
# Trocaire
# Gender Analysis Report
# Gedo Region, Somalia
# September 2019
# Trocaire

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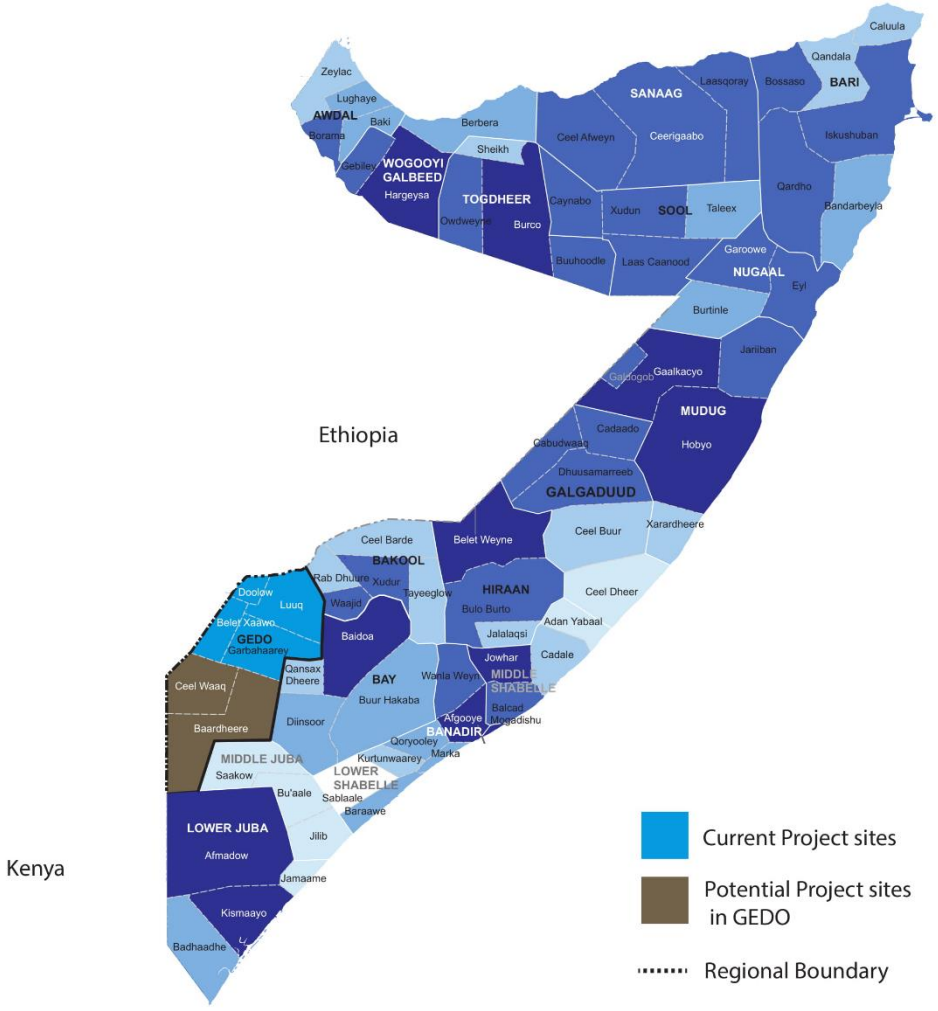
# Abbreviations

| | |
|---|---|
| IDP | Internally Displaced People |
| FGDs | Focus group discussions |
| WaSH | Water, Hygiene and Sanitation |
| SGBV | Sexual Gender-based violence |
| FGM | Female Genital Mutilation |
| IEC | Information, education and communication |
| KIIs | Key informant interviews |
| PwD | Persons with disabilities |

# Executive Summary

Somalia has experienced protracted complex emergencies resulting from high levels of poverty, decades of conflict, severe droughts and even famine. According to the 2019 Index for Risk Management (INFORM), Somalia tops the country's most at risk of humanitarian crisis like floods, droughts and conflict. The country has high vulnerability of the population exacerbated by inequalities and displacement and the lowest coping capacity necessitating humanitarian interventions.[1] With an emerging federal government, much of the basic services including education, healthcare, and access to water remains largely unavailable and provision of these services is dependent on support from Non-Governmental Organizations. In the past 2 years (2017- 2018) massive investments on drought response by humanitarian actors averted a famine. Conflict, drought, and the search for basic needs continues to push displacement in Somalia with 2.648,000 internally displaced as at August 2019.[2] For the purposes of this gender analysis – displacement and drought were selected as reference crises for IDP and host communities respectively.




