MULTI-COUNTRY REAL TIME EVALUATION OF UNICEF GENDER-BASED VIOLENCE IN EMERGENCIES PROGRAMMES

SOMALIA COUNTRY REPORT
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SOMALIA COUNTRY REPORT
July 2016

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This report for Somalia is one of seven country evaluations which form part of the Multi-Country Real Time Evaluation of UNICEF Gender-based Violence in Emergencies Programmes global evaluation. The Somalia country report was prepared by Vine Management Consulting Ltd, an independent company recruited by the Child Protection Section of Programme Division to conduct this evaluation. A five-person internal UNICEF Evaluation Management Group was responsible for the management of this evaluation including inputs to quality assurance.

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For further information, please contact:

United Nations Children’s Fund
Three United Nations Plaza
New York, New York 10017
evalhelp@unicef.org
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The Evaluation Management Group whose responsibilities have included supervising and guiding the evaluation team in each step of the process; reviewing, commenting and approving the evaluation deliverables; approving the final report and supporting dissemination and management response process is comprised of Mendy Marsh, GBViE Specialist, CPS, Krishna Belbase, Senior Evaluation Specialist, Evaluation Office, Jennifer Keane, CP Specialist on Knowledge, Planning and Evidence, and Laili Irani, Senior Adviser, Gender & Evaluation, Gender Section and Sophie Read-Hamilton, GBViE Consultant with the CPS.

1 Unfortunately, the evaluation team was unable to visit Somaliland and meet with local government officials there as initially planned.
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<td>Local Non-Government Organization</td>
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<td>Ministry of Women, Human Rights, and Development</td>
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<td>MRM</td>
<td>Monitoring and Reporting Mechanism on grave violations of children’s rights in situations of armed conflict</td>
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<td>National Action Plan</td>
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<td>UNICEF National Committee</td>
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<td>UNICEF Programme Cooperation Agreement</td>
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<td>PSS</td>
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<td>Somali Women Concern</td>
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<td>SWDC</td>
<td>Somali Women Development Center</td>
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<td>TASS</td>
<td>Tatamum (Solidarity) Social Society</td>
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<td>ToC</td>
<td>Theory of Change</td>
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<td>UK Aid</td>
<td>British Aid Programme (formerly DFID)</td>
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<td>United Nations Assistance Mission in Somalia</td>
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<td>USSC</td>
<td>UNICEF Somalia Support Cell</td>
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<tr>
<td>WASH</td>
<td>Water, Sanitation, and Hygiene</td>
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EXECUTIVE SUMMARY

The Child Protection Section of UNICEF’s Programme Division, New York, is undertaking a multi-country real time evaluation of UNICEF’s Gender-based Violence in Emergencies (GBViE) programming with the overall purpose of strengthening UNICEF’s current and future GBViE programming based on real time learning. The core of the evaluation is seven real time evaluations (RTE) which are being conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic and a brief study of the GBViE programme the Democratic Republic of Congo conducted by telephone.

This report presents the findings, conclusions and recommendations of the mission conducted in Somalia between March 8th and 23rd, 2016.

CONTEXT

The Federal Republic of Somalia is a politically complex nation state in the Horn of Africa that has been considered a “failed” or “fragile” state since the early 1990s. There are three distinct zones, each with its own government, making it a particularly challenging political environment. Somalia is subject to both an ongoing, protracted emergency due to armed conflict, terrorist activity, and weak government control, and recurring geographically-specific small- to medium-scale new emergencies caused by both climate change and conflict. The ongoing protracted emergency in Somalia has caused a long-term IDP situation. Many IDPs within Somalia have been displaced for more than a decade and most want to remain where they are rather than returning home, which is unusual in an IDP situation. Somaliland and Puntland have been relatively more stable than South Central Zone over the last decade— but security remains a major concern and significant impediment to development across the country.

UNICEF has been working in Somalia since 1972, and currently works across six different areas—WASH, Education, Health, Nutrition, Emergency Response and child protection, which includes GBV. GBV is rampant in Somalia, with domestic violence and rape reported in large numbers, a 98% rate of female genital mutilation (FGM), high rates of child marriage and systematic denial of resources for women and girls. The GBViE programme began in 2011 in response to the famine and grew quickly to establish a minimum package of services for survivors of GBV, delivered through local partners. The GBV Specialist who initiated the programme left in June 2015 and the new GBV Specialist began two weeks before the start of this evaluation mission.

CONCLUSIONS

Analysis of the findings from all of the evaluation criteria led to the following conclusions:

Successes

1. **UNICEF’s strong commitment to GBV programming at all levels of the country programme has been central to its success.** Senior management and the Child Protection team at national level and within the zones have expressed the need to prioritize GBV and their commitment to continuing GBV programming as a critical component of Child Protection. However, UNICEF previously advocated (albeit unsuccessfully) that GBV be considered as a Programme Criticality 1 within the humanitarian response and currently accepts the UN designation as a Programme Criticality 2.

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2 Focus Group Discussions (FGDs) with IDPs in Garowe and Mogadishu.

3 Five of these areas—WASH, Education, Health, Nutrition, and Child Protection— are UNICEF sections, while Emergency Response is a cross-cutting area.

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2. The successful establishment of emergency GBV response systems in all three zones is a significant achievement and contribution to the humanitarian response. There was a strong push to implement response services with a focus on medical attention, counselling, referrals and basic safety. Significant progress has been made given that nothing was in place at the start of the last big emergency in 2011; and all partners, staff, and UN agencies now speak confidently about the types of services available, and how survivors can access them. Community members reinforced their understanding of which agencies provide response to GBV and gave specific examples of services they had received.

3. There is strong support for the Communities Care approach and perception that it is working well. Comitato Internazionale per lo Sviluppo dei Popoli (CISP) reported that the Communities Care approach being piloted in Somalia is unique in its structured content and guidance; they are already seeing impact in terms of people’s willingness to engage in discussions on GBV, their outreach to others, and attitudes and behaviours. Though the data from the midline and endline is not yet available, initial summaries from Johns Hopkins University (JHU) indicate positive results. Interestingly, the colleagues in Central South Zone were able to describe the intervention more clearly than the colleagues at national level.

4. Partners understand and are widely using the GBVIMS for incident reporting. Implementing partners have been trained in and are utilizing the Gender-based Violence Information Monitoring System (GBVIMS) regularly. This is creating a large body of data on GBV in Somalia. UNICEF supports the system with a GBVIMS coordinator in Puntland.

5. Advocacy is generally strong at a high-level. There has been significant engagement with the government in drafting the FGM policy and sexual offenses bill. To date, the focus has been on getting the bills drafted, with implementation of the bills falling under the rule of law programme. Partners and staff, however, did not maintain a common understanding of where in process these laws are and what should happen once they are agreed.

6. UNICEF’s positive engagement in partnerships makes them a credible and valued partner and creates opportunities to strengthen GBV work. Implementing partners (IPs), government partners, civil society and other key informants generally reported that UNICEF is a positive partner who adds value to their work and is an important player in addressing GBV in Somalia. This has created opportunities for advancing GBV work, encouraging more government buy-in (e.g. development of the National Action Plan, FGM Bill, Sexual Offenses Bill), strengthening civil society and helping to guide the strategic direction of the GBV subcluster.

Areas for Improvement

7. GBV does not feature clearly in the UNICEF Country Programme Document (CPD). Though GBV is a fundamental part of the Child Protection programme, the language in the CPD is extremely limited and vague in relation to GBV. GBV does not feature clearly as a full UNICEF programme or programme component. This makes it challenging to maintain institutional accountability and commitment to quality GBV programming.

8. The quality of GBV response services is inconsistent across partners and is not systematically monitored. Interviews with implementing partners working outside of main areas raise significant questions about their understanding of fundamental concepts and quality of services, and concerns that some practices are inflicting harm. It is also unclear how UNICEF monitors the quality of services
of those partners who are assumed to be strong in response. UNICEF staff and implementing partners report that case management is working well but there is limited discussion around any areas for improvement and the effectiveness of referral systems. Psychosocial support and follow-up services remain at a basic level and could be expanded.

9. **Response services are most relevant to sexual violence and could be strengthened to address the vast number of reports of intimate partner violence (IPV).** There is a need to continue to adapt techniques and strengthen service provider skills for addressing multiple forms of GBV, particularly IPV. In particular, most partners do not engage in safety planning and mediate cases of IPV, which is not a recommended practice and could cause further harm to survivors. There is a need to explore alternatives to mediation and deepen understanding and skills to respond adequately to IPV.

10. **GBV is not systematically integrated into other UNICEF sectors.** UNICEF staff in other sections consider GBV to be important as well as the integration of GBV into other sectors, but have not made efforts to achieve this. There is little knowledge of the new 2015 IASC GBVIE Guidelines, which were not officially rolled out in Somalia, nor connection between programmes.

11. **There is an overall lack of understanding of prevention.** The overwhelming majority of UNICEF and IP programme staff equate prevention with awareness-raising, with awareness-raising focusing on services provided. There is little, if any, recognition of the concepts of primary, secondary, or tertiary prevention as well as addressing root cause versus contributing factors. Work on both risk mitigation and structural change is limited.

12. **Awareness-raising activities are ad hoc and do not seem to reflect principles of effective communication for development (C4D)/ behaviour change communication.** Awareness-raising is an important part of GBV programming, however, only if it is used strategically as part of clear strategies for response and prevention. Currently, awareness-raising objectives are not understood and are not situated within a well-defined process of change. The methods and content used do not align with best practice in communicating for change. In particular, awareness-raising is currently:
   a. Not grounded in a particular communication for development
   b. Focused on messaging rather than provoking critical thinking.
   c. Focused on negative consequences, rather than positive alternatives/ strengths or asset.
   d. Using communication materials as visuals only, rather than as programme tools for discussion.

13. **Focus on programme content is limited.** UNICEF and partner staff describe programme activities, but the content of such activities, such as training manuals, awareness-raising sessions, communication materials, is not developed and is mostly ad hoc. Programme content is often undeveloped, generic, and/or not linked to a broader strategy; and there is limited recognition that programme content is fundamental to quality programming.

14. **Coverage is limited to a few main areas and caters primarily to adult women; there is a need to explore alternative models for accessing remote populations and increasing access for adolescent girls.** The complexity and insecurity of Somalia make it an extremely difficult environment in which to operate, severely limiting safe access to affected communities. Understandably, programming is

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4 It is discussed below that CISP uses client satisfaction surveys as part of the Communities Care approach, however, it is unclear how UNICEF is involved in this process and the evaluation did not look into depth about how they are being used to inform programming.
concentrated predominantly in government-controlled cities that have significant UN presence. It is considerably more difficult to ensure and monitor quality of programmes outside these areas. At the same time, some partners consider that services can be provided to more remote communities, but that this will require new models of service provision and willingness to move away from standard approaches. Effort is also needed to reach and meet the specific needs of adolescent girls.

15. **Analysis of data to inform programming and connection between systems is lacking.** While there is a great deal of data collected by the programme, it is unclear how that data is analysed and utilized. Implementing partners input into the GBVIMS, but further analysis is not generally shared and discussed with them to inform programmes. Multiple partners noted confusion in rolling out the Child Protection Information Management System (CPIMS) system and the need for a streamlined approach to collecting and managing data between the 2 sub-clusters. The connections between the Monitoring and Reporting Mechanism (MRM) on six grave violations of children’s rights in situations of armed conflict and GBV programmes are not strong, both in terms of responding to cases reported in the MRM and how analysis from the two systems is used complementarily.

16. **Suitability of team structure requires review.** It was uncertain whether the staffing structure in each zone is best suited to accomplish the GBViE objectives. In addition, the staffing structure is not consistent across the three zones, which makes it challenging to maintain a cohesive programme framework and enable comparative results measuring.

**RECOMMENDATIONS**

Based on the findings and conclusions, and building on the GBViE work of UNICEF Somalia to date, the evaluation team offers the following recommendations:

**Recommendation 1: Develop/articulate a clear GBV strategy.** Connect the strategy to the three major outcome areas of the global GBViE Theory of Change (ToC): service delivery/response, risk mitigation, and long-term structural change. While the strategy will need to consider many things, it is recommended to:

a. **Include specific strategies for responding appropriately to different types of GBV, specifically intimate partner violence (IPV).** With support from UNICEF HQ, identify guidance, guidelines, techniques and skills that are specific to responding appropriately to IPV, incorporate into the strategy. Strategize around alternatives to mediation.

b. **Roll out the 2015 IASC GBViE Guidelines within UNICEF and with implementing partners.** When rolling out guidelines, ensure ongoing follow-up support to each sector. Include UNICEF-led clusters in the roll-out. Advocate with HC/RC and UNFPA for country-wide roll out of the 2015 GBV Guidelines. Request support from HQ for roll out process.

c. **Expand use of safe spaces for women and girls.** Review models for safe spaces that UNICEF uses in other countries, consider the feasibility of developing safe spaces with UNICEF partners in Somalia, and expand the services of those that are already functioning.

d. **Develop and include clear approach for primary prevention aimed at structural change.**

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5 Safe spaces are not the same as shelters, which have the capacity for housing survivors and their children in a safe way. Safe spaces are spaces where women and adolescent girls can come to engage in psychosocial support or empowerment activities, receive counseling and services, participate in discussions groups, etc. These spaces are protective, supportive, and ultimately help to empower women and girls.
i. Learn from the results of the Communities Care programme study:
   - If the results indicate success of the Communities Care approach, then roll it out in other zones in Somalia as feasible.
   - If the results do not indicate success, then identify the theory of structural change upon which UNICEF will base its primary prevention programming.

ii. Focus primary prevention programming content on addressing the root cause as opposed to manifestations of GBV.\(^6\)

iii. Strengthen staff and partner understanding of the difference between awareness-raising and prevention.

iv. Define the specific objectives of the awareness-raising component of the programme and adapt/develop content and materials so that it contributes strategically to UNICEF’s overall GBV strategy. Specifically:
   - Develop effective communication materials (C4D) in line with Communities Care and/or principles of effective communication for change (e.g. provoking critical thinking vs. messaging, using an strengths/benefits-based approach rather than focusing on negative consequences, asking questions).

v. Explore different approaches to economic and social empowerment. Consider the conditions necessary for these to become effective prevention strategies vs. general psychosocial support strategies, recognizing the potential unintended negative consequences.

vi. Include FGM within the structural change component of the strategy, linking it to methods for addressing the root cause.
   - Review available qualitative and quantitative data to agree upon UNICEF’s understanding of core drivers and contributing factors of FGM (including the effort started in Puntland)
   - Ensure that current programming is brought under the umbrella of GBV in a way that is safe and ethical.

b. Develop staffing structure that clearly meets the needs of the programme technically and administratively.

c. Consider how UNICEF engages both IDP and host communities.

*Lead Responsibility:* GBV Specialist

*When:* begin collaborative process by July 2016

**Recommendation 2:** Invest in strengthening the quality of basic response services offered, in line with key principles of quality response. To move this process forward, it is recommended that the programme:

a. Review the quality of basic response services offered, in line with key principles of quality response.

Create a list of all of the services currently being offered such as community-based response (volunteers and committees), intake, psychosocial support, medical care, referral, hotlines, safety planning, and follow-up. For each service, identify the standards and indicators of quality response. Conduct review through onsite visits, and structured questions and discussions with implementing partners. Some areas to review more closely include:

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\(^6\) There is a misconception that when we engage elders, leaders, and community members, we have to talk about all of the types of violence. But structural change starts with helping people to reflect upon the root cause—power imbalance—and understanding our own values. Therefore, the content of the programme does not have to start with types of violence, but can focus on exploration of power, values, and identity.
i. **Techniques and methods of GBV focal points and committees:** The methods of this work are not clearly defined and quality is unclear. Develop clear plans and systems for how this community-based work is implemented, supported and monitored. Ensure these plans are understood by focal points, committee members and staff and included in work plans. Identify the key understanding and skills needed for quality response by GBV focal points and committees and include in capacity-building plans.

ii. **Nature of psychosocial support.** Identify additional types of psychosocial support activities for women, adolescent girls and survivors that would be relevant in Somalia, drawing on experiences from other countries and understanding of the context. (e.g. skills-building activities, coffee ceremonies, etc.)

iii. **Level of follow up provided to survivors:** It is unclear how and to what extent follow-up is offered to survivors. Review the level and methods of follow-up provided to survivors and strategize around additional support needed.

iv. **Mediation and response to intimate partner violence (IPV):** The programme is currently engaging in mediation of cases of IPV with families and community leaders, which is not a recommended practice for IPV. This could actually cause further harm to survivors. It is recommended, therefore, to pause this aspect of programming and work on strengthening capacity around specific techniques and considerations for responding appropriately to IPV.

v. **Hotlines:** Review the systems for managing the hotlines, referring cases (including GBV and non-GBV), ratio of GBV to non-GBV calls, documentation, etc. Make decisions together with partners about whether to continue this aspect of programming. (Note: this can be done only in zones where there are hotlines).

**Lead responsibility:** GBV Specialist and Team Leaders (specific aspects of review to be led by GBV Officers who directly oversee implementation of the work).

**When:** As part of GBV strategy process

b. **Develop a plan for systematically monitoring quality of service provision in Somalia, with support from UNICEF HQ.** The process can include:

   i. Reviewing the experience of using the programme quality monitoring tools that were adapted from Communities Care for Somalia. Based on the learning from that experience, adapt further and/or scale up to other partners.

   ii. Reviewing the monitoring tools that will be included in the new GBV Resource Pack, once it is shared with COs.

   iii. Strengthening understanding of informal monitoring techniques with UNICEF staff.

   iv. Deciding upon the specific tools and techniques to be used and establishing clear systems, deadlines, and roles and responsibilities for doing so.

   v. Incorporating specific programme monitoring responsibilities into UNICEF and IP staff workplans,

**Lead responsibility:** GBV Specialist and GBV Team Leaders

**When:** Begin the review in quarter 3. Carry over work into 2017

**Recommendation 3: Strengthen the focus on programme content.** Work with the team to institutionalize the understanding that programme activities cannot exist without content and materials to support them.
The content should be clearly defined, in line with the programme’s theory of change, and as much as possible, delivered through creative means. To accomplish this, the team can:

a. Review programme content e.g. training manuals, awareness-raising materials, community dialogues, communication materials, etc.

b. For each area, discuss whether the content is aligned to the GBV strategy, the theory of behaviour change that the programme follows (see below) and best practices in line with the GBV Resource Pack and 2015 IASC GBViE Guidelines. Ensure that programmes are aligned with these guidelines.

c. Where there is no content currently, develop new content or adapt materials from other approaches.

