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Final report

Swiss Agency for Development and Cooperation (SDC)

Regional assessment on sexual and gender-based violence (SGBV) in the Horn of Africa (HoA)

HALCYON CONSULTING

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1. Executive summary

Sexual and gender-based violence (SGBV) is one of the areas of focus of the Swiss Humanitarian Aid Department (SHA) alongside the themes of Protection, Disaster Risk Reduction and Water. It is also an area where SDC, through the SHA, has more than a decade of experience. Much of SDC's work on SGBV is integrated into sectorial portfolios (the SDC thematic domains), mostly on health (sexual and reproductive health and HIV/AIDS), governance (rule of law, human rights) and protection. Switzerland's message for international cooperation 2017–2020 includes, for the first time, a strategic goal on gender equality, setting SGBV as one of the priorities. In November 2016, an operational concept on SGBV (2017-2020) was adopted by the SHA, laying out the future priorities and lines of intervention in relation to SGBV in the humanitarian sphere. By the end of 2020, SDC will be producing new global operational concepts on SGBV and Protection to shape the way forward for the next four years.

Based on SDC's portfolio review conducted in 2019, SGBV was agreed to be one of the four pillars of the Protection/Migration domain, and is also one of the areas pursued in Maternal and Child Health (MCH) pillar of the health domain. As a result, SDC agreed to commission this SGBV assessment to be able to identify areas of programming and entry points.

The purpose of this assessment is to better understand all aspects related to SGBV (e.g. prevention, response/service provision, challenges, gaps, legal framework, advocacy, stakeholders) in the region to inform SDC's programming, strategies and policies related to SGBV. The assessment will identify concrete entry points for SGBV programming in the Horn of Africa (HoA) based on the existing Swiss engagement in the region and Swiss comparative advantages, and provide tailored recommendations on how to engage.

The specific objectives of this assessment are:

- To assess SGBV-related interventions in three countries in the Horn of Africa (North-eastern Kenya, Somali region of Ethiopia and Somalia) through desk review and interviews with key informants and the affected populations;
- To review SGBV-related priorities and gaps in the countries under review, using the data to inform development of SDC policies, strategies and programs to address SGBV in the HoA region;
- To develop recommendations to help SDC operationalize its organizational commitments, taking into account existing data, experiences, strategies and previous and existing SGBV projects supported by the SDC HoA teams in Nairobi and Addis, and in line with the Operational Concept (2017-2020) on SGBV developed by SHA, as well as strategic goal 7 of the International Cooperation Message 2017-2020 (promotion of gender equality and women's rights).

The assessment was carried out by using primary and secondary data sources. Extensive analysis was undertaken and a comprehensive filtering and ranking process agreed with SDC and undertaken to determine a series of recommendations for SDC to consider taking forwards. Recommendations have been categorised by country and the HoA region, and split into three tiers of priorty recommendations.

The top priorities outlined in this assessment report are:

a. Northern Kenya

1. **Partner with UNHCR to support efforts to build more gender equitable justice systems for Somali women through support to the Garissa magistrate at the Dadaab camp.** As a potential complement, work with UNHCR and implementing partners to scale up capacity of paralegals to work in and across north-eastern counties through the traditional systems to build safer responses to survivors
2. **Work with CASI and UNICEF to support training of governmental and non-governmental child protection actors in northern countries on identifying risks of sexual violence for boys and standardizing referral pathways.** Draw from the CASI assessment and recommendations to build out a model for response to sexual violence and exploitation of boys through support to relevant actors. This represents a potential new area for SDC to support that aligns with SDC's commitment to improving services for male survivors of sexual violence.
3. **Build out the food security programmes in Wajir and elsewhere so that they support women and women's institutions to lead food projects.** Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods, and consider expanding to a regional approach.

b. Somali region of Ethiopia

1. **Develop a project with UNFPA and BOWCA to support building systems for GBV at the Jijiga-level in the Fafen Zone as a pilot, with the eventual plan to cascade to other zones and woredas**. Focus particularly on health and MHPSS, but also through coordination engage police and legal systems, including at the ministerial level, as well as key I/NGO partners such as the Ethiopian Women's Lawyers Association office in Jijiga (forthcoming). This investment aligns with SDC's priority for building out health services in Ethiopia.
2. **Support UNHCR to improve its GBV data systems in the coming year by upgrading from GBVIMS to Primero/GBVIMS+** (which includes case management capacity) and linking that to UNCHR's internal data management system. Funding for an integrated approach to improving data management could support UNHCR's commitment to greater inclusivity of refugees in national systems and also support UNHCR's plan for SGBV response for refugees to link to one-stop centres. This represents a limited investment for a positive return, and could be co-funded. This project could also link to the regional data manager deployed to the regional GBV Working Group, and ensure that UNHCR's investment in improving systems is aligned with and supported by the regional effort.
3. **Integrate attention to GBV in food security programmes**. Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods. Also consider this as a regional approach.

c. Somalia

1. **Leverage SDC's comparative advantage in policy advocacy and legislation to tackle the Sexual Intercourse Related Crimes Bill.** Enhance support for related policies and legislations, in particular the Sexual Offences Bill (SOB). Earmark scaled up funding for the SOB. Join political forces with

other governments at the highest level to advocate for new repressive laws to become enacted. Strengthening the capacity of the local actors, especially the government, (police, judges' lawyers and counsellors). Intensify advocacy support to reduce the opposition from religious leaders and groups to the SOB. Advocating with Middle Eastern counties who also support Somalia in different ways was also a recommendation from FCDO as a gap that is not being filled currently. SDC can also scale up its important unique role on advocacy to give a stronger voice and leadership on GBV over the long-term horizon.

2. **Support the scale-up and roll-out of GBVMIS across all states and to more actors.** Provide additional resources to support GBVMIS improvement and the extension of more capacity development for organisations and individuals to use GBVMIS instead of other systems which do not capture data online.

3. **Increase support for the wider legal/justice system.** SDC might consider supporting the legal/justice system over the longer-term, including strengthening the judiciary, the police and legal aid. Such support would be required at all levels across Somalia and Somaliland. Supporting research to help the sector understand how the legal/justice systems could be strengthened in Somalia

d. HoA regional

1. **Consider deploying a regional data expert for the regional GBV coordination mechanism that is tasked with building regional data systems** on Primero/GBVIMS+ or other sustainable platforms and building a regional dashboard similar to MENA. Consider linking this to African Union work on building data systems. Also link to UNHCR work on data systems in their refugee response in Ethiopia.

2. **Build on the work related to anticipatory actions (e.g. OCHA pilot in Somalia) for inclusion of GBV in these new frameworks in order to support preparedness approaches** in the Horn of Africa that address GBV in natural disasters. Consider food security as an entry point for preparedness

3. **Support the expansion of the CASI assessment initiative to Somalia and Ethiopia**, with a particular focus on identifying child protection capacity to address the issue of sexual violence and exploitation against boys. Consider placing someone from the SDC roster within the Child Protection Working Group in Kenya (or regionally) to focus on issue of sexual violence against boys. This is highly relevant to SDC's investments and also an important area of growth for child protection.

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2. Background to the assessment

SGBV[1] is one of the areas of focus of SHA alongside the themes of Protection, Disaster Risk Reduction and Water. It is also an area where SDC, through the SHA, has more than a decade of experience. Since then, cooperation modalities have evolved. SGBV has become a focus area not only in SDC's humanitarian aid portfolio, but also in its development cooperation priorities and, more generally, within the SDC thematic gender equality network. Much of SDC's work on SGBV is integrated into sectorial portfolios (the SDC thematic domains), mostly on health (sexual and reproductive health and HIV/AIDS), governance (rule of law, human rights) and protection. SDC also undertakes important global advocacy related to SGBV; for example, Switzerland advocated strongly for the inclusion of a stand-alone goal on gender equality (SDG 5) in the new Agenda 2030 for Sustainable Development.

Switzerland's message for international cooperation 2017–2020 includes, for the first time, a strategic goal on gender equality, setting SGBV as one of the priorities. In November 2016, an operational concept on SGBV (2017-2020) was adopted by the SHA, laying out the future priorities and lines of intervention in relation to SGBV in the humanitarian sphere. Through human rights dialogue with partner countries, Switzerland addresses SGBV as a regular item and has established strategic partnerships with key stakeholders such as UN Women, UNFPA, UNHCR, UNRWA and UNICEF, and also supports the UN Trust Fund to End Violence Against Women. By the end of 2020, SDC will be producing new global operational concepts on SGBV and Protection to shape the way forward for the next four years.

3. Purpose and objectives of the assessment

Purpose

Based on the portfolio review conducted in 2019, SGBV was agreed to be one of the 4 pillars of the Protection/Migration domain, and is also one of the areas pursued in Maternal and Child Health (MCH) pillar of the health domain. As a result, SDC agreed to commission the SGBV assessment to be able to identify areas of programming and entry points.

The purpose of this assessment is to better understand all aspects related to SGBV (e.g. prevention, response/service provision, challenges, gaps, legal framework, advocacy, stakeholders) in the region

[1] The IASC *Guidelines for Integrating GBV Interventions in Humanitarian Action* define GBV as an umbrella term for "any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females."[1] GBV includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. Sexual violence is understood as one form of GBV. The IASC GBV Guidelines emphasize that the term 'GBV' is most commonly used to underscore how systemic inequality between males and females—which exists in every society in the world—acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. GBV violates international human rights and in some cases international humanitarian law; moreover, many forms of GBV are criminal acts in national laws. GBV gravely impacts the survivor's physical and psychological health, social status and ability to participate in economic life. GBV not only negatively affects the survivor, but the family and community as a whole.

to inform SDC's programming, strategies and policies related to SGBV. The assessment will identify concrete entry points for SGBV programming in the HoA based on the existing Swiss engagement in the region and Swiss comparative advantages, and provide tailored recommendations on how to engage.

The specific objective of this assessment are:

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- To develop recommendations to help SDC operationalize its organizational commitments, taking into account existing data, experiences, strategies and previous and existing SGBV projects supported by the SDC HoA teams in Nairobi and Addis, and in line with the Operational Concept (2017-2020) on SGBV developed by SHA, as well as strategic goal 7 of the International Cooperation Message 2017-2020 (promotion of gender equality and women's rights).

4. Methodology and phases and of the assessment

The assessment was carried out through five phases.

Phase 1: Preparation

Initial meetings were held with SDC to understand expectations, and a preliminary desk review was carried out alongside initial meetings with key stakeholder to identify an initial list of key informants as well as key areas for investigation in the assessment.

Phase 2: Inception

An inception report was developed to direct the assessment. This comprised an outline for the assessment process; a proposed list of key stakeholders and beneficiary groups as targets for the assessment; interview tools and guides; data analysis plans; and ethical considerations..

Phase 3. Primary data collection

Primary data collection was carried out remotely and on-the-ground in Kenya (Kakuma and Northeast Kenya); Ethiopia (Somali region) and Somalia (including Somaliland and Puntland). Interviews with key stakeholders including UN agencies, governments officials, local and international NGOs, implementing partners and others working in the SGBV space took place remotely and in person. Information was also collected through focus group discussions with adults women and men (aged 19 and older) and adolescent girls and boys (aged 13 – 18). Service mapping with health care workers, psychosocial providers, legal response providers and police also took place where it was feasible and appropriate.

Phase 4. Data analysis and report drafting of the assessment report

A preliminary report compiled key findings and recommendations for SDC that seek to align the needs identified by GBV experts in the region with SDC priorities and capacities.

Phase 5. Finalisation

The final report will be used to develop a summary PowerPoint presentation to facilitate further discussions with the SDC and other stakeholders.

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5. Northern Kenya Assessment Findings

Background[2]

Context: Due to its location bordering several politically unstable states, northern Kenya is host to a variety of refugee communities, including in three of the four counties on which this assessment focuses, Garissa, Wajir, and Turkana. Garissa County, which borders Somalia, and Wajir County, which borders Somalia and Ethiopia, are home to the Dadaab refugee complex. Turkana County, which borders Uganda and South Sudan, is home to the Kakuma Refugee Camp and the Kalobeyei Integrated Settlement. The fourth country, Mandera, is a volatile region of the country which serves as an entry point for migrants coming from Somalia and Ethiopia.[3] Despite Kenya's relative development in comparison to its neighbours, Kenya's northern counties are among the least developed in the country,[4] with the host communities primarily comprised of semi-nomadic pastoralists.[5]

Scope of GBV: While statistics on the pervasiveness of GBV against women and girls in Kenya remain limited, existing data highlight issues of intimate partner violence, child marriage, female genital mutilation, and sexual assault. In Garissa, Wajir, and Mandera, although 10% of women report experiencing intimate partner violence,[6] nearly all women report having been subjected to some form of FGM, the highest percentage in Kenya.[7] Early marriage is also reportedly common among the host community in Wajir and Mandera. Likewise, statistics on GBV for women and girl refugees in Dadaab suggest the most prevalent forms are intimate partner violence, early marriage, FGM, rape, and sexual exploitation. In Turkana, 31.1% of host community women report experiencing intimate partner violence,[8] a quarter of women and girls report having been subjected to some form of FGM, close to Kenya's national average,[9] and a third of pastoralist girls are married before age 18.[10] Similarly, among residents of Kakuma Camp and the Kalobeyei Integrated Settlement, the most prevalent forms of GBV are intimate partner violence, sexual exploitation, and child marriage.[11] Although statistics are hard to come by, 7%[12]-18%[13] of men and boys in Kenya also report experiencing sexual violence.

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[2] For additional background information, see the annexes.
[3] Mandera County Government, 2020. "Background - County General Information." https://mandera.go.ke/background/
[4] UNICEF, Feb. 2016. Family Assets: Understanding and Addressing Child Marriage in Turkana," pg. vi
[5] Kipuri, Naomi and Andrew Ridgewell, 2008. "A Double Bind: The Exclusion of Pastoralist Women in the East and Horn of Africa," pg. 5
[6] Kenya National Bureau of Statistics, 2014. Kenya Demographic and Health Survey
[7] Ibid.
[8] Kenya National Bureau of Statistics, 2014. Kenya Demographic and Health Survey
[9] IRC, June 2020. "Gender Analysis for Household Assessments Conducted in Loima and Turkana Central Subcounties in Turkana County," pg. 48.
[10] NICEF, Feb. 2016. Family Assets: Understanding and Addressing Child Marriage in Turkana
[11] UN Women Kenya Country Office, 2019. Gender Assessment of Kalobeyei Settlement and Kakuma Camp, pg. 22
[12] http://crimeresearch.go.ke/wp-content/uploads/2018/02/wwwroot_publications_Gender-Based-Violence-in-Kenya.pdf
[13] UNICEF, 2013. "Violence against children in Kenya." https://www.unicef.org/esaro/VAC_in_Kenya.pdf

Legislative/Policy Environment: The government of Kenya has evolved relatively robust legislation to prohibit different forms of GBV and promote the protection of women and girls. Early and forced marriage is prohibited and criminalized by Kenya's Children's Act of 2008, its Marriage Act of 2014, and its Sexual Offences Act of 2006,[14] as is FGM by the Prohibition of Female Genital Mutilation Act of 2011,[15] and domestic and sexual violence by the 2014 Protection Against Domestic Violence and Sexual Offences Act.[16] For refugees and displaced persons, the Kenyan government has also instituted regulations including the Refugee Act of 2006, which promotes a framework to ensure the safety of refugee women and children in designated areas.[17] Apart from these laws, Kenya has established a number of national policy instruments addressing GBV, such as the 2014 National Policy for Prevention of and Response to Gender-based Violence[18] and the 2015 National Monitoring and Evaluation Framework towards Prevention of and Response to Sexual and Gender-based Violence in Kenya[19]

GBV Coordination and Funding

The Kenyan Ministry of Public Service, Youth, and Gender Affairs contains the State Department of Gender Affairs, mandated to mainstream gender in ministries, departments, and agencies, promote the development of gender policies, and coordinate programs to reduce SGBV. In 2011 the government also established a National Gender and Equality Commission (NGEC).[20] Until recently, NGEC was responsible, alongside the Gender Violence Recovery Center (GVRC) and the Collaborative Centre for Gender and Development (CCGD) for overseeing GBV coordination partners at that national level. The State Department of Gender has now assumed responsibility for leading coordination, with the NGO co-leads remaining the same.

Several national coordination partners, including CCGD, DRC, IRC and others are working in Northern Kenya, as described below. A key priority of the national GBV Working Group is to support county-level coordination partners in implementation of national policies and plans, as well as to ensure that county-level responses are coordinated within and across counties (with county-level coordination varying considerably across the country). The national GBV Working Group has also prioritized prevention efforts; however, these efforts have been significantly side-lined as a result of COVID 19, with the focus shifting to emergency service delivery in the context of restricted movement.[21]

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[14] UNICEF, Feb. 2016. Family Assets: Understanding and Addressing Child Marriage in Turkana," pg. 19
[15] UNHCR Office Kakuma, 2017. SGBV Strategy, Kakuma Refugee Camp, Kenya, pg. 4
[16] Ibid.
[17] UNICEF, Feb. 2016. Family Assets: Understanding and Addressing Child Marriage in Turkana,"
[18] See: http://psyg.go.ke/docs/National%20Policy%20on%20prevention%20and%20Response%20to%20Gender%20Based%20Violence.pdf
[19] See: http://www.ngeckenya.org/Downloads/National-ME-Framework-towards-the-Prevention-Response-to-SGBV-in-Kenya.pdf
[20] UN Women Kenya Country Office, 2019. Gender Assessment of Kalobeyei Settlement and Kakuma Camp, etc, pg. 11
[21] Key informant interview.

Linked to the GBV Working Group is a sub-working group to roll out the Child and Adolescent Survivors Initiative (CASI) assessment on the quality of and access to services for child and adolescent survivors in Kibera, Nairobi.[22] The working group is comprised of CASI, LVCT, the State Department of Gender and the Division of Children.

Separate from the national and county-level coordination, but with the involvement of government actors, are the refugee coordination mechanisms that exist in Dadaab, Kakuma, and for urban refugees in Nairobi. These UNHCR-led SGBV coordination mechanisms focus primarily on coordinating service delivery and referral for survivors. In the camps, the focus of coordination also includes ensuring mainstreaming of risk mitigation efforts across non-GBV specialist sectors, in line with UNHCR's global strategy on mainstreaming.

The GBV Coordination mechanism does not capture information from partners about the scope of funding. However, information from interviewees suggests that among refugee populations, UNHCR is the primary donor for GBV, with their funds for GBV received primarily from BPRM, as well as Japan. UNFPA supports the Kenya Red Cross in Kalobeyei and Kakuma, as well as IRC and DRC in Kakuma, with plans to extend further support to Turkana county through a joint UN 'delivering as one' project. ECHO supports DRC, IRC, NRC and TdH. UNICEF and UN Women support GBV programming reportedly primarily through CSOs, for example WomenKind in Garissa and Wajir. UNICEF and UNFPA have also been partnering with the government on an FGM project that includes the northern counties. UNICEF has for several years been funding the one-stop centre in Lodwar, as noted below, but that funding will stop at the end of the year. Other donors include DFID (security sector project with the local government in Wajir, Mandera and Garissa), Danida, and Finland. World Bank is supporting an infrastructure development project that is striving to integrate GBV mitigation measures in Turkana West, Garissa and Wajir South. Interestingly, MasterCard is supporting CCDG in COVID-19 response in Wajir that has a GBV component particularly targeting at-risk girls. As noted below, development plans linking refugee response and host communities have been drafted for Kalobeyei/Turkana West and Dadaab/Garissa, with support from IFC/World Bank and UNHCR with the county government, that each identify priorities for donor support. Generally, programming within refugee sites is relatively well-funded. Funding for GBV programming outside of refugee sites is very limited, particularly in Turkana Central and East, Wajir and Mandera.

[22] CASI has funding support from SDC. For more information about CASI, see https://gbvaor.net/support

GBV Prevention and Response Programming[23]

Garissa: The Dadaab complex is home to some of the earliest GBV programming operating in humanitarian settings. In many respects, this means key elements of GBV programming are comparatively well-established. There are strong referral pathways that include representation by all the sectors, and approximately fourteen actors participate in the SGBV coordination mechanisms (held monthly at Dadaab level, with camp coordination meetings held bi-weekly). DRC and IRC specialize in services for adult women, and TdH and Save the Children specialize in support to children, both boys and girls; each of these specialist agencies collects data and shares it with UNHCR through the GBViMS.[24] They also support model prevention programming, using the SASA! approach, as well as IRC's Engaging Men in Accountable Practice (EMAP). DRC also supports mentorship strategies that involve pairing girls with adult women.

Spotlight on Dadaab Court. In 2014, the Garissa County allocated land to UNHCR who undertook to construct a courthouse in Dadaab to enhance access to justice by the refugee and host communities. Phase 1 of the project entailed fencing of the premises and was completed in 2015. Phase 2 involved the construction of a courtroom and offices--completed in June 2017 and handed over to the Judiciary in November 2017. The Dadaab Law Courts comprises the Magistrate, Public Prosecutor, Probation Officer and the Kadhi's court. It was operationalized in 2020 after the deployment of judicial staff. The Kadhi's Court complements the Magistrates courts and deals with questions of Muslim law relating to personal status, marriage, divorce and inheritance where both parties are Muslims. However, financial constraints have curtailed Phase 3 of the project, which is meant to include deployment of security guards, construction of accomodation units for Judicial staff, procurement of furniture/furnishings and equipment/stationery for the offices/officers and deployment of a Prosecutor.

Clinical management of rape services exist in all the camps, provided by MSF, Kenya Red Cross and IRC. The one-stop centre in Hagadera camp has reportedly been recognized as a best practice.[25] Health providers have the capacity to testify in court. Both the police and RAS participate in the SGBV working group and have received training on survivor-centred care. Translators exists in the police stations to support survivors. UNHCR's partner on access to justice is the local NGO Refugee Consortium of Kenya (RCK), whose role is to provide legal counselling to persons of concern and to represent their cases in court. UNHCR has also evolved a project with the Garissa County government to bring a magistrate to Dadaab in order to facilitate prosecution of cases (see Box).

[24] UNHCR is now using Progres V 4 in many settings; plans are underway to transition GBVIMS to Progres V 4, which is reportedly the same model as GBVIMS. There are no plans to transition to PRIMERO/GBVIMS+, which is stronger than the GBVIMS in its case management tracking.
[25] Key informant interview.

This model of working with government is increasingly favoured, and will be accelerated with the implementation of the Garissa Integrated Social and Economic Development Plan (GISEDP).[26] According to interviewees, this plan calls on all lead actors in Dadaab to develop workplans that align with the GISEDP and that identify expectations around government contributions/leadership related to development in the county. The Ministry of Gender, Social Services, Children and Youth is responsible for leading on protection. When the plan is released it will purportedly provide donors with a clear idea of where gaps are in funding social and economic development priorities in Dadaab and larger Garissa, including related to GBV.

Garissa County is one of the most active in northern Kenya in relation to GBV programming, particularly related to child marriage, FGM and IPV. The Garissa Gender Working Group was established in 2018 by NGEC and the County Gender Department. Action Aid is currently working on a gender policy with the county government. There is a one-stop centre in Garissa. Child protection services for boys and girls are provided through the government and UNICEF, and UNICEF is also partnering with UNFPA on an FGM and child marriage project in Garissa, Wajir and Tana River. Services are also delivered through NGO actors that include a safe house in Garissa for girls, mentorship and school programmes. GirlKind Kenya, the Kemuthey Women's Network are other actors providing shelter services for girls and women. Pastoralist Kenya and WomenKind Kenya support education and empowerment programming. This list is not exhaustive, but rather provides a good indication of the higher number of GBV programmers in Garissa relative to other northern counties.

Turkana: As with Dadaab, GBV programming in Kakuma is well established. DRC is the lead agency, in collaboration with UNHCR. Alongside DRC, the Center for Victims of Torture provides PSS support, as does NRC on a small scale. LWF is designated to work with children. Swiss Contact, Action Aid Help International, and other partners provide livelihoods and other socio-economic and vocational support. The Kenya Red Cross runs a one-stop centre in Kalobeyei and IRC provides health services in Kakuma. Jesuit Refugee Service manages one safe haven for survivors of SGBV in Kalobeyei settlement; Jesuit Refugee Service, DRC, and the National Council of Churches of Kenya have also started a Safe Home Volunteer Programme to provide an alternative accommodation to survivors of SGBV. Police have been trained, as well as RAS, in responding to security incidents related to GBV. RCK provides legal support, and a magistrate comes to Kakuma twice a week. Partners report through the GBVIMS, but also use the KoboCollect app to improve referral monitoring. As with Dadaab, DRC has implemented SASA! and EMAP prevention programming.

According to one interviewee, the Kalobeyei Integrated Socio-Economic Development Programme is "fulfilling its goal" of boosting engagement between the host government and refugee response—with the magistrate being one example. A representative of the Gender Department also sits on the Kakuma coordination group which contributes to harmonized planning.

[26] According to one interviewee, the GISEDP was supposed to be launched early in the year but was help up due to COVID-19. The KISEDP for Kalobeyei in Turkana has been operational for two years.

Outside of Kakuma and Kalobeyei in Turkana East, there is some GBV programming in Turkana Central through the Lodwar Wellness Center. This one-stop centre was started in 2014 by IRC, with support from UNFPA and UNICEF. It is currently transitioning to government oversight, although this will likely involve a decrease in availability of services, including community outreach services. IRC would like to extend its presence if funding is obtained. IRC is also planning to work with the Catholic Diocese to put in place a Women-friendly space in Lodwar in order to initiate social and livelihoods opportunities for women and girls. There is a GBV coordination group that meets in Lodwar.

Wajir and Mandera. Unlike Garissa and Turkana, the scope of GBV-related activities and actors is relatively limited. There are reportedly one-off projects that receive funding periodically but the infrastructure to support GBV prevention and response is limited. In Wajir, a County Gender Desk was created as part of Wajir's devolution process. As of 2016, the CGD had a functional Gender Desk and toll free GBV Response Hotline that was established with the support of Mercy Corps, providing legal, medical and psychosocial accompaniment to survivors of rape, defilement, domestic violence, and sexual abuse and exploitation. It is not clear whether this service is on-going. There is infrastructure for a one-stop centre in Wajir, with the building reportedly supported by DFID, but it is not operational. There is no data collection.

In Mandera, there is no one-stop centre developed yet (only a room set aside at the county hospital), and the county government is reportedly not highly invested in building infrastructure to address GBV. DFID supports a security sector reform project that includes attention to GBV. CCGD is operating a COVID-19 recovery project that includes Mandera, and addresses the risks of women and girls to GBV; CCGD has also been monitoring the issue of trafficking of girls for marriage from Somalia to Kenya. Finland is supporting a Women, Peace and Security localization project in Mandera, Samburu and Baringo. Reportedly the Kenya Red Cross offers health services in Mandera, alongside the local NGO Health Poverty Action. The Mandera Women for Peace provides PSS services for women and girls as well as undertake community awareness-raising.

KISEDP, the Kalobeyei Integrated Socio-Economic Development Programme, is a comprehensive framework intended to strengthen the self-reliance, socio-economic conditions, and resilience of the 186,000 refugees and 320,000 host community members living in Turkana West. Planned across multiple sectors and taking into account a variety of stakeholders, the programme seeks to create an enabling environment for investment and job creation, through improved service delivery, local capacities, and laws and policies, while enhancing people's skills to develop the local economy. Currently in Phase I until 2022, KISEDP will mainstream gender equality, increase access to protection and assistance for women and girls, and address the root causes of gender discrimination through a variety of programs such as capacity building for community leaders, the development of gender-responsive laws and policies, and creating a permanent Gender Office for host and refugee communities. See https://www.unhcr.org/ke/wp-content/uploads/sites/2/2018/12/KISEDP_Kalobeyei-Integrated-Socio-Econ-Dev-Programme.pdf

GBV Risk Mitigation Mainstreaming

UNHCR has established a global gender mainstreaming project that requires non-GBV specialist actors to develop indicators for GBV risk mitigation in line with the IASC GBV Guidelines and UNHCR guidance. Kenya was one of its rollout countries. UNHCR monitors implementation of risk mitigation through reporting on the indicators. Although this approach is relatively new, it has reportedly generated positive benefits in risk mitigation.

