Gender Based Violence AoR Somalia

GBV AoR Strategy

June 2024 – December 2025

Introduction

Somalia is witnessing an unprecedented humanitarian crisis due to prolonged conflict and recurring droughts and flooding. Crop failures, water shortages, and loss of livestock and livelihood opportunities in communities already overwhelmed by inter-communal conflict have to date displaced approximately 3.8 million people from their homes, 78% of whom are women and children.[1] Women and girls especially those living with disabilities and from minority clans are exposed to heightened Gender based Violence Area (GBV) risks and exposure because of displacements. Increasing reports of Intimate Partner Violence (IPV) and sexual violence are rampart with grave consequences for the physical and mental health of women and girls.[2] Limited availability and access to services combined with stigmatization and fear of reprisal from the perpetrator, family members and community members at-large constitute major barriers to services. Avenues to seek justice or recourse for survivors are dogged with delays and perpetrators are not often held accountable due to weak rule of law and discriminatory social and cultural norms.

The GBV Area of Responsibility (AoR) is one of the AoR's in the Protection Cluster in the Somalia humanitarian response. The major aim of the GBV AoR is to work in collaboration with other clusters to ensure effective coordination of quality, timely and safe confidential GBV specialised services is available and accessible to vulnerable women and girls (including GBV survivors) in camps and host communities, impacted by conflicts and natural hazard events. The GBV AOR is led and co-led by UNFPA and International Rescue Committee (IRC) at Federal Government of Somalia (FGS) level. It currently operates 1 national and 21 sub-national platforms led by international, government and national partners with reporting responsibilities to the leadership at the FGS. The AoR has approximately 54 operational partners, the majority of whom are national or local organisations, working in highly insecure areas delivering services that communities often consider controversial owing to their focus on survivors of GBV. Despite the challenges of limited funding and availability of capacitated coordinators to operate area-based coordination; limited number of local specialised GBV service providers, the AoR continues to improve operations by enhancing local capacities for coordination through mentoring, supervision, and oversight.

In furtherance of the GBV AoR's primary purpose for quality service provision, it has developed a 18-month ***humanitarian*** focussed strategy to guide life-saving advocacy and programming efforts in ten prioritized districts as indicated in the 2024 Humanitarian Needs and Response Plan (HNRP).[3] These include Daynile, Kahda, Afmadow, Diinsoor, Jowhar, Baidoa, Jamaame, Belet Weyne, Bu'aale and Qansax Dheere. As per the "Integrated Response Framework", developed by the Humanitarian Country Team (HCT), partners will target vulnerable women and girls from those districts who are either newly displaced and/or those living in newly accessible communities.

The GBV AoR strategy adopts an integrated approach and interventions will be implemented under the below key strategic priorities:

- Improved access to high-quality, survivor-centred and age-appropriate GBV prevention and response services in the targeted districts by scaling up existing static services and expanding mobile services into newly accessible communities.
- Strengthened coordination of GBV-related interventions at existing hubs and increased support to those districts that have limited/no functioning coordination mechanisms.
- Enhanced and institutionalised GBV risk mitigation measures across key sectors such Camp Coordination and Camp Management (CCCM), Nutrition, WASH, Food Security and Shelter.

GBV situational brief Somalia:

Women and girls in urban and rural communities both in and out of camp settings face overlapping protection concerns that are exacerbated by the impact of conflict, and environmental shocks. While some clusters have shown incremental improvements in targets and objectives of the HNRP 2023 of the 2023 incidences of GBV have continued to steadily rise. Compared with 2022, data gathered through the Gender-Based Violence Information Management System (GBVIMS) in 2023 showed a marked increase in incidences of IPV (52% vs. 37%) and rape (15% vs. 11%). Perpetrators of rape were most often identified as male community members. Community outreach as well as capacity building of frontline service providers, two key interventions promoted in the previous Strategy, are purported to have led to a 38% increase of survivors accessing services during that same timeframe.[4]

Sites for Internally Displaced People (IDPs) should be a haven for women and girls, however poorly constructed shelters; limited WASH facilitates; lack of prioritisation during food distribution; and an absence of general protection measures, has led to sexual exploitation and abuse by gatekeepers and others in positions of power. A Camp Coordination & Camp Management Cluster-led gender analysis noted that shelters provide "little protection or privacy".[5] Male family members, who are travelling long distances to find grazing land for cattle or casual work, leave behind largely unprotected female and child-led households that are vulnerable to sexual exploitation and assault. Women and girls, particularly those facing extreme poverty in rural communities, must travel long distances (often in the dark) to find water and fuel, exposing them to sexual violence along the route and physical violence upon arrival, as they fight over scarce supplies. It is critical that other sectors actively mitigate potential GBV risks.