Lead responsibility: GBV Specialist and GBV Team Leaders in each zone

When: begin review following development of GBV strategy

Recommendation 4: Develop capacity-building plan for both UNICEF staff and implementing partners, based on the GBV strategy. When developing the GBV Strategy, discuss the standards, concepts and capacities needed by partners for quality implementation and UNICEF staff for providing quality technical assistance.

a. Identify the internal capacity-building needs of UNICEF staff as well as the capacity-building needs of IPs to strengthen response and prevention e.g. IPV response, framing discussions around values and power, C4D principles, primary prevention, providing quality technical assistance, programme monitoring.

b. Develop plan for capacity-strengthening that includes both UNICEF staff and IPs.

c. Review the types of technical assistance that UNICEF can provide to IPs beyond training e.g. onsite support, content review, asking strategic questions, check-ins. Discuss how the team can utilize these methods more strategically to understand and strengthen the quality of programming.

d. Incorporate technical assistance activities into the workplans of UNICEF GBV staff.

Lead responsibility: GBV Specialist and GBV Team Leaders in each zone

When: upon completion of GBV Strategy

Recommendation 5: Explore alternative options for expanding coverage, e.g. one-stop centres with mobile services, programmes for adolescent girls. Review learning from UNICEF Lebanon on mobile centres, as well as other sectors in other countries and consider other alternatives for increasing access within the restrictive security environment. Similarly, review engagement with adolescent girls in other context and develop targeted programming to ensure they don’t fall through the cracks.

Lead responsibility: GBV Team Leaders, Officers and partners in each zone, with support from GBV Specialist

When: In line with GBV strategy development

Recommendation 6: Develop clear system and timeline for regularly using and analysing GBVIMS and other data to improve programmes. In each zone it should be clear: who receives the consolidated data from UNFPA, whether this data is received on a monthly, quarterly, bi-annual and/or annual basis, what the role of the person receiving the data is, when and how that data will be shared with partners (set time monthly, quarterly, semi-annually and/or annually), and how the data will be reviewed together to inform programming.

Lead responsibility: GBV Team Leaders

When: immediately

a. Advocate with UNFPA to share consolidated data more openly, while maintaining ethical standards

Lead responsibility: GBV Team Leader in each zone (support from GBV Specialist at national level)

When: immediately
b. Review connections between GBVIMS and MRM, CPIMS, and MARA. Establish clear referral pathways for GBV cases and ways to exchange relevant information and learning.

*Lead responsibility:* GBV Specialist, MRM Specialist, CP Cluster lead

*When:* to be agreed

**Recommendation 7:** Advocate to include GBV more directly and substantially in the next CPD.

*Lead responsibility:* Chief, CP and GBV Specialist

*When:* prior to and during development of the upcoming CPD
1 INTRODUCTION

1.1 UNICEF’s Approach to GBViE

UNICEF defines Gender-based Violence (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. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.⁷ This definition draws on UNICEF’s core mission to protect the health and well-being of children and women and its mandate to support states and other duty bearers, civil society and communities to prevent all forms of violence against children and women in emergencies, including GBV, and to ensure availability of appropriate systems and services for survivors.

UNICEF is committed to providing comprehensive and coordinated programming across sectors to address the rights and needs of girls and women at risk of GBV holistically, leveraging UNICEF’s leadership and programming across humanitarian response, especially in Child Protection (CP), Education, Health, HIV/AIDS, Nutrition and WASH sectors. In addition to a programme response, UNICEF is global co-lead of the GBV Area of Responsibility (AoR), part of the Global Protection Cluster, with associated responsibilities for coordination and as a provider of last resort.

The Theory of Change (ToC) for UNICEF GBViE programming (see below) has been developed by the evaluation team and the Child Protection Section (CPS) Gender-based Violence in Emergencies (GBViE) Specialist based on the Resource Pack and other UNICEF GBViE guidance and strategies. The ToC was used to inform the evaluation approach and tools and is discussed during country evaluations with CO colleagues. As relevant the ToC will be updated to reflect evaluation findings.

1.2 Impact of Armed Conflict and Natural Disasters on GBV

GBV occurs in all societies in the world. However, conflict situations and disasters typically intensify many forms of GBV with which children and women live, even in times of peace and stability. Tensions at household level can increase intimate partner violence (IPV) and other forms of domestic violence (DV) specifically aimed at females, and affecting all children. The pervasive impunity which characterizes conflict settings can exacerbate sexual violence, including its use as a weapon of war. Poverty, displacement and increased dependency resulting from crises may increase the risk for women and girls of being forced or coerced to engage in sex in return for safe passage, food, shelter or other resources.⁸ Insufficient security in camps and informal settlements increases the risk of sexual and physical assault, as well as trafficking.

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⁷ UNICEF programmes to address GBVIE generally focus on the rights and needs of women and girls given their high vulnerability to violence rooted in systemic gender-based inequality in all societies. While prioritizing the protection of women and girls within UNICEF’s GBVIE programmes, UNICEF’s CP programmes may target specific protection-related rights and needs of boy survivors and those at risk, promoting their access to care and support.

The consequences of exposure to violence are as extensive as the scope of violence itself, in terms of the myriad acute and chronic health problems that accompany many types of GBV, and because victimization can increase risk of future ill-health for survivors. In humanitarian settings, where community support systems as well as formal health and psychosocial services are often severely compromised, the consequences of violence can be even more profound than in peacetime.

The extent and impact of GBV not only affects survivors, it also limits the ability of entire communities to heal from conflict. Violence may affect child survival and development, raising infant mortality rates, lowering birth weights and affecting school participation. GBV can limit women’s access to reproductive health services including family planning, leading to unwanted pregnancies and unsafe abortions, and increasing women’s risk of HIV infection.

While the primary responsibility to ensure people are protected from violence rests with the State, humanitarian actors play an important role in supporting measures to prevent and respond to GBV. According to the *IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action, 2015* (‘2015 IASC GBV Guidelines’), “All humanitarian actors must be aware of the risk of GBV and—acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their areas of operation” (p 14). This responsibility is supported by a framework that encompasses international and national law, UN Security Council Resolutions, Humanitarian Principles and Humanitarian Standards and Guidelines.

### 1.3 Background to the GBViE Evaluation

In the past decade, UNICEF has been at the forefront of efforts to prevent and respond to GBV in emergencies, both globally and at country level. UNICEF HQ is committed to supporting Regional and Country Offices (ROs/COs) to continue to deliver on UNICEF’s mandate to protect children and women from GBV, and to ensure the wellbeing of all children, through consistent and effective GBV prevention and response in emergencies. The Child Protection in Emergencies Team (CPiE), is currently developing a range of resources for COs to use for designing, monitoring and evaluating stand-alone GBV programmes and improved integration of GBV prevention and response across all sectors of UNICEF’s humanitarian response, in line with the Core Commitment’s for Children (CCCs) and other humanitarian standards. This includes the development of the new UNICEF GBViE Programme Resource Pack (‘Resource Pack’).

To facilitate continuous learning and improvement within UNICEF’s ongoing GBV response in emergency-affected countries and to inform the development of the Resource Pack, the CPiE Team of the CPS, in collaboration with ROs and COs, is undertaking this multi-country evaluation of UNICEF’s GBViE programming.

The evaluation is being conducted from November 2015 to end July 2016.

### 2 EVALUATION SCOPE AND METHODOLOGY

#### 2.1 Purpose and Objectives

The overall purpose of the multi-country GBViE evaluation is to strengthen UNICEF’s current and future GBViE programming based on real time learning.

The objectives are to:
1. Assess GBViE programming in UNICEF country programmes using standard criteria for evaluating humanitarian action to generate learning that informs future UNICEF GBViE programming.


3. Develop a real-time GBViE programming evaluation methodology that can be used by UNICEF and other GBViE actors.

4. Develop recommendations to help UNICEF operationalise its organizational commitments to GBViE at HQ, regional and country levels.

This evaluation assesses UNICEF’s programming response to GBV in seven current emergencies against standard criteria for evaluating humanitarian action, namely: relevance, effectiveness, connectedness/sustainability, coordination, coverage and efficiency. Evaluation questions to be addressed under each of these criteria are included in Annex 1.

For this RTE, guidance on good programming practice from two documents is being used as the benchmarks on which UNICEF GBViE programmes should be modelled. This guidance represents current thinking on best practice for GBViE programming for specialised and integrated programming respectively.9

(i) The GBViE Programme Resource Pack (the ‘Resource Pack’) currently being developed by the Child Protection Section of Programme Division, UNICEF, (CPS) provides detailed guidance for conducting assessments and designing and implementing specialised GBV programmes relevant to UNICEF’s operations. The Resource Pack includes information and resources for implementing a minimum package of essential services for GBV protection and response in the aftermath of an emergency or population displacement. It also contains guidance for expanded programming to strengthen structures, systems and services and institutionalize prevention, protection and response to GBV during ongoing response and throughout recovery.


2.2 Evaluation Focus and Scope

The evaluation will include data gathering at global, regional and country levels.

The core of the evaluation is seven real time evaluations (RTEs) which are being conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic, with missions lasting one to

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9 To clarify programming terms being used in the evaluation as well as the nature of GBViE programmes to be evaluated: 'GBV specific programmes' are understood to be:
Multi-sectoral response and referral services for survivors focusing on health care; security (including safe spaces) and psychosocial support (including within schools);
Dignity kits (distributed by Child Protection (CP) and Water, Sanitation and Hygiene (WASH) teams or just CP teams),
economic strengthening for adolescent girls, community based protection activities;
Prevention programming including work on social norms, economic and social empowerment of women and girls, legal and policy reforms.
'Integrated' programming refers to the mainstreaming of GBV prevention and risk mitigation approaches/activities across other sectors.
two working weeks each, and one brief country assessment conducted remotely for the Democratic Republic of Congo.\(^\text{10}\)

The primary focus of the evaluation is on learning:

- To promote learning in each of the RTE COs on how existing programmes can be enhanced in the light of good and emergent practice as captured in the 2015 IASC GBViE Guidelines and in the Resource Pack; and,
- To promote learning at HQ and ROs through evaluation findings, short case studies of good practice and more detailed comparative reviews of three GBViE specific interventions across three to four of the mission countries which will inform the development of the GBViE Resource Pack.

To provide an overall picture of UNICEF’s GBViE programming, a mapping exercise will be conducted by electronic survey of 39 UNICEF COs which are reporting against corporate targeted priorities within the Gender Action Plan (GAP).

**Implementing Partners**

Any evaluation of UNICEF programming means, *de facto*, an evaluation of the programming of their implementing partners (IPs). The country missions will clarify UNICEF’s role *vis à vis* their IPs and how these roles may differ in different contexts and in different types of emergencies. This will include clarification of the nature of support UNICEF staff are offering their partners, (national and international); and how UNICEF staff are overseeing partnerships and ensuring programme quality.

**GBV Sub-clusters**

The evaluation will not include an assessment of the global GBV Area of Responsibility (AoR), or of country level GBV sub-clusters (or other GBV coordination mechanisms) *per se*, as it is focused on the GBV programming function of UNICEF.\(^\text{11}\) It will, however, consider the extent/nature of UNICEF’s programming contribution in realizing sub-cluster strategy/plans for addressing identified gaps/priorities, and will address how the agency has added value to the whole GBV response (including leadership and advocacy activities) within the CO and across the response as a whole.

**GBV and Sexual Exploitation and Abuse (SEA)**

The evaluation ToR doesn’t specifically include SEA within the scope of this evaluation. However, in the light of the recent report on the UN response to allegations of SEA in CAR,\(^\text{12}\) several donor interviewees have indicated that UNICEF, as co-lead for GBViE, needs to have clear policies and guidelines in place to implement the UN Secretary-General’s October 2003 bulletin: *Special Measures for Protection from Sexual Exploitation and Sexual Abuse*.\(^\text{13}\) The evaluation scope will therefore include questions on the existence of protection from SEA (PSEA) policies and action plans, and familiarity with them by CO staff, and whether

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\(^\text{10}\) The length of each mission is dependent on the extent of the GBV programme and access to programme areas. The mission in Somalia was longer than the others, being 15 working days because of the complexity of travelling to different areas of the country and spending time in the CO in Nairobi.

\(^\text{11}\) An evaluation of the coordination function was not included in the ToR. Additionally, the UNICEF, via the Cluster Management Unit of UNICEF EMOPS and UNFPA HQ are undertaking a Review of the GBV AoR leadership function.


\(^\text{13}\) ST/SGB/2003/13, 9 October 2003
alleged victims of SEA are referred to the services provided for survivors of GBV.\textsuperscript{14, 15}

**Audience**

The primary audience for the evaluation findings and collated good practice is the CPS (who commissioned the evaluation and will use the findings to inform future priorities as well as the GBViE Resource Pack). Findings will also be used by GBV Specialists, CP specialists and Gender Advisors in Regional and Country Offices (CO) who are implementing, managing and providing support to GBV programmes. The secondary audience includes other sectors and UNICEF senior management at headquarters (HQ), Regional Offices (RO) and COs.

Given the paucity of evaluations on GBViE programming, it is hoped that the final evaluation report will also be of interest and use to other actors implementing and/or resourcing GBViE programmes.

**2.3 Methodology**

The evaluation is based on collection and analysis of primary\textsuperscript{16} and secondary data. Data collection will be through document review (at global level and for each mission country); key informant interviews (KIIs) with stakeholders at global, regional and country levels; focus group discussions (FGDs) with programme beneficiaries in country; and field observation by the evaluation team. CO staff are also being asked to self assess their programming against good practice checklists based on the 2015 IASC GBV Guidelines and the Resource Pack. Data from all sources will be triangulated. Two national consultants are being recruited to support the evaluations in each mission country to ensure that approaches and tools used are culturally sensitive and appropriate, and to support the team with language translation.

The evaluation team are visiting a selection of projects in each mission country to make field observations, interview implementing partner staff (IPs) and conduct FGDs with different groups of beneficiaries. Criteria have been developed for the selection of projects to be visited,\textsuperscript{17} but, in practice, final decisions have been taken by the CO evaluation focal point and CP Chief in advance of the evaluation team mission in light of accessibility, willingness of IPs to host visits and arrange FGDs, those projects with the most learning potential, and safety of beneficiaries, in-country staff and partners and the evaluation team.

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\textsuperscript{14} Creating a broad protective environment that reduces GBV will also reduce the risk of SEA. UNICEF and all other protection actors are obliged to mainstream prevention of GBV within all programmes. Along with mainstreaming GBV prevention, UNICEF also delivers targeted programming where possible to address identified risk factors for GBV. All of these efforts will contribute to protection against SEA. The IASC GBV Guidelines includes details of preventative and risk mitigation activities for different sectors to take that can contribute to PSEA.

\textsuperscript{15} Good Practice for SEA: SEA committed by UN/UNICEF staff or related personnel against any persons of concern is based on abuse of power and—in the case of women and girls, who are the primary victims of SEA—gender inequality and gender discrimination. The SG’s Bulletin requires that all humanitarian personnel ensure action is taken to prevent SEA in their areas of operation, and report it when they observe any risks or abusive behaviour. PSEA should link with GBV programming to ensure survivors’ rights are respected and to improve victim assistance and the development of community-based complaints mechanisms. SEA agency focal points should link with GBV actors to develop referral systems that support survivor-centered care. While CP and GBV staff in UNICEF country programmes should know and promote the key principles and standards of conduct outlined in the Secretary-General’s Bulletin, the accountability for PSEA lies with senior management (Country Representatives) and human resources (Heads of Human Resource Departments). The *IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action, 2015* ("IASC GBV Guidelines, 2015") fully support the mandate of the SG’s Bulletin and provide several recommendations within each sector guidance chapter on programming that mitigates SEA, including incorporating PSEA strategies into agency policies and community outreach.

\textsuperscript{16} Including both self-reported data by mission CO staff and data gathered by the evaluation team.

\textsuperscript{17} Level of investment, geographic and ethnic diversity, IP willingness to engage, innovative programming, women and children target beneficiaries, proximity/ accessibility, range of sectoral engagement.
Tools have been developed by the evaluation team to guide country mission preparation and collect and analyse data. These tools were tested during the first two missions and refined in light of that experience and comments by the Evaluation Management and Reference Groups. The final versions of the evaluation tools will be included in the Resource Pack to support future GBViE evaluations.

In line with RTE methodology, a workshop is held at the end of each country mission to share and validate the initial findings, and reflect, with CO colleagues how these findings can be used to enhance GVBiE programming in that setting.

The country mission reports capture findings, conclusions and recommendations for each mission, validated and refined by discussions in the workshops in country. The findings section of the country mission reports addresses the evaluation questions relating to each of the evaluation criteria (see Annex 1). The seven country mission reports will inform the final, overall evaluation report.

2.4 Evaluation Management
The evaluation has been commissioned by the UNICEF Programme Division, who also selected the case study countries and has closely overseen the process throughout.

A five-person UNICEF EMG was formed with responsibility for ‘daily management of the evaluation’ including supervision of the evaluation team, review of all products (Inception Report, tools, workplan, country and final reports, coordinate with the Evaluation Reference Group (ERG) and disseminate the final evaluation findings).

The Evaluation Reference Group ERG is composed of internal and external experts who provide quality oversight to the evaluation. The ERG includes the following individuals: Mary Ellsberg, Director, Global Women’s Institute at George Washington University; Mazeda Hossain, Social Epidemiologist, London School of Hygiene and Tropical Medicine (LSHTM); Jina Krause-Vilman, Senior Area Practice Lead, Refugees, Gender and Livelihoods, Near East Foundation; Maha Muna, Regional Gender Advisor, UNICEF CEE-CIS; Michael Copland, Regional Child Protection Advisor, UNICEF ESARO; Laurent Chapuis, Regional Child Protection Advisor, UNICEF MENARO; and Kate Alley, Emergency Specialist: Assessment, Planning, Monitoring and Evaluation, Humanitarian Policy Section, UNICEF EMOPS. Responsibilities include reviewing and commenting on the Inception Report, two early country reports and the draft final report, and sharing the final report with partners and networks. ERG responsibilities include reviewing and commenting on the Inception Report, two early country reports and the draft final report, and sharing the final report with partners and networks.