Another notable risk mitigation mainstreaming project in the region supported by the World Bank is DRDIP, which is aimed at development support to refugee hosting communities, and includes provision for GBV risk mitigation across livelihoods and WASH projects in sites in Turkana, Garissa and Wajir.[27]

Notable Gaps/Challenges in GBV Programming

Garissa

1. Downsizing of the camps in the Dadaab complex has been accompanied by downsizing of funding to GBV services; in fact, decreases in funding have reportedly hit the GBV sector harder than others.28 For example, DRC has only two PSS counsellors available for Dadaab camp, leading to exhaustion amongst PSS staff.
2. Despite the widespread efforts at risk mitigation in Dadaab, key informants noted that safety and security issues related to some services were ongoing, such as lack of lighting, flimsy shelter materials that put women and girls at risk.
3. Although some livelihoods and cash programming exists in Dadaab, it does not target survivors, and self-reliance among women and girls is still limited. Livelihoods capacity remains relatively low. There are no women-led organizations working in Dadaab.
4. In Dadaab, there are no female police officers. In Garissa town, police are also relatively weak; they are transferred often so there is no historical memory on survivor-centred approaches, and they typically use a crowded office to record GBV complaints.
5. The legal justice system is not sufficiently activated in and around Dadaab, in spite of a promising 'nexus' project involving collaboration between UNHCR and the Garissa county government to establish a Dadaab court. In Somalia, the informal system of justice is based on a traditional bench court that promotes alternative dispute resolution, most commonly referred to as Maslaha. Consistently, stakeholders interviewed in Dadaab for the assessment noted that one of the biggest obstacles to programming. The gender policy that Action Aid is developing with the

Voices from the field:
"How do they support her? Prayers, reporting the matter, marrying her off to the perpetrator if he is known, taking her to another village or town, marrying her off to a close relative to avoid word getting out." FGD male, Garissa

[27] DRDIP has produced a series of guidance notes on risk mitigation that reinforce the recommendations in the IASC GBV Guidelines, but particularly reference northern Kenya, available at https://documents.worldbank.org/en/publication/documents-reports/documentdetail/102451537203164341/understanding-and-addressing-gender-based-violence

[28] Key informant interview.

government will reportedly make recommendations related to Maslaha, and access to justice was highlighted as a priority for the Garissa GBV Working Group. As well, the UNHCR/government-support magistrate's Kadhi court may be able to go some way to replacing maslaha if the court remains operational.

Turkana

1. Refugee service providers acknowledge that their ability to meet the needs of the hosting communities is limited, even in the Kalobeyei settlement, because of the distance to services as well as the continued perception that services are meant for refugees. In addition, discussions with host communities suggested that there are GBV services available to them about which they are not aware, representing a lack of outreach to some host communities.
2. While there are strong referral pathways in Kakuma and Kalobeyei, key informants reported these systems may break down at the community level: chairladies or block leaders who are designated (and trained) to forward cases to services providers may not forward a case to DRC if they imagine it is not 'serious' enough.
3. In Kakuma in particular, in spite of the UNHCR effort at mainstreaming, issues remain related to lighting and shelter that result in GBV even inside the camps, including rape.
4. LGBTI groups who have been transported to Kakuma (reportedly for resettlement processing) have situated themselves outside of the UNHCR compound. They have been targeted by the host community and police.
5. In Kakuma and Kalobeyei there are no safe houses for survivors. Protection from police is perceived by some to be unreliable, with reports from focus group participants and key informants of police asking for bribes.
6. Even when services do extend to the host community, they are only able to reach those in close proximity to the camp. While the KISEDP is an important step in linking refugee and host community planning, lack of funding to fulfil the plans linked to KISEDP make realizing its potential challenging.
7. Elsewhere in Turkana services for GBV are limited, with the possible exception of Lodwar. However, the main Lodwar service (a one-stop centre run with the support of IRC) is at risk of scaling down due to lack of funding.

Voices from the field:
"We don't get sleep since thugs and bad people keep on patrolling in our compound and police are not concerned." - FGD adult female, Kakuma Camp

Wajir/Mandera

1. There is very limited GBV programming in these counties. The multi-sectoral response model does not work, particularly with relation to the police and courts. The Maslaha system is reportedly quite active. There are very few PSS services. There are no county policies for domestication of national policies related to GBV.
2. Community-awareness and social norms change interventions related to GBV are also quite limited, although men's groups do apparently exist to support attention to human

Voices from the field:
"Women are economically dependent on men and that puts them at risks of being violated. Illiteracy and lack of awareness not knowing violence against women should not be tolerated." - Key informant, Wajir

rights more broadly. There were no reports of longer-term programming efforts in these counties to combat GBV outside of work on FGM and child marriage.

General/Cross-Cutting

1. In the refugee sites, most of the agencies are operating with short-term grants (6 to 9 months). This not only undermines their ability to do prevention programming, it also prevents them from being able to scale up their services to the host community using models that support longer-term sustainability of interventions.
2. In general, outside of the refugee centres the focus of services is on the larger towns. There are no strategies or approaches to reach remote populations, even though women's networks and faith networks are reportedly fairly strong in many areas and can be facilitated to improve outreach to survivors. In the Somali communities outside of the camps, psychosocial support is quite limited because its seen as foreign to Islamic culture.
3. While the one-stop centres in the camps are reportedly strong, the existing centres in Garissa town and Lodwar do not have sufficient support and centres do not exist elsewhere (there is a structure in Wajir but it is not operational).
4. Outside of the camps, significant data gaps exist across the counties related to GBV. While the health care providers report into a system monitored by the Ministry of Health, no other partners report into a broader GBV database. The Garissa GBV Working Group collects data from its partners, but because there is no centralized system it is reportedly very difficult to analyse due to differences in reporting as well as repetition of cases.
5. Integrating attention to GBV in county plans is still a work in progress. This includes preparedness plans for counties; while these plans reportedly exist, they do not include attention to GBV.
6. There are evidently no cross-border programmes that look at GBV. Although DRC supports a Mandera Triangle resilience project through the Mixed Migration Center29, it reportedly does not address GBV specifically, or protection more broadly, despite the significant protection risks related to migration.30
7. The extent of sexual violence against boys remains unknown. While PSS and health services exists for boy survivors in the camps, there are few cases reported. In the larger counties, there are child protection networks but generally very low levels of reporting on sexual violence against boys. The Maslaha system contributes to this lack of awareness about the issue because cases are resolved through fines (and perpetrators are released to the community).
8. EMAP and SASA! have been implemented for a number of years in both Dadaab and Kakuma. These programmes have reportedly been an important step in social norms work related to GBV. However, they have not been evaluated so it is not possible to determine their impact.

[29] http://www.mixedmigration.org/regions/east-africa/

[30] One key informant indicated that the government in Turkana is training government personnel at the borders to identify issues related to GBV, but this could not be verified.

SDC Opportunities/Recommendations

First Tier Priorities

4. **Legal/justice sector:** Partner with UNHCR to support efforts to build more gender equitable justice systems for Somali women through support to the Garissa magistrate at the Dadaab camp. As a potential complement, work with UNHCR and implementing partners (RCK, Action Aid) to scale up capacity of paralegals to work in and across north-eastern counties through the traditional systems to build safer responses to survivors, including improving Kadhi courts so that the reliance on maslaha is lessened. This project is already underway, so the cost investment is low for the return, and aligns with SDC priorities for improving services and protection for refugees in Kenya.

5. **Child Protection:** Work with CASI and UNICEF to support training of governmental and non-governmental child protection actors in northern countries on identifying risks of sexual violence for boys and standardizing referral pathways. Draw from the CASI assessment and recommendations to build out a model for response to sexual violence and exploitation of boys in northern Kenya through support to relevant actors, including Department of Child Services and UN and NGO child protection and MHPSS actors. (Consider expanding this to a regional approach.) This represents a potential new area for SDC to support that aligns with SDC's commitment to improving services for male survivors of sexual violence.

6. **Food security sector:** Build out the food security programmes in Wajir and elsewhere so that they support women and women's institutions to lead food projects. Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods. (Consider expanding to a regional approach.) Given that food security is a significant SDC investment, integrating risk mitigation measures that also support durable solutions for women and girls, and women's empowerment, is an important area for scale-up across all food security interventions. SDC may wish to hire a consultant to work with food security actors to build out risk mitigation (including livelihoods) programming that is safe, ethical, and follows global good practice.

Second Tier Priorities

1. **Security sector:** Drawing from good practices in Kenya, support UNHCR and RAS to scale up presence of female police and develop a sustainable model of police training and support at the national level through enhancing the national training curriculum (building on existing efforts of UN Women, FIDA, and other partners), or as a pilot in one county to that can be replicated, and/or as part of the KISEDP or GISEDP.[31]

[31] Police training was repeatedly raised by key information as a critical area for investment. The Multi-Donor Trust Fund under the Kenya Accountable Devolution Programme is engaged in a police and health capacity-building project in Bomet county.

2. **Women's empowerment:** In all counties support localization through transitioning existing local women's networks to greater positions of influence and control in the community through, for example, a three-year pilot project aimed at building local women's and youth groups with focused capacity building and support, applying a tiered model for organizational development used by UNICEF in S. Sudan. Building on and linking to the work of the co-leads of the GBV Working Group, UN Women and UNFPA, conduct a mapping of women's networks and organizations and engage in participatory dialogue about how to build women's leadership. Use the Nexus Platform approach for funding multiple women's organizations under a shared umbrella. (Also consider this as a cross-border and/or regional option.)[32]

3. **General:** Review the workplans linked to the GIESDP and KIESDP for potential GBV investments. Consider co-funding models or matched financing for government-led initiatives.[33]

Third Tier Priorities

1. **Health sector:** Support IRC and the existing Wellness Center in Lodwar to continue its level of staffing and/or advance the preliminary work in Wajir and Mandera to train health and other providers on the one-stop model, which has been initiated in these counties but is not operational.

2. **Psychosocial sector:** Develop a training-of-trainer programme that utilizes women's networks to develop basic psychosocial support programming that is culturally appropriate and locally-led. For north-eastern counties in particular, draw from pilots by UNICEF and TdH in the MENA region that build on positive aspects of Islamic systems, facilitating access to services by Muslim women and adolescent girls, that also uses an explicitly feminist empowerment model for survivors. For Turkana, consider a similar project that builds on faith networks. Potentially use the PSS project to facilitate support to programmes within the camps, but also to build them out to the host communities and beyond. Consider using a women-friendly space model as a starting point.

[32] One option might be to link this to the Kakuma Kalobeyei Challenge Fund, a program of the International Finance Corporation (IFC), implemented with Africa Enterprise Challenge Fund, Turkana County Government, and UNHCR. The five-year program is designed to support private sector investment and unlock the economic potential of refugees and their hosts, in Kenya's Turkana County, and includes a core objective of developing and grow refugee and host community-owned businesses and create opportunities for women and youth. SDC reportedly is already providing support to this initiative, and could consider linking additional support to a specific strategy for supporting women's leadership in Turkana County on the issue of GBV. See https://kkcfke.org

[33] The Regional Durable Solutions Secretariat in reportedly considering these models.

HALCYON CONSULTING

5. Somali Region of Ethiopia Assessment Findings

Background[34]

Context: In the past two years, Ethiopia has experienced several major displacements, both internally and from around the Horn of Africa region due to conflict, inter-ethnic violence, and climate change.[35] The country now hosts around 2 million IDPs[36] and 800,000 refugees, the majority of whom are from South Sudan, Somalia, Eritrea, and Sudan.[37] The Somali Region, which is the focus of this assessment, is among the least developed parts of Ethiopia and is home to one of the largest populations of pastoralists in the Horn of Africa region,[38] as well as at least 200,000 Somali refugees[39] and tens of thousands of IDPs.[40]

Scope of GBV: While there is limited data about the scope of GBV, among all women in Ethiopia, 1 out of every 2 women interviewed for the 2016 Ethiopia Demographic and Health Survey reported experiencing intimate partner violence in their lifetime,[41] and surveys suggest that child marriage,[42] female genital mutilation,[43] and sexual exploitation are prevalent throughout the country.[44] Among the Somali Region's pastoralists, domestic violence and child marriage are persistent issues, as is FGM, with nearly 100% of pastoralist women and girls undergoing some form in their lifetimes.[45] These GBV issues are similarly common for refugee women and girls, with sexual exploitation and assault due to ongoing insecurity being notable risks.[46] For IDPs, the most common forms of GBV are domestic violence and FGM, although conflict and displacement have fuelled an increase in early marriages.[47] Data on the risks of sexual violence facing men and boys in Ethiopia is extremely limited.

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[35] Child Protection/Gender Based Violence Ethiopia, 2020. "Ethiopia Child Protection Area of Responsibility and Gender Based Violence Area of Responsibility Strategy (Sept. 2020-Sept. 2022)"
[36] UNOCHA, 2020. Humanitarian Needs Overview: Ethiopia, pg. 4
[37] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 2
[38] Kipuri, Naomi and Andrew Ridgewell, 2008. A Double Bind: The Exclusion of Pastoralist Women in the East and Horn of Africa
[39] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 2
[40] UNHCR and DRC, 2019. "Protection Assessment of Biiqa, Qoloji 1, Awjabur, Masle, Dugsi and Kaliyal IDP Sites in Fanfan Zone, Somali Regional State
[41] UN Women & Ministry of Women, Children, and Youth, June 2020. General Socio-Economic Status of Women and Girls in Afar and Somali Regions, and Barriers Hindering the Adoption of Family Law, pg. 6
[42] UNICEF, March 2016. Child Marriage in Ethiopia: A review of the evidence and an analysis of the prevalence of child marriage in hotspot districts
[43] UNICEF, 2020. A Profile of Female Genital Mutilation in Ethiopia
[44] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 3
[45] Kipuri, 2008. A Double Bind.
[46] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 3
[47] CARE, September 2019. "CARE Rapid Gender Assessment Report: Drought and Conflict-Affected IDPs and Host Communities in Somali Region, Liben Zone Ethiopia," pg. 7

Legislative/Policy Environment: The government of Ethiopia has developed a centralized legal framework for the protection of women from GBV in recent years. Child marriage is prohibited according to its Revised Family Law and Revised Criminal Code, which also outlaws domestic violence, rape, sexual violence, sexual exploitation, and FGM.[48] Complementing these laws, the government of Ethiopia has developed gender-responsive policies to further address GBV issues, including the 1993 National Policy on Women, the 2010 Strategic Plan for an Integrated and Multi-Sectoral Response to Violence Against Women and Children and Child Justice in Ethiopia,[49] the 2013 National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia[50], and the Roadmap for Ending Child Marriage and FGM/C 2020-24.[51]

GBV Coordination and Funding

Development coordination related to GBV is being led by Ministry of Women, Children, and Youth Affairs (MoWCYA) and at the regional level by Bureau of Women and Children Affairs (BoWCA). The Ministry and regional Bureaus are mandated to promote gender equality in political, economic, and social affairs in Ethiopia, to lead awareness creation activities on women's rights, to identify and develop strategies to eliminate practices that harm women, to prevent and respond to GBV, and to establish centres for health, psychological, and legal services for women, among other tasks.[52] Thematic working groups have also been established at nation and sub-national levels around specific GBV-related issues, such as anti-trafficking, child marriage and FGM. There is also reportedly a Development Assistant Group on Gender Equality that includes many development partners working on gender issues in Ethiopia.

The Child Protection Area of Responsibility and Gender Based Violence Area of Responsibility (CP/GBV AoRs) are combined into a single working group operating for IDPs under the cluster system. The CP/GBV Working Group is chaired at the national level by the MoWCYA and at regional level by BoWCA, and co-chaired by UNICEF (Child Protection AoR) and UNFPA (Gender-Based Violence AoR). The GBV/CP AoR has five key objectives in its 2020-2022 Strategy: 1) improving service provision; 2) community awareness; 3) capacity-building of frontline caseworkers; 4) enhanced sector risk mitigation; and 5) enhanced coordination. Presently, the AoR coordination structures get activated and deactivated depending on local needs and response capacity. In the Somali region this working group has hardly functioned during COVID-19; it reportedly has had three meetings since March, but is planning to resume in the coming weeks.[53] The UNFPA GBV co-lead is 'double-hatting' in the

[48] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 4
[49] See: https://www.gage.odi.org/wp-content/uploads/2018/12/GAGE-PLA-Policy-Note-Ethiopia-WEB.pdf
[50] Girls Not Brides, 2015. Country Fact Sheet: Ethiopia, pg. 1
[51] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 4
[52] https://www.facebook.com/pg/EthiopiaMoWCY/about/?ref=page_internal
[53] According to the most recent CP/GBV AoR strategy 2020-2024, about 80% of the targeted HRP 2020 woredas have no CP/GBV actors' presence for specialized services.

coordination role—managing programme oversight responsibilities in addition to coordination responsibilities.

Separate to the cluster system, UNHCR is leading refugee coordination and response. Child protection and gender-based violence working groups exist at the national level and in refugee hosting locations, including in the Somali region. Regional meetings are held in JIjiga with all partners who are signatories to the Standard Operating Procedures, as well as at camp level. At the camp level, the meetings typically include representatives of the Refugee Central Committee and the camp Women's Association. UNHCR also hosts separate coordination meetings for case management.

In terms of donors, BPRM is a key donor to refugee work on GBV, funding directly to INGOs and UNHCR. Funding also comes through the CERF and EHF. This project funding tends to be very short-term and presents on-going challenges in continuity and scope of programmes. Canada is funding UNFPA in a longer-term project to provide training to health staff, distribute dignity kits, and support women's empowerment in refugee, IDP and returnee sites. Norway is supporting work on FGM and child marriage, and also provides funding to UN Women (alongside Sweden and the Netherlands) for development work focused on government capacity building, including integrating GBV into the DHS. USAID also funds UN Women to support work on legal sector reform, and provides support to a CSO on GBV awareness-creation in the Somali region. Canada is reportedly scaling up work on GBV through Plan and UNICEF. The European Commission is also providing support to local NGOs for GBV prevention. In general, funding for GBV in humanitarian response is extremely limited. Notably, however, there is a Development Assistance Group on Gender, as well as an EU Task Force on Gender Equality. There is no specific donor coordination around GBV, addressing either development or humanitarian contexts.

GBV Prevention and Response Programming[54]

Host Communities and IDPs. As noted previously, BoWCA is the main provider of GBV services. They oversee the Jijiga one-stop centre and train medical providers in GBV.[55] Out of the 93 woredas in Somali region, 20 have medical officers who have received training on GBV. This year, BoWCA is planning for training in an additional 20 woredas. They also have a social services workforce responsible for CP and GBV case management services, with 2-3 social workers placed in each woreda, as well as in the one-stop centre. Government social workers are also placed in IDP camps and trained by partners including UNFPA and IRC to provide psychological first aid and referrals.[56] Although there are no shelter services, BoWCA works with community networks to identify temporary shelters as needed. BoWCA is also closely linked to a network of women's CSOs across the region.

[54] For a summary list of key GBV actors, see the annexes
[55] There is reportedly a site for a one-stop center in Melkadida but it is not yet operational.
[56] IRC is reportedly trying to second someone to BoWCA to support their GBV capacity but there are not enough funds.

BoWCA is a key partner with UNICEF and UNFPA on projects on FGM and child marriage and GBV and family law in the Somali region. UNFPA has supported awareness raising at the community level, as well as capacity building of legal and health partners. UN Women is in the process of starting a legal project to strengthen the application of family law in the region that will include supporting the Ethiopian Women's Lawyer's Association to set up an office in Jijiga. A key informant noted that there is a hotline linked to the police, but it is apparently not being used, perhaps because it is not known to the population.

Some of the key actors operating in IDP contexts are Action Against Hunger, CARE Ethiopia, IRC, PAPDA and Save the Children. Whether in IDP settings or in the host community, there are a very small number of INGO and NGO providers across the region, a function of the fact that the government has only recently opened up opportunities for civil society. In general, these I/NGOs provide PSS services, community awareness raising—particularly around the issues of FGM and child marriage--and health training. A variety of approaches have been used for community-awareness raising, including working with community leaders and faith leaders, as well as using mobile phone technology to share GBV prevention messages. However, very few of these projects have long-term funding, particularly those that serve IDP populations. Notably, one of these organizations, OWDA (funded in Ethiopia by the European Commission), has received support from GiZ to open an office in Somaliland—making them the first local NGO in Ethiopia to work cross-border. However, activities have not commenced due to COVID-19.[57]

BoWCA is responsible for data collection and management related to GBV. In 2019, the one-stop centre in Jijiga received 76 cases. More detailed data is very hard to obtain. UN Women is planning to support a module on GBV for the DHS planned for 2021.

Refugees. Relative to IDP and host community programming, SGBV programming in the refugee camps is quite evolved. Programming in the Somali region is led by UNCHR with IRC (Jijiga), IMC (Melkadida) and RaDO (all camps) as core partners. Approaches of these core partners include community education and outreach as well as implementation of Women and Girls Safe Spaces that provide PSS, skills training and recreational activities. Partners are also using the SASA! model for social norms work.[58] IRC is in the initial stages of implementing an initiative for adolescent girls in the camps, "Girl Shine."

UNHCR and partners have built up voluntary Women's Associations that support referrals for survivors as well as women's empowerment. ARRA provides legal services with support from DRC (Fafen) and NRC (Liben) and the Jijiga University School of Law (Fafen). ARRA is also responsible for the provision of health services. ARRA has been trained on CMR; nevertheless, UNCHR is currently considering options for linking to one-stop centres through a relationship with the government in order to facilitate refugee inclusion in national systems. Shelters were in the camps previously, but

[57] The information was collected by a field researcher. It is not clear whether OWDA considers their programme to be cross-border, although it was apparently characterized as such.
[58] The SASA! approach is being implemented in 18 camps across Ethiopia, with technical support from Raising Voices. There has not yet been any evaluation of the success of the approach in the Ethiopia refugee context.

they were not utilized by survivors, so UNHCR currently uses a system of housing survivors in need of shelter with community or religious leaders in the camps.

UNHCR supports use of the GBVIMS among its core partners. From January to September 2020, 48 cases were reported in three camps in Jijiga. Among these cases, one was a male survivor. UNHCR is currently undertaking an assessment to understand why reporting on SGBV is low.

GBV Risk Mitigation Mainstreaming

The GBV/CP Strategy for 2020-2022 has identified rollout of the GBV Pocket Guide as a priority. However, it is unclear whether or not any risk mitigation trainings are currently being provided for non-GBV specialist sectors working in IDP camps.

In refugee camps, UNHCR introduced a mainstreaming project in Ethiopia in 2019 focusing on Child Protection, Education and WASH. The project is based on a global agreement that supports sectors to identify specific GBV indicators (as with Kenya), and to integrate attention to GBV in all planning and interventions.

Notable Gaps/Challenges

Host Community and IPDs

1. There is very limited service delivery capacity on GBV outside of the refugee contexts. There is only one one-stop centre in the Somali region (in Jijiga) and until recently it was closed for COVID-19; even when open it reportedly lacks sufficient supplies. There are no women-friendly spaces. There are no shelters.
2. Capacity of BOWCYA is low and they are significantly overstretched because they are responsible for direct service provision. They lack even basic resources, such as lockable cabinets. The government social workers reportedly do not consistently follow a survivor-centred approach. Training for them is quite limited and there is no supervisory system.

> **Voices from the field:**
> "With GBV services, in the context of COVID-19, there just wasn't enough capacity to respond….it's like having a house made of cards and then you put a brick on it."
> - KII, Addis

3. Anecdotal reports suggest that violence against women and girls is commonplace in the IDP camps. However, GBV reporting is low. There are no specialized services in the camps related to GBV response. Basic services (WASH, education, health) are reportedly limited, and there is no indication that mainstreaming of GBV risk mitigation is taking place in the IDP response in the Somali region (as it is in the refugee context), even in terms of ensuring separate WASH facilities for males and females, distribution of hygiene kits, etc.59
4. Although there have been important efforts towards community engagement from some actors, particularly related to FGM and child marriage, there is reportedly relatively low engagement of community leaders in the issue of GBV in the Somali region and no local women's organizations that

[59] IOM's Displacement Tracking Matrix found in 2019 that there were no GBV services in the majority of sites in which IDPs are living (67%), and access to referral pathways was extremely limited *(IOM, October 22, 2019. Ethiopia National Displacement Report, Round 18: July-August 2019)*

are formally registered in the region. There is some "timidity on facing the issues of GBV,"[60] particularly in terms of addressing the foundations of gender inequality that inform all types of GBV women and girls experience.

5. BoWCA has an internal system of referrals, however, there are no standard survivor-centred referral pathways or systems of care, nor is there any data collection and management system. Each organization working on GBV may conduct their own programming assessment and collect their own data, but there is no protocol for shared data. For IDPs, the only source of data is the IOM data tracking matrix that has indicators related to GBV.
6. Food insecurity is a regular occurrence in the region,[61] but there appear to be no programming explicitly linking food insecurity and GBV, or nutrition and GBV. Nor do there appear to be livelihoods approaches for reducing the risks of GBV associated with food insecurity and other risk factors linked to poverty.

Refugees

1. Although there are women-friendly spaces, there are limited livelihoods opportunities for women and adolescent girls. There are reportedly risks for girls of being pressured into domestic work by their families. The attrition rate for girls as they progress through school is very high (not only among refugees, but countrywide) and the expectation is that COVID-19 will exacerbate this already significant problem. There is insufficient cash programming to address the needs of vulnerable refugee girls and their families.
2. According to key informants, the current GBVIMS data collection is outdated. It does not include case management. In the coming year, UNHCR is planning to update the system, which may involve PRIMERO/GBVIMS+.
3. UNHCR's country-wide rollout of SASA! prevention in refugee camps represents a significant investment, yet it has not been evaluated.

General/Cross-cutting

1. Although there are legal systems, they are not typically accessed by GBV survivors. Legal aid reportedly requires payment, as does transport to police, and in the absence of access, more traditional approaches (e.g. Sharia and elders' mediation) prevail. This is true in both the refugee and the IDP/host communities.
2. There is limited coordination of donors on GBV, which some key informants believe has resulted in replication of GBV programming even in a context where programming in general is quite limited. In particular, there appear to be a number of NGOs engaged in community awareness raising in the Somali region.

Voices from the field:
"The camp administration has its own structure to with the police to give legal services to survivors but our community gives priority to our system. This is because court procedures are costly and time taking." -KII, Jijiga

[60] Key Informant Interview
[61] UNOCHA assessed that Somali and Oromia regions have had the largest numbers of people who needed relief food at least nine times between 2013 and 2018. See https://www.unicef.org/ethiopia/media/2401/file/Somali%20region%20.pdf

3. There is no information about the issue of sexual violence against males. There is a widespread perception that it doesn't happen.
4. There are no cross-border programmes on GBV, even though several key informants emphasized the importance of this.

SDC Opportunities/Recommendations

First Tier Priorites

4. **Health and MHPSS.** Develop a project with UNFPA and BOWCA to support building systems for GBV at the Jijiga-level in the Fafen Zone as a pilot, with the eventual plan to cascade to other zones and woredas. Focus particularly on health and MHPSS, but also through coordination engage police and legal systems, including at the ministerial level, as well as key I/NGO partners such as the Ethiopian Women's Lawyers Association office in Jijiga (forthcoming). Work with international and national partners (e.g. IRC, OWDA) to support the development of standard operating procedures and coordination among multi-sectoral partners, as well as training and other capacity-building tools for health and MHPSS. Consider developing or expanding mobile outreach teams as part of this pilot as a way to expand service coverage. This investment aligns with SDC's priority for building out health services in Ethiopia.

