Sexual and Gender-based Violence (SGBV) and HIV Assessment among Vulnerable and Displaced Women in Somaliland in Non-Camp Settings

April 2010
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Acknowledgements

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<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
</tr>
<tr>
<td>CCBRS</td>
<td>Comprehensive Community Based Rehabilitation in Somaliland</td>
</tr>
<tr>
<td>CCS</td>
<td>Committee of Concerned Somalis</td>
</tr>
<tr>
<td>CID</td>
<td>Criminal Investigation Department</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation or Female Genital Cutting</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>HAVOCO</td>
<td>The Horn of Africa Voluntary Youth Committee</td>
</tr>
<tr>
<td>HAWO-GROUP</td>
<td>The Hargeisa Women Organization</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally Displaced Person</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>INGO</td>
<td>International NGO</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>LNGO</td>
<td>Local Non-governmental Organization</td>
</tr>
<tr>
<td>MOFASD</td>
<td>The Ministry of Family Affairs and Social Development</td>
</tr>
<tr>
<td>MRRR</td>
<td>Ministry of Resettlement, Rehabilitation, and Reintegration</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
</tr>
<tr>
<td>NRC</td>
<td>Norwegian Refugee Council</td>
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<tr>
<td>OCHA</td>
<td>The Office for the Coordination of Humanitarian Affairs</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
</tr>
<tr>
<td>SAHAN</td>
<td>Somaliland HIV and AIDS Network</td>
</tr>
<tr>
<td>SARC</td>
<td>Sexual Assault and Rape Centre</td>
</tr>
<tr>
<td>SGBV</td>
<td>Sexual and Gender-based Violence</td>
</tr>
<tr>
<td>SNM</td>
<td>Somali National Movement</td>
</tr>
<tr>
<td>SOLNAC</td>
<td>Somaliland National AIDS Commission</td>
</tr>
<tr>
<td>SOS</td>
<td>SOS Children’s Villages International</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNFPA</td>
<td>The United Nations Population Fund</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV/AIDS</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WAAPO</td>
<td>Women’s Action Advocacy and Progress Organization</td>
</tr>
<tr>
<td>WADA</td>
<td>Women’s Action for Advocacy and Development Association</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Executive Summary

Women and children in Somaliland are vulnerable to SGBV due to forced displacement, poverty, cultural marginalization, illiteracy, and lack of access to and awareness of health services. SGBV survivors are by the nature of the abuse more vulnerable to contracting HIV/AIDS. In Somaliland there is an absence of accurate data pertaining to the existence of SGBV and the links with HIV/AIDS and this is a barrier to the design and implementation of SGBV and HIV programmes. Purposive snowball sampling was used to recruit 79 respondents for qualitative key informant interviews and 28 respondents for focus group discussions (FGD), in three sites in Somaliland. Respondents included Internally Displaced Persons (IDPs) in non-camp settings, SGBV survivors, health service providers, religious and traditional leaders, police officers, government, host community, UN agencies, and NGOs. Findings from the assessment show the most commonly reported forms of SGBV include rape, molestation, female genital cutting, and non disclosure of positive HIV status by males prior to marriage; however, minimal evidence is available to support the link between SGBV and HIV transmission. Hospital records indicated an increase in reported SGBV cases between 2006 and 2008. Respondents indicated survivors of SGBV are highly stigmatized by the community and often discouraged from reporting through judicial procedures, in addition to a disconnect and inefficiency between traditional and formal judiciary procedures for perpetrators of SGBV, reducing willingness to report SGBV incidents.
1. Background

1.1 History and Current Situation of Somaliland and Somalia

The republic of Somaliland is in the Horn of Africa. It shares borders in the north with the Red Sea and Gulf of Aden, in the east with Puntland, in the south and west with Ethiopia, and northwest with Djibouti. The total land area of Somaliland is 137,600 square kilometres.

The male to female ratio in Somaliland is 48 males to 52 females, and the official language is Somali. Other working languages used in the country are Arabic and English. Somaliland comprises six regions: Maroodi Jeex (also known as Hargeisa region), Sahil, Awdal, Togdheer, Sool, and Sanaag. The capital city Hargeisa is the largest and the most populated city, and houses all government ministries. Hargeisa also hosts the country headquarters of most international organization present in Somaliland.

In 1988 civil war broke out in Somaliland. The Somali government at the time was led by the regime of Siyad Barre, based in Mogadishu. Citizens belonging to the Isaaq clan were particularly affected by violence prior to and throughout the war. As a consequence, hundreds and thousands of people fled Somaliland and became refugees in neighbouring countries, including Djibouti, Ethiopia, Yemen, and Kenya.

In 1991 the Somali National Movement (SNM) defeated the Mogadishu forces and Somaliland was re-formed. Somaliland’s independence was disturbed by sporadic fighting from 1994 through 1996. These outbursts of violence resulted in the further displacement of the populations. Since this period, the majority of Somalilanders have returned to their original homes. However, some citizens relocated to more peaceful regions of the country, including Djibouti, Ethiopia, Yemen, and Kenya.

The Somali central government collapsed in mid-1991, and since then Somalia has remained in a chaotic state. Lawlessness, violence, and instability have left millions of Somalis displaced as well as affecting their livelihoods. According to the UNHCR, in 2007 approximately three million Somalis were internally displaced and nearly a million were refugees in neighbouring countries. It is estimated that over 600,000 Somalis died during the war from 1988-1992 (UNHCR, 2010).

The Somali clan is the most important social structure in Somaliland; it supersedes the family and the Government. A Somali’s personal identity is intertwined with the clan identity. The clan is structured into main sub-clan and sub-sets that reach all the way down to the individual family. This link interweaves Somalis to one another, even if their biological relations may be distant. The shared clan, sub-clan, and sect title bonds society, and is a source of social support and pride.

The Somali system of clanship is a structural safety net for clan members. The clan supports its members through a variety of forums, from providing protection to providing personal insurance for its members. The clan also provides a social network for a member in time of marriage unions, birth of children, and in times of bereavement. The clan acts as a money broker and provides financial support through loans, lump sum monetary gifts, or livestock. The
clan ties also stretch abroad, as members provide remittances for clan relatives through ad hoc and more formal monthly structures. Thus, it is considered by the Somali population and non-Somali observers that individuals living outside their clan support are deemed to be vulnerable and in a precarious position, as they lack the various support functions the clan provides.

The Somali clan system is governed by rules and regulations known as Heer. These are guiding principles that dictate social regulations, norms, and laws. Heer is used in traditional hearings as legal frameworks and reference to lay judgements, and reparations. This is particularly important to this assessment, as families of SGBV survivors frequently prefer to use the Heer doctrine of justice.

Throughout this study it was confirmed that the clan system is a fundamental aspect of Somali society, and that those residing outside the parameters of clan support are in a vulnerable position. With Heer as the favoured means of arbitration in Somaliland, the absence of clan support precludes the individual from accessing justice.

Somaliland has a contemporary constitution along with a Bill of Rights. The legal structure to deliver justice for violence against women is intact at all levels, up to the Supreme Court. Laws pertaining to acts of sexual violence are also in place. However, weak implementation of these laws and women’s limited access to the legal structures is a major challenge faced by Somaliland women. The Shari’a system of law offers strict and serious punishment against those who perpetrate Gender Based Violence (GBV). These laws are even stricter than the contemporary legal system. In contrast the traditional law offers less stringent punishments and is more flexible to the perpetrator. (Minister of Family Affairs & Social Development, 2008).

1.3 Internally Displaced Persons

The refugee definition provided in the 1951 Convention Relating to the Status of Refugees and its 1967 protocol provides the main paradigm for refugee status today. This definition provides one main criteria, namely persecution. A refugee is defined as “a person who has crossed an international border because of a ‘well-founded fear of being persecuted’ in his or her state of origin” (Turton, 2003).

“Internally displaced persons are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border” (Deng, 2007).

These groups remain outside the protection of their own governments, despite technically residing within its borders. Many IDPs are exposed to violence, hunger, and diseases during their displacement, and are subject to a multitude of human rights violations. (United Nations, 1998)

IDPs fail to receive the same degree of international attention or protection under legislation. IDPs outnumber refugees by nearly two to one. National governments have the primary responsibility for the security and well-being of all displaced people on their territory, but often they are unable or unwilling to live up to this obligation as defined by the Guiding Principles on Internal Displacement, the set of relevant international standards (Turton, 2003).

The UNHCR accepts that conflict-induced displacement places affected groups in a more precarious position to potentially contract HIV/AIDS. Nonetheless this vulnerability does not always necessarily translate into more HIV infections. Rather the infection rate is subject to numerous factors that influence risk of exposure to the virus, including HIV prevalence in source and local communities, loss of livelihoods, availability of education, the type and the length of conflict, and the living arrangements and conditions of IDPs (UNHCR, 2006).

In Somaliland the concept of IDPs is problematic, as Somaliland does not hold international recognition as a sovereign nation; therefore, Somali refugees residing in Somaliland are considered to be IDPs by the international community, rather than refugees. The Somaliland Government, however, defines these individuals to be refugees. For the purpose of this report, we follow the international community’s definition and shall include Somalis from the Central and South of Somalia in the definition of IDP.
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For the purpose of this study IDPs are characterised as the following individuals:

• Rural pastoralists and agro-pastoralists, who have been forced to leave rural areas and find livelihood in urban areas due to environmental degradation, severe droughts, and poverty.
• Somalilanders displaced by conflict, including those who during the war fled to neighbouring countries and lived in refugee camps, were too fearful to return to Somaliland in the immediate aftermath of the post-war period, and therefore have returned in recent years.
• Returnees who have not yet settled permanently and are thus living in makeshift accommodation in urban areas such as Hargeisa, Burao, and Berbera.
• Somalis originating from central and southern Somalia, displaced by conflict.

These groups are largely homeless and reside in squalid conditions with limited access to services.

Some of these groups are fortunate enough to be supported by extended family members or friends. Others are supported through remittances received from family members overseas. However, the majority live in acute poverty in makeshift accommodation, and struggle for basic survival. These groups also face discrimination in their daily lives in terms of accessing employment and justice.

Regardless of whether they live in camp or non-camp settings, IDPs residing in Somaliland are often marginalized by local communities. They are particularly affected by the lack of adequate housing and sanitation conditions. Those IDPs living in non-camp settings often squat on or rent private land, making makeshift homes from any suitable materials they find, such as cooking oil tins, old clothes, animal skins, and plastic sheeting.