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18 EMG Terms of Reference
3 SOMALIA MISSION OVERVIEW

3.1 Mission Overview
The country mission to Somalia was conducted between the 8th and 23rd March as part of the UNICEF Gender-based Violence in Emergencies (GBViE) Multi-Country Real Time Evaluation (RTE). Two consultants from the evaluation team travelled to Nairobi and Somalia: Garowe (Puntland) and Mogadishu (Central South Zone) to collect data through a series of key informant interviews (KIIs) and focus group discussions (FGDs). In Somalia, two national consultants (1 male and 1 female) were hired in each zone to support the evaluation team with translation, contextual understanding and communication. On the final day of the mission, a debriefing workshop was conducted in Nairobi, first with the CP team (attended in-person by Nairobi-based staff and via teleconferencing for staff from the three zones), followed by a presentation to a broader audience including the CP team, five additional UNICEF staff (including the Deputy Representative, the Chief of Emergency Operations, the Chief of Section for Health), two Nairobi-based partner staff, and a representative from UNFPA.

3.1.1 Data Collection
The evaluation team compiled a country document review before the mission, to provide them with background on the Somalia and Country Office (CO) contexts as well as the emergency response and the current GBViE programme. Throughout the mission, additional documentation was requested from the CO, which has also informed the report.19 Self-assessment checklists were sent out to all UNICEF sections at the start of the mission, for programmes to rate themselves on GBV integration and programming against good practice as outlined in the GBV Guidelines. Results were received from only two sections—Education and Nutrition—and the GBV programme, and were used mainly to back up findings from qualitative interviews.

During the mission, a total of 43 KIIs were conducted with 56 individuals—42% female, 48% male—with UNICEF staff in Nairobi, Garowe, and Mogadishu, and with partners in government, UN agencies, INGOs, LNGOs/IPs.20 10 FGDs were conducted with 100 individuals—62% female, 38% male—representing displaced populations and host communities in Garowe and Mogadishu. FGDs with IDPs were conducted separately with adult women, adult men, adolescent girls and adolescent boys, whilst host community and GBV Focal Point FGDs were organised with men and women together. Given security restrictions, FGDs could only be conducted within the offices of UNICEF partners for a fixed amount of time. Key informants and FGD participants, both male and female, were generally positive about participating in the evaluation and willing to share their perspectives and experiences.

Interviews and Focus Groups were documented and collated

Table 1: Breakdown of Interviewees/FGD participants by gender

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF staff</td>
<td>8</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>FGD – older male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FGD – older female</td>
<td>62</td>
<td>38</td>
<td>100</td>
</tr>
<tr>
<td>FGD – youth male (15-24)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FGD – youth female, married</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FGD – youth female, unmarried</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>UN Agencies</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

19 See Annex 4 for bibliography
20 See Annex 2 for list of interviewees
3.1.2 Limitations
Limitations of this mission included: (1) It was not possible to visit Hargeisa and see the Somaliland programme, due to flight changes beyond the control of the evaluators; (2) No donors were available for interview\(^21\); (3) Security issues severely restrict movement and limit engagement to within the main cities, and even then, to an extremely limited degree; (4) Complexity of visiting three separate autonomous zones, each with different governments and contexts, as well as Nairobi central base in a limited time.

3.2 Country Overview
3.2.1 Country Context
The Federal Republic of Somalia is a politically complex nation state in the Horn of Africa. It is bordered by Ethiopia, Djibouti and Kenya and has a population of approximately 11.1 million.\(^22\) Somalia has been considered a “failed state” since the early 1990s. The “failed states index” (re-framed as the “fragile states index” in 2013), ranked Somalia as #1 until 2014, and #2, behind South Sudan, in 2014 and 2015.\(^23\) Somalia has no ranking on the Human Development Index or any of the other related indices.\(^24\) Somalia is within the top five countries in the world with the highest proportion of their population living in severe poverty.\(^25\) 3.2 million people continue to be in need of humanitarian and livelihood support; 855,000 of whom are in crisis and emergency.\(^26\)

The Transitional National Government was founded in 2000, followed by the formation of the Transitional Federal Government in 2006. During this time, two autonomous and semi-autonomous regions emerged in northern Somalia — the internationally unrecognized autonomous state of Somaliland and the semi-autonomous state of Puntland. The region to the south, commonly referred to as South Central Zone, is the seat of the internationally recognized Federal Government of Somalia, established in 2012, where it has varying degrees of control.\(^27\) The three distinct zones and political structures add particular complexity to the Somalia context, confounded by ongoing emergencies.

Somalia is subject to an ongoing, protracted emergency due to armed conflict, terrorist activity, and weak government control, and recurring geographically-specific small- to medium-scale new emergencies caused by both climate and conflict. The ongoing protracted emergency in Somalia has caused a long-term internally displaced people (IDP) situation. Many IDPs within Somalia have been displaced for more than a decade and most want to remain where they are rather than returning home, which is unusual in an IDP situation.\(^28\) Somaliland and Puntland have been relatively more stable than South Central Zone over

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\(^{21}\) The request to interview donors was put in at the last minute by the CP focal point for the evaluation. As GBV funding is internally allocated, there is not a clear relationship between specific donors and the GBViE program, and the request was made to the PM&E unit, rather than directly to donors. It was, therefore, difficult to get specific donors during the allocated time frame.

\(^{22}\) Population Reference Bureau, World Population Data Sheet, 2015.


\(^{24}\) Related indices include the inequality-adjusted index, gender inequality-adjusted index, and others.


\(^{26}\) UNICEF Somalia Annual Report 2015

\(^{27}\) Somalia GBV Working Group Strategy 2014-2016

\(^{28}\) Focus Group Discussions with IDPs in Garowe and Mogadishu.
the last decade – Somaliland more so than Puntland— but security remains a major concern and significant impediment across the country.

Somalia – across all three zones – has a particularly weak policy environment. Somalia ratified the Convention on the Rights of the Child (CRC) in October 2015 and this has been seen as giving “a lift” to work to address GBV and female genital mutilation (FGM) from a policy and advocacy perspective. Most female parliamentarians in Somalia have returned from the diaspora, which weakens their credibility within government and the strength of their position for passing GBV-related policies. Progress of the women’s movement is based on personalities, rather than embedded within systems.

3.2.2 GBV Context

GBV in emergencies

Within Somalia there are high levels of all forms of GBV. Rape and domestic violence (generally referenced as ‘physical assault’) were noted as the most commonly reported. UNICEF’s 2015 State of the World’s Children report indicated that there is 76% support for/justification of wife-beating amongst females in Somalia. There is also anecdotal and data evidence (through MRM) of high levels of Sexual Exploitation and Abuse (SEA) by “people in uniform” and low levels of accountability. Feedback given by UNICEF staff, UN and NGO partners, and UN Assistance Mission in Somalia (UNSOM) indicate that SEA is a big problem that goes largely unreported due to a lack of accountability and fear of survivors.

Table 2

<table>
<thead>
<tr>
<th>Types of GBV</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The majority of GBV cases reported between January and December 2015 were physical assault (49%). The second and third most commonly reported type of GBV reported were rape, which accounts for 19 percent (19%), and sexual assault, which accounts for 15 percent (15%) of the total GBV cases (see graph 1 below).</td>
<td></td>
</tr>
</tbody>
</table>

Graph 1: Reported Types of GBV (Jan - Dec 2015)

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29 KII, UNICEF CP Team
30 KII's, UNICEF and government partners.
32 According to the GBV WG Strategy 2014-2016, a baseline of data collected in 2013 from Banadir, Middle and Lower Shabelle, and Bari regions, indicated that the majority of cases reported were rape (41%), physical assault (DV) (39%), followed respectively by sexual assault, denial of resources, psychological abuse, and forced marriage. It is possible that a concerted effort on integrating DV into survivor response programming has contributed to higher reporting on domestic violence from the 2013 data used in the GBV WG Strategy of 39% to the 2015 consolidated GBVIMS statistic of 49%.
When the current UNICEF GBV programme began in 2011 in response to the famine in the Horn of Africa, UNICEF highlighted three main threats of GBV which had increased as a result of the emergency: 1) Unsafe checkpoints, official and unofficial, where girls and women were used as ‘payment’ for passing; 2) Al-Shabaab using forced marriage to terrorise and punish communities; and 3) Rape during firewood collection. During the evaluation, FGD participants from amongst communities in Garowe and Mogadishu reported that rape when collecting firewood remains a problem. Some FGD participants in Mogadishu also said that early and forced marriage continues to be used to terrorise communities, a sentiment that was echoed in key informant interviews.

The problem of GBV in Somalia is exacerbated by a culture of silence and stigma around GBV coupled with lack of accountability. While GBV continues to be widespread, it has been acknowledged that there have been positive shifts in public recognition that GBV exists within Somalia and the willingness to discuss it over the last decade.

**GBV in historical context**

Somalia has a history of harmful practices, specifically FGM and early marriage. Somalia has one of the highest rates of FGM in the world at 98%, with a 65% overall attitudinal support for the practice. Limited data exists that disaggregates between different types of FGM: namely Pharaonic (type III, infibulation – the most extreme type of FGM) and “Sunna” which is a catch-all term for all less extreme forms of FGM). Evidence suggests that even when there have been some changes in attitudes towards Pharaonic FGM, Sunna is still widely supported. For example, when the UNICEF-supported FGM policy, calling for the total abandonment of FGM, was submitted to parliament for approval, the reviewing government body changed the language to allow for Sunna, forbidding Pharaonic only. FGM rates have not changed due to either the protracted emergency or the numerous small-scale, localised emergencies that frequently occur throughout Somalia.

Early marriage for girls in Somalia is estimated at 45% for marriage under 18 and 8% for marriage under 15. While the provisional constitution of Somalia defines a child as under 18 (Article 29), it makes no referential link between this and marriage, and the understanding of the legal age of marriage varies widely, including amongst humanitarian actors.

**Legal framework**

The legal environment for protection from GBV in Somalia is weak. While the provisional constitution of the Federal Republic of Somalia, Article 15 [2] and [4], prohibits all forms of violence against women and FGM, these protections are neither reflected in practice nor within a comprehensive penal code. Rape, for example, is not considered a crime against an individual, but a lesser category of “crime against morality.” There are no clear guidelines for prosecution of rape or other GBV cases. Survivors who come

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34 KII, UNICEF.
35 FGDs and KII with partners.
38 Several key informants, including staff from UNICEF, UN agencies and NGO partners, reported the legal age of marriage as 14 or 15.
39 Article 15 [2]: “Every person has the right to personal security, and this includes: the prohibition of illegal detention, all forms of violence, including any form of violence against women, torture, or inhumane treatment.” Article 15 [4]: “Female circumcision is a cruel and degrading customary practice, and is tantamount to torture. The circumcision of girls is prohibited.”
40 The penal code in Somalia is an antiquated colonial-era system, dating back to the 1930s.
forward are often blamed for the attacks against them, and may themselves be charged with crimes such as prostitution should they report. In addition, each zone operates semi-autonomously in regards to passing laws, which means that the different zones are at different stages of legal reform, and advocacy is required at multiple levels.

Efforts to strengthen the legal environment around GBV, supported by UNICEF, have focused for the last two years on developing two laws: the FGM Bill and the Sexual Offences Bill. Both have been drafted and submitted to the parliament of the Federal Republic of Somalia for review, but are at various stages of approval. Puntland has outlawed all forms of FGM. At federal level (Central South Zone), the FGM bill was submitted to Parliament, calling for total abandonment of all forms of FGM, however, it was approved with only the abandonment of Pharaonic – type III – FGM (still allowing types I and II). The Ministry of Women, Human Rights, and Development (MoWHRD) and FGM advocacy groups, therefore, plan to resubmit the bill and continue lobbying efforts to outlaw all forms of FGM.

The Sexual Offences Bill would be the first comprehensive law on sexual violence in Somalia. It has not yet been approved in any zone. On May 17th of this year, the Sexual Offences Bill was endorsed by a group of high-level Somali officials, U.N. and African Union diplomats, and representatives from donor countries. However, if Parliament does not vote on the bill before August, when its mandate is set to expire, it will have to be reintroduced by the next cabinet.

Prior to the drafting of the two bills, the Federal Government of Somalia, working through the Ministry of Women, Human Rights, and Development (MoWHRD), adopted a National Action Plan (NAP) for Ending Sexual Violence in 2014. The NAP was developed with support from UNICEF, UNFPA, and UNSOM and involved a large number of stakeholders line Ministries including the Ministry of Health, Ministry of Defence, Ministry of Education. Donors and other stakeholders made commitments to support the implementation of the NAP at a London summit in 2014. One of the results was the drafting of the Sexual Offences Bill. However, it is unclear what other actions have since been taken in relation to the NAP and how this relates to current government efforts and legal reform. It is worth noting that Somalia is not a party to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), however, the MoWHRD has established a CEDAW advocacy team to champion its ratification, following the recent ratification of the Convention of the Rights of the Child (CRC).

Understanding structural and emergency-related GBV
The GBV Working Group (WG) Strategy 2014-2016 highlights that, whilst “conflict is at the core of GBV, deep-rooted cultural beliefs create persistent inequalities between men and women and place women at particular risk of being victimized.” Some humanitarian actors, believe that to date there has not been enough analysis of the different drivers of GBV—relating to either the protracted humanitarian crisis or the underlying socio-economic and cultural practice reasons— and that this stifles the ability to design and implement appropriate interventions in Somalia.

3.2.3 Humanitarian Response (General and GBV-specific)

41 Legal Action Worldwide: http://legalactionworldwide.org/sexual-offences-bill/
42 The Sexual Offences Bill took 17 months to draft, and was submitted to Parliament for review in December 2015.
43 Sperber, A. Somalia’s Uphill Battle to Criminalize Sexual Violence; Foreign Policy, 2016.
44 KII, government (Mogadishu).
45 KII, UN (Mogadishu).
The humanitarian context in Somalia is shaped by the presence of both the UN Assistance Mission in Somalia (UNSOM) and the African Union Mission in Somalia (AMISOM). UNSOM is an integrated mission, headed by a special representative to the Secretary General. All UN agencies, both political and humanitarian, are expected to coordinate activities within this framework. AMISOM has a peacekeeping mandate, and maintains a bilateral relationship with UNSOM. Both represent a significant external presence in Somalia and are the direct target of attacks by Al Shabaab. UNSOM was originally intended to move all UN operations to within Somalia. However, given the ongoing volatility of the security situation within Somalia, the UN and other humanitarian agencies continue to base operations and large numbers of staff in Nairobi. The UNICEF Somalia Support Cell (USSC) is located in Nairobi and is the base for the majority of international staff including the GBV Specialist and the Child Protection team. Within Somalia, movement is extremely limited by security concerns, which severely restricts staff access to programs and communities. UNICEF, like other agencies, relies substantially on the knowledge and experience of local organizations and on third-party monitoring.

Somalia is a clusterised country, with 11 different sectors represented in the cluster/sub-cluster coordination mechanism. Coordination mechanisms are led by the Humanitarian Coordinator (HC), and include a Humanitarian Country Team (HCT), an Inter-Cluster Coordination Group (ICCG), the Clusters and zonal/regional coordination structures. The GBV sub-cluster is co-led for the national level from Nairobi, by UNFPA and the local non-government organisation (LNGO) Somali Women Concern (SWC). GBV Working Groups are then convened at sub-national level in each zone, and co-led by a UN Agency (UNFPA, UNICEF, or UNHCR) and either an LNGO or the relevant line ministry. The GBV sub-cluster has at least four thematic Task Forces—FGM, GBVIMS, Case Management, and Clinical Management of Rape (CMR)—each led by a different agency. Table 2 outlines the coordination structures for the GBV sub-cluster, and points to the complexity of multiple zones and agencies. In 2014, the GBV sub-cluster developed a three-year strategy to guide the work of the sub-cluster, which was previously reported as being “disjointed.”

Table 3: GBV sub-cluster Coordination Structure

<table>
<thead>
<tr>
<th>Subcluster/Taskforce</th>
<th>Zone</th>
<th>City</th>
<th>Co-Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBV sub-cluster</td>
<td>National-level</td>
<td>Nairobi</td>
<td>UNFPA, SSWC</td>
</tr>
<tr>
<td>GBV Working Groups</td>
<td>Central South</td>
<td>Mogadishu</td>
<td>UNFPA, SSWC</td>
</tr>
<tr>
<td></td>
<td>Puntland</td>
<td>Bosaso</td>
<td>UNICEF/GRT, MoWDaFA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Galkayo</td>
<td>UNHCR, MoWDaFA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Garowe</td>
<td>UNFPA, MoWDaFA</td>
</tr>
<tr>
<td></td>
<td>Somaliland</td>
<td>Hargeisa</td>
<td>UNFPA, MoLSA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taskforces</th>
<th>Zone</th>
<th>City</th>
<th>Co-Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>Puntland</td>
<td>Bosaso and Garowe</td>
<td>TASS</td>
</tr>
<tr>
<td>Clinical Management of Rape (CMR)</td>
<td>National-level</td>
<td>Nairobi</td>
<td>IRC</td>
</tr>
<tr>
<td>FGM</td>
<td>National-level</td>
<td>Nairobi</td>
<td>UNICEF, UNFPA</td>
</tr>
<tr>
<td></td>
<td>Central South/Federal</td>
<td>Mogadishu</td>
<td>MoWHRD, MoH</td>
</tr>
<tr>
<td>GBVIMS</td>
<td>Central South</td>
<td>Mogadishu</td>
<td>UNHCR</td>
</tr>
<tr>
<td></td>
<td>Puntland</td>
<td>Garowe</td>
<td>UNICEF</td>
</tr>
</tbody>
</table>

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KII, UN (Nairobi)
Somalia receives hundreds of millions of dollars in aid every year, with particularly high levels coming in 2013, when donors pledged €1.8 billion in aid on the heels of the New Deal Compact. Levels of funding, however, are starting to reduce as donors begin to push for a shift from emergency to development programming. While some humanitarian actors are calling for a similar shift, many believe that the ongoing conflict and recurrence of new crises requires continued emergency support. In addition, the complexity of the political structures within the three different zones in Somalia mean that programming interventions must be distinctly tailored to each zone. Humanitarian initiatives require support from each of the three different government entities, in some cases producing the same document with three different cover pages and three different flags.