Trocaire works in four districts of Gedo; Luuq, Dollow, Belet Hawa and Garbaharey. This assessment focused on Dollow and Luuq district; the former hosts the largest Internally Displaced People (IDP) population in Gedo region with the last estimate recording 75,684 IDPs in Dollow.[3]

The Gender Analysis involved six FGDs per location and five key informant interviews (KII) and observations. Data collection took place 15th-16th September 2019.

[1] INFORM (2019) INFORM Global Risk Index 2019 Midyear available at https://drmkc.jrc.ec.europa.eu/inform-index/Results-and-data/INFORM-2019-Results-and-data

[2] UNHCR (2019) Operation Update Somalia available at https://data2.unhcr.org/en/documents/download/71541

[3] CCCM Cluster (2018) Estimated number of IDPs at sites assessed by CCCM (in 48 districts) available at https://data2.unhcr.org/en/situations/cccm_somalia

## Summary of key findings:

Vulnerability; both IDP and communities that have lived in Gedo, referred to as host community in this report concur that persons with disabilities and elderly are the most vulnerable due to their limited mobility, ability to work and are also inherently often excluded from humanitarian assistance.

### Barriers to accessing services

Major barriers to access observed in FGDs are services/interventions being limited compared to the need, physical location of services and unfair distribution/access to services; exclusion of minority groups based on clans/linguistic group was mentioned.

### Gender roles, responsibilities

Gender roles and responsibilities has seen a shift particularly at household level. Before displacement, men were breadwinners in their families and women did not work outside the home. After becoming displaced, women have become breadwinners and now work outside the home doing manual labor such as washing clothes for other people. Men on other hand noted the lack of livelihood opportunities as a major challenge to fulfilling the role they had previously of supporting their families' basic need

### Decision-making

Decision making in the public sphere is very much a male preserve. Women are not represented in the leadership structures in camps and have no decision-making role for community resources including humanitarian interventions, at family level women also have limited decision making with financial decisions being reserved for men particularly in the IDP community.

In the host community, women reported to have more decision making in individual resources such as a business but when it came to other assets such as land and agriculture men are prime decision makers.

### Protection of Women and Girls

While this gender analysis did not go into details about gender based violence (GBV) risks, some concerns were raised about women and girl's safety in FGDs and Key Informant Interviews (KIIs) explicitly mentioned prevalence of gender based violence and challenges for survivors to access services. In FGDs lack of gender-segregated latrines, inadequate number of latrines, lack of lighting in latrines and water facilities being located far from households was observed as protection risks for women and girls. Discrimination of women and girls as well as, rape, Female Genital Mutilation (FGM), early / forced marriage were identified as GBV affecting women and girls and restricting their enjoyment of their full range of rights.

### Access to information

In IDP communities, women majorly cited lack of information sharing by both humanitarian organizations and camp level leadership (Chiefs, block leaders) as the main barrier to their participation in community decision making.

### Exclusion

Exclusion of marginalized groups (linguistic – MayMay speaking community) there is intimidation of this language group and prejudice towards them, "Maymay isn't seen as a language and this community is looked down upon" respondent. "Sometimes names are removed from distribution lists because of tribalism" respondent

# Context Analysis

The culture of Somalia is patriarchal; women are discriminated against in many facets of life from life in the home to the political sphere. Women hold negligible places in public life and efforts to reform the status quo is often met with resistance, women in the public sphere often face threats to their live over their work on women's rights. [4] Emergencies affect men, women, boys and girls differently, the preexisting social norms particularly inequalities are exacerbated during emergencies resulting in higher vulnerability based on gender, identity group (clan), disability and displacement.

