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EVALUATION REPORT

Protecting Women and Girls Against Sexual and Gender Based Violence (SGBV), and Harmful Traditional Practices (HTPs) and Participation of Women In Peace -Building

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LIST OF ACRONYMS

ACT	Action by Churches Together
CBO	Community Based Organization
CEC	Community Education Committees
CEFM	Children Early and Force Marriage
CPWG	Child Protection Working Group
CWC	Child Welfare Committees
DAC	Development Assistance Cooperation (
FGM/C/C	Female Genital Mutilation / Cut
GBV	Gender Based Violence
GBVWG	Gender Based Violence Working Group
GBVMIS	Gender Based Violence Management Information System
HTP	Harmful Traditional Practices
IEC	Information, Education and Communication
IIDA	IIDA Women's Development Organization
IDP	Internally Displaced Persons
MOWDAFA	Ministry of Women Development and Family Affairs
MOJRA	Ministry of Justice and Religious Affairs
NCA	Norwegian Church Aid
NGO	Non – Governmental Organization
OECD	Organization for Economic Cooperation and Development
SGBV	Sexual and Gender Based Violence
SCI	Save the Children International
SSWC	Save Somali Women and Children
TOT	Training of Trainers
TASS	Tadamun Social Society
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nation Children Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Somalia has continuously experienced high levels of violence against women and girls, manifest in; sexual violations, female genital mutilation (FGM/C), physical abuse and widespread discrimination. Sexual and gender based violence (SGBV) has been associated with harmful cultural practices, religious misconceptions, contextual vulnerability and poverty. The project 'Protecting Women and Girls against Sexual and Gender Based Violence (SGBV), and Harmful Traditional Practices (HTPs) and participation of Women in Peace –building was a response to contribute to the reversal of the above trends. The project was a joint initiative between Norwegian Church AID (NCA) and Save the Children International (SCI) funded by Royal Norwegian Embassy and implemented by three local implementing partners.

The project was designed and implemented in two components. The SGBV component strengthens the resilience of women and girls in Mogadishu IDP camps. It is designed to improve the protection environment of girls and women through elimination of SGBV incidents in 4 target districts in Banadir region, Somalia. The FGM/C component draws on a Norwegian-funded, strategic partnership in Ethiopia between NCA and Save the Children. In Somalia, NCA and SCI similarly aimed to reduce support for FGM/C at the community level, by working with communities and specific change agents including; religious and traditional leaders to influence attitudes, as well as to strengthen the policy and service provision environments related to FGM/C. This project was implemented from 2014-2015, for which this evaluation has been undertaken. The FGM/C component was a pilot phase of a new programme envisioned to run from 2016-2020.

Methodology:

The purpose of the SGBV component was to assess if and how programme outputs were achieved according to the OECD/DAC 5 point criteria which includes; relevance, efficiency, effectiveness, impact and sustainability. From this, specific recommendations for possible further initiatives that build on this programme's results were to be made.

For the FGM/C component, the purpose of the evaluation was to conduct an in-depth appraisal of the project using OECD / DAC 5 point evaluation criteria to assess the extent to which the project achieved its objectives. The specific objectives included; assessment of extent to which FGM/C survivors had access to medical , psychosocial and support services; changes in knowledge attitudes and practices of duty bearers in challenging the practice; extent to which faith and community based structures influenced change of dominant social norms that drive FGM/C; mobilization of faith based organizations, communities and community based organizations to prevent FGM/C ; relevance, capacity and sustainability of various implementation structures supported by the programme and lessons learned, capture of good practices and other knowledge to inform the next phase of the programme.

A mix of approaches including; quantitative, qualitative methods were applied. Respondents were selected among direct beneficiaries and other stakeholders with interview consent and ethical considerations. Specific tools for each of the components including; structured questionnaires, key informant interviews and focused group discussions were administered. Cluster sampling methodology was applied in quantitative data collection while purposive sampling was applied in identifying key informants. The evaluation grid and results framework analysis were used to directly measure the performance of the programme. The analysis of data was undertaken in line with the outcomes and

presented in tables and figures. Content analysis of secondary and qualitative data was undertaken for in-depth explanations. Information from the three approaches were triangulated and incorporated in the findings.

The evaluation process faced various limitations. Failure of one partners to cooperate with the evaluation team left some areas in the IDP settlements in Mogadishu uncovered. Due to security limitations especially in Garbaharey and IDP settlements, it was not possible for the key investigators to reach all the areas and had to rely on trained enumerators. Due to sensitivity of the subject, at times it took effort and skilled facilitation to elucidate the required information. This process was also a costly undertaking demanding a lot in logistics. The M&E gaps, particularly the lack of an organized data collection system in the project forced the consultants to take more time in collecting and verifying data.

Findings: Both programme components have made significant gains in achieving the objectives that were envisioned at the outset. In the **SGBV component**; the project set out to protect women and girls against SGBV as one of the outcomes in zone K IDP settlements. Results show that solar lamps, energy savings stoves for risk reduction and intensified awareness were undertaken. It was not possible to confirm if the 10 security patrols that were to secure women in the IDP settlements were undertaken as planned due to difficulties associated with the implementing partner, IIDA, who did not cooperate during the evaluation exercise. As a result of these interventions, 96.8% of the SGBV survivors/right holders have information about SGBV. On risk reduction, 83% of SGBV survivors feel more secure than before. Three quarters 75% of the SGBV survivors report that SGBV cases have gone down. This largely as a result of risk reduction measures undertaken which ensured that the survivors did not risk collecting firewood as they had energy saving stove as alternative , while solar lamps provided protective lights in their dwellings.

The second outcome focused on providing SGBV survivors (women and girls aged 15 – 49 years) with psychosocial, medical and economic coping assistance. In restoring women's dignity, the project provided SGBV survivors with a dignity kit that constituted clothing, personal effects and other constituents for personal grooming. Four hundred SGBV survivors received 4 months tailoring courses and were provided with a kit to set up business practice. This empowered women and their families and was instrumental in preventing SGBV by ensuring that conflicts that emanated from domestic struggles to provide or secure livelihoods were addressed. Through SSWC support centres, 3,189 women, 89% of total in need, received restoration counselling. Primary health care services were provided to SGBV survivors although the project lacked capacity for specialized treatment. The provision of various services were supplemented with holistic capacity building in which the right holders and duty bearers including; religious and camp leaders underwent various trainings. Overall, 95% of the SGBV survivors report access to health services, 70% psychosocial services while 11% have security services within their reach.

The third outcome focused on having women participate in peace processes at local and national level. Results show that SGBV survivors 100 in total were enlightened on their various rights stipulated in the UNSCR resolution 1325 as the agents of change. However in outcome 4, religious leaders and other duty bearers were enlightened on their role to protect and promote women participation in line with the UNSCR 1325 resolution. The training was conducted towards end of the project in which there was limited influence time to implement the resolutions, behaviour change takes long, and as such, it will take time before the full impact is felt. On these two outcomes, the project has established

significant local capacity from which peace building and attention of SGBV from rights perspectives will be continuously supported.

FGM/C Component: Results show the project has made remarkable progress in the envisioned outcomes, but more needs to be done as FGM/C abandonment requires concerted long-term response. Outcome five focused on safety and justice of the GBV survivors, by provision of medical and psychosocial support services. Results show that 44 FGM/C survivors were seen for fistula complications out of which 13 received reconstructive surgery in border town of Mandera, Kenya, while the rest were seen for medical, psychosocial and obstetric needs. An assessment undertaken as part of evaluation found that 74.1% of the right holders had access to health services whenever they needed them. Even as links were made with the health systems, referral for GBV survivors in need of specialized treatment remains a gap.

Outcome six focused on influencing the faith and community based organizations to transform and change beliefs, attitudes and behaviour that uphold GBV including FGM/C. It is clear that the project has brought on board 42 religious leaders to influence behaviour change through community dialogues and mosque sermons. Religious leaders are now important leaders of the project and strategic role models for the project based on observed support in community dialogue, messaging undertaken in mosque sermons and some demonstrated examples of barring their daughters from FGM/C to set examples. Results indicate that 50% of the right holders received FGM/C information from religious leaders which underscores their role in disseminating anti-FGM/C messages enhanced by the project. On the awareness side; overall, the project has reached 84.1%of men, women and youth with anti-FGM/C messages delivered through community dialogues, print materials, media and by religious leaders. Furthermore 74.1% received comprehensive information with deeper understanding of the harmful effects of FGM/C. With this, 60.1% of right holders are of the opinion that FGM/C should been discontinued on the account of woman's health. Notably, 87.6 % of right holders are also of the opinion that FGM/C is declining due to intensified campaigns and improved knowledge.

However, the decline in the extreme form may conceal the sunna type which is still preferred even among some religious leaders. The trends in FGM/C are however supported by recent observations indicating FGM/C practitioners have moved away from the urban centres where programmatic interventions are mainly concentrated to rural areas where communities are not reached by interventions and readily accept FGM/C. Once the programmatic interventions are expanded in the rural areas, preferably in the next phase, it will leave the practitioners with fewer options, thus the practice may decline significantly. The behaviour change model adopted in urban settings utilizing the working groups, community dialogue meetings and religious leaders has yielded results. There has been limited information sharing across the project regions while operations research and documentation has only been undertaken in Puntland.

Outcome seven focused on mobilization of faith and community based organizations to reduce all forms of harmful traditional practices; it is clear there were regional differentials in the achievement of the objectives. In Puntland declarations against FGM/C (*Fatwas*) were made and government policy level support was mobilized. In Gedo, various stakeholders questioned the readiness of the community to make anti- FGM/C declarations due to potential interference from Al Shabaab and the fact that since the communities were not fully mobilized especially in the rural areas, it would be taken as a joke. Making premature declarations would cause irreparable damage and dent future intentions to pursue zero tolerance through the model. Despite this short coming, religious leaders were instrumental in pushing the FGM/C abandonment agenda in sermons and public prayers and gatherings

in Gedo region. In both locations religious leaders through the programme participated in documentation of key messages against FGM/C in reference to the Quran for dissemination in mosques. The envisioned coordination structures of working with clusters and networks were effective in Puntland, but were limited by the context in Gedo. The same happened to policy statements in Gedo region, except the local guidelines developed to make FGM/C practitioners compensate FGM/C survivors with hefty fines (50-150 camels) for damage inflicted in administering FGM/C.

Challenges: Various challenges stood in the way of realization of expected results of the programme. Harassment by SGBV perpetrators, minimal government, and uncooperative partners, cultural discriminatory stance on girls and women and insecurity were the main draw backs to the achievement of expected results on the SGBV component. The FGM/C component also had a share of challenges which included; the firm stand of some agents of change to the sunna type of FGM/C, erroneous perception that agents of change were making money and not genuine in their cause, relocation of the FGM/C practice from urban areas to rural outreach areas, minimal government support and insecurity in Gedo and limited information sharing were the main challenges. Overall, the project faced design limitations and M&E gaps and high costs for both community dialogue processes and surgical management of massive fistula cases that are detailed in the on-going sections.

Lessons learnt: The implementation process generated lessons for NCA/SC, SSWC and TASS worth considering in the next programming phase. **On SGBV component**; couple counselling was found to be an effective method of addressing intimate partner violence. Similarly the integrated SSWC centre was found to be an effective model of responding to SGBV under one roof with significant success. The need for shelter by some SGBV survivors should have been considered as part of the other risk reduction measures taken by the project as shelter was a felt need for the SGBV survivors. The discriminatory cultural context makes women and girls prone to SGBV due to failure to open up for fear of victimization and limited support in a male dominated system.

The **FGM/C component** has drawn many lessons and best practices; notably, the community stakeholders were able to convince Al Shabaab on the need to allow FGM/C interventions for the benefits of daughters and sisters despite earlier dissent. This implies that with justified negotiations, the project could achieve more. Due to local driven ownership, Garbaharey community have come up with penalties for FGM/C practitioners to compensate FGM/C survivors for damages, good effort for deterrence. The targeting of practitioners has also worked especially their open apologies and barred visit to Mecca sanctioned by religious leaders blamed on blood FGM/C money was another effective locally initiated effort. Religious leaders emerged as important champions against FGM/C which can be scaled up in the next phase. The school awareness part of this programme was important in inculcating values among both boys and girls against FGM/C and can be scaled up for generational change as well as expansion to non –school youth.

Conclusion: The project through the two components has made substantial achievements in the 7 outcome areas, but with challenges in a few elements. On the **SGBV component**, the project has achieved high level of awareness, reduced risks of women from SGBV and provided; economic, medical and psychosocial reprieve to the SGBV survivors. The capacity for participation among women in peace building has been put in place in readiness for peace building processes. The duty bearers and right holders having undergone training on UNSCR 1325, places them in the right position to continue influencing attitude and action by non- perpetrators of SGBV. In a nutshell, this project leaves right holders more aware of and protected against various forms of SGBV, safer from attacks, SGBV

survivors treated, healed by counselling, empowered by economic support and aware of their rights. The project has also inculcated knowledge and skills to duty bearers to effectively deliver on their work and advocate for girls and women rights as they confront SGBV from an informed perspective.

On the FGM/C component; the project linked the FGM/C survivors to health services and further supported others for specialized surgical operations but at a lower scale due to high costs. Majority of right holders indicated that they know of a place where they can access health and psychosocial services for FGM/C survivors. With exception of referral and specialized services that are not available, the project has delivered this outcome within the project confines although massive unmet needs for specialized services remain.

On the second outcome, the faith and community based structures organisations have been significantly influenced to transform behaviours and practices that uphold FGM/C. The mobilized religious leaders are now in the forefront of FGM/C abandonment agenda by championing for it through creation of awareness and use of religious influence to hold practitioners accountable, especially in Garbaharey. School and community dialogues have been established and confronted FGM/C in a big way. The influence of key messages from these groups has increased awareness, pushed public apologies from FGM/C practitioners in Garbaharey were expanded, change in the attitudes including use of former practitioners in the awareness campaigns. However, the increase of awareness raising on the harmful impacts of FGM/C has also elicited calls for its discontinuity with only a small pocket of religious and community leaders with misconceptions justifying the maintenance of *the Sunna* as a practice.

The achievements realised are therefore still negated by the continued resistance of certain proponents of the FGM/C/C practice like the keeping of the *Sunna* practice. During the period of programme implementation, communities, continued to show great strides towards zero tolerance of FGM/C. The progress in changing, knowledge, attitudes and practices is attributed to continuous awareness raising using various communication and advocacy approaches over a longer time span.

On outcome seven, faith and community based organizations have made substantial efforts to reduce FGM/C by participating in community dialogue, religious leadership and creation of awareness. In Puntland declarations have been made against FGM/C but in Gedo, the communities were not yet ready. In all locations religious leaders have used all platforms to speak against FGM/C with commendable drive and commitment. The project has been implemented in coordination with other structures in Puntland, an effort that suffered contextual limitations in Gedo region.

Recommendations: For programme improvement the following recommendations are made:

SGBV: There is need to empower women and girls to stand up for their rights by mobilizing local, to include men in support of women, make linkages to national support and appropriate networks, scale up the response in terms of programmatic efforts; ensure that the security patrols are implemented and maintained as planned to secure the gains made so far; integrate shelter support in future SGBV programmes; include men in counselling programmes, strengthen referral mechanisms for specialized medical attention; target school children with protection against SGBV , support religious leaders to effectively enhance their influence on SGBV and proper sequencing of activities in line with their plans for impact. Training and expanded engagement of religious leaders and generation of empirical evidence for more targeted programming are also recommended.

FGM/C: There is need for; appropriate policies backed by evidence from empirical and action research; proper community driven *fatwa* or declaration in Gedos; lobby government for legislation and enforcement of laws for zero tolerance to all forms of FGM/C, including *sunna;* upscale the interventions in the rural areas; intensify prosecution of FGM/C practitioners and compensation of the survivors, expand school FGM/C eradication programmes, reward, recognize communities that depart from the practice through culturally priced alternatives like livestock; map health workers medicalizing FGM/C for action; mobilize support and resources for attending the unmet need for fistula treatment, deepen the role of men especially the young men who are more receptive in the programme in terms of participation and scale so as to challenge negative masculinities and promote gender equality; develop and advance key messages through the radio as the reported common source of messages and coverage; share information on lessons and best practices across implementing partners for more informed response.