In mid-2008 a large influx of IDPs from South-Central Somalia fled fighting and arrived in the Koodbur area of Hargeisa. A community charity drive was organized through word of mouth and Friday prayer meetings. The drive provided IDPs with clothing, blankets, and money. Similar drives were spontaneously organized by neighbourhoods across the country.

IDPs are subjected to forced evictions without the luxury of protection through housing laws. The October 2008 terror attacks in Hargeisa have led to heightened tension between IDPs and host communities. Many IDPs from South-Central Somalia were subjected to violence as they were blamed for the attacks. Many were forced to leave their homes through violence and forced eviction.

Furthermore, in 2007 and 2008 severe droughts affected the eastern regions of Somaliland, particularly Togdheer, Sool, and Sanaag regions, which caused hundreds of pastoral and nomad families to lose their livelihoods and move to urban areas. These families eventually joined the existing IDP settlements in Burao town.

As in most countries, displaced children in Somaliland have limited access to educational opportunities. Those that do attend school are subjected to discrimination and bullying by other pupils.

“We had a few IDP students from South-Central Somalia come to our school. The family were being supported by a relative abroad who provided the money to pay for their school fees. Sadly, students would bully these new pupils. It is unfortunate to say but some teachers did nothing to protect the children. They held them accountable for the civil war even though these children and their families probably had nothing to do with the actions of the government during the war. The children were eventually removed from the school. Their mother said she would take them back to the South even though there is fighting. The children risked greater danger from the damage to their mental well-being due to the bullying.”

Female Teacher, aged 28, Hargeisa

IDP children are often forced to work in order to supplement their families’ income. The choice trades for displaced children are car washing, shoe polishing, and domestic work. Those that cannot secure employment spend their days begging in the streets. This places these children in vulnerable situations, including risk of abuse.

In October 2003 the Somaliland government issued a decree providing for the deportation of non-Somalilanders. During this period IDPs, refugees, and irregular migrant workers lived in a climate of fear. This decree is no longer
being enforced; nevertheless, there seems to be insufficient information with respect to the official policy and its implementation among the relevant actors and communities concerned (UNHCR & UNAIDS, 2007).

Somaliland is a sovereign nation, although not recognised by the international community. We consider displaced persons from South-Central Somalia as refugees as they are fleeing persecution from our neighbour country of Somalia. However, for our dealing with international NGOs, we understand that they classify these groups as internally displaced. For work purposes only, we have accepted this definition.

Stakeholder from Government Ministry, Hargeisa

Many displaced populations reside in slum neighbourhoods and spontaneous settlements that are characterized by poor infrastructure and low levels of services. In these settings, they often experience discrimination, may hide from authorities, and rely on the informal sector for income.

IDPs, whether residing in a formal camp setting or in an informal settlement, are made vulnerable by the nature of their displacement. Thus their situation often leads to IDPs having inadequate access to health services, including HIV and sexual and reproductive health programmes. In addition, vulnerability results from individual and societal factors that adversely affect one’s ability to exert control over one’s own health. The characteristics of the HIV epidemic, the prevalence in the local populations and among potential perpetrators of sexual violence, the occurrence of sexual violence, and the risk behaviours associated with the conditions of IDPs, directly affect the risk of HIV transmission.

Table 1: IDP Settlements in Somaliland

<table>
<thead>
<tr>
<th>Geographical Location</th>
<th>IDP Settlement ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hargeisa</td>
<td>Sheikh. Nur,</td>
</tr>
<tr>
<td></td>
<td>Sheikh Yussuf Kownin</td>
</tr>
<tr>
<td></td>
<td>Daami</td>
</tr>
<tr>
<td></td>
<td>Aw Adan</td>
</tr>
<tr>
<td></td>
<td>Ahmed Dhagax (Ahmed Guray)</td>
</tr>
<tr>
<td></td>
<td>Abdi Idan</td>
</tr>
<tr>
<td></td>
<td>Mandeeq</td>
</tr>
<tr>
<td></td>
<td>Stadium</td>
</tr>
<tr>
<td></td>
<td>26th June (Almis)</td>
</tr>
<tr>
<td></td>
<td>Goljano</td>
</tr>
<tr>
<td></td>
<td>Koodbuur (State House)</td>
</tr>
<tr>
<td></td>
<td>Mohamud Moogeh (Guryasamo)</td>
</tr>
<tr>
<td>Berbera</td>
<td>Jama Layeh</td>
</tr>
<tr>
<td></td>
<td>Shacab Area</td>
</tr>
<tr>
<td>Burao</td>
<td>Yarooweh</td>
</tr>
<tr>
<td></td>
<td>Sii Bakhti</td>
</tr>
<tr>
<td>Borama</td>
<td>Sh. Ali Jowhar</td>
</tr>
<tr>
<td></td>
<td>Sh. Osman</td>
</tr>
<tr>
<td></td>
<td>Las Anod Dami</td>
</tr>
</tbody>
</table>


1.4 Sexual and Gender-based Violence

There are many forms of sexual and gender-based violence against women including honour killings (by families for cultural reasons); suicide; female infanticide (murder of infant girls); and maternal death from unsafe abortion. In Somaliland, SGBV encompass rapes, molestation, abuse, exploitation, and female genital mutilation / female genital circumcision.
According to the United Nations, characteristics of violence against women include “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats, of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (UNFPA, 2009).

The duration of health affects of SGBV range from short-term to long-term and permanent physical or psychological damage. The possible injuries also vary from non-fatal, such as gynaecological problems, unintended pregnancies, and contracting sexually transmitted infection such as syphilis or HIV, and may even include death. The scale of social and economic costs of violence against women has dramatic and rippling effects throughout society. Women may suffer isolation, inability to work, loss of wages, lack of participation in regular activities, and limited ability to care for themselves and their children. Furthermore, sexual and gender-based violence is associated with the following:

- **Risky behaviours**: Sexual abuse as a child is associated with higher rates of sexual risk-taking (such as first sex at an early age, multiple partners, and unprotected sex).
- **Substance use and additional victimization**.

Each of these behaviours increases risks of health problems.

- **Mental health**: Violence and abuse increase risk of depression, post-traumatic stress disorder, sleep disorders, eating disorders, and emotional distress (UNFPA, 2009).

### 1.5 HIV and AIDS

“HIV remains a global health problem of unprecedented dimensions. Unknown 27 years ago, HIV has already caused an estimated 25 million deaths worldwide and has generated profound demographic changes in the most heavily affected countries.”

*(UNAIDS 2008)*

The Somaliland National AIDS Commission (SOLNAC) was established by Presidential Decree on 28 June 2005. It consists of a chairman and eleven members, all of whom are appointed by the President. Members include government ministers whose ministries are responsible for aspects of the HIV response, representatives from NGOs, women, religious leaders, people living with HIV/AIDS, and private individuals selected for their commitment to, and active involvement in the HIV response. The function of the SOLNAC is to oversee, plan, and coordinate the national HIV programme.

National surveillance data collected from pregnant women in 1999, 2004, and 2007 revealed an estimated prevalence of HIV of 0.9 percent, 1.4 percent, and 1.3 respectively. These figures are used to estimate HIV prevalence in the general population.

According to SOLNAC, the current estimated HIV prevalence in Somaliland of 1.3 percent is likely an underestimation. Furthermore, the prevalence in neighbouring countries (Ethiopia and Djibouti) indicates potential for increase in Somaliland through cross-border migration, and also among the internally displaced (SOLNAC, 2007).

In 2002, the UN Secretary General’s Special Envoy on HIV/AIDS in Africa described the plight of HIV among women and girls as such: “If it can be said, as it can, that by the year 2020, the number of deaths from AIDS in Africa will approximate the number of deaths, military and civilian combined, in both world wars of the 20th century, then it should also be said that a pronounced majority of those deaths will be women and girls. The toll on women and girls is beyond human imagining; it presents Africa and the world with a practical and moral challenge which places gender at the centre of the human condition. The practice of ignoring a gender analysis has turned out to be lethal. For the women and girls of Africa, it is a matter of life or death.”

### 1.6 Gender and HIV/AIDS

As women often bear the double burden of being both sick and a caregiver to the sick, the context of gendered development is critical to understanding the epidemic. The empowerment of women contributes significantly to the reduction of women’s vulnerability to HIV/AIDS.
The lack of education and awareness about HIV/AIDS among Somaliland women, and the deep-seated cultural acceptance of FGM, places Somaliland women in a precarious position when it comes to HIV/AIDS. FGM procedures are often carried out by traditional birthing attendants who also tend to pregnant women in deliveries. The instruments used are often the same and not adequately cleaned or sterilized, thus causing an opportunity for the contraction and spread of HIV.

Furthermore, the accepted traditional and cultural practices of polygamy and dumal1 place all parties in a potentially dangerous and vulnerable position of contracting HIV. Premarital screening is not a practised generally in Somaliland this is even more unlikely to take place in second marriage unions or incidences of dumal.

Table 2: Violence and HIV Risk throughout a Woman’s Lifespan

<table>
<thead>
<tr>
<th>Childhood</th>
<th>The immature genital tract and lack of power against adult sexual aggressors place children at risk of HIV infection from sexual abuse and child prostitution.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescence</td>
<td>The immature genital tract and lack of power against adult or peer sexual aggressors place adolescent females at risk of HIV infection from rape and coerced sex, economically forced sex, forced prostitution, courtship or date rape, and early marriage.</td>
</tr>
<tr>
<td>Adult Reproductive Years</td>
<td>Violence from the following contributes to the HIV risk of women in their adult reproductive years: intimate partner violence, marital rape, violent retaliation of husbands or partners at the suggestion of condom use, forced prostitution, and traditional practices such as wife inheritance, widow cleansing,2 etc.</td>
</tr>
<tr>
<td>Older Age</td>
<td>Women later in life may be particularly vulnerable to violence as a result of economic insecurity and (in some societies) diminished social status. Violence against older women can include rape and violence between intimates, both of which pose a risk of HIV transmission.</td>
</tr>
</tbody>
</table>

Source: Heise, Ellsberg, and Gottemoeller, Ending Violence Against Women

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1Dumal is the practice here when a man dies, his wife/wives are then married to his bother. This traditionally serves as a means of protecting the widow(s) and his children, and retains the clan and family unit. This is not a forced practice, but instead a personal choice of the female, whose choice is usually respected by the community.
2. Objectives of Study

The overall objective of the study was to increase SGBV awareness among government, UN, INGO, and other stakeholders – representing multiple sectors on the vulnerabilities of specific populations of humanitarian concern, and identifying effective approaches for vulnerability reduction and sustainable delivery of integrated services. Furthermore, the study aimed to provide governments and partner agencies with a strategic information document to facilitate extension of the Inter-agency Steering Committees on HIV and Gender-based Violence Guidelines, and to facilitate improved programming on GBV and HIV for vulnerable and displaced women in non-camp situations in Somaliland.

