GBV/FGM RAPID ASSESSMENT REPORT

In the Context of COVID-19 Pandemic in Somalia

GBV AoR Somalia
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In the Context of COVID-19 Pandemic in Somalia

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1.0 Introduction:

The GBV/FGM rapid assessment was organized and undertaken by the GBV AoR Somalia to generate data and information on the impact of COVID19 on GBV/FGM incidents and GBV service provision. It also interrogated factors around COVID and stigmatization, access to health services for women and adolescent girls and the impact of COVID19 on schooling for adolescents' boys and girls. This was important, to improve understanding of secondary impact of COVID19 on issues that are important to women and girls. Field work for the assessment was for a period of three weeks while collation of data, analysis and report writing was planned for two weeks. The purpose of the assessment was to provide valid primary data and information to inform programming and strategy for GBV prevention, mitigation and response through COVID19 lenses. Specific objectives include:

- Understand the impact of COVID19 on GBV/FGM trends
- Understand the effect of COVID19 on GBV service provision
- Understand coping strategies for COVID19 for women and adolescent girls

2.0 Summary of key data results:

The rapid assessment was planned for a period of 30 days. However, it took longer than planned because of some context/locational factors. As a result, field work for the assessment was for a period of 3 weeks while collation of data, analysis and report writing was for 2 weeks. Some of the critical data results are listed below;

i. GBV trends - 38 percent of community members indicated that there has been an increase in GBV incidents compared to the period before the COVID-19 pandemic. More respondents were from Federal member states - Galmudug, Hirshabelle, SWS, Jubaland (40 percent), followed by "Somaliland" (35 percent) the Federal member state of Puntland (25 percent). This was confirmed by 68 percent of service providers who agreed that there had been an increase in GBV incidents since the onset of the COVID-19 pandemic. The most reported cases are physical violence (34 percent), sexual abuse and harassment (20 percent), intimate partner violence (18 percent) and rape (18%).

ii. FGM trends: 31 percent of community members stated that there had been an increase in FGM incidents compared to the post-COVID-19 period. Most of the respondents who responded were from "Somaliland" (42 percent) followed by Federal member state of Puntland and other Federal member states (Galmudug, Hirashabelle, SWS, Jubaland) with 29 percent respectively. However, respondents from the Federal member states – Puntland, Galmudug, Hirshabelle, SWS, Jubaland (service providers – and community members) were of the opinion that FGM incidences had not increased.

iii. Impact on GBV service provision: 36 percent of service providers reported that COVID-19 has had a high effect on GBV service provision, while 52 percent stated that it had some level of effect on GBV service provision.

iv. Impact maternal/reproductive/nutrition health services for women and adolescent girls: Out of a total of 337 respondents; 33 percent indicated that COVID-19 has resulted in the closure of health facilities. 15 percent indicated that due to lack of funds they were not able to access the health services while 27 percent of the respondents said that they were not able to access the services because of the restricted movement that has been put in place to contain the spread of the covid-19 virus.

v. COVID-19 and stigmatization: 67 percent of the respondents (298 females, 208 males) indicated that there was a stigma against people who

showed COVID-19 symptoms. Respondents from the Federal Member States – (Galmudug, Hirshabelle, SWS and Jubaland) (189); Puntland (166) and Somaliland (151).

3.0 Methodology of Assessment

The GBV AOR conducted a countrywide Gender Based Violence (GBV) rapid assessment to examine COVID impact on GBV/FGM incidences and service provision; and to determine capacities of services providers currently providing services to survivors of GBV. Virtual meetings were organized with services providers in each participating state to inform them of the assessment. Methodology adopted includes the use of key informant interviews and Semi structured questionnaires to garner information from service providers and key community stakeholders (See tool attached in appendix).

3.1 Sample Size and Sampling Frame

A random sampling methodology was implemented, and 1,074 respondents were chosen as targets for the assessment. These includes 425 respondents from Federal Member States of Galmudug, Hirshabelle, SWS, Jubaland) 165 from Federal Member State of Puntland and 374 from "Somaliland". This sample size consisted of 756 members of the community (41 percent males, 59 percent females) and 318 service providers. KOBO Collect tool was used to collate and analyze the data. The frequency and percentage of respondents reporting the variables were calculated for each data individually, as well as for the overall demographics (table 3.1). Four specific characteristics were analyzed during the assessment: gender, age of respondent, persons with disability, and placement status.

3.2 Demographics of the Respondents

3.2.1 Age and Gender Distribution

A total of 1,074 respondents were included in this assessment. This includes 756 community members (310 males and 446 females) and 318 service providers (207 NNGOs, 68 INGOs and 43 Government agencies) across Somalia (tables 3.1 and 3.2).

Table 3.1: *Community members' distribution by gender and region*

Gender	Variables	Male	Female	Total	%
	Total	310	446	756	
	%	41%	59%	100%	
Region	FMS - Galmudug, Hirshabelle, SWS, Jubaland	145	159	304	40%
	Federal Member state of Puntland	110	130	240	32%
	"Somaliland"	55	157	212	28%

Table 3.2: *Service providers' distribution by region*

Organization Type	FMS – Galmudug, Hirashabelle, SWS & Jubaland	Federal member state of Puntland	"Somaliland"	Total	%
NNGO	75	25	107	207	65%
INGO	45	6	17	68	21%
Government Agency	1	4	38	43	14%
Total	**121**	**35**	**162**	**318**	**100%**

Most respondents (47 percent) are of age 25-45 years of which 211 were female and 141 were male. 33 percent of the respondents are of age 18-24 years, of which 145 were female and 102 were male. 21 percent of respondents are of age 46 years and above, of which 90 were female and 67 were male (table 3.3). There were more respondents from Federal Member States of Galmudug, Hirshabelle, SWS, Jubaland (85) compared to Puntland (49) and "Somaliland" (23).

Table 3.3: *Community members age distribution by gender and age*

Age Range	Gender				Region				
	Male	Female	Total	%	FMS – Galmudug, Hirashabelle, SWS, Jubaland	FMS Puntland	"Somali land"	Total	%
18 - 24 years	102	145	247	33%	84	77	86	247	33%
25 - 45 years	141	211	352	47%	135	114	103	352	47%
46 years and above	67	90	157	21%	85	49	23	157	21%

3.2.2 Disability Status:

To assess the disability status, the respondents were asked if they had any disability, 26 percent of respondents had disability while 74 percent had no form of disability from the three states (table 3.4). More women respondents are from the Federal Members States of Galmudug, Hirshabelle, SWS, Jubaland (93) as compared to Puntland (69) and "Somaliland" (31) who responded they had a disability.

Table 3.4: *Distribution of community members with disabilities*

Person with Disability	Gender				Region				
	Male	Female	Total	%	FMS – Galmudug, Hirashabelle, SWS, Jubaland	FMS Puntland	"Somaliland"	Total	%
Yes	81	112	193	26%	93	69	31	193	26%
No	229	334	563	74%	211	171	181	563	74%

GBV Service Providers Demographics:

A total number of 318 service providers responded (121 from Federal Member States of Galmudug, Hirshabelle, SWS, Jubaland, 35 Puntland and 162 "Somaliland") during the assessment. The Federal Member State of Puntland was the lowest which accounts for (11 percent). This can be attributed to the fact that GBV services are limited in the region or it could be due to funding gap in the areas of GBV. The respondents were mainly from NNGO which accounts for (65 percent) followed by INGO which stands at (21 percent) while government agencies were the least of the respondents and accounted for (14 percent) of the total responses.

3.2.3 Placement Status

Majority of respondents (38 percent) lived in an organized camp; 33 percent lived in the host community, 16 percent were returnees in villages/ home of origin, 8 percent lived in an organized settlement, 3 percent of the respondents were returnees living in a displacement camp and 2 percent lived in a public building (school, abandoned building etc.). Out of the total 756 persons who responded to the assessment, 304 were from Federal Member States of Galmudug, Hirashabelle, SWS, Jubaland , 240 from the Federal Member State of Puntland, and 212 from "Somaliland".

According to the service providers' respondents, the GBV services mainly targeted organized camps which stands at (31 percent) followed closely by host community at (30 percent), unorganized settlement at (14 percent), others at (10 percent), returnees living in village/home of origin at (7 percent), public building (school, abandoned building etc.) at (6 percent) and lastly returnees living in displacement camps at (3 percent) of the respondents. This illustrates that organized camps and host community are the highest beneficiaries of GBV services due to the vigorous awareness campaigns in the field or it might be most of the GBV facilities are stationed within the organized camps and host community

3.2.4 Main Sources of Income

19 percent of the respondents had formal employment while 54 percent were self-employed. 19 percent of the respondents had no source of income and 9 percent were casual workers. From the 54 percent of the self-employed respondents,243 were female and 162 were male. The respondents were asked if COVID 19 had any impact on their sources of income; 63 percent believed that COVID-19 had affected their source of income with the closure of business and termination of employment. 37 percent of the respondents felt no effect caused by COVID-19 on their source of income. Federal Member States of Federal Members States - Galmudug, Hirshabelle, SWS, Jubaland was the most affected with 226 respondents, 142 from Puntland, and 106 from "Somaliland" confirming their main source of income has been affected.

4.0 Limitations of the Assessment

The rapid assessment was planned for a period of 30 days. However, it took longer than planned because of some context/locational factors. As a result, fieldwork for the assessment was for a period of 3 weeks while collation of data, analysis and report writing was for 2 weeks. Other limitations for this assessment include:

- A challenging process of acquiring phone numbers of respondents because enumerators had reservations about traveling to IDP camps as it might expose them to corona virus. Not all data collection could be conducted over the phone as proposed because it was faster to collect the data from respondents once the enumerators were in the field and in contact with respondents, rather than risk the respondent changing their mind to be interviewed later when conducting the telephone interview. Enumerators therefore had to adapt to collecting data while ensuring a social distance between them and the respondent.
- A significant number of respondents refused to give consent to take part in the assessment due to the social distance rules set in place by the government and had to be replaced with those who were willing to participate.
- Selection of samples – Puntland had less GBV services providers and therefore the assessment had to increase the number of community service providers.
- Government partners conflicting priorities during the period of the assessment also implied that they had less time to give to the rapid assessment
- Huge data and the burden of translations for few data translators available for the assessment.

5.0 Data Analysis and Interpretation

5.1 Government Measures to Curb the Spread of COVID-19

Given that rapid assessment was necessitated by the COVID-19 situation, it was important to assess the level of knowledge of respondents of the measures put in place to curb COVID-19 and how they perceive its effectiveness. To assess how the knowledge of respondents about measures put in place by the government to curb the spread of COVID-19; community members were asked to identify measures that government has put in place to curb COVID-19 infection. In the Federal Member states - Federal Members States of Puntland, Galmudug, Hirshabelle, SWS, Jubaland, and also in "Somaliland" 29 percent of respondents identified frequent hand washing; 22 percent social distancing; and 21 percent wearing face masks. In addition, 17 percent of respondents identified the use of hand sanitizers in public spaces; 8 percent Curfew; and 2 percent had no response. 38 percent indicated that the measures put in place have little effect while 33 percent indicated that the measures had some effect and 29 percent of the respondent felt the measures are not effective. This may be because of community behavior or of non-strict adherence to measures to prevent COVID-19 infection.