1. INTRODUCTION AND BACKGROUND

Norwegian Church Aid (NCA) is a diaconal organisation mandated by churches and Christian organizations in Norway to work with people around the world to eradicate poverty and injustice. Diakonia is, according to our statement of principles, faith in action and is expressed through compassion, inclusive communities, responsible stewardship of creation, and the struggle for justice. Our vision is Together for a Just World. NCA provides humanitarian assistance and works for long-term development. In order to address the root causes of poverty, NCA advocates for just decisions by public authorities, businesses and religious leaders. Our support is provided unconditionally, with no intention of influencing anyone's religious or political affiliation. Most of our work is undertaken together with local civil society partners and faith actors.

NCA's distinctiveness as a professional humanitarian and development actor is present in our work when we affirm the values and mobilize the resources of faith that lie in our diaconal identity and ecumenical networks. In addition, through decades of work in varying contexts, Norwegian Church Aid has developed valued partnerships and positive experiences together with people and organizations' rooted in diverse religions and beliefs.

For over 90 years, Save the Children has been making a difference in children's lives in more than a 120 countries. We are the world's largest independent child rights organisation, underpinned by a vision in a world in which every child attains the right to survival, protection, development, non-discrimination and participation. Our mission is to inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives.

Save the Children is an organization for talented people with different backgrounds and perspectives. We are proud that our people are representative of the children we work with and we thrive on our diversity. We are an equal opportunity organisation dedicated to our core values including accountability, ambition, and collaboration, creativity and integrity. SC has Area Office in Puntland, Somaliland and South Central Somalia. Our culture is embedded in seven thematic areas namely Education, Child Protection, Health and Nutrition which includes Wash, Child Poverty, Child Rights Governance and Humanitarian Response.

NCA work in Somalia

NCA began its work in Somalia in 1993, following the humanitarian crisis caused by the collapse of the central government in 1991. NCA became active in Puntland following the 2004 tsunami and has maintained this presence with interventions supporting alternative livelihoods to piracy, food security, WASH, peace building and education. Work in Banadir and Lower Shabelle regions commenced in 2008 supporting WASH, GBV and Livelihood interventions. Implementation of programme activities is conducted directly by NCA or through partners in all target locations. NCA has Field offices in Garbaharrey, Garowe and Mogadishu, while Nairobi serves as a coordination and liaison office. NCA in Somalia is an active member of the Action by Churches Together (ACT) Alliance which has a coordination mechanism that facilitates collaboration with five other international organizations in Somalia (forum members) for the purpose of mobilizing resources and sharing information to support the Somalia population. NCA also collaborates with, and coordinates interventions through the UN Cluster mechanisms in Nairobi and at field level.

Save the Children's Work in Somalia

Save the Children has worked in Somalia/Somaliland since 1951. In 2015, Save the Children reached 941,000 people directly and a further 2.9 million people indirectly through our work in Health, Nutrition, Water, Sanitation and Hygiene (WASH), Food Security and Livelihoods (FSL), Education, Child Protection and Child Rights Governance. In Somalia/ Somaliland Save the Children has 400 staff across 12 field offices: Hargeisa and Borama in Somaliland; Bosaso, Garowe, Gardo and Galkayo in Puntland); Belet Weyne, Adaado, Abudwaq, Dhobley, Baidoa and Mogadishu in Central and South Somalia. Our Country Office - coordination and administration base - is in Nairobi, Kenya. Building partnerships is the heart of Save the Children's work. Programme/project activities are implemented directly by SC or through local CSO partners in all target locations, who understand local contexts. SC has close partnerships with relevant government Ministries, communities and children in target locations. SC is an active member of coordination mechanisms/clusters at national (Nairobi) and field level (Somaliland, Puntland, and Central South Somalia.

In 2013, NCA jointly developed a project partnership with SC with a focus of protecting women and girls against Sexual and Gender Based Violence (SGBV), and Harmful Traditional Practices (HTPs) and participation of Women in Peace building. Under this project, NCA focussed on both FGM/C and SGBV while SC had its sole attention on the FGM/C component, each working in their respective operational areas and with their local partners.

a) Brief on SGBV Programme

The SGBV component of this programme was implemented following increased reports on sexual violence cases in Banadir region. The intended focus was on protection against SGBV in conflict, participation of women in peace building processes and psychosocial assistance to survivors of SGBV. The programme was implemented over a period of two years among IDPs in Mogadishu by NCA and partners; Save Somali Women and Children (SSWC) in Zone K IDP settlement and IIDA Women's Development Organization working in Dharkanley, Wadajir and Holwadaag IDP settlements. Both partners (SSWC and IIDA) were engaged in protection and empowerment of GBV survivors with the aim of reducing their vulnerability to further abuse.

b) Brief on the joint NCA-Save the Children (SC) FGM/C Programme

The FGM/C programme was a joint initiative between NCA and Save the Children, an extension of similar arrangement undertaken in Ethiopia. NCA in partnership with SC implemented a two year project (2014-2015) that aimed at accelerating change towards zero tolerance to FGM/C. The programme was closely aligned to the UN Joint programme on FGM/C implemented by UNICEF and UNFPA. The NCA/SC programme also aimed at reducing support for FGM/C at the community level by working with communities and specific change agents including religious and traditional leaders to influence attitudes as well as strengthening the policy and service provision systems and structures related to FGM/C. The target locations were Garbaharrey, Garowe, Bosasso and Qadho districts in Gedo and Puntland respectively. The joint FGM/C programme concluded its first pilot phase in December 2015. The evaluation of this programme is intended to capture the experiences and milestones achieved during the period to inform the next phase of programming 2016-2020.

c) SGBV/FGM/C Status and Trends in Somalia Female Genital Mutilation

The nationwide cluster survey conducted by UNICEF ten years ago indicated that the practice of FGM/C was almost universal at 98 percent. In 2011, UNICEF conducted a cluster survey in Puntland which further revealed that 98 percent of women 15-49 years of age had undergone the cut. It was however reported that 30.1% of girls between 0-14 years had undergone the rite, implying an opportunity for programmatic intervention. It is widely accepted that the procedure, is carried out on girls between the ages of 4 and 14 and often performed by traditional practitioners, including untrained village midwives, without anaesthesia, using knives, scissors, razor blades or even broken glass. The instruments are often not sterile and the ritual is very often performed in unsanitary conditions. In urban areas, some families opt for a health practitioner to perform the operation. In Somalia, FGM/C is driven by religious and cultural motivators that push parents to secure social benefits perceived to guarantee marriage to their daughters and economic returns to themselves. The religious, cultural axis, dominant social norms and the economic benefits of the practitioner's side continue to drive FGM/C in the absence of firm legal and political commitment to abandon the practice. The *sunna* type of circumcision is believed to be allowed by the Muslim faith, a perception that continues to perpetuate the myth that the practice has religious basis.

Apart from FGM/C, Somalia women and girls experience other forms of GBV including; rape or attempted rape, wife beating, other forms of physical assault, child, early, and forced marriage and wide spread discrimination. Sexual and gender based violence (SGBV) results from lack of protection mechanisms, social and gender cultural norms and exposure associated with insecurity. Early marriages are deeply entrenched in culture, religious and customary norms that perpetuate the practice. Poverty, preservations of girls' and young women's dignity and chastity are often reasons why young girls and boys are forced into marriage. Recently, there has been increasing trends in sexual and gender-based violence as a result of the humanitarian situation. The culturally, entrenched harmful practices such as; FGM/C and CEFM exacerbate gender based violence and discrimination, with little programmatic attention.

Sexual and Gender Based Violence

Gender based violence manifested in wife beating, rape, physical assault, sexual harassment are common in Somalia. The male dominance in the community has transformed women into subjects of men readily coerced to accept and justify violence from men. The value of dowry is considered superior to interests of women who are obliged to be submissive even under obvious violations. The MICS study of 2006 indicated that 76% of women would readily accept to be beaten by a husband in some situations. The trend has been somehow reversed in Puntland in which a similar study found that 34% would allow men to beat them in some situations. Despite the reversal, the level of acceptance and practice of domestic violence among women remains high and particularly skewed in displacement set ups where poverty perpetuates them.

By and large, there are limited support services for survivors of GBV. Survivors mainly get apologies from perpetrators families and relatives which embolden the perpetrators to continue with the vice. Islamic sharia law is the main reference point as far as laws and policies to address cases of GBV are concerned. Leaders however are aware that the Somalia constitution has banned FGM/C, but enforcement remains weak or non-existent. There were public declarations 'fatwas' in Puntland but in Gedo the community has taken a position on FGM/C but is yet to be transformed to a declaration.

Furthermore, a customary law mainly administered by community elders is the 'unwritten' law that is used to address GBV. Lastly there is very low case reporting of GBV issues across Somalia largely because of a perception that no action will be taken or such action will be biased in favor of men who are the main perpetrators.

2. OBJECTIVES OF THE EVALUATION

Considering the differentiation of the two components, the evaluation exercise focused on both SGBV and FGM/C and as such the two components were assessed in line with their separate objectives. The overall objective of the project was to reduce sexual and gender-based violence for 150,000 (60% women) IDPS in Mogadishu and a reduction in all forms of FGM/C in Somalia. This was to be achieved through the following specific objectives that contribute to the achievement of the listed outcomes.

a) Evaluation Objectives- SGBV Component

The objectives of the evaluation for the SGBV component was to assess if and how programme outputs were achieved and the efficiency with which outputs were achieved as well as to assess the relevance and sustainability of the SGBV programme. This process was envisioned to provide specific recommendations to develop initiatives for improvement on the basis of programme results

b) Evaluation Objectives-FGM/C Component

The purpose of the evaluation of the FGM/C component to conduct an in-depth appraisal of the project using OECD / DAC 5 point evaluation (relevance, efficiency, effectiveness, impact and sustainability) criteria to assess the extent to which the project achieved its objectives. The specific objectives to achieve this included;

i) To assess the relevance, effectiveness, efficiency, sustainability and impact of the holistic approach adopted by the NCA/SC joint programme for the acceleration of the abandonment of FGM/C
ii) To assess the extent to which FGM/C survivors and groups at risk had access to medical & psychosocial support and livelihood support services.
iii) To assess any changes in the knowledge, attitude and practices of government authorities, civil society, teachers, community members and children in challenging FGM/C practices.
iv) To establish the level at which communities, faith and community-based organizations have been influenced to transform and change dominant social norms which include beliefs, attitudes, behaviours and practices that uphold FGM/C as a form of GBV through project interventions
v) To assess the extent to which communities, faith and community-based organizations have been mobilized to prevent and reduce all forms of harmful traditional practices
vi) To generate contextual data that will facilitate the refining of planned project activities and implementation strategies for the forthcoming phase of the FGM/C project
vii) Assess the relevance, capacity and sustainability of the various structures (e.g. district FGM/C forums, FGM/C Task Force, etc) including community based structures established & supported by the programme
viii) To provide recommendations, identify lessons learned, capture good practices, and generate knowledge to inform the design, planning, implementation and monitoring and evaluation of the next phase of the joint programme model and approach.

The report is organized around the seven main project outcomes which are partly reflected in the above specific objectives. The outcomes being evaluated are as follows:

***Women, Peace and Security thematic programme* – SGBV**
Outcomes:

1. Women and girls in humanitarian and conflict situations are protected against SGBV
2. Right holders have been provided with psychosocial, medical and other assistance
3. Women have participated in peace building processes at local and national level
4. Duty bearers are influenced to implement to implement UNSCR 1325 and related resolutions

***Gender-based Violence thematic programme*- FGM/C**
Outcomes:

5. GBV survivors and groups at risk have access to safety and justice
6. Faith and community-based organisations have been influenced to transform and change beliefs, attitudes, behaviours and practices that uphold GBV(FGM/C)
7. Faith and community-based organisations are mobilised to prevent and reduce all forms of harmful traditional practices

3. METHODOLOGY AND TECHNICAL APPROACH

3.1 Evaluation Design

The evaluation was post intervention in design, with focus on establishing the status of various outcomes and outputs as the implementation period closes. The evaluation of this project was made complex by addressing two set of objectives, each for SGBV and FGM/C components. Under consideration in this process was the mix of implementation arrangements with direct implementation and partnerships in some preferred areas. Thirdly, the two components were implemented in multiple locations with contextual differences and targeting variations.

The evaluation needed to respond to the objectives and in turn generate pertinent information for the programme in light of design complexities. A combination of qualitative and quantitative methods was used to generate primary data. Triangulation of information from primary data, secondary data and review of programme documents was corroborated to arrive at the findings.

3.2 Sources of Data

The objectives of evaluation required both the descriptive and in-depth explanations in establishing the differences made by the implemented interventions. For the purpose of data required, primary data was collected in qualitative and quantitative form. The secondary data from the programme was also used to answer some of the evaluation questions, where possible with field level verification.

Secondary Data

A review of both organizational and programmatic documents; including, specific project information ranging from design and implementation highlights was undertaken. Through this, it was possible to get programmatic, operational and contextual understanding of the project. The secondary sources of data were used for cross comparison with primary data, intended to establish coverage and performance of outcomes. Some of the secondary sources of data reviewed included; proposals, reports, partner documents, activity reports and other highlights.

Primary Data Collection

i) Quantitative Methods

Structured Questionnaires were administered to 100 right holders who constituted the SGBV survivors (women and girls) in order to take stock of various initiatives undertaken in the outcome. This was targeted in the areas where SGBV component was implemented. The questionnaire covered the main project outcomes and included contextual information for further analysis. For the FGM/C component, a structured questionnaire developed around the outcomes in line with baseline and evaluation objectives was developed and administered to right holders both men and women . A standard questionnaire was administered in the 4 districts where the project was implemented. The questions were intended to establish the extent to which the interventions have reached various targets and the outcomes that accrue to them. Structured questionnaires were administered to 442 men and women and subjected to analysis.

ii) Qualitative Methods

Qualitative methods were used to generate in-depth information on key outcomes. The method was applied to explain observed changes and the effects of programme in contributing to other non-quantifiable outcomes. Some of the objectives of the evaluation needed more engaging and depth of information with more probing that could only be generated from the qualitative sources. The method was also applied in conducting individual interviews and bringing community and other stakeholder perspectives in the assessment of the project.

Key informant Interviews (KII): The study generated information from key opinion leaders and stakeholders who are engaged in FGM/C/SGBV interventions to answer key evaluation questions. For FGM/C evaluation and SGBV evaluations, 26 and 8 key informants were interviewed respectively. Key informant guides organized in line with objectives of the evaluation were administered to; teachers, male role models, religious leaders, clan elders, women leaders, youth leader, FGM/C agents of change and health workers engaged in the programme. Key informants were also administered in the SGBV component to; camp leaders, health workers, local authorities, religious leaders and teachers. Information from key informants was important in assessing the roles of duty bearers in the transformative agenda of the two components of the project.

In-depth Interviews: Due to sensitivity of some of the elements of two components, in-depth interviews with the survivors of FGM/C and SGBV under the two project components were undertaken. For SGBV component 12 in-depth interviews were conducted while 8 in-depth interviews were conducted in FGM/ component. The respondents were drawn from the project beneficiaries to establish the extent to which the intervention had contributed to their transformation and well-being. Fistula victims, FGM/C survivors, victims of rape, physical assault, domestic violence and attempted

rape were interviewed. The findings were integrated in the main stream data while others formed important cases for documentation.

Focus Group Discussions (FGDs): For SGBV components, 4 FGDs were conducted between women only (community women and SGBV survivors) and general stakeholders for varied response. For the FGM/C component, 12 FGDs were conducted in the 4 districts targeting women only while others targeted general stakeholders encompassing all important ant right holders (women and girls) and duty bearers(religious leaders. local authorities, teachers, health workers, community members and change agents. This way, the process was able to generate both individual and community level perspectives of the evaluated interventions.

Summary of Methods and Targeted Respondents

SGBV Evaluation

Method	Targeted Respondent	Number
Structured Questionnaire	SGBV Survivors	100
Key Informant interview	Camp leaders, Male role models, religious leaders, community leaders, health workers, government officials	8
Focus Group Discussion	Women, Key stakeholders	4
In-depth Informant	SGBV survivors	12

FGM/C Evaluation

Method	Targeted Respondent	Number
Structured Questionnaire	Male and Female in households	442
Key Informant interview	Male role models, religious leaders, local authorities community leaders, health workers, teachers	24
Focus Group Discussion	Women, Key stakeholders and consolidated	12
In-depth Informant	FGM/C survivors (Fistula, other complications and general ones	8

Evaluation Grid: The project was assessed using Evaluation Grid based on the five Programme/programme Organizations for Economic Cooperation and Development / Development Assistance Cooperation (OECD/ DAC) evaluation criteria of relevance, effectiveness, efficiency, sustainability and impact. The Evaluation grid was applied in the refinement of questionnaires, identification of study targets and in the selection of the data collection methods used in the study. The findings of the specific elements of the criteria are detailed in the on-going section. The grid drew data from primary and programmatic sources and was organized into key findings as one of the objectives.

