SOMALIA

Integrated SRH and GBV Minimum Services Package

UNFPA - Humanitarian Response in Somalia

UNFPA is scaling up support to ensure that minimum services for SRH and GBV are fully available to Somali women and girls displaced and affected by the drought. An integrated SRH and GBV minimum response package is adopted to ensure a comprehensive initial response package to address the exacerbated needs of women and girls during a crisis. The response is focused on existing Emergency obstetric and newborn care (EmONC) facilities, One stop centres, GBV shelters and Women and Girls Safe Spaces; and identification of sites for additional facilities to improve the displaced population's access to care.

UNFPA will continue to deliver SRH and GBV development support in all other parts of the country.

	SRH COORDINATION SRH Working group in the health cluster		GBV COORDINATION GBV AoR	
Community Level Interventions:	**1) Community outreach and communications: about SRH risks, availability of services, and provision of some outpatient services**			
	1. Pregnancy and birth related risks: Promotion of facility-based deliveries, raising awareness of the causes of maternal and newborn mortality 2. Unintended pregnancy: Contraception (sharing information on complications related to pregnancies that are too early, too late, too many, or too close together) 3. Specific emphasis on current food insecurity and the relation between lack of birth spacing and low-birth weight as well as infant malnutrition. Counselling (and recommendation) on Post-Partum contraception. 4. Sexually transmitted infections (STIs): Impact on pregnancy, infertility 5. Clinical Management of Rape (CMR): Prevention and treatment of consequences of rape	Red Flags ▪ SRH providers initiate a dialogue with the patient on GBV related concerns and consider/propose involving GBV case manager, when relevant. ▪ SRH providers ensure information on GBV services and, if decided by the patient, organize a referral.	Information and referral GBV staff provide systematic information and facilitates access to SRH services for survivors and all women and girls in Women and Girls safe spaces (WGSS).	1. Communication of GBV related risks and information on services i.e. One stop centres(OSC), WGSS, Psychosocial Support (PSS), case management etc. 2. Ensure Psychological first aid and referral of the survivor to a GBV facility for further support 3. Dissemination of hotline numbers in the community
	2) Mobile Clinics[1]			
	Part of Outreach activities - A mobile clinic can ensure a limited amount of outpatient consultation: Contraception: the start-up and continuation of oral contraceptives and injection (IUD and Implant provision require intervention in a health structure) Antenatal care- ANC (not a MISP service!): for the identification of complications flagged through women's complaints - referral will be required for any treatment beyond prophylaxis Postnatal care- PNC: General check-up of Mom and Baby, breastfeeding support, identification of risks Clinical Management of Rape: Initial dialogue with the patient regarding rape/IPP, provide referral information, arrange for transport to services in a timely manner *Mobile clinic CANNOT ensure lifesaving services (EmONC and CMR). Referral to a health structure will be required.*	Pregnant minors, young adolescents, women and girls with disabilities in the maternity ward, emergency room, contraceptive services: Circumstances of pregnancy and related risk of violence, home environment (chronic violence), family support. Identification of needs for protection, livelihood, legal support Women and girls with unintended pregnancy: Circumstances of the pregnancy and related risk of violence including IPV. Specific attention to negative provider attitude (Denial of service for contraception) All patients in CMR service should be given the choice for referrals to PSS and case management. Referral should be accompanied by a person who can help navigate access to services including transportation Specific Obstetric profiles that may be subject to IPV or family violence: Infertility, recurrent miscarriages, recurrent stillbirth or early neonatal death, recurrent induced abortions, Obstetric fistula. (High number of pregnancies may trigger a discussion about the woman's reproductive choices)	Pregnant women for ANC and facility-based delivery Recently delivered women-girls for Post-natal care All women and girls in reproductive age: contraception and family planning Rape cases: CMR Women/girls with STIs and infertility concerns Women/girls with FGM related complications	Mobile clinics are also an entry point for identifying cases of intimate partner violence (IPV) and for referrals to CMR and PSS services CMR: Initial dialogue with the patient regarding rape/IPP, provide referral information, arrange for transport to services in a timely manner
Health Facility Level Interventions:	**Patient Centred, Empathetic & Non-Judgmental Care, Respectful Maternity Care**			**Service Delivery Facilities**
	EmONC BEmONC (7 signal functions) to address main cases of maternal and newborn mortality: 1. Provision of parenteral antibiotics(Infection-sepsis), 2. Provision of uterotonic drugs (parenteral oxytocin, misoprostol), 3. Provision of anticonvulsant drugs magnesium sulphate- ((pre) and eclampsia), 4. Removal of retained products of conception using appropriate devices -MVA (Abortion complications), 5. Manual removal of placenta Post-Partum Haemorrhage), 6. Vacuum assisted delivery (Prolonged labour)[3], and 7. Neonatal resuscitation (Neonatal asphyxia) CEmONC Provide all BEmONC functions as well as: - surgery for c-section and hysterectomy, repair of uterus (obstructed labour) - safe and rational blood transfusion (haemorrhage)			One stop centres[2] 1. PSS (initial & continuous as part of client care plan) 2. Case management (assessment and planning) including information on safe houses and accompanying care, safety planning for pregnant and lactating women/girls, counselling on family violence and intimate partner violence 3. CMR or referral for CMR 4. Livelihood support 5. Cash and Voucher Assistance with Do No Harm Approach 6. Referral for legal support 7. Dignity and Menstrual hygiene kits distribution, and sharing of available services Women and girls safe spaces (may or may not have a OSC): - Livelihood (social interaction and psychosocial) support; Awareness, risk communication and service availability (potentially tailored to sub-groups, e.g. adolescent girls, adolescent mothers, elderly, pregnant women). And Dignity and Menstrual hygiene kits distribution.