Similarly, services providers were asked what government measures are put in place to mitigate the spread of COVID-19 and were provided multiple choices. There was a marginal difference in

the responses as 24 percent indicated frequented hand washing, 24 percent -wearing of face masks, 23 percent noted social distancing, 20 percent indicated use of hand sanitizers in public places. However, only 7 affirmed curfews as a measure put in place to mitigate the spread of COVID-19. When asked the effectiveness of these measures 43 percent respondents indicated that these have little effect while 37 percent noted them as very effective. Only 20 percent felt that government measures were not effective.

5.2 Effect on Women, Men, Boys and Girls

To assess the proportional effect of government measures on women, men, boys and girls, a question was asked with multiple choices in each category.

For effects on women, 15 percent indicated limited sources of income due to restricted movement; 14 percent increased risk to physical violence in the home; 12 percent indicated increase household chores and increase psychosocial stress respectively while 11 percent noted increased risk to intimate partner violence and limited access to GBV support services respectively. In addition, 8 percent indicated that the measures affected access to services; 4 percent opined increased risk of attack when going to market or walking in isolated areas while 3 percent noted increased risk of attack when visiting latrines/ bathing facilities.

For effects on men, 22 percent stated that men lost their jobs, 17 percent increased psychosocial stress; and 16 percent felt that restricted movement has impacted on sources of income. In addition, 15 percent of service provider respondents indicated increased pressure from family; 13 percent noted less socialization, 10 percent affirmed violence in the home while 6 percent noted that men are unable to access services and resources. I percent did not provide any response.

For boys - 19 percent informed that COVID19 had caused school disruptions; 18 percent noted increased psychosocial stress; 13 percent mentioned less play time/socialization; 11 percent stated increased risk to paid labour and 11 percent increased risk to physical violence. Furthermore, 10 percent indicates that COVID19 has contributed to idleness for boys; 7 percent increased household chores, 6 percent increased risk of sexual violence/abuse, 5 percent unable to access services and resources while 1 percent indicated they did not know.

For Girls - 16 percent of service provider respondents indicated that their studies are disrupted, 13 percent noted increased household chores, 10 percent said that girls have less play time/socialization, 10 percent indicated increased psychosocial stress while 9 percent affirmed increased risk of physical violence and increased risk of early marriage in each category. In addition, 8 percent felt that it has contributed to idleness; 7 percent increased risk of sexual violence/abuse and 5 percent increased risk to paid labour. Furthermore, 4 percent of respondents in this category identified increased risk of attack when going to market or walking in isolated area; 4 percent inability to access services and 3 percent increased risk of attack when visiting latrines/bathing facilities.

5.3 Impact on GBV/FGM/CM Incidence

Respondents (community members) were asked if GBV incidents have increased, become less or remained the same. 38% indicated that there has been an increase in GBV incidents; 35 percent indicated GBV incidents are the same and 27 percent reported that it has become less (figures 5.1 and 5.2). Female respondents (186) compared to male (99) reported that GBV incidents has increased. More respondents from

Federal Members States of Galmudug, Hirshabelle, SWS, Jubaland (113) reported increase in GBV incidents followed by "Somaliland" (99) and Federal Member Ste of Puntland (73). This may be due to lack of sexual offences legislation or longer exposure of women and girls to their abusers owing to restricted movement, curfew and lockdown measures put in place by the government.

Fig 5.1: *GBV incidents before and during COVID-19*

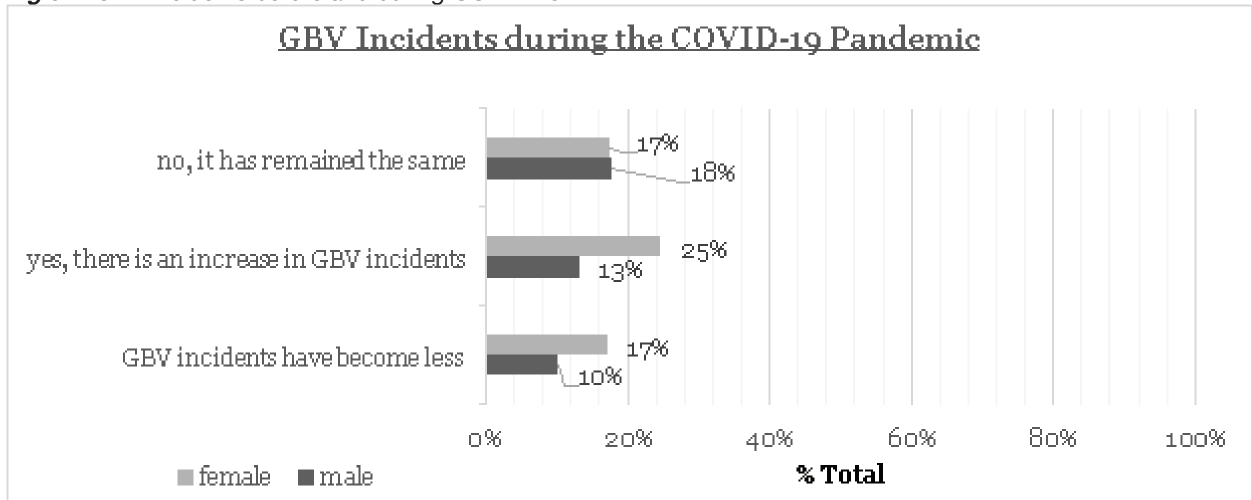
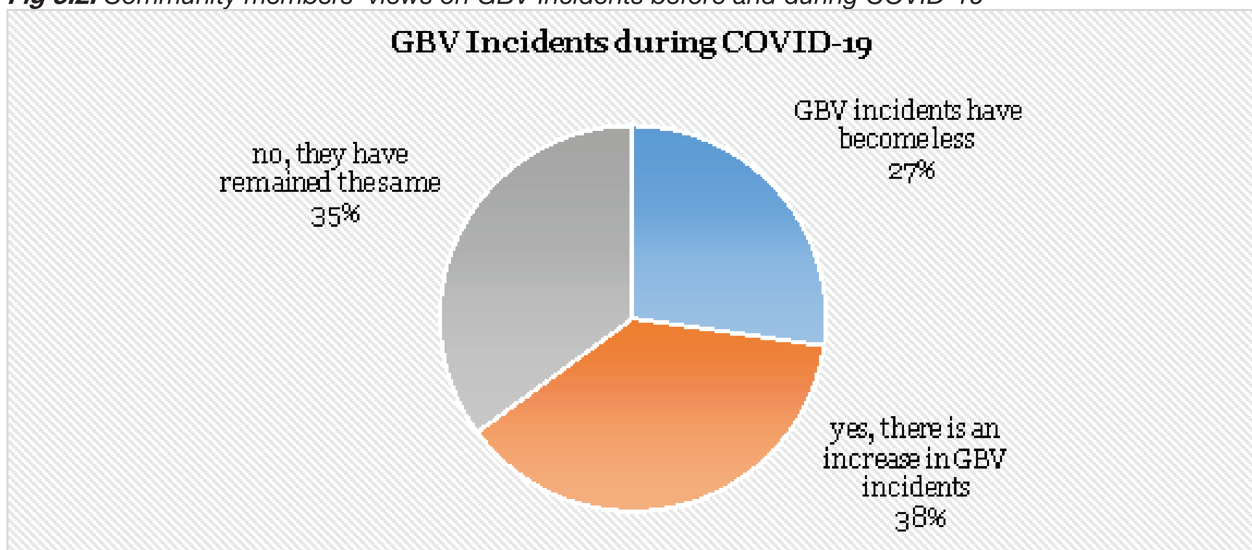


Fig 5.2: *Community members' views on GBV Incidents before and during COVID-19*



Similarly, GBV service providers who responded to the questionnaire indicated increase in the trend of GBV. To assess trends service providers were asked if GBV incidents increased in the community compared to the period before the COVID-19 pandemic. 67 percent of the responded confirmed there was an increase in GBV incidents and 33 percent believed there was no increase in GBV incidents. A higher number of respondents were in "Somaliland" (106), followed by Federal Member States of Galmudug, Hirshabelle, SWS, Jubaland with 78 respondents, and the Federal Member State of Puntland with the lowest 30 respondents who agreed that there was increase in trend of GBV incidents.

To assess further, those who agreed that there had been an increase were asked to identify which type of GBV witnessed the highest increase in trend. Responses indicate 34 percent physical violence, 20 percent sexual abuse and harassment, 18 percent indicated rape. Out of a total of 122 respondents from the three states, 64 respondents indicated an increase in rape case in "Somaliland", 43 respondents in Federal Member States of Galmudug, Hirshabelle, SWS, Jubaland and 15 respondents in Puntland.

For FGM, 31 percent of community members indicated that FGM has increased during COVID-19, 34 percent said it has become less while 35 percent said there has been no difference (figure 5.3). However, there was observed significant variations in the responses from the regions. 98 respondents affirmed FGM increase in "Somaliland", compared with 68 respondents each in Federal Member State of Puntland. This is in line with media and anecdotal reporting on FGM in recent months of May and June 2020. Major reasons adduced for increase in FGM include closure of schools (39 percent); source of income for Traditional Birth Attendants (TBAs) (28percent); and rainy season (19 percent). Other reasons include that communities believe that the Sunna type of FGM is part of Somali culture; community's way of life; to keep girls chaste and prevent promiscuity; unemployment and high cost of marriages; and the opportunity that the COVID-19 lockdown to allow time for healing.