Case Studies and Documentation of Lessons and Best Practices

Two success stories of how the interventions under the three areas have impacted on select beneficiaries were documented and annexed to this report for both SGBV and FGM components. A success story was documented from beneficiaries of the project in order to capture transformative change. Lessons learned were also drawn from key informants and the implementing partners.

During the process, review of secondary and primary data continuously drew out lessons at all levels. Some useful lessons emanating from each of the components have been captured for informing the programme in the next phase. Similarly, the implementation of the project encounters critical moments of innovation which led to observed improvements. Efforts were made to capture these practices especially the transformative ones for replication and possible scale up.

Results Matrix Analysis

This process largely depended on the results matrix as a guide to addressing the objectives that were drawn from the key outcomes. The results matrix was limited by lack of targets which made it impossible to objectively access performance.

The results matrix was used to assess the performance of each outcome areas. The same was applied in examining the status of the proposed outputs along with their timelines. The explanations for each of the outcomes were made through the primary data sources.

3.3 Data Analysis

Quantitative data was cleaned entered and analysed in SPSS version 20. The analysis focused on the demographics and the variables that were aligned to various outcomes to specifically speak to various objectives**.** The results were presented in tables and illustrative figures. The explanations of various outcomes were undertaken using qualitative data which was summarized by various themes.

Content analysis of secondary data including reports, proposals and project highlights was undertaken and used for cross-checking various elements of the primary data. All data sources were triangulated to arrive at plausible findings.

3.4 Scope and Target Population

The evaluation was restricted to the geographical scope covered under each of the components**.** The SGBV programme had been implemented in Banadir region, targeting Dharkanley, Wanadijir Holwaadaag and Zone K IDP settlements. Due to unavoidable circumstances, the evaluation only covered Zone K. The FGM/C programme has been implemented in Garbaharrey- Gedo, Garowe, Bossaso and Qhado in Puntland. All the four districts were included in the evaluation. The scope of the targeted groups under each of the components is detailed in the methodology.

For the FGM/C component, a sample of 442 was computed and allocated to the targeted districts through a cluster approach. Rights holders both men and women were interviewed at household level. For the SGBV component a sample of 100 was generated out the list of the SGBV survivors to whom the questionnaires were administered to, in their respective clusters. Like the FGM/C component, the informants for the qualitative data were drawn from various duty bearers and right holders targeted by the programme.

3.4 Challenges to the process and Mitigation

There were limitations in comparing some of the baseline data for SGBV with evaluation because of differences in the target groups by IIDA. Some of the baseline data collected on SGBV targeted boys and girls while the project targeted SGBV survivors, women and other stakeholders.

Due to cultural limitations, some men were not fully comfortable in answering some of the questions on FGM/C. The perspectives of men were critical in this process, necessitating the need for additional efforts to bring them on board. However, some respondent bias especially from men cannot be ruled out.

The evaluation was undertaken towards the end of the year and as such, it was not possible to trace some of the targeted respondents of non –local origin who had proceeded for holidays. There were some delays as the team targeted their other counterparts.

There were general concerns of security in the targeted areas of Garbaharey and Zone K which restricted the mobility of the technical team. Deliberate efforts were made to train and deploy qualified local enumerators to the field sites. The potential harm to the process and enumerators were kept to the bare minimum. The lead consultant was not able to go to the field sites in Mogadishu in person due to these security risks.

It was not possible to collect data from Dharkanley, Wanadijir and Holwaadaag, where the project was implemented in partnership with IIDA. The evaluation did not receive any cooperation from the implementation partner and could not force their way into the project sites. For this reason, the evaluation was restricted to Zone K where the sample for the quantitative data and informants were drawn.

There wasn't organized data collection systems linked to an M&E plan. There were discrepancies between the entire project targets and partner allocations which appeared not to have been differentiated from one source document. In some instances, some of the proposed activities were not undertaken, hence took time to verify partner reports with the ground realities.

4. DESCRIPTION AND INTERPRETATION OF FINDINGS

PART 1: SEXUAL AND GENDER BASED VIOLENCE (SGBV)

4.1 Programme Performance against Targets – SGBV

Outcome 1: Women and girls in Humanitarian and conflict situations are protected against GBV

Increased Awareness on SGBV

The project reached 96.4% of the targeted SGBV survivors in zone K and Dharkanley with key SGBV messages**.** SSWC reports indicated that a total of 7,100 people were reached with awareness messages. This constitutes all the SGBV beneficiaries reached through various interventions including; those who received dignity kits, energy saving stoves, training activities, vocational education and awareness campaigns. The main sources of information as noted was NGOs, which indicates that SSWC was effective in raising of awareness. Community interviews indicated that SSWC was the main source of this information. SSWC field monitors were noted to be active in the field to raise awareness through community dialogues, by male role models. It was not clear how many right holders SSWC was expected to reach as the partner proposal is not explicit on this.

The target for IIDA for awareness campaigns was 12,000 as per partner proposal. Accordingly to the annual report for 2014 from the organization, IIDA had managed to conduct awareness campaigns sessions and had in addition conducted radio programs and TV talk shows and gender dialogue sessions which could have reached more people. However, since the organization did not cooperate to undertake the evaluation, it was not possible to verify the information on scale of awareness or the actual number of beneficiaries reached.

The evaluation noted a good level of awareness of the different forms of SGBV such as; rape, ECM, divorce, inequality and domestic violence. This was attributed to the various sources of information such as TV, radio, camp leaders and NGOs and UN agencies, notable among them being SSWC, IIDA, catholic relief services (CRS) and UNICEF. NGOs and CBO constituted the highest provider of information in the target areas of the project at combined coverage of 65.3%. There has also been an improvement in incident reporting as 89% of right holders indicated an improvement in reporting.

Table 1: Sources of Information on SGBV among GBV Survivors (Multiple responses)

Source of Information	Count	Percent
Radio	10	13.3%
Television	5	6.7%
Religious leaders	9	12
NGO	27	36.0%
CBO	22	29.3%
Clan elders	2	2.7%
	75	**100**

Source: Primary Data

There were mixed effects of awareness creation in the community. The evaluation assessed the extent of knowledge that accrued to the survivors and community by extension. High levels of awareness were found, but with misconceptions to realization of comprehensive information. For instance, SGBV

survivors are still divided on whether domestic violence is appropriate. A sizeable proportion of SGBV survivors still believe rape results from provocation, while one fifth still do not view FGM/C and child, early and forced marriages as harmful traditional practices. As shown in the table below, misconceptions were more common among young women 15-24 years of age. Overall there is improvement in SGBV knowledge but this is far from being at a comprehensive level or universal in terms of coverage.

Table 2: Knowledge of SGBV among SGBV Survivors

Knowledge Measure	Response	Age of the Respondent			
		15-24	25-34	35-49	50 Plus
		Percent	Percent	Percent	Percent
Husband has right to discipline wife	AGREE	66.7%	46.3%	30.4%	50.0%
	DISAGREE	33.3%	53.7%	69.6%	50.0%
	NOT SURE	.0%	.0%	.0%	.0%
Rape results from woman provoking a man	AGREE	37.0%	22.5%	13.0%	14.3%
	DISAGREE	63.0%	77.5%	87.0%	85.7%
	NOT SURE	.0%	.0%	.0%	.0%
FGM/C and early marriage are not violence	AGREE	29.6%	17.1%	13.0%	14.3%
	DISAGREE	70.4%	82.9%	87.0%	85.7%
	NOT SURE	.0%	.0%	.0%	.0%
Wife beating is an expression of love	AGREE	37.0%	36.6%	21.7%	28.6%
	DISAGREE	63.0%	63.4%	78.3%	71.4%
	NOT SURE	.0%	.0%	.0%	.0%
Women have a choice in decision making process	AGREE	100.0%	97.6%	87.0%	100.0%
	DISAGREE	.0%	2.4%	13.0%	.0%
	NOT SURE	.0%	.0%	.0%	.0%
Culturally women are never allowed to seek education	AGREE	18.5%	17.1%	17.4%	14.3%
	DISAGREE	81.5%	82.9%	82.6%	85.7%
	NOT SURE	.0%	.0%	.0%	.0%
Women and girls denied opportunities when they refuse to be inherited	AGREE	22.2%	26.8%	43.5%	57.1%
	DISAGREE	77.8%	73.2%	56.5%	42.9%
	NOT SURE	.0%	.0%	.0%	.0%
Wife inheritance is must in the deceased family	AGREE	18.5%	34.1%	4.3%	42.9%
	DISAGREE	77.8%	63.4%	91.3%	57.1%
	NOT SURE	3.7%	2.4%	4.3%	.0%

Through this project, women and girls are more enlightened on causes of GBV. Over half of the assessed women and girls are now more conscious about threats of insecurity in the camps and the activities that predispose them to attacks. Similarly, at the household level women are more aware of the causes of domestic violence and more informed to address them. Increased knowledge has triggered community level reporting of various GBV through mobile phones.

Reduced Risks and Exposure in Target Areas

The project sought to reduce risk and exposure of girls and women from SGBV related incidents such as rape or physical attacks in undertaking their daily chores. Such included during darkness and encounters with potential perpetrators during collection of firewood. SSWC areas, Zone K and Dharkanley ten patrols were targeted for establishment to secure women and girls from attack within the settlements. No security watch patrols were established by SSWC under this project although they were planned for in the main proposal. The link between the main and partner proposal in regard to this intervention was missing. The camp leaders however reported that there are some local security men engaged in patrols (Madani) but their consistence has been curtailed by lack of incentives or support from any agency. It is however noted that SSWC provided energy savings stoves and solar powered lamps as was planned. This effort ensured that there is reduced risk and exposure of girls and in improved sense of security in their immediate neighbourhoods.

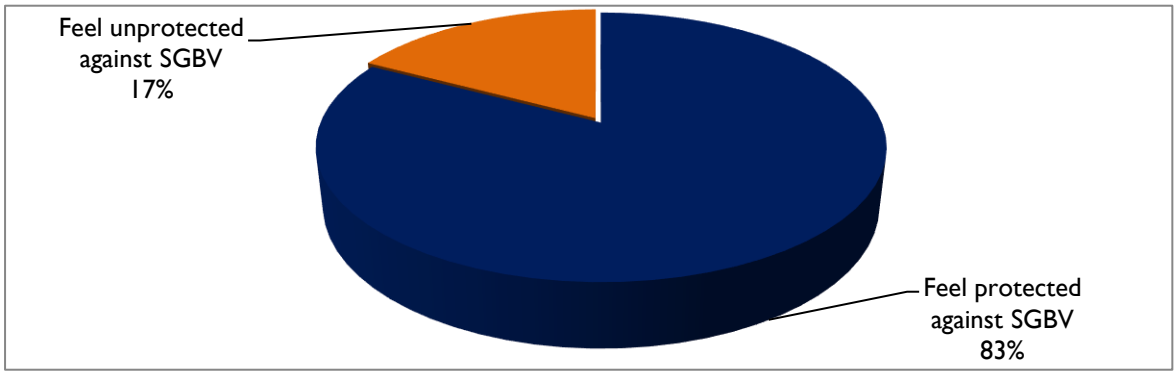
Table 3: Support Received from the project to GBV Survivors

Support Services	Freq.	Percent
Received dignity kits	84	96.6%
Received solar lamps	86	91.5%
Received energy cooking stove	83	85.6%
Available/ functional	**80**	**93.2%**

Source: primary data

To reduce risk and exposure for women and girls, SSWC supported 2000 beneficiaries. Of these, 1000 beneficiaries received solar lamps while another 1000 received energy saving stoves over the two years period. Respondents indicated that the combined effects of lighting, stoves and general awareness have contributed to reduction of cases of rape in the target areas. Even in the absence of consistent security patrols, 5 in every 6 right holders, 83% reported that they felt better protected. An assessment of the sample of 100 SGBV survivors found that majority received dignity kits 96%, solar lamps 91.5% while 85.6 received cooking stoves. At the time of the evaluation, the vast majority of the provided items were available and functional. This confirms that the project was effective and unbiased in support to the GBV survivor.

Fig1: SGBV Survivors Views on Protection



((“I used to live in a dark home where perpetrators and thief broke into my house during the night. The solar I was given is lighter and I can carry it around the house and I feel much safer moving around the settlement at night. I can also use it to charge my mobile phone and I charge my neighbours phones and they pay me some money in return also my children can read using the solar.....,” SGBV Survivor

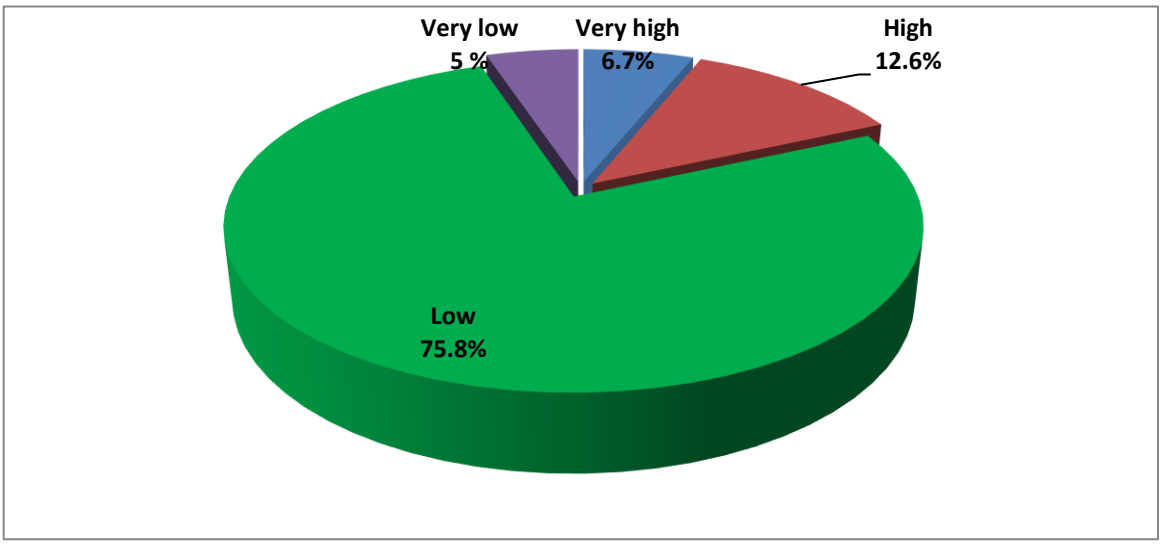
The interventions delivered under this project had far reaching effect on SGBV in the community. To the majority of women and girls, substantial security and protection has been put in place particularly, provision of solar lamps, energy saving cooking stoves and the general community security arrangement. The combined effect of awareness and risk reduction measures appear to have reversed the trends of SGBV cases in the targeted areas. Three quarters (75.5%) of right holders indicated that SGBV cases were decreasing; only 8% reported an increase, while the rest did not observe any change.

Table 4: Reported Trends in GBV in the last two years

Trends of GBV	Frequency	Percent
Increased	8	8.2
Decreased	74	75.5
Remained the same	16	16.3
Total	**98**	**100.0**

Similar to the above trends, three quarters of the SGBV survivors are of the opinion that the current levels of SGBV are quite low. This and the reported trends suggest that SGBV is yielding to programmatic intervention but still remains an issue of concern in the community. Secondly, the project has addressed some of the pre-disposing causes, but more still needs to be done to eradicate SGBV and particularly at legal and policy level.

Fig 2: Opinions on the Current Levels of SGBV (N=100)



Outcome 2: Right holders have been provided with psychosocial, medical and other assistance

Physical, psychological and economic coping capacity among women and girls survivors of SGBV

The project addressed the adverse consequences of SGBV by responding to their physical, psychological and economic needs that were important for their recovery and stability. It was confirmed that SSWC provided dignity kits to 96.6% of the beneficiaries in Dharkanley and Zone K out of the targeted 1000. The organization provided support to at least 7100 rights holders through combined interventions which included ; provision of dignity kits, solar lamps, energy saving cooking stoves, medical and psychosocial support and community awareness. This project made the GBV survivor more open to reporting and benefited from support together with their families. The table below shows the supported right holders by causes of GBV.