Decades of conflict is Somalia resulted in a shift in traditional gender roles; women took on breadwinner positions, which was a preserve of men in the pre-war era. More than half of Somali households are female headed, and approximately half of female-headed households are living below the poverty line. Furthermore, the country is one of the poorest in world with 69% of the population living in poverty according to a World Bank survey. Rural and internally displaced households are most poor due to lack of remittances, which the rest of the population accesses.[5]

Somalis share a culture and ethnic identity but Somali society is divided along intricate lines of clans and sub clans. Somalia has a noteworthy size of minority groups who have faced systematic discrimination for decades. The Rahanweyn clan is the largest minority clan who have a presence in Gedo and speak their own unique dialect of Somali known as **'afmaay'**. Other minority groups exist within Gedo, some have been assimilated by the Rahanweyn[6] Minorities have limited protection and access to basic services even humanitarian aid is subject to diversion by dominant clans. Additionally the minority groups also form the bulk of internally displaced persons (IDPs) in Gedo region and are people who fled from neighboring Bay and Bakool regions.

IDPs often live in undignified situation where they face a myriad of issues that deprive them of their rights such as unlawful evictions, poor housing and sanitation coupled with limited access to basic services. There is increased risk of GBV partly driven by negative coping mechanisms to crisis such as child marriage.[7] While all women in Somalia face protection risks. IDP women face multidimensional risks due to the intersectionality of their identities as women, from minority groups, household heads, divorcees etc. Sexual abuse and harassment is perpetrated against IDP women more by host community than by other IDPs "they take advantage of us because we have to go out and find work on our own". One woman also observed that locals call them names/ insult them – indicative of the wider discrimination minorities' face in both Luuq and other places.[8]

[4] United Kingdom Home Office (2018) Country Policy and Information Note Somalia: Women fearing gender based violence available via https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698322/somalia-women-fearing-gender-based-violence-cpin.pdf

[5] Somali High Frequency Survey Wave I (February 2016) Overview and Preliminary Results, Utz Johann Pape and Johan A. Mistiaen, Global Poverty and Equity Practice, The World Bank July 21, 2016

[6] De Waal Alex (1994) THE UN AND SOMALIA'S INVISIBLE MINORITIES available via https://www.culturalsurvival.org/publications/cultural-survival-quarterly/un-and-somalias-invisible-minorities

[7] Protection Cluster (2018) Somalia Humanitarian Country Team, Centrality of Protection Strategy – 2018-2019 available via https://reliefweb.int/report/somalia/somalia-humanitarian-country-team-centrality-protection-strategy-2018-2019

[8] Respondent quote,notes from Trocaire's Focus Group Discussion with IDP Women in Jaseera IDP camp in Luuq district, November 2018

# Gender Analysis objectives

The core objectives of this gender analysis were to:

- Understand roles and responsibilities of men, women, boys and girls in IDP and host communities and how these roles have changed after a reference crisis
- Explore the main needs and concerns of women,men,boys and girls in IDP and host communities
- To get insights to make Trócaire's programming more gender responsive and more inclusive in its service provision in different sectors

# Methodology

This research took a qualitative approach and entailed six FGDs in each district with adult men, women, adolescent men and women and KIIs. Some FGDs were gender specific and some had both men and women participating.

Local authority were informed of the purpose of the assessment and chiefs in IDP camps (Qansahley and Kabasa) were engaged to facilitate enumerators to convene and conduct the FGDs with community members. Enumerators selected could speak both Afmaay and the other Somali dialect. In each location a gender, balanced team of two male and two female enumerators were engaged to conduct FGDs. In Luuq, data was collected from the host community and in Dollow data was collected from IDP communities.

Tools utilized include:

- Activity profile
- Harvard Analytical framework Access and control tool (Resource use, control and benefit profile)
- Moser's Gender needs assessment tool
- IASC gender marker sectorial tip sheets

**Limitations:**

- The gender analysis could only be conducted in towns, rural locations could not be included due to time and logistical constraints
- The sample size was small at 40 people per location; this was due to time constraint
- Language; although enumerators were trained on how to conduct the analysis , the questionnaire was not translated hence some information could have been lost in translation

# Findings and analysis

The findings from both locations are presented together with stark differences noted between IDP and host community as they arise in specific areas of analysis. Key informant perspectives are also mainstreamed into the broader narrative to enrich the analysis.

