Documentation of Sexual and Gender Based Violence Project Intervention for IDPs/Returnees in Maroodi Jeex

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The Baring Foundation

WAAPO
Women Action for Advocacy and Progress Organization

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Photo on cover page taken at WAAPO Shelter, Hargeisa, Maroodi Jeex, Somaliland, courtesy of Forcier Consulting Field Researchers.

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Health Poverty Action (HPA) is a British international development organisation established in 1984 (formerly Health Unlimited), operating in 14 countries, including in Africa, Asia, and Latin America. Its core mission is supporting the poorest and most vulnerable people to access functioning primary healthcare by working with communities, health service providers, and policy makers. As an organization, it prioritises communities affected by conflict and political instability. In Somaliland, HPA has been operating since 1995 with funding from the Department for International Development (DFID), the European Union (EU), the United Nations High Commissioner for Refugees (UNHCR), and the United Nations Population Fund (UNFPA), among others, and regions including Sool, Sanaag, Woqooyi Galbeed, Sahil, and Togdheer.

For further information, please visit www.healthpovertyaction.org.

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The following individuals at Forcier Consulting contributed to the research and analysis of this report:

Dr. Juuso Miettunen, Project Manager

Sarah Butterfield, Project Officer

Salwa Yusuf, Fieldwork Manager

Sucaad Hussein, Lead Researcher

Istahil Naguib, Lead Researcher

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ACRONYMS

CHW	Community Health Worker
CID	Criminal Investigations Department
CSO	Civil society organisation
EC	European Commission
FGD	Focus group discussion
FGM	Female genital mutilation
GBVIMS	Gender-based violence information management system
HPA	Health Poverty Action
HC	Health centre
IDP	Internally displaced person(s)
KAP	Knowledge, attitudes, and practices
KII	Key informant interview
MCH	Maternal and child health
MoH	Ministry of Health
MoJ	Ministry of Justice
MoLSA	Ministry of Labour and Social Affairs
NGO	Non-governmental organization
NSA	Non-state actor
OECD – DAC	Organisation for Economic Cooperation and Development – Development Assistance Committee
SGBV/GBV	Sexual and gender-based violence/gender-based violence
SRHR	Sexual and reproductive health rights
TBA	Traditional Birth Attendant
WHO	World Health Organisation

1. Report Outline

This report on *Documentation of Sexual and Gender Based Violence of IDPs/Returnees in Maroodi Jeex, Somaliland,* will document and analyse findings from the city of Hargeisa, in Maroodi Jeex, Somaliland, pertaining to Health Poverty Action's sexual and gender-based violence (SGBV) programming in Hargeisa, particularly as it relates to the shelter home run by WAAPO for survivors of SGBV.

In this report we first provide an executive summary, including key findings from this study and resulting recommendations, followed by a background of SGBV in the Hargeisa area, as well as the background for HPA's local programming. After outlining the project objectives, research indicators, and study methodology, we discuss the study results in depth and broken down by OECD-DAC criteria for evaluating development assistant programmes: relevance, effectiveness, efficiency, impact, and sustainability. Finally, we present a conclusion of study results, including best practices, lessons learned, and recommendations for this shelter and for the model's replication on national and international levels.

2. Executive Summary

2.1 Key Findings

This study was conducted in Hargeisa city of Maroodi Jeex region of Somaliland to evaluate an HPA programme, the purpose of which was to create a shelter home/safe house for survivors of sexual and gender based violence. This programme is part of HPA's larger project, *Expanding Sexual and Reproductive Health Services for IDPs/Returnees in Maroodi Jeex, Somaliland.* The evaluation of HPA's shelter, implemented by local NGO WAAPO, included 14 key informant interviews and three focus group discussions. All interviews were conducted in Hargeisa, and evaluated not only the challenges and successes of the shelter, but also the viability of replicating the HPA shelter model in other locations. HPA's supplemental training and outreach programs, directed at key SGBV stakeholders such as ministry officials, lawyers, police, and local leaders, were also evaluated.

Based on a combination of qualitative interviews with key stakeholders on SGBV and SGBV survivors in the Hargeisa area, the HPA/WAAPO shelter and related training activities have been extremely successful in promoting change and a safe space for women in the local community. Since HPA's program began, more women have reported crimes of SGBV than previously, more perpetrators have been tried and put in jail, and more women than ever before have been able to access mental health, medical, and psychosocial care after experiencing traumatic cases of SGBV. However, the WAAPO shelter is only one safe space for women, in a very large country, with high levels of sexual violence, and the shelter's ability to reach all the women and children who need its services still remains minimal. Much more can still be done to respond to the needs of survivors, such as developing the capacity of the shelter, or perhaps opening shelters with similar models, developing a justice system that is properly equipped to handle and prosecute acts of SGBV, and expanding the training of local communities and key SGBV stakeholders.

Sewing work stations in the WAAPO shelter to help women in the shelter learn tailoring skills.

A variety of key stakeholders, including Ministry of Health officials, Ministry of Labour and Social Affairs officials, lawyers, police officers, community leaders, and religious leaders, have been educated and trained on SGBV, how to properly report SGBV and assist victims in reporting, where victims can be referred for assistance, and how to provide emotional and psychosocial care to survivors.

In 2014, the WAAPO shelter expanded their services to be able to serve even more women. They are not only able to provide safe shelter, but also food, water, skills training (tailoring lessons) to survivors, and English lessons. "This shelter does the best job of caring for victims," one survivor said. As its primary and most significant goal was to create a high-quality, safe space for survivors of SGBV, satisfaction with services is an important aim accomplished by HPA's programming.

WAAPO staff and caseworkers noted that they were previously (before HPA's programming) not capable of providing the quantity and quality of care in their programming that they are now able to with the help of HPA 's support in the creation of the shelter, and the provision of shelter services. Prior to HPA's assistance and the establishment of the shelter, one caseworker noted, they could only provide very minimal assistance to survivors, and their space and services were too small to serve many women. Before HPA assisted WAAPO in opening the shelter, there was zero ability for in-house care for women. As compared with 2014, when 182 survivors were given housing at the shelter. In addition, 330 women were provided with counselling and social mediation (a 150% increase from 2012)[1]. It was noted by all WAAPO staff interviewed that the training they obtained from HPA was particularly helpful in enabling them to provide the assistance needed by survivors. This included not only educational information about SGBV and providing psychosocial care, but also project management, monitoring, and technical advice. These skills will prove extremely useful for the long-term sustainability of the project.

Based on interviews with local community members, awareness raising activities led by HPA are reaching the community, even if the community members aren't aware that HPA is the organisation that is leading them. While most local community members were not aware of HPA, they were aware of its local NGO partner WAAPO and the support that WAAPO provides to women in general, especially victims of SGBV. They also spoke candidly about the negative repercussions of SGBV in their community, illustrating communities' awareness of the consequences of SGBV and changed attitudes. However, awareness raising activities should be expanded and directed targeted further at males, in order to tap into the significant attitude changes that are occurring in the local community right now.

2.2 KEY RECOMMENDATIONS

Across nearly all indicators, HPA was able either to accomplish or exceed their goals, impressive given the limited resources available to them and the difficulties of working on SGBV in the Somali context. Below, recommendations for future programming and continued work on SGBV are outlined.

- Nearly all interviewed stakeholders stated that community and religious leaders are the biggest obstacles, and the biggest potential assets, to reform. This is because the latter groups are unique in being universally respected by their communities. As such **more formal mechanisms to engage with community and religious leaders should be implemented going forward**. This should include not only educating leaders on SGBV, but also on how to engage in outreach and awareness raising activities, as well as how to advise community members who endure SGBV-related conflicts. Though community leaders received some training on SGBV and how to appropriately and actively respond to it, many feel that community and religious leaders were still an obstacle, oftentimes as a result of their strongly held sociocultural and religious beliefs – historically conservative. In the future, training is recommended on SGBV, survivors' legal rights, and the ways in which local leaders can communicate the negative consequences of SGBV.
    - In particular, **community and religious leaders should receive training on the formal justice system**. This training should include in-depth information about the advantages of the formal legal system for victims, so that stakeholders can encourage their community members to utilize it, rather than traditional *xeer* law, when seeking prosecution on matters pertaining to SGBV. As currently 12-50% of SGBV cases are resolved using the *xeer* traditional system, it is crucial that local leaders encourage their communities to use the formal legal system, upon understanding its greater benefits in these types of cases (more detail on the

[1] Health Poverty Action, Hargeisa, Somaliland. 2014 SRHR Endline Report.

benefits of using the formal justice system in SGBV cases is outlined in section 3.1). Only after this awareness in the community becomes more widespread, will we be able to see the positive effects of legal reforms in the formal justice system, as traditional forms of justice are not equipped to help victims recover and properly access justice.

- The main learnings garnered by participants of HPA trainings relate to basic definitions and concepts of gender and SGBV, rather than more in-depth and specific trainings on how to care for survivors of SGBV. The basic trainings conducted were a crucial first step in educating stakeholders on SGBV. Representatives from the shelter and the Ministry of Health said they would benefit greatly from information about how to work with survivors of SGBV, and how to care for those survivors, given their experience with trauma. In addition, it is recommended for future programming that **informational trainings/workshops on SGBV, how to prevent it on a community level, and its consequences for victims, should be made available to all local community members**. HPA should work with its extensive network of SGBV stakeholders to ensure this, since this kind of awareness-building is crucial to long-term success, as respondents almost universally suggested that the most prohibitive factor to reform was community attitudes. Mechanisms for awareness building include community conversation techniques or, given the extremely high levels of radio listenership on HPA's radio programme Saxon Saxo[2], briefings could be included in the programme.
- In 2014, over 340 Ministry of Health employees were trained as part of HPA's programming. These trainings covered topics including family planning, counselling, SGBV, SRH rights, clinical skills, neonatal care, and using the GBVMIS data management system.[3] With regard to SGBV, **it is recommended that additional effort be made to coordinate further with government ministries**. Currently, HPA works with the Ministry of Health and Ministry of Labour and Social Affairs. However, one MoLSA official noted that she had not received any training from HPA or WAAPO, and an MoH official noted the need for more in-depth training on psychosocial care and counselling. MoLSA staff lack of training shown in this study was due to that the ministry staff did not work for the MoLSA at the time of HPA's training, however it is one area in which even more can be done to enhance the knowledge and abilities of current ministry staff. An MoH official, MoLSA official, police, and shelter caseworkers all stated that they would like to see more training on how to better provide counselling and psychosocial care, as well as sensitivity and community awareness-building trainings. Though HPA previously implemented trainings for government ministries, this evaluation showed that many of the staff whom were trained no longer work for the ministries, as the turnover rate at the ministries is fairly high. As such, HPA should invest in helping ministry staff put mechanisms into place to address issues of SGBV, so that those mechanisms will still stand after trained staff has left.
    - **Avenues could be explored with government ministries, including the MoH and MoE, to see if it is possible to include SGBV as a formal part of school syllabi**. Teaching children at school-age about gender-based violence would have beneficial long-term effects.
    - **Additional coordination should be implemented in the future between WAAPO and the Ministry of Justice**. The movement for legal reform is just beginning, and will continue long after HPA ends its programming. Lawyers trained by HPA should be prepared to take a lead role in this.
- One positive consequence stemming at least in part from HPA programming is an apparent shift in men's attitudes towards sexual and gender-based violence. In the baseline report conducted by HPA in 2012, 63% of respondents believed it to be "sometimes justifiable" for a man to hit his wife. Based on qualitative data collected for this project, that may no longer be the case. Men interviewed showed a basic understanding of SGBV and could list its negative consequences for their communities. **Efforts**

[2] Health Poverty Action, Hargeisa, Somaliland. 2012 SRHR KAP Baseline Report.
[3] Hargeisa, Somaliland. Gender-Based Violence Information Management Systems (GBVIMS) Data. 2013 – 2014.

should be made to build upon this growing shift in attitudes by shifting outreach campaigns to men and fathers in the local community. Though HPA trainings with stakeholders appear to have been effective in changing attitudes and empowering key stakeholders to respond to SGBV cases, based on the endline evaluation report and focus group discussions conducted, general community attitudes still have room for improvement, given that many men interviewed were not aware of certain types of SGBV or what services were available to survivors in the local community. Additional outreach campaigns should be conducted throughout local communities, with assistance from community leaders and religious leaders.

    - **It is important that the key stakeholders working on SGBV understand and advocate for more behaviour change activities for men**. HPA and WAAPO staff both pointed out that most of the support that they receive in the community is from women, TBAs, and women's groups. As suggested earlier, additional awareness raising and outreach programming should be tailored for and specifically directed at men in the local community, specifically those on HPA's radio programming.