Table 5: GBV Survivors Supported by Cause (Multiple responses) N=98

GBV Type Experience	Frequency	Percent
Rape	46	47.4%
Attempted rape	6	6.2%
Attempted defilement	1	1.0%
Sexual assault	2	2.1%
Sexual abuse and exploitation	1	1.0%
SGBV experienced-physical assault	26	26.8%
Domestic	30	30.9%
Early and forced marriage	10	10.3%
FGM/C	11	11.3%

Dignity kits: Most of the GBV survivors were of poor vulnerable backgrounds hence they lacked the basic provisions for human dignity. The project took an important step in restoring dignity to 1000 GBV survivors by providing a kit that constituted basic provisions for dressing and glooming. The provision of dignity kits restored the confidence of women and girls with improved participation outcomes in other activities. Dignity kits equally increased their self-esteem as well.

Vocational training: The vocational training for GBV survivors was one of the high impact interventions that not only addressed the immediate causes of GBV, but empowered women for prevention and deterrence. The project enlisted 400 GBV survivors in a 4 months tailoring accredited course which culminated in provision of a business start-up package. The start-up kit included; 1pcs of sewing machine, 8 rolls of clothes ,8 boxes of threads, 3pcs of scissors, 1 chair and 1tape measure. Skill trainees who graduated have started small vendors through provision of startup kits and currently generating income for their family. The trained 400 GBV survivors engaged in their tailoring business which provided them with livelihood options which were important for deterrence of SGBV. Women who engaged in skills practice moved away from casual work where they were exploited and at times assaulted when they asked for their pay. Furthermore, survivors of intimate partner violence indicated disagreements and fights arising from households needs were reduced as women did not need to depend on men for household provisions. Those that received

> The tailoring course that I received enable me to earn a livelihood without having to suffer under other circumstances which made it possible for the enemies to target me……a GBV survivor

vocational training were particularly happy for the training which not only provided a short term reprieve but long term benefits to their livelihoods.

Medical and Psychosocial support: The SSWC SGBV survivors centre known as Hawa Tako in Mogadishu was supported by the project to provide medical assistance and psychosocial support to numerous calls for support from the catchment communities. The project benefitted 3,100 beneficiaries (89% women and girls). Beyond the basic provision of services, the centre has created the demand and facilitated women and girls to speak about SGBV which was previously characterized with stigma and silence.

Health Services: Health services were availed to survivors of rape, domestic violence in safe houses and some health facilities. The services were utilised but there were fears of confidentiality, fear of divorce on realization of rape and fear of attack and retribution. The project made further inroads in the service domain by bringing men on board for couple counselling. Consensus resulting from the process was found to be important in reducing the occurrence of GBV. Majority of GBV survivors especially FGM/C and rape reported they had no access to specialized treatment. In fact some of them suffer from post episode trauma symptoms to date. The project has been able to provide primary health care services but lacked specialized case management capacity. Similarly there was no evidence of effective referral mechanisms, beyond the GBV care centre. The SSWC centre had the capacity to only handle primary health care and psychosocial services. Similarly, the catchment health facilities lacked options for specialized treatment.

Increased Capacity of Medical Providers on SGBV Response

Cognizant of the central role that medical provider's play in case management and evidence handling, the project envisioned a standard training for medical practitioners. The training was allocated IIDA and since, we were unable to evaluate their project, we cannot verify if it happened or not. But a report from the organization indicated that a 5 day standard WHO training for medical providers was done and that nurses in the health facilities are providing services professionally.

A survey of the SGBV survivors overall indicated that health services were commonly received at 95%, psychological counselling 70%, and legal aid services at two thirds. Security still remains far from reach; only 11.2% indicated that they had good security. This could be attributed to the failed initiation of patrol groups targeted under this project. Overall, the project has fared well in provision of support and services through the SSWC centres, community outreaches and other facilities such as; health centres within the catchments. The services and commodities under partner control were effectively delivered. However, there appears to have been challenges implementing security services which needed more stakeholder coordination. The beneficiaries noted that plastic sheets were in high demand but were not provided as part of the package. Legal aid was however hampered by the fact that most of the perpetrators, particularly survivors of rape were not known though the SSWC centre provided some good level of legal aid (68.8%).

Table 6: Services available to GBV Survivors (Multiple Responses) N=80

Service available	Frequency	Percent	Total
Health services	76	95.0%	80
Security	9	11.2%	80
Legal aid	55	68.8%	80
Psychosocial Counselling	56	70.0%	80
Services available- Other	5	6.2%	80

Source: Primary data

Outcome 3: Women have participated in peace building processes at local and national level

Religious leaders advocate for women involvement in peace processes

This outcome intended to use the religious leaders as a voice in influencing the inclusion of women in peace processes. The outcome was to be further realized by underscoring the role of women in peace building and development processes. It is worth noting that these were important pre-requisites for engagement in peace building processes within the project design. In the short project term, it was not possible to nurture women for engagement into the peace processes at the national level. However, locally, women targeted through this programme have been engaged in the SGBV project which has a conflict resolution element.

The project aimed to train religious leaders and community leaders on UNSCR.1325 and women rights. It was found that SSWC trained the SGBV women survivors, on peace building but did not train the religious or community leaders. Based on the unverified annual report from IIDA, 30 religious leaders were trained, but this was not confirmed on ground due to non-cooperation of the NCA partner.. The SGBV survivor trained, are however important change agents at the local level particularly on issues of conflict resolution in their communities. Due to the volatility of the project areas due to the presence of militia groups, the involvement of duty bearers is quite limited and therefore such interventions will often be difficult to actualize. The evaluation noted in addition that SSWC had trained 100 SGBV survivors as change agents in their respective communities which largely constituted women but not girls. Since the duty bearers particularly religious leaders and community leaders were not trained on women advocacy, the role of women at the national level in peace building is lacking.

Outcome 4: Duty bearers are influenced to implement UNSCR 1325 and related resolutions

Increased Knowledge base of duty bearers

The knowledge of women group leaders, in UNSCR1325 was improved as envisioned. Twenty seven women leaders were trained with an emphasis on the integral role that women play in the peace building process as leaders not subjects. The training also targeted religious leaders and camp leaders for their role in SGBV programmes and peace building. The influence of trained duty bearers in peace building process could not be immediately established as the training was conducted towards the last quarter of the project. However, this is a long-term intervention whose impact will be felt in other project cycles. Overall, this project has developed substantial capacity for women at the local leadership and as right holder to continue peace building on SGBV response and other programmes. The camp leaders however contributed in the project in substantial way, seemingly having participated in similar initiatives before but not as target for this project which narrowed its focus to SGBV survivors as confirmed by the SSWC staff.

Religious leaders influence attitude change of GBV

The project intended to use the religious leaders to influence behavior change on SGBV on the basis of their standing in the society. IIDA annual report (unverified) indicates that religious leaders were trained while SSWC did not provide targeted trainings for religious leaders. However, their participation in other trainings facilitated their dissemination of anti-SGBV messages in mosque

sermons. In some areas, it was noted that religious leaders have also gone public with the key messages in various forums but the low coverage suggests that not many of them were involved. However, it appears their verbal dissemination of information did not directly influence attitude change particularly among women since they do not attend mosques. But there was observed behaviour change such as men allowing their wives to engage in business and positively contributing to resolution of SGBV conflicts. It was also noted however that the religious leaders were important pillars in various elements of the project and to who the SGBV survivors sometimes confided. The religious leaders provided a platform through which some of the cases were reported. There is a level of project ownership in the community whereby the camp leader and religious leaders reported that even in face of external support, the duty to protect vulnerable women and girls remains with the community.

4.2 Evaluation of SGBV Project in DAC/ OECD Criteria

a) Relevance

In our assessment, the SGBV project is highly relevant to the context and the felt needs of the IDP communities in the target areas. The project sought to address causes of rape, physical assault, wife beating and attacks by militia , idle youth and other potential perpetrators due to lack of protection. The target group for the project implemented by SSWC was largely the SGBV survivors and this constituted the core of the beneficiaries that are directly impacted by the problems being addressed. The interventions selected and implemented had direct benefits on target communities such as increased awareness on SGBV, risk reduction, use of services, the role of women in peace building, skills on how to advocate and to play the role of change agents and economic empowerment of survivors. In Mogadishu, the project did not directly contribute to change in policy on SGBV, but there were some efforts to advocate for the change in law against the perpetrators.

Some of the activities addressed ways to prevent occurrences of SGBV such as; provision of solar lamps and energy saving cooking stoves. These ensured that women and girls were not exposed by going to fetch firewood in the bushes or staying in unlighted houses. Peace building trainings focused on how women could play a positive role in conflict resolution in the camps. These activities were relevant to the situation facing women and girls that were the main targets of the project. In a nutshell the implemented interventions were tailored to address the causes of SGBV.

The intervention mix was highly relevant and suitable for the problem being addressed. However, some activities could be broadened. For instance, vocational skills training should be deepened with provision of business skills training so that the graduates can manage their businesses successfully. The use of male role models was an innovative way of promoting positive masculinity for support of women as; mothers, daughters, sisters and important part of the community. This strategy should be expanded so that more men who are keen to support women interventions are brought on board. The approaches used were in line with the social and gender based transformation programming. Working with men role models, community structures such as; camp leaders ensured that all community members played a role in addressing SGBV issues. SSWC largely targeted women but worked closely with other community leaders at the local level. There were efforts to advise men the value of empowering women to their families and this reduced the resistance on the part of men. This was successfully done through couple counselling. Identification of beneficiaries was done by the camp leaders and women rights activists from the camps ensuring that the right groups were selected to benefit from the project.

b) Efficiency

The cost of doing business in Mogadishu is generally high mainly due to the state of insecurity and oligopolistic tendencies as the businesses are controlled by few big traders. As such, in our assessment, SSWC made efforts to procure all project inputs at reasonable costs, but due to the price fluctuations that are common, it is difficult to establish the 'best value for money' locally. It was however noted that the organization did not exceed the donor allocated budget. While it is not clear how many beneficiaries SSWC reached in total, the indicative figure provided is 42,600 (7100 direct beneficiaries). It was not possible to establish the correct figure from IIDA projects but the last report indicated 6360 (1060 direct beneficiaries). Against a budget of US$550,000 (approx.), this translates to US$67 per direct beneficiary. The fact that IIDA may not have completed their project and reached the expected number of beneficiaries could be a contributing factor to this low value for money. However, considering that part of the project funds were invested in procuring stoves, solar lamps and start up kits for the vocational training graduates, the application of funds was reasonable from this perspective.

The partnership model between NCA and SSWC and IIDA as implementing partners brought advantages in terms of full access and acceptance in project sites. This is demonstrated by the fact that SSWC was able to implement the project in volatile IDP areas and largely completed most of the activities as noted during the field evaluation.

In terms of timelines, some of the activities were implemented towards the end of the project yet they were expected to bring change in the course of the project. Due to this limitation it was not possible to establish the contribution of some elements of outcome 4.

c) Effectiveness

The project through SSWC was able to deliver outcomes 1 and 2 to a reasonable degree of success. Under outcome one which focused on protecting women and girls against GBV in humanitarian and conflict situations, the interventions undertaken such as provision of solar lamps and cook stoves were effective. Provision of dignity kits, TOT on psychosocial and workshops on UNSCR 1325 and other trainings contributed significantly to realization of outcome 2; right holders were provided with psychosocial, medical and other assistance. There were some localized efforts by SSWC to ensure participation of women in peace building. Training on peace building was conducted targeting GBV survivors. However, no efforts were done at the national level to involve women in peace building. While training was done on UNSCR 1325, this targeted the beneficiaries of the project and not the duty bearers. As such this did not achieve the effectiveness criteria under outcome 4 of the project.

Change agents such as community, camp leaders, women leaders and religious leaders are contributing to the efforts to stop acts of SGBV. Religious leaders are advocating against SGBV during their sermons. This has been reflected in the high levels of awareness and comprehensive knowledge about SGBV observed among the right holders.

The project achieved some unexpected results. For instance beneficiaries of the vocational training who were offered training in tailoring also started small tailoring businesses which were diversified into other products. A good example is detailed in the attached case study. It was also noted that the GBV survivors had achieved a high level of self-esteem after the trainings and were able to stand up for their rights. Conversely the health component of the programme was restricted to basic services.

SGBV survivors did not have access to specialised services including structured referrals. However psychosocial and basic health services which were within SSWC capacity performed well.

The main contextual influence on project implementation was the adjustment of hours during the month of Ramadhan. The awareness campaigns hours were switched to evenings where more people could be available.

It was noted that the targeting of the project was quite fitting as it reached out to the most vulnerable people, the SGBV survivors both women and girls with interventions that were for protection, prevention and mitigation of the situation facing them. However, the proper targeting of other groups that could bring lasting structural changes such as duty bearers remains a weak area that the project did not address effectively.

The establishment of security patrols, 10 in total, were envisioned but were not undertaken. As the project made tangible gains in reducing risks of attack at the household level, the community level space and environment was left unattended. The community had to depend on ad hoc security patrols organized by the camp leaders with other stakeholder which is inconsistent as a result of funding limitations. This had an effect on the expected results of the project.

a) Impact

It would be difficult to conclude that the project has achieved the impact it was intended, but has attained significant outcomes which will lead to the realization of intended impact in the long term particularly if the intervention mix is sustained. There are reports that the project contributed has contributed significantly to reduction of SGBV. Seventy five percent of the SGBV survivors are of the opinion that cases have gone down. The same were of the opinion the trends of the same have been reversed significantly. Over 80 percent of the SGBV survivors reported that they felt better protected as result of this programme.

The interventions undertaken have the potential of attaining impact as they are relevant in the context facing the IDP survivors of the sexual and gender based violence. There are beneficiaries that started businesses after vocational training. Some even diversified their businesses to new income streams and today, they eke a living from them. There are change agents and male role models that are committed to support the SGBV work, now an in the future which is a sacrificial commitment given the prevailing social and cultural norms and practices that will take long to change. Equally camp leaders are at the forefront of campaigns against SGBV, though their engagement and those of religious leaders was not well structured. . These are proxy indicators of impact achievement though the duration of the project cannot directly demonstrate impact achievement.

There are notable changes in social norms, attitudes and behaviours that are signs of promising project impacts. Women reached with awareness on SGBV know their rights and can confidently claim or question the services being provided. However, while there are male role models committed to SGBV work, we noted that men are feeling generally left out (as they are not a direct target of the project) or threatened by the women empowerment and this need to be properly managed as it can result to further domestic problems. Men role models are an important pillar for this change process. It was noted that some of the SGBV survivors that are able to get three meals per day as a result of the income from the businesses established after being offered the vocational skill by SSWC. Some indicated they could generate income by using solar lamps to charge phones to other villagers at a

small fee. Therefore this not only reduces SGBV risks but supplement the livelihood sources of the duty bearers.

a) Sustainability

In current state, the project will continuously depend on external resources to continue the on-going interventions. There have been limited efforts by the partner to build self-reliance through the established structures. However sustainability is also hampered by fact that the people served are highly vulnerable some with individual weaknesses and needs to be supported.

The vocational trainings is likely to provide long term benefits to the beneficiaries who now have the tailoring skills and are self-employed, thus have sustainable livelihoods. The TOTs and change agents also formed an advocacy group that can continue supporting the SGBV campaign beyond the life of the project. There are some gaps such as how to ensure support services like basic skills in repair and maintenance of sewing machines. This skill was not a focus of the vocational training and may affect the sustainability of this intervention.

As noted, duty bearers were peripherally engaged at the local level and not at all at the national level. As such the institutional foundation for sustainability of this project, which is propped by having and implementing a strong policy regime to fight SGBV, is not developed. A deliberate engagement of the leadership of SSWC in national discourse might influence the development of such policies. But the involvement of government at national level faces some serious hurdles particularly because of insecurity and presence of militia groups in and around the project sites. It is risky to identify with government entities in a pronounced way.

It is early to speak firmly about sustainability of the SGBV work but the pillars for the same are being laid by SSWC and other NCA partners who are committed, in small ways, to make a difference to the suffering of women and girls related to not only economic empowerment but also SGBV. Mobilization of resources for continued response to SGBV will in the short term depend on external assistance as locally the government may only be able to improve security and but not fund other programme costs.