# Gender Roles and Responsibilities

**Table 1 Activity profile summary**

| DEMOGRAPHIC | WOMEN | MEN | GIRLS | BOYS | Changer after crisis |
|---|---|---|---|---|---|
| Role & Responsibilities | Buying groceries<br><br>Collecting firewood<br><br>Washing clothes<br><br>Taking care of children<br><br>Cooking | Daily manual labor to earn money<br><br>Blacksmiths<br><br>Business<br><br>Collecting firewood and charcoal<br><br>Breadwinners<br><br>Head of household<br><br>Farming<br><br>Driver | Clean house<br><br>Cooking<br><br>Collecting firewood<br><br>Going to school<br><br>Washing clothes<br><br>Making mats and brooms | Students<br><br>Fetching water<br><br>Playing football<br><br>Daily labor to earn money | Men are now at home jobless<br><br>Both men, women , boys and girls fetch water<br><br>Women are now breadwinners<br><br>Women are head of household where the spouse is deceased |

There are specific roles and responsibilities for men, women, boys and girls. Since the crisis a few things around roles and responsibilities. Concerning activities to do with fetching water was a preserve of women and girls; boys are also involved now. Additionally men were the breadwinners, now women work and are the providers particularly where the man has no work “Men have been replaced by women in the business field” respondent in Luuq.

Both men and women face challenges to provide for the daily needs of their families due to lack of livelihood opportunities.

## Decision-making

In general, women make decisions within the domestic realm but where finances are involved men are final decision makers. “A family’s financial management is a concern of the father.” an FGD respondent said. It was widely reported that men make decisions on finances, major resources such as land, farms and on community assets such as Water, Hygiene and Sanitation (WasH) infrastructure and who is targeted for humanitarian assistance.

In some instances women can make decision in the absence of a husband i.e. widow, some respondents said decision-making is shared; a husband consults the wife. Women are decision makers when it comes to childcare i.e. if and how long to breastfeed children, what to cook at home although men can provide advice or request a certain food to be prepared.

# Access and Control

**Table 2 Access, control and benefit profile summary**

| **Resources** | | | **Benefits** | | |
|---|---|---|---|---|---|
| List of resources | Women | Men | | Women | Men |
| Tea shop | AC | A | Money | AC | AC |
| Business | AC | A | Money | AC | AC |
| Farms | A | AC | Crops, money | A | AC |
| Casual jobs | A | A | money | AC | AC |
| Animals | A | AC | Milk, meat, money | A | AC |
| Humanitarian assistance | A | AC | Food, etc. | A | AC |
| Community infrastructure | A | AC | Water etc. | A | AC |
| Key: A- Access, C- Control | | | | | |

When it comes to access and control of resources, women make limited decision such as on family nutrition and in some instances in business if they own the business. Both household and community resources are controlled by men. One instances cited is men managing water taps while women only utilized the taps drawing water. Decisions over community resources including on humanitarian interventions are taken by local authorities, camp chiefs and block leaders within IDP camps. The decisions they make on who should receive assistance has been largely reported as skew and resulting in deliberate exclusion of the most vulnerable such as minority clans, persons with disabilities and elders.

# Access to information

Lack of information sharing was mentioned in all FGDs as a major barrier for women's participation in decision-making. "The organization representatives engage the chief and assistant chief, when it is the end of the process in site selection, you will find them in your household". "We just see toilets being built nobody informs us about it". The lack of information sharing by camp leaders is perceived as excercebating unfairness in aid distribution and resulting in nepotism and extortion. "Respondent commenting on humanitarian aid being handed over to camp leaders who are said to practice discrimination.

"We just hear things were brought and leaders distributed the items to his kin." "Sometimes names are removed from beneficiary lists due to clannism" respondent explaining that aid does not reach most deserving people due lack of information sharing and consequently lack of community participation.