On April 20, 2015, four UNICEF staff members were tragically killed in an attack outside of the UNICEF compound in Garowe, while five others were seriously injured. The attack was a deliberate assault against the UN, in a zone that had been considered to be relatively stable. The devastation of such an incident cannot be summarized in a report. In the aftermath of the loss, UNICEF began the hard work of emotional healing and adopting new security protocols to reflect the heightened risk. Plans to move key international staff positions to Somalia were put on hold and emphasis was placed on maintaining stability and security.

### 3.3 UNICEF GBV Programme

#### 3.3.1 GBViE Specific Programmes

GBV programming within UNICEF sits within the Child Protection (CP) section. The current CP programme has two humanitarian outputs and four development outputs. GBV is included as part of regular CP programming to achieve these outputs. The CP section aims to approach GBV as it does CP, i.e. through a systems approach, with strong focus on capacity-building, policy, and changing social norms. The CP team maintains a GBV Specialist position in Nairobi and allocates funding from its budget for GBViE programmes. There used to be a separate FGM Specialist position and programme, however, this structure is changing in 2016. The FGM Specialist position will be eliminated and FGM will be brought under the umbrella of the GBV programme.

GBV features only marginally within the current Country Programme Document (CPD) for UNICEF, which runs from 2011-2016-a one-year extension of the original. In addition, UNICEF previously advocated (albeit unsuccessfully) that GBV be considered as a Programme Criticality 1 within the humanitarian response and currently accepts the UN designation as a Programme Criticality 2.

**Programme start up**

UNICEF’s GBViE programme was established in 2011 as part of the larger emergency response to the famine across the Horn of Africa. The regional office (RO) brought in GBViE surge capacity to initiate the

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47 KII, UNICEF staff
48 KII, UNICEF CP Team
49 KII, UNICEF CP Team.
50 KII, UNICEF staff
51 Prior to 2011, there had been an FGM programme, without a major focus on other forms of GBV. It was not anticipated that there would be a large GBViE programme [KII, UNICEF].
programme, and the GBV specialist guided the programme for more than 3 years, leaving in June 2015. Initially, the programme focused primarily on service provision in “hotspot” areas—including checkpoints and Al Shabaab-held areas—where UNICEF was receiving large numbers of reports of GBV such as women being used as payment for crossing checkpoints and girls being forced into marriage by Al-Shabaab. UNICEF also supported two large fuel-efficient stove (FES) programmes of approximately $1 million each—one in Galkayo and the other in Mogadishu—as a means of risk mitigation. The FES programmes were discreet projects funded directly by donors; when the funding ended, the programmes were discontinued. By 2012-2013, the GBViE programme had expanded considerably—with a budget of approximately 7 million dollars—that was recognized by UNICEF NYHQ and the region as one of UNICEF’s leading GBViE programmes.

Minimum package of services
Since 2011, the GBViE programme has expanded significantly in an effort to provide a minimum package of essential services to GBV survivors in all three zones including clinical care (medical), psychosocial support (PSS), safety and legal assistance, as well as dignity kit distribution to survivors. Emphasis is put on medical care and PSS, which are accessible across the referral system, while safety/security and legal assistance are more limited in scope. UNICEF works through 8 local NGO partners to deliver these services, building on the strengths of each partner (e.g. Comitato Internazionale per lo Sviluppo dei Popoli (CISP) working on Communities Care—explained below— in addition to response). The GBViE program primarily serves IDPs, though services do not specifically distinguish between IDPs and host community and therefore, are available for anyone.

UNICEF partners provide the minimum package of essential services, either directly or through referrals to other actors. In 2015, the emphasis was on establishing effective case management systems. Two partners—Somali Women Development Centre (SWDC) and ElMan in Mogadishu—operate “Family Centres,” also known as “One-Stop Centres,” where survivors can access multiple services including medical and psychosocial support from one location. Partners train community-based volunteers and committees from within IDP communities to offer immediate assistance to survivors and make appropriate referrals. They often provide a transportation allowance to help survivors access services. In 2015, UNICEF supported the development of Clinical Management of Rape (CMR) Guidelines for Somalia, which were rolled out in 2016, including the development of a pool of master trainers who will continue training in all zones throughout 2016.

UNICEF supports the operations of a safe house for GBV survivors in Belet Weyne, north of Mogadishu, covering an estimated population of 271,620 and over 120 IDP camps. From September 2015 to February 2016, 304 survivors were hosted at the safe house, all of them accessing multi-sectoral services. In Somaliland, a shelter service was established in 2015, which provided safety to 170 GBV survivors in 2015. SWDC in Mogadishu and GRT in Puntland run 24-hour hotline services, though UNICEF only funds the GRT hotline.

52 KII, UNICEF CP Team
53 Ibid
54 KII, UNICEF CP Team. Local NGO partners include: GRT, Tatamum (Solidarity) Social Society (TASS), Somali Women Development Center (SWDC), Humanitarian Integrity for Women Action (HIWA), ElMan Peace and Human Rights Center, Socio-Economic Development and Human Rights Organization (Sedhuro), Comitato Internazionale per lo sviluppo dei Popoli (CISP), Comprehensive CBR in Somaliland (CCBRS)
56 Ibid.
**Capacity-building**

UNICEF works to strengthen the capacity of civil society and government partners by providing access to trainings, information, visits and assistance on specific requests. In 2015, capacity-building focused on establishing effective case management systems:

- In Puntland, UNICEF supported case management training for 25 service providers and worked with the Ministry of Women Development and Family Affairs (MoWDAFA) to translate case management and GBV training materials for use in Somalia.
- In Somaliland, UNICEF supported training on GBV case management, including use of the GBVIMS, for an additional four case managers and 16 GBV case workers.57

UNICEF GBV programme staff based in Hargeisa, Garowe, Mogadishu and in the Support Centre in Nairobi, provide mentoring and GBV training to ministry counterparts. UNICEF staff are in regular communication on policy, training, coordination, legal and monitoring issues and support government capacity to oversee programme implementation, in addition to co-leading coordination processes.

**Primary prevention, structural change, and risk mitigation**

UNICEF Somalia is one of two pilot countries rolling out UNICEF’s new Communities Care approach for GBViE prevention and response. Communities Care is a “participatory, community-based social norms intervention for sexual violence prevention and response.”58 Communities Care uses a structured, four-part approach, with clear content and programming tools to try to improve the quality of service delivery amongst healthcare workers and other services providers, and support community members to lead their own process of change. The approach empowers Community Dialogue Leaders (CDLs) to lead discussions within their communities that systematically explore the root causes of GBV. UNICEF is working in partnership with Johns Hopkins University (JHU), who are conducting a longitudinal randomized control trial (RCT) to measure the impact of the work. CISP in Mogadishu has currently completed one cycle of the intervention and have begun working with another set of groups. The approach is being piloted in 2 intervention communities, while maintaining 2 control communities. Communities Care is UNICEF’s primary prevention intervention in Somalia. Since it is a pilot program, only one partner in one zone is currently using it.

Outside of the Communities Care approach, UNICEF’s primary work on structural change (i.e. to transform conditions that foster GBV) has been focused on legal reform and strengthening government action, through initiatives such as supporting the government development of the National Action Plan on GBV and advocacy on the FGM and Sexual Offences bills. These initiatives were substantial undertakings that would not have been possible without UNICEF technical, financial, and strategic support. There is limited programming on behaviour change or addressing root cause of GBV beyond the Communities Care pilot. Similarly, while the start up of the programme focused on risk mitigation with initiatives such as fuel-efficient stoves and awareness-raising at checkpoints, risk mitigation does not feature prominently in current programming.

**FGM**

UNICEF has a long-standing FGM programme, established prior to 2011, which has been separate from, though linked to, its GBViE programme. The programme had its own FGM Specialist, staff, and programming strategy and activities. Prior to 2011, it was not anticipated that GBViE would become a

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large programme for UNICEF. Therefore, UNICEF maintained a separate FGM Specialist (and community-based focal point) position and GBV Specialist position in Nairobi, and separate staff positions dedicated to FGM and GBV within Somalia, as well as separate funding. Both fall within the Child Protection section. This structure is set to change in May 2016, when the FGM Specialist position will be phased out entirely and FGM brought into the portfolio of the GBViE programme.

3.3.2 Integrated GBViE Programming

GBV is not significantly integrated into other UNICEF programmes and sections. The 2015 Guidelines were field tested with the UNICEF-led WASH cluster—WASH—but have not been rolled out across UNICEF sections and are not known to most staff.

Child Protection

GBV is situated firmly within the UNICEF CP section. GBV is a core component of the CP programme, receives its funding and significant support (technical, strategic, leadership) from within the team. However, there is little integrated programming with other CP activities such as the MRM, working with separated and unaccompanied children or others.

WASH

The UNICEF-led WASH cluster participated in the field-testing of the 2015 GBV guidelines. However, the global guidelines team did not conduct any follow-up and so the initiative lost momentum. The WASH cluster was left feeling discouraged and demotivated, without any tangible results. There was no mention of GBV integration within UNICEF’s own WASH programming.

Education

The Education programme maintains a broad gender lens, but does not integrate GBV specifically into its programming. Gendered work focuses on increasing girls’ attendance in school, increasing the number of female teachers, and disaggregating educational research results by sex and age. The programme staff expressed the need to explore direct linkages between GBV and education. They also filled out the self-assessment and ranked themselves low on implementation of integrated programming but high on dimensions that encourage active participation of women and girls in programming, inclusion of women and girls in assessments, and identification of gender norms and practices that contribute to GBV within their sector.

Health and nutrition

Though medical services for survivors are a central component of UNICEF’s minimum package of GBViE services, there is no direct collaboration between UNICEF’s GBViE and Health programmes. UNICEF’s Health section does not engage in CMR training or services, and is not connected to specific efforts or protocols for CMR being used in-country. The UNICEF Health section is part of the Somali Joint Health and Nutrition Programme (JHNP), which clearly mentions FGM but no other forms of GBV. UNICEF senior management expressed that GBV should be more prominent in JNHP. Nutrition staff were not available for interview, however, they did fill out the self-assessment. While they ranked themselves low on implementation of integrated GBV programming (1-2 out of 5), they ranked themselves high on similar dimensions to education, including promoting active participation of women and girls, assessing gender norms around nutrition that might contribute to GBV and involving women and girls in assessments.

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59 KII, UNICEF.
3.3.3 Programme Funding

UNICEF Somalia’s CP programme has an operating budget of approximately $50,000,000 for the current CPD (2011-2016). The GBViE programme is funded through internal allocation by the Child Protection section (as opposed to specific project funding). According to interviews, CP is the best-funded section within the Somalia Country Office (SCO) against funds requested, with 80% received against requested.

It was not possible to determine the total annual budget for the GBViE programme for 2015 or previous years based on the documentation available. The CP team indicated that it would be difficult to ascertain this information because of how budgets are documented. However, it was possible to view the 2015 budget for CP, including GBV, from the government of Japan (GoJ); the largest donor for GBV activities. In 2015, the total budget available for GBV-related activities from the GoJ was approximately $1,820,000. This represented 91% of the total budget for CP from the GoJ. CP received 16% ($2,000,000) of the total UNICEF budget from the government of Japan ($12,350,000) for that year.

4 EVALUATION FINDINGS

4.1 Relevance

Alignment of UNICEF programming with assessed needs of beneficiaries (which may change over time), good GBViE programme practice and relevant UNICEF strategies and policies.

Overall, the programme is relevant to the needs of beneficiaries and aligns with UNICEF global commitments. Relevance is strongest in relation to the “minimum actions during immediate crisis-response.”

Alignment to needs of beneficiaries

All focus groups and key informant interviews highlighted GBV as a critical problem exacerbated by continuous emergencies, and the importance, therefore, of the response services supported by UNICEF. This is echoed in the data from the GBVIMS and the yearly Humanitarian Needs Overview. UNICEF’s programming to establish minimum essential services for survivors and case management systems, therefore, is directly relevant to the needs on the ground as understood by both beneficiaries and humanitarian actors.

Alignment with commitments and good practice

UNICEF Somalia’s commitment to GBViE programming aligns with UNICEF corporate commitments including the UNICEF Strategic Plan, Equity Approach, and Gender Action Plan (GAP). The programme also

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60 UNICEF Somalia, Programme Component Implementation Profile Cycle to Date (Child Protection: 01.01.2011 - 31.12.2016). According to the document, the following figures represent the CP Programme Component budget for the current CPD: Total Planned: $38,995,591; Total Funded: $55,641,295; Total Actual: $48,817,284.

61 The only exception was a former fuel-efficient stoves [FES] project that was funded directly by the government of Japan and implemented by Mercy Corps and Relief International at the start of the GBViE program. When that program ended, no further proposals were submitted for direct funding of GBViE-specific projects.

62 KII, UNICEF staff. UNICEF staff also reported anecdotally that the Somalia CP programme is one of the best funded of UNICEF’s CP programmes globally in relation to received vs. requested funds.

63 This is due to the system of documenting and tracking budgets for the programme components.


reflects good practice in relation to GBV response, most strongly in the immediate term, as outlined in the Resource Pack. Specifically, the programme aligns with the principles of “participation”, “ethics and safety,” and “survivor-centred approach” and the majority of the Minimum Actions During Immediate Crisis-Response (with the exception of risk mitigation and community-based safety assessments).66

### Table 4

<table>
<thead>
<tr>
<th>Minimum actions during immediate response to a crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Effective coordination of humanitarian action to address GBV.</td>
</tr>
<tr>
<td>2. GBV risk mitigation across clusters and sectors in line with IASC Guidelines.</td>
</tr>
<tr>
<td>3. Age-appropriate clinical and crisis care for sexual assault.</td>
</tr>
<tr>
<td>4. Safe spaces for women and girls.</td>
</tr>
<tr>
<td>5. Dignity kits.</td>
</tr>
</tbody>
</table>

UNICEF GBViE programming also connects clearly with the Somalia National Action Plan and the GBV Working Group Strategy (2014-2016) key results areas around service provision and response, access to justice and rule of law, and coordination. While the links between UNICEF’s GBV programme and the Busan New Deal Compact,68 the Six Pillar programme of Federal Government of Somalia (FGS), Puntland’s 2nd 5-year Development Plan, and the Special Arrangement for Somaliland, are not specifically defined, UNICEF’s close work with government in all three zones aligns well to these plans by strengthening key areas of GBV response and government services including medical, justice, and legal.

**Theory of change**

The programme has components that align to the immediate outcomes in the three major outcome areas in the global theory of change, i.e. survivors benefit from appropriate care, the likelihood of GBV is reduced, and conditions that foster GBV are transformed. Alignment is clearest in relation to service delivery for survivors and legal reform.

The programme itself does not have a clearly articulated Theory of Change or Strategy for GBV. Rather, there are 2 documents guiding the programme: the “UNICEF GBV Package Concept” and the “Somalia GBV Programme Structure.” Together, these represent the overall strategy for the UNICEF GBViE programme, outlining its objectives, strategies and activities. While the programme was designed in accordance with these documents, it was difficult to locate them and programme staff were generally not well-acquainted with them.69 In addition, there are some inconsistencies both within the documents and between the documents and the programme. Firstly, the documents use the language of GBV and sexual violence interchangeably, leaving questions about the core focus of the programme. Secondly, prevention through social norm change features as one of the 7 key strategies in the Somalia GBV Programme

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66 See Findings and Conclusions sections below for further details.
67 UNICEF GBViE Programme Resource Pack, 2016 (draft)
68 The New Deal for Engagement in Fragile States is the first set of principles guiding international engagement in conflict-affected states, endorsed in November 2011 by 44 countries and various international organizations. The Somali Federal Government, together with its international partners, decided to adopt the New Deal and endorsed the “New Deal Compact” on 16 September 2013 at the New Deal for Somalia Conference in Brussels, which was co-hosted by the Federal Government of Somalia and the EU.
69 KIs, UNICEF. The two listed documents were eventually shared with the evaluation team on the last day of the mission by the Chief of Child Protection.
Structure but does not feature at all in the UNICEF GBV Package Concept. Risk mitigation — including integration of GBV into other sectors and other strategies such as safety audits — is not included in either document. Thirdly, response to and prevention of SEA by those in uniform, and training of teachers feature prominently in the GBV Package Concept, but beyond one-off trainings, have not been key components of the GBV programme. Therefore, though these documents offer some framework for the programme, the programme lacks a cohesive, clearly articulated strategy.

Risk mitigation and structural change
The programme is less relevant to primary prevention than response. Risk mitigation has been limited and UNICEF sections such as WASH, Health, and Education are not integrating GBV into their programmes or utilising the IASC GBV Guidelines. In terms of structural change, the programme aligns with the need for legal reform—through the FGM and Sexual Offences bills—and government ownership, through development of the National Action Plan. However, there is limited work to address the root cause of GBV or promote long-term behaviour change (with the exception of the Communities Care initiative being piloted by CISP in Mogadishu). There is recognition by senior staff of the need to work towards more sustainable solutions, and strengthen the prevention component of the programme.

Assessments
According to interviews with UNICEF staff and partners, formal assessments have not been undertaken to design or make changes to the programme. In Garowe, staff mentioned that an assessment may have been conducted in 2012, but they could not verify this and no report was available. However, all partners reported seeking out the perspectives of women, adolescent girls and men through informal dialogues and visits, in order to inform their programmes.

FGM
Though FGM was not the focus of the evaluation, it is worth noting that the relevance of the current FGM programme in relation to GBViE was unclear. An FGM prevention strategy does exist for Puntland, but it was hard to determine how this translated into programming and whether partners understood their work within this framework. All interviewees noted that FGM is a significant problem in Somalia, but there were widely disparate views on whether the drivers of FGM are the same as other types of GBV, whether FGM is a problem directly linked to the emergency and therefore, whether FGM should be addressed separately from other types of GBV. FGM has been raised as an issue through the Communities Care programme and is beginning to be discussed to some extent in pilot sites.