[1] Mobile clinic is a liberally used term, most of the time it is simply outreach for risk and service availability communication, receiving critical patients and organizing their transfer, ensuring monitoring, supply and support in advanced health facilities (posts).

[2] OSC are located preferably within the confines of EmONC facilities or in the immediate vicinity

[3] **Note:** in case of diagnosis of obstructed labour, ensure referral to EmONC for c-section

SRH MINIMUM RESPONSE PACKAGE FOR THE SCALE-UP

Somalia faces one of the most complex and protracted humanitarian crises in the world. Nearly 50 per cent of the population - 7.6 million people need urgent and sustained humanitarian assistance due to the ongoing famine and drought. The majority of those displaced are women and children. Of these, 1,900,000 are women and girls of reproductive age. It is estimated that **240,000 women and girls are pregnant** in the affected population today, and over 80,000 will give birth in the next 3 months, or **900 deliveries per day**. Evidence shows that 15% of all pregnant women experience complications, implying **12,000 complicated deliveries in the next 3 months**. In the absence of qualified birth attendance and access to health services and facilities, maternal and newborn mortality, which is already very high in Somalia, is likely to increase to devastating levels. In addition, scarce resources and population displacement add to women's and girl's vulnerability and exposure to rape and other forms of GBV.

Somalia's maternal mortality ratio of 692 deaths per 100,000 live births is one of the highest in the world[4] and the fertility rate of 6.9 children per woman is also very high. Drought and displacement will further strain the already limited sexual and reproductive health (SRH) services and weak health system in the country. The effects of a lack of food and prevalent malnutrition are exacerbated for those who are pregnant or lactating and will have a negative effect on pregnancy outcomes and newborn survival. **Lack of nutrition and lack of access to and acceptance of health services contribute directly to women's and girls' ill health and maternal and newborn death.** Timely access to quality SRH services can prevent death, disease, and disability related to unintended pregnancy obstetric complications, rape and other forms of sexual violence, HIV infection, and a range of reproductive disorders. Neglecting SRH needs in humanitarian settings has serious and long-term consequences.