Many families on the brink of survival have adopted negative coping strategies, such as forcing girls into marriage for dowry and trading sex for basic necessities.[6] Early marriage is pervasive and customary throughout the country, with 45% of women aged 20 to 24 married before the age of 18[7] contributing to

the perpetuating the prevalence of Female genital mutilation at 98%[8] Girls forced into marriage have lower education attainment, poorer health outcomes and are much more likely to experience physical and sexual violence perpetrated by an intimate partner.[9]

Brief situational review - Ten prioritised districts for the HNRP:

The strategy prioritizes the 10 districts identified in the Summary Somalia 2025 HNRP[10]. These locations will also be reviewed quarterly by the GBV AoR Strategic advisory group (SAG) to align with the changes by the HCT in Somalia.

Across the 10 prioritised districts in the Somalia 2025 HNRP,[11] Multiple displacements are driven by conflicts and climate events such as flooding and droughts. Food insecurity, loss of livelihoods/income, and social networks are major factors contributing to increasing vulnerability of women and girls to sexual violence, abuse and exploitation. While similarities in impact on women and girls is evident, there are specific differences in the needs expressed by the affected women and girls in different locations. The need for basic hygiene kits, including dignity and Menstrual Hygiene Management (MHM) kits, are among the priority concerns for displaced women and girls. Loss of livelihood/income and pervasive food insecurity have ensured a dependency on humanitarian assistance for basic needs and increased adoption of negative coping mechanisms.

Daynille and Khada are districts in Banadir region which hosts a greater percentage of displaced populations, with women and girls experiencing limited mobility due to risks and exposure to sexual violence. In Kahda and Daynille, health, GBV and nutrition centres are located far away due to the destruction of existing infrastructure and displacements. These districts experience limited Psychosocial Support (PSS) and case management for GBV survivors, an issue made more complicated by the increasing incidence of drug abuse amongst young boys, subsequently increasing the risk of violence. Few Women and Girls Safe Spaces (WGSS) and GBV One Stop Centers (OSC) are open for services due to a lack of funding. Women and girls living with disabilities are discouraged to seek services due to infrastructure not catering for their needs. In addition, capacities for addressing the needs of child and male survivors are also lacking or insufficient.

In Belet weyne and Jowhar, displaced women and girls are impoverished and lack material and adequate legal support. Women and girls fleeing violence have nowhere to escape because of a lack of transitional shelters. The depleted stock of rape kit 3 has contributed to service gaps for rape and IPV survivors. Similarly, in Baidoa, Qansax Dheere and Dinsor, displaced women and girls risk exposure to GBV, rape and IPV, due to high poverty rates, worsened by high rates of unemployment for young persons. Women and girls raised concerns of men intruding in the evening with the intent to raping women, particularly targeting new arrivals and women without male protection, whose men travels to rural villages for farming. Women and girls from minority groups have reported increased GBV issues due to a lack of clan protection.[12]

The services available in these sites are located far from IDP camps, and aid distribution is supervised mainly by men, thereby increasing the risk of sexual exploitation. Shortage of Post-exposure prophylaxis (PEP) kits in key GBV OSC and health facilities providing Clinical Management of Rape (CMR) service provision. In Jamaame, Buala and Afmadow, FGM, Child, Early and Forced marriage and wife inheritance are all increasing, owing to the impact of food insecurity[13]. Reporting of sexual violence is low due to the mandatory reporting requirement. Stock of Rape Kit 3 limits the capacity of service providers to ensure services are available for survivors. Hostility from host communities is also a contributory factor to sexual violence.

GBV AoR Partners are present and providing services in Daynille, Khada, Afmadow, Jowhar, Baidoa and Belet Wyene. However, access limitation due to presence of armed groups are barriers to GBV service provision in Jamame, Bu'aale, Dinsoor and Qansax Dheere.