- Though the HPA and WAAPO shelter has been very successful at providing a safe house that services Hargeisa and nearby areas, the intervention could be improved further in the future by reaching further out, rural areas, in and around Maroodi Jeex. As it would not be cost or time efficient at this point to set up a shelter in more isolated and sparsely populated rural areas, in the future, **program interventions should invest available funds on transportation from rural areas of Somaliland to the safe house in Hargeisa, whenever possible**. In addition, employees at local MCHs (including MCHs in villages outside of Hargeisa) and other women's services should be made better aware of the services available at the WAAPO shelter in Hargeisa and better understand the WAAPO shelter referral process. MCH staff should also be trained on how to provide post-trauma care to victims of SGBV, particularly if they cannot get survivors to the shelter in Hargeisa as soon as possible. Lawyers, police, community leaders, and religious leaders noted that they did not think that the awareness activities conducted by HPA were reaching rural areas (which indeed were never part of the project target area). As such, future projects should consider holding SGBV workshops in rural areas, with key stakeholders as well as local community members.
    - On a related note, should funding permit, the shelter and the services it provides should look into expanding to accommodate potential increased demand from reaching out to communities and villages outside of Hargeisa. The shelter expansion should primarily include additional staffing and more beds for survivors.
- As this program is ending, **HPA, local and federal government institutions, and future donors should seek to provide additional trainings to WAAPO staff on fundraising, grant writing, and financial management, so they can not only manage the shelter without assistance, but also keep the shelter funded**. WAAPO should begin to move more towards the forefront of HPA programming, particularly in terms of outreach and training activities, in order to assure the community that these changes are being championed by local actors. The possibility of collecting local donations from the community or funding from the government should also be explored, as international donor funding may not be a long-term solution.

3. Overview

3.1 Research Area Background

In recent years, the de-facto autonomous Republic of Somaliland has made great strides in improving its infrastructure in a variety of sectors, yet remains in need of development and improvement in a number of key sectors, including health, services for IDPs and refugees, and gender equality – particularly sexual and gender-based violence (SGBV).

SGBV consists of a number of forms of sexual harm, including but not limited to, sexual assault, rape, FGM/C, forced marriage, and domestic abuse. SGBV is widespread across Somalia, and Somaliland is no exception. While crimes committed by soldiers and those in uniform has been reported as far less common in Somaliland than in south and central Somalia, rape and sexual assault are rampant, particularly in IDP communities. Though Somaliland is a comparatively more stable and secure region of the country, years of conflict have left Somaliland without a solid infrastructure to combat and respond to SGBV. The existence of quality health care and social services is incredibly weak, not to mention access to justice and legal assistance, particularly as it pertains to those seeking care for crimes of SGBV.[4]

The Somaliland Ministry of Health stated that, on average, Somaliland hospitals "receive a child raped daily."[5] From January to August 2015, 2,300 cases were reported of SGBV against children in Somalia, a number that is still vastly underestimated.[6] In 2013, 326 cases of rape were reported across Somaliland,[7] with 290 of these cases having been reported in Hargeisa alone.[8]Of those 326 cases, only 171 were criminally prosecuted, and a mere 54 resulted in convictions (primarily due to the minimal evidence presented).[9]It's worth noting that this number of rapes reported, though relatively low, was a substantial increase from previous years. While this could be attributed to a general increase in the amount of sexual assaults and rapes in Somaliland, it is also quite possible, and perhaps more likely, that this is a result of more women feeling empowered to speak out and report the crimes committed against them to the authorities.[10]

Prosecuting crimes of SGBV in Somaliland has risen greatly since 2013. To date, more than 75% of judges and prosecutors in Somaliland have had some form of formal legal training (significantly greater than in Puntland or South-Central Somalia). However, between 12-50% of SGBV cases are still prosecuted through customary *xeer* law, rather than national law. While many Somalis, including survivors of SGBV, prefer to have their cases prosecuted through *xeer*, because of the belief in Somali society that it can more effectively resolve conflict, *xeer* law is often ill-equipped to handle the complexities and sensitive nature of sexual assault, rape, and other SGBV cases. As well, through *xeer* women do not directly receive any compensation (this goes to male relatives) and are sometimes forced to marry their attacker.

Significant effort is made, however, to combat SGBV. Numerous local and international organisations are working on interventions throughout Somaliland to respond to and prevent incidences of SGBV. There have been huge improvements in the response sector. Police officers have been trained on how to handle reports of SGBV in their communities. Lawyers have been trained on how to prosecute these crimes through various formal and informal channels. Simply put, "GBV activities focused on response efforts in a humanitarian emergency context rather than a broader strategic response around prevention and access to justice and rule of law."[11]The UN has provided street lighting and lockable doors in IDP camps to decrease crime, however, while very significant, this

[4] Legal Action Worldwide. "Legal Aid Providers Supporting Survivors of Gender-Based Violence in Somalia – Report and Recommendations". October 2014. http://legalactionworldwide.org/wp-content/uploads/2014/10/GBV-Legal-Aid-Report-final-29.10.pdf

[5]Legal Action Worldwide. "Legal Aid Providers Supporting Survivors of Gender-Based Violence in Somalia – Report and Recommendations". October 2014. http://legalactionworldwide.org/wp-content/uploads/2014/10/GBV-Legal-Aid-Report-final-29.10.pdf

[6]OCHA. "2015 Humanitarian Needs Overview – Somalia". November 2014.

[7]Legal Action Worldwide. "Legal Aid Providers Supporting Survivors of Gender-Based Violence in Somalia – Report and Recommendations". October 2014. http://legalactionworldwide.org/wp-content/uploads/2014/10/GBV-Legal-Aid-Report-final-29.10.pdf

[8]UNDP Country Office Somalia: Gender Unit. "UNDP Somalia Gender Equality and Women's Empowerment Strategy (2011-2015) – Progress Report 2013".
http://www.undp.org/content/dam/somalia/Reports/Somalia%20Gender%20Progress%20Rpt.%202013.pdf

[9]Legal Action Worldwide. "Legal Aid Providers Supporting Survivors of Gender-Based Violence in Somalia – Report and Recommendations". October 2014. http://legalactionworldwide.org/wp-content/uploads/2014/10/GBV-Legal-Aid-Report-final-29.10.pdf

[10]Legal Action Worldwide. "Legal Aid Providers Supporting Survivors of Gender-Based Violence in Somalia – Report and Recommendations". October 2014. http://legalactionworldwide.org/wp-content/uploads/2014/10/GBV-Legal-Aid-Report-final-29.10.pdf

[11]Somalia Gender Based Violence Working Group. "2014 – 2016 Strategy".
https://unsom.unmissions.org/Portals/UNSOM/GBV%20WG%20Strategy%20final%20Jan%2029%202014_new.pdf

does not aim at the real causes of SGBV, particularly in the IDP community.[12]Much more needs to be done to not only respond to SGBV crises, but also prevent these crimes from being committed and the culture of impunity for the perpetrators.

IDPs, more so than almost any other particular group, are at risk of becoming victims of SGBV. With lower levels of income, minimal resources, poor shelter, inability to access security, justice, or other means of assistance, the estimated 35,000 IDPs in Somaliland[13] are at an extremely high risk of SGBV, leading to immense physical, mental, and psychosocial trauma. With the on-going draught and water shortages, female IDPs are particularly vulnerable, as women are often responsible for going out after dark by themselves to get water.[14] In addition, IDP settlements lack much basic infrastructure, such as toilets, the ability to lock doors, any light in their homes or surroundings, and close-by water points, which further adds to their vulnerability. In 2015 alone, as per the GBV Information Management System, 81% of SGBV cases that were reported across Somalia involved IDPs.[15]

3.2 PROJECT BACKGROUND

In order to begin combatting these deeply entrenched problems pertaining to SGBV, Health Poverty Action has been working to improve sexual and gender-based violence services in several areas of Somaliland, with funding from the European Commission and The Barings Foundation. Since the 1990s, Health Poverty Action, a British International NGO aimed at helping the world's most vulnerable communities obtain access to higher quality health care, has been operating in Somaliland, particularly in the regions of Sahil and Maroodi Jeex, to improve quality of and access to sexual and reproductive health rights and services for the most vulnerable populations in Somaliland. From 2011, this work started to address SGBV more systematically as part of a holistic reproductive health approach mainstreaming SGBV, with an EC funded project, entitled *Expanding Sexual and Reproductive Health Services for IDPs/Returnees in Maroodi Jeex, Somaliland.*

Since 2011, with funding from The Baring Foundation, HPA and WAAPO created the first shelter/safe house of its kind in Somaliland. This was done in Hargeisa city, Maroodi Jeex, Somaliland, in partnership with the locally based Women Action for Advocacy and Progress Organization (WAAPO) and the Somaliland Ministry of Health (MoH), and in cooperation with the local authorities, police, community, judicial system, and health sector. The project, specifically targeting the most vulnerable groups (predominantly IDPs and returnees), has aimed primarily to establish support for survivors of SGBV, through providing temporary shelter, food, health services, legal support, and psychosocial support. In addition, the project has sought to develop the capacity of the local authorities, police, community, judicial system, and health sector.

Project activities have included:

- Direct service provision through the shelter home for survivors of SGBV
- Capacity building of the MoH, WAAPO, police, judiciary, and other stakeholders
- Community-based interventions through Community Conversations
- Behaviour change communication activities through radio shows, theatre outreach, and distribution of print materials, such as leaflets and posters
- Data collection and database maintenance
- Coordination and networking among stakeholders, and advocacy

This shelter in Hargeisa has made great strides—including supporting approximately 330 women in 2014 and helping convict 86 perpetrators—in a context where SGBV was previously taboo, victims were blamed and

[12]Somalia Gender Based Violence Working Group. "2014 – 2016 Strategy". https://unsom.unmissions.org/Portals/UNSOM/GBV%20WG%20Strategy%20final%20Jan%2029%202014_new.pdf

[13] Food Security Analysis Unity (FSNAU/FAO) and United Nations Children's Fund (UNICEF). "Nutrition Survey Report: Hargeisa Returnees and IDP Settlements". September 2005.

[14]OCHA. "2015 Humanitarian Needs Overview – Somalia". November 2014.

[15] United Nations: Office of the Special Representative of the Secretary-General for Sexual Violence in Conflict. "Report of the Secretary-General Covering the Period from January to December 2014". 23 March 2015.

shunned, and most perpetrators were left free. With additional funding, this effective model has the potential to expand across Somaliland as a whole, with further development of the SGBV sector overall. This includes developing a justice system to prevent and deal with violent acts of SGBV, working to decrease the number of rape cases (particularly among vulnerable populations such as IDPs and returnees), and expanding the shelter model established in Hargeisa.

3.3 Objective

As such, the overall objective of this research is to examine and document the successes and lessons learned from the project in order to produce an in-depth report to influence future planning and policy development around SGBV in the region and beyond. Additionally, this research will demonstrate the successes of the shelter model, as well as advocate for its replication, where appropriate—on national and international levels.

The documentation investigated the SGBV project in Hargeisa through its relevance, effectiveness, efficiency, impact, potential scale-up, and lessons that could be applied in Somaliland and beyond.

4. Research Indicators

In addition to a qualitative analysis of the successes and lessons learned from the shelter in Hargeisa and related activities, this study will measure achievements in the context of the wider holistic SRHR project. The latter, implemented by HPA, aims to mainstreams SGBV across activities and actors. The WAAPO shelter in Hargeisa is part of HPA's larger program, *Expanding Sexual and Reproductive Health Rights for IDPs/Returnees in Maroodi Jeex, Somaliland.* This study will primarily measure the results, activities, and indicators of Expected Result 3, outlined below, as described in the log frame. As these indicators are primarily numeric, they have been measured from the pre-existing quantitative data provided by HPA pertaining to this study.

Aims	**Related Activities**	**Key Indicators of Achievement**
- Increased access to high quality SGBV services by those who require them.- Enhanced community action to prevent SGBV and support survivors. - Contribution to the development and implementation of policies, strategies, and replication of best practice models.	– Setting up and supporting a Network of all stakeholders (local authorities, police, justice system staff, human rights advocates and organisations, and civil society) in the fight against SGBV to meet quarterly in each of the target areas – Training of local authorities, justice officials, and police executives and officers on the rights of GBV survivors – Developing one SGBV data collection system for each target area, and equip and train health staff, courts and police for data collection. – Support to local human rights organisations to monitor SGBV cases – Facilitate access to basic medications like PEP and emergency contraceptives for rape cases – Transport and stationery support to the police to handle SGBV cases – Training of 36 community health workers as community counsellors and mediators for SGBV victims and their families – Establish a shelter home/counselling centre for SGBV survivors run by WAAPO. – Build the capacity of WAAPO to effectively support SGBV survivors. – Support monthly Community Conversations	– 300 of SGBV survivors receive psychological and/or clinical support by trained health staff – 90% increase in proportion of SGBV survivors who report satisfaction with support provided to them by police/justice system – 25 SGBV stakeholders taking part regularly in the Network meetings. – 50% increase in the number of SGBV survivors receiving receive counselling and social mediation at community level

	– Raise awareness and encourage behaviour change through production of IEC materials, regular radio shows, and community outreach theatre	

5. METHODS

In order to address the objectives of this exercise, Forcier Consulting conducted a desk review, focus group discussions (FGDs), and key informant interviews (KIIs). All draft tools were submitted to Health Poverty Action for comment and review prior to data collection.

