Flygtningenævnets baggrundsmateriale

Bilagsnr.:	**1190**
Land:	Somalia
Kilde:	Agency for Minority Rights and Development (AMARD)
Titel:	Gender-Based Violence (GBV) Rapid Assessment Report
Udgivet:	15. september 2025
Optaget på baggrundsmaterialet:	20. april 2026

Gender-Based Violence (GBV) Rapid Assessment Report

Coverage: *11 IDP camps (Buusley, Babado, Tirka, Hareeri Jiroon, Xafata, Lowforar, Buula Gomaar, Abbey, Cadaan Qaboowe, Weelbuurow, Wanini)*

Location: Baidoa (Baydhaba), Southwest State, Somalia
Period: 7th –11th September 2025

Conducted by: Agency for Minority Rights and Development (AMARD) with 8 trained enumerators

Executive summary

Between 7–11 September 2025, AMARD conducted a GBV Rapid Assessment across 11 IDP camps in Baidoa using 80 Key Informant Interviews (KIIs), 40 Focus Group Discussions (FGDs) with 408 participants, observation checklists, and service mapping. The aim was to identify urgent GBV risks, document barriers to services, and provide evidence to guide immediate and medium-term interventions.

Key Findings

- Intimate Partner Violence (IPV): Reported in 56% of KIIs and 30% of FGDs.
- Child/Early Marriage: Reported in 34% of KIIs and 50% of FGDs.
- Sexual Assault: Reported in 39% of KIIs and 48% of FGDs, mainly at latrines, water points, and camp peripheries.
- Sexual Exploitation: Reported in 28% of KIIs and 40% of FGDs, often linked to aid distribution.
- Harassment at WASH facilities and denial of resources consistently cited.
- Adolescent girls, minority women, and PWDs were identified as the groups most exposed to overlapping risks.

Service Gaps

- Only 48% of facilities were CMR-ready, with just 36% confirming consistent PEP/EC stocks.
- No WGSS/OSCs exist inside camps; survivors travel an average of 56–62 minutes to reach offsite NGO-run services.
- Referral pathway awareness remains low (48%).
- Psychosocial support is minimal and mostly informal through peer groups.

Beyond these gaps, survivors face multiple overlapping barriers: distance and travel time (46% of KIIs), stigma and fear of disclosure (41%), transport and treatment costs (29%), lack of privacy in services (24%), and clan/language bias (23%). PWDs reported near-total exclusion due to inaccessible facilities. In response, communities rely on fragile coping mechanisms such as restricting movement (54%), informal women's gatherings (44%), reliance on elders (36%), avoiding night-time movements (29%), and resorting to early marriage.

Immediate actions within two weeks should include installing solar lighting at WASH facilities, repairing locks on latrines, deploying temporary community watch groups, disseminating updated referral pathways in Somali (Maay and Maxaa), and activating mobile psychosocial and legal aid desks. Over one to three months, system-level priorities include establishing formal WGSS/OSCs in or near camps, strengthening CMR readiness, ensuring disability and minority inclusion, expanding community-based protection structures, and aligning interventions with HNRP protection priorities.

The assessment concludes that GBV risks in Baidoa are acute, systemic, and compounded by service inaccessibility. Without urgent dual-track action — combining immediate mitigations with sustained investments in survivor-centered services — women, girls, PWDs, and minority groups will remain at heightened risk of violence, exploitation, and exclusion.

1. Background & Objectives

Baidoa (Baydhaba) is one of Somalia's largest displacement hubs, hosting tens of thousands of internally displaced persons (IDPs) fleeing **armed conflict, climatic shocks, and recurrent droughts and floods**. The city's **11 major IDP camps covered in this assessment** (Buusley, Babado, Tirka, Hareeri Jiroon, Xafata, Lowforar, Buula Gomaar, Abbey, Cadaan Qaboowe, Weelbuurow, and Wanini) reflect the complex protection environment facing communities that have endured repeated cycles of crisis and displacement.

