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Gender-Based Violence (GBV) Rapid Assessment Report

Banadir Region – Daynile & Kaxda Districts

1–4 September 2025

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1. Executive Summary

Between **1st – 4th September 2025**, the **Women Resilience Initiative (WRI)** conducted a **rapid Gender-Based Violence (GBV) assessment** in **Daynile and Kaxda districts of Banadir Region**, which host some of the largest concentrations of internally displaced persons (IDPs) in Somalia. These areas face rapid population influx, overstretched services, and deteriorating protection conditions, leaving women and girls highly vulnerable to GBV. The assessment engaged **160 participants**, including **48 Key Informants (MCH staff, caseworkers, community leaders, youth leaders, camp managers, and teachers)** and **16 Focus Group Discussions (FGDs)** with ~112 participants (adult women, adolescent girls, adult men, and adolescent boys). Data were collected from **12 settlements across four catchments (CA02, CA07, CA11, CA15)** using KIIs, FGDs, and safety audits.

Key Findings

- **GBV Risks:** Sexual assault (25%), IPV (25%), and child/early marriage (27%) emerged as the top reported risks. Patterns varied: Daynile reported higher **sexual assault (28.6%)**, while Kaxda recorded higher **child marriage (40.0%)**. Denial of resources and psychological abuse were also noted.
- **Access to Services:** Only **56.2%** of informants knew of at least one GBV service point. **CMR readiness was low (37.5%)**, with frequent PEP/EC stock-outs. No formal **Women and Girls Safe Spaces (WGSS)** exist in either district; instead, women and girls gather informally without survivor-centred safeguards. Referral pathways were updated in only **43.8%** of sites. Accessibility for persons with disabilities was limited (**39.6%**). Average travel to services was **48 minutes at a cost of USD 1.29 per trip**, prohibitive for most IDPs.
- **Barriers:** Survivors face compounding barriers: **distance and cost (58.3%)**, stigma (33.3%), documentation/clan bias (18.8%), language/clan barriers (29.2%), and **escort requirements (45.8%)**. Escort restrictions were particularly reported in Daynile (50%).
- **Coping Strategies:** Communities rely on restrictive coping mechanisms: **avoiding movement at night (21.9%)**, moving in groups (21.9%), and **informal gatherings (18.8%)**. Reliance on elders for dispute resolution (18.8%) and use of male escorts (18.8%, higher in Kaxda) were also common. Men and boys remain largely disengaged from prevention.
- **Community Priorities:** Across FGDs, communities identified five urgent needs: **lighting at WASH points and pathways (70%)**, updated referral pathways (65%), formal WGSS (60%), cash/livelihoods support (55%), and **training/stocking for CMR services (50%)**.

Consolidated Gaps: The assessment identified seven cross-cutting gaps: absence of formal WGSS, weak CMR readiness, outdated referral systems, overreliance on informal gatherings, service awareness gaps (especially among minorities and PLWD), unsafe infrastructure, and limited male/youth engagement.

Recommendations: Immediate (0–3 months): Update referral pathways; restock PEP/EC and train MCH staff; install solar lighting at WASH points and settlement pathways; support informal women's gatherings with referral materials; and activate community feedback mechanisms. **Medium-term (3–12 months):** Establish formal WGSS in each catchment; recruit and train GBV caseworkers (1:20 case ratio); expand disability-inclusive infrastructure; provide CVA/livelihoods support for vulnerable women and girls; and engage men and boys in norm change campaigns.

The assessment underscores that **GBV risks in Daynile and Kaxda are urgent and systemic**. Survivors remain underserved due to structural service gaps, restrictive norms, and unsafe environments. Communities themselves have identified practical, priority solutions. Investing in **functional referral systems, safe infrastructure, inclusive service delivery, and formal WGSS** is critical to safeguarding the dignity, rights, and safety of women and girls in these urban IDP settlements.

2. Background

Banadir Region, which encompasses Somalia's capital Mogadishu and its surrounding districts, continues to be the **epicentre of displacement** in the country. The region currently hosts more than **1.5 million internally displaced persons (IDPs)**, driven from their homes by **armed conflict, recurrent droughts, floods, evictions, and ongoing insecurity**. Among its districts, **Daynile and Kaxda** stand out as the fastest-growing settlement zones, absorbing tens of thousands of newly displaced households in recent years. This rapid, unplanned urbanization has contributed to **severe overcrowding, inadequate infrastructure, and overstretched basic services**, creating conditions in which protection risks—particularly gender-based violence (GBV)—are widespread.

The socio-political context further compounds these risks. Communities are fragmented along **clan, minority, and displacement status lines**, with displaced women and girls often facing **double or triple layers of vulnerability**: as women in patriarchal systems, as IDPs with weakened social networks, and in many cases as members of minority clans who face systematic discrimination. Persons with disabilities (PLWD), especially women and girls, are further marginalized, with limited mobility and virtually no tailored protection or health services. Adolescent girls remain particularly exposed, often burdened with domestic responsibilities, subjected to early and forced marriage as a coping mechanism, and at risk of sexual exploitation in and around markets and water collection points.