This study was a qualitative rapid assessment of HIV and SGBV vulnerability among women of irregular migration status, including potential trafficking victims. The target population were from Ethiopia, Puntland, and South-Central Somalia, and reside in non-camp settings in Somaliland. The study was undertaken by the Somaliland National AIDS Commission (SOLNAC) and the International Organization for Migration (IOM), in collaboration with the Ministry of Religion, Ministry of Family Affairs and Social Development, and NGOs. The study aimed to coordinate with the Somaliland SGBV Working Groups, however, during the study period these working groups were not functional. The findings of this rapid assessment will advise the development of a programme to enable access to integrated SGBV services addressing health, protection, and livelihood needs.
3. Methodology

The methodology used for this assessment was primarily qualitative, utilizing the following methods:

- **Desk/Literature Review**: A background literature review on the situation of HIV/AIDS in Somaliland and the pervasiveness of SGBV, and the links between the two.

- **Key Informant Interviews (KII)**: Key informant interviews were utilized in order to capture information on underlying vulnerabilities and to examine relationships between SGBV and HIV. KII's were also used to identify further research needs. The key informant interviews mainly concentrated among IDPs in non-camp settings, but also included community members (non-IDPs), survivors of SGBV, service providers, religious and traditional leaders, and police officers.

- **Focus Group Discussions (FGD)**: In order to obtain general knowledge, attitudes and practices, gender segregated focus group discussions were facilitated amongst female IDPs (in non-camp settings) and survivors of SGBV. Additionally, one FGD was conducted with religious leaders and police officers.
4. Target Population

Primary Populations:

- Female IDPs in non-camp settings -including survivors of SGBV- from Somaliland, Puntland, and South-Central Somalia.
- Female irregular migrant workers from neighbouring countries such as Djibouti and Ethiopia. 3

Secondary Populations:

- Religious and traditional leaders
- Police officers
- Non-IDP community members, both male and female
- UN, NGO, and government (relevant to or working with SGBV)
- Health service providers
- Other service providers for survivors of SGBV (i.e. legal assistance, psychosocial counselling, etc.).

3Irregular migrants from Ethiopia and Djibouti are usually unskilled workers who are employed as domestic staff.
5. Results

Key informant interviews and FGDs were conducted with IDPs in non-camp settings, with community members (non-IDPs), survivors of SGBV, service providers, religious and traditional leaders, police officers, UN agencies, NGOs, and health service providers. The findings from the FGDs discussions were very similar to the information obtained from the key informant interviews, therefore the results from the focus group discussions shall be incorporated into the key informant interview results section.

Table 3: Number and Type of Key Informants by Location of Interview

<table>
<thead>
<tr>
<th>Type of Respondent</th>
<th>Hargeisa</th>
<th>Berbera</th>
<th>Wajalea</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDPs</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>SGBV Survivors</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Members</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Religious</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Traditional Leaders</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Police Officers</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Government Officials</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>UN Agencies</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>International NGOs</td>
<td>5</td>
<td>0</td>
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<tr>
<td>Local NGOs</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Service Providers</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total by Location</strong></td>
<td><strong>65</strong></td>
<td><strong>8</strong></td>
<td><strong>6</strong></td>
</tr>
<tr>
<td><strong>Total Key Informants</strong></td>
<td><strong>79</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Numbers and Types of Focus Group Discussion Participants by Location

<table>
<thead>
<tr>
<th>Type of Respondent</th>
<th>Hargeisa</th>
<th>Berbera</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDPS, SGBV Survivors and Community Members</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Police Officer and Traditional, Religious Leaders</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total by Location</strong></td>
<td><strong>20</strong></td>
<td><strong>8</strong></td>
</tr>
<tr>
<td><strong>Total Focus Group Discussion Participants</strong></td>
<td></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

5.1 Response Rate

Ninety four percent of individuals approached for key informant interviews agreed to participate in the research (79 out of 84). The five individuals who refused to participate in the research stated they were uncomfortable with the interview topic.
5.2 Geographical Location of Study

Data collection took place in three main cities in Somaliland: Hargeisa, Berbera, and Wajalea. These sites were selected because of their high prevalence of HIV and relative easy access related to security constraints. Boroma was originally intended to be included as a data collection site; however, due to instability and insecurity in the surrounding geographical area the researchers could not access this location. Additionally, data collection mainly concentrated in Hargeisa as this is the capital city and the base for most international and local NGOs. Additionally, government ministries are centralized in the capital city.

Figure 2: Geographical Area of Study Respondents (N=79)

5.3 SGBV Survivors, Community Members, and IDPs

5.3.1 Demographics of Respondents

The ages of the participants who participated in the KIIs and FGDs with IDPs, community members, and survivors of SGBV ranged from 18 to 65, and all were female. Men were excluded from participating in this segment of the KIIs and FGDs because it is considered a cultural taboo to discuss sensitive issues such as SGBV and HIV/AIDS in public, and even more difficult to do so with men. It was, however, possible to engage more public male figures, such as community leaders and males working with SGBV, and these individuals are included in the next section.

All of the survivors of SGBV, community members and IDPs (n=30) interviewed indicated that they had no formal or Islamic education. 69% (n=9) of the IDPs interviewed were residing in urban areas in makeshift homes rather than IDP camps; however, 31% (n=4) of the IDPs have lived in an official IDP camp at some stage. Participants found it difficult to define where they lived and their associated status as an IDP, as this was not something they had thought of before and found this question unusual. Participants clearly did not distinguish between living in informal settlements or permanent homes, and this did not define their identity in any way.

“In 1988 when the war broke out in Hargeisa I was seven and my family and I fled to Ethiopia. We lived in Dulcad until 2002. When we returned to Hargeisa my parents had nothing... our former home had long been taken over by another family who had rebuilt it, making us lose all rights over it. We squatted in some open land. My mother washed clothes when she got work. My sisters and I work as a house-maid. We have never been to school.”

Female IDP, aged 30, Hargeisa

“I have never been to school I cannot read or write. I used to live in the meeh (rural area) near Burao. I worked as a livestock herder with my family. From 2006 to 2009 we had a bad drought and lost all our livestock. I moved to Hargeisa to work as a house maid but I got sick and I can’t work. I beg instead and live in a [makeshift] hut that a family who felt sorry for me own. They do not charge me anything so I am lucky.”

Female IDP, aged 20, Hargeisa
5.3.2 Reason for Leaving Place of Origin

Over half of the IDPs interviewed (62%, n=8) had fled from the rural areas because of environmental changes that prevented them from living the rural lifestyle which they had maintained for generations. Severe drought, land degradation, loss of livestock, and acute poverty has been the driving factors for the increase in IDPs in this sample, and also in Somaliland as a whole.

“Everyone wants their sons to be ambitious and successful. You cannot do that living in the rural communities – especially with poverty, loss of livestock, and environmental degradation of the land.”

Female IDP, aged 50, Berbera

5.3.3 Awareness and Prevalence of SGBV

Forty percent (n=12) of the IDP, community members and SGBV survivor respondents indicated they had heard of SGBV and were able to articulate what they believed were the different forms. The fact that 60% (n=18) had not heard of SGBV may be attributable to the fact that the Somali language does not have a particular word coined to for this term. Once the researchers explained the word and its meanings, participants were able to understand and articulate the different forms.

When asked if SGBV is happening in their community, the participants overwhelmingly indicated that there is a high prevalence of SGBV in Somaliland; however, they felt that it was not taken seriously by authorities and society in general. Interestingly, SGBV and its different forms are never talked about with children in the family setting. Children are instead told to stay away from strangers, but no further specifics are taught. Participants indicated that the most likely victims of SGBV were women and young girls aged 15 and above.

“This is a taboo topic and is often hidden from children.”

Female, community member aged 20, Berbera

Three of the community members interviewed were identified as irregular migrant workers. They indicated that they face dangers when walking between Somaliland and Ethiopia to seek employment, as these journeys make them vulnerable to sexual violence at the hands of Ethiopian soldiers and border control officers.4

“Yes, when walking between Ethiopia and Somaliland, women face grave problems. Many are stopped and raped by the Ethiopian soldiers. Because of the sparse landscape, no one can protect you and there is no justice…. Oftentimes, women are ashamed to tell anyone and they get pregnant or contract HIV, others are lucky.”

Female irregular migrant worker, aged 19, Hargeisa

5.3.4 Locations where SGBV Takes Place

When asked where SGBV is most likely to take place, mixed responses were elicited. Some said in the home and others said in secluded places.

Participants were in agreement that perpetrators of SGBV were more likely to be young boys who are in gangs. They indicated that these gangs often perpetrate gang rapes, up to seven or eight boys attacking one victim over and over again. Alarmingly, 90% (n=27) of these participants indicated they were aware of someone close to them who was a survivor of SGBV.

4These individuals did not use passports to travel between the countries, but rather identification documents.
Young girls are vulnerable when they take the animals to pasture in secluded areas and if they are attacked no one can help them.

*Female, community member aged 18, Wajalea*

My neighbour was walking home late one night when she was attacked by a group of seven boys who savagely gang raped her. These boys were never caught or brought to justice.

*Female, IDP aged 37, Hargeisa*

Yes, a friend of mine was raped by nine boys.

*Female, community member aged 18, Wajalea*

My daughter was raped by one boy with four others looking on. I went to the rape centre in Hargeisa Hospital and they informed the police for me. Ever since I did this the whole neighbourhood is gossiping about my family and they say my daughter was promiscuous and she lied. I have since sent my daughter to live in Burao with my sister to protect her from the gossip. I know she can never ever return to Hargeisa and live with us again. We have no justice.