PART II: FEMALE GENITAL MUTILATION (FGM/C)

4.3 Programme Performance against Targets – FGM/C

Specific objective 2: To assess the extent to which GBV survivors and groups at risk had access to medical and psychosocial support and livelihood support services

Outcome 5: GBV survivors and groups at risk have access to safety and justice

The FGM/C survivors were provided with medical and psychosocial support as reported by the respondents from both Garbaharrey and target districts in Puntland state. The combination of support services that were received included medical treatment and some referrals, provision of dignity kits, access to justice (jailing of FGM/C perpetrators for example in Puntland), counselling. The project partners also provided awareness and trainings to communities on FGM/C .NCA particularly in Gedo region supported reconstructive surgery of 13 cases of fistula that were successfully undertaken in Mandera- Kenya. There is largely no treatment referral mechanism that is systematic across the project area in Gedo. The referral mechanism in Puntland is also weak. It was however noted that a majority

of women and girls in the target areas know about the availability of FGM/C services (74.1%). There is largely no specialized treatment capacity or trained professionals to handle complicated cases of fistula or other forms of violence on women and girls. There are no referral hospitals locally in the target areas for fistula or other conditions and referrals were made to either Kenya or Ethiopia. There is a massive need for fistula treatment but being a highly expensive process, more resources are needed to make any meaningful impact. However, even with low coverage, the specialized treatment given to fistula victims is one of the transformative interventions of this project. To most of the fistula survivors who were generally embarrassed and keeping indoors before, this presented a new lease of life.

Knowledge and Awareness to Prevent FGM/C

The project reached 84.1% of right holders with information on the need to abandon FGM/C. In the respective districts where the FGM/C project has been implemented by NCA/SC/TASS and local partners, there seems to be a high level of coverage of information as indicated on the table below. Gardo and Bossaso seem to have the highest proportion of people who received FGM/C messages. Garbaharrey and Garowe also equally indicate having received the information as well. It seems that the dissemination of information to abandon FGM/C was effective across the project target areas.

Table 7: Received Information to Abandon FGM/C at District level

District	Frequency	Percent	Total
Garbaharey	99	74.4%	133
Garowe	78	83.0%	94
Qhado	93	93.9%	98
Bossaso	84	88.4%	95
Total	354	84.1%	420

The study also found that the project utilized various channels to provide information on FGM/C. It is clear that NCA/SC/ TASS were among the main source of information (63.1%) but it is also noted that other sources to which NCA/SC/TASS and others contributed such as radio (58.1%), TV at 31.7% were used. It is also worth noting that religious leaders (50.1%), government officials (23.7%), male change agents (22.9%) organizing community forums at 20.7% all supported by NCA /SC/ TASS were used to reach substantial proportions of right holders. Clan elders were also an important source of information on FGM/C that can be leveraged in pursuit of zero tolerance.

Table 8: Sources of Information on FGM/C (Multiple responses)

Source information	N	Percent of Cases	Total
Male change agents	83	22.9%	362
Religious leaders	182	50.1%	363
Clan elders)	50	13.8%	362
community leaders	182	50.1%	363
Government officials)	86	23.7%	363
NGOs and community based organizations	229	63.1%	363
Radio	211	58.1%	363
TV	115	31.7%	363
Community forums	75	20.7%	362
Others)	20	5.5%	364

Specific objective 4: To establish the level at which communities, faith and community-based organizations have been influenced to transform and change dominant social

norms which include beliefs, attitudes, behaviours and practices that uphold FGM/C as a form of GBV through program intervention

Outcome 6: Faith and community-based organisations have been influenced to transform and change beliefs, attitudes, behaviours and practices that uphold GBV

There is increased knowledge and awareness across the project areas on preventing and reducing FGM/C cases. Awareness raising was a key activity that was undertaken through a combination of community dialogues, radio messages, use and dissemination of IEC materials, school-based extra curricula activities, and awareness by religious leaders. The analysis showed that only 11.4% viewed FGM/C as a religious requirement. Other perceived benefits of FGM/C detailed below include; cultural requirement 15.8%, cleanliness and hygiene 12.5%, for preservation of virginity and social acceptance each 10.6%. This will continue to help the effort to stop the practice of FGM/C/C across the project areas and can be attributed to the multi-faceted efforts made to create awareness. The project registered success in reaching out to school children with FGM/C awareness messages but was not successful with youth clubs due to lack of youth structures or platform to advance behaviour change agenda. This is particularly so because teachers were an integral part of the awareness programmes which took place in the schools. SC/TASS came up with a documentary on FGM/C that was to be used to raise awareness through radio and TV talk shows. The documentary was made, but due to the sensitiveness of the issue, it was not aired on television, but disseminated to a stakeholder forum.

Table 9: Perceived Benefits of FGM/C (Multiple responses)

Perceived benefits of FGM/C	N	Percent
No Benefits	90	9.1%
Cleanliness/Hygiene	124	12.5%
Religious approval	113	11.4%
For preservation of virginity	105	10.6%
Purity	98	9.9%
(For Cleanliness	78	7.9%
Social acceptance	105	10.6%
Better marriage prospects	88	8.9%
As a cultural requirement	157	15.8%
As a rite of passage	31	3.1%
Other reasons	4	.4%
	993	

The impact of the NCA/SC project can be felt through the perceived trends of FGM/C. For SC and its local partner TASS, it is reported that the FGM/C practice in the communities is mainly on the decline (87.6%=434) across all the target areas. There is however slight variations from district to district in opinions detailed below. Garbaharey District demonstrated a higher proportion of respondents reporting FGM/C decline.

Table 10: Opinions on Trends in FGM/C

Trends	Frequency	Percent

Increasing		22		5.1
Decreasing		380		87.6
Remained the same		32		7.4
Total		**434**		**100.0**
Opinions on Trends in FGM/C by districts				
	Garbaharey	**Garowe**	**Qhado**	**Bossaso**
Increasing	2.8%	9.4%	3.0%	6.2%
Decreasing	91.5%	86.5%	85.0%	85.6%
Remained the same	5.7%0	4.2%	12.0%	8.2%
Total	141 (100.0%	96 (100.0%)	97 (100.0%)	100.0%

It is noted that the SC/TASS project had succeeded in influencing the communities through the through community dialogues to stop FGM/C. 12 girls were rescued from the act as a result of the community conversations / dialogues where both parents and FGM/C practitioners were influenced. It is noted that 40 families were also specifically influenced to be anti-FGM/C champions in the communities, a situation that resulted in them declaring publicly that they will not allow their girls to go through the practice. In Garbaharey, community dialogue forums and campaign by religious leaders influenced a segment to abandon FGM/C. However, the community in its entirety has not taken a position on FGM/C since the interventions were largely centred in the urban centre. The community was not ready for consensus on declaration, but some other gains were made as a direct contribution of change agents.

Table 11: Knowledge of Harmful Effects of FGM/C (Multiple responses)

District	Frequency	Percent	Total
Garbaharey	97	76.4%	126
Garowe	60	64.5	93
Qhado	71	74.7	95
Bossaso	77	82.8	93
Total	305	74.7%	305
Knowledge of harmful effects of FGM/C Multiple Responses)			
Child birth complications)	267	74.6%	358
Bleeding	275	76.8%	358
Infections	260	72.6%	358
Fear/Depression)	153	42.7%	358
Low sexual drive)	140	39.1%	358
Others	11	3.1%	358

Harmful effects of FGM/C were known by 74% of right holders but with district differentials. The complications of FGM/C were also stated but with some such as health based ones such as bleeding, infections and child birth complications more known. The project has therefore made some effort in improving awareness.

Across the project areas, school children received information on FGM/C as was reported by the households members interviewed. The project target districts that had the highest number of school

children that received information were Gardo and Bassaso while an equally good number were reached in Garowe and Garbaharrey. The school forums have inculcated positive attitude in boys who expressed their readiness to marry uncircumcised girls and negate from the previously held misleading norms.

Table 12: School Children Received FGM/C Information Reported by Households

District	Frequency	Percent	Total
Garbaharey	95	69.3%	137
Garowe	59	62.1%	95
Qhado	84	84.8%	99
Bossaso	73	76.8%	95

It is clear from the evaluation that the communities largely do not support continuation of FGM/C practice across the project target areas (60.1%) which could be attributed to the project interventions. Garbaharrey (74.7%) and Bosasso (67.3%) seem to be the districts where the anti-FGM/C messages have had a deeper influence on the communities, faith and community based organizations. While the efforts to change beliefs, behaviours, attitudes and practices are notable, there is still a significant number who still believe that FGM/C/C should be continued (see Table 13) with Gardo having the highest number at 35%. There is a disconnect in the sense that majority of the people report support for discontinuation of FGM/C, yet practice has not been abandoned. However, it also implies that community is slowly getting enlightened on FGM/C and slowly disassociating with it.

Table 13: Respondent Views on the Continuation of FGM/C

	District				
Views on Continuation	Garbaharey	Garowe	Qhado	Bosasso	Total
Continued	24.2%	12.5%	35.0%	14.3%	21.6%
Stopped	74.7%	47.9%	50.0%	67.3%	60.1%
Depends	.0%	35.4%	7.0%	14.3%	14.0%
Don't Know	1.0%	4.2%	8.0%	4.1%	4.3%

The reasons given for the support to stop FGM/C in the communities clearly demonstrate that the communities understand health implications of the practice on the girls. It was clear that FGM/C is a practice that is not good for the women's health (89%). This is an important finding combined with the fact that FGM/C has no religious requirement, can be a strong *saxaarla* messaging perspective. It is important that these milestones in information are translated into practice in the next phases of programming.

Table 14: Reasons for Supporting Stop of FGM/C (Multiple responses)

Reasons for supporting FGM/C Abandonment	Frequency	Percent	Total
Not good for women's health	275	89.0%	309
No difference between circumcised and uncircumcised women)	59	19.1%	309
Not important	159	51.5%	309
Illegal	198	64.1%	309
Uncircumcised girls prosper	60	19.4%	309
Government and religious leaders are against it)	123	39.8%	309
Other	11	3.6%	306

Part of the envisaged operational research was conducted by SC/TASS and NCA. SC/TASS developed FGM/C documentary efforts while NCA printed some FGM/C booklets that were disseminated during awareness events such as 16 days of women activism and other public forums. There was a level of knowledge transfer, as visualized from the replication of the SC/NCA Ethiopia FGM/C partnership model into the Somalia context. There was also cross learning between NCA-SC Ethiopia and Somalia country programmes during a joint review forum as well as coordination of information sharing forums between NCA, SC and the Norwegian Embassy at Nairobi and Olso levels. This provided a forum for learning and experience sharing which was vital for targeted programming in the next phase of the project. Additionally, in 2014 there were a number of NCA and SC planning and coordination forums for staff and partners working under the project in Gedo and Puntland through the Local Technical Working Group established by both SC and NCA for the purpose of sharing information, challenges, lessons learnt and best practices during the course of the joint project implementation

Specific objective 5: To assess the extent to which faith and community-based organizations have been mobilized to prevent and reduce all forms of harmful traditional practices

Outcome 7: Faith and community-based organisations are mobilised to prevent and reduce all forms of harmful traditional practices

The evaluation noted that communities are aware of leaders that have made declarations on FGM/C. It seems Gardo (82.5% n=97) and Bossasso (81.1% n=95) have the highest number of right holders who are aware of leaders who have made declarations. A total of 42 religious leaders were mobilized by the project to support the FGM/C effort. There is however no full inventory of all the religious leaders in the project areas. There is an element of positive deviance with 40 families in making their own local declarations and halting of the practice from the same area. A significant number of community leaders have also declared their position on FGM/C in Gedo and Garbaharrey but not as many as the other areas. In SC/TASS areas, this resulted in some girls being rescued from the practice after convincing the parents and FGM/C practitioners to stop the practice.

Table 15: Knowledge of Leaders Making Declarations on FGM/C

District	Frequency	Percent	Total
Garbaharey	82	61.7%	133
Garowe	53	59.6%	89
Qhado	80	82.5%	97
Bossaso	77	81.1%	95

The leaders known to support FGM/C abandonment are led by religious leaders at 83%. Government officials (31.5%) are also quite instrumental in supporting the FGM/C abandonment effort as well as male role models (30.9%). Religious leaders consider themselves to be prime stakeholders in FGM/C programmes but some demonstrated misconceptions by supporting the sunna type. This complicated the FGM/C abandonment especially on the religious proponents of FGM/C.

In Garhabarey religious leaders pushed traditional circumcisers to offer public apologies and commitment to stop the practice which was done without hesitation. In another scenario, religious leaders barred an FGM/C practitioner from attending 'hajj' annual Muslim festival in Mecca on the account of using unholy blood money earned from circumcision. In Garbaharrey two Muslim clerics, are practising zero tolerance to FGM/C and openly show off their daughters who are uncircumcised in an effort to demonstrate leadership. Although religious leaders are receptive to FGM/C programmes, some are torn between stopping or continuing the *Sunna* type which is considered as favourable due to misplaced religious interpretation. Some of the religious leaders therefore require some support to fully embrace zero tolerance as still consider *Sunna* type as FGM/C free.

Table 16: Leaders Reported to be Supporting FGM/C Abandonment

Leader	Frequency	Percent
Religious leaders	269	83.0%
Male role models	100	30.9%
Government officials)	102	31.5%
Clan leaders)	44	13.6%

Both SC and NCA made efforts to build capacity of collaborating institutions on issues of FGM/C. Government district staff, MOWDAFA and other community based change agents were trained. In addition, district forums were established by SC/TASS in Gardo and Bossasso while at community level FBOs and community structures also conducted FGM/C forums. Those included MOWDAFA, MOJRA, youths, hospital, CBOs. The different institutions' representatives were trained, so that they could become change agents in their respective communities.

In Garbaharey, 5 community dialogue structures were established. The same were instrumental in spearheading community conversation sessions in Garhabarey. Through 5 community dialogue working groups, 111 community actors constituting religious leaders and community leaders were engaged in various forums championing FGM/C abandonment. Focus group discussions revealed that the members of these forums are well mobilized as they indicated their readiness to continue community dialogue sessions and anti- FGM/C messages beyond the life of the programme. The community leaders and faith actor exhibited a sense of duty in pushing for FGM/C abandonment and made efforts to hold perpetrators accountable but with limited legal enforcement.

Specific objective 6: To assess any changes in knowledge, attitude, practices of government authorities, civil society, teachers, community members and children in challenging FGM/C practices.

Changes in knowledge, attitude and practice – Government authorities

Both NCA and SC and their local partners are members of FGM/C-related coordination mechanisms in Puntland. These include the UN-led GBV working group and FGM/C taskforce chaired and co-chaired by MOWDAFA and UNFPA respectively. They are also members of the Inter-agency FGM/C taskforces, case management committee, GBV and Child Protection Working Group (CPWG), Gender Based Violence Working Group (GBVWG) based in Bossaso, Garowe and Gardo. The organizations are active in various coordination meetings among the key stakeholders include regional MOWDAFA government officials, community based structures (CECs, CWCs,) and Bosaso and Gardo district FGM/C taskforces which consists of various NGOs including TASS, SC, NCA, PSA, GRT and IHSAN which is an umbrella body of religious leaders. The forums were important for information sharing which provided the basis for action.

The government leaders and authorities from the National level, district to local authorities in Puntland are well involved in the fight against FGM/C. This is confirmed for instance by the President of Puntland participation in the Celebration of 16 days of Women Activism. There is also a dedicated Ministry, MOWDAFA which works with other stakeholders to address all issues of GBV from implementation of community intervention and policy development and advocacy. MOWDAFA has representation at regional and district level. MOWDAFA at one point worked with stakeholders in supporting the anti-medicalization policy which was meant at curbing acts of FGM/C being perpetrated by trained medical practitioners in hospital settings. Other arms of district level Government authorities are also involved in FGM/C work. They were instrumental in the establishment and functioning of the district level forums which has been one of the change agents in the community.

The UN agencies and civil society agencies are working jointly under working groups and task forces to address the wider GBV issues in Puntland. There were regular coordination meetings and information sharing and reporting mechanisms that are used by all. The project was aligned to a UNFPA-UNICEF joint programme advancing protection agenda forward.

The involvement of Government authorities to challenge practice of FGM/C in Garbaharrey is quite peripheral and this is mainly due to frequent turnover of administrations and general volatility of the districts. The presence of Al Shabaab also complicates their involvement in the FGM/C work. The police have been instrumental in pushing for arrest of FGM/C practitioner who undertakes the exercise under significant cover.