Although Mogadishu hosts a **dense concentration of humanitarian agencies and international actors**, the **reach of their services rarely extends equitably into the outlying IDP catchments** of Daynile and Kaxda. Health and protection facilities are concentrated in central areas, leaving peripheral camps underserved. **Maternal and Child Health (MCH) centres**, which should provide frontline support for survivors of sexual violence, are frequently **under-equipped and inconsistently staffed** to provide Clinical Management of Rape (CMR). Critical commodities such as **Post-Exposure Prophylaxis (PEP) and emergency contraception (EC)** are often out of stock, undermining timely and effective survivor care.

Equally concerning is the **absence of formal Women and Girls Safe Spaces (WGSS)** in the assessed settlements. WGSS are globally recognized as essential hubs for **confidential disclosure, case management, psychosocial support, and empowerment activities**. Their absence in Daynile and Kaxda forces women and girls to rely on **informal gatherings and ad hoc peer support**, which, while important for community solidarity, lack structured survivor-centred protocols, confidentiality measures, or the capacity to connect survivors to services. Without these spaces, disclosure remains limited, and risks often go unreported or unresolved.

Furthermore, **referral pathways**—the backbone of a coordinated GBV response—remain inconsistently updated, poorly disseminated, and often unknown to both survivors and frontline responders. This gap not only reduces trust in the system but also **delays or prevents survivors from accessing lifesaving services**. The **fragmented nature of service delivery**—with some NGOs working in isolation, limited integration between health, protection, and legal services, and weak accountability mechanisms—further contributes to gaps in survivor care and prevention.

Against this backdrop, the September 2025 rapid GBV assessment was designed to **generate localized evidence** from the most affected settlements of Daynile and Kaxda. It responds to the urgent need to capture community perceptions, highlight service gaps, and inform strategic decision-making by humanitarian partners. The findings will feed directly into the **Somalia GBV Area of Responsibility (AoR)** evidence base and guide priorities under the **2025 Humanitarian Response Plan (HRP)**. By providing a clear picture of risks, barriers, and community-driven recommendations, the assessment equips the GBV AoR, Protection Cluster, and donors with actionable insights to **prioritize urgent GBV interventions in urban IDP contexts** and to ensure that no woman, girl, or marginalized group is left behind in the humanitarian response.

3. Methodology

The assessment was designed as a **mixed-method rapid appraisal**, combining both quantitative and qualitative approaches to generate a holistic picture of GBV risks, service availability, and community coping mechanisms. The design deliberately balanced structured data collection through Key Informant Interviews (KIIs) with participatory engagement in Focus Group Discussions (FGDs), complemented by direct field observations of settlement infrastructure and service access points.

Site selection followed a purposive sampling approach, targeting **12 IDP settlements** across the **CA02, CA07, CA11, and CA15 catchments** in Daynile and Kaxda districts. These catchments were selected due to their high concentrations of displaced households, limited service coverage, and repeated identification by humanitarian actors as priority areas for GBV risk monitoring. Within each catchment, settlements were chosen to reflect diversity in size, population composition, and proximity to available services.

A suite of **data collection tools** was employed. First, **48 KIIs** were conducted with a cross-section of respondents, including Maternal and Child Health (MCH) nurses, GBV caseworkers, camp managers, women's leaders, youth representatives, teachers, and community protection focal points. These semi-structured interviews combined scoring of service availability and readiness with open-ended questions on perceived risks, access barriers, and gaps. Second, **16 FGDs** were facilitated with approximately **112 participants**, disaggregated by sex and age to ensure safe and inclusive participation: adult women, adolescent girls, adult men, and adolescent boys (6–8 participants per group). FGDs explored perceptions of safety, GBV risks, access challenges, and community priorities using participatory techniques such as safety mapping and ranking exercises. Third, **structured observation checklists** were applied to conduct safety audits of **WASH facilities, shelters, pathways, and market areas**, allowing the team to triangulate community perceptions with physical evidence of risks (e.g., lack of lighting, overcrowded latrines, absence of privacy barriers).

The assessment team consisted of **six enumerators (50% female)**, divided into two balanced teams. Enumerators were drawn from local communities and trained intensively prior to field deployment. The training covered the **WHO ethical and safety recommendations for GBV research**, informed consent procedures, safeguarding principles, referral protocols, and techniques for facilitating sensitive discussions without re-traumatizing participants. Team members were also oriented on the Somalia GBV AoR referral pathway and cluster-specific reporting mechanisms.

Ethical considerations were at the centre of the methodology. Enumerators were explicitly instructed **not to solicit personal stories or detailed accounts of GBV incidents**, in line with global standards. Instead, the assessment emphasized collective perceptions and generalized experiences. All participants were informed about the purpose of the exercise, their right to withdraw at any point, and the voluntary nature of participation. **Confidentiality was strictly observed**, with no names or identifying details recorded. At the conclusion of each session, participants were provided with **referral handouts** listing accessible GBV, health, and psychosocial support services in Somali language. Field supervisors monitored adherence to these protocols daily, ensuring the assessment upheld the principle of "do no harm."