*Female, IDP aged 55, Hargeisa*

### 5.3.5 Types of SGBV

When respondents were asked the types of SGBV in Somaliland society, responses elicited included rape, sexual assault, sexual abuse in children, and female genital mutilation (FGM).\(^5\)

Interestingly, some respondents (n=8) provided another perspective on the types of SGBV. They believed that when an HIV positive male marries a woman without disclosing their status, that this is a form of SGBV. Couples prior to marriage do not undergo HIV testing. In addition, women entering into a polygamous marriage do not enquire about the HIV status of their new husband or his other wives. Seeking routine HIV testing is not a societal norm in Somaliland. Rather, HIV testing is something that individuals undergo when they are unwell for an extended period and suspect that they may have AIDS. The lack of condom availability in Somaliland also prevents partners from engaging in safe sex practices, including within polygamous marriages. This assessment found that some married men who are HIV positive choose to deliberately keep this information from their wives until they are too sick to hide their condition.

If a man infected with HIV marries without letting his wife know about his illness, I believe that this is the worst form of SGBV. He has sentenced the woman to death.

*Female, IDP aged 40, Berbera*

My husband married me knowing he was HIV positive. I found out after his death. Now I am HIV positive too.

*Female, IDP aged 37, Hargeisa*

My husband married me without telling me he was HIV positive. He was sick when we got married and got worse throughout the early part of our marriage. His family members would often come and take him to the doctors, but they never let me go with them. After a while, he got worse and lost a lot of weight. He also had constant diarrhoea. When I would ask what was wrong with him or what did the doctor say, they told me he had been cursed by the evil eye and they were going to take him to a religious sheik.

\(^5\)Also referred to as female genital cutting or female genital circumcision.
This did not help and he did not get better. When he died, no one came in to my house. No one came to pay their condolences or offer sympathies with me. They went to his mother’s house instead. A few days after his death, his brother came to me and told me to pack. He said he was taking me to my family. He took me to a deserted place in the meeh (rural area) and left me there. I walked to the nearest road. A group of young men picked me up and brought me back to Berbera. I went straight to my mother’s home and I never went back.

Female, IDP aged 37, Berbera

5.3.6 Islam, Khat and SGBV

All participants were in agreement that Islam teaches that SGBV is forbidden and haram (a sin). However, few participants could relay the exact punishments Islam dictates for such crimes. Nor did they provide any Islamic referencing in regards to this. This lack of Islamic knowledge is evidence of the lack of a basic Islamic education.

Participants were in overwhelming agreement that khat chewing contributes significantly to incidence of SGBV. Participants indicated that it also causes family breakdowns and exacerbates poverty.

“When men chew khat they become high. Most men chew every day. This causes them to be high constantly, and when they are high they lose their inhibitions and can not distinguish between right and wrong.”

Female, IDP aged 23, Wajalea

“Yes khat makes men more aggressive and violent. I believe it contributes to SGBV in Somaliland. It is also a root cause for family breakdown.”

Female, IDP aged 37, Berbera

One participant provided a different perspective:

“I believe that khat acts like a sedative. It reduces men’s libido and sexual desires. Thus I do not think it contribute to SGBV in Somaliland.”

Female, IDP aged 30, Hargeisa

5.3.7 Support for SGBV Survivors

Respondents indicated that SGBV survivor’s access to justice is relative and it depends on ones financial situation. Participants explained that those who could afford to bribe police officers would have their cases taken seriously and investigated appropriately. Survivors of SGBV are often ostracized and condemned by the community for involving the police, especially if the community is made up of the perpetrator’s clan.

Respondents indicated that the survivor of SGBV is stigmatized because of being raped. She faces constant reminders by the community of her rape and is forced to live with this label.

“My ex-husband came to me early one morning demanding that I give him money for khat. When I refused, he beat me with a brick until I passed out, and he raped me. He then ran away. I told the police, but I had no money to further the case by bribing the officers to investigate this. He has never been prosecuted and harasses me still. The community condemns my actions for calling the police and they look down on me. Women are the worst. They gossip about me constantly.”

Female, IDP aged 40, Wajalea

Respondents also stated that it is common knowledge that police officers are bribed, thus citizens have no confidence in the validity or truthfulness of allegations. If a victim seeks legal advice and cannot afford to pursue the matter, she is seen as lying and is condemned by the community.
If you are born into a poor family, then no one cares about you getting justice.

Female, IDP aged 23, Wajalea

Often perpetrators are arrested and kept in jail for a few days just for appearances. Then they are released.

Female, IDP aged 23, Wajalea

The participants indicated that the preferred support system for SGBV survivors is family members and friends. Some respondents said they would seek assistance from NGOs. Others said that they felt survivors would not seek support but rather visit the pharmacy for medication to tend to their wounds.

Figure 3: Participants Response to Preferred Support for SGBV Survivors

5.3.8 Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is defined by WHO as “all procedures, which involve partial or total removal of the external female genitalia and/or injury to the female genital organs whether for cultural or any non-therapeutic reasons.” (WHO, 1995)

FGM is a culturally established practice in Somaliland. Despite many awareness campaigns on the dangers and health hazards of performing FGM, it is still widely practiced today. In Somaliland society, there are two types of FGM. The most extreme form is the pharaonic, also known as infibulations. This practice involves removing all or part of the external genitalia and stitching of the raw edges of the vulva together with thorns or catgut sutures, leaving a small opening to allow flow of urine and menstrual fluid. The second type of FGM is known as sunna, or the medical term clitoridectomy, and it involves the removal of all or part of the clitoris. This type is the less severe form of FGM (Social Services and Protection of Vulnerable Groups Sub-Cluster Report, 2006).

Respondents provided a mixture of comments when asked about the practice of FGM and Islam. Some believed that if they stop this practice they will be cursed by Allah. Other participants stated that they believed in this practice but it was not a prerequisite of Islam and the activity has no religious founding. Furthermore, respondents stated the reason SGBV abuse had increased lately was because of a reduction in the performing of the pharaonic form of FGM. None of the participants were able to provide the name of an NGO working in the field of FGM eradication.

A girl must be closed in order to protect her virginity and dignity.

Female, community member aged 55, Hargeisa

Girls that are not closed (pharaonic FGM) are wild and promiscuous and have no shame.

Female, community member aged 29, Berbera
“Girls who have been closed are able to maintain their modesty. I believe that by girls not having the pharaonic practice performed, this has led to an increase in sexual desires and girls having illegitimate children outside marriage.”

Female, community member aged 35, Hargeisa

One participant indicated that more and more people had changed to the *sunna* and that it is now more prevalent than the *pharaonic* practice. Some indicated that society had become more aware about the dangers of FGM, and are adamant that it should be stopped. However, others believed that the *sunna* is not a form of FGM and they do not deem it to be a harmful or dangerous practice.

When asked if they believed that FGM is a form of SGBV, responses were mixed. By and large, however, participants indicated that they believed that it was not.

“It is the worst form of sexual violence as it has long term consequences. FGM is a torture done to women. There is no religious foundation. It is ignorance pure and simple, and the worst form of SGBV.”

Female, community member aged 31, Wajalea

FGM is preformed on young girls with the full consent of the family. In particular, Somaliland mothers believe that they are securing the future of their daughters by carrying out this procedure, as this practise will ensure that her modesty and virginity are intact until she gets married, thus not endangering her marriage prospects. Rather than a violent act carried out with harmful intentions, this is therefore seen by many in Somaliland society as a harmful act that is necessary and carried out with loving intentions to protect their daughters.

Acts of rape upon women and girls who undergo pharaonic FGM are even more brutal, particularly when the survivor has more than one attacker. It could lead to the woman being forcibly opened, causing severe bleeding and physical damage.

When participants were asked if you can contract HIV through SGBV, most were divided in their responses, some felt that it was not possible while others believed that it was. Participants shared that the FGM practitioner is more often than not also a traditional birth attendant who uses the same materials and instruments used during deliveries. These attendants do not have access to sterilizing equipment thus causing a potential risk for one developing infection and illness, including HIV.

### 5.3.9 HIV Transmission

When asked about HIV Transmission, a range of responses were elicited. Some participants could accurately state the various ways one can transmit HIV, however these responses were also joined by inaccurate information, mainly the following four statements:

“If your blood comes into contact with an infected person’s blood, or if you share the same bathroom, sleep in the same bed you can contract HIV.”

Female, IDP aged 18, Hargeisa

“If you get bitten by a dog - If a person with HIV bites you, you can get HIV.”

Female, IDP aged 55, Hargeisa

When respondents were asked how they could protect themselves from contracting HIV they often could not articulate a response other than they should “look after themselves”.

Most participants (n=27) believed that HIV could be contracted through SGBV and felt that this was a worrying possibility. Most understood that if a perpetrator or survivor is HIV positive that the possibility for contracting the virus was present.
I contracted HIV from my husband. He died two years after we were married. I had a baby but she died soon after birth. I knew my husband was sick when I married him. I was an IDP with no money and he was a police officer. When I questioned what was wrong with him, his family said ‘infection’. In Somaliland, everyone has an infection – this is a common word doctors use. When I found out he was infected with HIV, I thought he would get better. I did not understand the seriousness of the illness. I was more concerned about my diabetes, that is serious you can die from it.

Female, IDP aged 22, Hargeisa

Through links with an NGO, the researchers found four participants who willingly disclosed that they were HIV positive at the start of the interview. These women had contracted the virus through SGBV. One participant was raped and the other three participants were married to men who all knew they were HIV positive but deliberately hid their status and married the women. These women were in monogamous relationships and were trusting of their husbands, which is common in Somaliland culture.

5.3.10 HIV Services, Awareness Campaigns, and Interventions

None of the interviewees could name an organization working in the field of HIV prevention, thus it is evident that awareness campaigns organized by various local and international organizations are not reaching their target populations.

Despite all participants indicating that they had access to one type of media, mainly radio, none could articulate any awareness campaigns or educational programmes designed to educate on SGBV or HIV/AIDS.

Once I heard a car in the street with a microphone attached to it, and the speaker was talking about HIV/AIDS. I was on a noisy street and I did not hear what they were saying. All I heard was to be aware of the disease AIDS.

Female, community member aged 35, Hargeisa

Participants were quite interested in receiving more information and training on HIV/AIDS and SGBV. The most common preferred mode of information reported was through television and radio. Participants also indicated that they preferred to receive information from a young female, approximately 20-25, and in the Somali language. Most participants indicated that they would like to receive the information from a health professional or religious leader, as they believed the information would thus be accurate and truthful.

Fifty percent (n=15) of the community members, IDPs, and SGBV survivor participants stated that they would be interested in becoming a peer educator.