Table 4.1 Research Methods Overview

Research Methods	
Desk Review	SRHR Project Proposal SRHR Logical Framework SRHR Health Facility Assessment Report 2011 SRHR Baseline KAP Survey Report 2012 EC SRHR Report 2011, 2012, 2013 & 2014 Various supplementary reports, produced by Legal Action Worldwide, FSNAU/FAO, Somalia GBV Working Group, OCHA, UNDP, and UN Office of Sexual Violence in Conflict
Key Informant Interviews (KIIs)	HPA Staff, female *(1 KII)* WAAPO Staff, male *(1 KII)* MoH Official, female *(1 KII)* MoLSA Official, female *(1 KII)* Community Leader, males *(2 KIIs)* Religious Leader, males *(2 KIIs)* Police, males *(2 KIIs)* Lawyers, male and female *(2 KIIs)* Survivors of SGBV, females *(2 KIIs)* **14 KIIs Total**
Focus Group Discussion (FGDs)	Shelter Caseworkers and Caretakers, female *(2 FGDs)* Male Community Members *(1 FGD)* **3 FGDs Total**

5.1 DESK REVIEW

Forcier Consulting conducted a comprehensive desk review to inform data collection tools, and performed an in-depth analysis of the project documents and secondary literature related to the *SGBV Project Intervention for IDPs / Returnees in Maroodi Jeex,* as well as the programming implemented by funding from the Barings Foundation. The desk review allowed Forcier Consulting staff to obtain a deeper understanding of the context within which the project was incepted—notably, an under-developed social support system for victims of SGBV, the lack of a judicial system in place to prevent and criminalise acts of SGBV, and a continued prevalence of rape cases in Somaliland despite increased awareness-raising initiatives. In addition, the desk review reviewed baseline quantitative data from 2012, primarily on knowledge and attitudes in the local community pertaining to SGBV. Key documents for the desk review included the SRHR Project Proposal, SRHR Logical Framework, SRHR Health Facility Assessment Report 2011, and EC SRHR Reports from 2011-2014, as well as data from the Gender-Based Violence Management Information Systems, the 2012 SRHR KAP Baseline Report, 2013 SRHR Midline Report, and 2014 SRHR Endline Report.

Additional external reports were reviewed for background on SGBV in Somalia. These included the 2014-2016 Strategy from the Somalia GBV Working Group, UNDP Somalia Gender Unit's UNDP Somalia Gender Equality and Women's Empowerment Strategy – Progress Report 2013, Legal Action Worldwide's Legal Aid Providers Supporting Survivors of SGBV in Somalia, the UN Special Report from the office of Sexual Violence in Conflict (March 2015), the OCHA Somalia 2015 Humanitarian Needs Overview, and FSNAU/FAO's Nutrition Survey Report: Hargeisa Returnees and IDP Settlements.

Pre-existing quantitative data from previous documents and assessments on the HPA programming in Maroodi Jeex was also analysed in order to address the project's key numeric indicators pertaining to SGBV.

5.2 Qualitative Tools

5.2.1 Focus Group Discussions (FGDs)

FGDs with shelter caseworkers and caretakers were triangulated with the quantitative data collected in the desk review and were the primary source of data on the successes and lessons learned regarding direct provision of services at the shelter, and helped the Researchers better understand the shelter environment. Additionally, the interviews with shelter caseworkers allowed Forcier analysts to triangulate the information collected from the other stakeholders, either corroborating or challenging the insights collected. This has been important as these interviews documented discrepancies in the experiences of frontline caseworkers and caretakers with, in particular, police, government authorities and religious leaders.

As men are key decision makers in Somali communities, an additional FGD was conducted with men from the surrounding community, in order to gauge key attitudes and perceptions towards gender-based violence, and to determine how men have and will continue to respond to victims of SGBV seeking assistance, particularly through the use of a shelter. Though the SGBV programming was designed to primarily target women, in Somaliland, in order for local programming to succeed, it is crucial to include men from the local community, and to ensure that men understand and value the aims and goals of the programming, as they are the most common leaders and decision makers in the family unit, and in larger communities in Somaliland.

For the achievement of maximum participation of the groups examined, participatory projective techniques were employed. Such techniques helped participants feel more comfortable with each other and the facilitator, in order that participants felt more at ease and this allowed for a deeper exploration of participants' knowledge and needs regarding sexual and gender-based violence and the purpose of the shelter in Maroodi Jeex, and sought to ensure a greater sense of ownership of the research process and consequently any associated future programming.

5.2.2 In-Depth Interviews / Key Informant Interviews (KIIs)

In order to further evaluate the study objectives, KIIs were conducted by the Researchers with community leaders, religious leaders, lawyers, police, Women Action Advocacy Progress Organisation (WAAPO) staff, Health Poverty Action staff based locally in Hargeisa, an official from the Somaliland Ministry Of Labour and Social Affairs (MoLSA), an official from the Somaliland Ministry Of Health (MoH), and survivors of SGBV. One interview was conducted with each of the following key informants: HPA staff, WAAPO staff, MoH staff, and MoLSA staff, while two KIIs were conducted with SGBV survivors, police, lawyers, community leaders (one of which was conducted by HPA staff), and religious leaders (one of which was conducted by HPA staff), for a total of 14 KIIs overall.

Interviews with HPA staff, WAAPO staff, police, the MoH official, and the MoLSA official targeted respondents who have worked directly on this programming or have been trained on issues pertaining to SGBV by HPA/WAAPO. Interviews with lawyers were initially designed to include those who had previously received training from HPA/WAAPO on the past SRHR project, however, as they were not available during the fieldwork period, lawyers currently working with WAAPO were interviewed instead.

Utilising the OECD criteria for evaluation, these informants provided insights into the project's relevance, effectiveness, efficiency and impact through their unique vantage points as key stakeholders in the *SGBV Project Intervention for IDPs / Returnees in Maroodi Jeex*. Staff from the Ministry of Labour and Social Affairs and the Ministry of Health, as well as WAAPO, the police, judiciary, and lawyers, highlighted first-hand the effectiveness and impact of the capacity building element of this project. Community leaders and religious leaders provided insight into the relevance of community-based interventions through community conversations implemented by Health Poverty Action. Furthermore, staff from Health Poverty Action provides key information about the impact of behaviour change communication activities, including the use of radio shows, theatre outreach, and the distribution of print materials such as leaflets and posters. Staff from Health Poverty Action also provided insights into the effectiveness of coordination and networking among stakeholders and advocacy groups.

KIIs with survivors of gender-based violence were facilitated by the Forcier Consulting Researchers and targeted project beneficiaries (survivors of gender-based violence). Two KIIs were conducted within this group (only survivors over the age of 18 were targeted). Interviews with the project's beneficiaries strictly followed principles contained in the WHO's ethical and safety recommendations[16] for researching, documenting and monitoring sexual violence in emergencies and GBV guiding principles: confidentiality, safety, respect, and non-discrimination. Project beneficiaries were able to provide first-hand accounts of the project's relevance, effectiveness, efficiency and its unique impact on their lives.

5.2.1 Sampling

For the KIIs with survivors of SGBV, respondents were purposively chosen according to preselected criteria relevant to the particular research questions, particularly that they are survivors of gender-based violence and that they have made use of the services provided at the shelter. After HPA and WAAPO staff approached all potential participants and explained to them the purpose and process of the project and the interview, Forcier proceeded with re-confirmation of consent, and began the interview process.

Participants for the additional key informant interviews, as well as the FGDs, were also identified in consultation with HPA, according to their position in the various targeted groups (MoH, police, etc.), and whether they had received capacity building services from the HPA programming.

5.3 Limitations and Challenges

1. This study is predominately exploratory and qualitative (though previously collected quantitative data is used to triangulate information). That quantitative data was largely collected prior to the creation of the WAAPO shelter. With the qualitative tools utilized for this study, we intend to capture individualized experiences with the project's activities and to highlight individuals' attitudes, knowledge and behaviour within Maroodi Jeex, regarding the shelter in Hargeisa and related issues. As such, this research can only cautiously speak to tendencies and trends beyond the immediate group of people interviewed.
2. As the research participants are from the project activity area, they have been the targets of numerous information campaigns on the topics in question. This evaluation is intended to observe attitudes and behaviours in urban Maroodi Jeex, in hopes that this can better inform programming in other regions of Somaliland. However, any generalisations to the Somaliland population derived from the knowledge, attitudes, and behaviour of the project activity area residents should thus be treated with caution.
3. As with any study on a sensitive subject such as sexual and gender-based violence, extreme care was taken when interviewing victims. Consequently, all questions posed to SGBV victims were necessarily indirect. While this approach may have limited information that could be obtained from these interviews, it also ensured that victims of SGBV were as comfortable as possible during interviews, and would not re-experience traumatic events. To compensate for a potential gap in information, shelter caseworkers and caretakers provided Researchers with specifics on the most common motives among women who have used the shelter. The limitation of not being able to ask survivors directly about their traumatic experiences and what led them to the shelter was mitigated by incorporating data from the GBVMIS database on types of violent cases that were seen at the shelter. Additional related questions were covered in interviews with SGBV survivors, such as how they feel at the shelter and the level of care provided to them.
4. Upon conducting research at the shelter, it was noted that many of those currently using the shelter services are Somali diaspora, returnees, and IDPs, whom had all grown up outside of Somalia, as well as refugees from Ethiopia and Yemen. As such, one of the respondents showed a minimal level of understanding of the Somali language (the language in which all interviews were conducted), and this led to a simplification of questions and responses to questions in the interview.

[16] WHO Ethical and Safety Recommendations for Researching, Documenting, and Monitoring Sexual Violence in Emergencies. Geneva, Switzerland: World Health Organization; 2007.

5. It was initially intended during project design that interviews with lawyers from the judiciary would consist of those lawyers who had received training through HPA's SRHR project intervention, in order to measure the comparative effects of the training on various key stakeholders. However, as the lawyers who received training as part HPA's *Expanding SRH Rights* project (the project this evaluation covers) were not available during the duration of fieldwork, it was instead decided to interview lawyers who are relatively new to the programme and currently working with HPA's local partner WAAPO on SGBV-related programming, but who did not receive HPA training.
6. Two interviews, in addition to the 15 conducted by Forcier Consulting, were conducted by HPA staff, due to timeline and budgetary constraints. One interview with a community leader and one with a religious leader were conducted by HPA. It is possible that being interviewed by HPA staff about HPA programming and its problems and successes could have influenced those respondents' responses. However, additional interviews with a community leader and a religious leader were conducted by Forcier Consulting, and responses did not greatly differ from those conducted by HPA.

6. Key Findings

6.1 Project Activities

Beneficiaries of the HPA programming were overwhelmingly positive about the services that HPA provided including through training and direct receipt of services from the WAAPO shelter. As per HPA yearly review reports, it is clear that HPA implemented a number of their planned programs effectively. These interventions are as follows.

6.1.1 Set up a network of SGBV stakeholders

Quarterly meetings were held with key SGBV stakeholders in 2014 in order to improve coordination and networking among stakeholders, and organize implementation and outreach programs. At the various meetings, local NGOs, Somaliland Human Rights Commissions, MoH, MoJ, MoLSA, traditional and religious leaders, and representatives from the judiciary were all present. It was discussed at these meetings that all reported cases must be properly recorded (to which all parties agreed), and all women who reported crimes must be referred to a hospital for a check of any harm done. It was also agreed that the Criminal Investigations Department (CID) would carry out an investigation of whether or not various bodies were reporting and recording incidences of SGBV correctly. Finally, a plan for outreach activities was discussed, which included giving public speeches on the radio, awareness raising with school children, community mobilization, and preaching in mosques.

6.1.2 Train stakeholders on the SGBV data collection system

An SGBV data collection system for the target area was developed, and training was provided to health staff, court officials, and police officers on how to properly make use of the data collection system, including such things as computer recording and reporting of SGBV-related data. More than 200 TBAs, MoH staff, and community health workers were trained on the GBVMIS data collection system in 2014.[17]

Training of local authorities and other key SGBV stakeholders (ministry officials, police, lawyers, and local leaders) was also conducted by the project. In conjunction with the quarterly stakeholder meetings that were conducted in 2014, training of key stakeholders were also carried out by HPA staff. Trainings took place with local authorities, justice officials, CSOs, police chiefs, and police officers. The trainings primarily taught and reviewed basic gender concepts, emotional and physical consequences of

"NGOs refer to us monthly the cases and we calculate, and tell the government the level of GBV. If it is a high level, as the government, we try to solve it and minimize the problems." – Ministry of Labour and Social Affairs Staff

[17] Hargeisa, Somaliland. Gender-Based Violence Information Management Systems (GBVIMS) Data. 2013 – 2014.

SGBV, knowledge of human rights, available human rights instruments that protect women specifically, and the ways in which the Somaliland National Constitution, the National Gender Policy, and other Somaliland-wide documents preserve women's rights. The trainings also successfully identified methods for improving the abilities of healthcare professionals and justice workers to handle SGBV cases in a sensitive and holistic manner. This was done through sharing case studies, role playing, and trainees sharing their own personal experiences, or experiences that they had witnessed.

However, one group of shelter caseworkers with whom an FGD was conducted stated that they did not receive any training from HPA. This is because these are newer employees, and have not worked for the shelter during a round of training, but it should still be ensured that all caseworkers receive training as soon as possible, so they can most effectively and sensitively care for the victims seeking assistance in the shelter.