Finally, data analysis followed a **triangulation approach**. Quantitative data from KIIs (e.g., service availability scores, perception ratings) were aggregated to generate frequencies and averages. Qualitative insights from FGDs were coded thematically to identify recurring patterns, community priorities, and outlier perspectives. Observation data were cross-checked against both KIIs and FGDs, reinforcing the reliability of findings. This combined methodology ensured that the assessment produced evidence that was both **statistically robust** and **deeply grounded in lived community realities**.

4. Findings

4.1 GBV Risks

The assessment confirmed that **GBV risks are pervasive across both Daynile and Kaxda**, with variations in type and intensity between districts.

In **Daynile**, **sexual assault (28.6%)** was the most frequently reported GBV risk, followed closely by **intimate partner violence (25.0%)**. Key informants linked sexual assault to unsafe pathways, poorly lit WASH facilities, and evening movement to markets. FGDs reinforced these findings, with adolescent girls explaining they avoid using latrines after dark out of fear. IPV was consistently described as widespread, but often treated as a "private family issue," discouraging disclosure.

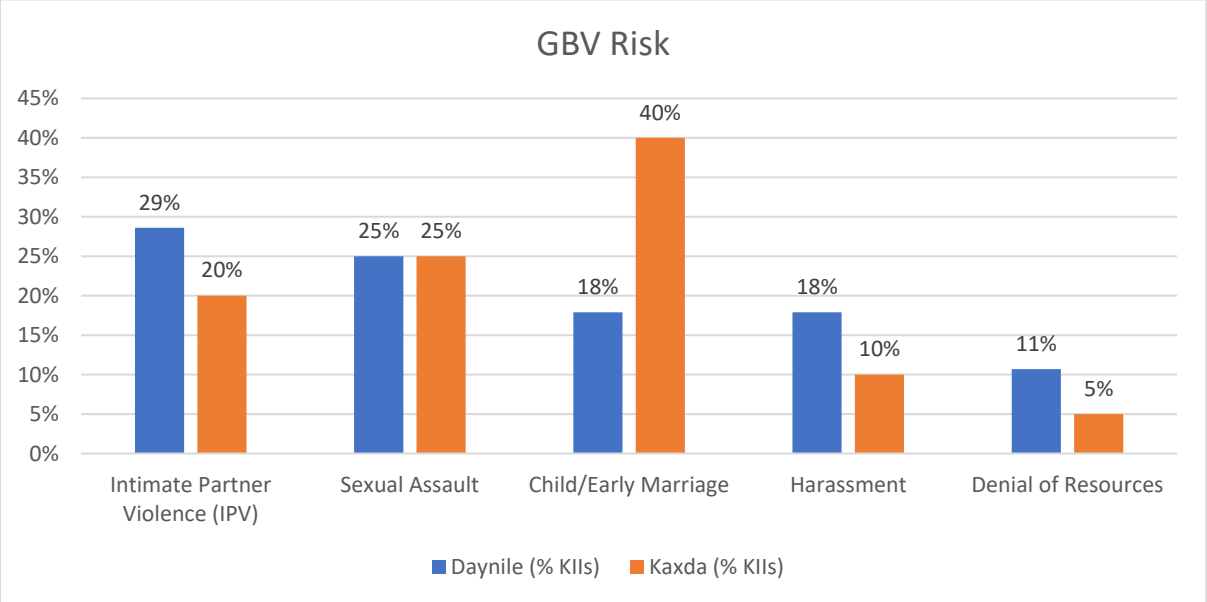
In **Kaxda**, the leading concern was **child and early marriage (40.0%)**, far higher than in Daynile (17.9%). Parents described economic stress and dowry practices as primary drivers, while adolescent girls framed the practice as a denial of rights and opportunities. IPV was also significant (25.0%), mirroring Daynile, while sexual assault was reported by 20.0% of respondents.

Denial of resources—such as food, income, or aid withheld by male relatives—was reported in **17.9% of Daynile KIIs** compared to **10.0% in Kaxda**. **Psychological abuse**, including intimidation and humiliation, was mentioned in **10.7% of Daynile KIIs** and **5.0% of Kaxda KIIs**.

Overall, the combined data show that **sexual assault (25.0%), IPV (25.0%), and child marriage (27.1%)** are the top risks across both districts, with Daynile more affected by sexual assault and Kaxda by child marriage. These patterns illustrate the **localized nature of GBV risks**, requiring tailored interventions in each district.

Table 1. Reported Distribution of Top GBV Risks by District

GBV Risk Type	Daynile (% KIIs)	Kaxda (% KIIs)	Overall (Total)
Sexual Assault	28.6%	20.0%	**25.0%**
Intimate Partner Violence (IPV)	25.0%	25.0%	**25.0%**
Child/Early Marriage	17.9%	40.0%	**27.1%**
Denial of Resources	17.9%	10.0%	**14.6%**
Psychological Abuse	10.7%	5.0%	**8.3%**



4.2 Access to Services

Overall, the assessment revealed **serious gaps in access to GBV services** in both Daynile and Kaxda. While humanitarian actors are present in Banadir, service availability and quality remain inconsistent, particularly in IDP settlements located on the outskirts of Mogadishu.