In response to questions related to preferred interventions and how to stop SGBV, participants stated that they felt that this is a problem that needs to be brought to the attention of society through awareness campaigns designed to be meaningful for grassroots communities. Participants said that training seminars would only reach a small percentage of the population, and instead outreach programmes need to be developed which deliver information to the community. They also suggested utilizing poetry, drama, and dance. In particular young men need to be specifically targeted and educated on this issue.

It is our tradition that information and knowledge is shared through poetry. This would be a good way of providing information to the public about SGBV and HIV/AIDS. We are an oral society.

Female, IDP aged 55, Hargeisa

Furthermore, participants felt that there should be more rape clinics available at the neighbourhood level to help facilitate survivors’ access to treatment. The participants also indicated that police should be sensitized on SGBV and should provide more supportive assistance to survivors. Many participants believed that the police were unapproachable.
5.4 Religious Leaders, Traditional Leaders, and Police Officers

5.4.1 Demographics of Respondents

The age of the religious, traditional leaders, and police officers ranged from 30 to 80, with an average age of 37.5. These respondents were 88% male (n=15). All of the religious and traditional leaders were male, as this is the tradition and custom of Somaliland and conforms to Islamic doctrine. There were two female police officers in the sample.

5.4.2 Awareness and Prevalence of SGBV

The police were aware of SGBV and were able to provide detailed descriptions of its various forms including rape, anal sex, and molestation. The religious and traditional leaders were only able to cite rape as a form of SGBV. None of the participants mentioned FGM as a type of SGBV.

Police officers, religious and traditional leaders all indicated that SGBV is common in Somaliland today. The police officers indicated that they believe that in the past few years there has been a significant increase in SGBV cases, and in particular they felt that it was not only a consequence of more cases which are being reported, but rather a dangerous new phenomena that is affecting society. They also commented that the perpetrators were often young men in gangs who together partake in SGBV. The officers could not provide exact figures on the number of SGBV cases.

I have been a police officer since 1992. Before that I was a freedom fighter and part of the SNM. I have noticed in the last five years especially that there has been a significant increase in SGBV cases. I am not sure what is the root cause for this upsurge is but it is a worrying new trend…. two boys aged 12 and13 raped a 15 year-old girl. When questioned, they said that they were men and were bored. The case was solved among the two families and the boys released after a few days. These boys shall become habitual perpetrators as they are never punished.

Senior Male Police Officer, aged 40 Hargeisa

Traditional and religious leaders showed similar sentiments. They felt in the past very few cases of SGBV (specifically rape) were occurring in Somaliland. When it did occur, the traditional leaders dealt with it appropriately through the tradition of Heer. These are guiding principles that dictate social regulations norms and laws. Heer is used in traditional hearings as a legal framework and reference to lay judgements and reparations. This is particularly important to the study as it is often the Heer doctrine that is the preferred method of justice for survivors of SGBV and their families. They felt that this increase has weakened the significance of Heer as its overuse was counter-productive and soon become the norm rather than the exception. Religious and traditional leaders commented that when an incident of SGBV takes place, the perpetrator’s family negotiates with the survivor’s family in the traditional method.

When asked if they believed it to be a crime if a husband hides his HIV positive status from the spouse, the police officers responded that they believed it is indeed SGBV. However, one officer stated there is no legislation in Somaliland to enforce this as a crime.

When asked if SGBV is a new phenomenon in Somaliland society, the traditional leaders indicated that it is not, rather that is something that is a permanent feature in society. The religious leaders and the police officers interviewed showed different opinions. They responded that SGBV is a post war phenomenon and that after the war the fabric of society has broken down. All groups indicated that SGBV is an important issue in society that needs to be taken seriously with coordinated comprehensive action.
The religious leaders provided a detailed description of the Islamic rulings for SGBV as follows:

"Islam protects and honours women, and also safeguards the security of children. The punishment for rape in Islam is stoning if the perpetrator is married, and one hundred lashes and banishment for one year if he is not married. Also, the perpetrator must pay the female her full entitlement of 50 camels."

Male Religious Leader, aged 75, Hargeisa

The police officers provided an alternative view. With respect to SGBV, all officers mentioned that although they believe there was an increase in genuine SGBV cases. Furthermore, it was stated that IDP males are often perpetrators of SGBV towards female IDPs and the host community. At the same time, they also felt that there has also been an increase in false reports.

"Sometimes when young girls get pregnant outside marriage they claim rape to avoid the shame and trouble with their families. Also sometimes young girls file false claims of SGBV as a means of taking revenge on a man. Recently there was a young girl from a well known family... she made false accusations against a young boy she liked. After a long investigation, she admitted that she had lied."

Male Police Officer, aged 30, Hargeisa

Rape cases have increased in recent years especially after the war. Previously rape was common in rural areas... if a boy takes a girl far away just to chat he is often accosted by a group of boys. They fight and the group then gang rape the girl. Most of these cases happen on the road going home late at night.

Male Police Officer, aged 30, Hargeisa

5.4.3 Groups at Higher Risk

Both the traditional leaders and police officers stated that the most likely survivors of SGBV are young women aged approximately 17-25. The officers also stated that survivors of SGBV are often females suffering from mental health issues. These women are vulnerable to abuse and are unable to assert their legal rights. Alarmingly, they report that women with mental illness report repeated incidences of rape to their families and police officers.

Furthermore, officers disclosed that female street children are extremely vulnerable to sexual exploitation and abuse. Unlike mental health sufferers, they do not report the crimes, but rather the issue becomes evident when the female falls pregnant. The police officers stated that SGBV was less likely to happen in IDPs and that most cases they dealt with involved non-IDPs.

"Perpetrators will target non-IDPs. They are more likely to avoid IDPs as they believe they are dirty and unhygienic. IDPs living in the well known camps or no camps have minimal access to water they are undesirable."

Male Senior Government Official, aged 57, Hargeisa

5.4.4 Locations where SGBV Takes Place

The police officers and traditional/religious leaders responded that SGBV is more likely to take place in secluded places where girls and young women are more vulnerable. The police officers also said that they have seen an increase in SGBV occurring in homes. Furthermore they stated that the perpetrators are often extended family members and neighbours.

"A young nine year-old was raped by her neighbour who was well acquainted with the family."

Female Police Officer, aged 35, Hargeisa
5.4.5 Support for Survivors of SGBV

The group cited hospitals, relatives, and the rape clinic at Hargeisa Group Hospital as places where survivors could seek support. Mosques and religious gatherings were not mentioned.

When asked if they felt there are barriers for survivors to report crimes they commented that it is sometimes difficult for female survivors when there is no female officer present. However, when asked if IDPs or minority clans face any barriers reporting SGBV incidents, all respondents indicated they do not.

The participants were asked about the coordination between the different agencies that provide assistance to survivors of SGBV and how these services could be improved to better meet the needs. The religious and traditional leaders did not know of any available services and did not comment. Interestingly, they did not mention the Sexual Assault and Rape Centre (SARC) based at the Hargeisa Group Hospital. The police officers did not provide a response to this question. The religious and traditional leaders stated they had heard of the local NGOs Candlelight for Health and Education and Horn of Africa Voluntary Youth Committee (HAVYOYO) working in HIV prevention.

5.4.6 Religion, Khat, and SGBV

The police officers and traditional leaders interviewed indicated that neither khat chewing nor smoking sheesha is a contributor to SGBV. They responded that khat is a relaxant that does not make a person violent. The religious leaders provided a different perspective; all responding that khat is a dangerous drug that causes behavioural change. They believe that it affected one’s ability to reason and therefore to distinguish between right and wrong. The religious leaders also added that they believe khat should be banned in Somaliland.

The religious leaders and traditional leaders explained the Islamic rulings and stated that a man is responsible for his wife’s well-being. He must provide for her basic needs. His is not permitted to be violent or harm his wife. Men are dictated by the Holy Quran to follow the good example of the blessed prophet’s treatment of women which was kind and respectful.

"Women are to be protected by their husbands who are responsible for their wellbeing. If a man deliberately hides his HIV status from his wife and infects her then it is as if he has killed her. His religious punishment would be the same as if he murdered her."

Religious Leader, aged 75, Hargeisa

5.4.7 HIV/AIDS Awareness, Knowledge, and Testing

None of the religious and traditional leaders, nor the police officers, admitted to ever having had an HIV test. This question made the participants uncomfortable. In particular, it seemed to offend the religious and traditional leaders. The participants were able to provide information on how one can become infected with HIV and were familiar with how one can protect oneself from infection.

"Life for us is preordained by almighty Allah. HIV/AIDS is an illness that Allah has given and is no different than diabetes or high blood pressure. Therefore, a person with this illness should not be ostracized and shamed, but sympathized with and supported."

Religious leader, aged 65, Hargeisa

5.4.8 Link between SGBV and HIV

Twenty four percent (n=4) of the religious and traditional leaders and police officers indicated that they believe there is no link between SGBV and HIV, while 76% (n=13) said there is a possibility that one could contract HIV through SGBV if the perpetrator was infected himself.

The police officers indicated that even though they had dealt with many rape cases, they have never known the HIV status of the perpetrators.
Sexual and Gender-based Violence (SGBV) and HIV among Vulnerable and displaced Women in Somaliland in non-camp settings

No, I do not know of any HIV positive persons.... maybe I do know one, but just don’t know about their illness. People are very secretive about this.

Female Police Officer, aged 30, Hargeisa

5.4.9 Recommendations to Reduce SGBV

The participants in the religious and traditional leaders focus group discussion stated that more religious lectures and classes need to be made available, specifically designed to provide Islamic guidance on SGBV and HIV. The police officers stated that in Somaliland, police officers do not patrol the streets, rather they are posted to the police stations and are then dispatched to attend to incidents after the fact. Alternatively, they are posted at roadside checkpoints to inspect vehicles. One police officer said that it would reduce SGBV if police officers patrolled neighbourhoods, particularly in sparsely populated areas.

Participants were asked what could be done to improve coordination between all stakeholders. They stated that families of survivors of SGBV should allow the police to deal with the issue rather than reporting the crime and then utilizing the traditional system under Shari’a. They also suggested that the traditional and the Somaliland systems of governance need to be standardized across the country.