***Fig 5.3**: Community members' views on FGM incidents before and during COVID-19*

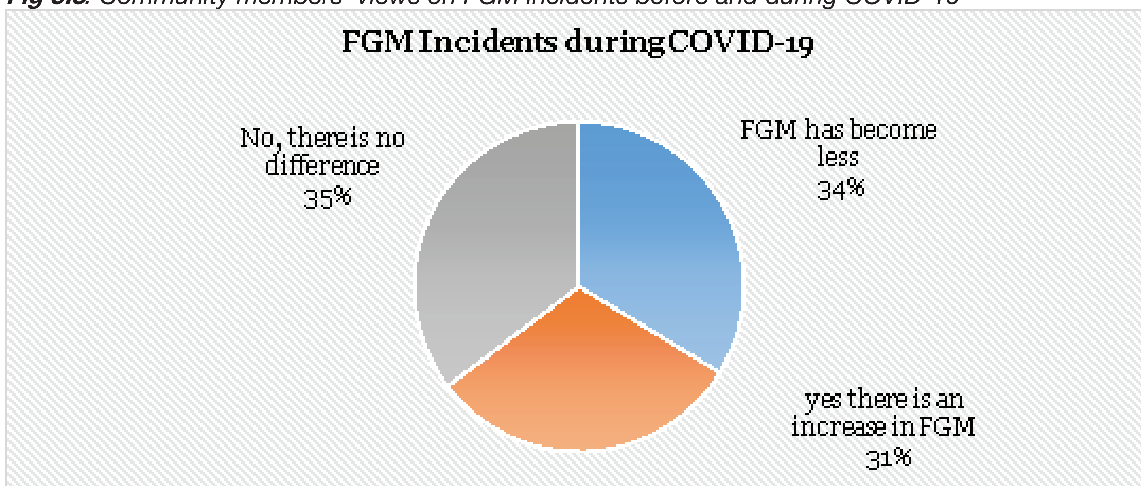
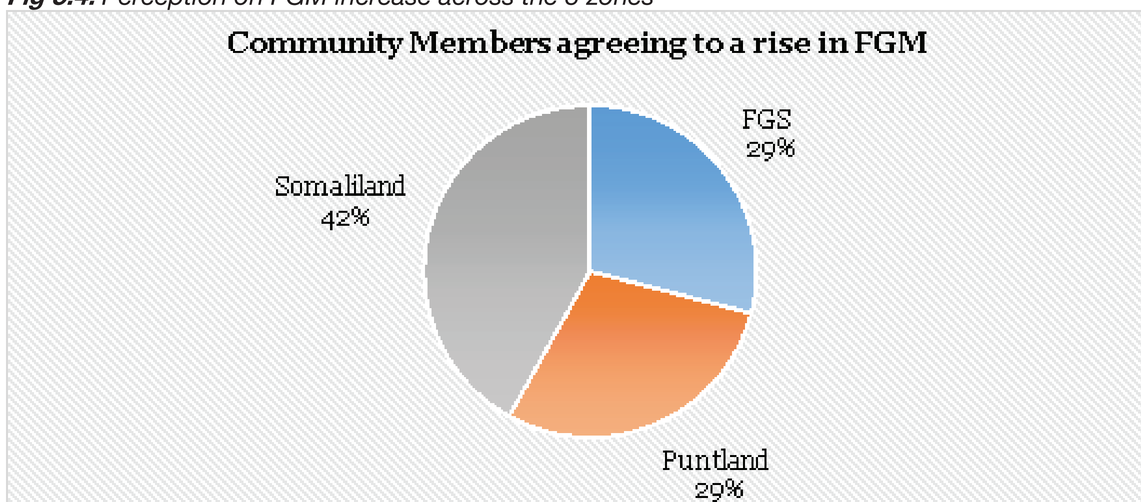


***Fig 5.4:** Perception on FGM increase across the 3 zones*



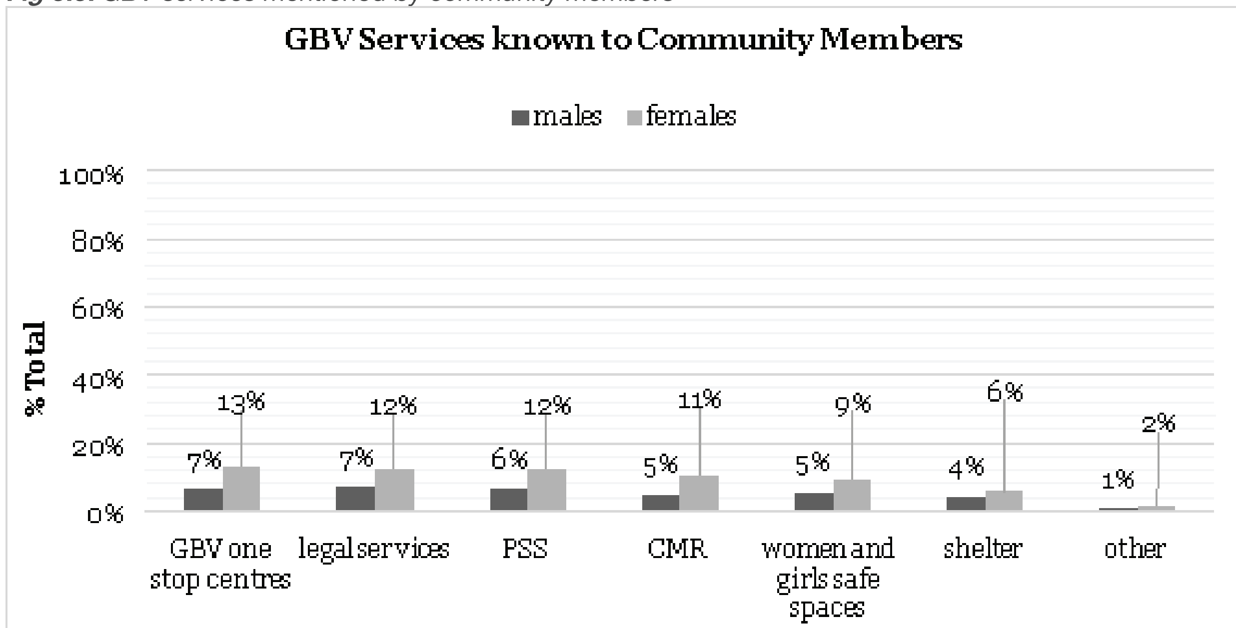
Likewise, GBV service providers affirmed there has been some change in FGM trend since COVID and noted the increase mainly in the Somaliland region. Service providers were asked to compare the period before the COVID-19 pandemic three months ago, if the FGM cases reported in the community have increased. Only 26 percent of the respondents confirmed an increase in FGM. Out of the total 83 service providers who responded that there was an increase in FGM; 35 were from Somaliland followed by FGS and Puntland with 24 persons.

For child marriage, 41 percent of respondents believed these incidents have remained the same; 32 percent felt these have become more while 27 percent were of the opinion that these have decreased. When respondents who were also asked for reasons for the increase in child marriage; higher number of respondents (30percent) informed that child marriage is a way of life; 27 percent attributed it to loss of livelihoods as a result of COVID-19 while another 27 percent said it was due to disruption in schools. From the data obtained respondents from the Federal Member States of Galmudug, Hirshabelle, SWS, Jubaland reported the most probable increase 91 persons in agreement compared to 90 persons each in Federal Member State of Puntland and "Somaliland". The link between disruptions in schools meant that young girls of school age were available to be cut by their parents who felt that it was important to use the opportunity of the lock down.

5.4 Knowledge of Multi-sectoral GBV Services including Hotlines

The assessment shows that 38 percent of respondents (180 female and 180 male) agreed that they have knowledge of GBV services in their community whereas 62 percent (266 female and 202 male) had no knowledge of the GBV services. This could imply limitation of service provision or the need to widely disseminate information on existing referral pathways and prioritize integrated referral pathways. The services mostly identified include GBV one stops centers (20 percent), Psycho-social services (19 percent), legal services (19 percent), Clinical management of rape (16 percent), women and girls' safe spaces (15 percent) and shelter (10 percent) (figure 5.5). The respondents were asked if they were aware of GBV hotline numbers, only 18 percent of respondents had knowledge of hotlines while 82 percent had no information of GBV hotlines in their communities. The respondents in the Federal Member States of Galmudug, Hirshabelle, SWS, Jubaland were the highest proportion who do not have knowledge of hotline services available in the community which accounts for (43 percent) out of the total percentage. These findings reveal that most of the respondents - especially women and girls (59 percent) neither have information nor are aware of the hotline services available in the community. This may be due to the fact that there is limited or no dissemination of information related to hotlines services or the GBV service providers do not prioritize the inclusion of hotline services in the awareness outreach campaigns in the community as well as in the media platforms.

Fig 5.5: GBV services mentioned by community members

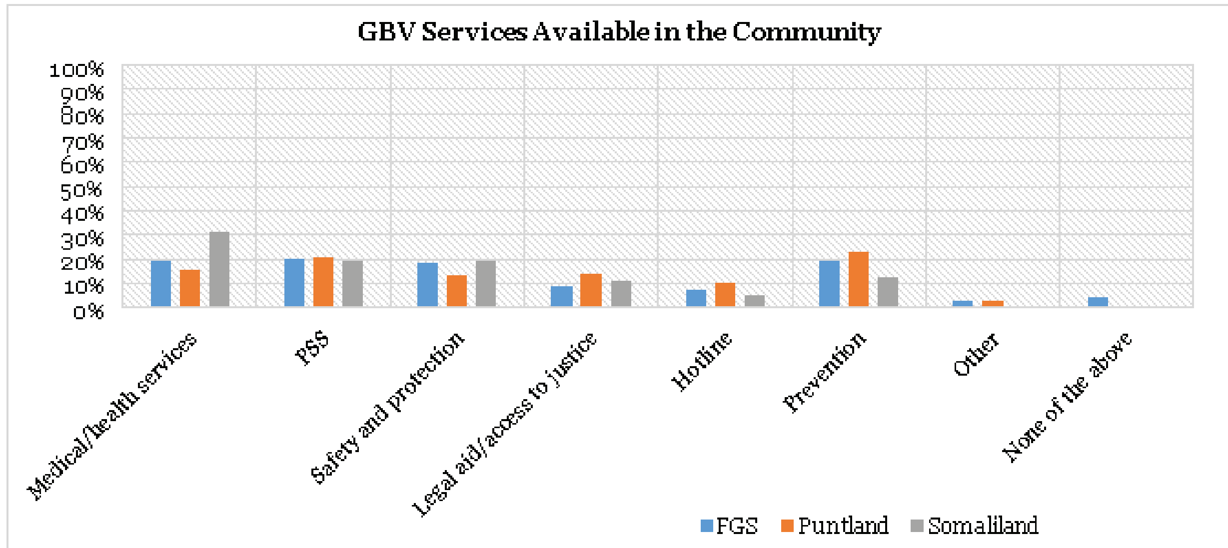


5.5 GBV services availability:

Community members indicated that most service available in the following order - medical/health services at (24 percent), PSS (20 percent) and Safety and protection (18 percent). These services were the highest because they are the basic services that most of GBV service providers offer to the survivors of gender-based violence. The respondents also mentioned Prevention at (17 percent); Legal aid/access to justice at (11 percent), Hotline at (7 percent), other and none of the above were at (2 percent) respectively. These findings showed that hotline services are below average due to the unavailability or limited hotline services or most of GBV service providers do not consider these service as a viable option. Notably, these findings also showed (2 percent) of GBV service providers are also providing multi-sectoral services including Child protection and child rights advocacy, Education, Nutrition and General health care and as well as mainstreaming their services on COVID19 prevention and response.

GBV service providers also agreed with community on the types of services most provided by their organizations. These include medical/health services (24 percent); followed by psychosocial support (20 percent); then safety and protection services (18 percent); GBV prevention services (17 percent); legal aid (11 percent); and hotline services (2%) (figure 5.6). Other services available in the community include nutrition, education, culture, and material support (dignity kits, NFIs).