Adapting to changing needs
Overall, the GBViE programme has adapted well to changing needs and there is recognition of the need to continue to evolve, particularly in regards to long-term programming. The programme start-up itself represented an adaptation to a recognized need, i.e. surges of GBV at noted flashpoints. As the magnitude of the problem continued to unfold, the programme expanded in an effort to meet the need, taking on more local partners and establishing a minimum package of services across all three zones, including case

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70 The 7 key activities and strategies include: Provide clinical care on a timely and professional manner to survivors of violence; 2) Provide accurate legal aid for survivors seeking legal redress; 3) Ensure procedures, standards and protocols are reflecting the protection needs of women and children; 4) Develop social work workforce to ensure standardization of social work; 5) Ensure systems, protocols and standards for psychosocial care are available; 6) Provide survivors of GBV with psychosocial services on a timely manner; 7) Prevent violations against girls and women from taking place.
71 UNICEF GBV Package Concept and Somalia GBV Programme Structure documents.
72 KIs, UNICEF staff and Evaluation Self-Assessment Checklists for UNICEF Sections
73 KIs, UNICEF senior staff.
74 KIs, UN partners.
management. The programme is beginning to work towards more sustainable solutions by broadening work with government on legal reform, piloting the Communities Care approach, and incorporating FGM into its GBV program.

4.2 Effectiveness

The extent to which the programme/activity is achieving or is likely to achieve its stated purposes, on the basis of outputs delivered.

The programme has been most effective in meeting objectives around immediate response to survivors, particularly of sexual violence, and less effective in mitigating risks, addressing the root cause of GBV and changing behaviours.

Access to services

UNICEF has been effective in improving survivors’ access to life-saving, multi-sectoral services for care and support. In all three zones, partners are offering a minimum package of essential services for GBV survivors which includes medical care, safety/security (including referral to the police, shelters, etc.), basic psychosocial support (i.e. counseling), referral, and case management. Though it was not possible to visit most of the services because of security issues, their existence was evident from the interviews and programme documentation. According to the consolidated GBVIMS report for Somalia, 9,582 total cases of GBV were reported in 2015 through the GBVIMS. These cases did not all come through UNICEF partners, but the data clearly indicates that survivors are accessing available services. The establishment of these services, including the GBVIMS, is an important achievement since the inception of the programme in 2011, when most services did not exist. The model of “one-stop centers” supported by UNICEF is generally seen as a good practice, and partners such as UNHCR have expressed interest in seeing this replicated more widely. It is important to note that despite these important gains in access to services, there are still significant challenges in reaching populations outside of main towns/cities, due to insecurity and restrictions on movement (see section on “Coverage” below), which is a critical gap.

The initial focus on service provision was a strategic decision made by the Somalia GBViE programme to address a clear need and uphold UNICEF’s GBV mandate. The Somalia CO’s clarity around UNICEF’s mandate to address GBViE is notable, in comparison to other contexts where this mandate has been less clear to the country programme.

Quality of services

There appears to be considerable variation in quality between partners. In Central South Zone, the challenge of coverage versus quality was apparent, with the partners within Mogadishu seeming to have stronger capacity than those outside of Mogadishu. National partners operating outside of Mogadishu demonstrated limited understanding of GBV which affects the quality of services offered. For example, one partner who operates a safe house for women, indicated response to survivors that potentially reinforces the acceptability of GBV, i.e. “This is life. You have to go on.” They explained that they speak with the husbands of women experiencing domestic violence before they return home and that this “resolves” the problem and the “husbands don’t beat them anymore,” which indicates a fundamental

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75 UNICEF Somalia’s 2015 Annual Report indicates that over 9000 survivors received support. As this reflects the total number within the GBVIMS consolidated report, it is unclear how many survivors received direct support from UNICEF partners.

76 KII, UNICEF staff.
misunderstanding of the nature of intimate partner violence. In addition, though all staff and partners reported that case management is “going on well,” there was limited reflection on how the system could be improved, what some of the gaps might be, and the effectiveness of referrals. One UN partner also expressed the need to review the quality of case management, beyond just the availability.\(^{77}\)

There are questions about the quality of additional GBV services provided by partners, in particular GBV hotlines (Gruppo per le Relazioni Trnsculturali (GRT)’s UNICEF-supported hotline in Puntland, and SWDC’s AMISOM-funded hotline, “Ceebla,” that runs alongside its UNICEF-funded services). In Puntland, UNICEF staff did not mention the GRT Support Line in key informant interviews and GRT mentioned it as an afterthought, only broadly explaining its functioning. It was unclear how cases are referred and documented through the hotline, how calls are logged (the call log reviewed was incomplete and inconsistent), and what happens to all the cases who call in that are not GBV cases. GRT staff estimated that they have received approximately 6,000 calls to the hotline\(^{78}\), though the vast majority of cases are not GBV and are not documented. In Mogadishu, it is unclear how the AMISOM-funded hotline connects with SWDC’s UNICEF-supported GBV work.

**Scope of services**

Given the strategic focus on immediate response to crisis, which prioritizes response to sexual assault, the programme has not yet developed specialized skills and services, e.g. safety planning, to respond to intimate partner violence (IPV), which is widely reported. Partners do not demonstrate understanding of the dynamics of IPV (which relates to the strategic focus on response to sexual violence). As the programme becomes more established, it is necessary to expand the scope of skills and services in order to adequately meet the needs of survivors of GBV and avoid doing harm. In particular, IPs report that they engage in mediation between partners in response to IPV. This is generally not recognized as a good practice in GBV response, as it can cause more harm to the survivor, given the imbalance of power and cycle of power, control, and violence.

Similarly, services such as psychosocial support and safe spaces are currently offering the minimum that is essential. Psychosocial support in the context of the programme refers primarily to the initial intake and response to survivors. There are many different kinds of psychosocial support activities that can be valuable to women and girls, which the programme can begin to explore. The role of safe spaces can also be further explored and developed. Safe spaces, where feasible, can offer important services for the empowerment and protection of women and girls beyond individual case management, e.g. psychosocial activities, skills-building, women and girls’ groups, etc.

**Approach to prevention**

The programme does not have a clear approach to prevention—neither for risk mitigation and/or structural change— and respondents demonstrated limited understanding of core concepts in prevention such as primary prevention vs. risk mitigation, good practice programming, theories of behaviour change and communication for social change. While all UNICEF staff and partners reported that they work on prevention, in reality, little prevention programming exists beyond the Communities Care pilot initiative. Activities labelled as “prevention” were not grounded in a theory of behaviour change, and therefore, were not designed in a way to make them most effective. Staff and partners equated prevention programming with awareness-raising, and awareness-raising focused only on available services and basic

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\(^{77}\) KII, UNICEF partner.

\(^{78}\) The exact time period of this estimate is unknown
GBV concepts. Activities generally lacked content or communication materials/programming tools, relying instead on unstructured discussions of general GBV ideas.\textsuperscript{79}

UNICEF’s most structured prevention initiative is the Communities Care approach, being piloted by CISP in Mogadishu. CISP reported highly positive things about the approach both in terms of process and impact. On the process side, they find the toolkit to be very useful for facilitators because of the depth, structure, and detail of the content. Content is carefully developed to tackle the root cause of the problem, and activities explained in detail to guide facilitation of discussions, with all necessary materials included. In terms of impact, CISP explained that within three weeks, they saw group members facilitating discussions with their families and friends, and sparking debate within their own communities.\textsuperscript{80} The preliminary findings shared by Johns Hopkins University (JHU) from the Randomized Community Trial (RCT) also indicate some positive impact- the evaluation team did not have access to the preliminary findings, but both the Chief of Child Protection and CISP staff reported broadly that they were positive.

**Risk mitigation**

The evaluation found very little integration of GBV into other sectors. The GBV Guidelines have not been rolled out across UNICEF sections or humanitarian clusters. The UNICEF-led WASH cluster participated in the field testing of the new GBVIE Guidelines, which had been seen initially as a welcome step by the Cluster, but with the gap in GBV Specialist and follow up, the process never bore fruit. The WASH section within UNICEF did not indicate integration of GBV into its programming.

All other sections that were interviewed (Health, Education, Nutrition, and the Chief of Emergencies) were not aware of the 2015 IASC GBV Guidelines and had passing knowledge of the existence of the 2005 IASC GBVIE guidelines. Upon learning about the new Guidelines, the Chief of Emergencies noted how valuable this guidance would be for all sections, and proceeded to circulate them to focal points in each section. The Education programme maintains broad gender-related objectives around increasing girls’ attendance and the number of female teachers in schools, but does not integrate GBV specifically into its programming. There is no direct collaboration between UNICEF’s GBVIE and Health programmes, despite medical services for survivors being a central component of UNICEF’s minimum package of GBVIE services. UNICEF senior management expressed that GBV should be more prominent in JNHP.\textsuperscript{81} Interestingly, the two sections that filled out the self-assessment—Education and Nutrition—both ranked themselves low on implementation of integrated programming but high on dimensions that encourage active participation of women and girls in programming, inclusion of women and girls in assessments, and identification of gender norms and practices that contribute to GBV within their sector. This echoes qualitative interviews, which indicated almost a complete lack of integration yet awareness of its importance.

**Programme content**

Conceptualisation of GBViE programming is based more around activities then content. This means that while several types of activities are occurring—community dialogues, awareness-raising, capacity-building with volunteers, for example — there is a lack of creative programming tools or structured guidance being used to implement the activities outside of the Communities Care pilot e.g. communication materials, discussion guides, curriculums. Community-based awareness-raising and discussions are done ad hoc based on staff or volunteers’ knowledge, without any supportive

\textsuperscript{79} KII’s, UNICEF and partners.  
\textsuperscript{80} This was monitored through an Excel questionnaire.  
\textsuperscript{81} KII’s, UNICEF.
programming tools, as are capacity-building activities for community volunteers. Staff and volunteers are not versed in principles or strategies of effective communication. In some cases, the materials being used (such as the flip boards showing scenes of violence against women), have the potential to perpetuate harmful behaviours.

Similarly few training modules exist, to be used with either staff or community members, and there are no standard training packages for different skills. Only one training module was shared with the evaluation team from a UNICEF partner, which was simply text on a PowerPoint, covering a wide range of GBV-related topics in one presentation. Therefore, capacity-building is limited. There is a similar lack of creative communication materials, discussion guides, or other programming tools to guide community-based activities. Staff knowledge and capacity centres mainly on principles of response, and

Data/ Results
There are no formal monitoring tools or processes in place for measuring programme quality and results. Beyond the GBVIMS, partners rely on informal observations and discussion with beneficiaries, as well as annual or bi-annual review meetings to monitor quality of programmes while UNICEF relies on partner reports and sporadic site visits. UNICEF in Somalia uses third party monitoring, but it was unclear from the evaluation how GBV is integrated into this system or how data is used to inform programming.

While UNICEF’s programme is offering valuable services, the quality of services is not well understood. There are no formal systems in place for monitoring programme quality – a common challenge for GBV programmes. The exception to this is CISP, who are using the client satisfaction survey form that is part of the Communities Care approach. Informally, UNICEF staff and partners reported broadly that all is going well, but lacked more detailed analysis of programme quality. Understanding of programme quality is hindered by the fact that UNICEF staff access to programmes is severely restricted due to security concerns. Technical assistance to partners focuses more on general programme support, trainings, and reporting and less on strategic or in-depth technical guidance.

The GBVIMS is being used widely across Somalia and by all UNICEF partners. The GBVIMS intake forms are the basis of partners’ case management system and they are inputting regularly into the system. In Puntland, there is a UNICEF staff member dedicated to supporting the GBVIMS. Data is sent to UNFPA monthly for consolidation. However, the consolidated data is not being used to inform programming. The system for receiving consolidated data from UNFPA is not clear and UNICEF does not then have a regular system for sharing and reviewing consolidated data with partners. There was strong criticism from both UNICEF staff in Nairobi and the UNHCR Protection Cluster lead that UNFPA are resistant to sharing data and want to be the sole owner of GBVIMS information. UNICEF staff seemed resigned to the fact that the information-sharing protocol is “very strict.” Despite criticism, there is no dedicated advocacy by UNICEF staff for more regular sharing of consolidated data. In addition, it is unclear how non-GBV cases that are reported through the programme are documented and referred.

82 KII, partners.
83 Training module shared by GRT in Puntland.
84 International Committee for the Development of Peoples.
85 Given the depth of the Johns Hopkins’ University study on the Communities Care approach, gathering additional information specifically about this approach was not prioritized. Evaluators did not review the client satisfaction surveys, but received feedback from CISP that they were utilizing them.
86 The programme was without a GBV Specialist from June 2015 to March 2016, which left a major gap in technical assistance both within UNICEF and with partners.
87 Key informant interviews with UNHCR Protection Cluster lead in Mogadishu, UNICEF GBVIMS Coordinator in Puntland, interim UNICEF GBV Specialist in Nairobi (regularly FGM Specialist), and UNICEF Chief of Child Protection.
There has been confusion around how to manage data effectively using multiple data systems— the GBVIMS, CPIMS, MRM, and MARA. After hasty efforts to integrate all GBV data within the CPIMS (which was established after the GBVIMS was already up and running), organisations went back to using the GBVIMS, which seems to be functioning more effectively than the CPIMS. The systems operate in silos, without links for referrals of cases or cross-referencing of information and/or trends. For example, if MRM monitors receive an incident report of a GBV case of someone over 18, which does not meet the MRM criteria, they do not document it, and make referrals only on an ad hoc basis. There has been a meeting led by the Protection Cluster with UNICEF support on how to coordinate the multiple data management systems, including the possibility of using Primero. For FGM, the country office is waiting on data from the new Multiple Indicator Cluster Survey (MICS). There is substantial data included in the 2013 FGM strategy for Puntland. However, it is unclear how, in practice, this has informed the current approach to FGM work. Similar data and strategies have not been completed in other regions.

Advocacy
Programme advocacy has been mainly at a high-level, focused on drafting the Sexual Offenses Bill and FGM policy. Both bills have been drafted and are at varying stages of review and approval by parliament. This is a significant achievement by UNICEF, and required supporting three different Ministries on two separate bills (UNICEF leading on the FGM policy and UNFPA leading on the Sexual Offenses Bill). The evaluation team received widely variable feedback about where in process the bills are, partially related to the challenges of working in three different zones and the complexity of processes. The team has focused on the drafting of the bills and there is less clarity on how to maximize the benefit once they are passed. While UNICEF staff, Ministry officials and UNFPA praised UNICEF’s efforts around the two bills, there was also feedback from the Protection Cluster Coordinator and Comprehensive Community-Based Rehabilitation in Somalia (CCBRS) that UNICEF could be doing more “lower” level programmatic advocacy, as well as maintaining the high-level focus. CCBRS raised the example of establishing GBV desks within the police force, which UNICEF indicated has already begun in Somaliland.

Leadership
The prioritisation of GBVIE by UNICEF leadership at multiple levels, has been central to the programme’s effectiveness. At the start of the programme, UNICEF Somalia created a dedicated GBVIE Specialist position and have continued to allocate funding internally for GBVIE programming. The previous UNICEF Representative advocated within the humanitarian system for GBV to be included as Programme Criticality 1, and played an instrumental role in the development of the GBV WG Strategy. In addition, the Chief of Child Protection has committed to GBVIE as a core component of Child Protection programming, which means that it is not something that is seen as “extra.” She has committed to maintaining the GBVIE Specialist position and allocating funds for programming.

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88 Input from UNICEF staff during the GBVIE RTE Feedback Session and key informant interview with UNHCR Protection Cluster Lead, Mogadishu.
89 In the MICS, the attitude measurement differentiates between Pharaonic and Sunna types, but no differentiation is made between types of FGM in terms of numbers of who’ve been cut
90 KII, UNICEF.
91 The programme criticality framework is a common UN system framework for decision making that puts in place guiding principles and a systematic structured approach in using programme criticality as a way to ensure that programme activities can be balanced against security risk.
92 The former UNICEF Rep is credited with helping to align the Strategy to the New Deal Compact and gaining RC and HCT support. Despite his advocacy, GBV remained Programme Criticality 2 under the system-wide categorisation.
In all interviews, respondents expressed appreciation for the skill and commitment of the GBViE Specialist, who started the programme in 2011. Her leadership and advocacy is credited with the establishment of a minimum package of services, as well as strong relationships with government, strategic direction for the GBV Working Group, and development of the National Action Plan. There is currently no GBV Specialist in the Regional Office, therefore, regional support has been minimal. HQ support has been instrumental in rolling out the Communities Care programme as well as the GBVIMS, and in providing direct technical assistance to the CO in the absence of a regional specialist. Support from HQ also made it possible to field test the 2015 GBV Guidelines with the UNICEF-led WASH Cluster in Somalia (though the gap in GBV Specialist made follow up traveling in country, unfortunately, lack of follow-up led to disillusionment within the WASH Cluster and lack of uptake of the new Guidelines.

4.3 Sustainability / Connectedness

To what extent do emergency response activities take into account and support a longer-term approach, including in connection with UNICEF’s regular development programming.

The primary focus of UNICEF’s GBV programme to date has been on minimum essential response for survivors from IDP communities. Longer-term response needs are not yet being addressed and longer-term prevention is being piloted with one partner. UNICEF’s efforts to promote sustainability, center on building the capacity of civil society and supporting the government in legal reform. With the foundations of response in place, UNICEF can begin to look towards more sustainable solutions.

Programme design

Focus on immediate response was a strategic decision made at the start of the programme. Service delivery is designed within the context and strategy of the overall humanitarian response, without strong connection to UNICEF’s framework for sustainable resilience programming. The establishment of GBV focal points and committees as part of the response system is a step towards promoting sustainability, though the quality and depth of their work is not well understood. Longer-term needs such as economic and social empowerment are not yet being addressed, while longer-term prevention is now being piloted with Communities Care.

Partnerships

Local partners all report that the support they receive from UNICEF is necessary and valuable to their work.93 UNICEF’s contribution to capacity-strengthening of local partners has been critical in establishing the minimum set of services for survivors, including case management, and introducing the GBVIMS, which all partners are using. Local availability of such services is essential to sustainability. Beyond this minimum package, however, UNICEF’s role and capacity in helping partners improve the depth of their analysis of GBV and look more critically at the quality of their work, is limited. Beyond trainings, strengthening capacity is not systematic, is reliant on occasional visits and one-off trainings and focused on general monitoring of activities more than nuanced reflection on programme quality.