Against this background, the priority needs for the 10 locations include CMR; updating and developing referral pathways to indicate real-time availability of services, including referrals for livelihood and legal services; supporting operations for existing GBV OSC

and WGGS; increasing capacity for service provision; improving PSS and case management services; implementing multiple cash voucher assistance (CVA); implementing routine mentoring and training for service providers to ensure pooled updated capacity at locations need; supporting human resource capacity for coordination; and prioritising GBV mitigation and collaboration with key clusters operating in locations in need of improved GBV integration. For example, planned interventions with Nutrition clusters to improve privacy for lactating women, assessment for IPV and proximity of service centres. .

Coordination

Effective coordination is a critical element to ensuring access and improving quality of services. Limited or lack of coordination in geographical areas with a large burden of need is detrimental to improving service quality. GBV AoR has the largest representation of local and national organisations. The GBV AoR has state sub-national coordination platforms in 10th targeted districts of including Hirshabelle chiared by WARDI, Southwest chaired by AMARD and co-chiared by MoWHRD, Jubaland chaired by ALIGHT and co-chiared by MoWHRD, Banadir chaired by NoFYL.

Despite the large numbers of partners, the AoR has been unable to mobilise and adequately address the needs of vulnerable women and girls (including GBV survivors), due to lack of GBV service providers in remote locations with high burden of need for GBV specialised services.

Other factors include the growing number of displaced people; stock out of rape treatment kit 3; and dependency by affected women and girl on humanitarian aid, due to erosion of livelihoods or incomes. The lack of expert local or international coordinators as a result of limited funding, poses another major barrier to providing adequate coordination required to deliver services. As the AoR leadership is fund-constricted, it struggles to retain the team required at the national level required.

To address these challenges, the GBV AoR is progressively advocating and encouraging GBV implementing actors to broaden service provision and coordination to rural locations, using the footprints of humanitarian actors including local Civil Society Organizations (CSOs) and Women-led Organizations (WLOs). The GBV AoR proactively engages with and maps the presence of actors in rural and hard-to-reach areas, and continues to mentor and train these organisations to update their capacity. The AoR is also engaging with UNFPA and other actors to address the stock out of Kit 3 to accelerate access to rape and IPV treatment for GBV survivors. As part of the AoR's resource mobilisation activities, a messaging strategy is being developed for different audiences with the objective of retaining the existing AoR team and recruiting GBV area-based expert coordinators.

Priority Strategic Interventions:

The GBV AoR's 18-month humanitarian response strategy will be anchored upon three strategic priorities, under which operational partners will deliver the following life-saving interventions, as identified in the 2025 HNRP and endorsed by the HCT through the "Integrated Response Framework (IRF)":

1. Improved access to high-quality, survivor-centred and age-appropriate GBV prevention and response services in the targeted districts by scaling up existing static services and expanding mobile services into newly accessible communities.

    - **Clinical management of rape (CMR)** services that include care for IPV survivors, forensic evidence collection and psychosocial support will be scaled up at static health care facilities and expanded through mobile services.
    - **Care and treatment of IPV survivors** will be delivered at OSCs and WGSS. The first point of contact for the majority of survivors of IPV is the WGSS within the community. Depending on the need, they may be referred to an GBV OSC and/or other advanced health facilities for further medical attention. Midwives, where possible, will be deployed to WGSS to facilitate basic treatment of IPV and share information on SRHR. This integrated service model (GBV/SRH) has proven successful in other districts.
    - **Specialized case management that includes psychosocial support (PSS)** and counselling will be provided in OSCs and WGSSs by staff trained on global standards of care. Critical aspects of case management include using trauma-informed theory to develop case action plans that meet the assessed safety, health, psychosocial and, if possible, legal needs of a survivor.
    - **Cash Voucher Assistance (CVA)** will be delivered to survivors and those at-risk of GBV through close collaboration with the Cash Working Group, World Food Programme (WFP) and Food and Agriculture Organization (FAO). Selection criteria that minimize potential protection concerns and maximizes resiliency and recovery will be developed and utilized.
    - **Dignity kits that include items for menstrual hygiene management (MHM)** will be distributed in WGSSs and through mobile outreach using community-informed distribution criteria. As noted above, the lack of these basic necessities has forced survivors and those at-risk of GBV to engage in transactional sex and/or enter into other types of exploitative relationships.

2. Strengthened GBV coordination at existing national and sub-national coordination platforms and increased support to districts with limited/no functioning coordination mechanisms.

