IV	Legal Framework