[4] 1 in 20 women aged 15 today will die of pregnancy/ birth related complications by age 49 (SHDS2020)

COORDINATION

In its scale up efforts, UNFPA advocates for and proposes to lead the SRH working group as part of the health cluster at the national and sub-national levels. UNFPAs direct support to MISP[5] services implementation in the drought affected region builds on existing programs that support a number of BEmONC and CEmONC centres in the area. UNFPA will further work with implementing partners to identify, establish and support additional sites for accessible health facilities aligned with the needs of the population.

MINIMUM SERVICES

In line with the Inter Agency Minimum Initial Service Package for SRH in Humanitarian settings, UNFPA promotes the scale up of quality SRH services in drought affected areas in Somalia.

1. MATERNAL AND NEWBORN CARE

Ensuring safe delivery, routine new-born care, and lifesaving emergency obstetric and new-born care (EmONC) services to prevent maternal and newborn morbidity and mortality during a crisis is a key component of SRH in Humanitarian settings. Competent health care providers and essential supplies for safe births and management of obstetric and new-born complications are necessary to avert preventable maternal and newborn death.

2. CLINICAL MANAGEMENT OF RAPE

Services to address consequences of sexual violence (e.g., injuries, infection, unintended pregnancy and trauma) must be available in all primary healthcare facilities. Quality services also require **skilled staff to provide compassionate, timely, and confidential care**.

CMR is often the entry point to comprehensive services for survivors who can then be referred to case management and psycho-social support for follow-up and recovery.

3. PREVENTION OF UNINTENDED PREGNANCIES

A rights-based approach to contraception and family planning ensures confidentiality and privacy, informed choice, and consent. During humanitarian crisis, the affected population must be informed of the availability of services, with an emphasis on their rights. In addition, a range of long-acting reversible and short-acting methods must be available at healthcare facilities and promoted through community outreach action.

4. HIV AND STI PREVENTION

While the prevalence of HIV in Somalia is very low, STIs (including hepatitis) are as much a concern as anywhere. The importance of **universal precautions for infection prevention** and specific attention to safe and rational **blood transfusion** are priorities. For any person with a known HIV-positive status, continuous access to ARV treatment during the crisis needs to be ensured. **Syndromic management of other STIs** needs to be ensured at primary health care level for all people in need. In addition, access to condoms must be ensured.

5. REFERRALS

Delays in reaching a healthcare facility due to challenges related to transportation can only be reduced by establishing an around-the-clock referral system to facilitate transport and communication **from the community to primary health care** facilities, specifically basic emergency obstetric and newborn care facilities **(BEmONC)** and, in the case of complications, to **hospital level**, comprehensive maternal and newborn care **(CEmONC)**.

[5] The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crisis situations

MODE OF SERVICE DELIVERY

1. BASIC EMERGENCY AND NEWBORN CARE

During a humanitarian crisis, basic emergency obstetrics and newborn care (BEmONC) centres are primary health care (PHC) facilities that must be equipped to ensure 7 signal functions to address pregnancy and birth-related complications, which present the main causes of maternal and newborn death i.e., Obstetric haemorrhage, infection, pre-eclampsia, obstructed labour, and abortion complication as well as birth asphyxia in the newborn.

The 7 signal functions are:

1. Provision of parenteral antibiotics,
2. Provision of uterotonic drugs (parenteral oxytocin, misoprostol),
3. Provision of anticonvulsant drugs (magnesium sulphate),
4. Removal of retained products of conception using appropriate devices,
5. Manual removal of placenta, assisted vaginal delivery (vacuum extraction), and
6. Newborn resuscitation are essential and lifesaving interventions.
7. EmONC facilities need to be functional around the clock, all days of the week.

General hygiene measures, waste management and universal precaution for infection control, including PPE equipment in the delivery room, need to be in place.

Guidelines and job aids for staff available and visible in the delivery room and newborn resuscitation area.

Services for the **clinical management of rape** (CMR) are integrated into BEmONC and provide compassionate survivor-centred clinical care and referral for additional GBV services and survivor-centred support.

Contraceptive services must be available and provide rights based, confidential care.

2. COMPREHENSIVE OBSTETRIC AND NEWBORN CARE

Comprehensive emergency obstetric and newborn care centres (CEmONC) are hospitals that, in addition to the providing all BEmONC services, are equipped to conduct surgery under general anaesthesia (caesarean section, laparotomy), as well ensuring rational and safe blood transfusion.