    - **Local/national organisations will lead coordination efforts at sub-national level**. Where possible, the GBV AoR will recruit and build the capacity of partner organisations to

successfully deliver on the six core functions of coordination in the targeted districts lacking coordination forums.

- **Standard Operating Procedures (SOPs)** for GBV prevention and response interventions that include critical elements, such as information-sharing protocols and referral pathways will be developed and/or updated in each of the targeted districts. The development process is a key learning opportunity for partners to understand and embrace global standards of care and minimize ethical and safety concerns.
- **Information management** outputs, such as service mapping; technical oversight and expansion of partners contributing to the GBVIMS; and engagement in needs assessments will be extended to the targeted districts.

3. Enhanced and institutionalized GBV risk mitigation measures across key sectors such CCCM, Education, WASH, Food Security, Nutrition and Shelter.

- **Multi-sectoral safety audit exercises** will be conducted regularly at field (in camp and camp-like settings) and policy level.
- **Integrated GBV risk mitigation frameworks** will be developed in partnership with each cluster based on evidence-based risk analysis. Partners will ensure that recommendations are addressed in a timely manner at field level and advocate with members of the HCT to institutionalise measures at a policy level.

Support for GBV AoR partners - Delivery of Proposed interventions

The GBV AoR leadership will actively provide support to the broadening and implementation of coordination and service provision through oversight and mentoring. The GBV AoR will undertake mapping of GBV service organizations through the 5Ws[14] and organize reporting discussions to address capacity gaps and provide technical support, guidance, and advice to ensure provision of services using the GBV survivor-centred approach. During these meetings, GBV service providers will be requested to share insights into methodologies utilized to provide services and discuss information or data related to client satisfaction feedback. This will enable the leadership to provide adequate guidance. WLOs will receive capacity-enhancement support through on-the-job mentoring by the GBV AoR leadership. UNFPA and (IRC) as co-leads will make deliberate efforts to participate and provide guidance to the platform's coordination efforts, led by the WLOs. The AoR leadership will also provide leadership and guidance on the efforts by sub-national platforms to improve funding and visibility through the production and dissemination of context-specific infographics depicting the situation of women and girls. For locations such as Jamame, where there are limited services and no coordination, the AoR leadership will actively seek to provide virtual mentoring and guide local organization to establish a GBV working reference group and map GBV service providers and referral pathways to promote access and standardisation of services provided.

Guidance on Proposed prioritisation

Provided herein is context-specific guidance for delivering activities in alignment with the types of humanitarian events in alignment with the GBV AoR Contingency planning document[15] and Intergrated Response Framework, Somalia (2024).

Context	Activities Proposed
Pre-Conflict/Drought/ Floods	• Mapping of human resources available for GBV coordination and service provision and communication/prevention materials • Provide training/orientations for coordination and service provisions • Mapping of GBV response structures • Contextualize, review and disseminate operational guidelines • Prepositioning of commodities and supplies (Dignity, MHM kits, etc) • Ensure referral pathways and SOPs are updated and disseminated • Develop and engage key clusters in the response on GBV mitigation. • Conduct community awareness sessions on GBV, available services, and reporting mechanisms • Strengthen partnerships with local NGOs and community-based organizations to enhance GBV service delivery. • Engage in advocacy efforts to ensure GBV issues are prioritized in all phases of the crisis response among the relevant clusters and partners running response on the ground
Active conflict/Drought/ Flood	• Distribution of Hygiene kits, including Dignity and MHM kits through existing or temporary GBV facilities and other partner platforms in IDP camps • Deliver PSS, CMR and case management through existing GBV facilities where not possible use integrated mobile outreach teams. • Provide cash assistance to assist referrals/transport/other basis services. • Participate in multi-cluster assessments to direct targeting. • Collect, analyze, and share GBV-related data to inform response strategies
Post Conflict/Drought/ Flood	• If possible, consider the use of multipurpose cash for livelihoods promotion and protection. • Support the community-based prevention/protection networks including key stakeholders. • Collect data on GBV incidents, service provision, and community needs to understand the post-crisis situation and to document and have learning materials to adjust future interventions accordingly. • Analyze the collected data to identify trends, gaps, and areas needing improvement. Share findings with stakeholders to enhance coordination and response efforts • Continuously monitor and evaluate GBV programmes to ensure they meet the needs of affected populations and adapt strategies based on feedback and data analysis

Modes of Service delivery

The above services will be delivered where possible through existing OSCs and WGSSs. Temporary service sites and mobile service modalities will be established in new contexts to ensure women and girls can safely and confidentially access life-saving interventions. Partners will establish and/or build on the following integrated service delivery models that recognize the intersectionality between GBV and sectors such as nutrition, SRH and food security. The models were successfully piloted during the 2022 drought and famine response.