6.1.3 Support local human rights organisations

Though the WAAPO staff member interviewed had not participated in HPA training, as he did not work for WAAPO yet at the time the training was conducted, he noted that they have provided WAAPO with a great deal of advice regarding program management that has been extremely helpful in WAAPO's day-to-day work. In the future, his suggestion was the HPA conduct additional trainings on how to use the GBV Information Management System (GBVIMS), and how to properly report and record crimes of SGBV.

Overall, through HPA's work in 2013, the number of people who came forward seeking help for SGBV-related crimes rose 746%. To WAAPO specifically, 592 cases of SGBV were reported in 2014 (compared with the 70 cases reported in 2013). In addition, WAAPO helped file 162 SGBV cases to the court system in Somaliland. WAAPO also appointed volunteer lawyers to help represent victims of SGBV in court.

6.1.4 Provide transportation and stationary to police

HPA and WAAPO also provided material contributions in order to better facilitate the reporting/recording processes. As the police stations lacked proper materials to record reported cases in a timely manner, WAAPO provided stationary (such as pens, papers, and books) and fuel costs to support coordination amongst stakeholders and better equip the police forces to report SGBV-related crimes.

6.1.5 Train Community Health Workers

In a separate training, an additional 36 Community Health Workers, including nurses and midwives, were trained on how to provide effective and sensitive counselling and treatment to SGBV survivors at various health facilities and training centres.

6.1.6 Establish shelter

Most significantly for the purposes of this study, WAAPO provided shelter for 182 survivors of SGBV in their shelter in 2014, all women and children. Of the 182 survivors that came to the shelter, 146 were women and 41 were children.[18] All who came to use the shelter were provided with counselling upon their arrival. In 2014, there was the total number of reported cases increased by 59% since 2013. The types of cases seen ranged from rapes (163 cases), being hit by a partner (61 cases), slapped (23 cases), and beaten (15 cases).[19]

"We provide two services: psychosocial, which is caring and counselling psychologically and giving shelter where they can reside for awhile, rest, and get food. And we provide medical assistance, so we can take the case, once the victim is calm, and refer them to the Hargeisa Group Hospital or BaahiKoob centre." – WAAPO Shelter Case Worker

Demand for the WAAPO shelter grew to a degree where the shelter no longer had enough space for all of those who sought its services. As such, the shelter home was relocated in 2014, and can now

[18] Health Poverty Action, Hargeisa, Somaliland. 2014 SRHR Endline Report.
[19] Hargeisa, Somaliland. Gender-Based Violence Information Management Systems (GBVIMS) Data. 2013 – 2014.

accommodate 40-60 more patients per month. In addition, survivors using the shelter were given the opportunity to learn employable skills, such as tailoring. As often women who are survivors are unable to get into the workplace after they have been assaulted, either because finding employment is difficult or (more likely) because they had previously been dependent on their husband's or family member's income prior to seeking the shelter services, this is extremely significant. Many shelters are solely used as a safe haven for women to escape to after they have been attacked, whereas the WAAPO shelter is not only helping the women recover, but also helping the women be capable of reintegrating into society after they leave the shelter one day. Another survivor (a returnee from Yemen) also noted that she was at the shelter, people were helping her to begin learning English. A caseworker also noted that some women are being taught how to do henna designs in the shelter. All of these skill-building activities at the shelter will help prepare survivors to reintegrate into the workplace and find gainful employment after leaving the shelter.

6.1.7 Community Outreach and Awareness Raising

Regarding outreach, HPA and WAAPO have led and conducted a number of outreach activities in the local community. As it related to the shelter home, those outreach activities included playing tapes in the common areas of the shelter home and women's sexual and reproductive health rights and care available to them. At the FGD gathering knowledge and attitudes of men in the local community, at least three men articulated that though they were not aware of HPA, they were aware of WAAPO, as well as the fact that WAAPO provides legal aid and services for people who are victims of SGBV, illustrating that even if HPA's name isn't reaching the local community, the knowledge of the services they provide is. A religious leader interviewed also stated that he was aware of the services that HPA provides in his community, because he is an active leader in the community, and he takes part in awareness-raising activities in certain areas of the community, as well as in mosques.

6.2 Effectiveness

Though the primary objectives of HPA's programming are being met, the reach of the services could be improved for future programming. As of the time of this report, interviews with both HPA and WAAPO staff indicated that the main community support they receive is from women, women's groups, and traditional birth attendants (TBAs). While one community leader and one religious leader said that they had received training from HPA, additional trainings that cover more in-depth topics of SGBV and can be accessed by more local leaders are needed, as nearly all other interviewed stakeholders stated that community and religious leaders would be the biggest obstacles, and the biggest potential assets, to implementing reform in their communities, because they are universally respected. This is a process that has already begun through HPA, with 80 stakeholders trained on SGBV in 2011, and an additional 140 trained in 2012, which included community and religious leaders. Though the other two community/religious leaders who participated in this study said they did not receive formal training, this is likely not representative of the community as a whole, and they did note that HPA/WAAPO successfully coordinated with them on outreach activities in their communities. As such, **more formal mechanisms to engage with community and religious leaders are recommended**. **These mechanisms should include educating leaders on SGBV, as well as how to engage in outreach and awareness raising activities, and how to advise anyone in their community who comes to them with SGBV-related conflicts.**

Educating a variety of community and local leaders via trainings was an effective means of changing attitudes. This was noted in particular as it applied to the police, lawyers, and local leaders. All noted that they learned a great deal from the HPA trainings, or other forms of engagement with HPA. **These informational trainings/workshops should be expanded to not only key stakeholders, but all local community members**. This could be an extremely effective and productive way of informing local community members about the dangers of SGBV, and the rights and services that survivors have available to them. This awareness is crucial to the long-term success of the programming, as respondents almost universally suggested that the most prohibitive factor to true reform was community attitudes regarding traditional practices and legal systems.

Regarding the objective of holding community conversation meetings, one participant, a community leader, discussed that he had been invited by HPA to participate, and they were a positive opportunity to talk freely about SGBV and related issues. Project reports on HPA programming indicate that six community conversations were conducted per month during 2014, at the six target MCHs of this project. Across these monthly meetings, a

total of nearly 600 people from the local community participated, including TBAs, CHCs, police officers, and sheikhs.

"There are many reasons why people come here. For example, difficulties with her family and getting expelled from her home, as well as domestic violence." – WAAPO Shelter Caseworker

As per the activities outlined above, and their respective positive responses, the objectives of this study, to evaluate the provision of shelter services and SGBV-related activities being conducted by HPA and WAAPO, are effectively fulfilling the needs of the community. All project objectives related to SGBV were met with related activities being conducted for all objectives. The main goals of the project, training and capacity building relevant SGBV stakeholders and direct provision of services through a shelter safe house, are both being achieved. Beneficiaries interviewed all articulated that the programming being done by HPA and WAAPO was responsive to the needs of the community, and it was clear that the project activities are in fact reaching the local community and having a positive effect.

6.3 RELEVANCE

With such high numbers of SGBV in Maroodi Jeex, and Somaliland at large, there is no doubt that the services being provided by HPA are urgently needed in the local community.

Interviews with ministry officials from the MoH and MoLSA revealed positive experiences with the HPA/WAAPO training. An MoH official stationed at an MCH facility just outside of Hargeisa noted that she received training from HPA/WAAPO on SGBV, in the form of a formal PowerPoint lecture, but also noted that she would like to receive additional trainings on how to prevent SGBV, how to conduct psychosocial counselling, and general guidelines for caring for victims. HPA did provide technical expertise and conduct trainings with nurses and TBAs at the Hargeisa Group Hospital, the subject matter of these trainings was largely pertaining to general family planning, birth spacing, and sexually transmitted infections, but not specifically about SGBV. Nonetheless, the MoH staff stated that all the MoH and MCH workers were very satisfied with the training because it helped them gain knowledge about SGBV that they had been missing in their day-to-day work. A MoLSA official also stated that trainings could be improved by including a greater variety of stakeholders, particularly more religious and community leaders, and by training stakeholders more on how to conduct independent awareness-raising activities in the community.

Field Researcher reading the informational posters hung up in the WAAPO shelter.

WAAPO's shelter caseworkers were another key stakeholder group that received training from HPA prior to and during their work at the shelter. Much like other groups, most of the shelter caseworkers noted that they were all very satisfied with the training that HPA had provided them with. In an FGD, shelter caseworkers said that they had not only provided them with training, but also provided the shelter with food, expansion and additional beds, coordination between the police officers, and coordination with the MCH for healthcare of the survivors. As with the MoH official, shelter caseworkers stated that they would like to see more training on how to better provide counselling and psychosocial care.

One police officer who received HPA training stated that the training he received was extremely important for the work he does, and it has better equipped him to spread messages about how to respond to SGBV cases, as well as how he can better understand SGBV in general. His only hope was that more people in his community could access these trainings, to become more educated about SGBV, how to prevent it, and how to respond to it when it does occur. A second police officer confirmed the importance of the training he had received, and added that he would like to receive additional trainings, if possible, on how to raise awareness about SGBV in the community, particularly about the long-term impacts of SGBV on its victims.

Lawyers interviewed also articulated the success of the trainings they received, stating that they received information on what constituts SGBV and how to help victims access their rights, particularly those who have been raped or experienced FGM. Lawyers and police both noted that they were very satisfied with the trainings they received from HPA, largely because they received so much new knowledge about SGBV that they were not aware of before the workshops.

In KIIs with survivors of SGBV who are currently using the shelter services, respondents confirmed that care being provided at the shelter included everything that they needed, such as food, water, and hygienic supplies, and the quality of care was high. One survivor noted that the "shelter does the best job possible of caring for its victims." As the primary goal of this project was to provide safe and quality shelter to survivors, survivor satisfaction with the services is a crucial accomplishment for HPA and WAAPO.

It is important to note though, that **additional trainings and outreach activities are needed, particularly regarding counselling and sensitivity training** for MoH staff, MCH staff, and WAAPO caseworkers. From a majority of interviews with stakeholders, it seemed that the primary knowledge they received from HPA trainings was regarding basic definitions and concepts of gender and SGBV, rather than more in-depth and specific trainings on how to care for survivors of SGBV.

Another priority for HPA should be the inclusion of the most relevant community stakeholders, such as community leaders and religious leaders, in trainings. It was articulated by a number of respondents that community members looked to local leaders for advice, guidance, and setting an example. Though HPA project reports indicated that religious leaders had participated in a number of network coordination meetings, no specific trainings for religious leaders were spontaneously mentioned in interviews. As such, community leaders and religious leaders should receive further and specific training on understanding SGBV and how to encourage their communities to properly and actively respond to it.

One community leader and one religious leader interviewed noted that they had received some training from HPA. The community leader indicated that the training consisted of HPA educating the local leaders on what SGBV is and how and to what extent it exists in their communities. Two of the local leaders specified that they know about the referral system in place for reporting cases of SGBV within the formal justice system, however they had not been consulted by any of their community members on an SGBV-related issue since they had learned about the referral system, and so they had not actually used the referral mechanism. Both local leaders indicated that they would like to have more training, particularly on how to raise awareness about these issues in their communities.

"We can overcome this when the people and the government work on this together, so the law institutions also work with them and follow up in the law…and also conduct awareness so people will understand what contributes to problems like this." – Ministry of Health Staff

Hargeisa seemed to be an ideal location to pilot a safe house for SGBV survivors, given its higher population and larger available resources to assist those in need, as well as its proximity to reporting and referral mechanisms, such as the judiciary, the police, and a high quality hospital. However, **more needs to be done to make community members aware of the services that the shelter provides**. While those who are using the shelter are getting so much out of the services, knowledge of the shelter is not widespread. In an FGD with men from the local community, it was stated that while some knew of WAAPO as an organization that helps women, they were not aware of the services that WAAPO provides for survivors of SGBV. In the baseline KAP survey (conducted in 2012), 70% of respondents (mostly women) had received messages on SRH rights, primarily through HPA's Saxon Saxo radio programme, though they were not

necessarily aware that it was HPA and WAAPO providing the information and services, the information was reaching them. It was additionally noted by the Researchers that although many people in the community do not know of HPA and WAAPO by name, knowledge of Saxon Saxo is very widespread and commonly listened to. A total of 88% of respondents from the baseline stated that they had listened to the Saxon Saxo radio programme. In 2014, Saxon Saxo played at least three programmes that pertained to SGBV and its prevention. Given the large audience that Saxon Saxo garners, producing additional content on SGBV should be considered by project staff.

All actors interviewed, particularly community and religious leaders, noted that the shelter was a much-needed service for those in need in the area. Survivors agreed that the shelter provided them with a safe haven and psychosocial care that they would otherwise most likely not have been able to access.

It was also noted that there is a great deal of positive coordination happening amongst the various SGBV reporting and referral mechanisms. As pointed out by the WAAPO caseworkers and other key stakeholders, HPA and WAAPO have been working in coordination with the police force to report cases of SGBV, the judiciary to prosecute SGBV and enact formal legal reforms, the BaahiKoob centre[20] to provide additional psychosocial counselling to survivors, Hargeisa Group Hospital to provide medical care for survivors, and community and religious leaders to raise awareness in their communities about the negative impacts SGBV has on their communities. One survivor stated that she came to the shelter for help, because, as a returnee from Yemen, she went to the UNHCR for help, and they directed her to come to the shelter for help and safety. The significance of this coordination should not be overlooked, as it encourages more survivors of SGBV to seek care and justice regarding the respective crimes committed against them, and furthers the spread of knowledge about SGBV in the community. These local and regional mechanisms working together are crucial in order for the shelter to continue to do relevant work and provide services that benefit the community.