UNICEF has worked closely with government to develop plans and policies aimed at creating structural change beyond the humanitarian emergency. UNICEF led the cooperation with the government to develop the National Action Plan (NAP) on GBV in 2014 and helped to draft both the FGM Policy and Sexual Offenses Bill. These are important achievements towards creating an enabling environment for prevention of GBV. Though the bills have not yet been passed into law in all three zones, several interviewees reported significant positive changes in the government’s willingness to talk about GBV as

93 KIIs, UNICEF implementing partners.
an issue in Somalia, rather than denying its existence - an important change since the start of the program. At an even higher level, UNICEF supported the campaign to ratify the CRC, which was signed by the FGS in October 2016. Similar efforts are planned to support ratification of the CEDAW. These global commitments represent a step towards embedding the rights of women and children within the legal system of Somalia.

Long-term prevention

The Communities Care programme is rooted in the concept of sustainable solutions, as it seeks to foster personal reflection, community-led dialogue, and ultimately, social norm change. Community Discussion Leaders (CDLs) facilitate structured activities with groups of community members, and community members create action plans for change. CISP has reported that they can see positive impacts in the community; more detailed understanding of the results will be possible following the Communities Care impact evaluation.

4.4 Coordination

The extent/nature of UNICEF CO programming contribution to realizing GBV-sector strategies/plans/priorities and how UNICEF has added value/to been affected by the GBV sector response within the CO and across the response as a whole.

UNICEF staff and partners report that UNICEF coordinates well both bilaterally and as a member of the GBV sub-cluster and related Working Groups. There is limited coordination between the UNICEF GBViE programme and other clusters.

Respondents noted that UNICEF’s contribution to the GBV sub-cluster and related working groups has been extremely valuable. UNICEF has played a critical role in helping to set the strategic direction of the GBV sub-cluster including the development of the national-level GBV sub-cluster workplan, establishment of referral systems and case management in each zone, and development of the inter-agency information-sharing protocol (ISP) for the GBVIMS. UNICEF articulates the strategic direction clearly in programming and advocacy. UNICEF’s ability to engage a wide variety of stakeholders, from armed actors to government to donors and sub-cluster members has been important to the sector. This includes milestones such as drafting the National Action Plan for Somalia and supporting development of the national-level workplan for the GBV sub-cluster. UNFPA raised concerns about UNICEF “going at it alone” in relation to the NAP while UNICEF had concerns about working through the subcluster. Ultimately, all partners, including government, UNICEF and UNFPA were satisfied with the results. Given UNICEF’s strong relationship partners, UNICEF would be well positioned to play a leading role in the MARA, which it is not doing currently.

Partners noted that the absence of a GBV specialist in UNICEF was felt greatly within the sub-cluster/working groups and weakened UNICEF’s ability to provide technical guidance to the groups. One partner suggested that this was true specifically around emergency response and that the sub-cluster has been losing its emergency response focus as a result. The gap has also been felt in technical leadership around the connection between FGM and GBV. There is a lack of consensus around if and how FGM fits within the work of the GBV sub-cluster, with members including it in the GBV sub-cluster/working group workplan but the Protection Cluster lead maintaining that this is not a GBViE issue. UNICEF did not have a clear position on this nor the capacity to broker discussion on the way forward. The lack of a GBV

94 KII, UN Interview with Protection Cluster Coordinator
95 KIIs, UN and Cluster staff
Specialist also meant that UNICEF did not take the lead in rolling out the new GBV Guidelines with other Clusters.

One of the biggest coordination challenges has been around GBVIMS data-sharing and management. Multiple respondents reported that UNFPA want to maintain “ownership” of all the data, and often refuse to share data, even when it is within the ethical guidelines. Therefore, consolidated information is not being used to inform the work of sub-cluster members, including UNICEF and its partners, nor the broader Protection Cluster. UNICEF staff demonstrated varying levels of understanding of the distinction between sharing consolidated information in an ethical way and sharing identifiable data irresponsibly. They have mostly accepted the lack of data sharing even in circumstances where data-sharing is warranted and appropriate. At country level, UNICEF has not been leveraging its position as a member of the global steering committee member for the GBVIMS, to advocate for changes in the way consolidated data is shared and utilized.

In relation to other clusters, the gap between GBV Specialists meant that UNICEF has not engaged other clusters in rolling out the new 2015 IASC GBViE guidelines. There has been some progress in developing systems for good cooperation with the Child Protection sub-cluster, including standard operating procedures (SOP) that were developed between the two sub-clusters. However, actual linkages between CP and GBV programmes are less apparent and could be made more explicitly, particularly within UNICEF’s own programmes such as MRM and education.

4.5 Coverage

The extent of UNICEF’s programming reach (geographic and numerical) compared with the needs of those at risk of or affected by GBV as assessed by UNICEF and/or the GBV sector as a whole.

Coverage of GBV services is generally good within main hubs such as Mogadishu and Garowe. However, the reach and quality of services beyond these central locations is more limited. In addition, there is a lack of specialized services for adolescent girls that might help to better reach and support that demographic.

In the context of Somalia, there are clear challenges of access outside of the main government-controlled cities. Security poses a serious threat to movement, particularly for international organisations, UN agencies and their staff. This leaves the UN relying heavily on remote management. For UNICEF, as for many other international agencies, there is a correlation between distance from main cities and ability to reach target populations safely, resulting in progressively less programming the further you get outside of the main hubs. A similar effect can be seen in the capacity of local partners and the ability of UNICEF to support them as you move out of major hubs, meaning progressively diminished quality of services with increasing distance from the major hubs. UNICEF tries to bring partners together in central locations or in Nairobi for trainings and meetings. However, it remains frustrating for partners that they cannot receive more onsite support.96

While security threats are a real concern, some respondents believe that there is room to explore alternatives for increasing access to affected populations, and that UNICEF needs to be more proactive in this regard.97 Local partners indicated that there is a need to be more effective in using local organizations and staff to reach areas that international organizations cannot access. Another partner raised the idea

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96 KIIs, UNICEF implementing partners.
97 KIIs, UN and NGO partners
of providing mobile outreach services that are connected to existing one-stop centres in terms of staffing, training and support. This is a similar model to the one used in Lebanon, where services would be roving—set up temporarily in hard-to-reach areas for a finite amount of time—while remaining linked to an established programme.

In terms of demographic coverage, there are gaps in engaging adolescent girls beyond management of GBV cases. A large number of cases reported are adolescent girls, who receive services provided within the minimum essential response package. However, with the exception of ElMan in Mogadishu, there are no specialized programmes for adolescent girls, including targeted outreach and support tailored to their specific needs. Partners did not differentiate between the needs of adolescent girls and women in their programs, which is an area for further growth and development. ElMan runs skills-building sessions with adolescent girls including tailoring, tie-dye, and literacy. Girls who participate in these activities laud their value and expressed a need for more similar services.

4.6 Efficiency
Measure of outputs versus inputs in terms of having appropriate levels of financial and human resource capacity in place, both within UNICEF and via implementing partners, and how well these have been used to generate outputs.

UNICEF’s budgeting system made it difficult to ascertain the complete annual cost of GBV programming, or the annual cost of the GBV programme per zone. Funding has been sufficient to carry out planned activities, however, it was hard to reach definitive conclusions about value for money. The strength of the former GBVIIE Specialist was widely recognised as key in establishing the GBVIIE programme, and her departure has left a significant gap which, it is anticipated the recent arrival of her replacement will fill.

Programme funding
Allocation of funding to GBV is done as a bulk cost, rather than itemized per zone or specific activity. Therefore, it is difficult to get a clear understanding of the GBV budget for each zone or nationally. There is not one overall GBV programme budget that exists, but rather a collection of donor budgets into which GBV is incorporated, either overtly or within a broader CP line item. This made it impossible to determine the full annual budget for GBV programming. According to interviewees, the 2012-13 total GBV budget was approximately 7 million dollars and the current annual budget for GBVIIE programmes in Puntland is approximately $400,000 (with FGM programmes in Garowe having a separate annual budget of approximately $200,000). To date, the funding for GBV activities has been sufficient to conduct its planned activities and remain a core component of the CP programme. However, as GBV does not feature directly in the CPD and budgeting depends upon internal allocation, it means that continued funding for GBV programming rest heavily on the discretion of the CP Chief rather than being embedded into UNICEF’s core areas of programming and fundraising.

Human resources
Since the departure of the GBV Specialist in June 2015, the Child Protection team agreed not to take on any new GBV initiatives or strategies until the new specialist arrived; the new GBV Specialist arrived in March 2016 and will be traveling to Somalia for the first time in April. The FGM Specialist has been filling the position in the interim and the focus has been simply on keeping the programmes stable. The attacks of April 2015 in which four UNICEF staff members were killed, also has had a significant impact on the entire team and the programme.

98 KIIs, UNICEF implementing and UN partners.
There is the sense within UNICEF that the success of GBViE programming is dependent upon commitment from high levels of leadership and a strong dedicated GBV Specialist. Both the previous Country Representative and previous GBViE Specialist were very committed to GBV, as noted by multiple UNICEF staff and partners. There is perception that the new Country Representative also is/will be strong on GBV, and that the arrival of the new GBV Specialist will help to take the GBViE programme to the next level. The CP team is working to institutionalize GBV as a fundamental part of the section, and core area of UNICEF’s mandate.

UNICEF Somalia has grown substantially over the past few years, as new and protracted emergencies continue to affect the country. The CO has recently engaged in an exercise with an external consultant to try to streamline its structure, examining the number of positions it maintains versus its outputs. At the same time, the Child Protection team is streamlining by removing the separate FGM specialist position at national-level and folding FGM into the GBViE portfolio. Plans to cut some Nairobi-based positions and move some positions to Mogadishu have been halted after the attack on UNICEF staff in Garowe. The structure of the GBViE team varies in each zone. In Puntland, there is one position dedicated solely to “admin and paperwork” and another position dedicated solely to GBVIMS.

UNICEF is now signing 2-year PCAs with partners which involves longer term funding commitments. This is welcomed by partners who believe that multi-year funding is essential to GBViE programming. In general, partners are happy with UNICEF as a donor and partner and recognize their financial contribution as critical to their ability to continue GBViE programming. There are sometimes delays with new PCAs being signed that hampers services, however, this was not seen as a drastic or recurring problem.

5 PROTECTION FROM SEXUAL EXPLOITATION AND ABUSE (PSEA)

Throughout Somalia, many respondents indicated that sexual exploitation and abuse (SEA) by ‘people in uniform’ is a widespread problem. In Mogadishu, one partner gave strong feedback that not only is SEA by people uniform widespread, but that there is no way to hold perpetrators accountable. According to the interview, there was a time a few years ago when women would report SEA from within the AMISOM compound. They would report, but no actions would be taken to hold perpetrators accountable. This made the situation even harder for them, leaving them with stigma and fear for their safety. Now, women do not report SEA. In the case of one partner, they were expressly prohibited within their AMISOM-funded GBV programme, to receive calls about GBV violations from within the AMISOM compound.

The Chief of Child Protection is the designated PSEA focal point within UNICEF. This means that she is responsible for ensuring adequate response to survivors who report SEA cases to UNICEF. She understands the protocols well for responding to cases of SEA, however, they receive few reports. UNICEF receives reports of PSEA primarily through the MRM. According to key informants, few cases that are reported through the GBVIMS are SEA. This is particularly notable, given the feedback from partners that without accountability, women stop reporting. For those cases that come through the MRM, no action is taken on cases beyond including them in the MRM; the MRM is used primarily as a monitoring tool, not a means of referral or service provision. Lack of liaising between the MRM and the GBV referral and case management system is a weakness of the MRM system, particularly around SEA. Referrals for cases of

99 KII, UNICEF Nairobi.
100 KII, UNICEF Garowe.
101 KII, UNICEF IP.
alleged SEA reported through standard case management channels also need to be looked at, and internal capacity strengthened to respond to such cases.

6 GOOD PRACTICE CASE STUDIES

To be completed

7 CONCLUSIONS

Analysis of the findings from all of the evaluation criteria led to the following conclusions:

Successes

1. **UNICEF’s strong commitment to GBV programming at all levels of the country programme has been central to its success.** Senior management and the Child Protection team at national level and within the zones have expressed the need to prioritize GBV and their commitment to continuing GBV programming as a critical component of Child Protection. However, UNICEF previously advocated (albeit unsuccessfully) that GBV be considered as a Programme Criticality 1 within the humanitarian response and currently accepts the UN designation as a Programme Criticality 2.

2. **The successful establishment of emergency GBV response systems in all three zones is a significant achievement and contribution to the humanitarian response.** There was a strong push to implement response services with a focus on medical attention, counselling, referrals and basic safety. Significant progress has been made given that nothing was in place at the start of the last big emergency in 2011; and all partners, staff, and UN agencies now speak confidently about the types of services available, and how survivors can access them. Community members reinforced their understanding of which agencies provide response to GBV and gave specific examples of services they had received.

3. **There is strong support for the Communities Care approach and perception that it is working well.** CISP reported that the Communities Care approach being piloted in Somalia is unique in its structured content and guidance; they are already seeing impact in terms of people’s willingness to engage in discussions on GBV, their outreach to others, and attitudes and behaviours. Though the data from the midline and endline is not yet available, initial summaries from Johns Hopkins University (JHU) indicate positive results. Interestingly, the colleagues in Central South Zone were able to describe the intervention more clearly than the colleagues at national level.

4. **Partners understand and are widely using the GBVIMS for incident reporting.** Implementing partners have been trained in and are utilizing the Gender-based Violence Information Monitoring System (GBVIMS) regularly. This is creating a large body of data on GBV in Somalia. UNICEF supports the system with a GBVIMS coordinator in Puntland.

5. **Advocacy is generally strong at a high-level.** There has been significant engagement with the government in drafting the FGM policy and sexual offenses bill. To date, the focus has been on getting the bills drafted, with implementation of the bills falling under the rule of law programme. Partners and staff, however, did not maintain a common understanding of where in process these laws are and what should happen once they are agreed.

6. **UNICEF’s positive engagement in partnerships makes them a credible and valued partner and creates opportunities to strengthen GBV work.** Implementing partners (IPs), government partners,
civil society and other key informants generally reported that UNICEF is a positive partner who adds value to their work and is an important player in addressing GBV in Somalia. This has created opportunities for advancing GBV work, encouraging more government buy-in (e.g. development of the National Action Plan, FGM Bill, Sexual Offenses Bill), strengthening civil society and helping to guide the strategic direction of the GBV subcluster.

**Areas for Improvement**

7. **GBV does not feature clearly in the UNICEF Country Programme Document (CPD).** Though GBV is a fundamental part of the Child Protection programme, the language in the CPD is extremely limited and vague in relation to GBV. GBV does not feature clearly as a full UNICEF programme or programme component. This makes it challenging to maintain institutional accountability and commitment to quality GBV programming.

8. **The quality of GBV response services is inconsistent across partners and is not systematically monitored.** Interviews with implementing partners working outside of main areas raise significant questions about their understanding of fundamental concepts and quality of services, and concerns that some practices are inflicting harm. It is also unclear how UNICEF monitors the quality of services of those partners who are assumed to be strong in response. UNICEF staff and implementing partners report that case management is working well but there is limited discussion around any areas for improvement and the effectiveness of referral systems. Psychosocial support and follow-up services remain at a basic level and could be expanded.

9. **Response services are most relevant to sexual violence and could be strengthened to address the vast number of reports of intimate partner violence (IPV).** There is a need to continue to adapt techniques and strengthen service provider skills for addressing multiple forms of GBV, particularly IPV. In particular, most partners do not engage in safety planning and mediate cases of IPV, which is not a recommended practice and could cause further harm to survivors. There is a need to explore alternatives to mediation and deepen understanding and skills to respond adequately to IPV.

10. **GBV is not systematically integrated into other UNICEF sectors.** UNICEF staff in other sections consider GBV to be important as well as the integration of GBV into other sectors, but have not made efforts to achieve this. There is little knowledge of the new 2015 IASC GBVIE Guidelines, which were not officially rolled out in Somalia, nor connection between programmes.

11. **There is an overall lack of understanding of prevention.** The overwhelming majority of UNICEF and IP programme staff equate prevention with awareness-raising, with awareness-raising focusing on services provided. There is little, if any, recognition of the concepts of primary, secondary, or tertiary prevention as well as addressing root cause versus contributing factors. Work on both risk mitigation and structural change is limited.

12. **Awareness-raising activities are ad hoc and do not seem to reflect principles of effective communication for development (C4D)/ behaviour change communication.** Awareness-raising is an important part of GBV programming, however, only if it is used strategically as part of clear strategies.

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¹⁰² It is discussed below that CISP uses client satisfaction surveys as part of the Communities Care approach, however, it is unclear how UNICEF is involved in this process and the evaluation did not look into depth about how they are being used to inform programming.
for response and prevention. Currently, awareness-raising objectives are not understood and are not situated within a well-defined process of change. The methods and content used do not align with best practice in communicating for change. In particular, awareness-raising is currently:

1. Not grounded in a particular communication for development
2. Focused on messaging rather than provoking critical thinking.
3. Focused on negative consequences, rather than positive alternatives/ strengths or asset.
4. Using communication materials as visuals only, rather than as programme tools for discussion.

13. Focus on programme content is limited. UNICEF and partner staff describe programme activities, but the content of such activities, such as training manuals, awareness-raising sessions, communication materials, is not developed and is mostly ad hoc. Programme content is often undeveloped, generic, and/or not linked to a broader strategy; and there is limited recognition that programme content is fundamental to quality programming.

14. Coverage is limited to a few main areas and caters primarily to adult women; there is a need to explore alternative models for accessing remote populations and increasing access for adolescent girls. The complexity and insecurity of Somalia make it an extremely difficult environment in which to operate, severely limiting safe access to affected communities. Understandably, programming is concentrated predominantly in government-controlled cities that have significant UN presence. It is considerably more difficult to ensure and monitor quality of programmes outside these areas. At the same time, some partners consider that services can be provided to more remote communities, but that this will require new models of service provision and willingness to move away from standard approaches. Effort is also needed to reach and meet the specific needs of adolescent girls.