Integrated service models				
Model 1	**Model 2**	**Model 3**	**Model 4**	**Model 5**
GBV/SRH Mobile teams – inclusion of PSS and SRH actors in mobile teams for improved/integrated service reach to remote locations.	One Stop Centers – ensuring that OSCs provide wrap-around services such as RH counselling, case management/PSS, safety planning and legal aid.	Integrating inter-cluster GBV focal points into existing GBV/updated referral pathways to ensure that vulnerable women and girls have access to food /cash and other assistance offered by other clusters.	GBV risk identification and mitigation across clusters such as CCCM, FSC, Health, Wash and nutrition – conduct inter-sectoral safety audits and work with cluster leads to put in measures that actively mitigate those risks.	Using existing WGSS and GBV one stop centres to deliver information on nutrition, birth spacing and GBV prevention.

Guiding Principles and Approaches

This strategy adopts a survivor-centred, human rights-based approach to service provision, ensuring that vulnerable women and girls, including survivors of GBV, give informed consent, make their own choices, and have their wishes and rights respected. Partners will uphold and actively promote the guiding principles of respect, confidentiality, safety, and non-discrimination throughout their work.

Previous approaches focused on the nexus between the development and humanitarian response to GBV. Emphasis was placed foremost on life-saving service delivery, but partners also attempted to address longer-term recovery goals, such as building the capacity of local actors to "localize" service delivery, changing cultural norms around harmful traditional practices, and strengthening the rule of law. Through these efforts, the GBV AoR successfully developed SOPs that guide the work of local partners in strategic sub-national hubs. With dedicated funding, partners also built the capacity of local organisations, including WLOs, to lead coordination at sub-national level. These past initiatives will serve as a foundation for this humanitarian-specific strategy.

What is new for this GBV AoR strategy?

The primary approach for this strategy is **GBV mitigation and integration** of GBV concerns in key clusters - Health, Food Security, CCCM, Education, CASH and Nutrition. This approach is critical to ensure that clusters are all actors working to prevent, reduce, and mitigate the incidence of GBV within the operations of the clusters by adopting and implementing actions and indicators that address and report on GBV via the HNRP targets and objectives. The GBV AoR will seek opportunities to deepen its collaboration with the Health, CCCM, Cash Working Group, Food Security, Education and Nutrition clusters using a GBV mitigation lens as entry points. The GBV AoR will also promote integration of GBV and SRH services through WGSS centres by: advocating with the Ministry of Health (MOH) placement and support qualified midwives and nurses to deliver counselling on Reproductive Health (RH) commodities and information; undertake assessment for IPV and facilitate confidential referrals and follow-up for CMR to GBVOSCs and associated health facilities.

Secondly, this strategy will promote **localization of coordination and service delivery through activating WLO leadership to coordinate GBV reference groups.** In areas where WLOs are not present, the GBV AoR will work with actors to establish and operate community-based prevention networks for GBV in the 10 prioritised locations, especially in Jamame district.

The third approach is **broadening service data generation** to inform advocacy for funding mobilization, direct targeting and focus of service delivery using the GBVIMS platform. Presently, the coverage for the GBVIMS platform is extremely limited due to attrition of service providers organisation staff previously trained for GBVIMS data collection and the closure of services due to funding. This has impacted the capacity of the AoR continue to ensure valid data for improving service provision. Previously, the GBVIMS hosted 40 service provider organizations, however, presently only between 20-23 organizations report on the platform. The GBV AoR is piloting the migration to GBVIMS+, a technological enhancement to the original legacy of GBVIMS, to improve the quality of GBV response services by incorporating advanced features for better data protection, case management and service delivery.