6.4 EFFICIENCY

While this study did not include an in-depth financial analysis, project efficiency was evaluated in a variety of ways, chiefly whether or not resources were being used to their maximum ability. To begin with, it seems that some shelter staff are being used inefficiently. While caseworkers at the WAAPO shelter are deeply committed to their work, there is a significant knowledge gap that inhibits the care that they are able to provide, and often survivors need to refer to other facilities to receive the psychological care that they are in need of, such as Hargeisa Group Hospital. In-depth and extensive training for caseworkers should be made a priority before they start working at the WAAPO shelter facility. Without psychological and sensitivity training, the caseworkers will not be able to provide the survivors with the support they need upon their arrival to the shelter, and the rest of their stay there. If caseworkers do not have the training or ability to provide psychological support, the shelter should either hire additional counsellors to staff the shelters or use their extensive relationships with other SGBV stakeholders around Hargeisa, to refer the survivors to nearby areas for counselling, such as the Baahi Koob centre.

Additionally, some of the survivors seeking out the shelter services do not speak Somali well or at all, as they are refugees or returnees who have spent little time in Somalia. During data collection, only one native Somali speaker was presently using the shelter. Other shelter users were either returned or refugees, from primarily Ethiopia and Yemen. As such, it is extremely difficult for them to communicate with the WAAPO staff, as indicated by the caseworkers, and other persons and mechanisms that are put in place to assist them. One caseworker added that often there is tension between survivors of different nationalities, and while the caseworkers do their best to resolve these problems on their own, they are not properly equipped to do so. This issue should be addressed with caseworkers in their training, in the sense that all WAAPO caseworkers should learn better tools to resolve conflict amongst those using the shelter facilities.

One area in which efficiency of the program cold be improved is in the area of seeking justice. An overwhelming majority of respondents, including the an MoLSA official, an MoH official, police, and the members of the judiciary, said that women prefer to seek *xeer* (traditional law) forms of justice, rather than using the formal justice system. Though the survivors interviewed did not indicate which type of justice they preferred, nearly all

[20]The BaahiKoob centre is a centre in Hargeisa that provides medical and psychosocial care to survivors of SGBV, and refers survivors to mechanisms where they can report the crimes committed against them and seek justice through the formal legal system.

key stakeholders (including women), stated that they believed that women were not using the formal justice system, but rather *xeer* or shari'a. However, it is not clear if this is because the women actually prefer *xeer,* because they believe it is the only mechanism available to them, or because they feel pressure to use traditional rather than formal forms of justice as a result of social stigma.

As such, promoting and reinvigorating the formal justice system is well founded, but inefficient if victims of SGBV are not seeking out its services. Before the justice system can be more widely used, additional efforts must be made to educate women and men in the community about the benefits of using the formal justice system over the *xeer* traditional system. This is beginning to be done through the community conversations and the Saxon Saxo radio programme, but there is no indication that these methods have specifically discussed how women can use the referral and reporting mechanism to get justice for SGBV. Project reports indicated that using the laws of Somaliland to get justice for SGBV was a topic of discussion in the community conversations. This should be expanded upon to ensure that those attending the community conversation meetings understand actually how to use the formal justice system and why it is beneficial, and can thus bring this knowledge back to their neighbours and fellow community members. This should be included as part of an adapted training for key SGBV stakeholders in the region, particularly for community and religious leaders, in which stakeholders are given more in-depth information about the positives of the formal legal system. Only after this awareness in the community becomes more widespread, will we be able to see the positive effects of legal reforms in the formal justice system.

This element of the evaluation, efficiency, also addresses whether or not an alternative model would have been more efficient than the shelter/safe house model that is currently being applied. Based on the interviews conducted, this shelter, in conjunction with stakeholder training and outreach, has been extremely beneficial to the community at large. Though the shelter does not offer all services that are necessary for many survivors of SGBV, such as medical care, the coordination between other SGBV reporting and referral mechanisms greatly strengthens the efficiency of the WAAPO shelter model. The shelter's relationship with the judiciary, the police, Hargeisa Group Hospital, and the BaahiKoob centre are key to maintaining the efficiency and effectiveness of this shelter.

Areas where efficiency in this regard can be improved are through **strengthened coordination with community and religious leaders, as well as the government.** One community leader stated that he had received training and assistance from HPA, but mostly regarding FGM and not other forms of SGBV, and he needs assistance in order to raise more awareness in his community about the problems – something he noted that he was eager to do. One religious leader said that often his community members come to him for advice on matters pertaining to SGBV, and together they "solve [the problem] in an Islamic way –sometimes we have cases with a husband and wife and we create a solution." It is clear that religious and community leaders need much more extensive training on how to refer and report cases of SGBV in their community, as these traditional forms of justice are not equipped to help victims recover and properly access justice.

A fieldwork Researcher conducts an FGD with male community members at the WAAPO offices.

Additional efforts should be made to also coordinate further with government ministries. Currently, HPA is working with the Ministry of Health and Ministry of Labour and Social Affairs. However, the MoLSA official interviewed noted that she had not received any training from HPA, and the MoH official noted the need for much more in-depth training on psychosocial training and counselling.

6.5 IMPACT

For this project, it is difficult to measure long-term impacts of the HPA programming, as the HPA project ended very recently, and changes in attitudes (particularly regarding a highly sensitive topic such as SGBV) can take years to emerge. However, in some regards, changes in attitudes have already become clear, which is an extremely positive sign for the future.

For one, the men from the local community who participated in this FGD spoke quite knowledgably about SGBV, and while this cannot be entirely attributed to HPA's programming, it is a very positive indicator of programmatic success. Almost all men in the FGD noted that SGBV consists of violence against women. Men also noted the importance of their communities working to decrease the levels of SGBV. One man said that he used to believe that victims of FGM were "unmarriagable", and therefore saw the practice as positive for women, but now he understands that FGM is a harmful and dangerous practice. One man even noted that he is aware of extensive nationwide anti-FGM campaigns in Djibouti and Ethiopia, and he hopes that Somaliland will soon do the same.

One respondent in particular recalled a personal story on the issue:

> What happened to me once was that I went out of my home and my wife didn't tell me anything, and when I came back to my home, my young daughter told me that her mom took my other young daughter…to give her FGM. Then I ran after them then I found that my daughter was bleeding. She was full of blood in her dress and completely all over her. I took her immediately into station [health centre] and then they said me 'Hey man, don't play in the women's work.' I have felt sorry even to this day. I hate and feel sorry about this. So we must put in prison whoever is doing this.

Though tragic, this father's anger and sadness at his daughter's procedure shows a major shift in attitudes. Other men in the discussion also made it clear they thought that those who conducted FGM, as well as perpetrators of rape, should be put in jail. Prior to recent years, fathers of young girls not only allowed, but also encouraged their daughters to be circumcised. Efforts should be made to build upon this growing shift in attitudes by shifting outreach campaigns to target men and fathers in the local community.

"Not all the people report [these cases], because there is a Somali saying 'Do not let everyone know your shame that only you should know.' But this is wrong, and every victim must report and get justice." – Lawyer

Police and lawyers interviewed also exhibited a reaffirming attitude regarding sexual violence. (Though we do not know what their specific attitudes were prior to HPA programming, lack of awareness about SGBV and complicity in its continuation was widespread and baseline reports indicated that 63% of baseline respondents indicated that it is ok for a man to beat his wife[21], but by the 2013 midline 41% of respondents were aware of SGBV services available in their communities[22]). Both police officers interviewed acknowledged that women are innately more vulnerable to crimes of SGBV as a result of where they stand in society, which is far away from the victim blaming that has been commonplace in the past. They did, however, note that it is still very common in the community to victim blame women who have been raped. Often, one police officer noted, raped women are mocked and harassed in the street, particularly young, single women. This can oftentimes be a reason why women are forced to marry their attackers, because the families would like to ensure that their daughters will get married, and it will be more difficult for her to find a husband now that there is a perception that she has "lost her dignity with the community" (from a KII with a police officer).

A number of respondents in this study all indicated that the biggest obstacles preventing long-term change to were community attitudes. Though the HPA trainings with stakeholders appear to have been extremely effective in changing attitudes and empowering key stakeholders to respond to SGBV cases, most respondents believed that general community attitudes, outside of the key stakeholder groups, have not changed enough to make a

[21] Health Poverty Action, Hargeisa, Somaliland. 2014 SRHR KAP Baseline Report.
[22] Health Poverty Action, Hargeisa, Somaliland. 2014 SRHR Midline Report.

difference. As the midline and endline evaluations did not study community attitudes, this is a nearly impossible indicator to measure. **Additional outreach campaigns should be conducted throughout local communities, with assistance from community leaders and religious leaders.**

It is also important to note that though none of the respondents engaged in victim blaming, a very positive sign in attitude changes, one police officer mentioned a few ways that women can change their behaviour in order to decrease their chances of being raped or assaulted. While these techniques can be helpful, it is important that the key stakeholders working on SGBV understand and advocate for more behaviour change activities among perpetrators rather than among victims. As suggested earlier, **awareness raising and outreach programming should be conducted specifically directed at potential perpetrators** (usually men) in the local community. Thus far, HPA and WAAPO staff both pointed out that most of the support that they receive in the community is from women, TBAs, and women's group. There is a lot of room for this support to be expanded.

In general, HPA and WAAPO have done an overwhelmingly positive job at improving response mechanisms for SGBV cases. Police reports have increased since HPA programming has begun, numbers of women reporting crimes have increased, lawyers have prosecuted more cases, and the shelter has provided safe haven for more women. These are all notable and significant advances. However, improvements are still lacking regarding HPA prevention activities. As the WAAPO staff member pointed out, HPA and WAAPO programming are meant to be divided into two categories: prevention and response. Medical care, counselling, reporting, and prosecuting are all a part of the response program, and all have made significant strides. Prevention activities, though, such as outreach and awareness raising, are still lacking. Prevention activities should go beyond awareness raising activities such as advertisement campaigns and radio shows.

"The reasons why people might not want to report cases is that they fear they might not have a defender and they fear their family and their school, and the stigma can cause the girl to drop out of school." – Local Community Leader

Program leaders should engage with community leaders and religious leaders to determine how they can most effectively speak to and inform the local community of SGBV crimes and how widespread and problematic it is. It was suggested by a few respondents, including an MoH staff member, a police officer, HPA staff, and a lawyer, that awareness raising as part of the education in schools could be extremely effective. A few suggested that SGBV should be included as a formal part of school syllabi. Teaching children at school-age about sexual violence would have beneficial long-term effects. This should be explored as a possibility with relevant ministries, including the MoH and Ministry of Education.

Regarding the impact on survivors, it is probably too early to tell the long-term impacts of the shelter, however, both survivors interviewed were very grateful for the services that were provided to them. Though previous project progress reports did not measure the quality of the shelter, but only the number of users (in 2012, 131 people used the shelter services), survivors using the shelter during this evaluation noted its success, as did the MoH representative. In 2014 alone, 330 survivors received counselling, 182 received housing, 162 cases were filed in court, and 86 perpetrators were convicted[23]; all as a result of the shelter. One survivor stated that she had everything she needed available to her, as well as more opportunities for education, and she feels safe and the shelter does a very good job of helping her and other victims of domestic violence. Another survivor also said that she received high quality care, and is treated very well by the shelter staff. While one survivor was learning English and one was learning tailoring skills, both are learning skills that will help their long-term chances of gaining employment and obtaining a sustainable livelihood, which is crucial for the long-term impact of the shelter on improving their lives.

Though the shelter is located in Hargeisa, referral mechanisms that have been established are being used to help women from other towns and cities come to the shelter in Hargeisa. One of the survivors interviewed was from Burao, and was referred to the shelter by a partner of HPA/WAAPO in Burao (it was not specified who the partner was, but most likely it was a local MCH). This was just one case study of the reach of the shelter going

[23] Health Poverty Action, Hargeisa, Somaliland. 2014 SRHR Endline Report.

well beyond its initial aims, and reaching even more removed rural women. However, it seems that this does not happen often, and women in rural areas, though outside the scope of project intervention, are often not able to access the services at the shelter. A WAAPO staff member noted that rape is particularly common in rural, pastoralist communities, and these women are generally unable to access trauma services. Even for women who are aware or referred to the services that WAAPO provides, he said, there is oftentimes no transport available from the rural areas to Hargeisa.

This project was not meant to reach outside of urban Maroodi Jeex, however there is certainly demand in rural areas for the services that HPA is providing in Hargeisa and the surrounding areas. Though it would not be cost or time efficient at this point to set up a shelter in more isolated and sparsely populated rural areas (and is not currently part of the programme's aims), program interventions should attempt to invest more on transportation from rural areas to the safe house in Hargeisa, where funding permits, in order to meet the growing demand for these services outside of Hargeisa. In addition, employees at local MCHs and other women's services should be made aware of the services available at the WAAPO shelter in Hargeisa and better understand how they can refer women to the WAAPO shelter. If funding is available, training should be expanded to MCH staff outside of Hargeisa on how to provide post-trauma care to victims of SGBV, particularly if they cannot get survivors to the shelter or to a hospital in Hargeisa as soon as possible. Lawyers, police, community leaders, and religious leaders noted that they did not think that the awareness activities conducted by HPA were reaching rural areas where services may be needed, even though those are not project implementation areas. As such, if further funding for expansion of the project's successful approach becomes available, workshops should also be held in rural areas, with key stakeholders as well as all local community members, on SGBV.