Changes in knowledge, attitude and practice – school teachers and students

School teachers were mobilized to support and challenge FGM/C practice. In Puntland, SC and TASS supported school activities and exchanges, debates, poetry competitions and sports tournaments in Bossasso and Gardo. . Children and youth in the schools had consultative discussions on the consequences of FGM/C/C and role that children can play in campaigning for its eradication.. For example some of the trained boys openly declared during school assembly sessions that when they grow up they would marry an uncut girl because they now understood the negative impact the practice has on girls and entire family.. It was noted that after the awareness of school children, the community education committees, children and youth discussed with their parents about FGM/C/. Through 8

schools (4 each in Qhado and Bossaso, 3280 (1300girls and 1980 boys) school children were reached key messages. Considering the attitude demonstrated by boys above, the coverage of this intervention has far reaching effects on attitude and future practice of FGM.

In Garbaharrey, school were also mobilized to form anti-FGM/C support groups that were trained and raised awareness among the students, to their parents and in the communities. The groups had dialogue forums that have been instrumental in disseminating information and changing attitudes of the school children, teachers and other stakeholders. In total 8 schools (primary and secondary) were reached while 16 community education committee (CEC) members each representing the 8 schools were mobilized. This made it possible for the project to reach 5400 school children with key messages through direct dissemination and sports.

Changes in knowledge, attitude and practice – community members

In general, community members from across the project target areas in Garbaharey and Puntland were well mobilized to abandon the FGM/C practice. The change agents have been advancing FGM/C abandonment as envisioned although the slight discordance on the *sunna* type was experienced. The communities were found to have taken stand on FGM/C with rural-urban differentials forcing the practitioners to flee from some areas in order to continue with the practice. Equally coming out is the fact that in Garbaharey for instance some practitioners were able to offer public apologies and open regrets for the damages that they had caused various women in their years of practice.

There were instances where girls were rescued from FGM/C/C after the communities directly countered the practice.. Community members through the change agents sought retribution in the form of compensation for the survivors of FGM/C from the perpetrators by proposing stiff penalties/ compensation for young girls that experience FGM/C. The proposed compensation demands are beyond the reach of practitioners, in order to force them out of the vice. It was also noted that young boys and male youths had taken a stand by insisting that they will marry uncut girls, a clear testimony that the anti-FGM/C message was reaching this cohort which is important to erase the deeply rooted practice. The above demonstrates that the project has made significant changes in attitudes although cultural norms remain in the way of fully abandoning FGM/C.

Table 17: Respondent Would Allow Sister or Daughter to undergo FGM/C

District	Total	Percent
Garbaharey	139	43.9
Garowe	94	18.1%
Qhado	100	46%
Bosasso	99	29.3%
	432	153(35.4%)

Overall, the evaluation further revealed that right holders had varied views as to whether they could allow their daughter/sister to be circumcised. The observed levels demonstrate that less than half would allow circumcision of their children or close relatives. This is a manifestation of continuous campaign for the abandonment of FGM/C with community and individual level receptiveness.

Specific objective 7: To assess the relevance, capacity and sustainability of the various structures (e.g. district FGM/C forums, FGM/C Task Force, etc) including community based structures established and supported by the programme.

In Puntland, the project is being implemented within the wider UN protection cluster. This is where the GBV working group and the FGM/C Task Force were linked. As such, this framework in our assessment is sufficient to ensure that there is continuity and sustainability as all the different protection and GBV stakeholders are part of it. Various efforts to continuously build the capacity of the cluster members were observed. There is also standardization of information sharing and reporting a tool that ensures that different stakeholders use the same standards and harmonized parameters in their work. A case in point is the tool used for reporting cases of GBV. Structures such as District FGM/C Forums will also add value and ensure continue of the work after project lapse.

Garbaharrey district and the wider Gedo region has no such structures implying that individual agencies basically undertake efforts that are not coordinated or harmonized with any others. Part of the reason for this is the instability caused by insecurity and the presence of militia groups. Further, NCA is one among the very few agencies intervening in the Gedo region on issues of GBV in general and FGM/C in particular.

In both project sites however, the community structures such as CECs, CWCs and youth groups are active on issues of FGM/C and are linking well with NCA, SC/TASS and other community structures such as religious leaders and clan elders. Community dialogues forums are good avenues to ensure that discussions on FGM/C continue at community level.

4.4 Evaluation of Project in DAC/ OECD Criteria

a. Relevance

Studies (MICS 2006, 2011 and 2014) indicate that FGM/C prevalence among adult women in Somalia ranges between 97-98%. As such, the FGM/C project is addressing a felt need of the community and a gap in programmatic response, specifically targeting the victims and perpetrators of the practice. The project model targets the right holders and duty bearers thus ensuring that the approach addresses actions that can be done with and by communities and those that require intervention of right holders in a good balance. The main interventions are well designed to reverse the FGM/C practice particularly by behaviour change communication through both awareness and advocacy. Community structures and use of faith actors fits well in the Somali context. The programme brought together the efforts of all relevant stakeholders and ensured that the right holders benefited from the programme.

In Puntland, the project worked with and engaged various stakeholders including MOWDAFA to develop and finalise an anti-FGM/C policy which was passed into law. The Sexual Offences Bill was also passed into law. These are relevant laws which if effectively implemented would significantly contribute to eradication of the FGM/C practice, early child marriages and other GBV related challenges facing communities, women and girls.

The initiative was an effort to protect girls from FGM/C/C and other associated outcomes such as CEFM and school drop outs. FGM/C is detrimental to reproductive and maternal health, development of girls and women, discrimination, trauma and overall violation of girls and women rights, and the inter-generational transfer of poverty. FGM/C complications has heavy burden on reproductive health and has cost implications to rudimentary health system that characterizes majority of the geographical

areas covered by the project. The programme also contributes to other global and regional campaigns, and policy frameworks calling for the abandonment of the harmful cultural practice.

b. Efficiency

In Puntland, the cluster, partnership and referral approach was used in joint and shared implementation of activities to reduce on costs as some cost items were under-budgeted such as, community dialogue. The project also suffered from currency fluctuations. Use of media was noted to be one of the ways to reduce costs yet have a wide audience reach.

The partnership model first between SC and NCA was a good example of drawing lessons from a different country to build and replicate new program in a different country context. By working in respective geographical areas NCA/SC increased the reach of the project without an overload of operational costs. The partnership model facilitated sharing of information on lesson and best practices with overall improvement in programme efficiency. The engagement of SC's local partner ensured that the project is owned by the communities from a more conversant partner at a relatively lower operational cost. Secondly, the project established local community dialogue structures that brought together various community leaders in the communities and schools who expressed their commitment to carry on the interventions even after the end of the project. This local driven ownership was vital for efficiency and sustainability.

There is very high unmet need for surgical fistula treatment in the target area. However the cases treated through the programme were cost intensive on the payment of specialist costs and logistics. In future, the project should consider either building local capacity or enrol more fistula patients for cost effectiveness. The project can also partner with other agencies and link with specialists who can offer services for free or at a lower cost. The concerted efforts of the entire health system have to be mobilized to respond to unmet needs for fistula treatment which is massive from many years of accumulation.

c. Effectiveness

In Puntland, the outputs of the project were largely achieved as envisioned. A majority of the women and girls know where to and are accessing the FGM/C services. Medical and psychosocial support services have been promoted though use of the referral mechanism. However, medical attention for FGM/C survivors remained a weak area of the project particularly for specialist services such as fistula. Psychosocial support was mainly provided through counselling. The project was successful in establishing and supporting community level structures for challenging the FGM/C status quo. The knowledge and awareness of FGM/C was created across the areas through various means such as advocacy initiatives such as 16 days of activism and other events, community dialogues, district FGM/C forums meetings, trainings of CECs, teachers, youth groups etc. In total, an estimated 1.2 million were reached through behaviour change messages. This demonstrates significant coverage under the difficult circumstances. Some level of operational research was conducted, but the utilization of findings through documentary was inhibited in Puntland.

The lack of government collaboration and support in Gedo region is a factor that overall reduced the effectiveness of the project as supportive policy framework were not developed on implemented. The support by religious leaders and clan elders was notable in pushing the FGM/C agenda. The involvement of Government in Puntland through a dedicated ministry was noted to be an important

factor supporting policy level FGM/C advocacy. The future implementation of such policies is what will make the real difference.

The security context in Gedo also reduced the effectiveness of the project as some key stakeholders were partly or not engaged at all. It took time to convince some interest groups such as, Al Shabaab that FGM/C affected their daughters or sisters. Also, among community leaders and religious leaders there is still acceptance of the *sunna* type of FGM/C. The shift from the more injurious types of FGM/C to this supposedly lighter form can be seen as a positive transitional step but a drawback to zero tolerance/ total abandonment of the practice. This demonstrates that the drivers of FGM/C remain, but the project managed to influence the communities in a way that the next phase can continuously build on.

The project also produced unexpected results. For instances, schools that were not targeted by the project were reached with FGM/C messages following the inter-school competitions, they formed their own FGM/C clubs as a result a clear spin-off of the FGM/C interventions in neighbouring schools.

While the projects resulted in the FGM/C practitioners stopping the FGM/C which was giving them income and status in the community, it is not clear which other alternatives that they pursued. As such, this can have relapse effect unless alternative livelihoods are provided to them such as other vocational skills, IGAs or small start-up businesses. However, caution should be undertaken to avoid a situation which appears to justify the FGM/C vice.

d. Impact

Despite the cultural stand on FGM/C, the behaviour change interventions implemented in this project have influenced the communities to reconsider a number of things about the practice. Data from qualitative sources indicated that a significant proportion of change agents have abandoned the practice. Equally, some communities have cushioned their girls from the practice, while others have opted for the sunna type of FGM. With some transition to the sunna type, there is an opportunity to dispel religious and cultural misconceptions since there is more clarity that FGM/C is not a religious requirement. Overall, majority of the communities are of the view that FGM/C is decreasing, indicating a good precedence for the next phase of programing

The main impact of the FGM/C project is more felt in urban settings where the SC/NCA programme is concentrated. Due to programmatic intervention, the practitioners are now moving from the urban areas to rural areas where the practice is undertaken under cover. It is however noted that rural areas are experiencing increasing cases of FGM/C/C implying that concentrating the interventions in the urban areas was a design gap. There is risk that urban communities might be taking the girls to rural areas for circumcision so that it appears that in urban areas the practice is reduced, while in fact it is the strategy that has change. Both rural and urban areas should be targeted.

The project has also influenced social-transformative behaviours. For instance, it was not expected that men would firmly sit and discuss the FGM/C issue as it was seen as a 'women's issue….', however men have witnessed the health complications that come with some forms of FGM/C and have incurred costs in medical bills that they now understand that FGM/C is a community wide problem demanding the attention of all.. The project has therefore brought new thinking regarding FGM/C and even other GBV issues in the communities. Though the full impact of this will take time to be achieved, there is

clear progressive shift from the conservative norm dominated thinking to more open and engaging position on FGM/C.

The discrimination of girls who are not cut is also reducing across the project areas. Uncut girls were previously not married and could not slaughter animals. Young men sensitized are now more willing to marry girls who have not gone through FGM/C mainly stating that they know the is health and economic benefits such as less medical bills due to birth complications and risk of fistula.

The project has transformed the lives of some fistula survivors who underwent reconstructive surgery in a big way. Majority who were discriminated and even divorced have their lives back. In fact one of them is married and expecting a child. From the catchments where the fistula treatment beneficiaries came from there are a sizeable number of women waiting for their turn to undergo this life changing treatment.

e. Sustainability

In both regions, the community momentum to continue the interventions for FGM/C eradication has has been put in place. However, the need to continuously facilitate the work of community structures requires some funds which are sourced externally. There have been limited efforts to generate any resources locally but the in-kind contribution of communities through participation in meetings, creation of space and other voluntary work has been notable. In the short term the project will therefore largely depend on external funding.

The sustainability of the project interventions particularly in Garbaharrey is partly pegged on the presence of a stable government, willing to change HTPs and development of key policies. This is likely not to happen in the short to medium term implying that NGOs such as NCA/SC will continue to play a key role in absence of effective government support. However the established community structures such as CECs, CWCs, youth groups and so forth can assure a level of operational sustainability by engaging directly with or without NGO support. The presence of militia groups is a challenge but some of them have been sensitized to accept the FGM/C interventions and seem to be cooperating. In Garbaharey for instance, the strategy used to solicit for AS support was by convincing them that the harmful effects of FGM/C did not spare anyone including their daughters, sisters and even their female relatives.

The sustainability of the FGM/C interventions in Puntland is more likely with the kind of on-going engagement between duty bearers and the right holders. The community structures established and trained are in place and committed to the fight while duty bearers including MOWDAFA are engaged in firmly pushing the FGM/C agenda and development of policies. The implementation of the same remains the main hindrance to the success of the entire anti-FGM/C effort.

In all areas, the projects cannot be said to have reached the point of self-continuity and sustainability. The project has made some significant impact and has achieved a number of outputs and outcomes, but will require to be continued for some time before they can take a life of their own. This is particularly so because the Anti-FGM/C networks and structures established under the project are still quite nascent and eradication of FGM/C which is deeply rooted in the communities is a longer term process, dependant on continuous community awareness and acceptance that the practice is inimical to women and girls' rights and wellbeing. Where there are FGM/C and sexual offences policies,

they need to be implemented, well-resourced and monitored. Where there are none, they need to be either developed or a level of declaration *'fatwa'* needs to be agreed and followed.

NCA and SC should lobby the government, particularly in South Central to develop and implement relevant FGM/C policies and to prioritize FGM/C and GBV issues in the national agenda. This will include establishing dedicated line Ministries that have sufficient budgets to support FGM/C work.

5. FACTORS AFFECTING PERFORMANCE

Challenges to program implementation

On the project implementation, there were a number of challenges to the overall performance. There however seemed to be more challenges in Gedo compared to Mogadishu and Puntland. The main challenges included the following:

Sexual and Gender Based Violence (SGBV)

- Taking legal action and reporting particularly cases of SGBV was hampered by harassment by perpetrators. This was particularly so since in South Central particularly; there is no proper justice system and no sufficient legal action/ enforcement taken against perpetrators.
- The protective environment for instance in Mogadishu is not adequately conducive in the IDP camps. This is coupled with general poverty which increases vulnerability where there is no sufficient domestic protection such as protected shelter.
- There is a trend where the noble idea of community security patrols has been increasingly commercialized with patrol groups demanding protection fee to beneficiaries who may not even afford. This of community security patrols has been increasingly commercialized with patrol groups demanding protection fee to beneficiaries who may not even afford. This is likely to pose as risky as such groups can turn into militia outfits and further expose the SGBV survivors to more harm. The project did not provide patrols as envisioned
- The SGBV survivors felt that the dignity kit was not complete without provision of shelter as some had been left homeless. Future support to the survivors will need to put such provisions under consideration to ensure that the gains made in other interventions are not eroded.

Female Genital Mutilation

- There is a perception in some communities that the stakeholders engaged in FGM/C work as change agents such as religious leaders are financially benefitting from the project. As such, some beneficiaries are not fully convinced of their interest and therefore not fully supporting the FGM/C fight.
- In some instances, the religious leaders are not fully committed to zero tolerance to FGM/C and accept the mild form of FGM/C such as *Sunna.* Though this is a mid-way progress, more needs to be done to convince them that FGM/C is the same regardless of the severity of the physical impact on the victim.
- There is a trend where the FGM/C practitioners are shifting to rural areas as the level of anti-FGM/C awareness increase in urban areas. This demonstrates that that the practitioners

advance FGM/C for their own selfish gains, hence challenging the project to come up with targeted interventions that not only address cultural and religious attitudes but also deliberate perpetration of the practice.