Fig 5.6: *Available GBV services in sampled communities*



5.6 GBV Services Accessible in Community including Reasons for Limited Access

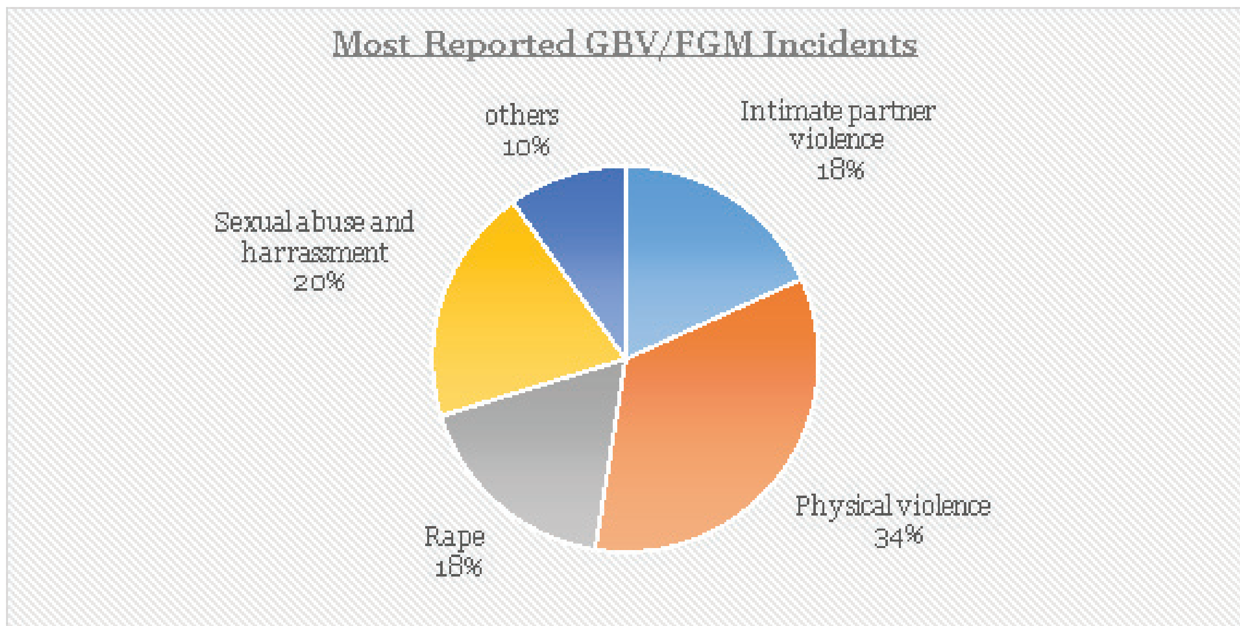
The assessment reveals that accessibility of GBV services in the community is below average. Only 47% of the respondents (139 Male and 216 Female) stated that they had access to GBV services while 53% (171 Male and 230 Female) of the respondents claimed that they do not have access to GBV services. The highest proportion of the respondents with no access to GBV services were from Federal member states of Galmudug, Hirshabelle, SWS, Jubaland which accounts for (23 percent) while Federal member state of Puntland accounts (15 percent) and Somaliland accounts (15 percent). This could be because in some locations GBV, services are not available or service sites are not within a commuting distance. Furthermore, the respondents were asked multiple choice questions to understand the reasons for the limited access to GBV services and their responses were as follows, Lack of sufficient medicine at health facilities at (24 percent), No female staff providing services (16 percent), Priority is given to men (15 percent), Location of services are not convenient for girls and women (privacy, distance, etc.) at (12 percent), Not safe for girls/women to travel to the services sites (10 percent), Women not permitted to access the services by their families (7 percent), Others (6 percent), No male staff providing services (5 percent) and lastly Opening hours of service not convenient for girls/women (5 percent).

In addition, 50 percent of GBV service providers reported service disruption due to covid-19. Such services include legal support (with the closure of courts) and community awareness campaigns (due to need for social distancing), psychosocial support services and child friendly spaces. Service providers from the Federal member states of Galmudug, Hirshabelle, SWS, Jubaland - reported the highest rate of service disruption (68) followed by "Somaliland" (65) and Federal member state of Puntland (26).

5.7 COVID-19 and GBV/FGM Cases Reported

68 percent of service providers stated that there has been an increase in GBV cases in recent months compared to the period before the COVID-19 pandemic. When asked about the type of cases that have increased, 34 percent said physical violence; 20 percent stated sexual abuse and harassment; 18 percent stated intimate partner violence and 18 percent stated rape (figure 5.7). 10 percent of service providers mentioned other GBV incidents that include FGM, child abandonment and family separation.

Fig 5.7: *Most reported cases during COVID-19 pandemic*



5.8 Education, COVID and FGM

51 percent of respondents had children of school going age while 49 percent did not. More women respondents (207) as compared to men (176) responded in the affirmative which aligns with the fact that more women than men bore responsibility of the household care including of the children hence, are more informed than males. To assess the COVID-19 impact, respondents were asked if their children were going to school before COVID and provided multiple choices. Overwhelming majority 67 percent of the respondents indicated yes both boys and girls were going to the school as compared to 21 percent who indicated that only boys, 5 percent indicated only girls were going and 7 percent noted none of them were going.

To determine why children were not going to school, a question with multiple-choice answers was asked to determine why children were not in school. 61 percent (164 females' vs 134 males) indicated closure of schools, 27 percent (72 females' vs 58 males) noted reduced household income to pay for school, 5 percent (16 females vs 9 males) were of the opinion that COVID-19 has no effect on schooling while 7 percent (17 females' vs 16 males) indicated other as reason. School closure was noted as the primary reason by all states (FGS 148, Puntland 101, and Somaliland 49) followed by reduced income to pay for the

fee/equipment where Puntland recorded higher number of responses (63) as compared to FGS (46) and 21 in Somaliland. Respondents were then asked to indicate coping strategies that they have developed because of the COVID effect on their children education and were provided multiple choices. 32 percent indicated that they seek support from relatives, 24 percent indicated that they are not doing anything about it, 22 percent engaging them in study at home, 14 percent seek support from friends and 8 percent indicated other in the choice.

72 percent indicated that school closure had no impact on FGM incidence while 28 percent affirmed that it contributed to the increase in FGM incidents. Furthermore, respondents were asked number of girls that they know have been cut. 81 percent of responses in the three regions indicated that they have seen 10 or less girls who have been cut. It is important to note that 21 percent of the respondents noted that their household income have decreased thus, they are unable to pay for the fee/equipment while 4 percent respondents also noted that they lack coping mechanisms developed to deal with economic stress. An increase in Intimate Partner Violence(IPV) is inevitable given the friction over scarce household resources. Parents may also be less inclined to invest in girls' education due to lack of financial resources.

5.9 Community's Trusted Person to Deal with GBV Incidents

The respondents of this survey indicated in their feedback on the different people they trust to report GBV incidences in the community. A high number of respondents report to a family member (40 percent), community leader (23 percent), police (18 percent), NGO working with women (8 percent), any female aid worker (4 percent), friend (3 percent), do not know (3 percent), other (2 percent), and UN agency (1 percent). These findings show that there is increasing confidence and trust of GBV survivors to report incidents to the police in contrast to what was reported on a similar indicator in a 2019 joint GBV/CP rapid assessment. Similarly, this survey validates the previous rapid assessment conducted in Nov-Dec 2019 which showed that most of the respondents had good faith and trust in their family members and the community leaders.

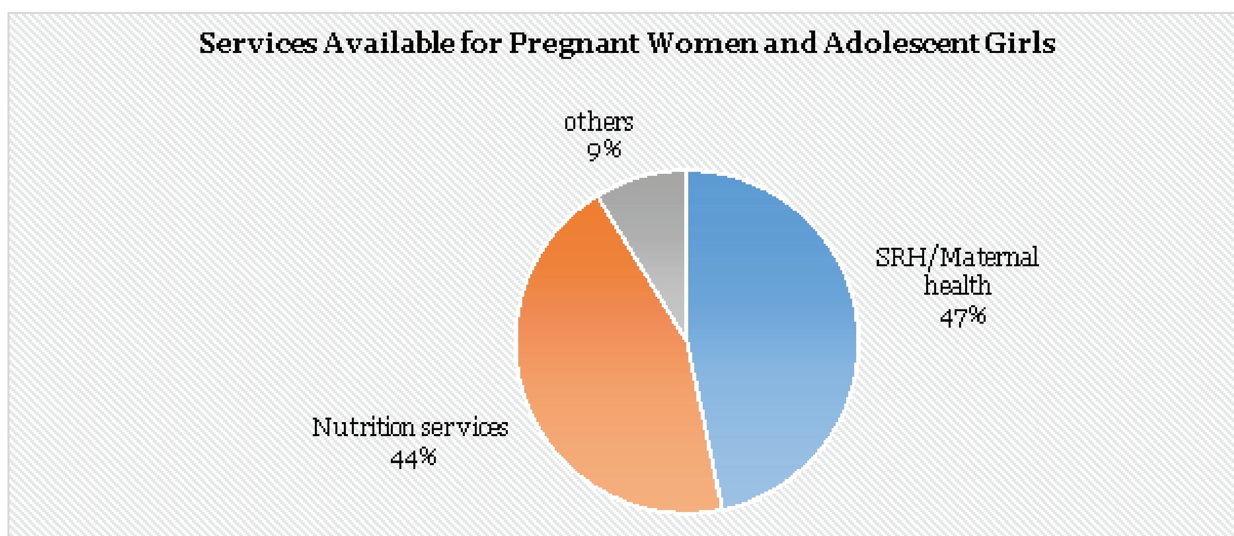
Similarly, service providers also identified an increasing trust in the police. When they were asked who they think GBV survivors sought help from; 40 percent of respondents informed that GBV survivors seek help from family members; 25 percent from police; 15 percent from community leader and 12 percent from NGOs. In addition, 42 percent of service providers inform that there has been reports of sexual abuse and harassment while 58 percent did not think so. Furthermore, when they responded to the multi-choice question on what measures has been put in place to protect women and girls from GBV; 21 percent identified increase in number of police officer; 19 percent increase in female police officers; 17% GBV awareness and education; and 15% identified establishment of community safety groups.

5.10 Impact of Covid-19 on Health Services and Sanitary Commodities

The respondents were asked about how COVID-19 has affected access to health services. Out of a total of 337 respondents; 33 percent indicated that COVID-19 has resulted to the closure of health facilities. 15percent indicated that due to lack of funds they were not able to access the health services. 27percent of the respondents said that they were not able to access the services because of the restricted movement that has been put in place to contain the spread of the

covid-19 virus. 5percent of the respondents indicated that COVID-19 had no effect to the health services. Puntland had the highest number of respondents 140 out of 337 reporting the closure of health facilities due to covid-19 followed by Somaliland (103) and Federal Government (94). The inability to access health services because of the impact of COVID-19 could further drive the gains made for the health of women and girls. It appears that COVID-19 impact of livelihoods has a direct impact on women's ability to assure their wellbeing and that of the family. It important that cash programming in Somalia broaden to target more vulnerable women and adolescent girls. In addition, respondents were asked if pregnant women and adolescent girls still had access to maternal and reproductive health and nutritional services. 47percent of which male (193) and female (286) said that they were able to access the SRH/Maternal health services while 45percent of which Male (179) and Female (278) were able to access nutritional services (figure 5.8).