6.6 SUSTAINABILITY

Sustainability is a key evaluative element of HPA's programming, however HPA's numerous trainings of key stakeholders and close relationship with local NGO WAAPO, have set up the program to be in a very good place for long-term program sustainability. A WAAPO staff member stated that while he is sure the shelter will continue to be used after HPA has stopped their programming, he is concerned the quality of care will not remain the same, as they will lose a great deal of their financing and the shelter will no longer have the same capacity. All four caseworkers agreed with this assessment, stating that "There will be big obstacles – like finances, food, numbers of victims [seeking help] – all of these will decrease." As numerous trainings and capacity building activities have been conducted with staff, all indicated that the primary issue would not be local staff inability to run the shelter, but rather lack of finances. As such, HPA, or other donor organizations, should also seek to train WAAPO staff on fundraising and financial management, while still assisting WAAPO on grant writing initiatives, so WAAPO can not only manage the shelter without assistance from donors, but also keep the shelter funded with adequate financing.

"Somehow [the shelter will stay open], maybe we can keep open the program, but not as HPA has done, because it needs high capacity." – WAAPO Staff

Across the board, all respondents said that they were not aware of any problems that HPA had created in the community, and the majority in fact said that, to their knowledge HPA had worked very well with the community and remains very highly respected. An HPA staff member did note that the organisation faces some resistance in the community by being labelled as "Western organisation", saying that sometimes women will come to the shelter seeking help, and when her husband finds out, he will come and complain to HPA, saying that they are doing "the work of foreigners" and this is not part of Islam. It should be noted, however, that both religious leaders that were interviewed emphasized that SGBV is strictly prohibited in Islam, particularly rape and domestic violence[24].

"First, Islam has forbidden SGBV. God said, there should be no oppressor for mankind. Islamic religion has banned all violence whatsoever, and people should understand that." – Religious Leader

[24] Though Islam forbids most recognized forms of SGBV (with the exception of FGM, currently being debated by Imams, which is only permitted in certain *hadith*), only rape and domestic violence were discussed by the religious leaders interviewed for this study.

This is the primary reason why the project has very strategically given more profile to WAAPO than to HPA, with most communities seeing the shelter and other activities as "WAAPO" initiatives rather than HPA's. As such, WAAPO should begin to move more even more towards the forefront of HPA programming, particularly in terms of outreach and training activities.

Additional trainings should be conducted with relevant staff as well (by WAAPO senior staff if HPA staff cannot conduct these). As mentioned earlier, WAAPO shelter caseworkers should receive further training on psychosocial care. Even if the shelter continues to work with and refer survivors to the Hargeisa Group Hospital and the BaahiKoob centre, the shelter caseworkers need to be able to provide a basic level of sensitivity and care when dealing with survivors of SGBV. Though most shelter caseworkers were trained (two were not), they stated that training did not include SGBV sensitivity. Case workers interviewed specifically requested training on providing psychosocial care, as it is a key component of their job (however, training in psychosocial care was provided to community health workers). Ministry of Health workers should receive similar sensitivity training. If possible, WAAPO staff should travel to surrounding rural areas to train local MCH workers, as well.

Additional coordination should be implemented between WAAPO and the Ministry of Justice in the future. The battle for legal reform is just beginning, and will continue long after HPA ends their programming. The lawyers that have been trained by HPA should receive additional trainings on legal practices and how to best coordinate with government ministries, so that they can be prepared to take a lead role in this.

The final key factor to long-term sustainability of HPA's work is awareness campaigns. Changes in attitude can take time; awareness and outreach campaigns should not end when HPA completes their programming at the shelter. HPA should ensure that WAAPO has solidified relationships with the local stakeholders, particularly community and religious leaders, whom HPA has worked with, so that they are able to continue working closely with the local communities. In particular, more awareness activities should be conducted with men about the prevalence and dangers of SGBV.

A Researcher conducts an interview with a local police officer who has received training from HPA.

All respondents (HPA staff, WAAPO staff, WAAPO caseworkers, and SGBV survivors), agreed that the shelter model used in Hargeisa could and should be replicated elsewhere across Somaliland. WAAPO staff noted that establishing shelters in Awdal and Togdheer would be a good place to start. Now HPA has begun implementing the EC-funded STOP project in these areas, which also works on SGBV-related activities. The respondents all noted that SGBV is such a widespread problem across Somaliland, and too many women are without support given there is only one shelter in the entire country.

Survivors noted that they thought the shelter model could be replicated elsewhere because the staff and the facility treated them so well and with such care, and there is demand for the shelter services in other areas. However, the appropriateness of the shelter model elsewhere in Somaliland cannot be taken for granted, especially in terms of ease of implementation. Given the more established infrastructure in Hargeisa, it may not be as easy to sustain this same model in other smaller cities and rural areas. Without the support of all of the organisations that work together in Hargeisa, the shelter would struggle in rural areas to provide all of the post-trauma services needed by survivors of SGBV. Instead of setting up additional shelters at other locations in Somaliland at this time, **resources should be directed at educating and training leaders in rural areas or areas far from Hargeisa**, such as Burao and Borama, particularly on how to use referral mechanisms, and setting up transportation systems to help women outside of Hargeisa know about and be able to more readily access the Hargeisa shelter.

7. Conclusion and Key Recommendations

7.1 Lessons Learned: Successes and Challenges

Taking all factors into consideration, HPA's programming on SGBV in Hargeisa city of Maroodi Jeex has had major successes. The objectives of establishing a shelter, setting up a network of SGBV stakeholders, training on the SGBV data collection system, training of local authorities and other stakeholders, supporting local human rights organisations (largely, WAAPO), facilitating access to medication (through coordination with Hargeisa Group Hospital and the BaahiKoob centre), providing transport and stationary to police, and training community health workers were all completed or on-going at the time of this study.

The biggest successes of the HPA programming were undoubtedly the direct provision of services through the shelter and the trainings conducted. With 184 women and children using the shelter housing services in 2014 alone, the shelter is making a huge difference in the lives of survivors of SGBV in Hargeisa. The shelter model has been particularly successful in not only helping victims with their recovery, but also preparing them to reintegrate into society through the teaching of tailoring, henna, and other skills for the workforce.

All respondents who were interviewed spoke highly of the training they received. Training was employed on such topics including the definitions of SGBV, the prevalence of SGBV in Maroodi Jeex, the negative consequences of SGBV, how to provide psychosocial care and medical care, sensitivity training, how to spread awareness in one's own community, program management and monitoring, and technical advice.

Another major success of HPA's work is the network of SGBV stakeholders that are now working together. The coordination amongst these various groups (the judiciary, police force, MoH, MoLSA, Hargeisa Group Hospital, and BaahiKoob centre) has been extremely beneficial to providing care to survivors and raising awareness in surrounding communities, in addition to lowering cost and decreasing any waste of resources.

There are two major challenges that HPA has and will continue to face in providing services in the future. The first is the reach of the shelter. While the shelter was successful in providing services in urban Maroodi Jeex, survivors outside of the project scope had difficulty with access. Though Maroodi Jeex is not a very large area, many areas outside of Hargeisa are difficult to access due to poor roads. It is very difficult for survivors to access the services that are available in Hargeisa, but also not feasible at this point in time to set up safe houses in many rural villages outside of Hargeisa (though one survivor interviewed for this study was from Burao, outside of the project area, and had been referred to the Hargeisa shelter by a local HPA partner in Burao). Nearly all respondents indicated that they were aware that the shelter has trouble reaching women in rural areas, whether it be due to those women simply not knowing the Hargeisa shelter exists or rather not being able of getting the transport to access its services. Though reaching rural areas was not part of the project's objectives, expanding the reach to rural areas for future programmes that HPA may implement would enable the shelter to service even more survivors who are in need.

The second major problem for HPA programming is the attitudes of the local community members. Attitudes, particularly on such a highly sensitive issue as SGBV, can take years to change. While the FGD with men from the local community showed positive signs of attitude changes (most men were aware of SGBV, its negative consequences on the community, and the fact that more needs to be done to prevent it), there is still a lot of work that needs to be done; a majority of respondents referred to local, traditional attitudes in response to questions about the biggest obstacle to decreasing SGBV.

7.2 Recommendations

Across nearly all indicators, HPA was able either to accomplish or exceed their goals, particularly given the limited resources available to them and the difficulties of working on SGBV in the Somali context. Below, recommendations for future programming and continued work on SGBV are outlined.

- Nearly all interviewed stakeholders stated that community and religious leaders are the biggest obstacles, and the biggest potential assets, to reform. This is because the latter groups are unique in being universally respected by their communities. As such **more formal mechanisms to engage**

with community and religious leaders should be implemented going forward. This should include not only educating leaders on SGBV, but also on how to engage in outreach and awareness raising activities, as well as how to advise community members who endure SGBV-related conflicts. Though community leaders received some training on SGBV and how to appropriately and actively respond to it, many feel that community and religious leaders were still an obstacle, oftentimes as a result of their strongly held sociocultural and religious beliefs – historically conservative. In the future, training is recommended on SGBV, survivors' legal rights, and the ways in which local leaders can communicate the negative consequences of SGBV.

  - In particular, **community and religious leaders should receive training on the formal justice system**. This training should include in-depth information about the advantages of the formal legal system for victims, so that stakeholders can encourage their community members to utilize it, rather than traditional *xeer* law, when seeking prosecution on matters pertaining to SGBV. As currently 12-50% of SGBV cases are resolved using the *xeer* traditional system, it is crucial that local leaders encourage their communities to use the formal legal system, upon understanding its greater benefits in these types of cases (more detail on the benefits of using the formal justice system in SGBV cases is outlined in section 3.1). Only after this awareness in the community becomes more widespread, will we be able to see the positive effects of legal reforms in the formal justice system, as traditional forms of justice are not equipped to help victims recover and properly access justice.

- The main learnings garnered by participants of HPA trainings relate to basic definitions and concepts of gender and SGBV, rather than more in-depth and specific trainings on how to care for survivors of SGBV. The basic trainings conducted were a crucial first step in educating stakeholders on SGBV. Representatives from the shelter and the Ministry of Health said they would benefit greatly from information about how to work with survivors of SGBV, and how to care for those survivors, given their experience with trauma. In addition, it is recommended for future programming that **informational trainings/workshops on SGBV, how to prevent it on a community level, and its consequences for victims, should be made available to all local community members**. HPA should work with its extensive network of SGBV stakeholders to ensure this, since this kind of awareness-building is crucial to long-term success, as respondents almost universally suggested that the most prohibitive factor to reform was community attitudes. Mechanisms for awareness building include community conversation techniques or, given the extremely high levels of radio listenership on HPA's radio programme Saxon Saxo[25], briefings could be included in the programme.
- In 2014, over 340 Ministry of Health employees were trained as part of HPA's programming. These trainings covered topics including family planning, counselling, SGBV, SRH rights, clinical skills, neonatal care, and using the GBVMIS data management system.[26] With regard to SGBV, **it is recommended that additional effort be made to coordinate further with government ministries**. Currently, HPA works with the Ministry of Health and Ministry of Labour and Social Affairs. However, one MoLSA official noted that she had not received any training from HPA or WAAPO, and an MoH official noted the need for more in-depth training on psychosocial care and counselling. MoLSA staff lack of training shown in this study was due to that the ministry staff did not work for the MoLSA at the time of HPA's training, however it is one area in which even more can be done to enhance the knowledge and abilities of current ministry staff. An MoH official, MoLSA official, police, and shelter caseworkers all stated that they would like to see more training on how to better provide counselling and psychosocial care, as well as sensitivity and community awareness-building trainings. Though HPA previously implemented trainings for government ministries, this evaluation showed that many of the staff whom were trained no longer work for the ministries, as the turnover rate

[25] Health Poverty Action, Hargeisa, Somaliland. 2012 SRHR KAP Baseline Report.
[26] Hargeisa, Somaliland. Gender-Based Violence Information Management Systems (GBVIMS) Data. 2013 – 2014.

at the ministries is fairly high. As such, HPA should invest in helping ministry staff put mechanisms into place to address issues of SGBV, so that those mechanisms will still stand after trained staff has left.

- **Avenues could be explored with government ministries, including the MoH and MoE, to see if it is possible to include SGBV as a formal part of school syllabi**. Teaching children at school-age about gender-based violence would have beneficial long-term effects.
- **Additional coordination should be implemented in the future between WAAPO and the Ministry of Justice**. The movement for legal reform is just beginning, and will continue long after HPA ends its programming. Lawyers trained by HPA should be prepared to take a lead role in this.