- The scale of services provided and accessible to FGM/C survivors does not match the massive need for treatment. This is particularly so for the complicated medical conditions such as fistula, and other related complications. he cost of correcting such conditions is prohibitively high for poor a family which implies that without external support, the FGM/C survivors will suffer from untreated fistula conditions including; birth complications and continued social exclusion.
- The medicalization of FGM/C is a key challenge to the reduction of the practice particular where the trained health staffs utilizes public facilities to undertake the cut at a fee. Considering that this takes place in a concealed set up, it not easy to hold health workers accountable. Thus working closely with health workers in mapping the vice from an insider perspective is recommended.
- Communities in Gedo are quite not ready yet for a fatwa declaration on FGM/C. They need more and deeper awareness and possibly a government framework that will criminalize FGM/C practice. Equally religious leaders need to be convinced about zero tolerance. The intensified efforts to address cultural stereotypes such as; misconceptions about benefits of early marriage need to be collectively addressed to reach at a declaration.
- The minimal engagement of Government authorities is a hindrance to the effective implementation of the FGM/C project as key institutional frameworks, structures and policies are not in place. This was particularly experienced in Garbaharey whereby the interventions that called for government support were largely curtailed.
- In Garbaharrey, the presence of militia groups poses a threat to effective implementation particularly because the Government local authorities are not able to support the FGM/C fight due to related risks and turnover.
- At partnership level, the context in Somalia did not sufficiently allow for mutual project implementation and lesson learning between SC & TASS and particularly between the Puntland and Gedo region. The anticipated knowledge transfer was minimal as each agency seemed to implement their own project. The Gedo region with various pocket of militia control and limited exposure varies from more stable areas of Bossaso, Garowe and Qhado where the project was implemented. Therefore the learning points between varied by context and were further limited by complex logistics.

> "…why don't you use this money on other important projects rather than concentrate on a simple organ of a woman……." a community member from Garbaharrey asked the enumerator.

- The response to FGM/C is a costly process which needs financing of community dialogue forums, fistula treatment and various other forms of facilitation. In a way the project faced funding limitations reaching some of the needs and will continue to struggle at the current scale of resources. The project for instance managed to reach 13 out of the many FGM/C survivors in need of surgical treatment.
- The results framework stipulated the outcome areas and respective indicators but there no M&E plan stipulating the process and targeting. Without this, systematic collection of data has been lacking beyond periodic reporting.

Project design and partnerships challenges - SGBV Component:

- While the main SGBV & FGM/C proposals submitted to donors are clear on overall outcomes, the document is not clear on what the target population per location is for each of the local partners particularly SSWC and IIDA. Additionally, partner proposals for SSWC and IIDA are not clear on what proportion of the total target beneficiaries each partner was to reach. This makes it difficult for the evaluation to establish whether the targets were reached or otherwise. Additionally, some of the proposals of partners are not standardized and not using the NCA format as would be expected therefor missing some crucial details.
- It was not possible to evaluate the work implemented by IIDA as the NCA partner did not cooperate with the evaluation team. The IIDA sub-grant only lasted 2014 implying the need to exclude it from most of the activities implemented in 2015.
- The IIDA project evaluation should have been done soon after the first year of the project lapsed. Understandably, undertaking the evaluation over a year later when staff had left and other agencies have probably intervened would have not been an ideal situation.
- The evaluation of SGBV in particular has noted some significant inconsistencies between the expected deliverables of the partners and what was construed to be actioned from the NCA main proposal. As such, in some instances, the NCA proposal may have an output but its delivery by the partners may not happen because it was not made explicit at the sub-grant approval stage. This is a design problem that should be addressed in the future, to ensure clear harmony between the mother project proposal and the allocated partner deliverables. Similarly, the template for both proposals and reporting to NCA are either not harmonized or followed consistently. The reports from both IIDA and SSWC demonstrate this fact.
- The project lacked an M&E plan and systematic way of data collection in respect to indicators, target, source and committed responsibilities. This limited data analysis and updates for any important implementation feedback.

6. LESSONS LEARNED & BEST PRACTICES

Both the SGBV and FGM/C projects elicited a number of lessons learnt and best practices that are enumerated in this section of the report. In general the partnership model between SC and NCA was a good test of replicating a successful model from Ethiopia to the Somali context. The approach where both the duty bearers and right holders are targeted with context-appropriate interventions ensures that FGM/C issues are addressed holistically.

Specific lessons learnt and best practices by each of the project component are detailed as follows:

Sexual and Gender Based Violence (SGBV)

- The engagement of both men and women in couple counselling with a good strategy to reduce cases of SGBV and particularly domestic violence in zone K
- The SSWC support centre is a good model through which SGBV survivors receive services in an integrated set up. The centre is able to address multifaceted needs of the SGBV survivors. The structures and systems established in the centre serve the survivors without the need for additional investment. This can be replicated in other areas.
- The success of SGBV programming can be better if provision of shelter is an integral part. Without shelter women and girl remain vulnerable despite other risk reduction measures ,

- SGBV survivors as the best agents of change due to their first- hand experience with the vice. Once supported to speak out, their level of commitment to the SGBV cause was found be commendable.
- Empowerment of SGBV survivors through vocational training and business start- up was found to not only accelerate healing but also reduce domestic violence associated with struggles for livelihoods.
- The discrimination of women and girls within the context still makes them vulnerable to victimization even after undergoing physical violence and sexual violations. This fear undermines case reporting, disclosure and inability of women to stand up for their rights giving SGBV fertile grounds for continuation.

Female Genital Mutilation / Cutting

- It is important to take time and convince the dissenting voices of the need to change their position as was successfully done with militia groups in Gedo who eventually supported the fight against FGM/C. The militia were convinced that those who go through FGM/C and suffer during child birth are their daughters and sisters – this seemed to convince them and they allowed the campaigns against FGM/C to continue.
- There are small pockets of efforts to recompense victims of FGM/C by the practitioners. In Gedo, there is a local guideline, sort of a social contract that is being followed to ensure that practitioners compensate their victims for FGM/C acts – if fully implemented, this is likely to lead to reduction in the supply side of the practice. But there is also need to address the demand.
- Increasingly there is open repentance and offering of apologies by the FGM/C practitioners who decide to come to the open and declare a stand against the practice. Religious leaders for instances in Gedo have declared that there is no going to mecca for practitioners as a sign that they have to stop the practice.
- There is a level of positive deviance by male role models, some families and religious leaders who have shun the FGM/C practice. These can be used in the future to continue to change the behaviours, attitudes and beliefs on FGM/C.
- School based anti-FGM/C efforts seem to be bearing fruits with young people indicating their willingness to marry uncircumcised girls. Such interventions have the potential to lead to a generation of people who will completely be against the FGM/C practice in its various forms.
- Some families have abandoned FGM/C/C practice; this shows some changes in community beliefs and attitude, hence long term strategy would be required to ensure complete attitude and culture change into positive outcomes. There is need for the project to extend to the far rural areas where FGM/C/C is rampant, and where FGM/C practitioners seem to be relocating to.
- Despite having knowledge on the harmful effects of FGM/C, Some mothers prefer social protection provided by culture by upholding the practice rather than face the consequences which could result from defying the cultural norm. They fear their daughters being shunned and stigmatised –hence would rather sacrifice the health of their girls as opposed to seeking for medical support during complications. However it is also important to note that with sufficient and regular awareness raising, some mothers and fathers understand the complications of FGM/C/ and are willing for their children to undergo medical treatment. They also understand the value of providing adequate emotional support for FGM/C survivors

during and after medical treatment to ensure the integration and acceptance of these young girls into society.

- Religious leaders emerged to be strong champions against FGM/C despite the religious misconceptions. The leaders demonstrated remarkable commitment which was reflected in recognition by communities as one of the principal sources of information on FGM/C. Religious leaders will continue to be important players in the pursuit of zero tolerance to FGM/C. Their role in the program should be intensified.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 SGBV Conclusions and Recommendations

a. Conclusions on SGBV

Outcome 1: Women and girls in Humanitarian and conflict situations are protected against GBV

Increased Awareness on SGBV

The project made substantial gains in raising awareness in the target areas. The direct beneficiaries of the project were largely reached with appropriate information which has been manifested in increased knowledge among the SGBV and the right holders. Overall, there was an improvement in awareness delivered the planned channels, but in one partner areas it was not possible to establish the status. Even as the project made efforts to improve knowledge and awareness some pockets of of misconceptions remain. SGBV lacked the legal and human rights understanding of various violations implying limited comprehensive information that will need to be continuously pursued. This will be important for identification and case reporting for targeted response.

The project has demystified SGBV and made women in IDP settlements more conscious about the security risks that they face including the importance of case reporting. Women are now aware of need to avoid dark alleys and potential hotspot such as firewood collection points. Equally, SGBV survivor received solar lights and cooking stove to avoid risks from exposures. Through the awareness interventions, the project has increased reporting through mobile phones to GBVIS. In nutshell the project has delivered tangible results as far as awareness is concerned but fell short of comprehensive information which is requires more time to internalize.

Reduced Risks and Exposure in Target Areas

To a good extent, the reduction of risk and exposure of women and girls from SGBV issues was significantly successful and innovative. The risk reduction items such as cooking stove and solar lamps were provided in a fair criterion. As a result of this intervention SGBV survivors feel more protected. The project did not establish the planned security patrols and this negatively affected the broader risk reduction objectives. Overall, women individual and household security risk was reduced but the community environmental still harbours some risks in absence of security patrols.

Outcome 2: Right holders have been provided with psychosocial, medical and other assistance

Physical, psychological and economic coping capacity among women and girls survivors of SGBV

The project addressed the adverse consequences of SGBV by responding to their physical, psychological and economic needs that were important for their recovery and stability. It was confirmed that SSWC provided dignity kits to targeted beneficiaries. In one way or other, the organization provided psychosocial support through the project to right holders though it is not clear what scale was expected. The project increased access to psychosocial services and built local coping capacities with resultant improvement in case reporting.

Dignity kits: Most of the GBV survivors were of poor vulnerable backgrounds hence they lacked the basic provisions for human dignity. The project took an important step in restoring dignity to GBV survivors by providing a kit that constituted basic provisions for dressing and glooming. The provision of dignity kits restored the confidence of women and girls with improved participation outcomes in other activities. The selection criteria ensured that the more needy and deserving received them kits generating more impact.

Vocational training: The vocational training for GBV survivors was one of the high impact interventions that not only addressed the immediate causes of GBV, but empowered women for prevention and deterrence. The GBV survivors have benefitted from the tailoring course and provision of a business start-up package which has enabled them to start their own business. The GBV survivors are now on the path to becoming self-reliant with their tailoring and related businesses providing livelihood, stability and deterrence from SGBV. The increased economic independence has reduced vulnerability that emanated from various exposures in the quest to provide for themselves and their families. With women more empowered, domestic violence emanating from disagreements over household provisions is significantly addressed.

Psychosocial support: The project through SSWC SGBV survivors centre known as Hawa Tako in Mogadishu has provided medical assistance and psychosocial support to right holders from the catchment communities as planned Beyond the basic provision of services, the centre has created the demand and provided a safe space for women and girls to recover and to speak about SGBV which was previously characterized with stigma and silence. The involvement of men in conflict resolution was observed with men affirmatively participating in couple counselling and other joint initiatives to address domestic violence.

Health Services: The project ensured provision of medical services particularly through the GBV care centre and through other health facilities. Though the services were utilised, there were fears of confidentiality, fear of divorce on realization of rape and fear of attack and retribution. Majority of GBV survivors specially FGM/C and rape reported they had no access to specialized treatment. In fact some of them suffer from post episode trauma symptoms to date. The project has been able to provide primary health care services but lacked specialized case management capacity. Similarly there was no evidence of effective referral mechanisms, beyond the GBV care centre. The SSWC centre had the capacity to only handle primary health care and psychosocial services. Similarly, the catchment health facilities lacked options for specialized treatment. In the next phase therefore, more efforts should go into improving access to user friendly services, structured referrals

Male change agents: There were a few male role models or change agents that latently involved in the project particularly on issues such as couple counselling. The consensus resulting from the process was found to be important in reducing the occurrence of GBV at household level. The success of response on SGBV will therefore continuously require involvement of men, thus the projects should consider bringing more men on board.

Increased Capacity of Medical Providers on SGBV Response

The training of medical providers on SGBV as planned was a missing link in this project. The delivery of user friendly services with special considerations for the SGBV survivors depended on the capacity building of health workers which wasn't delivered. Notably WHO had conducted some health workers training which the project rode on. The capacity building of health workers to deliver these services is an important link that will need to be continuously pursued.

Outcome 3: Women have participated in peace building processes at local and national level

Religious leaders advocate for women involvement in peace processes

The intended use of religious leaders to influence inclusion of women in peace building was not achieved as planned. The role of women in peace building was linked to religious leaders training on UNSCR resolution 1325 which was not realized. However, women and GBV survivors were trained on peace building as change agents important for peace building at the local level. The project therefore built capacity for peace build locally but the national level involvement of women through project and religious leaders influence fell short. The next project will need to revisit this intervention for any meaningful peace building. Support for religious leaders and higher level leadership is required for involvement of women in peace building as cultural barriers and threats from various interest groups discourages them.

Outcome 4: Duty bearers are influenced to implement UNSCR 1325 and related resolutions

Increased Knowledge base of duty bearers

The project combined training of duty bearers and right holders in the quest to improve their knowledge to influence in implementing UNSCR 1325 and other resolutions. The duty bearers trained included the camp leaders drawn from various settlements thus the oversight to implement the resolutions in the camps is made available. However it is clear that the duty bearers such as higher government officials with greater influence in implementation of resolutions were not reached. This implies that the implementation of the resolutions may be affected by limited political will.

The project reached women leaders as right holder and duty bearers for their integral role in peace building through training. Due to delays in training and engagement, their contribution to implementation will be followed and felt in the next phase. However the camp leaders with improved knowledge will continuously apply the principles support of its ideals.

Religious leaders influence attitude change of GBV

The religious leaders through the mosque platforms were instrumental in disseminating anti-SGBV messages in target locations. Despite lack of non–targeted trainings, the religious leaders reached out the public with key messages. Although religious leaders demonstrated some efforts in influencing attitudes, better results would have been attained through project based training and structured engagement which did not take place. This may be considered as a priority in the next phase of programming. The project intended to use the religious leaders to influence behavior change on SGBV on the basis of their standing in the society. Though the project did not provide targeted trainings for religious leaders, a few were quite instrumental in integrating anti-SGBV messages in mosque sermons. In some areas, it was noted that religious leaders have also gone public with the key messages in various forums but the low coverage suggests that not many of them were involved. However, it appears their verbal dissemination of information did not directly influence attitude change particularly among women since they do not attend mosques. In addition, there is a level of project ownership in the community whereby the camp leader and religious leaders reported that even in the face of external support, the duty to protect vulnerable women and girls remains with the community.

b. Recommendations on SGBV

Based on the findings a number of recommendations for closing the gaps have been made as follows;

- There is need to empower women and girls to stand up for their rights and link up with appropriate networks locally and nationally.
- Enhance and deepen programmimg efforts at the institutional level along with creation of enabling legal framework. This is in cognizant of the fact that the war against SGBV is far from over and higher scale of response is required.
- The component of community patrols should be strengthened to have the expected deeper impact on household level interventions of reducing risk and exposure of women and girls. Security patrols should be embedded in the community structures so that the associated costs are removed.
- Future initiatives should consider providing improved shelter so that the protective environment is improved significantly. Notably, the success of other initiatives is to an extent dependent on security at the household level.

- Integrate men in support to SGBV survivors to ensure that solutions to SGBV have far reaching effects. This can be built on couple counselling documented as one of the good practices
- Follow up and support to vocational trainees should be well integrated in the project design. This can include further trainings such as in business skills and technical areas such as; repair and maintenance of equipment provided during the training.
- Strengthen the medical referral mechanism particularly of complicated cases requiring specialized treatment and care
- Specifically target men as change agents and role models so that the attitude change on issues of SGBV and women empowerment in general gets rooted in the communities
- It will be important to target school children and school set-ups with SGBV preventive work as this is likely to have a long term effect. This has been effective in the sister FGM/C project.
- To enhance health support, provide trainings to medical providers so that the entire continuum of care and support for SGBV is completed.
- Support trainings of religious leaders and other community leaders on their role to support GBV survivors and more so at the strategic level such as; engaging with government on policy issues
- Strengthen religious leaders involvement in championing against SGBV for the special status they occupy and their convincing potential
- Project interventions particularly focusing on behaviour change should be done early in the project life to allow sufficient time for realization of results.
- Male involvement in required as part of the solutions to SGBV. However this needs to be balanced to avoid infiltration of perpetrators who may potentially bring more harm to SGBV survivors and women in general. It is important that empirical and action research is periodically undertaken to generate evidence and viewpoints for effective design and informed implementation.