Fig 5.8: *Available services in the community for women and adolescent girls*



Furthermore, respondents were asked if COVID-19 impact on women and girls' access to sanitary and hygiene items. 47 percent of the respondents of which male (140) and women (215) reported that the access to sanitary and hygiene items for women and girls was affected due to COVID-19. However, 53 percent informed that there was no impact on the access to sanitary and hygiene items. This could imply an improvement in IDP camps and host communities or better access to dignity protection commodities for women and girls.

Community members were then asked the nature of the effect that COVID-19 has had on the access to sanitary and hygiene items for women and girls. Response include Insufficient family income since priority is to purchase food items; Reduced supply of dignity kits distribution by NGOs/aid workers due to fear of contracting COVID-19; increase in prices of sanitary pads; movement restriction; limited supply of sanitary pads and soap since the onset of COVID-19 and School closure due to COVID-19, and many girls were getting sanitary pads at school from aid workers. Some coping strategies identified include – visit to hospitals where they can get free sanitary supplies; giving in to sexual advances in order to get money for sanitary pads; use of re-usable pads; and maintaining high standards of hygiene to avoid the need for soap all the time.

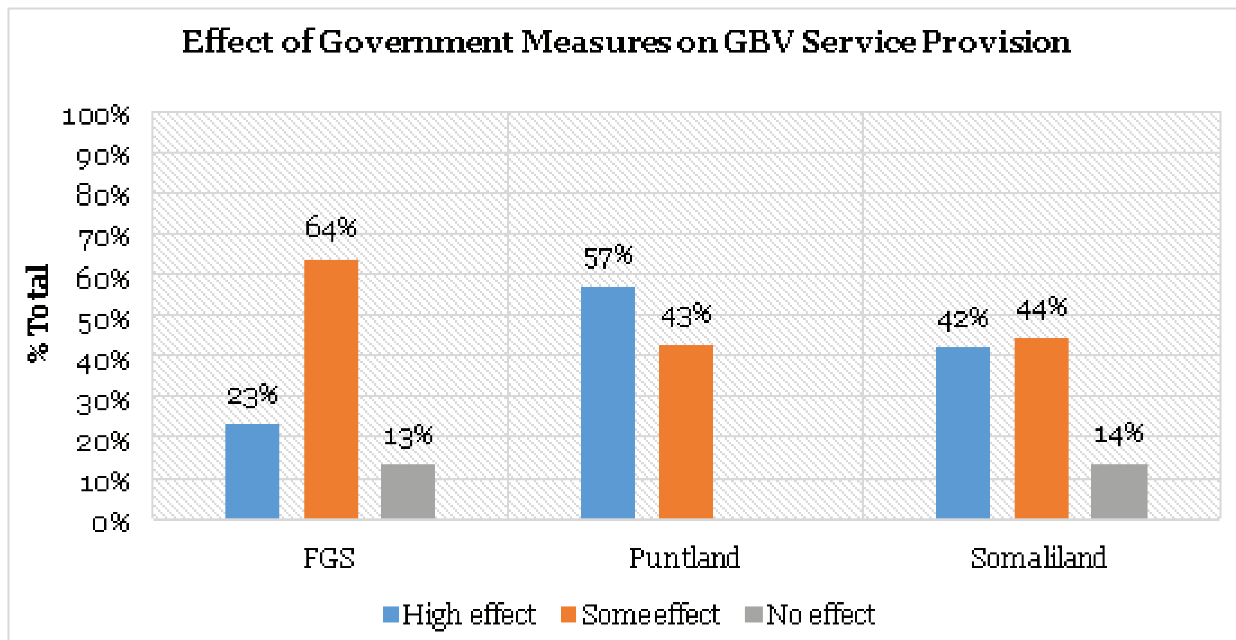
5.11 Covid-19 and Stigmatization

67 percent of the respondents of which 298 were female and 208 were male indicated that there was stigma against the people who showed the symptoms of Covid-19 while 33 percent of the respondents informed that there was no stigma against people who showed COVID-19 symptoms. This could be due to the fact that COVID-19 is a new virus that has no cure established yet hence a lack of knowledge about how it spreads, a need to blame someone, fears about disease and death, and myths and stereotypes about the disease. Respondents from the Federal Member States of Galmudug, Hirshabelle, SWS, Jubaland reported the highest rate of stigma (189) followed by Federal member state of Puntland (166) and "Somaliland" (151).

5.12 Impact of Government Measures on GBV Service Provision

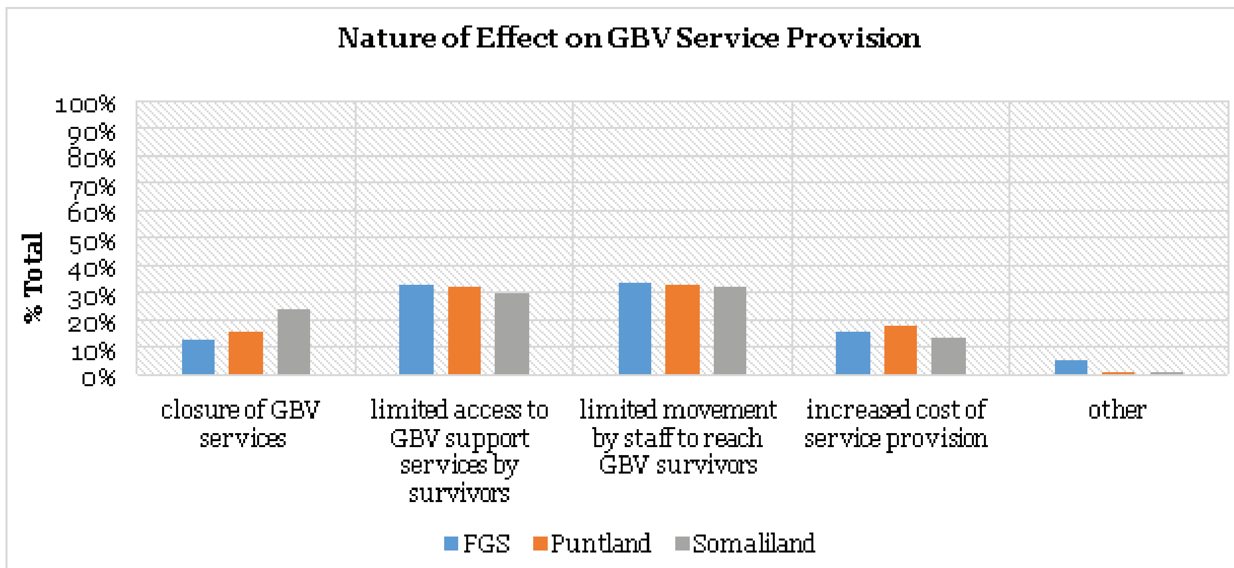
Service providers were asked if COVID-19 had any impact on service provision. 52 percent of respondents agree that there was some effect on GBV service provision; 28 percent felt there was no effect while 36 percent were of the opinion COVID-19 had high effect on GBV service provision. Out of the three regions, government measures had the highest effect in the Federal Member State of Puntland, where 57 percent of service providers in the region reporting a high impact on GBV services; followed by "Somaliland" with 42 percent; and other Federal Member States of Galmudug, Hirshabelle, SWS, Jubaland with 23 percent. "Somaliland" recorded the highest percentages on 'no effect' at 14percent, while respondents from Federal Member State of Puntland recorded the lowest percentages on 'no effect' on GBV services at 0 percent.

Fig 5.9: Government measures and GBV service provision



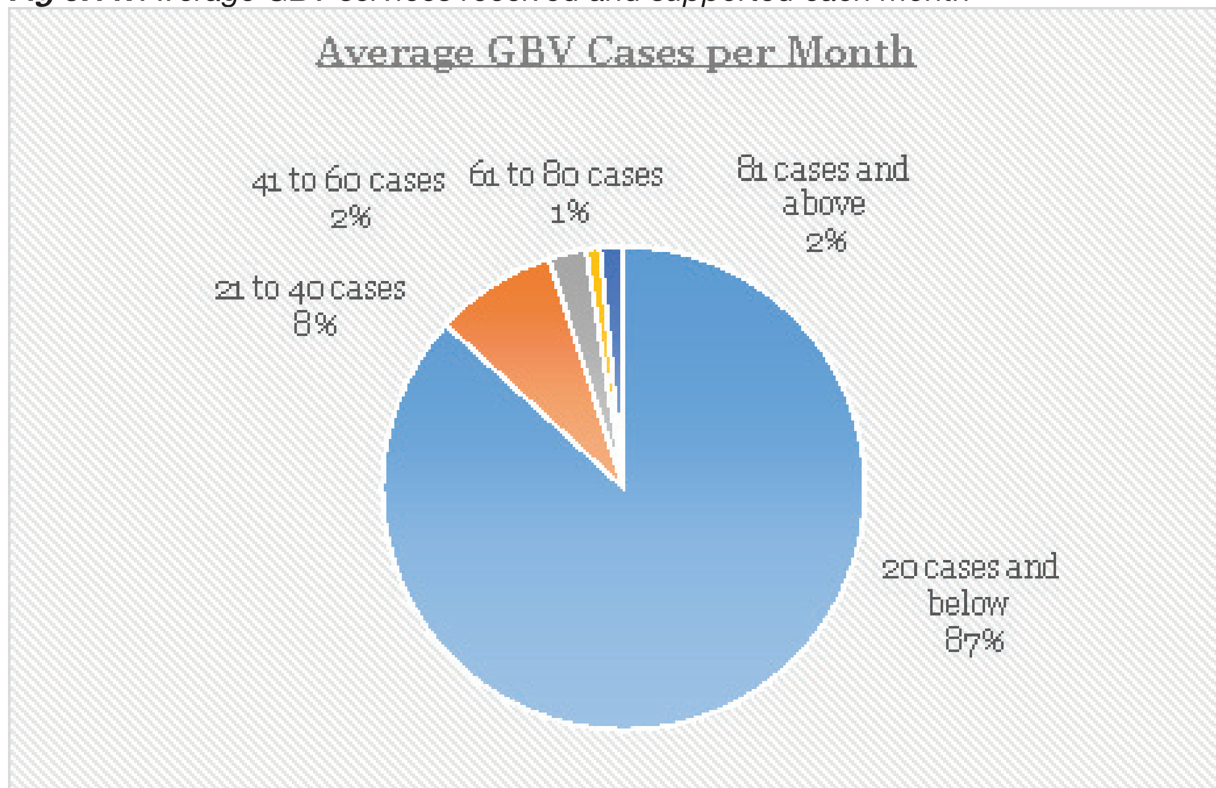
When asked the nature of the effect on GBV services; 33 percent identified limited movement of staff; limited access by GBV survivors (31 percent); closure of GBV services (19 percent); and increased cost of service provision (15 percent). 2 percent identified other factors which include – fear of COVID-19 infection; lack of protective equipment and remote methodology for service provision (figure 5.10). Respondents from the three regions agree that GBV service provision has suffered some impact due to COIVD-19. With limited services prior COVID-19, further restriction of services would deny services to the GBV survivors who are most in need of these services.