# Barriers to accessing services

## WASH

Women and girls are mostly responsible for collecting, handling and storing water, men are responsible for treating water. Lack of participation of community members particularly women in water infrastructure or latrines projects was mentioned as a key barrier to meaningful access of these infrastructures.

Due to limited number of taps, women need to go early because of long queues. Additionally, those managing water sources impose a little amount of money, which community members cannot afford to pay consequently some go to get water from the river.

Women also noted that the location of water points is far, that water is not adequate for their needs. Latrines are equally inadequate, far from the home, furthermore males and females are using the same latrines, and toilets that do not have lights during the night was a key concern for women and girls. One person sometimes locks the shared communal latrines. All these factors necessitate community members including women to go into bushes to practice open defecation.

In one camp, women fight over water taps and this sometimes causes them to be arrested; boys and girls also fight over usage of water taps.

## Health

One of the major barriers to women and girls accessing health was service providers being of opposite sex. When asked about their preferences when it comes to the sex of the healthcare provider, most FGD respondents expressed that they prefer a same sex service provider to serve them. However, women in Kabasa generally observed they prefer male health service providers because they are more respectful and welcoming, while female staff are disrespectful.

"The health facility is far from IDP camps, there is no vehicle to take someone to the health facility." A key informant also observed that lack of transport especially in health emergencies was a major barrier to women accessing medical care.

Privacy in terms of both gender of health care provider and the lack of privacy in the hospital spaces is hindering women from seeking healthcare.

Quality of care was another factor inhibiting women's access to healthcare. "The doctor is not available; when they give you an appointment, you only see the nurse" FGD respondent. Incomplete services was cited as a quality issue; "the lab doesn't not have all the tests, they say they lack equipment, they sent us to the external lab. A nurse will only ask you questions and send you to the pharmacy even without lab

testing, when we question this we are told - are you the healthcare providers or we are". Inadequacy of drugs at the hospital was a major challenge; sometimes patients are prescribed drugs and asked to purchase them at pharmacies since they are not available in the hospital. For the most poor who cannot afford, this becomes and added burden. Respondents also perceived the service providers to be unqualified; "for all health problems you have, amoxicillin is prescribed" no one does any examination they just ask you questions and prescribe the amoxicillin.

**Maternal health barriers to access**

Fears around family planning medication being administered to women in hospital is a contributing factor in women not accessing healthcare. "Some husbands refuse for their wives to go to health facilities; he thinks she may be given family planning medication" Key respondent comment.

Lack of compassion in the maternity by some staff was noted as off putting; "the midwives don't check on you, even you call them they don't examine you but say it is not yet time (labor)". A key informant, a female community influencer whose role is to educate women on the benefits of seeking pre-natal, postnatal and service and the importance of delivering in a hospital observed that the hospital in Dollow does not do testing for dengue fever and full blood testing required during pregnancy. She also commented on how security curfews imposed by local authority whereby there are no vehicle movements during the night is curtailing access to maternal care. She also noted a gap in the lack of voluntary testing and counselling on HIV.

## Nutrition

When it comes to nutrition some social gender norms on nutrition noted during the FGDs impact on nutritional outcomes. There is generally good awareness of the nutritional needs of pregnant women and lactating women a balanced diet containing diverse food groups was mentioned.

Among the IDP community, girls are breastfed more than boys; this is attributed to the baby's tendencies "girls will latch on to the breast even when there no milk in the mothers breast unlike boys who won't". Although this is not overt gender based discrimination, the belief needs to be addressed so that mothers are aware of best breastfeeding practices for better nutritional outcomes of both boys and girls.

There is a belief that the baby will grow big if a pregnant woman eats a certain amount of food. Other gender norms are that men eat before women and children eat first.

Mothers are decision makers on breastfeeding, fathers can advise them. Women/mothers make decisions on breastfeeding and on family nutrition i.e. what to cook since they prepare the food. There is limited male involvement in infant young child feeding practices and family nutrition more broadly. In host communities, unlike in IDPs both girls and boys are breastfed well.