- One positive consequence stemming at least in part from HPA programming is an apparent shift in men's attitudes towards sexual and gender-based violence. In the baseline report conducted by HPA in 2012, 63% of respondents believed it to be "sometimes justifiable" for a man to hit his wife. Based on qualitative data collected for this project, that may no longer be the case. Men interviewed showed a basic understanding of SGBV and could list its negative consequences for their communities. **Efforts should be made to build upon this growing shift in attitudes by shifting outreach campaigns to men and fathers in the local community**. Though HPA trainings with stakeholders appear to have been effective in changing attitudes and empowering key stakeholders to respond to SGBV cases, based on the endline evaluation report and focus group discussions conducted, general community attitudes still have room for improvement, given that many men interviewed were not aware of certain types of SGBV or what services were available to survivors in the local community. Additional outreach campaigns should be conducted throughout local communities, with assistance from community leaders and religious leaders.
  - **It is important that the key stakeholders working on SGBV understand and advocate for more behaviour change activities for men**. HPA and WAAPO staff both pointed out that most of the support that they receive in the community is from women, TBAs, and women's groups. As suggested earlier, additional awareness raising and outreach programming should be tailored for and specifically directed at men in the local community, specifically those on HPA's radio programming.
- Though the HPA and WAAPO shelter has been very successful at providing a safe house that services Hargeisa and nearby areas, the intervention could be improved further in the future by reaching further out, rural areas, in and around Maroodi Jeex. As it would not be cost or time efficient at this point to set up a shelter in more isolated and sparsely populated rural areas, in the future, **program interventions should invest available funds on transportation from rural areas of Somaliland to the safe house in Hargeisa, whenever possible**. In addition, employees at local MCHs (including MCHs in villages outside of Hargeisa) and other women's services should be made better aware of the services available at the WAAPO shelter in Hargeisa and better understand the WAAPO shelter referral process. MCH staff should also be trained on how to provide post-trauma care to victims of SGBV, particularly if they cannot get survivors to the shelter in Hargeisa as soon as possible. Lawyers, police, community leaders, and religious leaders noted that they did not think that the awareness activities conducted by HPA were reaching rural areas (which indeed were never part of the project target area). As such, future projects should consider holding SGBV workshops in rural areas, with key stakeholders as well as local community members.
  - On a related note, should funding permit, the shelter and the services it provides should look into expanding to accommodate potential increased demand from reaching out to communities and villages outside of Hargeisa. The shelter expansion should primarily include additional staffing and more beds for survivors.

- As this program is ending, **HPA, local and federal government institutions, and future donors should seek to provide additional trainings to WAAPO staff on fundraising, grant writing, and financial management, so they can not only manage the shelter without assistance, but also keep the shelter funded**. WAAPO should begin to move more towards the forefront of HPA programming, particularly in terms of outreach and training activities, in order to assure the community that these changes are being championed by local actors. The possibility of collecting local donations from the community or funding from the government should also be explored, as international donor funding may not be a long-term solution.

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9. Appendix

9.1 Qualitative Tools

9.1.1 KII – Health Poverty Action Staff

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action and SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also end leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV in the region and beyond. This discussion should not take more than one hour.	
Age: Gender: Position Title:	– General characteristics
1. Can you describe what your organisation does? 2. What is your role within that organisation? 3. What do you define as sexual and gender based violence? 4. How prevalent is the issue of GBV in the community you work? (Domestic violence, FGM, sexual assault, rape, verbal abuse) 5. Are some kinds of GBV more common than others?	– Relevance of HPA programming
The following questions are about the services your organization provides in relation to SGBV.	
6. What services do you provide in relation to GBV? (Medical care, psychosocial care, clinical management of rape, counselling, community outreach activities, awareness raising) 7. Have you provided training on SGBV? To which groups? How often? What did the training consist of? 8. What types of services does HPA provide to the shelter? 9. Can you elaborate on the behaviour change communication activities HPA has conducted? a. Were these activities effective? Who did these activities reach?How can these activities be improved? 10. What more could be done to raise awareness on the services your organisation provides? 11. What kind of resistance do you face? 12. Which groups in the community are most vocal in supporting your work?	– Effectiveness and efficiency of HPA programming
The last set of questions asks about the role of your community and this shelter in curbing SGBV.	
13. Do you feel community and religious leaders are supportive of the work your organisation is doing? 14. How do you try to involve community and religious leaders in the work you are doing? 15. What are the biggest challenges this shelter has faced? 16. Do you think that this shelter's model could work in other areas? Across Somaliland? In the rest of Somalia? Internationally?	– Relevance of HPA programming – Sustainability of HPA programs (specifically, the shelter model)
Thank you for your time and participation.	

9.1.2 KII – Women Action for Advocacy and Progress Organization (WAAPO) Staff

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action and SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also end leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV in the region and beyond. This discussion should not take more than one hour.	
Age: Gender: Position Title:	– General characteristics
I will start by asking you some general questions about sexual and gender based violence in your community.	
1. Can you describe what your organisation does? 2. What is your role within that organisation? 3. What do you think of when you hear the phrase 'sexual and gender based violence'? 4. How prevalent is the issue of GBV in the community you work? (Domestic violence, FGM, sexual assault, rape, verbal abuse) 5. Are some kinds of GBV more common than others?	
The following questions will ask you about the work your organization does with SGBV.	
6. What services do you provide in relation to GBV? (Medical care, psychosocial care, clinical management of rape, counselling, community outreach activities, awareness raising) 7. How many people access your services on a monthly basis? 8. Which kinds of people access the services you provide? (Men, women, girls, boys) 9. Which groups of people do you have most difficulty in reaching with your work? Why? (Men, women, girls, boys) 10. How do you think you could encourage these groups to access your services? 11. What kinds of outreach work do you conduct in the community? How do you conduct these activities? a. Awareness raising on services? b. Awareness raising on issues of GBV? 12. What more could be done to raise awareness on the services your organisation provides? 13. What more could be done to raise awareness on the issues of GBV in your community? 14. Do you face any resistance from the local community when you are conducting outreach activities? a. What kind of resistance do you face? 15. What are the biggest challenges that you face in offering care to survivors? What kinds of additional trainings or resources would help you to deal with these challenges? 16. Which groups in the community are most vocal in supporting your work?	– Effectiveness, efficiency, and impact of capacity building – Relevance and impact of HPA programs (including capacity building, shelter service provisions, and community-based interventions)
The following questions are about any training you may have received from HPA on SGBV.	

17. What training and mentoring have you received from HPA? 18. Was it easy to understand? (Pictures and writing, verbal, etc.) 19. Is there any kind of training or mentoring that you were hoping to get from HPA that you have not yet received? What kind of training or mentoring? Why do you think this kind of training or mentoring is important? Do you think that this kind of training or mentoring will be available in the future? Why or why not? 20. Are you satisfied with the training and mentoring that you received from HPA? Why or why not? a. How useful was the training to you in your everyday work? b. Was the information easy to apply? 21. Has the HPA provided any other support to you aside from training to help out carry out activities relating to GBV? (What, how much, was it useful) 22. How satisfied are you with the support that HPA has provided to your staff? Please explain your answer.	– Effectiveness and impact of capacity building
The next set of questions will ask you about the role SGBV plays in your local community.	
23. Do you feel community and religious leaders are supportive of the work your organisation is doing? 24. How do you try to involve community and religious leaders in the work you are doing? 25. Has HPA's programming created any problems for your facility or for this community? If yes, please tell me about these problems? What do you think caused these problems? How could these problems be prevented in the future? 26. If HPA had to stop their programs here, would you be able to continue providing services at the same level of quality? Why or why not? What are the negative things that would happen if HPA were to stop their program here? What kind of resources or training would you need in order prevent these negative things from happening? 27. What could HPA do to improve its trainings here? 28. Have you been able to pass on the knowledge that you have gained to other people in your facility? What about people outside your facility? Why or why not? 29. How well do you think the HPA program coordinates with other programs in the area that help provide support to survivors of GBV?	– Relevance and impact of HPA programming
The final questions are about challenges and the future of the shelter.	
30. What are the biggest challenges this shelter has faced? 31. Do you think that this shelter's model could work in other areas? Across Somaliland? In the rest of Somalia? Internationally?	– Sustainability of HPA programming
Thank you for your time and participation.	

9.1.3 KII – Ministry of Health (MoH) Staff

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action and SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also end leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV in the region and beyond. This discussion should not take more than one hour.	
Age: Gender: Position Title:	– General characteristics
I will start off by asking you about how survivors of sexual and gender based violence can access justice and support.	
1. What do you think of when you hear the phrase 'sexual and gender based violence'? 2. What effects do you think it has on the victims? How about the communities? 3. What kinds of legislation are in place to protect people from it? 4. Where can people get support and treatment if they have been victims of it? 5. Does your ministry of program taken any actions to address theproblems? 6. How well do you think people can seek justice if they've been a victimof SGBV? 7. Do you know if people prefer xeer, sharia, or national law for settlingSGBV disputes? Why do you think that is?	– Relevance of HPA programming
The next set of questions will ask about any training you may have received from HPA or their local partners.	
8. What training and mentoring have you received from HPA? 9. Was it easy to understand? (Pictures and writing, verbal, etc.) 10. Is there any kind of training or mentoring that you were hoping to get from HPA that you have not yet received? What kind of training or mentoring? Why do you think this kind of training or mentoring is important? Do you think that this kind of training or mentoring will be available in the future? Why or why not? 11. Are you satisfied with the training and mentoring that you received from HPA? Why or why not? 12. How useful was the training to you in your everyday work? 13. Was the information easy to apply? 14. What could HPA do to improve its trainings here?	– Efficiency and effectiveness of HPA training/capacity building
The final questions are about what challenges exist in your community regarding SGBV.	
15. What do you think are the biggest problems in trying to reduce theamount of SGBV in the communities? 16. How do you think these obstacles should be overcome? 17. Which stakeholders in the communities do you think are mostimportant in overcoming these obstacles in the future?	– Relevance and sustainability of HPA programming
Thank you for your time and participation.	

9.1.4 KII – Ministry of Labour and Social Affairs (MoLSA) Staff

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action and SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also end leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV in the region and beyond. This discussion should not take more than one hour.	
Age: Gender: Position Title:	– General characteristics
I will start off by asking you about how survivors of sexual and gender based violence can access justice and support.	
1. What do you think of when you hear the phrase 'sexual and gender based violence'? 2. What kinds of legislation are in place to protect people from it? 3. Where can people get support and treatment if they have been victimsof it? 4. Does your ministry of program taken any actions to address theproblems? 5. How well do you think people can seek justice if they've been a victim of SGBV? 6. Do you know if people prefer xeer, sharia, or national law for settling SGBV disputes? Why do you think that is?	– Relevance of HPA programming
The next set of questions will ask about any training you may have received from HPA or their local partners.	
7. What training and mentoring have you received from HPA? 8. Was it easy to understand? (Pictures and writing, verbal, etc.) 9. Is there any kind of training or mentoring that you were hoping to get from HPA that you have not yet received? What kind of training or mentoring? Why do you think this kind of training or mentoring is important? Do you think that this kind of training or mentoring will be available in the future? Why or why not? 10. Are you satisfied with the training and mentoring that you received from HPA? Why or why not? 11. How useful was the training to you in your everyday work? 12. Was the information easy to apply? 13. What could HPA do to improve its trainings here?	– Efficiency and effectiveness of HPA training/capacity building
The final questions are about what challenges exist in your community regarding SGBV.	
14. What do you think are the biggest problems in trying to reduce theamount of SGBV in the communities? 15. How do you think these obstacles should be overcome? 16. Which stakeholders in the communities do you think are most important in overcoming these obstacles in the future?	– Relevance and sustainability of HPA programming
Thank you for your time and participation.	

9.1.5 KII – POLICE

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action and SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also end leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV in the region and beyond. This discussion should not take more than one hour.	
Age: Gender: Position Title:	– General characteristics
First I am going to ask you a few questions about access to justice for victims of SGBV in your community.	
1. What do you think of when you hear the phrase 'sexual and gender based violence'? 2. What kinds of legislation are in place to protect people from it? 3. Do you know where can people get support and treatment if they have been victimsof it? 4. What actions do the police take to address theproblems? 5. How well do you think people can seek justice if they've been a victimof SGBV? 6. Do you know if people prefer xeer, sharia, or national law for settlingSGBV disputes? Why do you think that is? 7. Do you think the people who need to access the protection services access them? a. Why, why not? b. What types of people use the service most? *(Men/women/girls/boys)* c. Is there a certain group in the community who these services aren't reaching? d. What could be done differently in order to reach these groups? 8. Can you think of any reasons why people might not want to report cases of GBV? (*Probe: stigma, fear, feel hopeless, family etc.*) a. What do you think could be done to overcome this?	– Impact and relevance of capacity building and behaviour change communication initiatives
The next set of questions will ask you about any training you may have received from HPA or their local partner.	
9. What training and mentoring have you received from HPA? 10. Is there any kind of training or mentoring that you were hoping to get from HPA that you have not yet received? What kind of training or mentoring? Why do you think this kind of training or mentoring is important? Do you think that this kind of training or mentoring will be available in the future? Why or why not? 11. Are you satisfied with the training and mentoring that you received from HPA? Why or why not?	– Effectiveness and impact of capacity building
The following questions will ask about the role of SGBV in your community as a whole.	
12. What do you think are the biggest problems in trying to reduce theamount of SGBV in the communities?	– Relevance and sustainability of HPA programs

13. How do you think these obstacles should be overcome? 14. Has HPA's programming created any problems for your facility or for this community? If yes, please tell me about these problems? What do you think caused these problems? How could these problems be prevented in the future? 15. What challenges have HPA faced in working with local stakeholders and how could these be overcome? 16. Which stakeholders in the communities do you think are most important in overcoming these obstacles in the future?	
Thank you for your time and participation.	