Fig 5.10: Nature of COVID-19's effect on GBV service provision



87 percent of GBV service providers receive an average of 20 cases and below each month (figure 5.11). Only 3 percent of the service providers receive an average of 61 to more than 80 GBV cases a month. 90 percent of service providers across the three states receive and support an average of 40 cases and below each month.

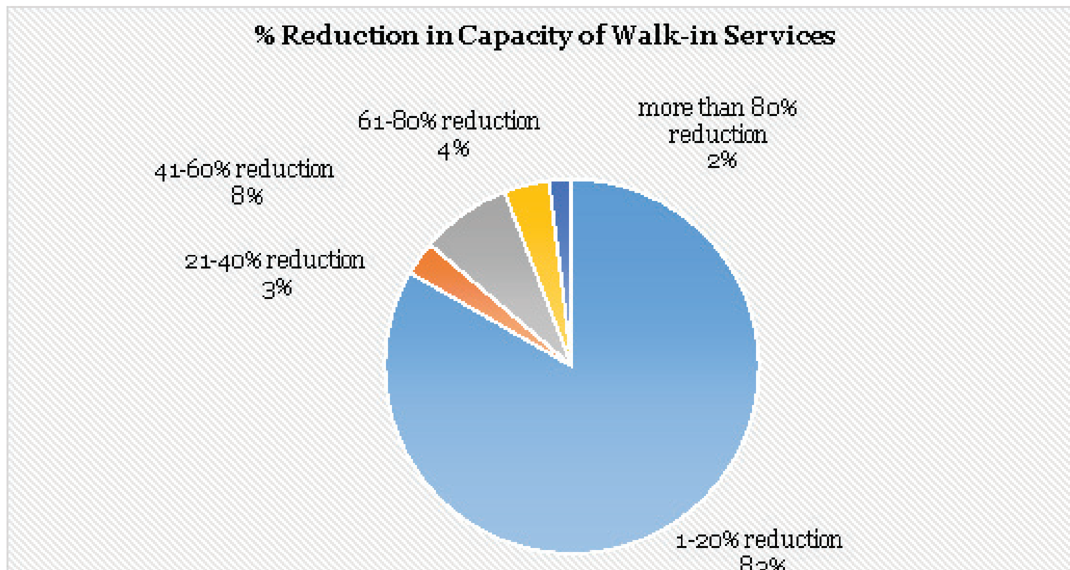
Fig 5.11: Average GBV services received and supported each month



5.13 Impact on Walk-in Services/Hotlines/Mobile teams for GBV

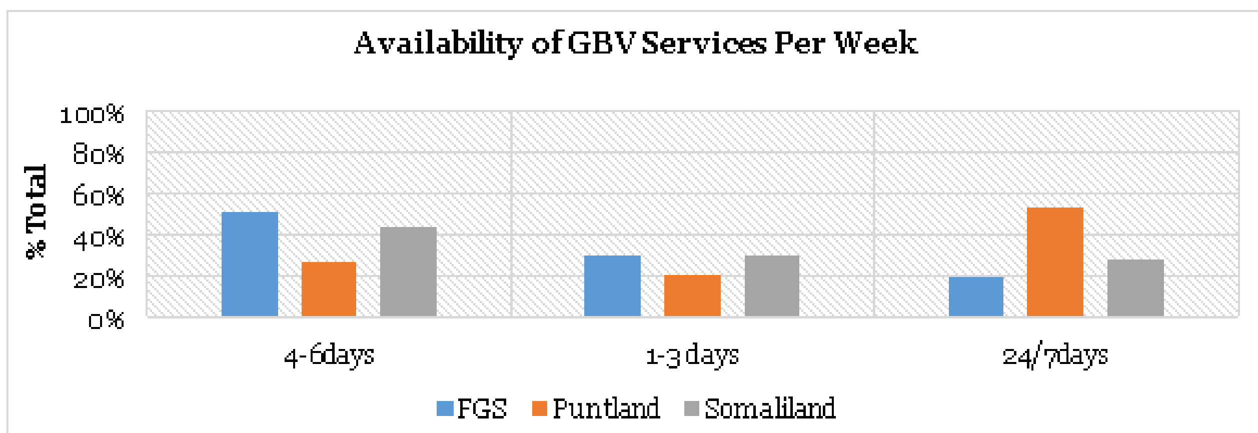
68 percent of service providers reported that they provide walk-in services compared with 32 percent who do not provide such services. 66 percent added that the walk-in services are still operational while 34 percent responded that the services are no longer operational. 83 percent said they have suffered a 1-20% reduction in capacity; 3 percent indicated a 21-40% reduction; 8percent indicated a 41-60percent reduction; 4 percent 61-80% reduction and 2 percent more than an 80% reduction (figure 5.12).

Fig 5.12: *COVID-19 impact on capacity of walk-in service provision*



In addition, respondents were asked to indicate the number of days these services were available. 44 percent reported from 4-6 days: 28 percent respectively for 1-3days and 24/7 period (figure 5.13).

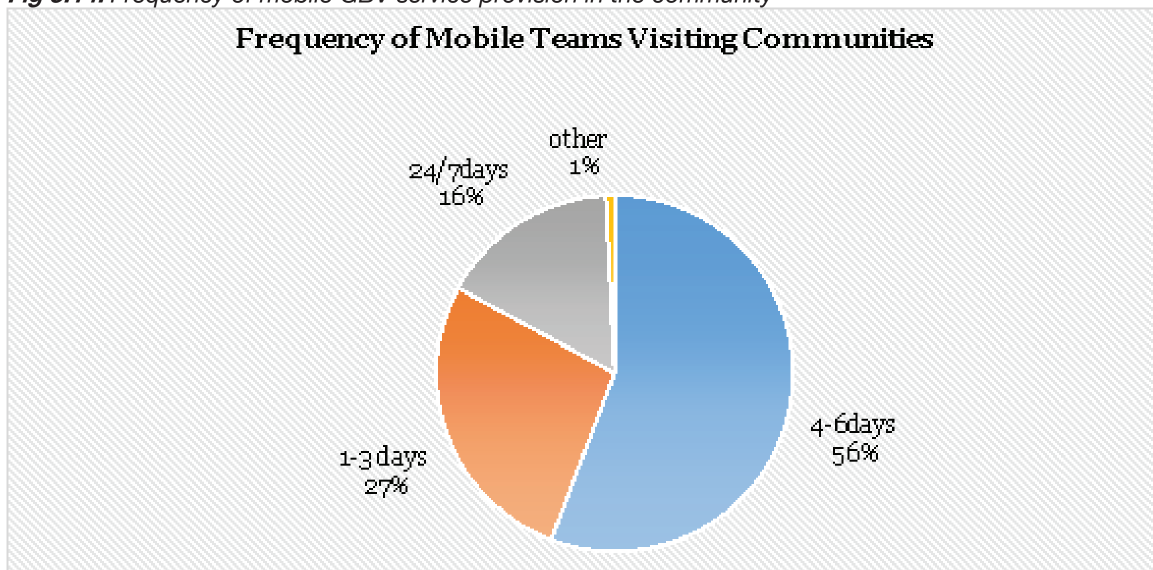
Fig 5.13: *Availability of GBV service provision each week*



For hotline services – 35 percent (111 of 318) service providers in Federal member states of Galmudug, Hirshabelle, SWS, Jubaland and "Somaliland" confirmed that they offer hotline services while 65 percent do not offer such services. A greater number of respondents (50 percent) said their hotlines were available 4-6 days a week while 35 percent indicated that this service was available to GBV Survivors' 24/7days a week. 11 percent indicated 1-3 days whereas 4 percent had no response. There are helplines in Federal member state of Puntland, but utilization appears to be very limited (please refer to Annex 1). There may be need for improved dissemination, funding for airtime or staffing support to improve the operations of these hotlines in order to ensure availability and access by GBV survivors.

For mobile team services - 59 percent of service providers mentioned that they do not provide mobile services for GBV compared to 41 percent who stated that they do. 56 percent indicated that their mobile teams go into the community for 4-6 days per week; 27 percent 1-3 days per week; 16 percent 24/7 per week and one percent had no response (figure 5.14).

Fig 5.14: *Frequency of mobile GBV service provision in the community*



5.14 Capacity of Service Providers to Respond to and Mitigate COVID-19

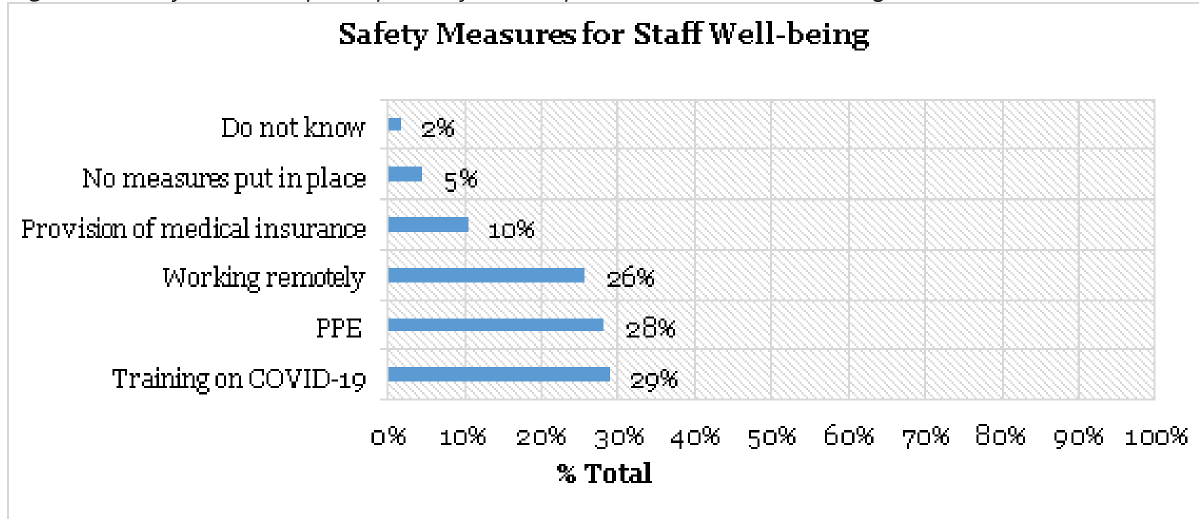
According to the assessment 68 percent of the respondents indicated that they have the capacity to deliver GBV services during COVID-19 crisis while 32 percent of the respondents believe that their capacity for response for GBV services is limited during COVID19 pandemic. The majority of the respondents that indicated they have the capacity can be due to the fact that they have familiarized and adopted to the guidelines developed by the GBV AoR Somalia including continuity of GBV Service provision during COVID19 and as well as Case management guidance note. This finding also showed that high percentage of respondents with limited capacity to provide GBV services within COVID19 context in "Somaliland" at (21 percent). This could be as a result of lack organizational capacity to adopt to the remote methodology for service provision.