5. **Data collection.** UNHCR intends to improve its GBV data systems in the coming year by upgrading from GBVIMS to Primero/GBVIMS+ (which includes case management capacity) and linking that to UNCHR's internal data management system (Progress V 4). The rollout of an updated case management system may present opportunities to improve data management systems amongst national partners, particularly the one-stop centres. Funding for an integrated approach to improving data management could support UNHCR's commitment to greater inclusivity of refugees in national systems and also support UNHCR's plan for SGBV response for refugees to link to one-stop centres. This represents a limited investment for a positive return, and could be co-funded. This project could also link to the regional data manager deployed to the regional GBV Working Group, and ensure that UNHCR's investment in improving systems is aligned with and supported by the regional effort.

6. **Food Security.** Integrate attention to GBV in food security programmes. Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods. (Also consider this as a regional approach.) As noted in the Kenya section above, because food security is a significant SDC HoA investment, integrating risk mitigation measures that also support durable solutions for women and girls, and women's empowerment, is an important area for scale-up across all food security interventions. SDC may wish to hire a consultant to work with food security actors to build out risk mitigation (including livelihoods) programming that is safe, ethical, and follows global good practice.

Second Tier Priorities

1. **Women's empowerment.** Take advantage of the BoWCA link to women's CSOs. Work directly with BoWCA to support localization through transitioning existing local women's networks to greater

positions of influence and control in the community through, for example, a three-year pilot project aimed at building local women's and youth groups with focused capacity building and support, applying a tiered model for organizational development used in S. Sudan. Conduct a mapping of women's networks and organizations and engage in participatory dialogue about how to build women's leadership. (Also consider this as a cross-border and/or regional option.)

2. **Child Protection:** Work with Child Protection to undertake widespread training among health and social workers on sexual violence against boys as a first step in raising awareness of the need to improve attention to this issue. (Also consider this as a regional option.)

Third Tier Priorities

1. **GBV Risk Mitigation.** In line with one of the core objectives of the GBV Working Group's Strategy 2020-2024, support UNFPA in the rollout of the GBV Pocket Guide to all humanitarian sectors in all IDP camps in the Somali region. Accompany the rollout with basic training on GBV risk mitigation.

2. **Governance.** Consider using the SDC roster to deploy an international (or national staff person) to BoWCA in Fafen or Liben zones with a terms of reference for building women's participation in peace-building as a strategy for reducing GBV, as part of SDC's governance work. Use the upcoming elections as an opportunity to support the development of strategy for ending GBV as a component of peace-building in the Somali region.

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6. Somalia Assessment Findings

Background

Context: For decades, Somalia has been wracked with conflict, persistent insecurity, natural disasters, gender inequality,[62] [63] lack of protection by state authorities and recurring humanitarian crises continue to expose civilians to heightened risks of sexual violence. It has one of the largest populations of IDPs in the world (2.6m people), with displacement driven by the conflict with al-Shabab, fear of violence, drought, lack of livelihood opportunities and evictions. Increased population in urban centers has intensified pressure on limited services, such as health, education and housing.[64] About one third of the total population - around 4m people - is in need of humanitarian assistance, [65] including a total of 1.25 million girls and 850,000 women. [66]

Scope of GBV: Data on GBV across Somalia has been a long-standing challenge, partly due to information system weaknesses, and also due to under-reported due to stigma and fear of retaliation. However, very recent data indicates younger women are more likely to experience physical violence; with 16% of women aged 15-19 reporting they had experienced violence since the age of 12.[67] Among older women aged 45-49, 11% report experiencing physical violence since the age of 12.[68] There is 76 per cent support for and/or justification of wife-beating among females in Somalia.[69] The most common perpetrators of violent acts were their husbands.[70] The 2019 GBVIMS recorded an increase in reported cases of sexual violence against children and FGM.

Data on sexual violence against men and boys is more limited, although cases are reported in SGBV centres. Violence of any kind for nomadic population groups is lowest among all population groups.[71] FGM remains almost universal: 99% of Somali women aged 15 – 49 have undergone female circumcision.[72] IDPs are particularly at risk of SGBV due to limited security in the settlements, [73] general poor living conditions, the requirement to undertake risky livelihood practices to survive, and limited clan protection. Women's help-seeking behaviours in Somalia also remain very low. 83% of ever-married women aged 15 – 49 who had experienced emotional, physical or sexual violence did not seek any help. In Somaliland, the situation is similar: 82% of rural women did not seek help to stop any violence, and 72% of urban women did not seek help. Communities often shun sexual assault survivors because they believe they are tainted and cannot be married.

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[62] Federal Government of Somalia (2017). "Somalia Drought Impact and Needs Assessment." Volume I, Synthesis Report.
[63] The country's Gender Inequality Index (GII) is 0.776 (2012), ranking it the fourth lowest globally.
[64] OCHA (2019). "Somalia Humanitarian Response Plan: January-December 2019."
[65] OCHA (2019). "Somalia Humanitarian Response Plan: January-December 2019."
[66] OCHA (2018). "Humanitarian Needs Overview."
[67] The Somali Health and Demographic Survey 2020
[68] Ibid.
[69] UNICEF (2016). "Multi-Country Real Time Evaluation of UNICEF Gender-Based Violence in Emergencies Programme: Somalia Country Report." Child Protection Sector, Evaluation Report
[70] The Somali Health and Demographic Survey 2020
[71] Ibid.
[72] Ibid.
[73] IDP Sites – Safety Audits, Sept – Oct 2017, UNICEF, UNFPA and GBV Working Group (Draft Report)

Legislative/Policy Environment: In 2013, Somalia signed a Joint Communique with the Special Representative of the Secretary-General (SRSG) on the Prevention of Sexual Violence in Conflict. Since then the GBV sub-cluster has coordinated closely with the government and has been a driving force behind policy reforms such as the Sexual Offenses Acts endorsed in Puntland and Somaliland (2016 and 2017), advocacy around an FGM Bill, and consultative workshops around child marriage.[74] Between 2013 and 2015, several stakeholders worked with Ministry of Women and Human Rights Development of the Federal Government of Somalia to spearhead the drafting of the first Somali Sexual Offences Bill. the Puntland Minister for Women Affairs and Family Development in preparing their equivalent bills. In May 2018, the SOB was endorsed by Cabinet. However, due to extensive pressure from various groups, including influential religious groups and powerful religious leaders, the SOB was never given a first hearing in parliament. By June 2020, the SOB was dismissed and replaced with a dangerous and contradictory draft law on Sexual Intercourse Related Crimes Bill. This allows child marriage and forced marriage, and normalizes violence against women and girls. It reclassifies rape as a misdemeanour and removes punishment for other serious sexual offences.

In addition, there is also a draft Refugee Act in parliament, and the Act for the Protection of IDPs potentially being adopted.

GBV Coordination and Funding

In Somalia, UNFPA and the Ministry of Women and Family Affairs chair the SGBV Working Group,[75] and in Somaliland it is chaired by UNFPA and the Ministry of Employment, Social and Family Affairs (MESAF).[76] UNICEF and the Ministry of Women and Family Affairs chair the Child Protection Working Group in Somalia, and in Somaliland it is UNICEF and MESAF.[77] The Subcluster, 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.

The Ministry of Health (MoH) is responsible for all health-related issues on SGBV including case identification, response, counselling, awareness raising programs on SGBV. One stop centres and health facilities are fall under the administration of MOH. MOH also actively participates in the GBV working group and coordinates with other line ministries. Ministry of Interior (MoI) is responsible for IDPs placements and general protection, although very little protection is provided to the IDPs communities. The Ministry of Justice lead on all legal related issues of SGBV including legal assistance, legal advice, as well as the punishment of perpetrators. However, despite its central role the Ministry does not actively participate in the GBV working group meetings. Unique to Somalia, the Ministry of Endowment and Islamic Affairs (MoEIA) has a critical role in GBV as all issues related to policy and legislations of SGBV lies with the Ministry. Religious leaders throughout the country align to this Ministry too and which provide it with significant muscle.

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[74] UNFPA Global Evaluation, Somalia Desk Review, 2018.
[75] https://gbvaor.net
[76] The FGM Task Force is now incorporated into the SGBV Working Group
[77] http://cpwg.net

Somalia's funding landscape is made up of a multitude of donors who support a wider range of programmes and interventions that are related to GBV. The total amount of funding available to support GBV in Somalia is not fully know and has not been quantified, in part due to its integration within multiple programmes and sectors. Recent analysis carried out by UNWomen[78] indicates that while the amount of funding requested for women and girls has increased, it still falls short of the overall response. Around 14% of UNFPA's annual funding is allocated to GBV and UNICEF estimate that around $6m- $7m per year of their child protection budget is spent on GBV activities (around 40% of their child protection budget).[79] In 2020, UNFPA disbursed $2.6m in grants to their 14 implementing partners.

The UK's FCDO is the largest bilateral donor operating across Somalia and Somaliland and who provides a very extensive range of protection interventions through many large programmes, and which includes GBV prevention and mitigation support.[80] The Scandinavian partners support GBV mainly through UNFPA's country programme, alongside Italian Cooperation and SDC. Sida is the largest contributor to the UNFPA programme and their GBV interventions. UN Women supports several programmes related to GBV including women's leadership, representation and participation of women in political parties and political decision making. UNHCR lead the protection cluster and provides a range of support in 126 IDP sites out of a total of 2,300 across the country. Here UNHCR mitigates GBV for IDP communities by fencing camps, providing security as well solar lighting and gender-segregated toilets in camps. They work through six local partners, two of who cover Mogadishu and southern Somalia and four others spread across the states.

GBV Prevention and Response Programming

Host Communities and IDPs.

There are around 60 organisations working on numerous SGBV priorities across Somalia. 20% of these are in Banadir region, and the balance dispersed across other regions.[81]

[78] Funding for Gender Equality and the Empowerment of Women and Girls in Humanitarian Programming, UN Women, June 2020

[79] Key informant interviews with UNICEF and UNFPA, October and November 2020

[80] Key FCDO programmes include Social Norms and Participation (SNaP) which is a £12.45 million programme of which £9.95 million is FCDO contribution, and £2.5 million is a Norwegian Aid contribution. SNaP is a four year programme that is focussed on increasing Somali women's participation in decision-making and challenge harmful practices. It is delivered through two components, including the United Nations Joint Programme on Women's Political Empowerment80 and the Challenging Harmful Social Norms (CHANGES)[80] component which are implemented across a wide part of Somalia including Kismayo, Mogadishu, Hargeisa, Burao, Erigavo, Beletweyne, Galckayo, Adado and Badhan. Other important FCDO programmes that support GBV include the *Adolescent Girls' Education in Somalia (AGES)*[80] which is implemented in Somalia (Banadir/Mogadishu, Jubaland and South-West Administration) and targets the hardest to reach, out-of-school girls, and the *Somali Girls Education Promotion Programme (SOMGEP)*[80] which is a four-year programe implemented in Somalia (Somaliland, Puntland and Galmudug states). One of the project activities is promoting positive shifts in gender and social norms through dialogue with religious leaders, authorities, elders, girls and both male and female role models and empowering mothers through adult literacy and financial literacy classes, village savings and loans groups, and business coaching and mentoring. The project is implemented by CARE in partnership with ADRA, Havoyoco, TASS and Nagaad.

[81] UNFPA Somalia

UNFPA's primary GBV focus is on IDPs and host communities and they operate across all of Somalia, including the FMSs as well as Somaliland. Most of their work is through more than local implementing partners which includes both government ministries and departments, as well local and international implementing partners. UNFPA has carried out some cross border FGM research between Somalia and Kenya and Ethiopia, to inform the development of a plan of action for intergovernmental collaboration to across the cross-border dynamics of FGM.[82] However, the report did not explore other cross-border GBV components and no specific cross-border interventions have begun.

UNICEF has been supporting GBV work in Somalia since 2011, including through the Somalia Women Development Centre, based in Mogadishu, that provides survivors of GBV with medical, psychosocial and legal support.[83] UNICEF is also funding a two-year 'Strengthen Shelter Service and Promote Referral Mechanism in Somaliland Project' that aims at expanding services of the shelter home/counselling centre for SGBV survivors run by WAAPO; ensuring children accompanying survivors to shelters obtain short term pre-school education, art therapy sessions and drama play activities; reducing incidents of women's vulnerability to SGBV, and increasing their economic status; and enhancing the capacity of WAAPO to respond GBV in the other urban communities and strengthen referral pathway, while protecting survivor safety and rights. The project has established two additional SGBV survivor shelters in Boroma and Burao. UNICEF also support programmes that tackle social norms and masculinity, as well as improving the attitudes and practices of adolescent boys towards girls.

In Somalia, including the FMS and Puntland, Muslim Aid supports GBV one-stop centres, especially through salary top ups, staff trainings and providing supplies. CARE's main role in GBV and child protection used to be support and funding for risk mitigation measures and GBV services to IDPs and refuges/returnees communities in Puntland especially. IRC prioritise GBV prevention and service delivery, and NRC provides shelter for women in the IDPs/returnees. NCA provides shelter, non-food items and access to security and justice. Save the Children's main role in GBV and child protection is to provide risk mitigation measures and GBV services to women/girls across Puntland, partly with support from SDC. DRC provides shelter, non-food items and access to security and justice.

In the southern states of Somalia, the main local organisations include Save Somali Women and Children (SSWC), who run a GBV crisis centre which provides free medical treatment and psychosocial support and legal aid to GBV survivors of gender-based violence. SSWC also support anti-FGM campaigns. Gargaar Relief Development Organization (GREDO) is based in Baidoa and is currently working with CARE in Baidoa, Dinsoor and Wanlaweyn districts on social norm change.[84]

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[82] *Beyond the crossing: FGM across borders (Ethiopia, Kenya, Somalia, Tanzania and Uganda),* UNFPA, November 2019. The report was carried out under the *Joint UNICEF-UNFPA Joint Programme on Elimination of FGM: Accelerating Change*

[83] https://www.unicef.org/somalia/stories/japans-support-unicef-steps-response-gender-based-violence-women-and-children

[84] https://www.gredosom.org/ongoing-projects/

In Puntland, the main local organisations that runs centres is Takuulo, although their centre are only located in Garowe. TASS is a non-profit that works in Sanaag, Bari, Sool, Nugal, Mudug and Banadir regions. TASS plays an important role in protection clusters in Puntland, and works with Norwegian Church Aid(NCA) and Save the Children Joint Programme to end Female Genital Mutilation & Child, Early and Forced Marriages (FGM & CEFM) (2020-2024) in in Bosaso and Qardo districts.

Save the Children, Plan International, Action Aid, Oxfam and ISF are the main international NGOs working in Somaliland and they all implement relevant programs and are active in the coordination meetings. These INGOs are also funding by community-level programs implementing by CSOs in Somaliland.

In Somaliland, several organisations run on-stop centres. WAAPO works awareness raising programs on different areas of SGBV and runs shelters in Hargeisa[85], Burao and Boroma. NAFIS and WAAPO have collaborated in recent years and NAFIS has integrated three support centres in Hargeisa, Boroma and Burao to support women severing FGM complications, and also creating strong referral mechanisms within 21 mother and child health centres and three hospitals. The Baahikoob One-Stop Centre which was formally known Sexual Assault and referral Centre (SARC), is one of the well-known and effective SGBV stop centres in Somaliland based in the Hargeisa Group Hospital's maternity department. The centre provides free-of-charge post-rape care services, it is the entry and referral point for all survivors of gender-based violence. Apart from those centres there are also other organizations including WAAPO, NAFIS (FGM),[86] NAGAAD[87] and HAYOCO which provide medical service, psychosocial, legal services and referrals. SOFHA is also the only organization which has health facilities which provides SGBV health services including FGM complication management although there are no systemic services available for other SGBVs. There is also a legal aid clinic hosted by University of Hargeisa and funded by UNDP.

The numerous local professional health associations that operate across all parts of Somalia also support some aspects of SGBV awareness raising within their members, for examples the Puntland Association Midwives (PAM) and the Somaliland Nursing and Midwifery Association (SLNMA)

Refugees. UNHCR leads on GBV issues for refugees across Somalia, although UNICEF, UNFPA and IOM also support GBV interventions for some refugee populations – mainly in Bosaso in Puntland and Berbera in Somaliland where there are concentrations of Yemeni refugees. However, UNHCR also concentrates some of its national programme on IDPs, and UNFPA also indicated that starting in 2021 they will also start to focus on refugee communities in selected locations (further details not available until their new country programme is publicly available).

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[85] Also supported by CARITAS with SDC support, as well as UNICEF and previously the EC

[86] https://www.netzkraft.net/profil.php?teilnehmer=3220&lg=en

[87] The Nagaad Network works on FGM, domestic violence, child and forced marriage and support for rape survivors in all Somaliland regions. It provides legal empowerment of women and communities with legal knowledge, training of paralegals, networking with legal aid service providers and capacity building of law enforcement officers with emphasis on female members of the police.

The WAAPO shelter and safe house in Hargeisa, Somaliland, supports some refugees populations including from Yemen and Ethiopia, although the numbers are said to be low compared to local populations.

GBV Risk Mitigation Mainstreaming

Mainstreaming SGBV in different sectors including the humanitarian and livelihood programmes exist at some level including in livelihood programs but there is a need to improve mainstreaming programs across Somalia. This was reported by all principle GBV agencies operating in Somalia. UNICEF and UNFPA – with partners - integrate GBV with nutrition and WASH programs implemented by UNICEF, WFP, ActionAid, Save the Children and ACTED.

Notable Gaps/Challenges

Host Community and IPDs

1. One-stop centres remain low in number across Somalia and the states, as well as Somaliland. Psycho-social support to SGBV survivors, including higher levels of care, is also a significant gap. The number of qualified services providers across Somalia remain very low There is only one forensic lab in the whole of Somalia. One stop centres are not fully utilised by women due to a complex range of reasons which include families preventing women from using them, community stigmas and local religious and traditional customs that prefer to deal with GBV cases and punishments locally and without referral to one stop centres.
2. Despite long-term funding to prevent FGM across Somalia, FGM prevalence across the country has remained constant for years. The deep-rooted nature of harmful practices and negative attitudes towards women and girls in Somali society remains entrenched. Approaches need to be bold and ambitious and tackle systemic challenges.
3. While many local organisations across Somalia do exist and they provide a range or essential, localised support, including support to safe houses and one-stop centres, their capacity remains limited.
4. Funding cycles generally (for both international and local agencies receiving humanitarian funding) are typically short-term and with high management costs, which hinders long-term and bold SGBV programming.

Refugees

1. According to key informants, the current GBVIMS data collection is outdated. It does not include case management. In the coming year, UNHCR is planning to update the system, which may involve GBVIMS+.
2. Restricted humanitarian access in some parts of south and central Somalia remains a major challenge, which increases risk to women and girls from GBV, results in very limited provision of services and support GBV survivors. One stop centres are not available and neither are most agencies that can provide support and referrals.

General/Cross-cutting

1. The capacity of (and support from) certain local actors, especially the government, (police, judges' lawyers and counsellors) remains limited. The current re-writing of the SOB into the Sexual

Intercourse Related Crimes Bill has created further tensions and limited the support from many officials and institutions across Somalia.

2. Stakeholders indicated that while there are extensive gaps regarding all aspects of SGBV programming and support, it was reported that there is a reduced focus on prevention. Supporting more socio-economic interventions, working with men and boys to improve their behaviours and social norms, tackling religious barriers well as policy/advocacy were highlighted extensively by key stakeholders as key gaps in prevention.
3. Intentional cross-border GBV initiatives in the Horn of Africa region are non-existent

SDC Opportunities/Recommendations

First Tier Priorites

4. **Leverage SDC's comparative advantage in policy advocacy and legislation to tackle the Sexual Intercourse Related Crimes Bill.** Enhance support for related policies and legislations, in particular the Sexual Offences Bill. Earmark scaled up funding for the SOB. Join political forces with other governments at the highest level to advocate for new repressive laws to become enacted. Strengthening the capacity of the local actors, especially the government, (police, judges' lawyers and counsellors). Intensify advocacy support to reduce the opposition from religious leaders and groups to the Sexual Offences Bill. Advocating with Middle Eastern counties who also support Somalia in different ways was also a recommendation from FCDO as a gap that is not being filled currently. SDC can also scale up its important unique role on advocacy to give a stronger voice and leadership on GBV over the long-term horizon.

5. **Support the scale-up and roll-out of GBVMIS across all states and to more actors.** Provide additional resources to support GBVMIS improvement and the extension of more capacity development for organisations and individuals to use GBVMIS instead of other systems which do not capture data online. Consider support for a national gender equity data bank. Consider support for the roll out of the new GBVMISplus model that is currently being piloted and key staff trained

6. **Increase support for the wider legal/justice system.** SDC might consider supporting the legal/justice system over the longer-term, including strengthening the judiciary, the police and legal aid. Such support would be required at all levels across Somalia and Somaliland. Supporting research to help the sector understand how the legal/justice systems could be strengthened in Somalia and was highlighted by some partners as an potentially important contribution

Second Tier Priorities

1. **Increase the focus on prevention and root causes.** Stakeholders indicated that while there are still extensive and significant gaps regarding SGBV support, there is less of a focus on preventive aspects. Prevention could take many aspects, especially given that needs, although working with men and boys, especially adolescents, as well as policy/advocacy were highlighted extensively by key stakeholders as key prevention components.

2. **Scale up SGBV service delivery through more one stop centres and qualified services providers**. Scale up the number of one stop centres across Somalia, and increase support for the

clinical management of rape. SDC can build off its experiences supporting WAAPO and their centre in Hargeisa. Increase the number of one stop centres in less accessible areas, including in FMS, and outside of the main urban areas. Extend psycho-social support to SGBV victims, including higher levels of care, and support for men and perpetrators. Increase the number of qualified services providers across the country. Support the establishment of more forensic labs across Somalia, currently there is only one forensic lab in whole Somalia. Support is also needed, however, to encourage more women to use the one stop centres that are available.

3. **Increase the attention on local organisations, enhance their capacity through larger organisations, extend their funding cycles and move towards funding those with more capacity directly.** Consider long-term support to specifically enhance the capacity of local organisations, and beyond the typical one or two year programme funding cycle. Consider support to create a localised GBV network in Somalia to help increase capacity and coordination among local agencies

4. **Support the development of the National GBV Strategy, 2021 – 2023.** Consider specific support to the next three year National SGBV Strategy which will be developed in early 2021 through the SGV working group and led by UNFPA. Consider support to create a bigger vision for GBV in Somalia that goes beyond a three year perspective.

Third Tier Priorities

1. **Increase support to bold youth programmes that aim at improving the attitudes and practices of the next generation.** Stakeholders have strong views on the need for greater support to be dedicated to improving the attitudes and behaviours of male adolescents and youths – as evidence suggests there is some potential for changes in younger generations and with regards to tackling cultural, social and religious norms. Consider support to expand promising UNICEF work with male youths and GBV to new locations beyond Mogadishu and Jubaland.

7. Horn of Africa Regional Assessment Findings

Regional Initiatives Related to or Supportive of Addressing GBV

There are several regional structures and initiatives that can be leveraged to combat GBV. The African Union Policy and Action Plan of 2010 commits to creating an enabling and stable political environment, mainstreaming gender in all key issues and sectors of development, strengthening legislation and legal protections against discrimination to ensure gender equality, and promoting the effective participation of women in peacekeeping and security. Similarly, the Intergovernmental Authority on Development (IGAD), has established a gender strategy framework seeking to raise awareness on the importance of gender mainstreaming, to broker partnerships promoting gender equality and women's empowerment, and to strengthen capacity of African institutions to enhance gender quality.[88]

The African Regional Conference on Women (Beijing +25) released a political declaration acknowledging increased advocacy against GBV across Africa and applauded continued criminalization of GBV[89]. The Conference also promoted a Platform of Action, which included an overarching goal on eliminating all forms of discrimination and violence against women and girls as a prerequisite for gender equality and women's empowerment. Steps towards this goal include engaging traditional leaders to eliminate violence and harmful practices, such as child marriage and FGM, to provide care and support services, including access to justice, social, and legal services, to address intersecting forms of discrimination and violence against women and girls, including those with disabilities, the elderly, refugees, and IDPs, to enforce zero tolerance and address the impunity of GBV perpetrators, and to encourage States to strengthen and enact legislation protecting GBV survivors as victims of violence.

Ethiopia is home to the Spotlight Initiative Regional Programme for Africa, an EU and UN partnership seeking to eliminate all forms of violence against women and girls, eliminate harmful practices, and promote sexual and reproductive health and rights.[90] The Spotlight Initiative Regional Programme for Africa includes funding for the UNFPA-UNICEF Joint Programme on Female Genital Mutilation and the UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage. The regional programme also supports the strengthening of women's movements in Africa by providing dedicated funds to civil society organizations, including through the UN Trust Fund to End Violence Against Women. While the Spotlight Initiative represents a major investment from the European Union, Spotlight will be working throughout 2021 to identify supplemental donors to support the three primary domains of work: strengthening legislation; improving data systems; and building capacity of CSOs.

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[88] IGAD Secretariat, 2015. "IGAD Gender Strategy and Implementation Plan 2016-2020" https://resilience.igad.int/wp-content/uploads/2020/06/Gender-IGAD-Gender-Strategy-Vol-1-Framework-2016.pdf

[89] https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/e1902218-beijing25_declaration-english-.pdf

[90] Spotlight Initiative, 2020. "Where we work." https://www.spotlightinitiative.org/where-we-work?region=africa

Recently, Kenya chaired a meeting with the Commonwealth Ministers for Gender and Women's Affairs, including the leaders of all Commonwealth countries, on the impact of COVID-19 on women and girls, the need for a gender-sensitive response, and ways to address structural and systematic barriers towards gender equality.[91]

The GBV AoR REGA and IRC co-lead a regional coordination mechanism that seeks to build GBV linkages across the east and southern Africa that is comprised of 25 organizations. The Working Group has an annual workplan and is prioritizing four pillars for action: preparedness and risk mitigation; information management and data; advocacy; and meeting emerging crises.

Cross-Border Work in the Region

The research team was not able to identify any significant cross-border programming in the region addressing GBV. As noted previously there are reportedly migration programmes working in the Mandera triangle through the Mixed Migration Center[92], but these do not integrate attention to GBV. There have also been some efforts to identify risks for girls crossing the border in Wajir being trafficked for marriage by CCGD (noted above). There is a recognition as well of the cross-border issues related to FGM, where people travel across borders (Moyale was identified as a high-risk area) to have FGM performed, and some discussion amongst USAID about the possibility of building out a cross-border approach to this issue, but with no immediate plans. IFRC similarly advocated the value of cross-border programming while recognizing its absence in the region. There is historical precedent for cross-border programming, such as an ECHO cross-border project related to the Somali refugee crisis in 2011.

Common Challenges in the Region

1. Data collection appears to be a major challenge across the region. While UNHCR and partners have introduced GBVIMS systems in refugee contexts, data collection elsewhere is extremely poor. This leads to challenges in identifying trends related to help seeking.
2. The only consistent approach to service delivery in the region is through the one-stop centre model. The one-stop model is strong in Dadaab and Kakuma, and there is a one-stop in Lodwar. In the Somali region of Ethiopia there is only one functioning one-stop in Jijiga. While there are a few one-stop centres in Somalia, they are not integrated into a government model of response. As an approach, the one-stop centre may be better positioned to support a survivor-centred response, but its limited presence effectively means survivors outside of refugee camps or urban areas cannot access care and support.
3. Prevention across the region is supporting important work on social norms change through interventions including EMAP, SASA! and Communities Care. However, Communities Care is the only intervention that has been evaluated, and then only in the pilot stage.
4. Across the region, despite the ongoing exposure to disasters, preparedness efforts reportedly do not routinely address GBV risks, either through government or UN. In one example,

[91] Ministry of Public Service and Gender, Sept. 3, 2020. "Meeting of Commonwealth ministers for gender and women's affairs on impact of COVID-19." http://www.psyg.go.ke/?p=2899

[92] http://www.mixedmigration.org/regions/east-africa/

an anticipatory action pilot spearheaded by OCHA in Somalia did not target the issue of GBV. This also includes important work in the areas of food security

5. There does not appear to be any regional donor coordination around GBV. The regional GBV Working Group, while undertaking important work to link and support partners working throughout the region, does not have a plan or approach that is defined by or linked to a regional strategy. At the programmatic level, there do not appear to have been any efforts to address GBV through a regional or a cross-border approach.