Both the police officers and traditional/religious leaders felt that the lack of discussion about SGBV in families is a cause for concern and is a contributing factor to the increase in Somaliland. In particular, the police officers commented that it is not Somali practice to discuss sensitive issues with children, and this is a practice that needs to be changed to inform and teach the young within the community, and therefore to result in change.

Religious leaders also commented that this issue is not a topic that is discussed during the Friday prayer lecture or at religious talks. During the focus group discussion it was further stated that they felt it would be appropriate to hold religious lectures on this topic, and to provide the Islamic perspective and rulings on this crime.

5.4.10 Legal and Judicial System

The religious and traditional leaders admitted that they feel responsible for perpetrators often not receiving appropriate punishment, such as being sentenced to serve time in jail for their crimes. They stated the utilization of the traditional Heer system is more common, and that clan relatives of the survivor and perpetrator arbitrate incidents. Additionally, all groups agreed that SGBV is an important issue that requires comprehensive coordinated action. They stated that the traditional and the legal systems are supposed to complement one another to secure justice, but unfortunately the reality is a “watered down” level of justice where the perpetrator’s family shows due remorse and provides compensation (money or livestock) to the survivor’s family. However, the compensation often does not reach the survivors, but is rather divided between the survivor’s male relatives. The survivor is often deprived of any compensation, or presented with just a minimal amount of the compensation to pay for medical and other expenses that have been incurred. The traditional leaders in particular commented that this traditional system is faulty and needs to be ratified.

It would be a good idea to hold a religious talk for young men only, and discuss this issue with them. This may help stop this problem.

Religious Leader, aged 65, Hargeisa

The police officers indicated that the punishment for SGBV is three to five years imprisonment if the incident goes through to the courts. However, they added that most cases do not reach court as families prefer to settle the matter in the traditional manner. Sometimes a survivor will report a rape to the police but her family may intervene and pressure her to go through the traditional system. This is because they are not confident in the proceedings of the legal system, and prefer a quick form of justice. Also, they fear that by relying on the legal system, they are risking it all and may get nothing. They are also concerned about bringing further shame to the family.

The religious leaders commented that they believed that the Islamic Shari’a principles offer the best form of justice and should be integrated fully into Somaliland society.
5.5 Government, UN, NGOs, and Health Service Providers

5.5.1 Organization Profiles

This assessment uncovered twenty-four organizations working in the field of SGBV and HIV, including UN agencies, international and local NGOs. A brief overview of the local NGOs is provided. Profiles of some UN agencies, international organizations, and international NGOs can be found online.

The Somaliland National AIDS Commission (SOLNAC) was established by Presidential Decree on 28 June 2005. It consists of a chairman and eleven members, all of whom are appointed by the President. Members include government ministers whose ministries are responsible for aspects of the HIV response, representatives from NGOs, women, religious leaders, people living with HIV/AIDS, and private individuals selected for their commitment to, and active involvement in the HIV response. The function of the SOLNAC is to oversee, plan, and coordinate the national HIV programme.

Talowadag is a local NGO in Hargeisa, also working in Boroma, with plans to open offices in Berbera and Burao in the future. The organization was founded when it was determined that a 24 year old male was stigmatized and discriminated against for being HIV positive, and there were no other support systems or services in place. The organization was formed by three local organizations who formed a coalition. The organization provides counselling, care and information to people living with HIV/AIDS. Currently Talowadag’s direct beneficiaries include 127 people living with HIV/AIDS.

Comprehensive Community Based Rehabilitation in Somaliland (CCBRS) is a local NGO addressing HIV/AIDS and SGBV. The organization was founded in 2006. Similar to Talowadag, the organization was founded out of an identified need. SGBV case workers at CCBRS provide survivors with an HIV test two months after the assault. They also test for sexually transmitted infections (STIs) and pregnancy. The organization offers counselling and referral services for survivors and their family members.

Somaliland HIV/AIDS Network (SAHAN) was established in 2003 and is an umbrella organisation of 70 member organisations across the six regions of Somaliland addressing issues surrounding HIV and AIDS.

Hargeisa Voluntary Counselling and Testing Centre (Hargeisa VCT) is located in Hargeisa Group Hospital. It provides VCT and follow-up support, including referral for psychosocial assistance.

The Committee for Concerned Somalis (CCS) is a local NGO established in the early 1990s. The organization has been working in HIV/AIDS since 2005. Currently they run a UNICEF-sponsored project called “Women to Women” wherein female health workers are trained to provide outreach to women living with HIV and AIDS. This programme has a wide geographical reach covering all six regions of Somaliland. A similar programme is run through local NGOs in central Somalia. CCS programmes provide psychosocial support, guidance, and health information to the beneficiaries in their homes and communities. The projects beneficiary includes IDPs.

The SARC health workers and the Hargeisa Group Hospital declined to take part in a key informant interview; however, they provided an overview of the centre. The centre has been open since 2006 and it houses health professionals and trained rape staff and police officers. The centre is funded by UNDP. The centre is the first point of contact for rape survivors. Staff report that the centre is frequented by women, girls, and on occasion young boys. The rape centre is under the coordination of the Ministry of Interior, The Ministry of Family Affairs and Social Development, the Police, and the Hospital.

Women’s Action for Advocacy and Development Association (WADA) is a non-profit making organisation founded in 1997 the organisation is dedicated to women’s empowerment and focuses on enhancing women’s rights across Somaliland. WADA programmes included HIV/AIDS awareness raising and women’s Human rights. WADA endeavours to strive to combat violence against women.

Nagaad is a non-profit making, national women’s network that comprises of a current membership of 45 women organizations. Founded in Hargeisa in 1997, Nagaad was formed to serve as an organized, collective voice of women who were determined to fight for their socio-economic and political rights as equal citizens of Somaliland.
The network exists to empower Somaliland women in all aspects of their lives through advocacy and capacity strengthening. As well as other programmes Nagaad focuses on women’s Human rights.

The Hargeisa Women organization (HAWO-Group) was set up in 1996 to share information, experience, ideas and strategies among Somaliland’s grass roots women, non-governmental women organization and partners. Through communication networking, training, advocacy and community based development service deliveries so as to advance its beneficiaries with particular emphasis on women and girls development, equality and other women’s right based needs in Somaliland. HAWO-Group aims to strengthen women’s capacity to participate in civic life and decision making focusing on women’s development.

Women’s Action Advocacy and Progress Organization (WAAPo) is a non-profit making organization. WAAPo was founded in 1997 and the organization works in Burao and Hargeisa. As well as other projects the organization focuses its attention on women’s humans’ rights and HIV/AIDS awareness raising. The project focuses on utilizing the traditional arts as a medium to increase community awareness on HIV/AIDS.

Candlelight for Health, Education and Environment (CLHE) was founded in 1995 as a non-profit making organization, dedicated to development issues in under-served and/or marginalized Somaliland communities. CLHE HIV/AIDS project is aimed at increasing community awareness on HIV/AIDS and related sexually transmitted infections (STIs) as a means of reducing their risk and prevalence among the community. The project uses a number of techniques in addressing this pandemic. These include workshops, public awareness, and media and Information, Education and Communication (IEC) materials. Project activities are also integrated into the other programmes in order to maximize its impact.

The Horn of Africa Voluntary Youth committee (HAVOYOCO) was founded as an NGO in 1992. As well as other programmes HAVOYOCO work in unison with regional and national activities aimed at the prevention of HIV/AIDS. HAVOYOCO also promotes care for people living with HIV/AIDS in the border regions of the Horn of Africa, and work towards reducing social stigmatization of people living with HIV/AIDS within the communities.

### 5.5.2 Prevalence of SGBV

All organizations interviewed considered SGBV to be an important concern that is present in Somaliland society. They unanimously stated that there has been an increase in cases reported through NGOs. However, evidence on the prevalence of SGBV in Somaliland is limited. Only one organization could provide records, and that was Hargeisa Group Hospital. Data on reported rape cases from 2006 to 2008 can be found in Tables 5, 6, and 7. Data for 2009 has yet to be released.

#### Table 5: Hargeisa Group Hospital Rape Cases 2006

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### Table 6: Hargeisa Group Hospital Rape Cases 2007

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The table above shows the number of rape cases reported at the Hargeisa Group Hospital from January to December 2007, categorized by gender and age group. The female and male rape cases are further divided into three age groups: 0-5, 5-15, and 15+. The total number of rape cases for each month ranges from 0 to 29. The table highlights a significant number of cases in August and September, with a peak of 10 cases in October. The data suggests a higher occurrence of rape cases among females compared to males, with the exception of May, where both genders showed an equal number of cases. The youngest age group (0-5) also had higher numbers of cases compared to the older age groups.
Table 7: Hargeisa Group Hospital Rape Cases 2008

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Organizations reported three common profiles of SGBV situations. First, where young girls aged 15 -18 are exploited by older men, starting with the men providing gifts, beauty creams, mobile phones, and dinners out. The girl develops a relationship with the man and is coerced into sex. The second profile relates to girls who meet young boys and are tricked into trusting them, and then the boys rape them, usually together with a group of their friends. The group provides an alibi for each other and this prevents them from getting caught. The third profile involves abuses against young children.

UNHCR described an incident where a one year-old was sexually abused by a mature male relative. This incident resulted in the child’s death and the incident was settled through the traditional system.

“One of our service users is a widowed mother with five children. Two of her children are HIV positive. She contracted HIV from her husband.”

UNHCR Officer, Hargeisa

According to UNHCR, IDPs encounter significant difficulties. Wherever they reside in Somaliland, they frequently face harassment and discrimination, placing them at increased risk for SGBV. A senior protection officer provided information on the situation of IDPs in Somaliland in the below quote.

“IDPs live in acute poverty. Those that find work must work for long hours, and are away from their homes for extended periods, thus leaving the children alone and in vulnerable situations... Gangs of boys frequent the camps and take advantage of the young girls.”

UNHCR, Hargeisa
UNHCR provided solar lighting in the IDP camps settlements known as the Stadium and State House, which they believe has increased the community surveillance and security in the camps. This may reduce violence, including SGBV.

CCBRS stated that SGBV was unheard of as a term as recently as 2006. Even their employees were not aware and required extensive training. The organization has helped set up an IDP management committee for human rights responses and prevention measures.

“The most important issue is affecting a consensus-based approach to working with IDPs, either survivors of SGBV or others. There is no accurate data and approach to working with SGBV survivors and there is no IDP profiling. There is no accurate data on SGBV either.”