The assessment showed that 41 percent of the respondents have received trainings to respond and mitigate to GBV incidences during COVID19 while over half of the respondents (59 percent) have not received any training on COVID19. This may be due to the fact that some of the service providers may not have the equipment or reliable internet infrastructure to take advantage of zoom meetings.

5.15 Measures put in place by organization for staff welfare and protection

On the staff welfare and protection, 29 percent of the staff received training on how to prevent COVID19 infection; 28 percent said that they have received PPE equipment's for protection; 26 percent of the staff work remotely from various location due to COVID-19 restriction while 10 percent responded that they have a medical insurance cover. The assessment also showed that 5 percent of the staff said that there are no measures put in place for their welfare and protection while 2 percent did not know about the measures implemented by the organization for their welfare and protection. This shows that majority of the staff are aware of the measures that have been put in place and the organizations are putting their staff welfare and protection as a core priority during this COVID19 pandemic.

Fig 5.15: *Safety measures put in place by service providers for staff well-being*



5.16 Coping and Safety Measures

17% of sampled service providers reported that community members have adopted several coping mechanisms to minimize their protection threats. One of the coping mechanisms by parents is to subject children to paid labour to complement reduced/lost household income. Other coping mechanisms identified include the following –

Men	Women	Girls	Boys
○ Consulting with community elders on the way forward ○ Following the security measures put in place by the government ○ Reciting the Quran and praying regularly ○ Production of home-made masks for sale	○ Walking in groups with other female friends when traveling to fetch water, firewood, to the market ○ Asking a male relative to escort her to a distant/remote location ○ Staying at home and avoiding social interaction ○ Seeking support from service providers offering case management ○ Attending psychosocial support services that are available ○ Use of known hotlines to report cases of violence ○ Seeking help from community centers	○ Staying at home and avoiding social interaction ○ Using safer routes and traveling in groups when traveling to market or to collect firewood ○ Avoiding the outdoors at odd hours	○ Engaging in paid labour to generate income

6.0 Conclusion and Key recommendations:

From the foregoing assessment findings, it is evident that COVID-19 has impacted on the trends for GBV and FGM. It also revealed an impact on GBV service provision including the provision of hygiene and sanitary items for women and adolescent girls. Vulnerable population such as women and girls, especially those living in IDP camps are prone to increased sexual and gender based violence due to pre- existing conditions. In order to reduce the impact of COVID restrictions to the survivors there is a need to adopt innovative approaches. GBV service provision needs to receive priority attention in terms of provision of protective equipment and funding to improve infrastructure and staffing to meet the recommendations for remote methodology for GBV service provision.

Specific recommendations are below-

Knowledge/awareness/access on GBV services

- Improved community awareness campaigns on available GBV services including hotline numbers targeting vulnerable groups e.g. women and girls with a focus in FGS. GBV partners with the support of GBV Area of Responsibility (AOR) Somalia, to equip community leaders and police with available information on GBV services and hotline number as they are identified most trusted persons to whom community members report for support.
- Regularly update referral pathways to reflect operational services as well as continue to develop and operationalize multisector referral pathways. The information regarding updated referral pathways should also be disseminated on regular basis to communities through awareness campaigns. .
- It is important for improved messaging on the linkages between COVID19, GBV and FGM to communities to encourage their buy in to act to protect women and girls from sexual and gender-based violence and FGM.
- It is important to improve messaging on the linkages between COVID, GBV and FGM to communities to encourage their buy in to act to protect women and girls from sexual and gender bases violence and FGM.

GBV service provision

- Improved provision and frequency of mobile service provision to reach remote communities with limited or no access to GBV services.
- Improved provision of remote psychosocial support to affected families to enable them cope with negative effects of COVID-19.
- Provision of personal protective equipment for GBV service provider especially for shelter service providers
- Funding allocation support the improvement of GBV service centers infrastructure to ensure compliance to the recommendations of the Somalia government for COVID19 prevention
- Support task shifting for GBV staff to avoid burnout and reduce time of exposure

- Improved support to GBV survivors and other vulnerable women and girls for direct cash assistance, cash for voucher assistance and cash for work
- Increase supported for more GBV service providers to undertake livelihood support programmes to increase resilience for women and girls (include female headed households)

Advocacy

- It is important to continue to advocate for donors, humanitarian actors to ensure that GBV services such as CMR continues to be treated as essential service during and beyond COVID
- Cross cluster and sectoral collaboration to integrate GBV concerns continues to be essential during this COVID19 era to improve GBV mitigation and improve opportunity to address needs of GBV survivors key clusters

7.0 List of Annexes

Annex 7.1: Hotline Service Providers Data – January – June 2020

Location	Organization	Jan	Feb	Mar	April	May	June
FMS - Galmudug, Hirshabelle, SWS, Jubaland	SWDC	579	977	990	1065	1318	1648
FMS - Galmudug, Hirshabelle, SWS, Jubaland	NOFLY	202	501	515	798	1103	1345
"Somaliland"	MESAF	150	400	500	650	850	1300
FMS - Puntland	MOWDAFA & MAATO KAAL	9	6	13	13	11	14
TOTAL		**940**	**1,884**	**2,018**	**2,526**	**3,282**	**4,307**

The data from the table above aligns with the findings of the assessment as to the increase in the trends of GBV. It shows an increase in the reporting of GBV cases with hotline service providers from January to June 2020. The percentage increase for Federal member states of Galmudug, Hirshabelle, SWS, Jubaland was about 283 while "Somaliland" was about 767.

Annex 7.2 GBV Rapid Assessment Questionnaire – Community Members

Note: This tool is for use during interviews with community members in target locations across Somalia, ensuring an equal representation of men, women, significant number of people with disabilities and respondents across all age groups (see methodology).

I: General Information

Date of data collection:

Region: FGS Somaliland Puntland

District:

Village:

Name of Monitor:

II: Demographic Information of Respondent

1. Age of respondent
   a. 18 - 24 years
   b. 25 - 45 years
   c. 46 years and above
2. Gender of respondent: male/female
3. Does the respondent have any disability? (visual, physical, etc.) Y/N
4. Is there any member of your family with a disability? (visual, hearing/speech impediments, physical, etc.) Y/N
5. Record the placement status of the respondent:
   a. Living in an organized camp
   b. In a host community
   c. In an unorganized settlement
   d. Living in a public building (school, abandoned building etc.)
   e. Returnee living in village/home of origin
   f. Returnee living in a displacement camp
6. What is your main source of income?
   a. Formal employment
   b. Self-employed
   c. other

Specify if other

7. Has COVID-19 had any impact on your source of income? Y/N

If yes, please explain how?

III: Knowledge of Available GBV Services

8. What are the measures that have been put in place to mitigate spread of COVID-19 in your area?
    a. Frequent handwashing
    b. Wearing face masks
    c. Use of hand sanitizers in public spaces
    d. Curfew
    e. Social distancing
    f. other

Specify if other

9. Are COVID-19 measures put in place by government working?
    a. Yes, very effective
    b. Not effective
    c. Yes, little effect

Please explain your answer

10. Compared to the period before the COVID-19 pandemic three months ago, have you noticed an increase in domestic violence and sexual assault/rape in your community?
    a. GBV incidents have become less
    b. yes, there is an increase in GBV incidents
    c. no, it has remained the same

Please explain your response above:

11. What do you understand by FGM?
12. What types of FGM practices do you know?
13. What are the types of FGM that has been on the increase?
14. What are the reasons why you think that FGM is on the increase?
    a. disruption in schools
    b. rainy season
    c. source of income for TBAs
    d. other

Specify if other

15. Compared to the period before the COVID-19 pandemic three months ago, have you noticed an increase in FGM in your community?
    a. FGM has become less
    b. yes there is an increase in FGM
    c. No, there is no difference

Please explain your response above:

16. Compared to the period before COVID-19 pandemic three months ago, have you noticed an increase in early/child marriage?
    a. Child/Early marriage has become more
    b. Child/Early marriage has become less
    c. No increase - it is the same

Please explain why you think so

17. If you think that child marriage is more - why do you think that caused this increase
    a. disruption in schools
    b. disruption in sources of income/livelihoods
    c. it is the community's way of life
    d. other
18. Are you aware of any available services that address domestic or sexual violence/rape incidents in your community? Y/N

19. If yes, which services are these?
    a. PSS
    b. CMR
    c. GBV one stop centres
    d. Shelter
    e. women and girls' safe spaces
    f. legal services
    g. other

Specify if other

20. Are you familiar with any hotline number(s) you can use to report a domestic violence or sexual assault/rape incident in case it happens to you or a member of your community? Y/N
21. If yes, what is the number(s)?
22. Is everyone in the community able to access the available services for GBV survivors? Y/N
23. If no, give a reason why:
    a. Priority is given to men
    b. No female staff providing services
    c. No male staff providing services
    d. Lack of sufficient medicine at health facilities
    e. Girls/women not permitted to access the services by their families
    f. Not safe for girls/women to travel to the services sites
    g. Location of services are not convenient for girls and women (privacy, distance, etc.)
    h. Opening hours of service not convenient for girls/women
    i. Other

Specify if other

24. If yes, which services are accessible?
    a. PSS
    b. CMR
    c. GBV one stop centres
    d. Shelter
    e. women and girls' safe spaces
    f. legal services
    g. other

Specify if other

25. Who do community members trust most to help them deal with domestic violence or sexual assault/rape incidents?
    a. Family member
    b. Community leader
    c. Police
    d. NGO working with women
    e. Any female aid worker
    f. UN agency
    g. Friend
    h. Do not know
    i. Other

Specify if other

IV: Access to GBV Services

Education

26. Do you have children of school-going age? Y/N
27. If yes, before the COVID-19 pandemic, were all your children attending school?
    a. yes, both boys and girls
    b. no, only boys
    c. no, only girls
    d. none of them
28. If only boys, what are the reasons? (do not read options to respondent, select one that closely matches the response given)
    a. not enough money to send them all
    b. girls stay at home to help domestic tasks
    c. it is not safe/acceptable for girls to go to school
    d. girls' schools are not functional
    e. girls stay at home to help with paid labour
    f. other

Specify if other

29. If only girls, what are the reasons? (do not read options to respondent, select one that closely matches the response given)
    a. not enough money to send them all
    b. boys stay at home to help domestic tasks
    c. boys stay at help to help with paid labour
    d. girls' schools are not functional
    e. other
    f. does not apply

Specify if other

30. If none of them, what are the reasons? (do not read options to respondent, select one that closely matches the response given)
    a. not enough money to send them all
    b. children stay at home to help domestic tasks
    c. children stay at home to help with paid labour
    d. no school in the area
    e. other
    f. does not apply
31. How has the COVID-19 affected your children's access to education?
    a. reduced household income to pay for school fees/equipment (uniform,
    b. school closure
    c. no effect on education
    d. other

Specify if other

32. If affected, what are you doing to cope with your children's education needs?
    a. seeking support from relatives
    b. seeking support from friends
    c. engaging them in exercises
    d. other
    e. nothing

Specify if other

33. Has there been an increase in FGM/C during the period girls are not attending school in your community? Y/N
34. If yes, how many girls have do you know of during this period?