6. Although the regional economic communities are playing an increased role in development progress, they have not been tapped to scale up attention to the problem of GBV regionally or at the country level. It is unclear how and whether the regional Spotlight Initiative may link to these regional bodies, since much of its support is to CSOs.

7. In general, localization is understood to be a very important aspect of GBV work, particularly in terms of building sustainable systems that continue the work of addressing GBV beyond the emergency, and also because evidence links scale up of women's networks and women's empowerment efforts to improved recovery, resilience and stability. Localization is a priority for the global GBV AoR. However, this approach does not appear to be used in a strategic way in any of the countries under review. Instead, the prevailing approach is for individual donors and implementing partners to link with CSOs for project-related activities. There are concerns not only that this creates duplication of services (especially problematic in settings with such limited funding for GBV), but also means that there is no strategic or overarching approach to localization, or any explicit link between localization and durable solutions, resilience, peace and security, etc.

8. Particularly in Ethiopia and northern Kenya, there is a strong local perception that boys are not at risk of sexual violence. This perception not only exits amongst the general population, it is shared by some service providers and child protection actors working at the local level. Even if cases do arise, they are reportedly addressed through traditional mechanisms.

Recommendations to Build on Regional GBV Work via SDC Support

First Tier Priorities

4. **Consider deploying a regional data expert for the regional GBV coordination mechanism that is tasked with building regional data systems** on Primero/GBVIMS+ or other sustainable platforms and building a regional dashboard similar to MENA. Consider linking this to African Union work on building data systems (which may be supported by the regional Spotlight Initiative, with whom SDC could partner). Also link to UNHCR work on data systems in their refugee response in Ethiopia.

5. **Build on the work related to anticipatory actions (e.g. OCHA pilot in Somalia) for inclusion of GBV in these new frameworks in order to support preparedness approaches** in the Horn of Africa that address GBV in natural disasters. Consider food security as an entry point for preparedness, possibly hiring a consultant to support SDC to work with its partners to not only build essential GBV risk mitigation into food security programming, but also to build attention to GBV in food security preparedness planning.

6. **Support the expansion of the CASI assessment initiative to Somalia and Ethiopia**, with a particular focus on identifying child protection capacity to address the issue of sexual violence and exploitation against boys. As noted previously, consider placing someone from the SDC roster within the Child Protection Working Group in Kenya (or regionally) to focus on issue of sexual violence against boys. This is highly relevant to SDC's investments and also an important area of growth for child protection.

Second Tier Priorities

1. **Develop a regional localization initiative that incentivizes international organizations to partner with local organizations to address GBV**, with a clear exit strategy for the international organizations. Link this in both advocacy and programming to durable solutions strategies. Consider partnership with Spotlight.

2. **Consider ways to link with regional economic communities such as IGAD to support integration of GBV risk mitigation into initiatives**, and/or to situate GBV experts in these communities to build capacity as part of SDC's deployment tool.

Third Tier Priorities

1. **Spearhead a regional donor group on GBV** and/or GBV-specific donor consultation forums within regional donor mechanisms that allows SDC to both advocate for and model funding approaches that are critical to the success of GBV programmes, including longer-term funding; localization approaches supporting development of women's organizations as well as government capacity; the importance of promoting gender equality as part of durable solutions; scaling up pooled funding; investment in monitoring and evaluation; etc.

2. **Develop a regional approach to GBV capacity building in the health sector through scale-up of the one-stop approach in underserved areas**, through partnership with IRC, UNFPA, , the Red Cross, USAID and others with a history of supporting one-stop interventions. Consider developing regional standards for one-stop centre responses to survivors.

3. **Consult with the global Prevention Collaborative partners to consider potential prevention interventions that can reach remote populations**, including through technology. Also consider replicating the Communities Care model in underserved areas in the region, to combine capacity building of service providers and prevention approach.[93] Consider, where possible, strategies for introducing social norms components into existing training curricula for providers (e.g. for police and health care providers). Ensure that any support to prevention includes an evaluative component.

4. **Support a protection monitoring system at the Moyale border** (and other border areas with significant cross-border movement) to identify multiple GBV issues related to border crossing, girls at

[93] The Communities Care model has been piloted in Somalia. However, in N Kenya and Somalia, IRC, DRC and other colleagues are using social norms change interventions from EMAP and SASA!, as noted previously.

risk of trafficking for marriage, perpetrators in flight, as well as other GBV concerns that reflect and contribute to GBV.

HALCYON CONSULTING

Annexes

Annex 1: Background Notes to GBV Programming in Northern Kenya

Context

Garissa County, which borders Somalia, and Wajir County, which borders Somalia and Ethiopia, are home to the Dadaab refugee complex. Established in 1991 for Somalis fleeing civil war, the government has taken recent measures to scale down the number of refugees in the Dadaab complex, where two of the five camps were closed in 2011 as part of a voluntary repatriation programs.[94] Even so, there is little sign of the protracted refugee situation dissipating in the near future.[95] The complex is currently made up of three camps, Dagahaley, Ifo, and Hagadera, inhabited by approximately 218,873 refugees and asylum seekers. North of Wajir is Mandera County, a volatile region of the country which serves as an entry point for migrants coming from Somalia and Ethiopia and experiences frequent violence between Kenyan security forces, clan militias, and al-Shabaab fighters.[96]

Further west is Turkana County, which borders Uganda and South Sudan, and is home to the Kakuma Refugee Camp and the Kalobeyei Integrated Settlement. Kakuma was established in 1992 following the arrival of displaced persons during the Second Sudanese Civil War and Ethiopian and Somali refugees fleeing civil strife in their countries. After another influx of South Sudanese refugees in 2013, UNHCR , the World Bank, and the Turkana County Government created the Kalobeyei Integrated Settlement as a means of promoting refugee and host community self-reliance and improving socio-economic conditions.[97] Together, the Camp and Integrated Settlement are now inhabited by 196,666 registered refugees and asylum seekers.[98] Kakuma is where UNHCR has relocated LGBTI individuals in order to work towards their resettlement. The groups, however, are reportedly at risk of violence, including by police.[99]

Scope of GBV

According to a 2013 World Health Organization study, around 41% of women in Kenya aged 15-49 report experiencing physical or sexual intimate partner violence within their lifetimes, with 26% of

[94] UNHCR, 2020. "Dadaab Refugee Complex." https://www.unhcr.org/ke/dadaab-refugee-complex
[95] UNHCR, 2015. Kenya Comprehensive Refugee Programme, pg. 6
[96] Mandera County Government, 2020. "Background - County General Information." https://mandera.go.ke/background/
[97] UNHCR, 2020. "Kalobeyei Settlement." https://www.unhcr.org/ke/kalobeyei-settlement
[98] UNHCR, 2020. "Kakuma Refugee Camp and Kalobeyei Integrated Settlement." https://www.unhcr.org/ke/kakuma-refugee-camp
[99] Key informant interview.

women reporting such an experience within the past year.[100] With regard to child marriage, UNICEF's 2017 State of the World's Children report estimate that 4% of girls in Kenya are married by age 15 and 23% are married by age 18.[101] Similarly, one in five women and girls in Kenya, or 21%, report having undergone some form of FGM,[102] although the practice varies widely among ethnic groups, with 94% of Somali women and girls reportedly having undergone FGM.[103] Many of these GBV risks appear to have increased since Kenya began enacting confinement measures related to COVID-19. For example, there has been a 775% increase in calls to the national gender-based violence hotline,[104] and a 35.8% increase in reporting of sexual offenses as of September.[105] In addition, teen pregnancies have increased: as of early July, 152,000 teenage girls reported being pregnant, a 40% increase of Kenya's monthly average.[106]

In terms of national data related to sexual violence against males, Kenya's National Crime Research Centre reported in 2014 that 7.4% of men reported ever experiencing sexual violence.[107] In research undertaken by UNICEF, 18% of men reported experiencing sexual violence[108] prior to age 18, with the most common perpetrator being romantic partners (43%), followed by neighbours (21%).[109] Despite this prevalence, reporting of sexual violence against men is extremely low; only 16.7% of those having experienced some form of sexual violence reported or had someone else report the act to authorities.[110]

Looking to the northern counties, according to Kenya's Demographic and Health Survey, 10.1% of women and girls in Kenya's north-eastern region, where Garissa, Wajir, and Mandera counties are located, report having ever experienced physical violence at the hands of a partner and 0.6% report having ever experienced sexual violence, the lowest of any region in the country.[111] This low percentage likely reflects the silence and stigma that accompany GBV.[112] Almost all women (97.5%) in Garissa, Wajir, and Mandera report having been subject to some form of FGM, the highest percentage in Kenya,[113] with Somali pastoralists reportedly unaware of the risks of FGM and of

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[100] Muuo, et al., Barriers and Facilitators to Care-Seeking among Survivors of Gender-Based Violence in the Dadaab Refugee Camps, pg. 3
[101] Girls Not Brides, 2020. "Kenya." https://www.girlsnotbrides.org/child-marriage/kenya/
[102] Kenya COVID-19 Gender Based Violence and Female Genital Mutilation Response Plan 2020
[103] UNICEF, 2020. A Profile of Female Genital Mutilation in Kenya
[104] UN Kenya Country Team, 2020. Kenya Emergency Appeal, pg. 5
[105] UN Kenya Country Team, 2020. Kenya Emergency Appeal, pg. 7
[106] Patridge-Hicks, Sophie, Aug. 19, 2020. "Rise in Teenage Pregnancies in Kenya Linked to COVID-19 Lockdown." https://www.globalcitizen.org/en/content/rise-in-teenage-pregnancies-during-kenya-lockdown/
[107] http://crimeresearch.go.ke/wp-content/uploads/2018/02/wwwroot_publications_Gender-Based-Violence-in-Kenya.pdf
[108] Sexual violence for males includes unwanted sexual touching, unwanted attempted sex, and pressured sex.
[109] UNICEF, 2013. "Violence against children in Kenya." https://www.unicef.org/esaro/VAC_in_Kenya.pdf
[110] http://crimeresearch.go.ke/wp-content/uploads/2018/02/wwwroot_publications_Gender-Based-Violence-in-Kenya.pdf
[111] Kenya National Bureau of Statistics, 2014. Kenya Demographic and Health Survey
[112] Oxfam, 2017. Protection Assessment Report: Kenya Emergency Drought Response 2017
[113] Ibid.

Kenya's laws prohibiting the practice.[114] In Wajir an estimated 98% of pastoral girls in rural areas undergo the most severe form of FGM, , while 10-20% of girls in urban areas are subject to less severe forms of cutting.[115] Early marriage is reportedly common in Wajir and Mandera[116], with girls typically married between the ages of 9 and 17.[117] Although data on sexual violence in Mandera is generally lacking, a 2018 survey on crimes states that 36.9% of crimes reported to police in the County were acts of rape, and women report feeling more vulnerable than men during attacks by al-Shabaab due to their responsibility for protecting children when men flee.[118]

Studies and service delivery statistics on GBV in Dadaab suggest the most prevalent forms are intimate partner violence, rape, sexual exploitation, and early marriage.[119] According to the Danish Refugee Council (DRC), over 1,000 cases of GBV are reported in Dadaab annually.[120] In FGDs held with female GBV survivors in Dadaab in 2017, 66.7% reported experiencing IPV in their lifetimes, with 51% experiencing it in the prior twelve months.[121] Demographically, young, single, unmarried, and newly arriving female refugees were seen as having elevated risk of physical and sexual violence due to their assignment in less secure housing and their lack of social networks.[122] As is true in the host community, FGM is extremely prevalent among Somali refugees, who make up the majority of the camps' inhabitants. In addition, during Kenya's COVID-19 lockdown, teenage pregnancies in Dadaab increased by 28% compared to the average from 2019, demonstrating setbacks linked to school closures and the inaccessibility of certain services, like safe spaces for girls.[123]

In the Rift Valley Region, where Turkana County is located, 31.1% of women and girls participating in the 2014 DHS reported having experienced physical violence at the hands of a partner, and 9.3% reported sexual violence, close to the national average of 36.9% and 13.3% respectively.[124] In a 2018 study by the Center for Victims of Torture, women and girls from the Turkana host community in

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[114] UNICEF, 2017. "Baseline Study Report Summary: Female Genital Mutilation/Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya," pg. 26
[115] Oxfam, 2017. Protection Assessment Report: Kenya Emergency Drought Response 2017
[116] Saferworld, 2020. "A war that hurts us twice. Inside Kenya's war on terror: community perspectives on security in Mandera county."
[117] Coffey, 2018. Kenya Improving Community Security Programme (ICS), County Assessment Report: Wajir
[118] Saferworld, 2020. "A war that hurts us twice. Inside Kenya's war on terror: community perspectives on security in Mandera county."
[119] Raising Voices and IRC, 2018. Dadaab Case Study: Learning from SASA! Adaptations in a Humanitarian Context, pg. 3
[120] Danish Refugee Council. Preventing Gender-Based Violence in Dadaab Refugee Camp: Engaging Men Through Accountable Practice (EMAP), pg. 1)
[121] Muuo, et al., Barriers and Facilitators to Care-Seeking among Survivors of Gender-Based Violence in the Dadaab Refugee Camps, pg. 7
[122] Muuo, et al., Barriers and Facilitators to Care-Seeking among Survivors of Gender-Based Violence in the Dadaab Refugee Camps, pg. 3
[123] Smith, Emma, Aug. 14, 2020. "Dramatic rise in Kenya early pregnancies amid school closures, IRC data suggests." https://www.devex.com/news/dramatic-rise-in-kenya-early-pregnancies-amid-school-closures-irc-data-suggests-97921
[124] Kenya National Bureau of Statistics, 2014. Kenya Demographic and Health Survey

Kakuma reporting domestic violence as a common issue in their lives.[125] In a 2020 study undertaken in Turkana, 12% of women and 4% of girls reported violence in the home as a major security issue.[126] Over a quarter of these women and girls also reported having been subjected to some form of FGM, a bit above the national average of 21%.[127] With regard to child marriage, a 2015 UNICEF report found one-third of Turkana pastoralist girls married before the age of 18 in order to bring economic benefits to their families.[128] According to a June 2020 gender analysis by IRC, 62% of girls in Turkana County highlighted early marriage is their biggest security concern.[129] A third of these girls feared sexual violence, alongside 22% of adult women.[130] Survival sex has reportedly become an increasingly widespread coping mechanism among pastoralist women and girls who have little means of supporting their families.[131] Since the COVID-19 lockdown, adolescent pregnancies have also increased threefold in Turkana County.[132]

Among residents of Kakuma Camp and the Kalobeyei Integrated Settlement, the most common types of GBV cited in a 2019 assessment were sexual violence, intimate partner violence, survival sex, child marriage, forced marriage, and domestic violence.[133] A 2017 UNHCR SGBV strategy noted that IPV is the most reported form of GBV in Kakuma,[134] with rape and physical and emotional violence also thought to be high, though infrequently reported.[135] Similar to the situation of women and girls in the Turkana host community, early marriage is widely practiced within Kakuma.[136] And as in other refugee encampments, women and girls remain at high risk of sexual assault when collecting fuel and firewood, where they may be targeted, and also because of poor shelter and lack of protection

[125] Golden, Shannon, 2018. "Assessing Mental Health in Kalobeyei: A Representative Survey of Refugees and Host Community." The Center for Victims of Torture, pg. 23
[126] IRC, June 2020. "Gender Analysis for Household Assessments Conducted in Loima and Turkana Central Subcounties in Turkana County," pg. 48.
[127] Ibid.
[128] UNICEF, Feb. 2016. Family Assets: Understanding and Addressing Child Marriage in Turkana
[129] IRC, June 2020. "Gender Analysis for Household Assessments Conducted in Loima and Turkana Central Subcounties in Turkana County," pg. 48.
[130] IRC, June 2020. "Gender Analysis for Household Assessments Conducted in Loima and Turkana Central Subcounties in Turkana County," pg. 48.
[131] Oxfam, 2017. Protection Assessment Report: Kenya Emergency Drought Response 2017
[132] Smith, Emma, Aug. 14, 2020. "Dramatic rise in Kenya early pregnancies amid school closures, IRC data suggests." https://www.devex.com/news/dramatic-rise-in-kenya-early-pregnancies-amid-school-closures-irc-data-suggests-97921
[133] UN Women Kenya Country Office, 2019. Gender Assessment of Kalobeyei Settlement and Kakuma Camp, pg. 22
[134] UNHCR Office Kakuma, 2017. SGBV Strategy, Kakuma Refugee Camp, Kenya, pg. 4
[135] MarketShare Associates & International Finance Corporation, December 2019. Gender Assessment of Kakuma Refugee Camp and Town & Kalobeyei Settlement and Town, pg. 62
[136] UNHCR Office Kakuma, 2017. SGBV Strategy, Kakuma Refugee Camp, Kenya, pg. 4

fencing in the camps.[137] In Kakuma, teenage pregnancies have skyrocketed as a result of Kenya's COVID-19 lockdown; 62 were reported in June 2020 in comparison to just eight cases in June 2019.[138]

GBV-Related Legislative and Policy Environment

The Constitution of Kenya provides men and women with equal treatment and the right to equal opportunities in political, economic, cultural, and social spheres. Early and forced marriage is prohibited and criminalized by Kenya's Children's Act of 2008, its Marriage Act of 2014, and its Sexual Offences Act of 2006.[139] Kenya's Sexual Offences Act recognizes men as potential victims of sexual violence.[140] The Children's Act also prohibits FGM,[141] as does its Prohibition of Female Genital Mutilation Act of 2011, which criminalizes all forms of the practice and any form of degradation intended to ridicule a girl or woman for not having undergone FGM,[142] and the 2014 Protection Against Domestic Violence Act, which classifies FGM as violence, provides protective measures for survivors of FGM and domestic violence, and outlines further prohibited acts such as forced marriage, sexual violence in a marriage, stalking, and verbal abuse.[143] In addition to prohibiting early marriage, the Sexual Offences Act of 2006 is the country's primary law on sexual violence, outlawing various forms of rape, sexual assault, defilement, incest, sexual abuse, and sexual harassment.[144] For refugees and displaced persons, the Kenyan government has also established regulations, including the Refugee Act of 2006, which promotes a framework to ensure the safety of refugee women and children in designated areas, and the Prevention, Protection and Assistance to Internally Displaced Persons and Affected Communities Act of 2012, which provides measures to protect displaced women.[145]

In addition to the country's broad legal framework, Kenya also has a number of national policy instruments addressing GBV. The 2014 National Policy for Prevention of and Response to Gender-based Violence[146] outlines a whole-of-government GBV prevention and response coordination structure to facilitate a national coordinated approach to GBV and ensure effective programming, improve the enforcement of laws and policies toward GBV prevention and response, increase

[137] MarketShare Associates & International Finance Corporation, December 2019. Gender Assessment of Kakuma Refugee Camp and Town & Kalobeyei Settlement and Town, pg. 63
[138] Smith, Emma, Aug. 14, 2020. "Dramatic rise in Kenya early pregnancies amid school closures, IRC data suggests." https://www.devex.com/news/dramatic-rise-in-kenya-early-pregnancies-amid-school-closures-irc-data-suggests-97921
[139] UNICEF, Feb. 2016. Family Assets: Understanding and Addressing Child Marriage in Turkana," pg. 19
[140] See: https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127528.pdf
[141] UNHCR Office Kakuma, 2017. SGBV Strategy, Kakuma Refugee Camp, Kenya, pg. 4
[142] Ibid.
[143] Ibid.
[144] UNICEF, Feb. 2016. Family Assets: Understanding and Addressing Child Marriage in Turkana,"
[145] Ibid.
[146] See: http://psyg.go.ke/docs/National%20Policy%20on%20prevention%20and%20Response%20to%20Gender%20Based%20Violence.pdf

accessibility of support services, and improve long-term sustainability of GBV prevention and response interventions. The 2015 National Monitoring and Evaluation Framework towards Prevention of and Response to Sexual and Gender-based Violence in Kenya[147] offers a coordination strategy encompassing state and non-state responses, including the establishment of an integrated SGBV multisectoral monitoring and evaluation system and ongoing monitoring and evaluation of national efforts to prevent and respond to SGBV in order to build an evidence base for future funding, advocacy, programming, and decision-making. The National Guidelines on the Management of Sexual Violence[148] establish country-wide standards for service provision including counselling, treatment, management of injuries, HIV and STD care, and pregnancy prevention in addition to outlining a referral pathway for survivors of sexual violence. The Guidelines provide a framework outlining standards of care for survivors of sexual violence that is inclusive to men and boys. While laying out the procedures for examining both men and women, including follow up, the Guidelines also specifically outline steps for the examination of young boys.

With regard to FGM, Kenya recently enacted the National Policy for the Eradication of Female Genital Mutilation in 2019, enhancing existing initiatives that seek to end the practice through strengthened multi-sectoral coordination, the promotion of public education and community dialogues, building capacity for law enforcement against the practice, and more frequent data collection.[149] In addition, in light of the current COVID-19 situation, the Kenyan government, in collaboration with UNFPA, is currently finalizing the COVID-19 Gender-based Violence and Female Genital Mutilation Response Plan 2020, to support scale-up of GBV prevention and response across the country as part of the COVID-19 response.[150]

[147] See: http://www.ngeckenya.org/Downloads/National-ME-Framework-towards-the-Prevention-Response-to-SGBV-in-Kenya.pdf

[148] Kenya: https://www.law.berkeley.edu/wp-content/uploads/2015/10/Kenya_Natl-Guidelines-on-Mgmt-of-Sexual-Violence_3rd-Edition_2014.pdf

[149] Kenya Vision 2030, Jan. 2019. "National Policy on the Eradication of Female Genital Mutilation." http://psyg.go.ke/wp-content/uploads/2019/12/NATIONAL-POLICY-FOR-THE-ERADICATION-OF-FEMALE-GENITAL-MUTILATION-1.pdf

[150] "Kenya Covid-19 Gender Based Violence and Female Genital Mutilation Response Plan 2020" Note: this strategy is still in draft form and has not be signed off by government.

Annex 2: Background Notes to GBV Programming in the Somalia Region of Ethiopia

Context

While the country once hosted the world's highest number of IDPs, nearly 3.2 million at the beginning of 2019, the number is now estimated to be around 2 million, or nearly 2% of Ethiopia's population.[151] More recently, continued conflict in the western state of Benishangul Gumuz, along the border between Oromia and the Somali Region, and in the West Guji zone of Oromia and the Gedeo zone of the Southern Nations, Nationalities, and Peoples Region has led to the displacement of thousands of new IDPs, with increasingly complex humanitarian needs and specific gender-based violence concerns.[152]

Despite development advances throughout the country, host community settlements and refugee camps in the region continue to have limited access to basic services and poor infrastructure, as described further below. In addition, traditional gender roles are quite strong among all communities in the region, with women typically relegated to the domestic sphere to raise children and take care of household chores[153]. Reflective of this environment, women and girls in the Somali Region face an array of GBV risks, including intimate partner violence, forced or early marriages, female genital mutilation, and sexual assault and exploitation.[154]

Scope of GBV

More specifically, 40% of women report experiencing psychological violence, 28% report experiencing physical violence, and 14% report experiencing sexual violence.[155] The DHS also indicates child marriage is pervasive in Ethiopia, where the median age at first marriage is 16.5 years, with approximately one-third of women married by age 15, and two-thirds by age 18.[156] Despite a reduction in recent decades, female genital mutilation also remains an issue in the country, with 65% of women and girls aged 15-49 having undergone the practice.[157] Due to ongoing conflict and displacement, the risk of sexual exploitation of women and girls, such as survival sex, has also

[151] UNOCHA, 2020. Humanitarian Needs Overview: Ethiopia, pg. 4
[152] Internal Displacement Monitoring Center, 2019. "Global Report on Internal Displacement." https://www.internal-displacement.org/sites/default/files/publications/documents/2019-IDMC-GRID-spotlight-ethiopia.pdf
[153] IRC – Ethiopia Program, February 2019. Girl Shine Baseline Assessment for Refugee Adolescent Girls in Hilaweyn and Buramino Camps, pg. 5
[154] UNHCR, 2020. Somali Refugees in Ethiopia: Jijiga Region Situational Update, pg. 1
[155] UN Women & Ministry of Women, Children, and Youth, June 2020. General Socio-Economic Status of Women and Girls in Afar and Somali Regions, and Barriers Hindering the Adoption of Family Law, pg. 6
[156] UNICEF, March 2016. Child Marriage in Ethiopia: A review of the evidence and an analysis of the prevalence of child marriage in hotspot districts
[157] UNICEF, 2020. A Profile of Female Genital Mutilation in Ethiopia

increased.[158] As a whole, however, GBV remains "grossly underreported" by victims due to fear of retaliation and stigmatization and an overall lack of comprehensive services and resources.[159]

Among the Somali Region's pastoralists, domestic violence and physical abuse are traditionally accepted practices, seen as appropriate means of instilling discipline upon a wife or daughter.[160] While the median age of first marriage in the Somali Region stands at 17.6 years, older than the nation's median, an estimated 14% of girls in the region married between the ages of 10-17.[161] Most endemic to the region is the prevalence of female genital mutilation, with nearly 100% of pastoralist women and girls undergoing some form of FGM in their lifetimes.[162] Unique to the region is also the persistence of the most severe form of FGM, which 69% of women in the Somali Region undergo, as opposed to 7% in the country as a whole.[163]

Although there are few studies on the GBV risks facing refugees in the region, limited data suggests issues are widespread. In a 2015 study conducted by Johns Hopkins researchers to develop a GBV screening tool, nearly 65% of female refugees in the Somali Region were reported to have experienced at least one form of GBV within the prior twelve months.[164] While this number is high, additional studies suggest it may be an underestimate, as at least 50% of women in the community do not believe a woman can be raped by her husband.[165] Early marriage is believed to be fairly common among refugees,[166] as is FGM (nearly 99%), which according to UNHCR has not decreased significantly since it became outlawed in recent decades.[167] Refugee women in the Somali Region also remain at risk for sexual exploitation and assault, especially when collecting firewood, an ongoing issue.[168]

In 2019, IOM's Displacement Tracking Matrix found GBV to be the most common security incident reported by IDPs in the Somali Region, occurring in 9.6% of screened sites.[169] Further assessments