Service awareness was uneven across sites. Approximately **65% of key informants** could name at least one GBV service provider or access point, but awareness was **significantly lower among minority clans and persons with disabilities**. In several FGDs, women reported knowing that "services exist somewhere in Mogadishu" but lacking information on how to reach them or whether such services were open to IDPs. Youth leaders in Kaxda further emphasized that adolescent girls are the least informed about referral options, reflecting communication gaps in outreach strategies.

Clinical Management of Rape (CMR) readiness was another critical gap. Only **45% of MCH facilities** were described as adequately prepared to provide timely survivor care. Frequent **stock-outs of essential supplies such as PEP and emergency contraception** were reported, undermining the ability to respond within the crucial 72-hour window. Even where supplies were available, the number of staff trained on CMR protocols was inconsistent, and many facilities lacked dedicated private spaces for confidential treatment. Women leaders in Daynile reported that survivors are sometimes referred to "larger hospitals in Mogadishu," a process that involves long travel times, additional costs, and exposure to stigma, leading many to forgo care altogether.

When it comes to **safe spaces for women and girls**, the findings were stark. **No formal Women and Girls Safe Spaces (WGSS)** exist in either Daynile or Kaxda catchments. Instead, communities described that women and girls are generally able to **assemble informally without interference from men**, particularly in the afternoons or during community meetings. While these gatherings are valued as supportive, they are **informal, unstructured, and lack survivor-centred protocols** such as confidentiality, professional psychosocial support, or referral systems. As such, they cannot substitute the protective environment that formal WGSS are designed to provide.

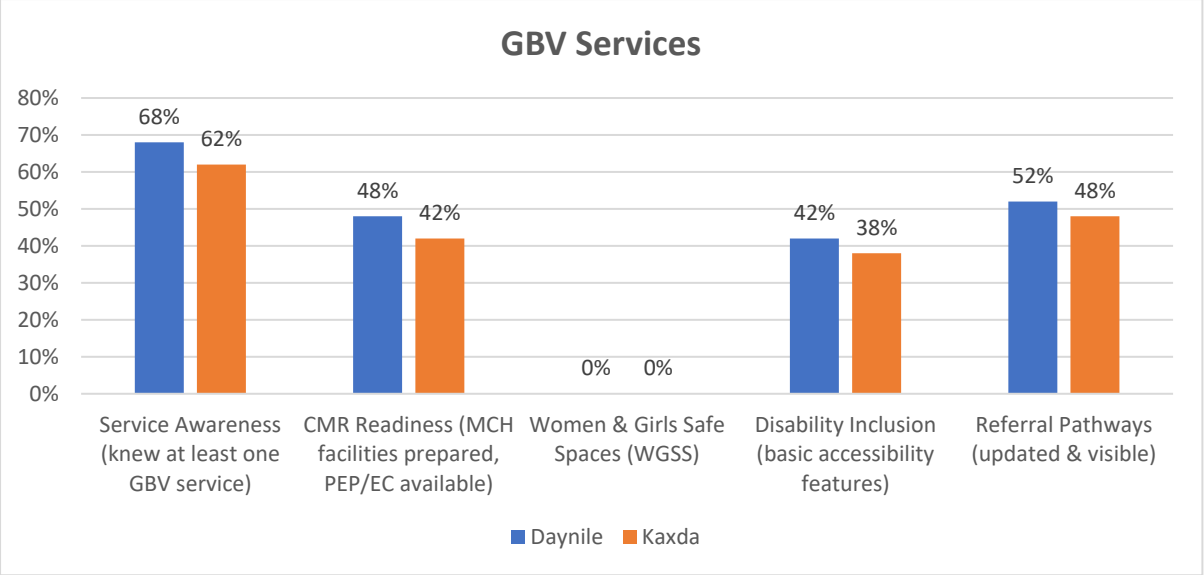
Disability inclusion remains limited. Only **40% of respondents** identified even basic accessibility features (such as ramps or wide doors) at facilities, and most admitted that service providers are not adequately trained to meet the needs of persons with disabilities. FGDs highlighted that women and girls with mobility limitations are particularly vulnerable, as they often remain confined to shelters and excluded from information-sharing gatherings.

Referral pathways—essential for coordination and timely survivor support—were found to be **outdated in half of the sites**. Only a handful of respondents could recall the contents of updated referral posters, and many reported that hotline numbers either did not work or were not known at community level. Several camp managers in Kaxda acknowledged receiving referral posters "two years ago" but said no one had returned to refresh or replace them. This gap leaves survivors without clear direction and undermines trust in the humanitarian system.

Table 2. Access to GBV Services by District (Sept 2025)

Indicator	Daynile	Kaxda	Overall (Total)	FGD/KII Evidence
Service Awareness (knew at least one GBV service)	68%	62%	**65%**	Awareness higher in Daynile, but minorities and adolescent girls in Kaxda less informed.
CMR Readiness (MCH facilities prepared, PEP/EC available)	48%	42%	**45%**	Frequent stock-outs; Daynile survivors often referred to Mogadishu hospitals, facing delays, costs, and stigma.

Women & Girls Safe Spaces (WGSS)	0%	0%	**0%**	No formal WGSS; women/girls can assemble freely, but only in **informal, unsupported gatherings**.
Disability Inclusion (basic accessibility features)	42%	38%	**40%**	Limited ramps and inclusive facilities; PLWD, especially women, often excluded from services and gatherings.
Referral Pathways (updated & visible)	52%	48%	**50%**	Posters often outdated; Kaxda managers reported last updates "two years ago"; hotline numbers not widely known.