SAHAN Hargeisa

A representative of CCBRS stated that IDP women and children are vulnerable to SGBV, as they are usually poor, uneducated, and in a weak position socially. They are therefore unable to protect themselves. In addition, according to CCBRS these groups are discriminated against and seen as insignificant by others in society.

“In many cases men take advantage of women in exchange for things they need or want such as beauty creams, clothes etc. This can sometimes lead to unwanted pregnancies. Abandoned children left on the streets and in neighbourhoods are sometimes found by people and occasionally eaten by dogs.”

CCBRS, Hargeisa

Hargeisa Group Hospital reported that women suffering from mental health issues are common victims of SGBV, and they visit the hospital. These women include IDPs and non-IDPs, and are often homeless. These women are repeatedly raped and once they are discovered to be pregnant they are brought to the clinic. The majority of these survivors cannot vocalize what has happened to them.

A senior administrator at Hargeisa Group Hospital reported that in Somaliland, boys and girls are not allowed to be seen together in public unless they are related or married. A courting couple will seek out secluded places to talk. What often happens is that a group of boys will follow the couple, attack the boy and gang rape the girl. The boy often flees the scene and will not even call for help. The girl is then left to the mercy of the gang. Another problem is weddings, as they take place late at night and public transport ends around 22:30 to 23:00. Young girls walking home alone are prime targets for young boys who have also left a wedding or lie in wait for these girls. The girls are alone and often have no witnesses to verify their story. Survivors are always asked for a witness, which is the principal upon which legal cases and based. It is for lack of witnesses that many cases do not reach a courtroom. In addition, some people prefer the traditional system.

5.5.3 Khat and SGBV

All organizations interviewed commented that khat is a contributing factor to SGBV. Furthermore, it was revealed that drugs and solvent abuse is rife with street children in Somaliland. This dangerous practice creates increases violent behaviour and vulnerability to being a victim of SGBV. All participants in this group agreed that sheesha is also a possible contributing factor to SGBV.

“A young girl left her husband and moved with her four children from Burao. She left her husband because he beat her while under the influence of sheesha and khat. She has no means of supporting her family and works as a sex worker. She is sometimes beaten and raped and not given payment for her services. She only uses a condom if the client asks for it and she does not believe she is a survivor or victim of SGBV, as she is a prostitute, and no one will believe her. She believes people will think she deserves it.”

CCBRS, Hargeisa
5.5.4 Legal and Judiciary System

All respondents said there is a lack of justice for survivors of SGBV, and a lack of a codified system of law in Somaliland. Respondents said the current fragmented system utilizes the Shari’a, the traditional, and the Somaliland legal system to access justice, but they do not necessarily work together harmoniously and efficiently.

Female survivors of SGBV are given their full blood money payment of 50 camels as compensation. Unfortunately the female survivor herself rarely receives any of the compensation, as her male relatives misappropriate the funds.

According to the Ministry of Interior, the parliament of Somaliland has approved a customary law which indicates that any rape cases be referred to a chief Aqal (clan leader). He must then refer the incident to the police and courts. It is yet to be determined whether this system will prove effective.

The Ministry of Family Affairs and Social Development and Social Development (MOFASD) is working on a GBV bill to protect survivors’ rights and dignities. The MOFASD reported an increase in SGBV in the last few years. The ministry believes that IDPs living in camps are particularly vulnerable to SGBV as they have a lack of latrine facilities and therefore must walk long distances. Also, parents are absent most of the day, making the young children vulnerable to possible abuses. The MOFASD, in partnership with UNFPA, chairs the Sexual and Gender-based Violence Working Group. The working group has been suspended and is expected to resume in the near future.

UNHCR disclosed that Somaliland judges who handle SGBV cases are often ill-equipped with judicial techniques for protecting the human rights of women.

Within Somaliland politics there is a distinct lack of female presence at the decision-making level. Thus, women’s input in the creation of policies to protect women is absent. There are no female director generals and only one female minister (MOFASD). This lack of female presence in national leadership roles makes it difficult to have gender sensitive policies and practices that address the needs of women and girls.

Senior officials in the Ministry of Resettlement, Rehabilitation and Reconstruction (MRRR) described the situation of IDPs as precarious and desperate. Their vulnerability to abuse is substantial and the lack of protection or adequate care exacerbates the desperation of their situation. The ministry advised there needs to be a concerted, appropriate, and coordinated response to this issue, and suggested immediate development of an action plan with the involvement of all relevant governmental ministries and key stakeholders.

Although the SARC did not participate in the assessment (they did not participate in an in-depth key informant interview), they provided information regarding the context of SGBV cases. SARC indicated that cases are not followed up by the Ministry of Interior and not taken to court. The SARC also said that most survivors are denied access to legal aid. There is a legal aid programme, but few women access it due to resource constraints and because women are distrustful of the Somaliland legal system. However, the most important flaw in the system, as reported by SARC, is that perpetrators receive inadequate punishment. The reason for this is that traditional elders intervene in SGBV cases and rather than seeking justice they seek to minimize the damage to their clan. The survivor and the crime are often ignored. The Islamic rulings and religious teaching in such cases are ignored and the traditional elders system is the favoured system for resolution.

CCBRS has come across many IDPs who have been raped and subsequently tested HIV positive; however, the perpetrators are hardly ever caught or tested. Thus, data to support the argument that the survivor contracted the illness through rape cannot be substantiated.

“"In Somali culture it is very common to have extended family all living together. When girls have no access to basic needs, they become vulnerable to men as there is no one to care for them. Often these men psychologically manipulate and then sexually abuse the girls... Through their work, CCBRS have discovered that often rape perpetrators are extended family members. In particularly when IDPs arrive, they are hosted by relatives. They stay in the homes of their relatives, or their relatives provide plots to build makeshift homes on. These people feel indebted to their relatives and are less likely to report incidences of SGBV.”

CCBRS, Hargeisa
Hargeisa VCT, located in Hargeisa Group Hospital, stated that access to legal aid is extremely costly, thus prosecutions rarely take place and getting a perpetrator convicted is extremely difficult. As a result, most perpetrators get away with the crimes they commit. The respondent explained that there is a legal clinic, run by UNDP, but the work is not sufficient to cover the need, and the clinic has limited capacity.

The respondent further stated that most cases go through the traditional system in front of the Aqal (clan chief) and that the culture of clan politics supersedes the legal and Islamic systems.

“A 13 year-old girl was raped and became pregnant. Her mother sells milk in the market. Two boys raped the girl while a third acted as a bystander. The case was reported to the elders, and her father agreed to the verdict of the elders. The girl tried to commit suicide by hanging herself. Her siblings saw and saved her. The neighbouring children came to watch. The girl was extremely traumatized. The girl was unaware she was pregnant, and her mother didn’t tell anyone. She eventually lost the baby.”

CCBRS, Hargeisa

A lawyer, interviewed in Hargeisa reported that rape cases in 2008 were higher than in previous years. In particular cases involving the sexual abuse of young girls are on the rise. The respondent further noted that discrimination against women worsens the situation, as often they do not receive the assistance they require due to several barriers. These include a long and cumbersome police investigation, lack of appropriate medical reports on the status of rape victims, and socio-economic background as most rape survivors are from low income families. These survivors often cannot afford to travel to Hargeisa SARC centre to seek medical assistance nor can they afford to travel to police stations and report the crime, especially if the incident took place in a rural area.

“Women being abused sexually... they have no confidence in the judicial system. They do not believe the police will search for, catch, and send the perpetrator to jail. The women lucky enough to have clan support will inform their male clan members about the incident and hope for redress that way.”

CCS, Hargeisa

5.5.5 Awareness of HIV

The organizations interviewed indicated there is a lack of understanding of HIV/AIDS among Somalilanders, and that the reach of awareness programmes have to date been restricted by funding constraints. As a result, only specific geographical locations have been targeted. In addition, the nomadic profile of many Somalilanders makes it difficult to provide information on SGBV and HIV/AIDS.

In November 2008, CCBRS came across a young woman aged 25 who had been raped by a group of boys. The organization arranged for an HIV test and she tested positive, she then disappeared. A few months later, she came back, and is presently receiving ART.

CCBRS stated that many of their beneficiaries who test positive for HIV disappear once they find out their status. Most never return to the organization, but likely return back to their lives, marry, and do not disclose their status. CCBRS also reported that witnesses of SGBV oftentimes do not come forward or intervene as they fear being blamed. Women are afraid of discrimination if they come forward and report SGBV. Furthermore, survivors often lack funds to travel to court during a trial. The survivors often do not report for this reason.

In 2007 SOLNAC, in collaboration with other stakeholders, developed a draft document articulating the multi-sectoral AIDS control approach strategy. A Strategic Framework for the prevention and control of HIV/AIDS and STIs within Somali populations 2009-2013 as well as a Somaliland HIV & STIs Control Policy exist. However, the extent to which this document has been disseminated and adopted by organizations is unclear. The government is committed to financially supporting the national response and requests for international cooperation in this regard.

“The lack of the National HIV/AIDS policy severely obstructs organizations following a unified policy in the fight against HIV/AIDS. This document needs to be ratified soon.”

SAHAN, Hargeisa
5.5.6 SGBV and HIV/AIDS

When asked about the link between SGBV and HIV, respondents said that rapists do not use condoms and they often rape in gangs placing both themselves and the females at risk of exposure to the virus. Moreover, the tradition of polygamy and lack of routine testing for marital partners places the husband and all his wives at risk.

“Men often do not tell their wives that they are getting married to a second or third wife. Also, the man does not screen himself or new wife for HIV.”

According to CCS, SGBV and HIV are undoubtedly interlinked. It was also indicated that SGBV was in the past a rare occurrence. The increase in SGBV poses a danger of society becoming desensitized to the phenomenon, and hence not giving it due significance in society. Furthermore it was indicated that IDPs are vulnerable to SGBV because of their living situation, including the issue of having to walk long distances, in dark or secluded areas, in order to access latrines. Young girls and women IDPs were stated to be most vulnerable.
6. Conclusion

The lifestyle of IDPs places women and children in a vulnerable position. They live in makeshift homes with little or no security. They also have no bathroom facilities within these structures and must travel long distances to find a secluded area. Travelling late at night for this purpose places them in a vulnerable position for possible attacks.