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[158] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 3
[159] Child Protection/Gender Based Violence Ethiopia, 2020. "Ethiopia Child Protection Area of Responsibility and Gender Based Violence Area of Responsibility Strategy (Sept. 2020-Sept. 2022)"
[160] Kipuri, Naomi and Andrew Ridgewell, 2008. A Double Bind: The Exclusion of Pastoralist Women in the East and Horn of Africa
[161] UNICEF, March 2016. Child Marriage in Ethiopia: A review of the evidence and an analysis of the prevalence of child marriage in hotspot districts
[162] Kipuri, 2008. A Double Bind.
[163] UNICEF, 2020. A Profile of Female Genital Mutilation in Ethiopia
[164] Wirtz, et al., Comprehensive Development and Testing of the ASIST-GBV, pg. 8
[165] UN Women & Ministry of Women, Children, and Youth, June 2020. General Socio-Economic Status of Women and Girls in Afar and Somali Regions, and Barriers Hindering the Adoption of Family Law, pg. 7
[166] UN Women & Ministry of Women, Children, and Youth, June 2020. General Socio-Economic Status of Women and Girls in Afar and Somali Regions, and Barriers Hindering the Adoption of Family Law, pg. 4
[167] UNICEF, 2020. A Profile of Female Genital Mutilation in Ethiopia
[168] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 3
[169] IOM, October 22, 2019. Ethiopia National Displacement Report, Round 18: July-August 2019

have suggested intimate partner and domestic violence to be the most common forms of ongoing GBV among IDPs,[170] with female IDPs in the Hudent and Moyale Woredas reporting the risk of violence at home to be a greater risk for women than incidents of violence while fetching water or collecting firewood.[171] Much like for female pastoralist and refugees in the region, FGM is considered to be highly common for women and girl IDPs.[172] As with other communities in the region, ongoing conflict and displacement has fuelled an increase in early marriages as a coping mechanism for economic destabilization.[173] Among IDPs in the Hudent and Moyale Woredas, 51% reported that most girls marry between ages 11 and 15, while 45% reported girls marrying between 16 and 18.[174] Likewise, a 2018 case study of Ethiopian IDP vulnerabilities suggested that sexual violence among women and girls was widespread during displacement.[175]

While men and boys may also be victims of sexual violence in Ethiopia, data on the subject is extremely limited. One study of male high school students in Addis Ababa suggests that the issue is not uncommon, with 4.3% of respondents reporting having been raped in their lifetimes, and 68.2% of respondents reporting having been sexually harassed.[176] Such statistics are likely underreported though, as an overall lack of awareness of sexual violence towards men remains an ongoing issue, with outreach limited, and very few health or protection services targeting males survivors.[177] This problem is almost certainly exacerbated for LGBT individuals due to the hostile environment in Ethiopia, where there are no legal protections for such groups and homosexuality is illegal and punishable by imprisonment of up to 15 years.[178]

Legislative and Policy Environment

Ethiopia's Constitution recognizes protection from domestic violence as fundamental right and Article 35 of the Constitution affirms equality between men and women and their right to participate

[170] UNHCR and DRC, 2019. "Protection Assessment of Biiqa, Qoloji 1, Awjabur, Masle, Dugsi and Kaliyal IDP Sites in Fanfan Zone, Somali Regional State
[171] Partnership for Pastoralists Development Association & UNFPA "Assessment Report on: Comprehensive Community Based Protection for Drought and Conflict Affected Communities in Hudet and Moyale Woredas of Dawa Zone, Somali Region", pg. 20
[172] CARE, September 2019. "CARE Rapid Gender Assessment Report: Drought and Conflict-Affected IDPs and Host Communities in Somali Region, Liben Zone Ethiopia," pg. 7
[173] UNHCR and DRC, 2019. "Protection Assessment of Biiqa, Qoloji 1, Awjabur, Masle, Dugsi and Kaliyal IDP Sites in Fanfan Zone, Somali Regional State
[174] Partnership for Pastoralists Development Association & UNFPA, Jan 2020. "Assessment Report on: Comprehensive Community Based Protection for Drought and Conflict Affected Communities in Hudet and Moyale Woredas of Dawa Zone, Somali Region"
[175] Jones, Nicole, Workneh Yadete and Kate Pincok, May 2019. Raising the visibility of IDPs: a case study of gender- and age-specific vulnerabilities among Ethiopian adolescents
[176] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682909/
[177] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 3
[178] https://www.equaldex.com/region/ethiopia

in political, social, and economic life on the basis of equality.[179] The country's Revised Family Law prohibits marriage for men and women under the age of 18 (Article 7), and emphasizes equality between spouses (Article 50).[180] Ethiopia's Revised Criminal Code has also increased the punishment for child marriage (Articles 647-648), domestic violence (Articles 555-560), rape, (Article 620), sexual violence other than rape (Articles 623-625), sex with a minor (Articles 626-627), sexual exploitation (Articles 635-636), trafficking (Article 597), FGM (Article 565), and psychological and emotional abuse (Articles 580 & 650).[181] In addition, Ethiopia's Federal Ministry of Women, Children, and Youth Affairs established a National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia in 2013, with specific targets for reduction of child marriage, abduction and FGM[182], and has adopted a Roadmap for Ending Child Marriage and FGM/C 2020-24, stipulating key interventions to end both practices.[183] However, there are a number of remaining gaps in the legal framework. Most notably, while increasing the punishment for marital rape, economic and psychological violence, and sexual harassment and stalking, Ethiopia's Criminal Code does not explicitly criminalize these acts. The country also lacks any mechanism to offer civil remedies for victims of GBV.[184]

In line with its legislative framework, the government of Ethiopia has developed a number of gender-responsive policies over the past decades.[185] Starting in 1993 with the National Policy on Women,[186] which created a framework for the mainstreaming of gender at all levels of government and called for the creation of regional gender bureaus and established the Ministry of Women's Affairs, such policies have sought to promote a whole-of-government approach to gender equality. Reflecting this, the 2010 Strategic Plan for an Integrated and Multi-Sectoral Response to Violence Against Women and Children and Child Justice in Ethiopia sought to build the system and capacity of health, justice, security, education, and social actors to prevent and respond to GBV, to promote the adoption and implementation of protective laws, to improve service delivery to GBV survivors, to mobilize communities against this issue, and to strengthen overall coordination.[187] Similarly, the 2013 National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children[188] to

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[179] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 4
[180] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 4
[181] Ibid, pg. 19-21
[182] Girls Not Brides, 2015. Country Fact Sheet: Ethiopia, pg. 1
[183] UNHCR, 2017. Ethiopia National Refugee Strategy for Prevention and Response to Sexual and Gender Based Violence 2017-2019, pg. 4
[184] Child Protection/Gender Based Violence Ethiopia, 2020. "Ethiopia Child Protection Area of Responsibility and Gender Based Violence Area of Responsibility Strategy (Sept. 2020-Sept. 2022)"
[185] https://2ed20v44ucst1ujckp24w1ks-wpengine.netdna-ssl.com/wp-content/uploads/2018/11/GBV-in-Ethiopia-Systematic-Lit-Review-Fall-2018.pdf
[186] See: https://openknowledge.worldbank.org/handle/10986/9885
[187] See: https://www.gage.odi.org/wp-content/uploads/2018/12/GAGE-PLA-Policy-Note-Ethiopia-WEB.pdf
[188] See: http://www.africanchildforum.org/clr/policy%20per%20country/2018%20Update/Ethiopia/ethiopia_htp_2013_en.pdf

address FGM and child and forced marriages in the country rests on a plan of improving community awareness on the impacts of such practices, to strengthen the existing protection framework, including improving institutions to enforce laws against these practices, and to provide support services to those affected by HTPs. Building off of this policy is Ethiopia's National Costed Roadmap to End Child Marriage and FGM/C 2020-2024,[189] which outlines strategies to eliminate child marriage and FGM by 2025 such as multi-sectoral coordination, generating an evidence base, engaging traditional and religious leaders in community mobilization, and harnessing positive cultural traditions, such as community dialogue.

[189] See: https://www.unicef.org/ethiopia/media/1781/file/National%20Roadmap%20to%20End%20Child%20Marriage%20and%20FGM.pdf

Annex 3: Northern Kenya GBV Response Actors

(Note: this list is indicative rather than exhaustive.)

Name	Location	Area of Focus	Scope of Services
		Wajir County	
Raia Development Initiative (RDI)	Wajir	Psychosocial	Women in peace and security, countering violent extremism, women empowerment, advocacy and sensitization, promoting and protecting rights of minority, gender justice
Wajir Women for Peace	Wajir	Psychosocial	Women empowerment, advocacy and sensitization, access to justice
Rural Agency for Community Development and Assistance (RACIDA)	Wajir	Security	Community policing, WASH and nutrition
County Hospital	Wajir	Health	Designated services managed by Police and County Gender Department to attend to cases of SGBV survivors
County Gender Department	Wajir	Protection, psychosocial	Has specific gender officers providing legal, medical and psychosocial accompaniment to survivors of rape, defilement, domestic violence, and sexual abuse and exploitation.
Mercy Crops	Wajir	Protection	Established toll free GBV Response Hotline
		Garissa County (Dadaab)	
UNHCR	Garissa	Technical support and coordination	Sensitization campaigns, Engaging Men through Accountable Practice awareness raising in Dadaab
UNICEF	Garissa		Child protection, education, health and nutrition, WASH,

			communication for development
Refugee Affairs Secretariat (RAS)	Dadaab	Camp management	Camp management, registration, protection, repatriation, community services
Refugee Consortium of Kenya (RCK)	Garissa and Dadaab	Protection, legal and psychosocial support	Protection community services, registration, repatriation and resettlement
Danish Refugee Council (DRC)	Hagadera Camp, Ifo Camp	Psychosocial support, case management, awareness raising	GBV, livelihoods, runs a comprehensive GBV prevention and response program providing survivors and their dependents with case management, psychosocial support, two protective spaces, and livelihood support such as business start-up grants, runs Engaging Men through Accountable Practice to increase men's buy-in, engaged religious leaders and elders in the traditional justice system to increase buy-in for VAWA programs
Lutheran World Federation (LWF)			
Action Aid	Fafi Subcounty	Protection	Promotion of women's rights, livelihood diversification, governance and accountability, emergency response, safe house for girls
Kenya Red Cross	Ifo Camp	Health services in Ifo Camp	Health, nutrition, GBV
International Rescue Committee (IRC)	Dadaab	Health services in Hagadera Camp, awareness raising	Health, nutrition, GBV, runs one-stop GBV response center at main hospital in IRC compound, holds SASA!

			interventions to mobilize community against VAWA
Médecins Sans Frontières (MSF	Dagahaley Camp	Health services in Dagahaley Camp	Health, nutrition, GBV
Women's Initiative Healthcare (WEFKO)	Garissa	Health, legal	GBV services, HIV/AIDS services, legal aid
SIMAHO (Sisters Maternity Home)	Garissa	Health	Maternal and reproductive aid, HIV and TB testing, GBV, FGM, DRR
Kamuthey Women Network	Kamuthey-Garissa	Psychosocial	Women empowerment, mentorship, community safe houses, awareness creation and sensitization
Womankind Kenya	Garissa and Tana River	Psychosocial	Child protection and education, women empowerment and governance, peace building and conflict transformation, climate change resilience, livelihoods
Girlkind Kenya	Jarirot-Garissa	Psychosocial	Women empowerment, awareness creation and advocacy, countering violent extremism programming, governance
Pastoralist Girls Initiative	Garissa and Tana River	Psychosocial	Livelihoods, gender empowerment, environmental maintenance
Islamic Relief	Garissa	Health, livelihoods	Cash transfers for vulnerable, NFI distribution for emergencies, Health programming for HIV/AIDS and GBV
CARE International	Garissa	Case management	Along with IRC hosts support scenters offering case management support
Turkana County			
UNHCR	Host community, Kakuma	SGBV coordination, protection,	UNHCR mainstreams SGBV prevention into programs of all sectors. This includes

	Camp and Kalobeyei Integrated Settlement	awareness raising, legal	engaging and empowering the community to identify and respond to SGBV, identifying and responding to the needs of male survivors of SGBV, and case management and specialized services, engaged community leaders through awareness raising sessions, established confidential complaint mechanisms to refer services to survivors, established permanent and mobile courts for survivors to access justice
UNICEF	Kakuma Camp	Health	With IRC and UNICEF runs Turkana Wellness Centre, a one-stop service center for suvivors of sexual violence
Refugee Affairs Secretariat (RAS)	Kakuma Camp	protection	
Refugee Consortium of Kenya (RCK)	Kakuma Camp and Kalobeyei Integrated Settlement	Legal, Psychosocial, Livelihoods	Provide legal counselling and representation and psychosocial support as well as micro-grants to SGBV survivors.
Danish Refugee Council (DRC)	Kakuma Camp and Kalobeyei Integrated Settlement	Psychosocial	Microenterprise development for women through savings loans, business skills development, scholarship programs, economic empowerment, helps run Safe Home Volunteer Programme as an alternative means of accommodation for SGBV survivors
International Rescue Committee (IRC)	Kakuma Camp	Protection, Health	Runs emergency hotline for SGBV survivors, wellness center in Turkana District

			Hospital with free medical, psychosocial, follow up care
Lutheran World Federation (LWF)			
Jesuit Refugee Services (JRS)	Kakuma Camp and Kalobeyei Integrated Settlement	Protection	Manages temporary shelter for survivors of SGBV, helps run Safe Home Volunteer Programme as an alternative means of accommodation for SGBV survivors
Kenya Red Cross (KRC)	Kalobeyei Integrated Settlement	Health	SGBV services, runs hospital with staff that provide clinical support to GBV survivors, psychosocial support and referrals to other programmes/services
Action Africa Help International	Kalobeyei Integrated Settlement		Microenterprise development for women through savings loans, business skills development, scholarship programs, economic empowerment, capacity building training in financial literacy, enhanced access to loans and credit for refugees and host community
Center for Victims of Torture (CVT)	Kalobeyei Integrated Settlement	Psyschosocial	Provides counselling to GBV survivors in Kalobeyei
Mandera County			
Rural Agency for Community Development and Assistance (RACIDA)	Mandera	Security	Community policing, WASH, livelihoods, nutrition
Mandera Women for Peace	Mandera	Psychosocial	Advocacy and sensitization, women empowerment, ending VAWG
Kenya Red Cross	Mandera	Health	Nutrition, SGBV services
Health Poverty Action (HPA)	Mandera	Health	Health, SGBV services

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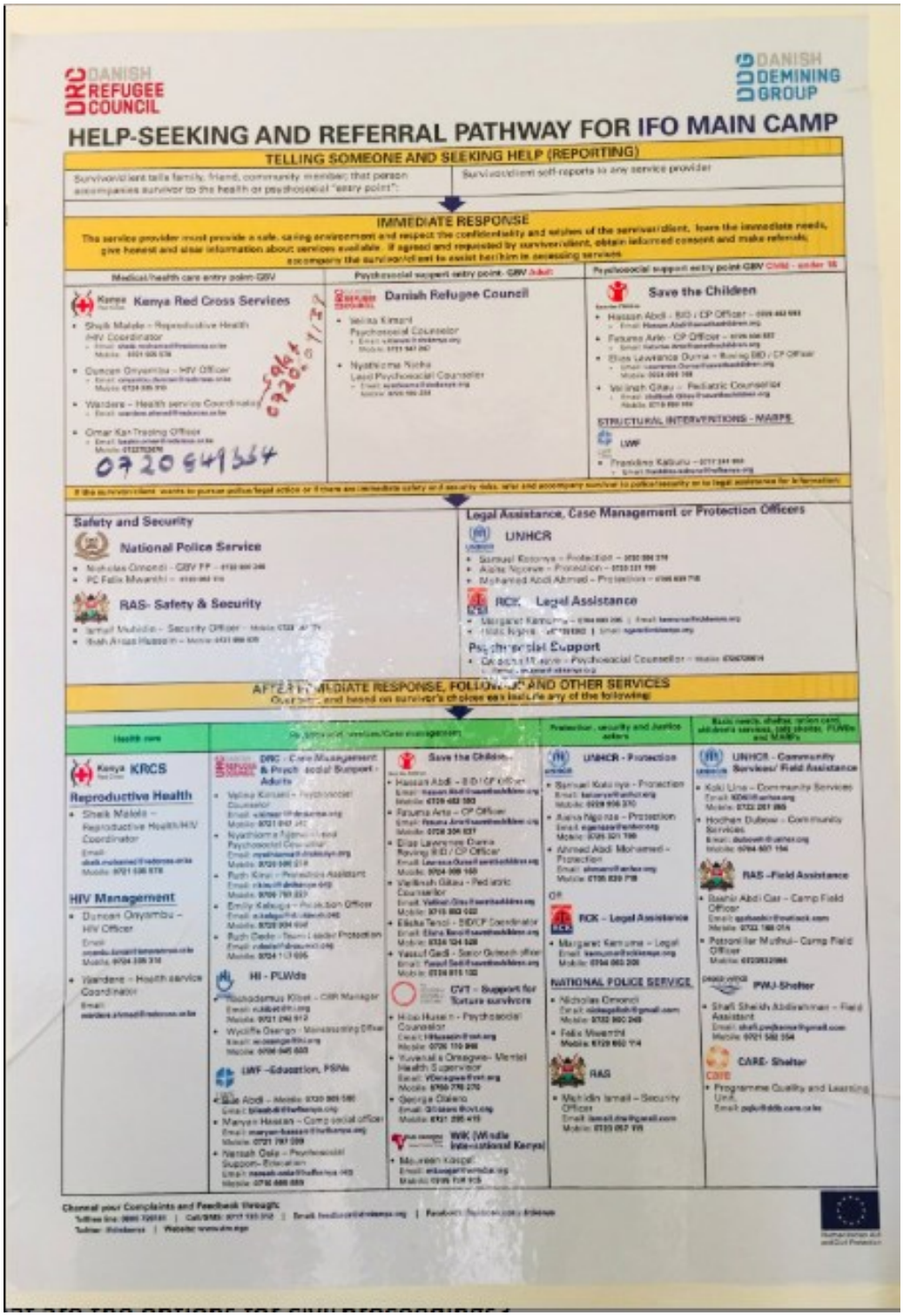
Annex 4: Somali Region of Ethiopia GBV Response Actors

Name	Location	Area of Focus	Scope of Services
IDPs and Host Community			
Himilo	Jijiga Town (but servicing victims from many different zones)	Psychosocial, Protection	Support for victims of sexual violence, support for victims of government violence
Médecins du Monde (MDM)	Jijiga Town, Qoloji IDP Camp	Psychosocial, SGBV	Mental support, home isolation, house to house community engagement, capacity building of health staff, identifying SGBV survivors and linking to one stop center
International Rescue Committee (IRC)	Sitti Zone, Qoloji IDP Camp	SGBV, Child Protection	Community awareness raising and govn capacity building
Bureau of Women, Children, and Youth Affairs (BoWCA)	Qoloji IDP Camp, Liben Zone	Psychosocial	Gender equality programming, SGBV services, leads Child Protection and GBV Area of Responsibility
UNFPA	Fafan Zone	Health, Psychosocial	Training health staff and community awareness creation, dignity kits, women empowerment, chairs GBV Area of Responsibility
Organization for Welfare and Development in Action (OWDA)	Gode Zone	SGBV, livelihoods	Development programming for pastoralists
Partnership for Pastoralist Development Association (PAPDA)	Dawa Zone, Liben Zone	Health, Psychosocial	Providing dignity kits, women friendly spaces

Action Against Hunger	Shebele Zone	Psychosocial Support	Mental health services
Save the Children	Moyale Woreda, Hudet Woreda, Sitti Zone	Health	FGM programming
Women's Development Reliance Organization	Jijiga		??
OWS	Nogob	Protection	Previously involved in FGM
Refugees			
UNHCR	Fafan Zone, Liben Zone, Shebele Zone	Protection	Coordination, child protection, SGBV, funding other programs
Danish Refugee Council (DRC)		Protection	General protection (not specifically GBV)
International Rescue Committee (IRC)	Sitti Zone, Qoloji IDP Camp	SGBV, Child Protection	Women and girl's wellness center
Norwegian Refugee Council (NRC)	Fafan Zone, Liben Zone	Psychosocial, Legal	Information counselling, legal aid for community and survivors
Norwegian Church Aid	Somali region	Health	FGM programming
International Medical Corps (IMC)	Bokolmayu Camp, Dolo Ado, Liben Zone	Psychosocial	Provided psychosocial support to GBV survivors in camps, trained camp providers on basic counselling, trained officials on identifying, reporting, and managing cases of GBV, treatment of STIs and FGM, conducted awareness raising with clan and religious elders, constructed 14 women's centers

Rehabilitation and Development Organization (RADO)	Jijiga Town, Melkadida Camp, Bokolmayu Camp	Psychosocial	Conducted GBV awareness raising sessions with men, implemented psychosocial programs in camps with UNHCR, established SGBV survivors counselling rooms at all camps, established women and girls safe space in Melkadida camp, implements case management and referral services

Annex 5: Northern Kenya Referral Pathway Sample



Annex 6: BoWCA Referal Pathway Somali Region

Psychosocial and Case Management	Medical Actors Services	GBV prevention & response coordination services	Justice and Prosecution Services/Police, Justice bureau & Court
- Assess survivor's needs & plan actions to meet needs. - Provide Basic emotional support (counselling) - Follow-ups on survivor's needs Skill building and recreational activities - Promote social networks and community integration - Empower and provide skill building activities - Provide information about GBV - Facilitate referral to other services (CMR, safety and other community	- Conduct examination - Treat injuries - Prevent unwanted pregnancies - Prevention and treatment of STIs (PEP provision for rape cases) - Prevent STIs and HIV/AIDS - Emergency contraceptive if sexual incident is - reported within five days of occurrence - Safe and consented referrals to other service providers	- Provide referral Information and contacts of Multi- Sectoral support and resources for the survivor - Provide GBV Advice Advocacy and Awareness for survivors - Conduct Education and Training Coordination of activities of civil society and other stake-holders - Communications Services for Survivors and Families	- Apprehend perpetrator - Create charge & follow it - Ensure that the survivor is comfortable during the inter-view and medical examination - Show utmost respect for the survivor's privacy - Convey no judgmental behaviour during the interview. - Demonstrate a high level of sensitivity toward the survivor/family at all phases of this or-deal - Assign a family liaison officer to liaise and to arrange meetings with the survivor/family to keep them abreast of all information regarding the status of the case
Regional Level			
Psychosocial and Case Management	**Medical Actors Services**	**GBV prevention & response coordination services**	**Justice and Prosecution Services/Police, Justice bureau & Court**
Organization: BoWCA **Contact person:** Gizew Debelew **Phone:** 0915749082 **Title:** GBV project focal person **Address/Place:** Jigjiga, SR BoWCA	**Organization:** Regional Helatn Bureau **Contact person:** Fatuma Bidiye **Phone:** 0915077641 **Title:** WOMEN & YOUTH SUPPORT PROCESS OWNER **Address/Place:** Jigjiga, SR RHB	**Coordination Cluster:** CP/GBV Sub cluster **Contact Persons:** Guled or Kebir **Phone:** 0912176679 or 0920272763 **Title:** Gender officer or RPO **Address/Place:** Jigjiga, Somali region	**Organization:** Police commission **Contact person:** Farhiya Abdurehman **Phone:** 0915748336 **Title:** **Address/Place:**
Organization: BoWCA/One stop centre **Contact person:** Firdows Abdi **Phone:** 0915101513 **Title:** Social worker **Address/Place:** Jigjiga, One stop centre, Karamara hospital	**Organization:** Karamara Hospital **Contact person:** Dr. Mohammed **Phone:** 0911907697 **Title:** Medical doctor **Address/Place:** Jigjiga, One stop centre, Karamara hospital		**Organization:** Police, Justice & court/one stop centre **Contact persons:** Faysel Wali & Mohamed Moalin **Phone:** 0915744124 & 0915744124 **Title:** Police officer & Prosecutor **Address/Place:** Jigjiga, One stop centre, Karamara hospital
Fafan Zone			
Psychosocial and Case Management	**Medical Actors Services**	**GBV prevention & response coordination services**	**Justice and Prosecution Services/Police, Justice bureau & Court**
Qoloji 1 & 2			
Organization: BoWCA **Contact person:** Istahil Ali **Phone:** 0920267803 **Title:** Social worker **Address/Place:** Babile/Qoloji	**Organization:** Bureau of Health **Contact person:** Mohammed Farah **Phone:** 0911390395 **Title:** Health Officer **Address/Place:** Babile/Qoloji		**Organization:** Police **Contact person:** Abdinasir Ahmed **Phone:** 0920270816 **Title:** Police Officer **Address/Place:** Babile/Qoloji
Organization: BoWCA **Contact person:** Trik Tahir **Phone:** 0933414626 **Title:** Social worker **Address/Place:** Babile/Qoloji			
Harawa Woreda			
Organization: Harawa Wowca **Contact person:** Abdinasir Esman **Phone:** 0915066100 **Title:** Social workers **Address/Place:** Harawa Woreda	**Organization:** Harawa health centre **Contact Person:** Abdulaahi Muse **Phone:** 0915100025 **Job title:** Medical Doctor **Adress/Place:** Harawa		**Organization:** Harawa police force **Contact person:** Abdinasir Ahmed **Phone:** 0920270816 **Job Title:** Social worker **Address/Place:** Harawa
Dawa Zone			
Psychosocial and Case Management	**Medical Actors Services**	**GBV prevention & response coordination services**	**Justice and Prosecution Services/Police, Justice bureau & Court**
Hudet Woreda			
Organization: OWDA **Contact person:** Aisha Sharif **Phone:** 0916327192 **Title:** Social workers **Address/Place:** Hudet Woreda	**Organization:** Hudet health center **Contact person:** Asna Abdi **Phone:** 0968645969 **Title:** CEO **Address/Place:** Hudet wored	**Organization:** PAPDA **Contact person:** Sadam Ebrahim **Phone:** 0911880548 **Title:** Program Officer **Address/Place:** Hudet woreda	**Organization:** Prosecutor **Name:** Abikedir Abdirehman **Job title:** prosecutor **Address:** 0932578421 **Organization:** Prosecutor
Organization: PAPDA **Contact person:** Deqo Sheban **Phone:** 0982264650 **Title:** Social workers **Address/Place:** Hudet Woreda			
Moyale Woreda			
Organization: Moyale Woreda **Name:** Sadia Ibrahim **Job:** Moyale Wowca Head **Phone:** 0930953176 **Address/Place:**	**Organization:** Moyale helath office **Contact person:** Istralin Mohammed **Job title:** expert **Phone:** 0912360407 **Adress/Place:** Moyale	**Organization:** PAPDA **Contact person:** Abdulahi Aden **Phone:** 0932564588 **Title:** Program officer **Address/Place:** Moyale	**Organization:** PAPDA **Contact person:** Abdulahi Aden **Phone:** 0932564588 **Title:** Program officer **Address/Place:** Moyale
Organization: OWDA **Contact person:** Hodan Mohammed **Job Title:** GBV officer **Phone:** 0930730032 **Address/Place:** Moyale	**Organization:** Moyale health office **Contact Person:** Sadia ibrahim **Job title:** Nutrition Expert **Phone:** 0930453176 **Address/Place:** Moyale		
Organization: PAPDA **Contact person:** Farhiya ALiyow **Phone:** **Title:** Social workers **Address/Place:** Moyale			
Sitti Zone			
Psychosocial and Case Management	**Medical Actors Services**	**GBV prevention & response coordination services**	**Justice and Prosecution Services/Police, Justice bureau & Court**
Aisha			
Organization: Aisha Wowca **Contact person:** Abdifatah Tahir **Phone:** 0928055562 **Title:** Social worker **Address/Place:** Aisha town	**Organization:** Aisha health center **Contact person:** Niman Abdulahi **Phone:** 0982985926 **Title:** Health officer **Address/Place:** Aisha town		**Organization:** Aisha police force **Contact person:** Ahmed Elmi **Phone:** 0915013315 **Title:** Police officer **Address/Place:** Aisha town

Annex 7: Recommendations Linked to SDC Priorities[190]

Northern Kenya													
	Recommendation	**Alignment with key finding**	**Alignment with SDC Strategy**	**Regional**	**Cross-border**	**SGBV specific**	**SGBV mainstreaming**	**Advocacy related**	**Nexus/ Development**	**Synergies with existing GBV programmes**	**Available SDC funding or co-funding opportunities**	**New SDC project requires or linked to existing project**	**SDC comparative advantage**
1.	**Health sector:** Support the existing Wellness Center in Lodwar to continue its level of staffing and/or advance the preliminary work in Wajir and Mandera to train health and other providers on the one-stop model, which has been	Y		N	N	Y	N	N	Y	Y	GoK already providing some funding	Y	Small programme with potentially good returns on building out capacity