Food taboos are that some parts of meat are not eaten such as heart, kidney, lungs, others observed they had no food taboos.

A key barrier noted to accessing nutritional services is the limited number of nutrition centers in some locations.

## Women and girls access to rights

On the role of men and boys in advancing development of women and girls, most key informants observed that men and boys are barriers to women and girls accessing their rights. "They discriminate against girls; girls don't go to school and encourage early/forced marriage". Another key informant noted that men can have a positive role, "they want girls and women to be important people in society"

According to key informants interviewed, women and girls experience sexual, physical, emotional and psychological abuse by both their intimate and none intimate partners but survivors of GBV have no access to legal and medical services do to the strong cultural influence and mal-practices that further stigmatize survivors.

Sensitive SGBV cases like rape, attempted rape and FGM are underreported and resolved through an informal traditional justice system, which has no support at all for the survivors to meet their emotional, psychological, legal and medical needs.

## Barriers to accessing GBV services

### Stigma

Women who are sexually abused feel ashamed and undignified." They also feel they will be blamed over the incident by their parents, neighbors, and other community members hence they fear accessing services." A key informant notes

There is lack of a strong referral network that could enable survivors get different services easily. "Survivors of physical violence hate the long process as they spend some hours or more than have a day at the police station to access an abstract for the medical doctor's feedback." There is a prevailing belief that to access legal services a survivor must first present to the police rather than a hospital that can also refer survivors to legal aid.

### Harmful cultural practices on dealing with SGBV

"Rape and attempted rape are under reported do to the strong influence of the community key influential leaders who always propose and encourage the survivor and his family members to accept the case to be resolve through the traditional justice system. The family members of the survivor proposes that the perpetrator should forcefully get married to their daughter (the survivor) as they feel that she might have already conceive through the rape, has lost dignity and the confidence to marry someone of her choice and they also fear that she will never be married as a consequence of the incident."[9]

### Awareness of existing services

A high percentage of women both in the IDP and host community are not awareness of the existing Clinical Management of Rape (CMR) services and their importance specifically the prevention of HIV/AIDS, unwanted pregnancy and Sexually Transmitted Infections (STIs).

### Distance of services

Lack of transportation cost to access a distant health services is a barrier particularly for poor women and girls.

[9] Key informant Interview, Dollow

# Main needs and concerns

**Women empowerment**

Literacy for adult women and girls was mentioned by key informant as an important aspect in improving the situation of women. Creation of a women information center was suggested as a way to engage women and provide them with information on a range of issues.

Gender balance in community leaders is viewed as a barrier to women's participation at community level decision making; creating specific slots in decision-making structures in the community was put forward as a way to improve women's participation.

Income generation activities for women was recommended as an intervention to empower women.

A key informant also observed that some women require extra support "widows and divorced women need extra care in the community".

**Inclusion**

Unfairness in distribution of aid was a major issue in IDP camps, one community member that equal treatment of all community members needs to be practiced by those overseeing interventions.

Disability; "Dollow hospital is not designed to enable disability access hence this becomes a barrier for for persons with disabilities"

Corruption should be minimized especially during distribution; minority groups do not access to services because of skewed processes.

**WasH**

Purchase of water is a burden for community members who cannot afford to pay; a factor that drives women and girls to continue fetching water from the river, which creates risks for women, and girls

Toilets are shared between men and women and are locked by an individual; lack of adequate sanitation facilities for women and girls emerged as a major gap, this gap is creating an undignified situation where they resort to go to the bushes to practice open defecation.

Construction of adequate latrines and water points and community mobilization on proper use of sanitation facilities was proposed as a way to address gaps. Additionally, lack of lighting in the latrines at night is a protection risk for women and girls

A key informant recommended employing female community hygiene promoters who would have more access and can engage women on hygiene and sanitation issues.

The community requested for a pit for throwing waste from households to be dug for them to ensure proper waste management.

**Health**

"FCIs are doing a good job connecting the community to the hospital; we should have more health education. Increase number of community health workers to carry out public awareness" a key informant emphasized the need to create more community level health interventions.