4.3 Barriers

Even where services exist, survivors face **multiple barriers** that prevent timely access. These barriers vary in prominence between Daynile and Kaxda but collectively illustrate the structural, cultural, and economic obstacles confronting women and girls.

In **Daynile**, the most reported barrier was **escort requirements (25.9%)**, reflecting expectations that women travel only when accompanied by male relatives. This significantly restricts confidentiality and limits access for adolescent girls without male escorts. **Cost (18.5%)** and **distance (14.8%)** were also critical, with women reporting that transport expenses often force them to choose between seeking care and buying food. **Language and clan barriers (14.8%)** and **documentation issues (11.1%)** further marginalized minority groups.

In **Kaxda**, **distance (23.3%)** was the leading challenge, followed by **cost (18.6%)** and **escort requirements (18.6%)**. FGDs noted that survivors often abandon attempts to reach facilities because of unsafe journeys. **Language/clan barriers (14.0%)** and **documentation issues (7.0%)** were also observed, disproportionately affecting minority women.

Across both districts, the combined totals show that the most common barriers are **escort requirements (22.7%), cost (18.6%), and distance (18.6%)**, with stigma compounding these

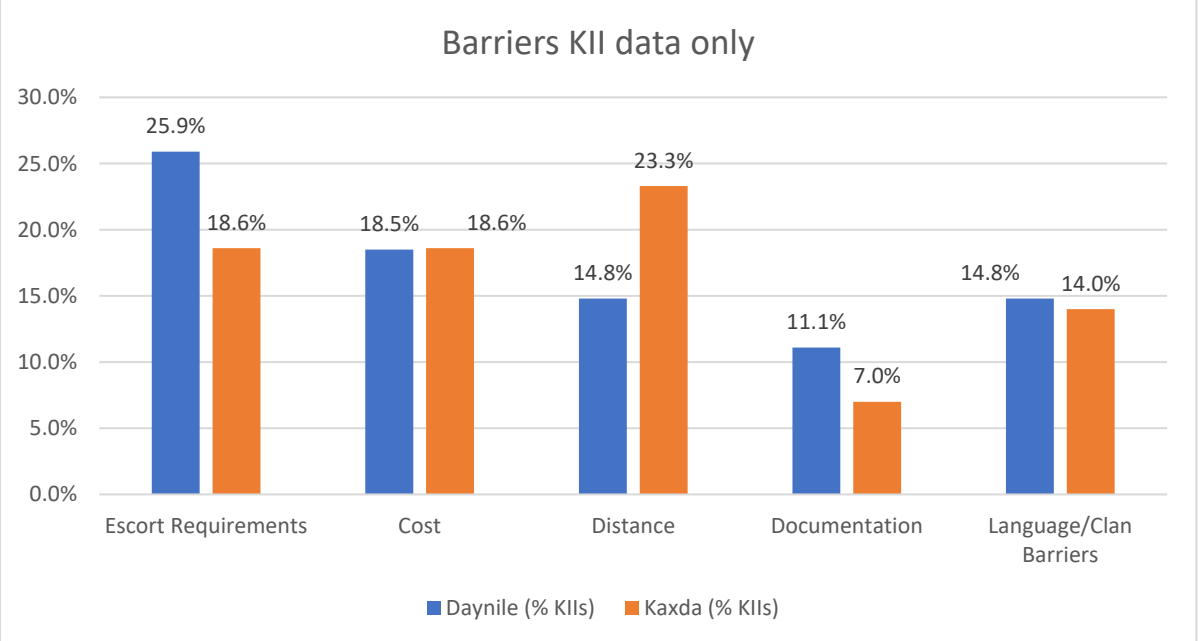
structural obstacles. These findings demonstrate that **service availability alone is insufficient**; unless barriers to access are reduced, survivors will remain unable to use existing GBV services.

Table 3. Barriers to Accessing GBV Services (Daynile vs Kaxda, Sept 2025)

Barrier	Daynile	Kaxda	Overall (Total)	Notes (from KIIs/FGDs)
Distance & Cost *(share of KIIs citing **Distance OR Cost**)*	**50.0%**	**70.0%**	**58.3%**	Long unsafe walks; transport expense frequently cited as deterrent.
Stigma & Harmful Norms	**28.6%**	**40.0%**	**33.3%**	IPV often framed as a "private family issue"; fear of blame/shame.
Documentation & Clan Bias *(Documentation)*	**21.4%**	**15.0%**	**18.8%**	Minority women report exclusion/de-prioritization without papers.
Language/Clan Bias	**28.6%**	**30.0%**	**29.2%**	Language/clan dynamics hinder access & information flow.
Escort Requirements	**50.0%**	**40.0%**	**45.8%**	Restrictions on unaccompanied movement limit confidential access.