[190] Green shading indicates a recommendation and/or a criteria that the recommendation meets strongly; amber indicates a a partial match; and red indicate no match to the criteria.

	initiated in these counties but is not operational.												
2.	**Legal/justice sector:** Partner with UNHCR to support efforts to build more gender equitable justice systems for Somali women through support to the Garissa magistrate at the Dadaab camp. As a potential complement, work with UNHCR and implementing partners (RCK, Action Aid) to scale up capacity of paralegals to work in and across north-eastern counties through the traditional systems to build safer responses to survivors, including improving Kadhi courts so that the reliance on maslaha is lessened.	Y, UNHCR identified need	Migration/ Protection Protection and Durable Solutions	N	N	Y	N		Y	Programme already exists	Relatively small investment in line SDC capacity	No new project required	Good opportunity for impact through relatively small investment

3.	**Security sector:** Drawing from good practices in Kenya, support UNHCR and RAS to scale up presence of female police and develop a sustainable model of police training and support at the national level through enhancing the national training curriculum (building on existing efforts of UN Women, FIDA, and other partners), or as a pilot in one county to that can be replicated, and/or as part of the KISEDP or GISEDP	Y	Migration/ Protection Protection and Durable Solutions	N	N	Y	N	N	Y	There have already been efforts to train police and there are partners available. Would need to explore interest and availability.	Would need to explore UNHCR, others?	Y	Protection?
4.	**Psychosocial sector:** Develop a training-of-trainer programme that utilizes women's networks to develop basic psychosocial support programming that is	Y	Migration/ Protection	N	N	Y	N	N	Y	N	Unclear	Y	Localization approach

	culturally appropriate and locally-led. For north-eastern counties in particular, draw from pilots by UNICEF and TdH in the MENA region that build on positive aspects of Islamic systems, facilitating access to services by Muslim women and adolescent girls, that also uses an explicitly feminist empowerment model for survivors. For Turkana, consider a similar project that builds on faith networks. Potentially use the PSS project to facilitate support to programmes within the camps, but also to build them out to the host communities and													

	beyond. Consider using a women-friendly space model as a starting point.												
5.	**Child Protection:** Work with CASI and UNICEF to support training of governmental and non-governmental child protection actors in northern countries on identifying risks of sexual violence for boys and standardizing referral pathways. Draw from the CASI assessment and recommendations to build out a model for response to sexual violence and exploitation of boys in northern Kenya through support to relevant actors, including Department of Child Services and UN and	Y		Possibly	N	Sexual violence against boys, important to build on CP capacity	N	Y	Y	SDC already supporting CASI	Cofunding with UNICEF?	N	SDC investment in addressing sexual violence again males

	NGO child protection and MHPSS actors. (Consider expanding this to a regional approach.)												
6.	**Women's empowerment:** In all counties support localization through transitioning existing local women's networks to greater positions of influence and control in the community through, for example, a three-year pilot project aimed at building local women's and youth groups with focused capacity building and support, applying a tiered model for organizational development used by UNICEF in S. Sudan. Building on and linking to the	Y	Migration Protection Durable Solutions	Possibly	Possibly	Y	N	N	Y	Could work with local GBV coordination partners and government	UNFPA, UN Women and GBV Working Group?	Yes but with existing partners	Localization

	work of the co-leads of the GBV Working Group, UN Women and UNFPA, conduct a mapping of women's networks and organizations and engage in participatory dialogue about how to build women's leadership. Use the Nexus Platform approach for funding multiple women's organizations under a shared umbrella. (Also consider this as a cross-border and/or regional option.)[191]													

[191] One option might be to link this to the Kakuma Kalobeyei Challenge Fund, a program of the International Finance Corporation (IFC), implemented with Africa Enterprise Challenge Fund, Turkana County Government, and UNHCR. The five-year program is designed to support private sector investment and unlock the economic potential of refugees and their hosts, in Kenya's Turkana County, and includes a core objective of developing and grow refugee and host community-owned businesses and create opportunities for women and youth. SDC reportedly is already providing support to this initiative, and could consider linking additional support to a specific strategy for supporting women's leadership in Turkana County on the issue of GBV. See https://kkcfke.org

7.	**Food security sector:** Build out the food security programmes in Wajir and elsewhere so that they support women and women's institutions to lead food projects. Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods.	Y		Possibly/ preferably	Possibly	N	Y	N	DRR	Food Security	Funding through food security?	N	Food Security Investments
8.	**General:** Review the workplans linked to the GIESDP and KIESDP for potential GBV investments. Consider co-funding models or matched financing for	Y		N	N	?	?	Perhaps	Y	Possibly, depending on intervention	Unclear	Unclear	This is simply a recommendation to link to the GIESDP and KIESDP to identify potential priorities and partnerships for

	government-led initiatives												supporting GBV programming.

Somali region of Ethiopia													
	Recommendation	**Alignment with key finding**	**Alignment with SDC Strategy**	**Regional**	**Cross-border**	**SGBV specific**	**SGBV mainstreaming**	**Advocacy related**	**Nexus/ Development**	**Synergies with existing GBV programmes**	**Available SDC funding or co-funding opportunities**	**New SDC project requires or linked to existing project**	**SDC comparative advantage**
1.	**Health and MHPSS.** Develop a project to support building systems for GBV at the Jijiga-level in the Fafen Zone as a pilot, with the eventual plan to cascade to other zones and woredas. Focus particularly on health and MHPSS, but also through coordination engage police and legal systems, including at the ministerial level, as well as key I/NGO partners such as the Ethiopian Women's Lawyers Association office in Jijiga (forthcoming). Work	Y	Health in Ethiopia	Possible link to one-stop regional project?	N	Y	N	N	Y	Training already underway to build out health capacity on GBV through government and UNFPA	UNFPA, UN Women, USAID?	Y	Health

	with international and national partners (e.g. IRC, OWDA) to support the development of standard operating procedures and coordination among multi-sectoral partners, as well as training and other capacity-building tools for health and MHPSS. Consider developing or expanding mobile outreach teams as part of this pilot as a way to expand service coverage.												
2.	**Data collection.** UNHCR intends to improve its GBV data systems in the coming year by upgrading from GBVIMS to Primero/GBVIMS+ (which includes case management capacity) and linking	Y	Protection/ Migration Improved Services Durable Solutions	Possibly	N	Y	N	N	Y	UNHCR	UNHCR	Y	Building out data systems

	that to UNCHR's internal data management system (Progress V 4). The rollout of an updated case management system may present opportunities to improve data management systems amongst national partners, particularly the one-stop centres. Funding for an integrated approach to improving data management could support UNHCR's commitment to greater inclusivity of refugees in national systems and also support UNHCR's plan for SGBV response for refugees to link to one-stop centres. (Also consider this as a regional approach.)													

3.	**Women's empowerment.** Take advantage of the BoWCA link to women's CSOs. Work directly with BoWCA to support localization through transitioning existing local women's networks to greater positions of influence and control in the community through, for example, a three-year pilot project aimed at building local women's and youth groups with focused capacity building and support, applying a tiered model for organizational development used in S. Sudan. Conduct a mapping of women's networks and organizations and engage in	Y	Migration/ Protection	Possibly	Possibly	Y	N	Potentially	Y	N	Unclear, but relatively small investment?	Y	Localization

	participatory dialogue about how to build women's leadership. (Also consider this as a cross-border and/or regional option.)												
4.	**Child Protection:** Work with Child Protection to undertake widespread training among health and social workers on sexual violence against boys as a first step in raising awareness of the need to improve attention to this issue. (Also consider this as a regional option.)	Y		Possibly	N	Sexual violence against boys, falls within CP domain	N	Y	Y	N	UNICEF?	CASI if this is regional	SDC investment in addressing sexual violence again males
5.	**GBV Risk Mitigation:** In line with one of the core objectives of the GBV Working Group's Strategy 2020-2024, support UNFPA in the rollout	Y	Migration/ Protection Protection Mainstreaming	N	N	N	Y	N	N	?	?	Possibility for Integration into existing sector	Protection Mainstreaming

	of the GBV Pocket Guide to all humanitarian sectors in all IDP camps in the Somali region. Accompany the rollout with basic training on GBV risk mitigation.											programme?	
6.	**Food Security:** Integrate attention to GBV in food security programmes. Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods.	Y	Food Security Protection/ Migration Livelihoods	Potentially	Potentially	N	Y	Potentially	Y	Y	Funding through Food Security?	Linked to existing food security investments	Food Security Priorities Livelihoods
7.	**Governance.** Consider using the	Y	Under Migration/	N	N	Y	N	Y	Y	N	UNICEF is interested in	Y	Localization

	SDC roster to deploy an international (or national staff person) to BoWCA in Fafen or Liben zones with a terms of reference for building women's participation in peace-building as a strategy for reducing GBV, as part of SDC's governance work. Use the upcoming elections as an opportunity to support the development of strategy for ending GBV as a component of peace-building in the Somali region.		Protection, no Governance priority for Ethiopia								peace-building work		

Somalia													
	Recommendation	**Alignment with key finding**	**Alignment with SDC strategy**	**Regional**	**Cross-border**	**SGBV specific**	**SGBV mainstreaming**	**Advocacy related**	**Nexus/ development**	**Synergies with existing GBV programmes**	**Available SDC funding or co-funding opportunities**	**New SDC project required or linked to existing project**	**SDC comparative advantage**
1	**Increase the focus on prevention and root causes.** Stakeholders indicated that while there are still extensive and significant gaps regarding SGBV support, there is less of a focus on preventive aspects. Prevention could take many aspects; policy/advocacy were highlighted extensively by key stakeholders as key prevention	Yes, the assessment found that there is a need for more comprehensive work on prevention of SGBV very broadly and across multiple areas	Partially aligns with the SDC strategic domains of justice, migration and protection	There is some potential for regional prevention work, but this seems unlikely at this stage as there are very few regional programmes that currently exist	There is some potential for regional prevention work, but this seems unlikely at this stage as there are very few regional programmes that currently exist			There are some advocacy related components that could be targeted within a wider prevention programme		Build on UNFPA country programme Contribute to several other DPs working in this area Lots of programming opportunities and opportunities to integrate with others	Some potential but no direct links to existing programmes are currently very feasible	New SDC Project required	Could build on SDC's advocacy comparative advantage

	components. Consider support to the Communities Care programme.												
2	**Scale up SGBV service delivery through more one stop centres and qualified services providers.** Scale up the number of one stop centres across Somalia, and increase support for the clinical management of rape. SDC can build off its experiences supporting WAAPO and their centre in Hargeisa. Increase the number of one stop centres in less accessible areas, including in FMS, and outside of the main urban	Yes, there is insufficient coverage of one stop centres in Somalia – as highlighted by several stakeholders	Aligns with SDC's strategic priority on health in Somalia	Regional OSCs are unlikely given their high cost	Regional OSCs are unlikely given their high cost Difficult to coordinate also between country borders and governments					UNFPA, UNHCR and others	Opportunities exist to support through existing support to the UNFPA country programme and perhaps Save the Children Opportunities exist for co-funding but given the expense of OSCs, it is unlikely that they offer could value for SDC to support given the limited funds available from SDC	Links to existing UNFPA country programme support – and potentially others such as Save the Children support	Builds on SDC's support to WAAPO centres in Somaliland

	areas. Extend psycho-social support to SGBV victims, including higher levels of care. Increase the number of qualified services providers across the country. Support the establishment of more forensic labs across Somalia.												
3	**Increase the attention on local organisations, enhance their capacity through larger organisations, extend their funding cycles and move towards funding those with more capacity directly.** Consider long-term support to specifically enhance the capacity of local	To some degree, the assessment found that the capacity of local organisations needs to be strengthened and some local organisations could have the capacity to play a greater role in GBV if they have more	Localisation is increasingly an important SDC strategic consideration					Some support to local organisations could be advocacy focussed		UNFPA, UNHCR, UNICEF and others all support local partners and so support could build from this	UNFPA Somalia country programme is already supported by SDC	UNFPA Somalia country programme is already supported by SDC	

	organisations, and beyond the typical one or two year programme funding cycle. Consider support to create a localised GBV network in Somalia to help increase capacity and coordination among local agencies, especially in southern Somalia and Somaliland where there are several local organisations that deliver important interventions and, with increased and focussed support, could be grown and strengthened	enhanced capacity											
4	**Support the development of the National GBV Strategy, 2021 – 2023.** Consider	Yes, the assessment found that the current		No, this is Somalia specific	No, this is Somalia specific			The strategy will focus on advocacy		Good opportunities to co-fund with other organisations	Funding could be through SDC's support to the existing		

	specific support to the next three-year National SGBV Strategy which will be developed in early 2021 through the SGV working group and led by UNFPA.	strategy is due to be updated								that will also support the development of the strategy – but funding for the strategy sis assumed to not be overly critical as others are already supporting it	UNFPA country programme		
5	**Leverage SDC's comparative advantage in policy advocacy and legislation to tackle the Sexual Intercourse Related Crimes Bill.** Enhance support for related policies and legislation, in particular scaled-up funding and high-level Swiss advocacy for the SOB. Join political forces with other governments to advocate for the	Yes, the assessment has identify that the new Sexual Intercourse Related Crimes Bill is highly threatening to any improvements in SGBV in Somalia	Links to the justice sector	Build on UNFPA country programme Contribute to several other DPs working in this area	Has no cross-border feasibility					Many existing GBV programmes are already supporting	UNFPA country programme that is already supported by SDC Also possible linkages to the SDC support to the UNJPLG and also support to the NGP consortium under the governance domain?	Funding could be through SDC's support to the existing UNFPA country programm e	Swiss neutrality and advocacy etc

	newly-tabled Sexual Intercourse Related Crimes Bill. Strengthen the capacity of the local actors, especially the government, (police, judges, lawyers and counsellors). Intensify advocacy support to reduce the opposition from religious leaders and groups to the Sexual Offences Bill. Advocating with Middle Eastern counties who also support Somalia in different ways was also a recommendation from FCDO as a gap that is not being filled currently. SDC can also scale up														

	its important unique role on advocacy to give a stronger voice and leadership on GBV over the long-term.												
6	**Increase support for the wider legal/justice system.** SDC might consider supporting the legal/justice system over the longer-term, including strengthening the judiciary, the police and legal aid. Such support would be required at all levels across Somalia and Somaliland. Supporting research to help the sector understand how the legal/justice	Yes, the assessment found that access to justice is very limited	Links to the justice sector	No – as no justice work with SDC in Kenya and Ethiopia	No – as no justice work with SDC in Kenya and Ethiopia						Possible linkages to the SDC support to the UNJPLG and also support to the NGP consortium under the governance domain?		Links to SDC"s justice sector work in Somalia

	systems could be strengthened in Somalia and was highlighted by some partners as an potentially important contribution												
7	**Increase support to bold youth programmes that aim at improving the attitudes and practices of the next generation.** Stakeholders have strong views on the need for greater support to be dedicated to improving the attitudes and behaviours of male adolescents and youths – as evidence suggests there is some potential for changes in younger generations and with regards to	Stakeholders identified that working with young people is important but only one stakeholder stressed the importance of working with young people as agents of change	Young people are not SDC priorities per se	Has some potential but nothing specific on regional is being carried out at this time	Has some potential but nothing specific on cross-border is being carried out at this time			Some aspects of youth work will have advocacy components		UNICEF and Ujamaa	Possibly through the existing Save the Children programme and also through UNFPA country programme?		SDC not really known for youth programming per se

	tackling cultural, social and religious norms. Consider support to expand promising UNICEF's partnership with Ujamaa with male youths and GBV to new locations beyond Mogadishu and Jubaland.												
8	**Support the scale-up and roll-out of GBVMIS across all states and to more actors.** Provide additional resources to support GBVMIS improvement and the extension of more capacity development for organisations and individuals to use GBVMIS instead of other systems which do not	Yes, the assessment found that availability and use of data is limited in Somalia and there are opportunities to strengthen the GBVIMS	Not necessarily with the regional SDC strategy but SDC are interested in doing more on data and the GBVIMS	Has good potential	Has good potential			Data can be used for advocacy purposes		Los of existing attention and programming support for the new GBVIMS	No linkages to existing SDC programmes at this time	Linkages to existing programmes supported by others	

	capture data online. Consider support for the roll out of the new Primero+ model that is currently being piloted and key staff trained.													

Horn of Africa Region													
	Recommendation	**Alignment with key finding**	**Alignment with SDC Strategy**	**Regional**	**Cross-border**	**SGBV specific**	**SGBV mainstreaming**	**Advocacy related**	**Nexus /Development**	**Synergies with existing GBV programmes**	**Available SDC funding OR Co-funding opportunities**	**New SDC project required or linked to existing SDC project**	**SDC comparative advantage**
1.	Consider deploying a regional data expert for the regional GBV coordination mechanism that is tasked with building regional data systems on Primero/GBVIMS+ or other sustainable platforms and building a regional dashboard similar to MENA. Consider linking this to African Union work on building data	Yes	Migration/ Protection Improving Services	Yes	N	Yes	N	Yes: Better data can be used for advocacy	Yes	Yes: already a precedent for this	Available through SDC; small financial investment through deployment	Linked to existing coordination mechanism	Deployment function

	systems (which may be supported by Spotlight).												
2.	Develop a regional approach to GBV capacity building in the health sector through scale-up of the one-stop approach in underserved areas, through partnership with IRC, UNFPA, , the Red Cross, USAID and others with a history of supporting one-stop interventions. Consider developing regional standards for one-stop centre responses to survivors.	Y	No health priority in Kenya	Y	Potentially?	Y	N	N	Y	One-stops are a priority for the gov and/or UNFPA in Ethiopia and Somalia; Kenya also uses the model	Could be expensive project	New project required	Health Priority, ability to do the project regionally
3.	Consult with the global Prevention Collaborative partners to consider potential	Y	Migration/ Protection Durable Solutions	Y	N	Y	N	N	Y	Could build on SASA in Kenya and Ethiopia and Communities	?	Y	Links to durable solutions and is a necessary gap to fill in

	prevention interventions that can reach remote populations, including through technology. Also consider replicating the Communities Care model in underserved areas in the region, to combine capacity building of service providers and prevention approach.[192] Consider, where possible, strategies for introducing social norms components into existing training curricula for providers (e.g. for police and health care providers).									Care in Somalia			GBV programming, but no clear SDC advantage

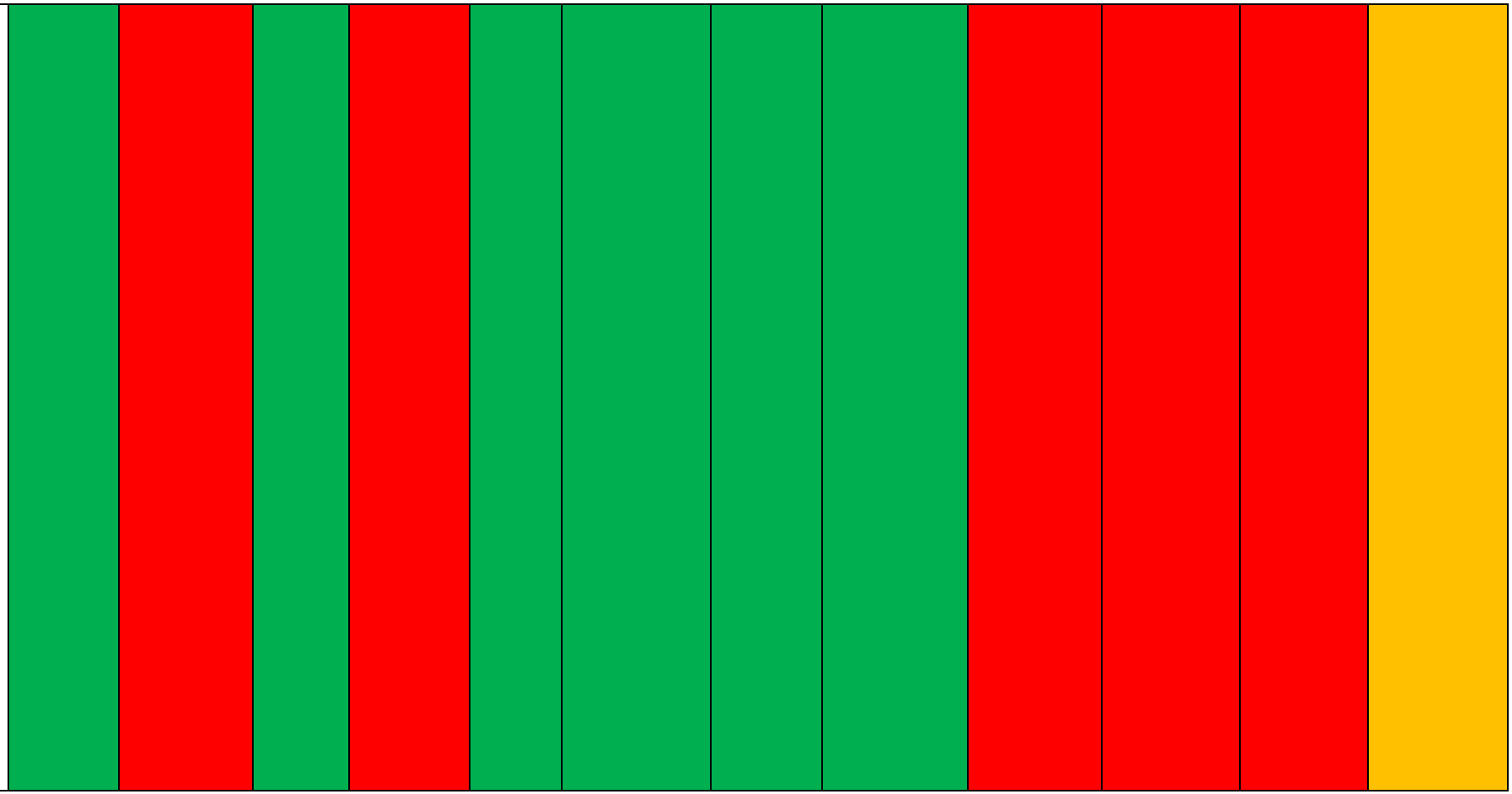
[192] The Communities Care model has been piloted in Somalia. However, in N Kenya and Somalia, IRC, DRC and other colleagues are using social norms change interventions from EMAP and SASA!, as noted previously.

	Ensure that any support to prevention includes an evaluative component.												
4.	Develop a regional localization initiative that incentivizes international organizations to partner with local organizations to address GBV, with a clear exit strategy for the international organizations. Link this in both advocacy and programming to durable solutions strategies. Consider partnership	Y	Migration/ Protection Durable Solutions	Y	N	Y	N	Could have an important advocacy element	Y	N	SDC could have the organisations on a roster and provide incentives rather than full funding for programming through a bidding process.	Y	Localization

	with Spotlight.												
5.	Support the expansion of the CASI assessment initiative to Somalia and Ethiopia, with a particular focus on identifying child protection capacity to address the issue of sexual violence and exploitation against boys. Consider placing someone from the SDC roster within the Child Protection Working Group in Kenya (or regionally) to focus on issue of sexual violence against boys.	Y	Migration/ Protection as well as SDC commitment to building capacity of humanitarian response to meet the needs of male survivors	Y	Potentially	Sexual violence against boys, so more relevant to CP than GBV, thus building out the CASI link	N	Potentially	Y	CASI	Co-funding through other CASI partners?	No	Deployment capacity for the CP support person
6.	Support a protection monitoring system	Y	Migration/ Protection	N	Y	N	Y	N	N	Protection programming rather than	N	Could link with existing	Migration protection

	at the Moyale border (and other border areas with significant cross-border movement) to identify multiple GBV issues related to border crossing, girls at risk of trafficking for marriage, perpetrators in flight, as well as other GBV concerns that reflect and contribute to GBV.									GBV programming		protection monitoring	
7.	Build on the work related to anticipatory actions (e.g. OCHA pilot in Somalia) for inclusion of GBV in these new frameworks in order to support preparedness approaches in	Y	Food Security is a priority for SDC at the regional level	Y	N	N	Y	Y	Y	Synergies with Food Security	Unclear, could be a part of Food Security Funding rather than new GBV funding	N	Food Security Investment; Advocacy Capacity

	the Horn of Africa that address GBV in natural disasters. Consider food security as an entry point for preparedness.												
8.	Consider ways to link with regional economic communities such as IGAD to support integration of GBV risk mitigation into initiatives, and/or to situate GBV experts in these communities to build capacity as part of SDC's deployment tool.	Y	Already working with IGAD but unclear in terms of strategy	Y	N	Possible	Possibly	Y	Y	Could work with Spotlight	Small investment through deployment	Deployment	Deployment capacity, Advocacy capacity
9	Spearhead a regional donor group on GBV and/or GBV-	Y		Y	N	Y	Y	Y	Y	N	N	N	Advocacy capacity

	specific donor consultation forums within regional donor mechanisms that allows SDC to both advocate for and model funding approaches that are critical to the success of GBV programmes, including longer-term funding; localization approaches supporting development of women's organizations as well as government capacity; the importance of promoting gender	

	equality as part of durable solutions; scaling up pooled funding; investment in monitoring and evaluation; etc.												

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Management response to
The Regional assessment on sexual and gender-based violence (SGBV) in the Horn of Africa (HoA)

Management Response

The Management Response (MR) states the position of the SDC on the recommendations of the regional assessment on sexual and gender-based violence (SGBV) in the Horn of Africa (HoA). The MR provides a solid basis for strategic decision-making regarding the development of an Entry Proposal (EP) on a regional SGBV engagement in the HoA. The relevant stakeholders and focal points in the HoA and at headquarters (HQ) level have been consulted.

Reviewing the Assessment

The assessment was conducted by Halcyon Consulting Limited, a consultancy firm involving a team of experts. The assessment process was well managed and included close involvement of the SDC's team comprising the gender focal points, focal persons from the health and protection/migration teams and the management from Addis Ababa and Nairobi Offices.

The main purpose of the assessment was to better understand all aspects related to SGBV in the HoA region to inform SDC's programming, strategies and policies when it comes to SGBV. The assessment was also aimed at identifying concrete entry points for SGBV programming in the HoA based on the existing Swiss engagement in the region and Swiss comparative advantages, and provide tailored recommendations on how to engage. The objectives were largely met by the assessment team. The SDC appreciates the comprehensiveness of the assessment report and the sound analysis of SGBV programmes in the region.

The report's analysis and recommendations are considered to be a useful basis for determining the strategic orientation of the new SGBV programme and options to work on SGBV mainstreaming within the existing SDC supported programmes in the HoA.

Main findings

The regional SGBV assessment was conducted in the period August- December, 2020. The assessment involved a document review and collection of primary and secondary data. There were challenges due to COVID-19 travel restrictions to conduct a quality assurance of the data collected from the field by the lead consultants. However, the team was able to come up with a detailed analysis on the aspects outlined in the terms of reference of the assessment and a number of recommendations.

The assessment report included detailed information on the SGBV context, scope of GBV, legislative and policy environment, GBV coordination and funding, GBV prevention and response mechanisms, GBV risk mitigation and mainstreaming, notable gaps and challenges in GBV programming in Northern Kenya, Somali Region of Ethiopia and Somalia. The analysis was presented separately for these geographical locations. At the HoA level, the assessment elaborated the regional initiatives related to addressing GBV, cross-border work, and common challenges in the HoA region. Based on the findings, the

assessment pointed out opportunities for SDC to engage and recommendations at the HoA level and in each of the geographic priorities.