Security curfew at night in both Dollow and Luuq is a major barrier in access to healthcare. Good quality services at hospitals was proposed as a way to increase the community's health seeking behavior.

**GBV**

Early, forced marriage and FGM are rampant but there is no organization actively working on this, a key noted the need to have an organization that can work on FGM. There is lack of a good referral system; the lack of legal services for survivors of GBV is a major gap on Gedo.

The lack of gender segregated latrines and lack of lighting is a protection risk for women and girls and hinders their meaningful access to sanitation facilities.

**Livelihoods**

Job creation was mentioned severally in FGDs as a mean of addressing the lack of livelihood opportunities ; businesses and vocation training were main ideas proposed to overcome the lack of livelihood for both men and women

**Other**

Recreational activities for youth was proposed as an intervention that would be crucial for youth.

IDP Community requested more schools as an area of priority for their community.

# Recommendations

The gender analysis provides useful information on the different needs of women, men, boys, girls, and the gender specific barriers to accessing humanitarian interventions by IDPs and host community in Doolow and Luuq. Incorporating findings into programming will ensure the programs are adapted to meet the needs of women, men, boys and girls, reduce GBV risks and effective.

## Overall recommendations

Trocaire programs in each sector should track service usage with a focus on sex, age, disability and other forms of diversity (clan etc.) in order to design inclusive and responsive programs.

Diverse staff; both in terms of gender and language. There should be adequate male and female staff, and staff who speak Afmaay Somali dialect.

Participation of all demographic groups of the community is crucial, there is negligible community engagement that is limited to engaging leadership.

Deliberate measures on inclusion minority groups, women, person with disabilities (PWDs) and elders should be in place. Targeting criteria should ensure the most vulnerable groups are reached and that data is sex, age, disability aggregated to inform program adaptation.

Humanitarian actors should share information with communities on what the intervention is and criteria for targeting program participants. Information on availability of services can also be disseminated through IEC materials.

## Sector Specific Recommendations

**Health**

- Adequate gender balance in health staffing
- Physical accessibility of health facilities for PWDs
- Provide privacy both in outpatient consultation and in maternity by installing curtains, training staff on ensuring privacy
- Take services closer to the communities particularly IDPs
- Address night movement restrictions for ambulance with local authorities
- Train staff on appropriate code of conduct and compassionate care for clients
- Share information with communities on what health services are provided
- More awareness on right to provide feedback and complaints
- Conduct quality checks on services being provided and address gaps
- Include GBV messaging in health related outreach activities about the benefits and availability of
- clinical management of rape services for survivors of sexual violence and contact information for GBV focal person(s)

**WasH**

- Ensure participation of all demographic groups particularly women and girls on site selection for WasH infrastructure
- Encourage women's participation in water committees
- Provide community hygiene sensitization alongside latrine construction to ensure proper hygienic use of latrines
- Involve women in design and management of water and sanitation facilities
- Provide piping and adequate number of taps to reduce distance to access water
- Involve female hygiene promoter's /hygiene workers in conveying hygiene messaging
- Design WasH interventions with GBV risks mitigation i.e. gender segregated latrines, designs that provide adequate privacy and lighting
- Ensure WASH staff are trained on GBV referral and can provide community members with information on where and how to access GBV services
- Nutrition
- Design IYCF messaging that takes into account gender norms in the community
- Address harmful cultural beliefs linked to nutrition and pregnancy and child feeding practices
- Design nutrition program with GBV integration considerations; location and timing of nutrition services should be convenient for women

# Gender / GBV specific programming recommendations

- Support strengthening of the referral system through the Gedo regional protection cluster; specific outputs will be on updating standard operating procedures, training of service providers on referrals and creating awareness in communities on the referral pathways.
- Set up safe spaces for women within communities that will serve as location to provide several services including awareness on GBV and health services available for women and safe referrals to hospitals.
- Prioritize Women's involvement in all programming by providing same sex service providers, creating avenues for women's participation such women only FGDs during needs assessment and throughout the program cycle.
- Conduct safety audits at health facilities and respond to the priority areas identified.
- Conduct GBV risk assessment for each sector and area of intervention and put in place risk mitigation measures