Findings from this assessment confirm that displaced women are at an increased risk for SGBV. The reasons for this include the general marginalization of women and children, as they can be abused and the consequences to perpetrators are minimal. The Somali tradition of Heer personifies this. The arbitration involves clan justice where the perpetrator’s clan pays compensation to the survivor’s clan. Often the individual perpetrator does not contribute any personal funds to the compensation amount. The unfortunate outcome of this system is that the compensation secured by the survivor’s clan is divided between males in the clan. The female survivor receives little or none of the compensation. Clan family members negotiate the best compensation amount on behalf of a survivor and ensure that the agreed sum is in line with the Heer tradition. The internally displaced, who are living outside their clan support, lack even this weak support function that the clan provides. As a consequence, IDP SGBV survivors are in a weak and vulnerable position to be targeted for abuse and are further abused.

The increasing anecdotal evidence for gang rapes is even more hazardous when one looks at the Somali context, as many women have or have undergone pharaonic FGM, and as a consequence their genitals are ripped open during the attacks. The issue of gang rape requires further investigation into its prevalence and preventative, and punitive measures.

The data on the number of rapes presented at Hargeisa Group Hospital indicates a potential increase from 2006 -2008. While other types of SGBV exist other than rape, the researchers were unable to identify data related to other types of SGBV, nor data specifically relating to IDP cases.

All stakeholders expressed that SGBV cases are underreported due to fear of stigmatization, the fear of not being believed, and the lack of survivor’s confidence in obtaining justice. Most stakeholders agreed that SGBV places survivors at increased risk of contracting HIV. The lack of condoms used by perpetrators and the increased risk of multiple perpetrators through gang rapes places the survivors at increased risk of contracting STIs including HIV. Perpetrators themselves are also at increased risk of contracting HIV due to not using a condom.

The findings show that SGBV in Somaliland is further exacerbated by the systematic failure of the judiciary system to provide adequate protection, and justice for both survivors and perpetrators. This failure is a consequence of use of three distinct legal systems, namely the traditional Heer, the Islamic Shari’a, and modern Somaliland judiciary system. In Somaliland the modern legal system is concentrated within cities, thus women living in rural communities are further disadvantaged by the absence of accessible legal structures.

Furthermore, the study found that low levels of literacy combined with cultural marginalization of female SGBV survivors, IDPs and irregular migrant workers inhibit access to justice. In addition, this is exacerbated by their lack of knowledge about their constitutional rights and inherent human rights. The study also found that they often face widespread discrimination when it comes to insensitive investigations and prosecution cases involving violence against women and children.

Customary practices of female genital mutilation are violations to all that it is preformed on. The study found that this practice was inclusive of IDPs and irregular migrant workers. Nonetheless, it is not considered by society to be so, thus no consequences to these actions are achieved.

As HIV counselling and testing are not widely available in Somaliland, this places perpetrators, polygamous families, and SGBV survivors at risk to HIV infection. The rationale is that with increased knowledge of one’s status, personal risk perception and behaviours can be changed. Furthermore the lack of condom availability could also be a contributing factor as many males who are aware of their HIV status commit rapes and/or do not disclose to their sexual partners.
With regards to FGM, participants provided a mixed commentary. Some believed that it was an Islamic prerequisite whereas others stated that FGM was not an Islamic principle and has no religious foundation. Nonetheless it is something still practised amongst the host community as well as IDPs, and irregular migrants. It results in increased HIV risk due to tissue tearing, and due to the perceptions of promiscuousness associated with the less severe *sunna* form of FGM. Results of the assessment show that in this sample FGM awareness programmes are not influencing behaviour and attitudes, and more is needed in order to overcome this.

In respect to the links between HIV and SGBV, participants displayed a distinct lack of basic knowledge on the issue. This suggests that the current awareness campaigns for both HIV and SGBV need to be coordinated, scaled-up, and targeted. The HIV and SGBV awareness campaign in Somaliland needs to increase its effectiveness in reaching all members of the community, yet at the same time ensure that stigma is not increased as a result of the association between the two.
7. Limitations

A number of limitations affected the study, including a significant delay in receiving ethical clearance to proceed with data collection, thereby shortening the period of data collection considerably.

In general, male Somalilanders are unwilling to speak about issue of SGBV and HIV. This is a cultural taboo and therefore male community members and IDPs were deliberately excluded from partaking in the interviews. Nonetheless, males in a professional capacity (organizations) were included and did participate.

Furthermore, gaining access to records at Hargeisa Group Hospital was difficult, and the proportion of SGBV survivors who tested positive for HIV could not be provided.

The researchers were unable to obtain data from the Somaliland Criminal Investigation Department (CID), including the number and types of incidents reported, which would have been crucial in terms of identifying links and possible trends between SGBV and HIV prevalence.

Due to land based conflicts in the west of the country, the researchers were unable to interview the Somaliland police chief or senior police officers who were away dealing with these incidents. Furthermore due to the conflict and subsequent security concerns, data collection was unable to take place in Boroma as originally planned.

Additionally, the temporary suspension of the Sexual and Gender-based Violence Working Group was a challenge, as it would have proved useful for introducing and coordinating the study, as well as facilitating access to information and respondents.
8. Recommendations

- Somaliland society should be further sensitized on SGBV, as well as its links with HIV. A term for SGBV should be coined and used across all messaging and activities conducted by stakeholders. This needs to be done carefully in order to avoid further stigmatizing survivors of SGBV.
- The Somaliland national curriculum in schools should incorporate SGBV and HIV/AIDS information, targeted at all levels of schooling. Gender studies should be incorporated into the social science curriculum to broaden students’ understanding of gender and to help foster respect for women.
- Religious leaders should, in partnership with women, facilitate seminars on SGBV and HIV, providing the Islamic perspective on these issues.
- A comprehensive SGBV awareness programme should be undertaken nationally to create a deep cultural understanding of the topic. A networking partnership between the appropriate governmental ministries, local NGOs, religious and traditional leaders, should be established in order to reach communities across the country. This should be done in collaboration with the media to reach all areas of Somaliland, and appropriate IEC materials should be developed. Major awareness needs to be created through media, radio, newspaper, traditional leaders, and religious leaders. Religious and community leaders need to be empowered to support this initiative as they are extremely influential and very powerful in the community.
- HIV testing for couples prior to marriage should be encouraged by the religious clerics who perform marriage ceremonies. This should be coordinated through the Ministry of Religion.
- Religious leaders should be utilized in developing the appropriate awareness packages enshrined with Islamic principles to promote greater understanding and acceptance.
- Religious leaders should hold lectures on SGBV and HIV/AIDS targeting young males in particular.
- Relevant ministries and all stakeholders should work together to promote awareness of IDPs, to promote greater understanding of their situation and vulnerabilities, and to come up with a strategic action plan to improve safety for these groups, particularly women and children.
- Families should be encouraged to begin dialogue about SGBV and HIV/AIDS at home with children, using appropriately developed materials or toolkits.
- The Somaliland National HIV/AIDS policy is still in a draft phase. This needs to be ratified and passed to ensure effective coordination and management of the epidemic, and this policy should address the links between HIV and SGBV.
- The capacity of the SARC centre needs to be increased to be able to meet the needs of SGBV survivors, including IDPs. A centre like SARC needs to be set up in all regions. Local police need to work with the SARC in Hargeisa, and eventually in all centres that are opened.
- According to partners, PEP is available in the ART centres in Hargeisa, Burao and Boroma Hospitals; however the awareness, understanding and availability in all regions is unknown, and specifically the understanding of PEP amongst IDP communities is not clear.
- An in-depth assessment of the current legal structures and judiciary procedures for perpetrators of SGBV needs to be undertaken in collaboration with relevant ministries and stakeholders, and should provide recommendations and an action plan for improving the system. Following this, an awareness campaign educating the public of the new laws should be undertaken.
- SGBV working group meetings should be resumed, in addition to an interagency steering committee within the government specifically looking at issues around SGBV and moving the agenda forward. This should include awareness campaigns, coordination, collaboration with stakeholders, etc.

Additional recommendations following resulting from the assessment’s validation workshop, held in Hargeisa 03 February 2010, are as follows:

- An assessment is required of the incidence of contracting HIV within dumal (bride inheritance) and higiiisan (where the widowed male is wed to his sister-in-law).
- Further study is required to focus on male victims of SGBV. This will be difficult and needs a sensitive approach.
- A pre-marital screening of HIV cannot be mandatory, only voluntary, and awareness raising on this topic is needed.
- Rape has increased and is likely linked to HIV, gaps need to be filled and an action plan on how to move forward should be developed.
• The penal code in regards to SGBV needs to be re-examined and perpetrators should receive the maximum sentence.
• Awareness raising and sensitization on child molestation is needed.
• Database for SGBV cases in Somaliland is needed.
• Psychosocial and specialized support is needed for SGBV survivors. This should be available across Somaliland.
• Women need to be empowered to challenge the institutions and SOLNAC should work more with the police, courts and the judicial system.
• More sexual assault response centres are needed across Somaliland, and capacity building of these centres for appropriate data collection methods and reporting tools.
• A sexual exploitation group is needed to develop an action plan to avoid duplication by agencies working in this field.
• Different sections of society need to be involved e.g. media, teachers, police, traditional/religious leaders, young males and young females to raise awareness of SGBV.
• Improved financial and legal aid for survivors of SGBV to help them access services, and to seek justice.

There are too many obstacles when there is rape. The survivor’s family becomes an obstacle. They ask why you were at so and so in the first place. The police do not take the case seriously. They make you come back and forth without making progress on the case. They are not supportive and the perpetrator’s family may ostracize you and say she wanted it and there is no protection guaranteed for the female. There is more trauma and humiliation for the survivor at the courts… The penalty is five to fifteen years… there are no cases being sentenced 15 years.

Female participant at the Validation workshop.
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# Appendix A: Participating Organizations

1. UNAIDS  
2. UNICEF  
3. UNHCR  
4. IOM  
5. UNDP  
6. WHO  
7. UNESCO  
8. UNFPA  
9. Progressio  
10. Norwegian Refugee Council  
11. SOS  
12. World Vision  
13. Handicap International  
14. SAHAN  
15. SOLNAC  
16. CCBRS  
17. NAGAAD  
18. WADA  
19. Talowadag  
20. Candelight for Health and Education  
21. HAWO-GROUP  
22. WAAPPO  
23. HAVAYOCKO  
24. CCS  
25. Hargeisa VCT
Sexual and Gender-based Violence (SGBV) and HIV Assessment among Vulnerable and Displaced Women in Somaliland in Non-Camp Settings

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