Health

35. Before the COVID-19 pandemic, did you have safe access to health facilities?
    a. yes, everyone in our family
    b. yes, but only some members of the family
    c. none of us had access to health facilities

If none, give reason

a. no enough money to pay for health care
b. no functioning health facility in the area
c. not safe to travel to health facilities
d. other

Specify if other

36. How has the COVID-19 affected your access safe to health facilities?
    a. no enough money to pay for health care
    b. no functioning health facility in the area
    c. not safe to travel to health facilities
    d. other

Specify if other

37. If affected, what are you doing to cope with your current health/medical needs?
    a. seeking support from relatives
    b. seeking support from friends
    c. using home remedies
    d. other

Specify if other

38. Do you think someone with COVID 19 or showing symptoms will face discrimination? Y/N
39. Which group in the community will be mostly affected by discrimination during the COVID pandemic?
    a. IDPs
    b. People with disabilities
    c. Minority group
    d. other

Specify if other

40. What kind of services are still available for pregnant women and adolescent girls?
    a. SRH/Maternal health
    b. Nutrition services
    c. others

Specify if other

41. Has COVID-19 impacted on access to sanitary and hygiene items for women and girls? Y/N

Please explain your answer

42. Share any additional information concerning the issue of gender-based violence in your community:

Thank you for your time!

Annex 7.3: GBV Rapid Assessment Questionnaire – Service Providers

Note: This tool is for use during interviews with GBV service providers (key informants). The target respondent is an officer directly handling cases at the organization since they can provide accurate information.

I: General Information

Date of data collection:

Region: FGS Somaliland Puntland

District:

Name of Monitor:

II: Organization Information

Gender of person providing information: male/female

Designation of person providing information:

Name of organization/agency providing GBV services:

Email of contact person at organization:

Phone of contact person at organization:

Select type of organization/agency: NNGOINGOGovernment Agency

Location of organization/agency offering services (district/village)

1. What type of setting does your target community live in?
    a. Living in an organized camp
    b. In a host community
    c. In an unorganized settlement
    d. Living in a public building (school, abandoned building etc.)
    e. Returnee living in village/home of origin
    f. Returnee living in a displacement camp

Specify if other

2. Who manages the community?
    a. Government
    b. Armed forces
    c. UN agency
    d. NGO
    e. Private organization or individual
    f. Other

Specify if other

III: GBV Services in Context of COVID-19

3. Which GBV services do you provide?
    a. Medical/health services
    b. PSS
    c. Safety and protection
    d. Legal aid/access to justice
    e. Hotline
    f. Prevention
    g. Other
    h. None of the above

Specify if other

4. Has any of the services you provide been disrupted due to the COVID-19 pandemic? Y/N

If yes, which of the services have been affected?

5. What are the measures put in place by the government/other agencies to mitigate spread of COVID-19?
    a. Frequent handwashing
    b. Wearing face masks
    c. Use of hand sanitizers in public spaces
    d. Curfew
    e. Social distancing
    f. Other

Specify if other

6. Are COVID-19 measures put in place by government working?
    a. Yes, very effective
    b. Not effective
    c. Yes, little effect

Please explain your answer

7. How have the measures put in place by the government and lead agencies to mitigate COVID-19 affected women in the community?
    a. increased household chores
    b. limited sources of income due to restricted movement
    c. increased risk to physical violence in the home
    d. increased risk to intimate partner violence
    e. limited access to GBV support services
    f. increased psychosocial stress
    g. loss of job (source of income)
    h. increased risk of attack when visiting latrines/bathing facilities
    i. increased risk of attack when going to market or walking in isolated areas
    j. unable to access services and resources
    k. do not know
    l. other

Specify if other

8. How have the measures put in place by the government and lead agencies to mitigate COVID-19 affected men in the community?
    a. loss of job (source of income)
    b. limited sources of income due to restricted movement
    c. increased psychosocial stress
    d. increased pressure from family
    e. violence in the home
    f. less socialization
    g. other
    h. unable to access services and resources
    i. do not know

Specify if other

9. How have the measures put in place by the government and lead agencies to mitigate COVID-19 affected boys in the community?
    a. increased psychosocial stress
    b. increased risk to paid labour
    c. increased risk to physical violence
    d. disrupted studies
    e. increased household chores
    f. less play time/socialization
    g. Idling at home

h. increased risk of sexual violence/abuse
i. other
j. unable to access services and resources
k. do not know

Specify if other

10. How have the measures put in place by the government and lead agencies to mitigate COVID-19 affected girls in the community?
    a. increased household chores
    b. disrupted studies
    c. less play time/socialization
    d. Idling at home
    e. increased risk to physical violence
    f. increased risk to early marriages
    g. increased psychosocial stress
    h. increased risk to paid labour
    i. increased risk of attack when visiting latrines/bathing facilities
    j. increased risk of attack when going to market or walking in isolated areas
    k. increased risk of sexual violence/abuse
    l. other
    m. unable to access services and resources
    n. do not know

Specify if other

11. How have the COVID19 measures put in place by the government affected GBV service provision?
    a. No effect
    b. Some effect
    c. High effect

Please specify

Specify if other

12. On average, how many GBV cases do you receive and support per month?
13. Compared to the period before the COVID-19 pandemic three months ago, have GBV incidents increased in the community? Y/N
14. If yes, which cases have increased?
    a. IPV
    b. Physical Violence
    c. Rape
    d. Sexual abuse and harassment
    e. others

Specify if other

15. Compared to the period before the COVID-19 pandemic three months ago, have reporting for FGM cases to your organization increased in the community? Y/N
16. If yes, what do you think is causing this increase?
17. Does your organization provide walk-in services to GBV survivors? Y/N
18. If yes, are these services still fully operational? Y/N
19. If not, please provide percentage of reduced capacity
20. How many days a week are your walk-in services available?
    a. 24/7days
    b. 4-6days
    c. 1-3 days
    d. other
21. Does your organization operate a helpline for GBV survivors? Y/N

22. If you answered 'YES' how many days a week is your helpline services available?
    a. 24/7days
    b. 4-6days
    c. 1-3 days
    d. other
23. Does your organization have mobile teams that provide services to GBV survivors? Y/N
24. If you answered 'YES' to the previous question, how many days a week does your mobile team go out into the community?
    a. 24/7days
    b. 4-6days
    c. 1-3 days
    d. other
25. From your experience with the services that your organization provides; what significant GBV risks do women and girls face due to COVID19?
26. Have you adopted any COVID-19 mitigation measures to enable you continue providing safe GBV services in the community? Y/N
27. If yes, what measures have you adopted?
    a. Providing safety equipment for field staff (gloves, face masks, sanitizer)
    b. Building capacity of staff on response to COVID-19
    c. Allowing staff to work from home
    d. Applying social distancing measures at work
    e. Providing safety equipment for GBV survivors seeking services/target community members
    f. Applying social distancing measures during field activities
    g. Other

Specify if other

28. Do you have qualified staff with capacity to respond to GBV Cases during the COVID-19 crisis? Y/N
29. Has any of your staff received training to mitigate and respond to GBV Cases during the COVID-19 crisis? Y/N

If yes, who provided the training?

30. What topics did the training cover?
31. What measures have you put in place for welfare and protection of staff?
    a. PPE
    b. remotely working
    c. training
    d. medical insurance
    e. None of the above
    f. other
    g. Do not know

Specify if other

IV: Access to GBV Services

32. Has there been any impact on provision of GBV services to GBV survivors? Y/N
33. Which service has been most affected?
    a. Medical/health services
    b. PSS
    c. Safety and protection
    d. Legal aid/access to justice
    e. Hotline
    f. Prevention
    g. Other
    h. None of the above

Specify if other

Please explain your answer

34. If any of the services above are not available in the community, ask the informant to specify where GBV survivors/friends and family goes to access these services.

35. What other services are available for referrals to other organizations within your network?
    a. Education
    b. Clean water
    c. Hygiene/dignity kits
    d. Women and girls' friendly spaces
    e. Food aid/distribution
    f. Non-food items distribution
    g. Latrines
    h. Shelter
    i. Other

Specify if other

36. Is everyone in the community able to access the above services?
37. If no, give a reason why:
    a. Priority is given to men
    b. No female staff providing services
    c. Lack of sufficient medicine at health facilities
    d. Girls/women not permitted to access the services by their families
    e. Not safe for girls/women to travel to the services sites
    f. Location of services are not convenient for girls and women (privacy, distance, etc.)
    g. Opening hours of service not convenient for girls/women
    h. Other

Specify if other

V: Coping and Safety Measures

38. Are there any coping mechanisms adopted by men, women, girls and boys in this community to address different protection threats or minimize their protection problems? Y/N
39. Specify each coping mechanism, indicating whether it is men, women, girls, boys who have adopted this mechanism:
40. When members of the community have been victims of some form of gender-based violence, from whom do they mostly seek help?
    a. Family member
    b. Community leader
    c. Police
    d. NGO working with women
    e. Any female aid worker
    f. UN agency
    g. Friend
    h. Do not know
    i. Other

Specify if other

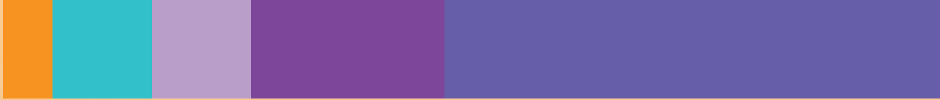
41. Are there reports of sexual abuse/exploitation in the community? Y/N
42. If yes, who does these reports?
    a. Government
    b. Military
    c. Police
    d. UN Agency
    e. Peacekeepers
    f. NGOs
    g. Other

Specify if other

43. What safety measures have been put in place by police and/ peacekeeping forces to minimize the risk of gender-based violence in this community?
    a. Increase in number of police officers
    b. Increase in number of female police officers
    c. Police/peacekeeping patrols around the community
    d. Increase in number of female peacekeepers
    e. Community safety groups established
    f. Educating girls/women on how and where to report GBV incidents
    g. Do not know
    h. Other

Specify if other

Thank you for your time!



Contacts:

Nkiru I. Igbokwe - igbokwe@unfpa.org