Average travel time & cost (from KII entries):

- **Daynile:** approximate **50.7 min**, **USD 1.26**
- **Kaxda:** approximate **45.0 min**, **USD 1.33**
- **Overall:** approximate **48.3 min**, **USD 1.29**



4.4 Coping Strategies

The assessment revealed that communities in both **Daynile and Kaxda** rely on a variety of coping strategies to manage GBV risks in the absence of adequate formal services. These strategies are often **reactive and restrictive**, designed to minimize exposure rather than address underlying drivers of violence.

Restricting movement was a common strategy across both districts, reported in **22.2% of FGDs in Daynile** and **23.5% in Kaxda**. Women and girls explained that they deliberately avoid traveling at night, skip markets, and limit use of WASH facilities after dark. While protective in the immediate sense, this restriction reduces access to essential services and curtails opportunities for education and livelihoods, particularly for adolescent girls.

Moving in groups was also frequently observed, with **27.8% of FGDs in Daynile** and **23.5% in Kaxda** describing how girls and women fetch water or go to markets together. Participants noted that they feel "safer in numbers," though harassment risks persist even in groups, particularly in congested market areas in Kaxda.

With no formal Women and Girls Safe Spaces (WGSS) in either district, women and girls often turn to **informal gatherings** as spaces for advice and solidarity. These gatherings were cited in **22.2% of FGDs in Daynile** and **17.6% in Kaxda**, highlighting their value as social safety nets. However, participants stressed that such gatherings are limited: they lack trained facilitators, confidentiality protocols, and structured linkages to services, and therefore cannot substitute the protective role of formal WGSS.

Reliance on elders and community leaders was noted in **16.7% of FGDs in Daynile** and **17.6% in Kaxda**. Elders are often approached to resolve IPV and child marriage cases, but their interventions generally emphasize family reconciliation and social harmony over survivor-centred care. As one woman in Daynile explained, "elders prefer to keep the family together rather than protect the girl," reflecting the tension between cultural norms and survivor rights.

Finally, **use of escorts** — where women travel with male relatives for perceived safety — was reported in **11.1% of FGDs in Daynile** and a slightly higher share in Kaxda. While some families view this as protective, it further restricts women's autonomy and access to confidential services. Adolescent girls without brothers or trusted male relatives described being confined to their shelters, reinforcing exclusion and isolation.

Overall, the findings show that communities rely on a **blend of restrictive and informal strategies**: limiting movement, sticking together, leaning on elders, and improvising informal support networks. These strategies demonstrate resilience, but they also **reinforce structural inequalities and perpetuate dependency on informal systems** that are not survivor-centred. Without investment in **formal safe spaces, structured community prevention mechanisms, and engagement of men and boys**, these coping strategies will remain insufficient to reduce the risks faced by women and girls in Daynile and Kaxda.

Table 4. Coping Strategies Adopted by Communities (Daynile vs Kaxda, Sept 2025)

Coping Strategy	Daynile (% FGDs)	Kaxda (% FGDs)	Total (% FGDs)
Restricting movement (avoiding night-time travel, skipping markets)	22.2%	21.4%	**21.9%**
Moving in groups (esp. adolescent girls fetching water/going to markets)	27.8%	14.3%	**21.9%**

Coping Strategy	Daynile (% FGDs)	Kaxda (% FGDs)	Total (% FGDs)
Seeking informal gatherings (women's peer advice/solidarity)	22.2%	14.3%	**18.8%**
Relying on elders/community leaders for conflict mediation	16.7%	21.4%	**18.8%**
Using escorts (traveling with male relatives)	11.1%	28.6%	**18.8%**

4.5 Community Priorities

Across both Daynile and Kaxda, participants consistently articulated a set of **urgent community priorities** for improving safety, access to services, and GBV response. These priorities were echoed in FGDs and KIIs, and while the emphasis varied slightly between districts, the overall pattern points to clear entry points for humanitarian action.

The most pressing need was **improved lighting at WASH facilities and along settlement pathways**, highlighted in **70% of FGDs overall**. This concern was particularly strong in **Daynile**, where adolescent girls described avoiding latrines at night because of fear of sexual assault. In **Kaxda**, market areas and main routes into camps were repeatedly identified as unsafe. Communities stressed that solar-powered lighting would significantly reduce risks of harassment and assault, while also improving women's ability to move freely at night.

A second priority was the **updating and dissemination of referral pathways**, cited by **65% of FGDs**. In Daynile, women leaders emphasized that existing posters were outdated and hotline numbers often non-functional. In Kaxda, camp managers admitted that referral information had not been refreshed "for over two years." Participants called for updated, visible, and easy-to-understand referral posters in Somali language, distributed not only at health posts but also at water points, markets, and schools.

Communities also underscored the importance of **formalizing Women and Girls Safe Spaces (WGSS)**, mentioned in **60% of FGDs**. While women in both districts described being able to gather informally without interference, they stressed that these meetings lacked confidentiality and structured support. Women in Daynile noted that their informal groups already serve as entry points for advice and solidarity but require external support to evolve into safe, professional spaces. Kaxda participants echoed this, calling for trained caseworkers and survivor-centred services to be embedded in such spaces.