The recommendations from the assessment were many and provided a wide range of options for SDC's future engagement including suggestions to support specific existing interventions and initiatives. Through a close follow-up and series of consultations with the consultants, the final report of the assessment included a prioritization of the recommendation made by the consultants. However, given the high number of recommendations and limited understanding of SDC's priorities in the HoA by the external team, the HoA team together with the relevant thematic focal points had to further prioritize the recommendations and identify feasible entry points.

The assessment led to recommendations specific to the Somali Region of Ethiopia, to Northern Kenya and to Somalia as well as ideas for regional engagements. Some of the country-level recommendations are related to recommendations on the regional level. Those recommendations that are both relevant at the regional level and country level are the most interesting for us, as we have set out to build a regional SGBV programme that is relevant to our whole geographic target area. We identified four areas to be of particular interest in the frame of the HoA Cooperation Programme: 1) Addressing data gaps, 2) engaging in advocacy and policy dialogue and strengthening coordination among stakeholders, 3) expand access to services through One Stop Crisis Centres, using the tools and findings from the existing Child and Adolescent Survivors Initiative (CASI) and finally 4) empowering local organizations and communities and building their capacities.

Out of the **32** recommendations, **3** are 'fully agreed' (green), **23** are 'partially agreed' (orange) and **6** are not agreed ('disagree' - red) – see table below. The SDC agrees build its new engagement on SGBV in the HoA by taking specific measures in line with the recommendations.

1. **[Recommendation 1.1.1]** **Legal/justice sector:** Partner with UNHCR to support efforts to build more gender equitable justice systems for Somali women through support to the Garissa magistrate at the Dadaab camp. As a potential complement, work with UNHCR and implementing partners (RCK, Action Aid) to scale up capacity of paralegals to work in and across north-eastern counties through the traditional systems to build safer responses to survivors, including improving Kadhi courts so that the reliance on maslaha is lessened. This project is already underway, so the cost investment is low for the return, and aligns with SDC priorities for improving services and protection for refugees in Kenya. *[No new project required; Good opportunity for impact through relatively small investment.]*	
2. [**Recommendation 1.1.2**] **Child Protection:** Work with CASI and UNICEF to support training of governmental and non-governmental child protection actors in northern countries on identifying risks of sexual violence for boys and standardizing referral pathways. Draw from the CASI assessment and recommendations to build out a model for response to sexual violence and exploitation of boys in northern Kenya through support to relevant actors, including Department of Child Services and UN and NGO child protection and MHPSS actors. (Consider expanding this to a regional approach.) This represents a potential new area for SDC to support that aligns with SDC's commitment to improving services for male survivors of sexual violence. *[No new project required; can be linked with SDC investment in addressing sexual violence again males.]*	

3.	[**Recommendation 1.1.3**] **Food security sector:** Build out the food security programmes in Wajir and elsewhere so that they support women and women's institutions to lead food projects. Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods. (Consider expanding to a regional approach.) Given that food security is a significant SDC investment, integrating risk mitigation measures that also support durable solutions for women and girls, and women's empowerment, is an important area for scale-up across all food security interventions. SDC may wish to hire a consultant to work with food security actors to build out risk mitigation (including livelihoods) programming that is safe, ethical, and follows global good practice. *[To be linked with the Food Security Investments.]*	
4.	**[Recommendation 1.2.1] Security sector:** Drawing from good practices in Kenya, support UNHCR and Refugee Affairs Secretariat (RAS) to scale up presence of female police and develop a sustainable model of police training and support at the national level through enhancing the national training curriculum (building on existing efforts of UN Women, FIDA, and other partners), or as a pilot in one county to that can be replicated, and/or as part of the Kalobeyei Integrated Socio-Economic Development Programme (KISEDP) or Garissa Integrated Social and Economic Development Plan (GISEDP). *[Recommended new project]*	
5.	**[Recommendation 1.2.2] Women's empowerment:** In all counties support localization through transitioning existing local women's networks to greater positions of influence and control in the community through, for example, a three-year pilot project aimed at building local women's and youth groups with focused capacity building and support, applying a tiered model for organizational development used by UNICEF in S. Sudan. Building on and linking to the work of the co-leads of the GBV Working Group, UN Women and UNFPA, conduct a mapping of women's networks and organizations and engage in participatory dialogue about how to build women's leadership. Use the Nexus Platform approach for funding multiple women's organizations under a shared umbrella. (Also consider this as a cross-border and/or regional option). *[Recommended new project but with existing partners such as UNFPA, UN Women and GBV Working Group.]*	
6.	[**Recommendation 1.2.3**] **General:** Review the work plans linked to the GISEDP and Kalobeyei Integrated Socio-Economic Development Plan (KIESDP) for potential GBV investments. Consider co-funding models or matched financing for government-led initiatives. *[Not clear to recommend whether or not new project is required. This is simply a recommendation to link to the GISEDP and KISEDP to identify potential priorities and partnerships for supporting GBV programming.]*	
7.	**[Recommendation 1.3.1] Health sector:** Support IRC and the existing Wellness Center in Lodwar to continue its level of staffing and/or advance the preliminary work in Wajir and Mandera to train health and other providers on the one-stop model, which has been initiated in these counties but is not operational. *[Recommended for a new project; Small programme with potentially good returns on building capacity.]*	

8. **[Recommendation 1.3.2] Psychosocial sector:** Develop a training-of-trainer programme that utilizes women's networks to develop basic psychosocial support programming that is culturally appropriate and locally-led. For north-eastern counties in particular, draw from pilots by UNICEF and TdH in the MENA region that build on positive aspects of Islamic systems, facilitating access to services by Muslim women and adolescent girls, that also uses an explicitly feminist empowerment model for survivors. For Turkana, consider a similar project that builds on faith networks. Potentially use the PSS project to facilitate support to programmes within the camps, but also to build them out to the host communities and beyond. Consider using a women-friendly space model as a starting point. *[Recommended new project]*	
9. **[Recommendation 2.1.1] Health and MHPSS:** Develop a project with UNFPA and Bureau of Women and Children Affairs (BOWCA) to support building systems for GBV at the Jijiga-level in the Fafen Zone as a pilot, with the eventual plan to cascade to other zones and woredas. Focus particularly on health and MHPSS, but also through coordination engage police and legal systems, including at the ministerial level, as well as key I/NGO partners such as the Ethiopian Women's Lawyers Association office in Jijiga (forthcoming). Work with international and national partners (e.g. IRC, OWDA) to support the development of standard operating procedures and coordination among multi-sectoral partners, as well as training and other capacity-building tools for health and MHPSS. Consider developing or expanding mobile outreach teams as part of this pilot as a way to expand service coverage. This investment aligns with SDC's priority for building out health services in Ethiopia. *[Recommended new project]*	
10. **[Recommendation 2.1.2] Data collection**: UNHCR intends to improve its GBV data systems in the coming year by upgrading from GBVIMS to Primero/GBVIMS+ (which includes case management capacity) and linking that to UNCHR's internal data management system (Progress V 4). The rollout of an updated case management system may present opportunities to improve data management systems amongst national partners, particularly the one-stop centres. Funding for an integrated approach to improving data management could support UNHCR's commitment to greater inclusivity of refugees in national systems and also support UNHCR's plan for SGBV response for refugees to link to one-stop centres. This represents a limited investment for a positive return, and could be co-funded. This project could also link to the regional data manager deployed to the regional GBV Working Group, and ensure that UNHCR's investment in improving systems is aligned with and supported by the regional effort. [Recommended new project.]	
11. **[Recommendation 2.1.3] Food Security:** Integrate attention to GBV in food security programmes. Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods. (Also consider this as a regional approach.) As noted in the Kenya section above, because food security is a significant SDC HoA investment, integrating risk mitigation measures that also support durable solutions for women and girls, and women's empowerment, is an important area for scale-up across all food security interventions. SDC may wish to hire a consultant to work with food security actors to build out risk mitigation (including livelihoods) programming that is safe, ethical, and follows global good practice. *[Recommended to link it to existing food security investments.]*	

12. **[Recommendation 2.2.1] Women's empowerment:** Take advantage of the BoWCA link to women's CSOs. Work directly with BoWCA to support localization through transitioning existing local women's networks to greater positions of influence and control in the community through, for example, a three-year pilot project aimed at building local women's and youth groups with focused capacity building and support, applying a tiered model for organizational development used in S. Sudan. Conduct a mapping of women's networks and organizations and engage in participatory dialogue about how to build women's leadership. (Also consider this as a cross-border and/or regional option.) *[Recommended a new project.]*	
13. **[Recommendation 2.2.2] Child Protection**: Work with Child Protection to undertake widespread training among health and social workers on sexual violence against boys as a first step in raising awareness of the need to improve attention to this issue. (Also consider this as a regional option.) *[Recommended to link it to CASI if it is regional.]*	
14. **[Recommendation 2.3.1] GBV Risk Mitigation**: In line with one of the core objectives of the GBV Working Group's Strategy 2020-2024, support UNFPA in the rollout of the GBV Pocket Guide to all humanitarian sectors in all IDP camps in the Somali region. Accompany the rollout with basic training on GBV risk mitigation. *[Recommended for a possibility for Integration into existing sector programme/protection mainstreaming.]*	
15. **[Recommendation 2.3.2] Governance**: Consider using the SDC roster to deploy an international (or national staff person) to BoWCA in Fafen or Liben zones with a terms of reference for building women's participation in peace-building as a strategy for reducing GBV, as part of SDC's governance work. Use the upcoming elections as an opportunity to support the development of strategy for ending GBV as a component of peace-building in the Somali region. *[Recommended new project.]*	
16. **[Recommendation 3.1.1] Leverage SDC's comparative advantage in policy advocacy and legislation to tackle the Sexual Intercourse Related Crimes Bill.** Enhance support for related policies and legislations, in particular the Sexual Offences Bill. Earmark scaled up funding for the SOB. Join political forces with other governments at the highest level to advocate for new repressive laws to become enacted. Strengthening the capacity of the local actors, especially the government, (police, judges' lawyers and counsellors). Intensify advocacy support to reduce the opposition from religious leaders and groups to the Sexual Offences Bill. Advocating with Middle Eastern counties who also support Somalia in different ways was also a recommendation from FCDO as a gap that is not being filled currently. SDC can also scale up its important unique role on advocacy to give a stronger voice and leadership on GBV over the long-term horizon. *[Funding could be through SDC's support to the existing UNFPA country programme.]*	
17. **[Recommendation 3.1.2] Support the scale-up and roll-out of GBVMIS across all states and to more actors.** Provide additional resources to support GBVMIS improvement and the extension of more capacity development for organisations and individuals to use GBVMIS instead of other systems which do not capture data online. Consider support for a national gender equity data bank. Consider support for the roll out of the new GBVMIS plus model that is currently being piloted and key staff trained. *[Recommended Linkages to existing programmes supported by others.]*	

18. **[Recommendation 3.1.3] Increase support for the wider legal/justice system.** SDC might consider supporting the legal/justice system over the longer-term, including strengthening the judiciary, the police and legal aid. Such support would be required at all levels across Somalia and Somaliland. Supporting research to help the sector understand how the legal/justice systems could be strengthened in Somalia and was highlighted by some partners as a potentially important contribution. *[Possible linkages to the SDC support to the UNJPLG and also support to the NGP consortium under the governance domain.]*	
19. **[Recommendation 3.2.1] Increase the focus on prevention and root causes.** Stakeholders indicated that while there are still extensive and significant gaps regarding SGBV support, there is less of a focus on preventive aspects. Prevention could take many aspects, especially given that needs, although working with men and boys, especially adolescents, as well as policy/advocacy were highlighted extensively by key stakeholders as key prevention components. *[New project required]*	
20. **[Recommendation 3.2.2] Scale up SGBV service delivery through more one stop centres and qualified services providers**. Scale up the number of one stop centres across Somalia, and increase support for the clinical management of rape. SDC can build off its experiences supporting WAAPO and their centre in Hargeisa. Increase the number of one stop centres in less accessible areas, including in FMS, and outside of the main urban areas. Extend psycho-social support to SGBV victims, including higher levels of care, and support for men and perpetrators. Increase the number of qualified services providers across the country. Support the establishment of more forensic labs across Somalia, currently there is only one forensic lab in whole Somalia. Support is also needed, however, to encourage more women to use the one stop centres that are available. *[Links to existing UNFPA country programme support – and potentially others such as Save the Children support. Recommended to build on SDC's support to WAAPO centres in Somaliland.]*	
21. **[Recommendation 3.2.3] Increase the attention on local organisations, enhance their capacity through larger organisations, extend their funding cycles and move towards funding those with more capacity directly**. Consider long-term support to specifically enhance the capacity of local organisations, and beyond the typical one or two year programme funding cycle. Consider support to create a localised GBV network in Somalia to help increase capacity and coordination among local agencies. *[Recommended to link it to UNFPA Somalia country programme which is already supported by SDC].*	
22. **[Recommendation 3.2.4] Support the development of the National GBV Strategy, 2021 – 2023.** Consider specific support to the next three year National SGBV Strategy which will be developed in early 2021 through the SGV working group and led by UNFPA. Consider support to create a bigger vision for GBV in Somalia that goes beyond a three year perspective. *[Funding could be through SDC's support to the existing UNFPA country programme.]*	
23. **[Recommendation 3.3.1] Increase support to bold youth programmes that aim at improving the attitudes and practices of the next generation**. Stakeholders have strong views on the need for greater support to be dedicated to improving the attitudes and behaviours of male adolescents and youths – as evidence suggests there is some potential for changes in younger generations and with regards to tackling cultural, social and religious norms. Consider support to expand promising UNICEF work with male youths and GBV to new locations beyond Mogadishu and Jubaland. *[Possibly through the existing Save the Children programme and also through UNFPA country programme.]*	

24. **[Recommendation 4.1.1] Consider deploying a regional data expert for the regional GBV coordination mechanism that is tasked with building regional data systems** on Primero/GBVIMS+ or other sustainable platforms and building a regional dashboard similar to MENA. Consider linking this to African Union work on building data systems (which may be supported by the regional Spotlight Initiative, with whom SDC could partner). Also link to UNHCR work on data systems in their refugee response in Ethiopia. *[Linked to existing coordination mechanism; deployment function.]*	
25. **[Recommendation 4.1.2] Build on the work related to anticipatory actions (e.g. OCHA pilot in Somalia) for inclusion of GBV in these new frameworks in order to support preparedness approaches** in the Horn of Africa that address GBV in natural disasters. Consider food security as an entry point for preparedness, possibly hiring a consultant to support SDC to work with its partners to not only build essential GBV risk mitigation into food security programming, but also to build attention to GBV in food security preparedness planning. *[Recommended to link it to SDC's investment on Food Security; not as a new initiative.]*	
26. [**Recommendation 4.1.3**] **Support the expansion of the CASI assessment initiative to Somalia and Ethiopia**, with a particular focus on identifying child protection capacity to address the issue of sexual violence and exploitation against boys. As noted previously, consider placing someone from the SDC roster within the Child Protection Working Group in Kenya (or regionally) to focus on issue of sexual violence against boys. This is highly relevant to SDC's investments and also an important area of growth for child protection.	
27. [**Recommendation 4.2.1**] **Develop a regional localization initiative that incentivizes international organizations to partner with local organizations to address GBV**, with a clear exit strategy for the international organizations. Link this in both advocacy and programming to durable solutions strategies. Consider partnership with Spotlight. *[SDC could have the organisations on a roster and provide incentives rather than full funding for programming through a bidding process. Recommended to have new project on this recommendation.]*	
28. **[Recommendation 4.2.2] Consider ways to link with regional economic communities such as IGAD to support integration of GBV risk mitigation into initiatives**, and/or to situate GBV experts in these communities to build capacity as part of SDC's deployment tool. *[Recommended to consider small investment through deployment.]*	
29. **[Recommendation 4.3.1] Spearhead a regional donor group on GBV** and/or GBV-specific donor consultation forums within regional donor mechanisms that allows SDC to both advocate for and model funding approaches that are critical to the success of GBV programmes, including longer-term funding; localization approaches supporting development of women's organizations as well as government capacity; the importance of promoting gender equality as part of durable solutions; scaling up pooled funding; investment in monitoring and evaluation; etc. *[Not a new project, link it to advocacy capacity.]*	
30. **[Recommendation 4.3.2] Develop a regional approach to GBV capacity building in the health sector through scale-up of the one-stop approach in underserved areas,** through partnership with IRC, UNFPA, the Red Cross, USAID and others with a history of supporting one-stop interventions. Consider developing regional standards for one-stop centre responses to survivors. *[New project required; could be expensive]*	

31. **[Recommendation 4.3.3] Consult with the global Prevention Collaborative partners to consider potential prevention interventions that can reach remote populations,** including through technology. Also consider replicating the Communities Care model in underserved areas in the region, to combine capacity building of service providers and prevention approach. Consider, where possible, strategies for introducing social norms components into existing training curricula for providers (e.g. for police and health care providers). Ensure that any support to prevention includes an evaluative component. *[Recommended to consider new project; could build on SASA in Kenya and Ethiopia and Communities Care in Somalia.]*	
32. **[Recommendation 4.3.4] Support a protection monitoring system at the Moyale border** (and other border areas with significant cross-border movement) to identify multiple GBV issues related to border crossing, girls at risk of trafficking for marriage, perpetrators in flight, as well as other GBV concerns that reflect and contribute to GBV. *[Could link with existing protection monitoring.]*	

Fully agree	Partially agree	Disagree

Overview of recommendations, management response and measures

1. **Northern Kenya**
   - *1.1. First Tier Priorities according to the consultant*

Recommendation 1.1.1		
Legal/justice sector: Partner with UNHCR to support efforts to build more gender equitable justice systems for Somali women through support to the Garissa magistrate at the Dadaab camp. As a potential complement, work with UNHCR and implementing partners (RCK, Action Aid) to scale up capacity of paralegals to work in and across north-eastern counties through the traditional systems to build safer responses to survivors, including improving Kadhi courts so that the reliance on maslaha is lessened. This project is already underway, so the cost investment is low for the return, and aligns with SDC priorities for improving services and protection for refugees in Kenya. *[No new project required; Good opportunity for impact through relatively small investment.]*		
Management response		
Fully agree	**Partially agree**	Disagree
This recommendation is not considered for further action because it is not linked to SDC's priorities as per the Swiss Cooperation Programme for the HoA.		

Recommendation 1.1.2
Child Protection: Work with CASI and UNICEF to support training of governmental and non-governmental child protection actors in northern countries on identifying risks of sexual violence for boys and standardizing referral pathways. Draw from the CASI assessment and recommendations to build out a model for response to sexual violence and exploitation of boys in Northern Kenya through support to relevant actors, including Department of Child Services and UN and NGO child protection and MHPSS actors. (Consider expanding this to a regional approach.) This represents a potential new area for SDC to support that aligns with SDC's commitment to improving services for male survivors of sexual violence. *[No new project required; can be linked with SDC investment in addressing sexual violence again males.]*

Management response		
Fully agree	**Partially agree**	Disagree
We agree that child protection actors in northern countries should have stronger knowledge regarding the risks of sexual violence for boys. We suggest that findings and recommendations from the CASI assessment will be further explored and feed our body of knowledge on the topic for future programming and learning, keeping in mind that the assessment was done in the particular context of the Kibera slums and that it covers barriers to access GBV services for both, boys and girls. See also response to the recommendations 2.2.2 regarding child protection in Ethiopia and recommendation 4.1.3 on expanding CASI in the region.		

Measures	Responsibility	Timing
a) The men and boys expert funded by SDC to be deployed during the beginning of 2022 to the GBV Area of Responsibility in Nairobi will ensure stronger integration of risks of sexual violence for boys and will revisit the findings of the CASI assessment to make sure they will inform the work in the region and feed into learning tools.	Gender and GBV advisor at HQ, Health NPOs in the HoA teams, RPA, men and boys expert.	Ongoing

Recommendation 1.1.3
Food security sector: Build out the food security programmes in Wajir and elsewhere so that they support women and women's institutions to lead food projects. Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods. (Consider expanding to a regional approach.) Given that food security is a significant SDC investment, integrating risk mitigation measures that also support durable solutions for women and girls, and women's empowerment, is an important area for scale-up across all food security interventions. SDC may wish to hire a consultant to work with food security actors to build out risk mitigation (including livelihoods) programming that is safe, ethical, and follows global good practice. *[To be linked with the Food Security Investments.]*

Management response		
Fully agree	**Partially agree**	Disagree
We agree that existing SDC supported food security interventions may provide good entry points to address SGBV at the community level for instance through livelihood activities. Some of the food security interventions have already identified the need to work on these issues. Mainstreaming will also enhance synergies between the food security and health domains. We suggest that for mainstreaming SGBV in the FS domain, we use the Gender analyses currently being done to identify how the food security projects could start including SGBV considerations - rather than adopting a systematic approach for the whole portfolio from the beginning. See also recommendation 2.1.3 on integrating SGBV measures in FS programmes in Ethiopia.		

Measures	Responsibility	Timing
b) Use the Gender analyses currently being done to identify how the project(s) within the food security domain could integrate measures to mitigate the risk of	Regional Food Security Domain team in discussion with	End of 2021

SGBV in their interventions. This can also be integrated to the update of the domain gender action plans.	gender focal persons	

1.2 Second Tier Priorities, according to the consultants

Recommendation 1.2.1		
Security sector: Drawing from good practices in Kenya, support UNHCR and Refugee Affairs Secretariat (RAS) to scale up presence of female police and develop a sustainable model of police training and support at the national level through enhancing the national training curriculum (building on existing efforts of UN Women, FIDA, and other partners), or as a pilot in one county to that can be replicated, and/or as part of the Kalobeyei Integrated Socio-Economic Development Programme (KISEDP) or Garissa Integrated Social and Economic Development Plan (GISEDP). *[Recommended new project]*		
Management response		
Fully agree	Partially agree	**Disagree**
This recommendation is not considered for further action because it is not linked to SDC's priorities as per the Swiss Cooperation Programme for the HoA.		

Recommendation 1.2.2		
Women's empowerment: In all counties support localization through transitioning existing local women's networks to greater positions of influence and control in the community through, for example, a three-year pilot project aimed at building local women's and youth groups with focused capacity building and support, applying a tiered model for organizational development used by UNICEF in S. Sudan. Building on and linking to the work of the co-leads of the GBV Working Group, UN Women and UNFPA, conduct a mapping of women's networks and organizations and engage in participatory dialogue about how to build women's leadership. Use the Nexus Platform approach for funding multiple women's organizations under a shared umbrella. (Also consider this as a cross-border and/or regional option). *[Recommended new project but with existing partners such as UNFPA, UN Women and GBV Working Group.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree on the importance to support grassroots approaches and local actors such as local women's networks and youth groups also in line with the localization agenda and our commitments to the Grand Bargain. Supporting and building up local capacities will be at the centre of our future SGBV engagement. We will further need to explore concrete entry points and map the existing local networks and stakeholder landscape and explore options for a localization approach such as suggested in the recommendation. See also response and measures to the recommendations 2.2.1 regarding women's empowerment in Ethiopia, recommendation 3.2.3 on enhancing local organisation's capacity in Somalia and recommendation 4.2.1 on developing a regional localisation initiative in the region.		
Measures	Responsibility	Timing
c) Map existing engagement and capacities of local organisations already active in Northern Kenya, understand the stakeholder landscape better and	NPO migration protection, Nairobi team	October 2021

identify concrete entry points and partnerships for SDC's engagement		

Recommendation 1.2.3		
General: Review the work plans linked to the GISEDP and Kalobeyei Integrated Socio-Economic Development Plan (KIESDP) for potential GBV investments. Consider co-funding models or matched financing for government-led initiatives. *[Not clear to recommend whether or not new project is required. This is simply a recommendation to link to the GISEDP and KISEDP to identify potential priorities and partnerships for supporting GBV programming.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree that GIESDP and KISEDP and the respective work plans are important planning tools to mobilize resources and ensure a coordinated approach around key priorities including GBV. However, our continuing engagement with the KISEDP will be through our long-standing partners in Kalobeyi/Kakuma (UNHCR, IFC, Swiss contact and Refugee consortium of Kenya) who we will encourage to consider taking up GBV in their interventions and when contributing to the discussions around the KIESDP. SDC will monitor the 4th components which is the protection pillar of the KISEDP. According to this pillar, child marriage is the most common protection concern in Turkana county, thus denying girls schooling. SGBV and child labour follow as second most concerning issues. There is a Turkana Gender and child protection network coordinating SGBV and child protection at county level, and normally liaises with national government for better services. This working group could be an entry point for SDC, to engage and further understand the context. Under the protection pillar of KISEDP there is also a flagship project on provision of sexual exploitation trainings to all teachers in the county. This is also a potential area of collaboration in future. GISEDP is not a public document as yet and thus SDC will engage with it when it is published or shared by the Garissa county government.		

1.3 Third Tier Priorities, according to the consultants

Recommendation 1.3.1		
Health sector: Support IRC and the existing Wellness Center in Lodwar to continue its level of staffing and/or advance the preliminary work in Wajir and Mandera to train health and other providers on the one-stop model, which has been initiated in these counties but is not operational. *[Recommended for a new project; Small programme with potentially good returns on building capacity.]*		
Management response		
Fully agree	**Partially agree**	Disagree
Given the considerable gap regarding service provision through One-stop centres (OSC) and their accessibility, we consider it important to increase the operation ability of OSC and the access to services through this model in Northern Kenya and the region as crucial. Thereby, we consider it essential that OSCs are anchored in the community. See also responses to recommendation 2.1.1 on outreach of OSC in Ethiopia, recommendation 3.2.2 on scaling up service delivery through OSC in Somalia and recommendation 4.3.2 on a regional scaling up of the one-stop model.		
Measures	Responsibility	Timing

d) Reach out to IRC Kenya and find out more about gaps and development needs of the wellness centres.	Regional health and migration domain team with the support from management	August 2021

Recommendation 1.3.2		
Psychosocial sector: Develop a training-of-trainer programme that utilizes women's networks to develop basic psychosocial support programming that is culturally appropriate and locally-led. For north-eastern counties in particular, draw from pilots by UNICEF and TdH in the MENA region that build on positive aspects of Islamic systems, facilitating access to services by Muslim women and adolescent girls, that also uses an explicitly feminist empowerment model for survivors. For Turkana, consider a similar project that builds on faith networks. Potentially use the PSS project to facilitate support to programmes within the camps, but also to build them out to the host communities and beyond. Consider using a women-friendly space model as a starting point. [*Recommended new project.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree that psychosocial support is crucial and SGBV interventions should apply culturally appropriate and locally-led models in this regard. However, other than setting up a new project on this specifically as per this recommendation, we will ensure that psychosocial support is a component in a SGBV intervention that is broader in scope.		
Measures	Responsibility	Timing
e) Include psychosocial support as a component of the SGBV intervention.	NPO Health and NPO migration	Up to December 2021
f) Contact key agencies in Northern Kenya and in Turkana county to follow up on this recommendation	NPO''s health and Migration	September 2021

2. The Somali Region of Ethiopia

2.1 First Tier Priorities, according to the consultants

Recommendation 2.1.1
Health and MHPSS: Develop a project with UNFPA and Bureau of Women and Children Affairs (BOWCA) to support building systems for GBV at the Jijiga-level in the Fafen Zone as a pilot, with the eventual plan to cascade to other zones and woredas. Focus particularly on health and MHPSS, but also through coordination engage police and legal systems, including at the ministerial level, as well as key I/NGO partners such as the Ethiopian Women's Lawyers Association office in Jijiga (forthcoming). Work with international and national partners (e.g. IRC, OWDA) to support the development of standard operating procedures and coordination among multi-sectoral partners, as well as training and other capacity-building tools for health and MHPSS. Consider developing or expanding mobile outreach teams as part of this pilot as a way to expand service coverage. This investment aligns with SDC's priority for building out health services in Ethiopia. *[Recommended new project]*
Management response

Fully agree	**Partially agree**	Disagree
Given the considerable gap regarding service provision and their accessibility, we consider it important to support the expansion of service coverage in the Somali Region of Ethiopia and the region, ensuring sustainability. Service provision should thereby be anchored in the communities and UNFPA may be not the right partner. See also responses to recommendation 1.3.1 on increasing the operational ability of OSC in Northern Kenya, recommendation 3.2.2 on scaling up service delivery through OSC in Somalia and recommendation 4.3.2 on a regional scaling up of the one-stop model.		