15. Analysis of data to inform programming and connection between systems is lacking. While there is a great deal of data collected by the programme, it is unclear how that data is analysed and utilized. Implementing partners input into the GBViE, but further analysis is not generally shared and discussed with them to inform programmes. Multiple partners noted confusion in rolling out the Child Protection Information Management System (CPIMS) system and the need for a streamlined approach to collecting and managing data between the 2 sub-clusters. The connections between the Monitoring and Reporting Mechanism (MRM) on six grave violations of children’s rights in situations of armed conflict and GBV programmes are not strong, both in terms of responding to cases reported in the MRM and how analysis from the two systems is used complementarily.

16. Suitability of team structure requires review. It was uncertain whether the staffing structure in each zone is best suited to accomplish the GBViE objectives. In addition, the staffing structure is not consistent across the three zones, which makes it challenging to maintain a cohesive programme framework and enable comparative results measuring.

8 RECOMMENDATIONS

Based on the findings and conclusions, and building on the GBViE work of UNICEF Somalia to date, the evaluation team offers the following recommendations:

Recommendation 1: Develop/articulate a clear GBV strategy. Connect the strategy to the three major outcome areas of the global GBViE Theory of Change (ToC): service delivery/response, risk mitigation, and long-term structural change. While the strategy will need to consider many things, it is recommended to:
a. Include specific strategies for responding appropriately to different types of GBV, specifically intimate partner violence (IPV). With support from UNICEF HQ, identify guidance, guidelines, techniques and skills that are specific to responding appropriately to IPV, incorporate into the strategy. Strategize around alternatives to mediation.


c. Expand use of safe spaces for women and girls. Review models for safe spaces that UNICEF uses in other countries, consider the feasibility of developing safe spaces with UNICEF partners in Somalia, and expand the services of those that are already functioning.

d. Develop and include clear approach for primary prevention aimed at structural change.
   i. Learn from the results of the Communities Care programme study:
      • If the results indicate success of the Communities Care approach, then roll it out in other zones in Somalia as feasible.
      • If the results do not indicate success, then identify the theory of structural change upon which UNICEF will base its primary prevention programming.
   ii. Focus primary prevention programming content on addressing the root cause as opposed to manifestations of GBV.
   iii. Strengthen staff and partner understanding of the difference between awareness-raising and prevention.
   iv. Define the specific objectives of the awareness-raising component of the programme and adapt/develop content and materials so that it contributes strategically to UNICEF’s overall GBV strategy. Specifically:
      • Develop effective communication materials (C4D) in line with Communities Care and/or principles of effective communication for change (e.g. provoking critical thinking vs. messaging, using an strengths/benefits-based approach rather than focusing on negative consequences, asking questions).
   v. Explore different approaches to economic and social empowerment. Consider the conditions necessary for these to become effective prevention strategies vs. general psychosocial support strategies, recognizing the potential unintended negative consequences.
   vi. Include FGM within the structural change component of the strategy, linking it to methods for addressing the root cause.
      • Review available qualitative and quantitative data to agree upon UNICEF’s understanding of core drivers and contributing factors of FGM (including the effort started in Puntland)
      • Ensure that current programming is brought under the umbrella of GBV in a way that is safe and ethical.

103 Safe spaces are not the same as shelters, which have the capacity for housing survivors and their children in a safe way. Safe spaces are spaces where women and adolescent girls can come to engage in psychosocial support or empowerment activities, receive counseling and services, participate in discussions groups, etc. These spaces are protective, supportive, and ultimately help to empower women and girls.

104 There is a misconception that when we engage elders, leaders, and community members, we have to talk about all of the types of violence. But structural change starts with helping people to reflect upon the root cause—power imbalance—and understanding our own values. Therefore, the content of the programme does not have to start with types of violence, but can focus on exploration of power, values, and identity.
d. Develop staffing structure that clearly meets the needs of the programme technically and administratively.

e. Consider how UNICEF engages both IDP and host communities.
   
   **Lead Responsibility:** GBV Specialist
   
   **When:** begin collaborative process by July 2016

**Recommendation 2:** Invest in strengthening the quality of basic response services offered, in line with key principles of quality response. To move this process forward, it is recommended that the programme:

a. Review the quality of basic response services offered, in line with key principles of quality response.
   
   Create a list of all of the services currently being offered such as community-based response (volunteers and committees), intake, psychosocial support, medical care, referral, hotlines, safety planning, and follow-up. For each service, identify the standards and indicators of quality response. Conduct review through onsite visits, and structured questions and discussions with implementing partners. Some areas to review more closely include:

i. **Techniques and methods of GBV focal points and committees:** The methods of this work are not clearly defined and quality is unclear. Develop clear plans and systems for how this community-based work is implemented, supported and monitored. Ensure these plans are understood by focal points, committee members and staff and included in work plans. Identify the key understanding and skills needed for quality response by GBV focal points and committees and include in capacity-building plans.

ii. **Nature of psychosocial support.** Identify additional types of psychosocial support activities for women, adolescent girls and survivors that would be relevant in Somalia, drawing on experiences from other countries and understanding of the context. (e.g. skills-building activities, coffee ceremonies, etc.)

iii. **Level of follow up provided to survivors:** It is unclear how and to what extent follow-up is offered to survivors. Review the level and methods of follow-up provided to survivors and strategize around additional support needed.

iv. **Mediation and response to intimate partner violence (IPV):** The programme is currently engaging in mediation of cases of IPV with families and community leaders, which is not a recommended practice for IPV. This could actually cause further harm to survivors. It is recommended, therefore, to pause this aspect of programming and work on strengthening capacity around specific techniques and considerations for responding appropriately to IPV.

v. **Hotlines:** Review the systems for managing the hotlines, referring cases (including GBV and non-GBV), ratio of GBV to non-GBV calls, documentation, etc. Make decisions together with partners about whether to continue this aspect of programming. (Note: this can be done only in zones where there are hotlines).

**Lead responsibility:** GBV Specialist and Team Leaders (specific aspects of review to be led by GBV Officers who directly oversee implementation of the work).

**When:** As part of GBV strategy process
b. Develop a plan for systematically monitoring quality of service provision in Somalia, with support from UNICEF HQ. The process can include:
   i. Reviewing the experience of using the programme quality monitoring tools that were adapted from Communities Care for Somalia. Based on the learning from that experience, adapt further and/or scale up to other partners.
   ii. Reviewing the monitoring tools that will be included in the new GBV Resource Pack, once it is shared with COs.
   iii. Strengthening understanding of informal monitoring techniques with UNICEF staff.
   iv. Deciding upon the specific tools and techniques to be used and establishing clear systems, deadlines, and roles and responsibilities for doing so.
   v. Incorporating specific programme monitoring responsibilities into UNICEF and IP staff workplans,

*Lead responsibility:* GBV Specialist and GBV Team Leaders

*When:* Begin the review in quarter 3. Carry over work into 2017

**Recommendation 3: Strengthen the focus on programme content.** Work with the team to institutionalize the understanding that programme activities cannot exist without content and materials to support them. The content should be clearly defined, in line with the programme’s theory of change, and as much as possible, delivered through creative means. To accomplish this, the team can:

a. Review programme content e.g. training manuals, awareness-raising materials, community dialogues, communication materials, etc.

b. For each area, discuss whether the content is aligned to the GBV strategy, the theory of behaviour change that the programme follows (see below) and best practices in line with the GBV Resource Pack and 2015 IASC GBViE Guidelines. Ensure that programmes are aligned with these guidelines.

c. Where there is no content currently, develop new content or adapt materials from other approaches.

*Lead responsibility:* GBV Specialist and GBV Team Leaders in each zone

*When:* begin review following development of GBV strategy

**Recommendation 4: Develop capacity-building plan for both UNICEF staff and implementing partners, based on the GBV strategy.** When developing the GBV Strategy, discuss the standards, concepts and capacities needed by partners for quality implementation and UNICEF staff for providing quality technical assistance.

a. Identify the internal capacity-building needs of UNICEF staff as well as the capacity-building needs of IPs to strengthen response and prevention e.g. IPV response, framing discussions around values and power, C4D principles, primary prevention, providing quality technical assistance, programme monitoring.

b. Develop plan for capacity-strengthening that includes both UNICEF staff and IPs.

c. Review the types of technical assistance that UNICEF can provide to IPs beyond training e.g. onsite support, content review, asking strategic questions, check-ins. Discuss how the team can utilize these methods more strategically to understand and strengthen the quality of programming.

d. Incorporate technical assistance activities into the workplans of UNICEF GBV staff.

*Lead responsibility:* GBV Specialist and GBV Team Leaders in each zone

*When:* upon completion of GBV Strategy

**Recommendation 5: Explore alternative options for expanding coverage, e.g. one-stop centres with mobile services, programmes for adolescent girls.** Review learning from UNICEF Lebanon on mobile centres, as well as other sectors in other countries and consider other alternatives for increasing access
within the restrictive security environment. Similarly, review engagement with adolescent girls in other context and develop targeted programming to ensure they don’t fall through the cracks.

Lead responsibility: GBV Team Leaders, Officers and partners in each zone, with support from GBV Specialist

When: In line with GBV strategy development

**Recommendation 6: Develop clear system and timeline for regularly using and analysing GBVIMS and other data to improve programmes.** In each zone it should be clear: who receives the consolidated data from UNFPA, whether this data is received on a monthly, quarterly, bi-annual and/or annual basis, what the role of the person receiving the data is, when and how that data will be shared with partners (set time monthly, quarterly, semi-annually and/or annually), and how the data will be reviewed together to inform programming.

*Lead responsibility: GBV Team Leaders*

*When: immediately*

a. Advocate with UNFPA to share consolidated data more openly, while maintaining ethical standards

*Lead responsibility: GBV Team Leader in each zone (support from GBV Specialist at national level)*

*When: immediately*

b. Review connections between GBVIMS and MRM, CPIMS, and MARA. Establish clear referral pathways for GBV cases and ways to exchange relevant information and learning.

*Lead responsibility: GBV Specialist, MRM Specialist, CP Cluster lead*

*When: to be agreed*

**Recommendation 7: Advocate to include GBV more directly and substantially in the next CPD.**

*Lead responsibility: Chief, CP and GBV Specialist*

*When: prior to and during development of the upcoming CPD*
Annex 1: Evaluation Questions

Relevance
1. To what extent is UNICEF GBVIE programming for care, support, protection, and risk reduction based on:
   a. assessed needs and data analysis? (Are the different needs of needs of women, adolescents, and children considered separately?)
   b. established good practice for GBVIE service provision, risk reduction and prevention? (Is UNICEF employing the most appropriate strategies to ensure further violence is reduced and survivors provided with appropriate services and support?)
2. To what extent has risk reduction been integrated into other UNICEF sector programmes?
3. To what extent do GBVIE programmes adapt to changing needs, and how well are the changing needs documented?
4. How well have views of survivors and other high risk groups (adolescent girls, women, children) been reflected in programme assessment, design, implementation and monitoring? (covers AAP)
5. Are programmes built on a clear Theory of Change for GBVIE programming? To what extent is this consistent with a corporate/regional Theory of Change and with UNICEF standards and guidelines expressed through the CCCs or elsewhere?
6. To what extent has a HRBA been taken in design, implementation, and monitoring of GBVIE programming?

Effectiveness
7. To what extent have UNICEF GBVIE programmes improved survivors' access to quality, life-saving, multi-sectoral services for care and support?
8. How quickly has UNICEF been able to establish services at the scale required?
9. To what extent has the programme contributed to preventing and mitigating risks of GBV for women, adolescents and children?
10. Are programme objectives clear and specific for different GBVIE areas of programming? How far have programme objectives been achieved / likely to be achieved?
11. Which have been the most/least effective programmes? Why?
12. How systematically have results been captured/used/learned from?
13. How and how effectively has 1) UNICEF leadership and 2) technical support from HQ, regional and country levels contributed to the effectiveness of UNICEF GBVIE programming? Including ensuring that GBVIE is included in the earliest response strategies and funding priorities?

Connectedness and Sustainability
14. How, and how effectively does UNICEF GBVIE programme design and implementation link emergency programming with UNICEF's longer-term programming to prevent and respond to GBV? Is UNICEF’s approach to GBVIE built into its conceptualisation and implementation of sustainable resilience programming?
15. How effectively have partnerships with civil society and government been built to address planned GBVIE outcomes?
16. How and to what extent has the capacity of local and national partners been strengthened through the programme?
17. To what extent has UNICEF’s internal and external advocacy contributed to improved GBV response and prevention? (Including clarifying UNICEF’s specific programme and leadership roles?)

Coordination
18. To what extent are programmes consistent with good practice (Resource Pack and revised GBVIE Guidelines)
19. Does/how does UNICEF add value to the GBVIE response (through leadership, standard setting, coordination)?

Coverage
20. Are there any gaps in GBVIE programming (specialised and integrated) in terms of geographical and demographic coverage? - how has UNICEF (a) identified the gaps and (b) taken action to close the gaps?

Efficiency
21. To what extent have UNICEF financial and human resource inputs been commensurate/adequate to the task of meeting GBV programming need?
22. To what extent have UNICEF inputs achieved value for money outputs?
## Annex 2: Interviews/Workshops participants (to be completed)

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Position</th>
<th>M/F</th>
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<tbody>
<tr>
<td>Steven Lauwrier</td>
<td>UNICEF – Management</td>
<td>Representative</td>
<td>m</td>
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<tr>
<td>Jeremy Hopkins</td>
<td>UNICEF – Management</td>
<td>Deputy Representative</td>
<td>m</td>
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<tr>
<td>Jean-Michel Delmotte</td>
<td>UNICEF- Management (Mogadishu)</td>
<td>Chief Field Officer</td>
<td>m</td>
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<tr>
<td>Sheema Sen Gupta</td>
<td>UNICEF – CP</td>
<td>Chief, Child Protection</td>
<td>f</td>
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<tr>
<td>Charity Koronya</td>
<td>UNICEF – CP</td>
<td>FGM Specialist/ interim GBV Specialist</td>
<td>f</td>
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<tr>
<td>Brendan Ross</td>
<td>UNICEF – CP</td>
<td>GBVIE Specialist</td>
<td>m</td>
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<tr>
<td>William Kollie</td>
<td>UNICEF – CP</td>
<td>Child Protection Officer</td>
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<td>Eston Njorge</td>
<td>UNICEF – CP</td>
<td>Child Protection Officer</td>
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<tr>
<td>Mohamoud</td>
<td>UNICEF – CP (Garowe)</td>
<td>Chief, Child Protection</td>
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<td>Kamal Nidan Adam</td>
<td>UNICEF – CP (Garowe)</td>
<td>Child Protection Officer</td>
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<td>Abdi Khani Ibrahim Hassan</td>
<td>UNICEF – CP (Garowe)</td>
<td>GBVIMS Coordinator</td>
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<td>Omar Mohamud Farah</td>
<td>UNICEF – CP (Garowe)</td>
<td>Child Protection Assistant</td>
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<td>Mohamed Nur Yalalow</td>
<td>UNICEF – CP (Mogadishu)</td>
<td>Child Protection Officer</td>
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<td>Abdisfatah Mohamud Abdi</td>
<td>UNICEF – CP (Mogadishu)</td>
<td>Child Protection Officer</td>
<td>m</td>
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<tr>
<td>Sarah Elamin Ng’inga</td>
<td>UNICEF – Donor Relations</td>
<td>Donor Relations Specialist</td>
<td>f</td>
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<tr>
<td>Hana Yoshimoto</td>
<td>UNICEF – Education</td>
<td>Education Specialist</td>
<td>f</td>
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<tr>
<td>Valerie Price</td>
<td>UNICEF – Education</td>
<td>Education Programme Manager</td>
<td>f</td>
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<tr>
<td>Lieven Desomer</td>
<td>UNICEF – Emergencies</td>
<td>Chief, Emergency</td>
<td>m</td>
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<tr>
<td>Dr. Anirban Chatterjee</td>
<td>UNICEF – Health and Nutrition</td>
<td>Chief, Health</td>
<td>m</td>
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<tr>
<td>Nana Essah</td>
<td>UNICEF – Supply</td>
<td>Chief, Supply and Logistics</td>
<td>f</td>
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<tr>
<td>Cormac O’Sullivan</td>
<td>UNICEF – Supply</td>
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<td>Giorgio Figus</td>
<td>UNICEF – Supply</td>
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<td>Patrick Laurent</td>
<td>UNICEF – WASH</td>
<td>Cluster Coordinator</td>
<td>m</td>
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<tr>
<td>Catherine Mutwiri</td>
<td>UNICEF – WASH</td>
<td>IM Officer</td>
<td>f</td>
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<tr>
<td>Michael Copland</td>
<td>UNICEF – Regional Officer</td>
<td>Regional Advisor CPE</td>
<td>m</td>
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<tr>
<td>Isatu Kemoh Bayoh</td>
<td>UNFPA</td>
<td>Gender Advisor/GBV Technical Specialist/ GBV Subcluster Coordinator</td>
<td>f</td>
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<tr>
<td>Penina Gathuri</td>
<td>UNFPA (Garowe)</td>
<td>International GBV Coordinator</td>
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<tr>
<td>Abdisalam Bahwal,</td>
<td>UNFPA (Garowe)</td>
<td>National Programme Officer</td>
<td>m</td>
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<tr>
<td>Abdulkadir Mohamed Dahir</td>
<td>UNFPA (Mogadishu)</td>
<td>Humanitarian Specialist</td>
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<tr>
<td>Mohammed Abdullahi Farah</td>
<td>UNHCR (Garowe)</td>
<td>Program Associate</td>
<td>m</td>
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<tr>
<td>Ghada A M Shawgi</td>
<td>UNSOM</td>
<td>Senior Women’s Protection Officer</td>
<td>f</td>
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<td>Abdisnars Moallin</td>
<td>UNSOM</td>
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<td>m</td>
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<tr>
<td>Annika Gerlach</td>
<td>UNHCR (Mogadishu)</td>
<td>Deputy Protection Cluster Coordinator</td>
<td>f</td>
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<tr>
<td>Nina Schreper</td>
<td>UNHCR (Mogadishu)</td>
<td>Cluster Coordinator</td>
<td>f</td>
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<tr>
<td>Abdiwali Mohammed Yusup</td>
<td>Government (MOWDAFA)</td>
<td>Acting GBV Director</td>
<td>m</td>
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<tr>
<td>Dr. Mina Hassan Mohammed</td>
<td>Government (MoWHRD)</td>
<td>Coordinator for Ministry of Women and Human Rights Chairperson of FGM Taskforce</td>
<td>f</td>
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<tr>
<td>Sadia Mohamed Nur</td>
<td>Government (MoWHRD)</td>
<td>Director of Gender</td>
<td>f</td>
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<tr>
<td>Abih Ahmed Hersi</td>
<td>NGO IP (CCBRS)</td>
<td>Executive Director</td>
<td>m</td>
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<tr>
<td>Francesco Kaburu</td>
<td>NGO IP (CISP)</td>
<td>Regional Programme Manager</td>
<td>m</td>
</tr>
<tr>
<td>Amelie Desgropes</td>
<td>NGO IP (CISP)</td>
<td>Research Coordinator</td>
<td>f</td>
</tr>
<tr>
<td>Salah Kheir Abdille</td>
<td>NGO IP (CISP- Mogadishu)</td>
<td>Senior Community Engagement Manager</td>
<td>m</td>
</tr>
<tr>
<td>Asma Said Ali</td>
<td>NGO IP (CISP- Mogadishu)</td>
<td>Child Protection Manager</td>
<td>f</td>
</tr>
<tr>
<td>Hared Ibrahim Osman</td>
<td>NGO IP (Sedhuro)</td>
<td>Programme Officer</td>
<td>m</td>
</tr>
<tr>
<td>Amina Maalim</td>
<td>NGO IP (Ospad)</td>
<td>Programme Officer</td>
<td>f</td>
</tr>
<tr>
<td>Zainab Elmi Abdi</td>
<td>NGO IP (TASS)</td>
<td>Programme Officer</td>
<td>f</td>
</tr>
<tr>
<td>Ibrahim Abdullah Mohad</td>
<td>NGO IP (TASS)</td>
<td>Programme Manager</td>
<td>m</td>
</tr>
<tr>
<td>Asad Osman Abdi</td>
<td>NGO IP (TASS)</td>
<td>Protection Coordinator</td>
<td>m</td>
</tr>
<tr>
<td>Farah Osman Said</td>
<td>NGO IP (GRT)</td>
<td>Field Manager</td>
<td>m</td>
</tr>
<tr>
<td>Name</td>
<td>Organization</td>
<td>Position</td>
<td>Gender</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Fardosa Muse</td>
<td>NGO IP (GRT)</td>
<td>Protection Coordinator</td>
<td>m</td>
</tr>
<tr>
<td>Fartun Adan</td>
<td>NGO IP (ElMan)</td>
<td>Director</td>
<td>f</td>
</tr>
<tr>
<td>Mumin Moallin Mohamoud</td>
<td>NGO IP (ElMan)</td>
<td>GBV Assistant Programme Manager</td>
<td>m</td>
</tr>
<tr>
<td>Alia Aden Abdi</td>
<td>NGO IP (HIWA)</td>
<td>Chairwoman</td>
<td>f</td>
</tr>
<tr>
<td>Salat Alas Daud</td>
<td>NGO IP (HIWA)</td>
<td>Programme Manager</td>
<td>m</td>
</tr>
<tr>
<td>Abdirahman Nuhmed</td>
<td>NGO IP (HIWA)</td>
<td>Finance Officer</td>
<td>m</td>
</tr>
<tr>
<td>Deqo Olad</td>
<td>NGO IP (SWDC)</td>
<td>Communications Officer</td>
<td>f</td>
</tr>
<tr>
<td>Zahra Ahmad</td>
<td>NGO IP (SWDC)</td>
<td>Legal Advisor and Human Rights Defender</td>
<td>f</td>
</tr>
<tr>
<td>Badriya Mohamed Farah</td>
<td>National Consultant (Garowe)</td>
<td></td>
<td>f</td>
</tr>
<tr>
<td>Mohammed Ali Ahmed</td>
<td>National Consultant (Garowe)</td>
<td></td>
<td>m</td>
</tr>
<tr>
<td>Hafso Ahmed Mohamed</td>
<td>National Consultant (Mogadishu)</td>
<td></td>
<td>f</td>
</tr>
<tr>
<td>Mohamed Omar Abdille</td>
<td>National Consultant (Mogadishu)</td>
<td></td>
<td>m</td>
</tr>
</tbody>
</table>
# Annex 3: Mission Itinerary