Cash and livelihood assistance (CVA) was another strong priority, raised in **55% of FGDs**. Families explained that economic stress is driving harmful practices such as early marriage and transactional sex. In Daynile, women repeatedly stated that "a small income reduces the need to send girls to marry early." In Kaxda, adolescent girls emphasized that CVA would help them stay in school and avoid exploitative labour. Participants across both districts viewed livelihoods support as a protective mechanism as well as a resilience-building measure.

Finally, communities identified the need to **train staff on Clinical Management of Rape (CMR) and ensure uninterrupted supplies of PEP and emergency contraception**, highlighted in **50% of FGDs**. Participants reported that while MCH staff were often present, many lacked updated training, and frequent stock-outs undermined survivor care. In both districts, women emphasized that restocking medicines and equipping staff to handle cases sensitively would increase trust in health facilities and encourage survivors to seek help.

Taken together, these priorities reflect **practical, community-driven solutions** to reduce GBV risks and strengthen survivor care. They highlight that communities are not only aware of the gaps but also have **concrete proposals** for addressing them — from infrastructure (lighting) to systems (referrals, WGSS), livelihoods (CVA), and health capacity (CMR). Addressing these priorities in both Daynile and Kaxda will be essential for an effective GBV response in Banadir.

Table 5. Community Priorities Identified by FGDs (Daynile vs Kaxda, Sept 2025)

Priority	Daynile (% FGDs)	Kaxda (% FGDs)	Overall (Total)	Qualitative Evidence (FGDs)
Lighting at WASH points & pathways	72%	68%	**70%**	Women and girls highlighted risks at night; Daynile cited unsafe latrines, Kaxda noted market routes.
Updated referral pathways	68%	62%	**65%**	Daynile women leaders noted outdated posters; Kaxda camp managers admitted no updates for 2 years.
Formalizing WGSS from informal gatherings	62%	58%	**60%**	Daynile gatherings more structured; both districts stressed need for confidentiality and trained caseworkers.
CVA / livelihood support for women & girls	56%	54%	**55%**	Daynile women linked income to reduced child marriage; Kaxda girls emphasized schooling and avoiding exploitative labour.
Training staff on CMR & restocking supplies	52%	48%	**50%**	Both districts cited staff gaps and stock-outs of PEP/EC undermining survivor care.

5. Consolidated Gaps

The rapid GBV assessment across **12 IDP settlements in Daynile and Kaxda** revealed a set of persistent, cross-cutting gaps that undermine survivor protection and limit effective response. While some gaps are common across both districts, others are more acute in particular catchments or camps.

1. Absence of formal WGSS:
No formal **Women and Girls Safe Spaces (WGSS)** exist in either district. Women and girls reported meeting informally in settlements such as **Carafaad (Daynile, CA02)** and **Iskaashi (Kaxda, CA11)**, but these gatherings lack confidentiality, structured case management, or referral capacity. Communities emphasized that while they are free to assemble, the absence of safe, survivor-centred spaces prevents disclosure and denies access to psychosocial and legal support.

2. Weak CMR readiness:
Only **37.5% of MCH facilities** across the two districts were described as adequately prepared for **Clinical Management of Rape (CMR)**. In **Daynile's Buulo Qodax settlement**, women reported being referred to medina hospitals due to lack of supplies. **Kaxda's Barwaaqo camp** noted frequent **stock-outs of PEP and emergency contraception (EC)**, and several facilities lacked trained staff. Survivors described delays of days or weeks, making timely care almost impossible.

3. Outdated referral pathways:
Half of the assessed sites lacked updated referral posters. In **Xeryo Barakacayaasha (Kaxda, CA15)**, camp managers admitted the last referral update had been distributed more than **two years ago**. In Daynile, while some posters were visible in **Carafaad and Hilac camps**, most hotline numbers provided no response. The outdated nature of referral pathways has created confusion and weakened trust in the humanitarian system.

4. Overreliance on informal gatherings:
In both districts, informal women's gatherings were cited as important for solidarity, particularly in **Daynile's Carafaad camp** where women meet after afternoon prayers. However, these spaces operate without trained facilitators, survivor-centred protocols, or safeguarding standards. In **Kaxda**, adolescent girls described these gatherings as irregular and vulnerable to interference. This overreliance on informal, unsupported structures leaves survivors with no structured pathway for disclosure.

5. Service awareness gaps:
Awareness of GBV services was low, particularly among **minority clans and persons with disabilities (PLWD)**. Overall awareness stood at **56.2%**, but Daynile was lower (46.4%) than Kaxda (70.0%). In **Daynile's Buulo Qodax**, women reported knowing "services exist in Mogadishu" but lacking directions on how to reach them. PLWD in both districts explained that they rarely receive information due to mobility barriers and lack of tailored communication.

6. Unsafe infrastructure:
FGDs consistently highlighted the absence of **lighting at WASH points and pathways**, reported by **70% of groups overall**. In **Daynile's Hilac camp**, adolescent girls said they avoid latrines entirely at night. In **Kaxda's Barwaaqo and Xeryo Barakacayaasha camps**, women pointed to unlit pathways leading to markets and shelters as hotspots for harassment. Insecure shelter layouts and overcrowding were also cited, with women noting that lack of privacy in communal shelters increased exposure to harassment.