9.1.6 KII – LAWYER

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action and SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also end leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV in the region and beyond. This discussion should not take more than one hour.	
Age: Gender: Position Title:	• General characteristics
First I am going to ask you a few questions about access to justice for victims of SGBV in your community.	
1. What do you think of when you hear the phrase 'sexual and gender based violence'? 2. What kinds of legislation are in place to protect people from it? 3. Do you know where can people get support and treatment if they have been victimsof it? 4. Does your organization/law office take any actions to address theproblems? 5. How well do you think people can seek justice if they've been a victimof SGBV? 6. Do you know if people prefer xeer, sharia, or national law for settlingSGBV disputes? Why do you think that is? 7. Can you think of any reasons why people might not want to report cases of GBV? (*Probe: stigma, fear, feel hopeless, family etc.*) 8. What do you think could be done to overcome this? 9. Do you think the people who need to access the protection services access them? a. Why, why not? b. What types of people use the service most? *(Men/women/girls/boys)* c. Is there a certain group in the community who these services aren't reaching? d. What could be done differently in order to reach these groups?	– Impact and relevance of capacity building and behaviour change communication initiatives
The next set of questions will ask you about any training you may have received from HPA or their local partner.	
10. What training and mentoring have you received from HPA? 11. Is there any kind of training or mentoring that you were hoping to get from HPA that you have not yet received? What kind of training or mentoring? Why do you think this kind of training or mentoring is important? Do you think that this kind of training or mentoring will be available in the future? Why or why not? 12. Are you satisfied with the training and mentoring that you received from HPA? Why or why not?	– Effectiveness and impact of capacity building
The following questions will ask about the role of SGBV in your community as a whole.	

13. Has HPA's programming created any problems for your facility or for this community? If yes, please tell me about these problems? What do you think caused these problems? How could these problems be prevented in the future? 14. What challenges have HPA faced in working with local stakeholders and how could these be overcome? 15. Which stakeholders in the communities do you think are mostimportant in overcoming these obstacles in the future? 16. What do you think are the biggest problems in trying to reduce theamount of SGBV in the communities? 17. How do you think these obstacles should be overcome?	– Relevance and sustainability of HPA programs
Thank you for your time and participation.	

9.1.7 KII – Community Leader/Religious Leader

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action and SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also end leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV in the region and beyond. This discussion should not take more than one hour.	
Age: Gender: Position Title:	• General characteristics
1. Can you describe your role in the local community? 2. What do you think of when you hear the phrase 'sexual and gender based violence'?	
The following questions will ask you about the services provided and activities conducted by HPA for victims of SGBV.	
3. Are you aware of the services offered by HPA/local partners? *(Clinical management of rape, medical services, psychosocial support, community outreach)* 4. Do you think the people who need to access the protection services access them? a. Why, why not? b. What types of people use the service most? *(Men/women/girls/boys)* c. Is there a certain group in the community who these services aren't reaching? d. What could be done differently in order to reach these groups? 5. How do they raise awareness about these activities? a. Do you feel lots of people are aware of the GBV services offered by HPA? b. How do they engage you in outreach and awareness raising activities? c. As a community leader, how do you engage the local community in understanding these issues? d. What could be done to improve awareness of these services? e. What do you think could be done to overcome this?	– Awareness raising – Behaviour change communication activities – Relevance and effectiveness of shelter program and behaviour change communication activities
The next set of questions pertains to the role SGBV plays in your community.	
6. Do local community members ever come to you for advice or support on issues pertaining to SGBV? 7. What point of view does Islam take on SGBV?(Only religious leaders) 8. What do you tell people if they ask you about how they should deal with those? 9. Could you describe the extent of the issue of GBV is in the local community? *(Prevalence, severity etc.)* 10. What are the challenges in combating GBV in the community? *(Attitudes, logistics, lack of infrastructure, insecurity)*	– Community capacity building – Relevance and impact of capacity building and community-based interventions
The following questions will ask you about the availability of access to justice and support for victims of SGBV.	
11. Can you think of any reasons why people might not want to report cases of GBV? (*Probe: stigma, fear, feel hopeless, family etc.*)	– Awareness raising – Effectiveness and impact of

12. How well do you think people can seek assistance and justice if they've been a victim of SGBV? 13. Do you know if people prefer xeer, sharia, or national law for settling SGBV disputes? Why do you think that is? 14. Do you know where people can get support and treatment if they have been victims of SGBV?	behaviour change communication activities
The next questions will ask about the relationship between HPA and key stakeholders in this community.	
15. In your opinion, how well has HPA worked with local community stakeholders such as yourself? a. Have you taken part in community outreach activities they have held and what did you think of them? 16. What challenges have HPA faced in working with local stakeholders and how could these be overcome? 17. Which stakeholders in the communities do you think are most important in overcoming these obstacles in the future?	– Effectiveness of: a. Behaviour change communication activities b. Community capacity building c. Coordination amongst stakeholders
The final set of questions asks about the general prevalence of SGBV in your community, and goals for the future.	
18. What do you think are the biggest problems in trying to reduce the amount of SGBV in the communities? 19. How do you think these obstacles should be overcome? 20. Are there any other comments you would like to make about HPA activities in relation to SGBV?	– Awareness raising – Effectiveness, efficiency and sustainability of HPA programming
Thank you for your time and participation.	

9.1.8 KII – SGBV Survivor

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action's SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV and the creation of shelters such as this one, in the region and beyond. This discussion should not take more than one hour.	
Age: Gender:	• General characteristics
I am going to begin by asking you a few questions generally about sexual and gender based violence in your community.	
1. What do you think of when you hear the phrase sexual and gender based violence'? 2. What do you think are the most common types of SGBV that face your community?	
Next we are going to talk about how this facility has helped you, and what types of services are available here.	
3. Were you referred to this shelter by someone in your community? a. If yes, by whom? (*Not the person's name, but the person's description, i.e. friend, aunt, etc.)* 4. What kinds of services has this shelter provided you with? 5. Do you know what other services the shelter offers? 6. Why did you not use these services? 7. Were there any services you needed that the shelter could not provide? a. Did someone explain to you why that service was not available? 8. What do you feel is the level of the quality of care provided here? 9. Why might people not use the services at the shelter? *Probe: didn't know about it, illiterate, didn't think they were being abused* 10. What do you think this shelter does best? 11. What do you think is the biggest problem the shelter has? 12. What can the shelter do to improve its services? 13. Does the shelter help people seek justice if they have been a victim of SGBV? 14. How do you feel the staff at the shelter has treated you? 15. Have you felt safe while at the shelter? Why or why not?	– Impact and effectiveness of shelter
The last questions are about the future of this facility and if similar ones should be used elsewhere.	
16. Do you think that the model of this shelter would work in other areas? Smaller villages? Across Somaliland? Greater Somalia? Internationally?	– Sustainability of shelter
Thank you for your time and participation.	

9.1.8 FGD Guide – WAAPO Shelter Caseworker

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action and SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also end leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV in the region and beyond. This discussion should not take more than two hours.	
Ages: Gender: Number of participants: Position Titles: Start time of FGD: End time of FGD:	– General characteristics
The first group of questions is about the services that this shelter provides.	
1. What services does this facility currently provide for survivors of sexual assault? 2. Before HPA started their program here, what kinds of services was the shelter able to provide? 3. Does the shelter provide any new services now that HPA is working with you? Which ones? 4. Are there any services the shelter used to provide but is no longer able to provide? What are the reasons that it can no longer provide these services? 5. Are there any services for survivors that you feel the shelter cannot currently provide that you would like to be able to provide? Why is the shelter not currently able to provide these services? What kinds of resources and support will be necessary for the shelter to be able to provide these services in the future? 6. Are there some survivors in the community who the shelter cannot serve? What kinds of services do they need? Why are you not able to serve these survivors? a. If it is not available, why not?	– Impact and effectiveness of shelter
The following questions will ask about what you have learned throughout the course of this program.	
7. Since this project began, what are the main lessons that you all have learned about providing care to survivors of sexual assault and gender-based violence? a. What about providing basic counselling? b. Please tell me about how you learned these lessons. c. Why do you think that these lessons are important? 8. Are there any special lessons that you have learned about providing care to children who have survived sexual assault? What are these lessons?	– Impact of shelter
The next set of questions is about how and why most people come to this shelter.	
9. How do most survivors who come to this shelter find out about the services? 10. What are the most common reasons people come here? Additional reasons? 11. Do men often use the services here? If so, for what purpose?	– Effectiveness and impact of community-based interventions
The following questions will ask about HPA's programming and training with your staff and this shelter.	
12. What are the most important things that HPA has done for this clinic?	– Effectiveness and impact of

13. What training and mentoring have you all received from HPA? 14. Is there any kind of training or mentoring that you were hoping to get from HPA that you have not yet received? What kind of training or mentoring? Why do you think this kind of training or mentoring is important? Do you think that this kind of training or mentoring will be available in the future? Why or why not? 15. Are you satisfied with the number of visits that you received from HPA workers? 16. Are you satisfied with the training and mentoring that you received from HPA? Why or why not? 17. Has HPA's programming created any problems for your facility or for this community? If yes, please tell me about these problems? What do you think caused these problems? How could these problems be prevented in the future? 18. If HPA had to stop their programs here, would the shelter be able to continue providing services at the same level of quality? Why or why not? What are the negative things that would happen if HPA were to stop their program here? What kind of resources or training would you need in order prevent these negative things from happening? 19. What could HPA do to improve its trainings here? 20. How satisfied are you with the support that HPA has provided to your staff? Please explain your answer. 21. How well do you think the HPA program coordinates with other programs in the area that help provide support to survivors of GBV? 22. Have you been able to pass on the knowledge that you have gained to other people in your facility? What about people outside your facility? Why or why not?	shelter and capacity building/training of shelter staff
The final questions will ask about challenges and potential improvements for the shelter.	
23. What are the biggest challenges that you/the shelter face in offering care to survivors? What kinds of additional trainings or resources would help you to deal with these challenges? 24. Do you think that this shelter's model could work in other areas? Across Somaliland? In the rest of Somalia? Internationally?	– Sustainability of shelter
Thank you for your time and participation.	

9.1.9 FGD Guide – Male Community Members

Questions	Indicators
Introduction: Hello, my name is _____ and I am working with Forcier Consulting. We're undertaking research as part of Health Poverty Action and SGBV Project Intervention. The purpose of the research is to explore the successes and lessons learned at this facility. I want to assure you that all the opinions you give are completely confidential. You may refuse to answer any particular question. You may also end leave the discussion at any point without any negative consequences. However, we would greatly appreciate your opinions on these topics, which will contribute to future planning and policy development around SGBV in the region and beyond. This discussion should not take more than two hours.	
Ages: Number of participants: Position Titles: Start time of FGD: End time of FGD:	– General characteristics
1. What do you think of when you hear the phrase 'SGBV?	
The next set of questions pertains to the role SGBV plays in your community.	
2. Could you describe the extent of the issue of SGBV is in the local community? *(Prevalence, severity etc.)* 3. What are the challenges in combating SGBV in the community? *(Attitudes, logistics, lack of infrastructure, insecurity)*	– Community capacity building – Relevance of capacity building and community-based interventions
The following questions will ask you about the services provided for victims of SGBV.	
4. Are you aware of any services offered to assist victims of SGBV? *(Clinical management of rape, medical services, psychosocial support, community outreach)* a. Do you know where people can access these services? 5. Do you think the people who need to access the protection services access them? a. Why, why not? 6. What types of people use the service most? (Men/women/girls/boys) 7. Is there a certain group in the community who these services aren't reaching? 8. What could be done differently in order to reach these groups? 9. How can awareness be raised about availability services? 10. Do you engage you in outreach and awareness raising activities?	– Awareness raising – Behaviour change communication activities – Relevance and effectiveness of shelter program and behaviour change communication activities
The following questions will ask about access to justice for victims of SGBV.	
11. Can you think of any reasons why people might not want to report cases of GBV? *(Probe: stigma, fear, feel hopeless, family etc.)* 12. Do you think victims of SGBV *should* seek justice? 13. How well do you think people can seek assistance and justice if they've been a victim of SGBV?	– Awareness raising – Effectiveness and impact of behaviour change communication activities
The final questions will ask about challenges and potential improvements in your community, in terms of SGBV.	
14. Who do you think are the most important stakeholders in this community to help address the problem of SGBV? 15. What do you think are the biggest problems in trying to reduce the amount of SGBV in the communities? a. How do you think these obstacles should be overcome? 16. Are there any other comments you would like to make in relation to SGBV?	– Awareness raising – Effectiveness, efficiency and sustainability of HPA programming
Thank you for your time and participation.	

FORCIER CONSULTING

Erin Satterlee
Partner
Forcier Consulting—Somalia
Forcier House
Masalaha District
Hargeisa, Somaliland
+252 (0) 633 467 763
erin@forcierconsulting.com