<table>
<thead>
<tr>
<th>Activity</th>
<th>Venue Sites</th>
<th>Responsibility</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wednesday 9 March: Nairobi</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-12:30 Meeting with UNICEF Child Protection team</td>
<td>UNICEF conference Room</td>
<td>Charity/Brendan</td>
<td>Conference Room reservation to be made</td>
</tr>
<tr>
<td>• Sheema</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Brendan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Charity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• William</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00-2:30 Meeting with Anirban-Chief Heath</td>
<td>UNICEF conference Room</td>
<td>Charity/Brendan</td>
<td></td>
</tr>
<tr>
<td>2:30-3:30 Meeting with UNICEF Deputy Representative</td>
<td>UNICEF conference Room</td>
<td>Charity/Brendan</td>
<td></td>
</tr>
<tr>
<td>3:30-4:30 Meeting with UNICEF Representative</td>
<td>UNICEF conference Room</td>
<td>Charity/Brendan</td>
<td></td>
</tr>
<tr>
<td><strong>Thursday 10 March: Nairobi</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:00-9:00 Education Section</td>
<td>UNICEF conference Room</td>
<td>Charity/Brendan</td>
<td>The evaluation questionnaire to be shared with the Chiefs in advance and if possible have a short briefing of the evaluation by the CP Chief</td>
</tr>
<tr>
<td>9:00-10:00 UNFPA –GBV Advisor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00-11:00 Chief PM&amp;E + emergency focal point</td>
<td>UNICEF conference Room</td>
<td>Charity/Brendan</td>
<td></td>
</tr>
<tr>
<td>11:00-11:30 Chief PM&amp;E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00-13:00 Chief Emergency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00-2:00pm Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00-3:00 Meeting with CISP</td>
<td>UNICEF conference Room</td>
<td>Charity/Brendan</td>
<td></td>
</tr>
<tr>
<td>3:00-4:00pm Meeting with selected GBVWG members( CISP, SEDHURO and other UNICEF partners in Nairobi)</td>
<td>UNICEF conference Room</td>
<td>Charity/Brendan</td>
<td></td>
</tr>
<tr>
<td><strong>Friday 11 March: Nairobi</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30-9:30 Interview/meeting with Sheema (Chief CP)</td>
<td>Sheema’s Office</td>
<td>Charity/Brendan</td>
<td></td>
</tr>
<tr>
<td>9:30-10:30 Interview Eston and William (CP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30-11:30 Interview the CPWG Coordinator- Bindu</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30-12:00 Interview Supplies Section - Nana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00-1:00 Donor Relations Specialist</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
1:00 - 2:00pm | Skype with Michael Copland

12th Saturday — REST

**Sunday 13 March: Travel to Somalia**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 (approx.)</td>
<td>Travel to Garowe arrive 12:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:45-3:30</td>
<td>Arrival to hotel and lunch</td>
<td>Int’l GH</td>
<td>Mohamoud / Kamal</td>
</tr>
<tr>
<td>16:00-17:00</td>
<td>Meeting with UNICEF CP team and CFO for briefing</td>
<td>UNICEF Conferenece room</td>
<td>Mohamoud</td>
</tr>
</tbody>
</table>

- Charity to ensure tickets are purchased
- Mohamoud to ensure visas are available
- Charity/Sheema to accompany the team also as part of orientation

**Monday 14 March: Garowe**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-10:30</td>
<td>Train national consultants</td>
<td>UNICEF Office</td>
<td>Robyn</td>
</tr>
<tr>
<td>8:30: 10:30</td>
<td>Interview with UNICEF CP staff</td>
<td>UNICEF office</td>
<td>Mohamoud</td>
</tr>
<tr>
<td>10:30-11:30</td>
<td>Logistics for the following day</td>
<td>UNICEF office</td>
<td>Mohamoud</td>
</tr>
<tr>
<td>11:30-12:30</td>
<td>Interview with MOWDAFA staff</td>
<td>UNICEF Office</td>
<td>Mohamoud</td>
</tr>
<tr>
<td>12:30-1:30</td>
<td>Interview with GRT staff</td>
<td>UNICEF office</td>
<td>Mohamoud</td>
</tr>
<tr>
<td>14:00-15:00</td>
<td>Interview with GBV Sub cluster Coordinator</td>
<td>UNICEF Office</td>
<td>Mohamoud</td>
</tr>
<tr>
<td>15:00-16:00</td>
<td>Interview with UNHCR</td>
<td>UNICEF Office</td>
<td>Mohamoud</td>
</tr>
<tr>
<td>15:00-16:00</td>
<td>Interview with GBVIMS Coordinator</td>
<td>UNICEF Office</td>
<td>Abdikhani</td>
</tr>
</tbody>
</table>

**Tuesday 15 March: Garowe**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-12:30PM</td>
<td>• Interview with TASS &lt;br&gt; • Focus groups with women/men/adolescent girls and boys (15-24) at community level.</td>
<td>TASS</td>
<td>Mohamoud</td>
</tr>
<tr>
<td>14:00-15:00</td>
<td>• FGDs and in-depth interviews continued at community levels continued</td>
<td>TASS</td>
<td>Mohamoud</td>
</tr>
</tbody>
</table>

- Robyn- adolescent boys<br> - Robyn- men’s group<br> - Katie- adolescent girls<br> - Katie- women<br>

**Wednesday 16 March: Travel to Mogadishu**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 am</td>
<td>Debriefing of CP Team and CFO</td>
<td>UNICEF offices</td>
<td>Charity- Ticket</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
<td>Location</td>
<td>Facilitator(s)</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>(cancelled b/c called to UN Compound to check in for flight)</td>
<td>Travel to Mogadishu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:30-17:30</td>
<td>Meeting with UNICEF CP team and CFO for briefing</td>
<td>Yalahow</td>
<td>Team to confirm the venue for FGDs and which partner is to prepare for which target group</td>
</tr>
</tbody>
</table>

**Thursday 17 March: Mogadishu**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Facilitator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:15</td>
<td>Brief with UNICEF Rep, Somalia</td>
<td>UNICEF compound (outside airport)</td>
<td>Robyn and Katie (new UNICEF GBV Officer beginning today)</td>
</tr>
<tr>
<td>9:30-10:00</td>
<td>Interviews with UNICEF CP team</td>
<td>UNICEF offices/ hotel</td>
<td>Robyn and Katie</td>
</tr>
<tr>
<td>10:00-12:00</td>
<td>Training of National Consultants</td>
<td>Peace Hotel</td>
<td>Katie</td>
</tr>
<tr>
<td>10:00-11:00</td>
<td>Interviews with MOWHRD officials</td>
<td>Peace Hotel</td>
<td>Robyn</td>
</tr>
<tr>
<td>11:00-12:00</td>
<td>Interviews with SWDC</td>
<td>Peace Hotel</td>
<td>Robyn</td>
</tr>
<tr>
<td>14:30-15:00</td>
<td>Interviews with UNHCR GBVIMS Coordinator</td>
<td>UNSOM</td>
<td>Katie</td>
</tr>
<tr>
<td>15:00-16:00</td>
<td>Interviews with UNHCR Protection Cluster Lead</td>
<td>UNSOM</td>
<td>Robyn</td>
</tr>
<tr>
<td>16:00-17:00</td>
<td>Interviews with UNSOM Women’s Protectin</td>
<td>UNSOM</td>
<td>Katie</td>
</tr>
</tbody>
</table>

**Friday 18 March: Mogadishu**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Facilitator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:00-15:00</td>
<td>Interview with El Man</td>
<td>Peace Hotel</td>
<td></td>
</tr>
<tr>
<td>15:00-16:00</td>
<td>Interview with CISP</td>
<td>Peace Hotel</td>
<td></td>
</tr>
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</table>

**Saturday 19 March: Mogadishu**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Facilitator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-10 am</td>
<td>Focus groups with women and host community members</td>
<td>SWDC</td>
<td>Robyn- Women, Katie- Host community members (male/female mixed)</td>
</tr>
<tr>
<td>10:30-12:00</td>
<td>Focus groups with men and adolescent girls</td>
<td>El Man</td>
<td>Robyn- adolescent girls, Katie- men</td>
</tr>
<tr>
<td>14:00-15:00</td>
<td>Interviews with HIWA</td>
<td>Peace Hotel</td>
<td>Katie</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
<td>Location</td>
<td>Participants</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>15:00-16:00</td>
<td>Interviews with UNFPA</td>
<td>Peace Hotel</td>
<td>Abdifatah</td>
</tr>
<tr>
<td>16:00-17:00</td>
<td>Debrief with UNICEF CP Team</td>
<td>Peace Hotel</td>
<td>Yalahow, Abdifatah</td>
</tr>
</tbody>
</table>

**Sunday 20 March: Mogadishu to Nairobi**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:30</td>
<td>Travel to Somaliland Hargeisa</td>
<td>UNICEF offices</td>
<td>Yalahow/Sylvester</td>
</tr>
<tr>
<td></td>
<td>Cancelled b/c of errors in flight booking- return to Nairobi in afternoon. Arrival in evening</td>
<td></td>
<td></td>
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</table>

**Monday 21 March: Nairobi**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Participants</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:30 am-5:00 pm</td>
<td>Consolidation of findings and recommendations</td>
<td></td>
<td>Katie/Robyn</td>
<td>Katie and Robyn</td>
</tr>
<tr>
<td>6:00pm-7:00 pm</td>
<td>Skype/Interview with IRC (Somaliland)</td>
<td></td>
<td>Robyn</td>
<td>IRC interview did not happen b/c of connectivity issues</td>
</tr>
<tr>
<td></td>
<td>Skype/Interview with Annika-Gerlack (Deputy Protection)</td>
<td></td>
<td>Katie</td>
<td></td>
</tr>
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</table>

**Tuesday 22 March: Nairobi**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Participants</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 am</td>
<td>Skype/Interview CCBRS</td>
<td></td>
<td>Robyn</td>
<td>Due to connectivity issues in Somaliland, UNHCR interview did not take place. Also WAAPC had a scheduling conflict so could not conduct an interview by Skype</td>
</tr>
<tr>
<td></td>
<td>Skype/Interview UNHCR (Somaliland)</td>
<td></td>
<td>Katie</td>
<td></td>
</tr>
<tr>
<td>11:45-1:45</td>
<td>Review recommendations</td>
<td></td>
<td>Robyn/Katie</td>
<td></td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Skype interview IRC</td>
<td></td>
<td>Robyn</td>
<td>Neither interview could take place b/c of connectivity problems in Somaliland and scheduling conflict</td>
</tr>
<tr>
<td></td>
<td>Skype interview Sylvester</td>
<td></td>
<td>Katie</td>
<td></td>
</tr>
<tr>
<td>3:00-3:30</td>
<td>Finalize recommendations and presentation</td>
<td></td>
<td>Robyn/Katie</td>
<td></td>
</tr>
<tr>
<td>6:00-9:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Wednesday 23 March: Nairobi**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Participants</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-10:00</td>
<td>De-briefing meeting with CP Team</td>
<td></td>
<td>Charity</td>
<td>Robyn and Katie (Brendan not available- in SAFE training)</td>
</tr>
<tr>
<td>10:30-12:30</td>
<td>Presentation of Findings and Recommendations to full team</td>
<td></td>
<td>Charity</td>
<td>Robyn and Katie (Brendan not available- in SAFE training)</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00</td>
<td>Departure from UNICEF Nairobi</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 4: Bibliography

IASC Guidelines for Integrating Gender-based Violence in Humanitarian Action, 2015
Draft GBVIE Programme Resource Pack, CPS, UNICEF
The Impact of War on Somali Men: An Inception Study, LOGiCA Study Series
Guide to the WASH Cluster Strategy and Standards (Strategic Operational Framework), 2015
Somalia Gender-based Violence Working Group, 2014-2016 Strategy
Somalia Initial Rapid Needs Assessment, Middle Shabelle, November 2015
Provision Constitution, Federal Republic of Somalia, Adopted August 2012, Mogadishu
Functionality Assessment, Bosaso GBV Working Group, 29 March 2012
WASH Minimum Commitments for the Safety and Dignity of Affected Populations, December 2014
Assessing Community Discussion Participants’ Beliefs
Mid-year Review of GBV Activities, UNICEF Somalia, 2012
Prevention of and Response to Gender-based Violence in Somalia, UNICEF Programme Structure
UNICEF GBV Package Concept, UNICEF Somalia
Gender-based Violence Information Management System: Somalia Consolidated Data Report, January – December 2015
Female Genital Mutilation Bill 2015, Federal Republic of Somalia, First Draft
Somali Protocol for Clinical Management of Rape, Implementing partners of MOH and ANPPCAN–SOM
Sexual Violence in Mogadishu, UNICEF Internal Briefing Note, July 2012
Lessons learned, GBV Working Group Functionality Assessments, Mogadishu and Bosaso, Somalia, 2012
Mogadishu GBV Working Group Functionality Assessment, March 2012
Mogadishu Advisory Group, 29 May 2013, Minutes
Nairobi Advisory Group, Social Norms and Community-Based Care, Meeting Minutes 01/08/2013
Trends and Patterns of GBV in Bossaso, Somalia, Consolidated Report for January – June 2014, GBVIMS
Strategy to Stop Health Professionals from Performing Female Genital Mutilation/Cutting for Puntland, 2014-2018
Strategic Communication for Development (C4D) Plan for Abandonment of Female Genital Mutilation/Cutting (FGM/C) in Puntland, UNICEF
Standard Operating Procedures for Response to Gender-based Violence and Child Protection in Bossaso, 2nd revision, 12 August 2015
Report on Baseline Survey, Relief International & Fuel Efficient Stove, June 2012
GBV Harmonised Messages
GBV Review Meeting – Concept Note, UNICEF Somalia Child Protection Section August 2012
GBV Sub-Cluster Bulletin, September – December 2015
GBV Working Group Consolidated Report, 2015
Comprehensive Community Based Rehabilitation Somaliland, Project Proposals 2011-2012 & 2013-2014
Comprehensive Community Based Rehabilitation Somaliland, Annual Progress Report, 2013-2014
Comprehensive Community Based Rehabilitation Somaliland, Annual Project Report, 2015
Somalia Strategic Response Plan, 2014
Somalia Humanitarian Needs Overview, 2016