3. INTEGRATED SRH/GBV OUTREACH TEAMS

Extending the reach of information and outpatient services (contraception) of SRH and GBV to hard-to-reach populations is essential.

The outreach teams ensure that communities receive information about SRH and GBV risks and availability of services.

Mobile teams can provide some contraceptive services and ensure referral for others, identify pregnancy complications, identify persons in need of CMR and other GBV services, and facilitate transfer to EmONC structures and GBV services.

Where access to a health facility is challenging or women do not seek facility-based deliveries, risk and service availability communication and the distribution of clean delivery kits to visibly pregnant women and birth attendants can promote clean deliveries, the early identification of danger signs and timely transfer to EmONC facilities.

GBV MINIMUM RESPONSE PACKAGE FOR THE SCALE-UP

With the onset of severe drought following four consecutive failed rainy seasons in Somalia, gender-based violence (GBV), especially intimate partner violence(IPV) and sexual violence are on a rise. The threat of a famine declaration is looming. A total of 7.6 million people or 50 per cent of the population is affected by the drought. 82% of the displaced are women and children.[6] Approximately 2.4 million school-aged children are affected by the drought including 1.7 million out of school.[7] Rising food prices, severe water shortage, death of livestock, and the loss of livelihoods have resulted in multiple displacements across most regions in Southern and Central Somalia. Most of these displaced populations are living in overcrowded and poorly equipped internally displaced persons (IDP) camps across Somalia, while some are staying in host communities.

The GBVIMS[8] data for 2022 indicate a 21 per cent increase in reported rape cases in the drought-impacted communities in 2021; a 60 per cent increase in reported cases of IPV; and a 20 per cent increase in the number of women and girls who accessed lifesaving GBV response services due to sexual violence and intimate partner violence (IPV)[9].

[6] Cf. Somalia Drought Response and Famine Prevention Plan, May - Dec 2022 here
[7] Ibid., page 34.
[8] The Gender-Based Violence Information Management System
[9] GBVIMS Ist and 2nd quarter aggregated report

Rape, IPV, sexual harassment, sexual exploitation and abuse, forced/child marriages, female genital mutilation, family abandonment, and forced abortion are some of the forms of GBV on the rise in the populations affected by the severe drought in Somalia.

From September 2022 to February 2023, UNFPA Somalia's GBV/Gender unit, in line with the declaration of a scaled-up humanitarian response will target to address the needs of a total number of 143,695 beneficiaries (20% of a total of 718,474 beneficiaries for OP1 areas of drought response) by providing quality, lifesaving, confidential and timely GBV mitigation and response services. Major strategies for this response include; service provision, capacity building, and provision of basic hygiene kits (including dignity and menstrual hygiene kits).

GUIDING PRINCIPLES AND APPROACHES

UNFPA will adhere to three approaches to deliver these services; the human rights-based approach, the community-based approach and the survivor-centred approach. Services will be designed to respond positively to culturally sensitive practices that empower women and girls. This delivery package aligns with the GBV AoR minimum package of interventions. It also adopts the 5-model integration approach of the Summary Strategy for GBV integration[10] into key clusters of the humanitarian response in Somalia (WASH, Health, Food Security, Nutrition).
Key services for the UNFPA GBV package include the following:

1. Clinical Management of Rape

According to partner reports, reporting of rape incidents increased during the drought by 21 per cent in 2022 compared to 11 per cent in the last quarter of 2021. Survivors of sexual assault, including survivors of rape, require an immediate medical response to heal injuries, administer medication to prevent or treat infections, and prevent unwanted pregnancies (where local laws allow). While treatment within 72 hours is preferable, particularly to administering post-exposure prophylaxis (PEP) to prevent HIV, survivors may present themselves much later than 72 hours and still require treatment[11]. UNFPA will prioritize the provision of CMR services and support the treatment of injuries from intimate partner violence.