Measures	Responsibility	Timing
g) Reach out to BOWCA in the Somali Region and INGO partners to map local women organizations and/or associations, with their level of engagement and geographic scope.	Addis Programmatic team	September 2021

Recommendation 2.1.2
Data collection: UNHCR intends to improve its GBV data systems in the coming year by upgrading from GBVIMS to Primero/GBVIMS+ (which includes case management capacity) and linking that to UNCHR's internal data management system (Progress V 4). The rollout of an updated case management system may present opportunities to improve data management systems amongst national partners, particularly the one-stop centres. Funding for an integrated approach to improving data management could support UNHCR's commitment to greater inclusivity of refugees in national systems and also support UNHCR's plan for SGBV response for refugees to link to one-stop centres. This represents a limited investment for a positive return, and could be co-funded. This project could also link to the regional data manager deployed to the regional GBV Working Group, and ensure that UNHCR's investment in improving systems is aligned with and supported by the regional effort. *[Recommended new project.]*
Management response

Fully agree	**Partially agree**	Disagree
We believe that insufficient data is a key hurdle to general awareness on SGBV, evidence-based programming and policy dialogue and fundraising for SGBV related interventions in the region. Therefore, improving data will be an objective of our SGBV regional programme. However, in line with our target region and population efforts to improve data will need to go beyond the refugee response. While it needs to be determined whether UNHCR would be a suitable partner, it will be important to better understand UNHCR's intent to improve GBV data systems but also reach out to other key SGBV actors in order to identify gaps, challenges and opportunities.		

Measures	Responsibility	Timing
h) Exchange with key SGBV actors in Ethiopia to better understand current status on data, systems in place and identify gaps, challenges and opportunities.	Addis Programmatic team (Health and protection)	Sept 2021

Recommendation 2.1.3
Food Security: Integrate attention to GBV in food security programmes. Ensure this approach integrates risk reduction measures for women and girls, including social norms change interventions with men and boys to support women's greater leadership in production management and systems. Link to livelihoods. (Also consider this as a

regional approach.) As noted in the Kenya section above, because food security is a significant SDC HoA investment, integrating risk mitigation measures that also support durable solutions for women and girls, and women's empowerment, is an important area for scale-up across all food security interventions. SDC may wish to hire a consultant to work with food security actors to build out risk mitigation (including livelihoods) programming that is safe, ethical, and follows global good practice. *[Recommended to link it to existing food security investments.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree that existing SDC supported food security interventions may provide good entry points to address SGBV at the community level for instance through livelihood activities. Some of the food security interventions have already identified the need to work on these issues. Mainstreaming will also enhance synergies between the food security and health domains. We suggest that for mainstreaming SGBV in the FS domain, we use the Gender Analyses currently being done to identify how food security projects could start including SGBV considerations - rather than adopting a systematic approach for the whole portfolio from the beginning. See also responses to recommendation 1.1.3 on integrating SGBV measures in FS programmes in Northern Kenya.		
Measures	Responsibility	Timing
i) Use the Gender analyses currently being done to identify how project(s) within the food security domain could integrate measures to mitigate the risk of SGBV in their interventions. This can also be integrated to the update of the domain gender action plans.	[Regional food security domain teams in discussion with gender focal persons	End of 2021

2.2 Second Tier Priorities, according to the consultants

Recommendation 2.2.1		
Women's empowerment: Take advantage of the BoWCA link to women's CSOs. Work directly with BoWCA to support localization through transitioning existing local women's networks to greater positions of influence and control in the community through, for example, a three-year pilot project aimed at building local women's and youth groups with focused capacity building and support, applying a tiered model for organizational development used in S. Sudan. Conduct a mapping of women's networks and organizations and engage in participatory dialogue about how to build women's leadership. (Also consider this as a cross-border and/or regional option.) *[Recommended a new project.]*		
Management response		
Fully agree	Partially agree	Disagree
We fully agree on the importance to support grassroots approaches and local actors such as local women's networks and youth groups also in line with the localization agenda and our commitments to the Grand Bargain. Supporting and building up local capacities will be at the centre of our future SGBV engagement. We will further need to explore concrete entry points and map the existing local networks and stakeholder landscape and explore options for a localization approach such working through BoWCA as suggested in this recommendation. See also response and measures to the recommendations 1.2.2 regarding women's empowerment in Kenya, recommendation 3.2.3 on enhancing local organisation's capacity in Somalia and recommendation 4.2.1 on developing a regional localisation initiative in the region.		

Measures	Responsibility	Timing
j) Map existing engagement and capacities of local organisations already active in South/South East Ethiopia, understand the stakeholder landscape better and identify concrete entry points and partnerships for SDC's engagement including through BoWCA.	NPO Health in Addis	Sept 2021

Recommendation 2.2.2		
Child Protection: Work with Child Protection to undertake widespread training among health and social workers on sexual violence against boys as a first step in raising awareness of the need to improve attention to this issue. (Also consider this as a regional option.) *[Recommended to link it to CASI if it is regional.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree that addressing SGBV through child protection could be an interesting option for SDC. In Ethiopia specifically, we have been supporting the child protection AoR through secondments and could benefit from the existing expertise. However, awareness of the issue should target communities rather than health and social workers whose awareness is already there. What could benefit health and social workers is more operational knowledge on how to integrate it their practice. See also response to the recommendations 1.1.2 regarding child protection and CASI in Northern Kenya and recommendation 4.1.3 on expanding CASI in the region.		

2.3 Third Tier Priorities, according to the consultants

Recommendation 2.3.1		
GBV Risk Mitigation: In line with one of the core objectives of the GBV Working Group's Strategy 2020-2024, support UNFPA in the rollout of the GBV Pocket Guide to all humanitarian sectors in all IDP camps in the Somali region. Accompany the rollout with basic training on GBV risk mitigation. *[Recommended for a possibility for Integration into existing sector programme/protection mainstreaming.]*		
Management response		
Fully agree	Partially agree	**Disagree**
This is not a priority for SDC at the moment. We disagree as the recommendation does not suggest an intervention that will be of the kind of long-term and comprehensive project we want to build up or support.		

Recommendation 2.3.2
Governance: Consider using the SDC roster to deploy an international (or national staff person) to BoWCA in Fafen or Liben zones with a terms of reference for building women's participation in peace-building as a strategy for reducing GBV, as part of SDC's governance work. Use the upcoming elections as an opportunity to support the development of strategy for ending GBV as a component of peace-building in the Somali region. *[Recommended new project.]*
Management response

Fully agree	Partially agree	**Disagree**
We disagree as the recommendation is not in line with Switzerland's governance objectives for the Horn of Africa. In addition, the recruitment of an expert from the SKH for the suggested deployment seems unlikely while national staff positions can only be supported in the framework of a broader project.		

3. Somalia

2.1 First Tier Priorities, according to the consultants

Recommendation 3.1.1		
Leverage SDC's comparative advantage in policy advocacy and legislation to tackle the Sexual Intercourse Related Crimes Bill. Enhance support for related policies and legislations, in particular the Sexual Offences Bill. Earmark scaled up funding for the SOB. Join political forces with other governments at the highest level to advocate for new repressive laws to become enacted. Strengthening the capacity of the local actors, especially the government, (police, judges' lawyers and counsellors). Intensify advocacy support to reduce the opposition from religious leaders and groups to the Sexual Offences Bill. Advocating with Middle Eastern counties who also support Somalia in different ways was also a recommendation from FCDO as a gap that is not being filled currently. SDC can also scale up its important unique role on advocacy to give a stronger voice and leadership on GBV over the long-term horizon. *[Funding could be through SDC's support to the existing UNFPA country programme.]*		
Management response		
Fully agree	**Partially agree**	Disagree
The need to play a more important role in advocacy has been recognized both by the regional Gender assessment and the Mid-term-evaluation of the strategy. Related to Gender, SDC suggests to prioritize its advocacy on 2 issues, i.e. SGBV and women's political participation. SDC plans to undertake collective engagement at appropriate platforms with other partners/donors on these two sensitive issues. SDC plans also to identify which issues in which programmes – esp. In Health and Migration domains but not only - require complimentary policy dialogue and influencing to strengthen gender equality and which platforms will be used; identify entry points for potential policy work at the sector/domain level (beyond the programmatic/technical level). SDC will finally explore concrete opportunities to link this recommendation to the already ongoing project with UNFPA Somalia country programme. See recommendation 4 and related measures on the Management response to the regional Gender assessment.		

Measures	Responsibility	Timing
k) Identify which issues in which programmes require complimentary policy dialogue and influencing to strengthen advocacy on SGBV and which platforms will be used; identify entry points for potential policy work at the sector/domain level (beyond the programmatic/ technical level); update the Domain action plan accordingly.	Regional thematic teams]	asap

Recommendation 3.1.2
Support the scale-up and roll-out of GBVMIS across all states and to more actors. Provide additional resources to support GBVMIS improvement and the extension of more capacity development for organisations and individuals to use GBVMIS instead of other

systems which do not capture data online. Consider support for a national gender equity data bank. Consider support for the roll out of the new GBVMIS plus model that is currently being piloted and key staff trained. *[Recommended Linkages to existing programmes supported by others.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We believe that insufficient data is a key hurdle to general awareness on SGBV, evidence-based programming and policy dialogue and fundraising for SGBV related interventions in the region. Therefore, improving data will be an objective of our SGBV regional programme. We will make use of the initiative by SDC HQ supporting/funding the Regional Emergency GBV Advisor (REGA) in Nairobi on data to complement the programme. We also will need to better understand the GBVMIS model, how it is been used in the sector and its potential. We will need to reach out to SGBV actors in Somalia in order to identify general gaps, challenges and opportunities regarding data. See also recommendations and measures under recommendation 2.1.2 on support to UNHCR's GBV data system and recommendation and recommendation 4.1.1 on deploying experts.		

Measures	Responsibility	Timing
l) Reach out to key SGBV actors in Somalia to better understand gaps, challenges and needs in regards to data and the use and potential of GBVMIS model in the sector.	NPO health in Nairobi	Sept 2021

Recommendation 3.1.3		
Increase support for the wider legal/justice system. SDC might consider supporting the legal/justice system over the longer-term, including strengthening the judiciary, the police and legal aid. Such support would be required at all levels across Somalia and Somaliland. Supporting research to help the sector understand how the legal/justice systems could be strengthened in Somalia and was highlighted by some partners as a potentially important contribution. [*Possible linkages to the SDC support to the UNJPLG and also support to the NGP consortium under the governance domain.]*		
Management response		
Fully agree	Partially agree	**Disagree**
We disagree as the recommendation is not in line with SDC's priorities in the Horn of Africa and Somalia specifically.		

3.2 Second Tier Priorities, according to the consultants

Recommendation 3.2.1		
Increase the focus on prevention and root causes. Stakeholders indicated that while there are still extensive and significant gaps regarding SGBV support, there is less of a focus on preventive aspects. Prevention could take many aspects, especially given that needs, although working with men and boys, especially adolescents, as well as policy/advocacy were highlighted extensively by key stakeholders as key prevention components. *[New project required]*		
Management response		
Fully agree	**Partially agree**	Disagree

We agree that focusing on root causes and prevention is important and find it important to address this in our upcoming SGBV programme. However, rather than initiating a project as per recommendation we will ensure that prevention is part of an intervention that is broader in scope. In addition, this recommendation can be mainstreamed to the already ongoing project with UNFPA Somalia. Also see recommendation 3.3.1 on social norms in Somalia and 4.3.3 on prevention initiatives in the region.		
Measures	Responsibility	Timing
m) The UNFPA programme already supports working with youth and adolescents. The HoA office to follow up on this aspect within the programme.	Health NPO, Nairobi	Ongoing

Recommendation 3.2.2		
Scale up SGBV service delivery through more one stop centres and qualified services providers. Scale up the number of one stop centres across Somalia, and increase support for the clinical management of rape. SDC can build off its experiences supporting WAAPO and their centre in Hargeisa. Increase the number of one stop centres in less accessible areas, including in FMS, and outside of the main urban areas. Extend psycho-social support to SGBV victims, including higher levels of care, and support for men and perpetrators. Increase the number of qualified services providers across the country. Support the establishment of more forensic labs across Somalia, currently there is only one forensic lab in whole Somalia. Support is also needed, however, to encourage more women to use the one stop centres that are available. *[Links to existing UNFPA country programme support – and potentially others such as Save the Children support. Recommended to build on SDC's support to WAAPO centres in Somaliland.]*		
Management response		
Fully agree	Partially agree	Disagree
We agree on the importance of service delivery through OSC, increase the quality of services and the need for scale up. UNFPA already supports 77 OSC in Somalia. See also responses to recommendation 1.3.1 on increasing the operational ability of OSC in Northern Kenya, recommendation 2.1.1 on building up services in the Somali Region of Ethiopia and recommendation 4.3.2 on a regional scaling up of the one-stop model. It was also agreed that support to OSC will be limited by available budget. Instead we should look at the NGOs working around the OSC and find entry points to work with them (especially on the link to community building aspects).		
Measures	Responsibility	Timing
n) In NE Kenya and the Somali region of Ethiopia the HoA office will identify local associations working with OSCs and find entry points to work with them.	Regional domain team.	October 2021.

Recommendation 3.2.3
Increase the attention on local organisations, enhance their capacity through larger organisations, extend their funding cycles and move towards funding those with more capacity directly. Consider long-term support to specifically enhance the capacity of local organisations, and beyond the typical one or two year programme funding cycle. Consider support to create a localised GBV network in Somalia to help

increase capacity and coordination among local agencies. *[Recommended to link it to UNFPA Somalia country programme which is already supported by SDC].*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree on the importance to support grassroots approaches and local actors in a long-term manner and in line with the localization agenda and our commitments to the Grand Bargain. Supporting and building up local capacities will be at the centre of our future SGBV engagement that will span over several years and project phases and thus to offer the opportunity for multi-year funding for the implementing partners. We will further explore concrete entry points such as working through larger organizations that can facilitate their empowerment as recommended here. See also response and measures to the recommendation 1.2.2 on women empowerment in Northern Kenya, recommendation 2.2.1 regarding women's empowerment in Ethiopia and recommendation 4.2.1 on developing a regional localisation initiative in the region.		

Measures	Responsibility	Timing
o) Map existing engagement and capacities of local organisations already active in Somalia, understand the stakeholder landscape better and identify concrete entry points and partnerships for SDC's engagement	Health NPO, Nairobi	Sept 2021

Recommendation 3.2.4		
Support the development of the National GBV Strategy, 2021 – 2023. Consider specific support to the next three year National SGBV Strategy which will be developed in early 2021 through the SGV working group and led by UNFPA. Consider support to create a bigger vision for GBV in Somalia that goes beyond a three year perspective. *[Funding could be through SDC's support to the existing UNFPA country programme.]*		
Management response		
Fully agree	**Partially agree**	**Disagree**
We will not consider this recommendation for our upcoming SGBV regional programme given that we aim at building-up a long-term engagement on SGBV starting only in 2022 but will work with UNFPA on this through our existing engagement.		

Measures	Responsibility	Timing
p) The support to UNFPA programme covers this aspects. The health team will closely monitor this aspect within the programme.	Health NPO, Nairobi	Ongoing

3.3 Third Tier Priorities, according to the consultants

Recommendation 3.3.1
Increase support to bold youth programmes that aim at improving the attitudes and practices of the next generation. Stakeholders have strong views on the need for greater support to be dedicated to improving the attitudes and behaviours of male adolescents and youths – as evidence suggests there is some potential for changes in younger generations and with regards to tackling cultural, social and religious norms. Consider support to expand promising UNICEF work with male youths and GBV to new locations beyond Mogadishu and Jubaland. *[Possibly through the existing Save the Children programme and also through UNFPA country programme.]*

Management response		
Fully agree	**Partially agree**	Disagree
We agree on the importance of working on social norms as part of preventing SGBV and find it important to address this in our upcoming SGBV programme. However, rather than initiating a project as per recommendation we will ensure that this aspect is taken up in our intervention that will be broader in scope. See also recommendation 3.2.1 on root causes and prevention in Somalia and 4.3.3 on prevention initiatives in the region.		

4. Horn of Africa

4.1 First Tier Priorities, according to the consultants

Recommendation 4.1.1.		
Consider deploying a regional data expert for the regional GBV coordination mechanism that is tasked with building regional data systems on Primero/GBVIMS+ or other sustainable platforms and building a regional dashboard similar to MENA. Consider linking this to African Union work on building data systems (which may be supported by the regional Spotlight Initiative, with whom SDC could partner). Also link to UNHCR work on data systems in their refugee response in Ethiopia. *[Linked to existing coordination mechanism; deployment function.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We believe that insufficient data is a key hurdle to general awareness on SGBV, evidence-based programming and policy dialogue and fundraising for SGBV related interventions in the region. Therefore, improving data will be an objective of our SGBV regional programme. We also understand that expertise is required to build the necessary systems, analyse data, communicate findings and build up advocacy strategies based on evidence. We therefore agree that funding or deploying experts to key SGBV actors in the region will be crucial. However, it needs to be further assessed whether it would be better to invest first in national data systems and dissemination of data before working on the regional level. We also will need to reach out to key SGBV actors in Ethiopia, Somalia and Kenya to understand their staffing needs and what specific expertise would be required to ensure we support strategic positions in the sector. We will also make use of the initiative by SDC HQ supporting/funding the Regional Emergency GBV Advisor (REGA) in Nairobi on data to complement the programme. See also recommendations and measures under recommendation 2.1.2 on support to UNHCR's GBV data system, recommendation 3.1.2 on scale up/roll out of GBMIS in Somalia and 4.3.1 on donor coordination.		
Measures	Responsibility	Timing
q) Reach out to key SGBV actors in Kenya, Somalia and Ethiopia to better understand staffing gaps, challenges and needs required to improve data and its use for programming and advocacy in the sector and identify strategic positions that we can support as part of our SGBV regional programme.	Regional programmatic team (Health and Protection/ migration)	Sept 2021
r) Include improving data and related systems as an objective in the regional SGBV programme to be pursued during the first phase in order to enable policy and advocacy work in the second phase.	tbd	PKD by end 2021 EB by mid-2022

Recommendation 4.1.2		
Build on the work related to anticipatory actions (e.g. OCHA pilot in Somalia) for inclusion of GBV in these new frameworks in order to support preparedness approaches in the Horn of Africa that address GBV in natural disasters. Consider food security as an entry point for preparedness, possibly hiring a consultant to support SDC to work with its partners to not only build essential GBV risk mitigation into food security programming, but also to build attention to GBV in food security preparedness planning. *[Recommended to link it to SDC's investment on Food Security; not as a new initiative.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree on the importance of anticipatory action and will integrate this in the design of our SGBV programme. In regards to FS, we find it more feasible to work on integrating SGBV responses in selected SDC supported FS programmes. See also recommendations 1.1.3 on FS in Northern Kenya and recommendation 2.1.3 on FS in the Somali Region of Ethiopia.		
Measures	Responsibility	Timing
None		

Recommendation 4.1.3		
Support the expansion of the CASI assessment initiative to Somalia and Ethiopia, with a particular focus on identifying child protection capacity to address the issue of sexual violence and exploitation against boys. As noted previously, consider placing someone from the SDC roster within the Child Protection Working Group in Kenya (or regionally) to focus on issue of sexual violence against boys. This is highly relevant to SDC's investments and also an important area of growth for child protection.		
Management response		
Fully agree	**Partially agree**	Disagree
We agree that focusing on issues of sexual violence against boys is crucial and we refer to recommendation 1.1.2 and related measure, i.e the deployment of a men and boys expert to the GBV AoR in Nairobi. At this stage, we will request the expert to assess the best ways of integrating these aspects in future programming, including in Somalia and Ethiopia. The expert will be integrated in the GBV AoR and will be best placed to interact with the Child Protection working group at regional level. However, it is not a priority to expand the CASI assessment initiative to Somalia and Ethiopia.		
Measures	Responsibility	Timing
s) The men and boys expert funded by SDC to be deployed in the beginning of 2022 to the GBV Area of Responsibility in Nairobi will ensure stronger integration of risks of sexual violence for boys and will revisit the findings of the CASI assessment to make sure they will inform future programming in the HoA Region.	Gender and GBV advisor at HQ, Health NPOs in the HoA teams, RPA, men and boys	Ongoing

4.2 Second Tier Priorities, according to the consultants

Recommendation 4.2.1		
Develop a regional localization initiative that incentivizes international organizations to partner with local organizations to address GBV, with a clear exit strategy for the international organizations. Link this in both advocacy and programming to durable solutions strategies. Consider partnership with Spotlight. *[SDC could have the organisations on a roster and provide incentives rather than full funding for programming through a bidding process. Recommended to have new project on this recommendation.]*		
Management response		
Fully agree	Partially agree	Disagree
We fully agree on the importance to support grassroots approaches and local actors in the region as per the recommendation as this is also in line with the localization agenda and our commitments to the Grand Bargain. Supporting and building up local capacities will be at the centre of our future SGBV engagement and we will further explore concrete entry points such as recommended here or exploring the idea of a pooled fund to support local actors. We also agree that advocacy should be an important element of our regional engagement. We believe that evidence coming out of our programmatic engagement and grounded in improved data will be a powerful tool to start working on the policy level at a later stage in the SGBV programme. See also response to the recommendations 1.2.2 regarding women's empowerment in Kenya, recommendation, recommendation 2.2.1 on women's empowerment in the Somali Region of Ethiopia, recommendation 3.2.3 on enhancing local organisation's capacity in Somalia and recommendation 4.2.1 on developing a regional localisation initiative in the region.		
Measures	Responsibility	Timing
t) Put a localization approach and the empowerment of local women's organizations at the centre of the Entry Proposal for the Regional SGBV Programme. Decide on what instrument is most suitable (e.g. facilitation approach through international organisations; new project or support of existing initiatives; contribution or mandate)	Regional programmatic team (health and migration/ protection) and Regional IC Management	PKD by end of 2021 EP by beginning of 2022

Recommendation 4.2.2		
Consider ways to link with regional economic communities such as IGAD to support integration of GBV risk mitigation into initiatives, and/or to situate GBV experts in these communities to build capacity as part of SDC's deployment tool. *[Recommended to consider small investment through deployment.]*		
Management response		
Fully agree	Partially agree	**Disagree**
We disagree with this recommendation as we do not think that IGAD is best placed to advance GBV risk mitigation. We might use IGAD for activities related to advocacy as a convener. The Swiss engagement with IGAD will continue to focus on institutional strengthening, migration and food security.		

4.3 Third Tier Priorities, according to the consultants

Recommendation 4.3.1

Spearhead a regional donor group on GBV and/or GBV-specific donor consultation forums within regional donor mechanisms that allows SDC to both advocate for and model funding approaches that are critical to the success of GBV programmes, including longer-term funding; localization approaches supporting development of women's organizations as well as government capacity; the importance of promoting gender equality as part of durable solutions; scaling up pooled funding; investment in monitoring and evaluation; etc. *[Not a new project, link it to advocacy capacity.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree that coordination around SGBV issues among donors would support a better aligned response, help mobilise resources and enable joint advocacy. Therefore, we will consider this as an important element to be taken up by our regional SGBV programme. Thereby, it will need to be assessed on what level (national or regional) support to donor coordination will be more valuable. In any case, we believe we need to build first our own expertise and create evidence with interventions we support in order to be a credible advocate for specific issues and take a leading role among donors. The recommendation will be taken up in a later stage of our regional SGBV engagement (e.g. in a second phase of the programme).		
Measures	Responsibility	Timing
u) Include the building up of donor coordination on SGBV in the regional SGBV programme once we have built our expertise and experience through our programmatic engagement. Foresee this in the EP by suggesting coordination and policy dialogue as an intervention line for the second phase of the programme.	tbd	EP by beginning of 2022

Recommendation 4.3.2		
Develop a regional approach to GBV capacity building in the health sector through scale-up of the one-stop approach in underserved areas, through partnership with IRC, UNFPA, the Red Cross, USAID and others with a history of supporting one-stop interventions. Consider developing regional standards for one-stop centre responses to survivors. [*New project required; could be expensive]*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree on the importance of strengthening capacities and service delivery through OSC, increase the quality of services, need for scale up and link them better to communities. See also responses to recommendation 1.3.1 on increasing the operational ability of OSC in Northern Kenya, recommendation 2.1.1 on building up services in the Somali Region of Ethiopia and recommendation 3.2.2 on scale up service delivery through OSC in Somalia.		
Measures	Responsibility	Timing
v) In NE Kenya and the Somali region of Ethiopia the HoA office will identify local associations working with OSCs and find entry points to work with them.	Regional HoA team	October 2021.

Recommendation 4.3.3

Consult with the global Prevention Collaborative partners to consider potential prevention interventions that can reach remote populations, including through technology. Also consider replicating the Communities Care model in underserved areas in the region, to combine capacity building of service providers and prevention approach. Consider, where possible, strategies for introducing social norms components into existing training curricula for providers (e.g. for police and health care providers). Ensure that any support to prevention includes an evaluative component. *[Recommended to consider new project; Could build on SASA in Kenya and Ethiopia and Communities Care in Somalia.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We agree on the importance of preventing SGBV such as through the recommended approach here and will include prevention aspects in our upcoming SGBV programme. See also recommendation 3.3.1 on social norms in Somalia, recommendation 3.2.1 on root causes and prevention in Somalia.		
Measures	Responsibility	Timing
No measures		

Recommendation 4.3.4		
Support a protection monitoring system at the Moyale border (and other border areas with significant cross-border movement) to identify multiple GBV issues related to border crossing, girls at risk of trafficking for marriage, perpetrators in flight, as well as other GBV concerns that reflect and contribute to GBV. *[Could link with existing protection monitoring.]*		
Management response		
Fully agree	**Partially agree**	Disagree
We can take the advantage of the presence of HEAL partners in Moyale and conduct the exercise of mapping out partners on the ground.		
Measures	Responsibility	Timing
w) Reach out to Health partners working in Moyale and explore the challenge on GBV issues across the Moyale Border.	Addis Programmatic team	August 2021

Acronyms

AoR	Area of Responsibility
BOWCA	Bureau of Women and Children Affairs
CASI	Child and Adolescent Survivors Initiative
CSOs	Civil Society Organizations
EP	Entry Proposal
FCDO	Foreign, Commonwealth & Development Office (of UK)
GBVIMS	Gender-Based Violence Information Management System
GISEDP	Garissa Integrated Social and Economic Development Plan
HEAL	One Health Units for Humans, Environment, Animals and Livelihoods
HoA	Horn of Africa
HQ	Headquarters
IDP	Internally displaced persons
IGAD	Intergovernmental Authority on Development
IRC	International Rescue Committee
KISEDP	Kalobeyei Integrated Socio-Economic Development Programme
MENA	Middle East and North Africa
MHPSS	Mental Health and Psychosocial Support
MR	Management Response
NGO	Non-Governmental Organizations
NPO	National Programme Officer
OWDA	Organization for Welfare and Development in Action
PSS	Psychosocial Support
RAS	Refugee Affairs Secretariat
REGA	Regional Emergency GBV Advisor
RCK	Refugee Consortium of Kenya
RPA	Regional Protection Advisor
S(GBV)	Sexual and Gender-Based Violence
SOB	Sexual Offences Bill
TdH	Terre des hommes
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
UNJPLG	United Nations Joint Programme on Local Governance
WAAPO	Women's Action Advocacy Progress Organisation