7.2 FGM/C Conclusions and Recommendations

c. Conclusions on FGM/C

Specific objective 2: To assess the extent to which GBV survivors and groups at risk had access to medical and psychosocial support and livelihood support services

Outcome 5: GBV survivors and groups at risk have access to safety and justice

The FGM/C project successfully provided both medical and psychosocial support to the beneficiaries in the two project areas of Garbaharey and target districts in Puntland state. However the services provided were basic through the normal health system with no referral and specialized treatment. The scale of the unmet need for specialised fistula treatment remained costly for project although some cases were managed. The beneficiaries of fistula surgery had a life changing transformation. Notably, future programming need to closely engage the health sector and mobilize national level support and attention towards treatment of fistula cases which are beyond the scope of one project.

The project has effectively reached various right holders with key messages and built some momentum for focused start to FGM/C abandonment. However, various cultural bottlenecks remain in the way of fully embracing zero tolerance to FGM/C. The next phase will need to step up efforts in dispelling various myths, cultural and religious misconceptions on FGM/C.

Specific objective 4: To establish the level at which communities, faith and community-based organizations have been influenced to transform and change dominant social norms which include beliefs, attitudes, behaviours and practices that uphold FGM/C as a form of GBV through program intervention

Outcome 6: Faith and community-based organisations have been influenced to transform and change beliefs, attitudes, behaviours and practices that uphold GBV

It is clear that there is increased knowledge and awareness across the project areas on ways, means and support services available for preventing and reducing FGM/C cases. Various means of awareness raising have been used to influence religious leaders to support transformation of beliefs, attitudes, behaviours and practices in communities. The religious leaders have effectively made it clear that FGM/C has no religious foundations. This is however characterized with misconceptions in a few others. Through community dialogue and school awareness, the project has recorded remarkable achievements in transforming attitudes and behaviours among the target groups. On this outcome, the project only faltered in not advancing dialogue and awareness through the out of school youth clubs. Community leaders have made efforts to hold the practitioners to account for their actions. Notably, community and religious leaders have come up with innovative proposals for compensating FGM/C survivors further underscoring the extent to which they have been influenced under the project. The overall contribution of religious leaders and community leaders in this project went on as originally envisioned.

Owing to these interventions, there is a general feeling that incidence of FGM/C is going down. The increased transition from extreme FGM/C to the sunna type is indicative of a community on threshold to change. The same has been manifested in Puntland whereby, community and religious leaders rescued 12 girls from the cut. In the same location, similar influence saw some families declaring no cut for their girls in the spirit of collective positive deviance. At the schools; teachers, the CEC and students were engaged as planned. Resulting from this, boys declared that they will marry

uncircumcised girls unconditionally which emboldened the girls in questioning the marriage rationale to FGM/C. The project has elicited the need for change and actual change but still contends with deeply seated cultural draw backs which will need to be continuously addressed. Little efforts have gone in undertaking operations research to generate evidence for more targeting programming.

There is evidence of knowledge transfer, as visualized from the replication of the SC/NCA Ethiopia FGM/C/C partnership model between SC and NCA but between Gedo region and Puntland State had little sharing of field experiences. Besides the final project reports which are activity-based, there is no concrete documentation of the project model, impact and lessons by the project partners.

Specific objective 5: To assess the extent to which faith and community-based organizations have been mobilized to prevent and reduce all forms of harmful traditional practices

Outcome 7: Faith and community-based organisations are mobilised to prevent and reduce all forms of harmful traditional practices

Notably, the project managed to transform and engage religious leaders and community leaders in influencing communities to abandon FGM/C. As envisioned, the religious and community leaders were instrumental in championing for the abandonment of the practice. The religious leaders were particularly central in advocating behaviour change through mosque sermons and other forums. As indicated in the foregoing sections, some religious and cultural misconception regarding the sunna type of FGM/C in a way affected harmonized messaging on FGM/C abandonment.

The project envisioned to engage all players in making declarations (fatwas) on zero tolerance to FGM/C. In Puntland declarations were made with reasonable success. This wasn't the case in Garbaharey in which the community, religious leader and various dialogue members felt that the community wasn't yet ready for the declaration. This is despite the fact that tangible gains have been observed in changes of attitudes, behaviour and general perceptions of the FGM/C practice. It is therefore clear that in Garbaharey, the interventions have influenced small group and behaviours but the wider community may not be fully mobilized to abandon the practice. In Garbaharey, the interventions were concentrated in the urban centres which again imply to make a declaration encompassing both rural and urban areas may have been inappropriate. Failure to make a declaration may have been driven by fear of militia that controls some swathes in the district. The pursuit of declarations in Garbaharey and follow up and renewal in Puntland should be enhanced in the next programming phase.

The communities are aware of leaders that have made declarations on against FGM/C practice. Gardo and Bossasso have the highest number of leaders that are known by communities to have made declarations. Following these declarations, families' particularly in Puntland have also taken a person stand with 40 families deciding not to cut their girls. Some girls were also rescued from undergoing the practice implying that both parents and practitioners were convinced to stop the practice. As mentioned religious leaders are at the forefront of fighting FGM/C followed by government officials and male role models. The pronounced support of religious leaders to the fight against FGM/C is a clear indication that the argument that the practice has some religious foundation is challenged, though some religious leaders still support some forms of FGM/C.

The analysis further shows waning support for FGM/C continuation implying that communities are better enlightened on the harmful dangers of the practice. However, the realization of FGM/C abandonment faces hurdles from one third who openly support the continuation and fact that support for discontinuation have not fully translated into practice. This indicates that the project has scored in changing attitudes and behaviours to some extent, but reversing the practices to scale will need some time. The next phase will need to aggressively counter the drivers of the practice amidst changing attitudes. The observed district variation in support for FGM/C continuation that may call for some context-specific variations in approaches being used. There is need to generate pertinent information that exhaustively addresses various gaps in attitudes, practices and detailed account of the drivers at various levels in order to take the response to another level.

Specific objective 6: To assess any changes in knowledge, attitude, practices of government authorities, civil society, teachers, community members and children in challenging FGM/C practices.

Changes in knowledge, attitude and practice – Government authorities

This project managed to mobilize the support of government in Puntland. The planned engagement of government in Puntland was effectively delivered through the MOWDAFA that has national and district level presence was important for implementation of the project activities. The government officials were in the forefront in support for policy development, including the anti-medicalization of FGM/C and positively supported the declarations (fatwa). This not only reflected their change of attitude but also demonstrate their drive in taking the FGM/C agenda forward. The government presence in Garbaharey was minimal, thus the project was not able to mobilize the support. The government authorities were aware of the project and provided enabling environment but no structured support. The turnover of administration officials and volatile security limited government participation. Apart from initial resistance from Al Shabaab, the project did not face hurdles. In the next phase, the project will need to strengthen the government relationship in Puntland and initiate structured partnerships with Garbaharey authorities for better impact.

Changes in knowledge, attitude and practice – Civil society including UN agencies

The support for FGM/C activities in various civil society and UN agencies has been on-going. Through this project the same has been enhanced, while direct support of TASS as partner has been achieved. The harmonized response to FGM/C through the working group was instrumental in bringing together the efforts of all in FGM/C response. Again, in Garbaharey, there was no inter-agency coordination as no other notable agency was engaged in FGM/C response. Even as much as NCA was focused on bringing other players on board, it wasn't possible. Overall there were better coordination outcomes on the Puntland side. In the next phase, mobilization of the local civil society and regional cluster will be required of the Gedo side.

The UN agencies and civil society agencies are working jointly under working groups and task forces to address the wider GBV issues in Puntland. They have regular meetings and have in place information sharing and reporting mechanisms that are used by all. In Garbaharrey, the FGM/C work is largely

taking place in the urban settings and is mainly lead by NCA with no other notable agency in the region.

Changes in knowledge, attitude and practice – school teachers and students

A number of interventions brought together teachers students and CECs as planned. Effective behaviour change interventions were delivered through appropriate methods. As envisaged, all the targeted groups demonstrated changes in attitudes on FGM/C with additional sense of responsibility. Teachers were in the forefront of campaigning against FGM/C and child early and forced marriages (CEFM) taking the challenge to the community and in Garbaharey convincing the local militia to support the initiative. Students including girls and boys were enlightened on the harmful effects of FGM/C with girls taking a firm stand against the cut while boys declared their unconditional willingness to marry uncircumcised girls when time comes. The coverage of the school interventions was substantial with more school youth reached than targeted. Reports from households indicated that even parents were aware that their children received key FGM/C messages from schools. The intended results to change behaviours attitudes and practices for teachers, school children and youth were achieved as envisioned. However, since a segment of 8 schools each in Gedo and Puntland were targeted, the next phase will need to upscale to other areas building on these results.

Changes in knowledge, attitude and practice – community members

In general, community members from across the project target areas in Garbaharrey and Puntland were well mobilized to abandon the FGM/C practice. The analysis indicates that larger proportions support discontinuation of FGM/C. Equally, majority indicated that they would not allow their daughter or sister to be circumcised. However, it is important to note that the community will need to be supported to translate the attitudes into practice. The community leaders with support have taken some pertinent roles such as developing some compensation guidelines, taking collective responsibility in urban areas that forced FGM/C practitioners in urban areas to scale down the practice. The interventions under this project delivered key messages to community members who embraced appropriate attitudes. However, due to the deeply embedded culture, it will take longer to abandon FGM/C and achieve zero tolerance. Some segments of the communities were receptive to various initiatives and directly acted to rescue girls from FGM/C, establish FGM/C free areas and supported locally drawn retribution guideline to compensate the survivors.

Specific objective 7: To assess the relevance, capacity and sustainability of the various structures (e.g. district FGM/C forums, FGM/C Task Force, etc) including community based structures established and supported by the programme.

The project has established effective structures that will continue to drive the FGM/C agenda locally even after end of the project. The community dialogue structures, Puntland Anti –FGM/C network, FGM/C task force and GBV working group have adequate local ownership and drive to advance FGM/C work. The project has also continuously built the capacity of the local structures which implies that the scale up and continuity of the FGM/C work can easily be undertaken. This project has also created good synergies that are important for information sharing and effectiveness. In Garbaharey for instance, the community indicated that FGM/C is their problem and were enlightened and ready to take it on ,regardless of whether they received external support or not. With such willingness, a little facilitative external support will go a long way in advancing zero tolerance.

d. Recommendations for FGM/C

In all project areas, the projects cannot be said to have reached the point of self-continuity and sustainability. However, the project has made significant impact while creating path for changes in attitudes, perceptions and behaviours. Notably, it is clear that the response against FGM/C will require some time to address as some of the drivers are culturally entrenched to yield in the short term. From the foregoing conclusions, several recommendations focused on gaps and programme improvement has been made as follows;

The more specific recommendations for the FGM/C project are as follows:

- There is need to enhance the work of FGM/C support networks and structures to continue championing for abandonment of FGM/C which is a long-term process. The structures need to be expanded to bring on board health workers, reformed practitioners and law enforcers
- Since FGM/C is still deeply entrenched in culture, there is need to continuously generate evidence to break the barriers through structured and action research
- Follow up the progress of fatwa implementation in Puntland and mobilise support for inclusive community driven process for fatwa declaration in Garbaharey
- Accelerate the development and implementation of FGM/C policies in South and solicit support for implementation of locally driven compensatory guidelines for FGM/C survivors and other mechanisms in Garbaharey
- There is need to map health workers who are medicalizing FGM/C for programme targeting and provide awareness raising to change their practices. The finalisation and adoption of the anti-medicalisation policy is important in order to ensure that legal action can be taken.
- Sustain behaviour change communication in target areas expand the similar interventions in the rural outreach areas which have comparatively higher FGM/C prevalence.
- Improvement of basic health services for FGM/C survivors is important to address non complicated cases. Fistula repair is a widespread problem requiring national level resource mobilization and building capacity of hospitals to handle fistula cases or alternatively refer for specialized services / scout for specialists to provide services inside the country
- Increase access to legal aid so that the case reporting can be effective and can act as a deterrent measure to the FGM/C practitioners and perpetrators of GBV in general
- Strengthen the role of religious leader in fighting FGM/C by training, providing the right tools and recognizing the champions through rewards. The list of religious leaders should be expanded to fully address potential religious misconceptions
- Increasing budget allocation for community dialogue and for support for FGM/C survivor is important for improving results. This calls for additional efforts in resource mobilization
- Enhance school based activities as children, being young, are more likely to absorb and internalize the anti-FGM/C messages and bring long term societal behaviour change
- Strengthen and expand communities that have declared a stand against FGM/C, follow up support should be provided to reduce veiled community pressure on them. This can include some form of a reward or incentives systems for those who pursue positive deviance
- Enhance support to community structures, such as Child welfare & Community Education Committees as well as the district FGM/C programmes existing in the community. Where possible the structures should be recognized for their work

- Establish or reach out to out of school youth by building on the success made in school awareness campaigns
- The men as role models strategy should be deepened to gain acceptance in the efforts to stop FGM/C. This is particularly critical as Somalia is largely a patriarchal society. This will reduce the negative masculinities promote gender equality and give women a voice in promoting zero tolerance to FGM/C as victims.
- Enhance use of radio as it has more audience reach and conduct surveys to ensure that the messages are reaching to and their content messaging strength and impact
- Enhance ways of knowledge transfer between the project partners as this is a key pillar of the project partnership model – this should go beyond basic project collaboration, coordination and reporting to back donors.
- There is need to target rural areas with anti-FGM/C work as there seems to be a diversionary tactic where FGM/C practitioners could be relocating to rural areas due to push-factors in urban areas as a result of the FGM/C project.
- Strengthen M&E systems not only for reporting but generation of strategic information for planning and decision making on key elements of the project.

8. LIST OF REFERENCES

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9. LIST OF ANNEXES

Annex 1: Sexual and Gender Based Violence (SGBV) Case Study

Case Study 1: Ambiya Ali Osman- A success Story;

My story from pain and anguish to success in business

The life of Ambiya drastically changed forever the day she was raped as she was fleeing conflict from south Somalia. She screamed for help, but nobody heard. Ambiya was completely shattered by the incident but did not lose her will to survive. With the support of SSWC who gave her psychosocial and medical support and also dignity kit and it was not long before she was back on her feet again. She is a beneficiary of the vocational training course.

Today, Ambiya is a successful small-scale entrepreneur who is busy in her small shop stitching clothes for the IDP community. This important change in her life happened after she joined the NCA funded project of the vocational training on tailoring which is provided for GBV women in the camp where she lives. She was lucky to be selected as a lot of other women survivors of violence are still languishing in poverty, carrying stigma every day, with humiliating scars of rape, physical assault without any help.

"Today am really happy and grateful for being part of this great initiative and I can't thank you enough by looking back how my situation was and now it shows there are good people in this world."- Ambiya Ali Osman

Annex 2: FGM /C Case Study

Success Story: 'I am not cut and will never be'….!!!

Fatima Kassim Abdullahi is a jovial 11 year old girl who is not circumcised. She hails from Garowe town and attends Dawaad primary school. She lives amongst a community that has practiced FGM for

a long time. But this time, she was lucky, thanks to NCA anti-FGM schools based initiatives advocating for abandonment in schools. Fatuma lives with her mother and has two elder sisters who have undergone FGM. There are fifteen girls in her class and she is among the few un-cut. Her mother, Lul Jama, underwent female genital mutilation- FGM/C when she was 8 years old. "It was very difficult," says Lul. "Being cut is an event I will never forget." Lul has two older girls both of whom have undergone FGM. The pain and suffering they share was a burden in her home that lead her to decide not to subject her youngest daughter, Fatuma to the cut.

"We are willing and ready to act as an example to parents, leading the path for others in the region to abandon the practice." Lul says.

Oblivious of the pain and agony her mother and sisters have under gone over the years, she brags to be the only un-cut girl in her family. Fatuma is confident and happy. She is top in her class. She looks older than her age mate, something her mother say is because her daughter is 'complete'. Fatima's dad supported her mother decision not to cut her. In a highly patriarchal society, Lul and her husband came into consensus in saving their youngest child of the agony and pain of circumcision and the risks associated with the act in her future days.

"My mother took a very courageous decision to go against our tradition. Girls talk about me in school" says Fatima. "I want to be a female doctor when I finish university so that I can help women and advise them against FGM in my country", says a jubilant Fatuma. She says" It will be a good gesture if all girls are educated and informed on the danger of FGM in Garowe and in the whole of Somalia"

The practice has been carried out for hundreds of years and involves cutting or other damage to the female genitalia. In its most extreme form - which is carried out on 93% of girls in Somalia - all the external genitalia are removed and the girl's vagina is sewn up.