2. Case Management and Psycho-Social Counselling and Support

UNFPA will support case management and psycho-social counselling and support (PSS), for women and girls including GBV survivors, those with disabilities and those from minority clans in the drought and conflict-affected areas of Somalia. The population in need of PSS and specialized case management is increasing among women and girls, IDPs and those living in host communities, not just because of the large-scale displacements due to the drought and conflict, but also multiple evictions. Many GBV survivors experience long-lasting psychological and social effects as a result. To ensure that survivors of GBV recover adequately, it is necessary to make quality, safe and confidential case management, psychosocial counselling services and referrals available with a survivors-centred approach.

3. Provision of Basic Material for Improving Dignity and Hygiene for Women and Girls

Increasing displacements have resulted in the loss of livelihood, as well as family and personal income for women and girls which enabled them to procure items that contribute to their personal security and hygiene. Without access to culturally appropriate clothing and hygiene items, the mobility of women and girls is

[10] GBV AoR Summary Strategy, 2022
[11] GBV minimum standards

restricted and ultimately their health is compromised. Maintaining dignity in crisis is a vital component to ensure that women and adolescent girls have a sense of personal security, confidence, and self-esteem to continue to seek opportunities for education and better livelihoods. With increasing poverty levels and the need for women and girls to move around to maintain daily lives, access livelihood and other opportunities they must have access to, and use dignity and menstrual hygiene materials. UNFPA stockpiles culturally and climatically appropriate dignity kits for disadvantaged women and adolescent girls displaced due to conflict or natural disasters.

4. Cash through Case Management and Cash for Mitigation and Prevention of GBV

UNFPA will support cash through case management for the prevention and mitigation of gender-based violence. This assistance will cover a range of minimal basic needs for transportation, food assistance, and contribution to rent in the case of relocation in line with the assessment plan of a survivor; as well as cash for medical treatment for physical injuries in case of IPV. When women and adolescent girls have access to economic resources, they can ensure that their basic needs for themselves and their families are met. It also widens women's overall choices. Discreet, dignifying, and flexible cash and voucher assistance for vulnerable women and girls in Somalia have contributed to strengthening women and adolescent girls' resilience and exposure to GBV and enabled them to prevent the occurrence of GBV.

5. GBV/SRH Integration

UNFPA is committed to exploring and utilizing entry points for sexual and reproductive health (SRH) service provisions in drought-affected locations with GBV integration. The integration will be implemented using the 5 integration models[12] of the GBV AOR summary integration strategy for the drought response.

These models include – clinical management of rape (CMR) integration through GBV one-stop centres; GBV/SRH mobile services; Integrating focal persons for health facilities into the GBV once-stop centres; mitigating GBV risks through the entry points with SRH projects and utilising midwives and family planning counsellors and IPV assessors in women and girls' safe spaces and GBV one-stop centres.

UNFPA partners will adopt and implement integrated packages for delivering humanitarian assistance designed by SRH and GBV experts.

TARGET BENEFICIARIES:

Primary Beneficiaries: Newly displaced IDPs in OCHA operational designated areas; this includes women, adolescent girls, female-headed households, pregnant and lactating women and girls, widows, women and girls living with disabilities, and women from minority clans.

Secondary Beneficiaries: GBV service providers, men, boys, community leaders and religious leaders.

In accordance with the Minimum Initial Service Package(MISP), UNFPA urges governments and donors to prioritise and fund services for sexual and reproductive health as well as survivors of gender-based violence, as critical and integrated services for all Somali women and girls affected by the drought.

[12] GBV AoR Summary Strategy for Integration in the Drought Response, Somalia 2022

Developed by the United Nations Population Fund

Somalia Country Office

For More Information, Please Contact:

Niyi Ojuolape
Representative

ojuolape@unfpa.org
+254 793 303 512

Nkiru Igbelina-Igbokwe
GBV/Gender Specialist

igbokwe@unfpa.org
+234 816 756 5330

Ahmed Aweis Ahmedroble
Reproductive & Maternal Health Specialist
ahmedroble@unfpa.org
+252 61 5858709