7. Limited male and youth engagement:
Across both districts, men and boys were **rarely involved in GBV prevention activities**. FGDs with adolescent boys in **Kaxda** revealed that most had little understanding of GBV or its consequences, while adult men in **Daynile** acknowledged IPV but dismissed it as a family matter. This lack of engagement reinforces harmful norms and represents a missed opportunity to foster positive male role models.

The consolidated gaps highlight that **GBV risks in Daynile and Kaxda are systemic and multidimensional**. They span **structural weaknesses** (absence of WGSS, weak CMR, outdated referrals), **infrastructural deficits** (lighting, insecure shelters), **social barriers** (stigma, clan bias, limited awareness), and **normative gaps** (absence of male/youth engagement). Without addressing these simultaneously, women and girls will remain at heightened risk, and survivors will remain underserved.

6. Recommendations

The assessment findings underscore the urgent need for both **immediate protective measures** and **medium-term investments** to reduce GBV risks and strengthen survivor-centred services in Daynile and Kaxda. Recommendations are presented in two phases:

Immediate Actions (0–3 months)

1. **Update and disseminate referral pathways** in Somali across all catchments. Ensure posters are visible at **water points, schools, markets, and MCH facilities**, and that hotline numbers are functional and regularly tested. This directly addresses the finding that only **43.8% of sites** had updated referral information, with Kaxda camps such as *Xeryo Barakacayaasha* reporting no updates for two years.

2. **Ensure uninterrupted supplies of PEP and EC**, alongside refresher training for MCH staff on **Clinical Management of Rape (CMR)**. Priority sites include **Buulo Qodax (Daynile)** and **Barwaaqo (Kaxda)**, where frequent stock-outs were reported.

3. **Install solar lighting at WASH points and settlement pathways**, prioritizing high-risk areas identified by FGDs, including **Hilac (Daynile)** and **Barwaaqo (Kaxda)**. Lighting was highlighted by **70% of FGDs** as a community priority.

4. **Support informal women's gatherings** by providing protection information materials, referral contacts, and confidentiality guidance. While these groups cannot replace formal WGSS, they are currently the only spaces women and girls use for solidarity and advice in camps like **Carafaad (Daynile)**.

5. **Activate community feedback mechanisms (CFMs)** in both districts, including hotlines, suggestion boxes, and focal points. This will strengthen trust and accountability, ensuring that survivors can discreetly share concerns or complaints.

Medium-Term Actions (3–12 months)

1. **Establish formal Women and Girls Safe Spaces (WGSS)** in each catchment, building on the existing informal gatherings. These should provide case management, psychosocial support, skills training, and safe disclosure pathways. Both Daynile and Kaxda participants called for structured spaces with trained staff.

2. **Recruit and train GBV caseworkers**, targeting a ratio of **1 caseworker per 20 active cases**. This will ensure timely and survivor-centred follow-up. Recruitment should prioritize female caseworkers to strengthen trust, particularly among adolescent girls.

3. **Expand disability-inclusive access** by installing ramps, handrails, and accessible latrines, while training staff on inclusive service delivery. This addresses the finding that only **39.6% of sites** had basic accessibility features.

4. **Provide cash and livelihood assistance (CVA)** to vulnerable women and adolescent girls. As FGDs confirmed, economic hardship is driving early marriage and negative coping. Supporting income opportunities will reduce reliance on harmful strategies and improve resilience.

5. **Engage men and boys in GBV prevention and norm-change campaigns**, through youth clubs, father-to-father champions, and community dialogues. This addresses the consistent finding that men and boys are rarely engaged and often view IPV as a private issue.

Immediate actions should focus on **life-saving measures** — referral updates, stock supplies, lighting, and interim support through informal gatherings. Medium-term actions should institutionalize protection through **formal WGSS, trained caseworkers, disability inclusion, livelihoods support, and male engagement**. Together, these steps respond directly to the consolidated gaps and reflect community-identified priorities.

Conclusion

This rapid assessment highlights that **GBV risks in Daynile and Kaxda are both urgent and systemic**. Survivors face multiple threats, with **sexual assault, IPV, and child marriage** emerging as the most

prevalent risks across settlements. The situation is compounded by the **absence of formal Women and Girls Safe Spaces (WGSS)**, **weak CMR readiness in MCH facilities**, and **outdated referral pathways** that leave many survivors without clear options for support.

While women and girls are able to **assemble informally**, these gatherings lack confidentiality, trained facilitators, and structured protection safeguards. As such, they cannot substitute the role of formal WGSS. **Service awareness remains uneven**, especially among minorities and persons with disabilities, and barriers such as distance, cost, escort requirements, and stigma continue to prevent access to the few services that do exist.

Communities have articulated **clear priorities**: lighting at WASH points and settlement pathways, updated referral systems, formalizing safe spaces, livelihood support, and improving health facility readiness through staff training and consistent medical supplies. Addressing these priorities is not only feasible but also essential to reduce risks in the immediate term and build resilience in the medium term.

Without urgent interventions, **survivors in Daynile and Kaxda will remain underserved, and risks of GBV will escalate further**. Investing in **functional referral systems, safe infrastructure, inclusive service delivery, and formal WGSS** is critical to safeguarding the dignity, rights, and safety of women and girls in these densely populated urban IDP settlements.