Objectives	Indicators	Baseline	Target	Means of Verification	Assumptions
Outcome: Improved utilisation of gender-based violence prevention and response services by women and girls in ten districts characterised by extreme/catastrophic needs in Somalia.					**The districts will be accessible by partners**
Output 1: Improved access to high-quality, survivor-centred and age-appropriate GBV prevention and response services in 10 districts characterised by high numbers of people with extreme/ catastrophic needs • *Support cash and voucher assistance for livelihood promotion and protection using the established safeguard systems.* • *Mobilise and deploy health and social workers to provide CMR and PSS at static and mobile facilities* • *Procure and distribute dignity kits that include menstrual hygiene management supplies.* • *Support the operation of GBV OSC, and WGSS.*	# of vulnerable women who safely access Cash and Voucher System	0	98,953	Post distribution monitoring	CVA will be available through other sectors that will prioritize vulnerable women and girls
	# of dignity kits distributed	0	282,722	Post distribution monitoring	Dignity kits will be available in-country and women and girls are able to access distribution sites
	#of functional One Stop Centres (OSCs)	30	32	Monitoring visits and quality assessments	Health centres remain open and functional
	# of operational Women and Girls Safe Spaces	19	29	Site visits and quality assessments	Communities are accessible and there are local partners able to staff the new WGSS

Objectives	Indicators	Baseline	Target	Means of Verification	Assumptions
Output 2: Strengthened coordination mechanism for prevention and response to GBV in 10 districts with extreme/catastrophic needs. • *Capacitate local/national GBV organisations to lead coordination efforts at sub-national level.* • *Develop and/or scale up existing SOPs to include the 10 targeted districts* • *Conduct service mapping in the affected districts and expand the reach of the GBV IMS to all newly formed OSCs*	# of WLOs and local CSOs with capacity to undertake GBV coordination at remote areas # of GBV Coordination platforms and supported to operate	6	10	Regular meeting minutes	There are enough partners to warrant the formation of new coordination hubs
	# of Districts covered by Standard Operating Procedures (SOPs)	5	10	Documents are finalized	There are partners in the newly opened areas able to deliver GBV services
	# of OCSs with a functional GBV IMS	30	32	Incident data is recorded and sent to national level on a monthly basis	The OSCs are functional
Output 3: Enhanced institutionalization of GBV risk mitigation measures across key sectors such CCCM, Education, WASH, Food Security, Nutrition and Shelter. • *Conduct multi-sectoral safety audit exercises at field (in camp and camp-like settings) and policy level.* • *Develop and implement integrated GBV risk mitigation frameworks in partnership with each cluster based on evidence-based risk analysis.*	# of safety audits conducted	0	4	Safety audit reports are finalized	
	# of cluster specific risk mitigation frameworks # of field focal points for key identified clusters trained, supported to development, and implement critical GBV mitigation actions	0	4	Frameworks are published	

Endnotes

1 2024 Somalia Humanitarian Needs and Response Plan, OCHA

2 UNFPA Somalia GBV Advocacy Brief, January-March 2023

3 2024 Somalia Humanitarian Needs and Response Plan, OCHA

4 Data is collected through the GBV AoR's GBV Information Management System; GBV incidences are recorded when a survivor accesses a response service for the first time, most frequently at a OSC. GBV IMS data merely provides a snapshot of the overall phenomenon since most survivors are unable/unwilling to access a service.

5 CCCM Rapid Gender Analysis 2022

6 Overview of Gender-Based Violence in Somalia, Advocacy Brief, 2022, UNFPA

7 Federal Government of Somalia. National Development Plan (2017 – 2019)

8 SHDS, 2020

9 Sharma, V., Amobi, A., Tewolde, S. et al. Displacement-related factors influencing marital practices and associated intimate partner violence risk among Somali refugees in Dollo Ado, Ethiopia: a qualitative study. Confl Health 14, 17 (2020).

10 Summary Somalia 2025 Humanitarian Needs and Response Plan (HNRP)

11 Daynile Kahda Afmadow Diinsoor Jowhar Baydhaba Jamaame Belet Weyne Bu'aale Qansax Dheere.

12 Sharma, V., Amobi, A., Tewolde, S. et al. Displacement-related factors influencing marital practices and associated intimate partner violence risk among Somali refugees in Dollo Ado, Ethiopia: a qualitative study. Confl Health 14, 17 (2020).

11 Banadir, Kismayo, Baardheere, Luuq, Baidoa, Galkayo, Garowe, Jamame, Afmadow, and Beletwyene

12 Inter-cluster field mission report, Baidoa, March 2024.

13 GBV AOR Focussed group discussions, Sept. 2024

14

15 https://gbvaor.net/co-ordination-tools-resources

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UNFPA