Displacement has placed **enormous strain on overstretched basic services**, including shelter, WASH, and health systems. Within this fragile environment, **women, adolescent girls, persons with disabilities (PWD), and minority groups** are disproportionately affected by **gender-based violence (GBV)** risks, such as Intimate Partner Violence (IPV), sexual assault, child/early marriage, harassment at WASH facilities, and denial of resources. These risks are aggravated by **insecurity, poor lighting, overcrowding, gatekeeper dynamics, and the absence of community protection structures**.

As highlighted in the **2025 Somalia Humanitarian Needs and Response Plan (HNRP)** and the ongoing **Humanitarian Reset agenda**, access to specialized protection services remains a critical gap. While some psychosocial and legal services are offered by local NGOs, there are **no formal Women and Girls' Safe Spaces (WGSS) or One-Stop Centers (OSC) within the Baidoa IDP camps**. Offsite NGO-run centers exist but are under-resourced and difficult to reach, with survivors often reporting travel times of an hour or more to access care. In parallel, health facilities struggle with **frequent PEP/EC stockouts** and limited CMR-trained staff, leaving survivors at heightened risk of unaddressed harm.

In this context, AMARD undertook a **GBV Rapid Assessment (7–11 September 2025)** to provide evidence-based insights for **urgent lifesaving interventions and medium-term protection programming**. The assessment was guided by a **survivor-centered, do-no-harm approach** and deployed **8 trained enumerators** across 11 IDP camps.

The objectives were to:

- **Identify urgent GBV risks and patterns in IDP camps:** Document the prevalence and settings of IPV, sexual violence, child/early marriage, harassment, and denial of resources.
- **Examine barriers to service access:** Highlight stigma, cost, distance, clan bias, and lack of disability-friendly services that prevent survivors from seeking timely care.
- **Map service availability and accessibility:** Assess the status of clinical management of rape (CMR), psychosocial support (PSS), legal aid, and referral pathways, identifying where services exist and where they fail.
- **Generate evidence to inform response and advocacy:** Support immediate, low-cost mitigation actions (e.g., lighting, latrine locks, community watch) and guide system-level reforms (e.g., establishing WGSS/OSC, ensuring CMR readiness, building inclusive referral

systems) in line with HNRP priorities and the humanitarian reset's focus on protection and dignity.

This rapid assessment serves as both an **operational tool for AMARD's programming in Baidoa** and a **strategic input into inter-agency protection planning**, reinforcing the case for increased investment in GBV and CP services in Somalia's humanitarian response.

2. Methodology

The Baidoa GBV Rapid Assessment was carried out between **7–11 September 2025** across 11 IDP camps. The approach combined **qualitative and quantitative methods** to ensure wide coverage and diverse perspectives.

Data Collection

- **Key Informant Interviews (KIIs):**
  A total of **80 KIIs** were conducted. Informants were drawn from both community structures and frontline responders, including:
  - 20 Women Leaders
  - 15 Protection Focal Points
  - 14 Camp Leaders
  - 13 GBV Caseworkers
  - 10 Health Workers
  - 8 Youth Leaders

This mix allowed the assessment to capture **community perceptions, service realities, and leadership views**.

- **Focus Group Discussions (FGDs):**
  40 FGDs with 408 participants were conducted across the camps. Groups were segmented to reflect gender, age, and vulnerability, ensuring inclusivity:
  - 13 groups with Women (18–35)
  - 9 groups with Women (36+)
  - 6 groups with Adolescent Girls (12–17)
  - 4 groups with Minority Women
  - 3 groups with Men (18–35)
  - 3 groups with Men (36+)
  - 2 groups with Persons with Disabilities (PWD)

Group size ranged from **6 to 14 participants**, averaging around **10 per group**.

- **Observation Checklists:**
  Enumerators visited communal areas such as **latrines, water points, markets, and camp**

peripheries to document environmental risks. Frequent issues observed included unlit latrine areas, broken locks, and overcrowded water points.

- Service Mapping:
  Rapid mapping was conducted to assess availability and accessibility of services. Findings confirmed:
  - Less than half of facilities were CMR-ready.
  - PEP/EC stockouts were common.
  - No functional WGSS or OSC inside the camps; existing centers are NGO-run and located offsite, with limited resources.
  - Referral pathways were outdated or not clearly visible.

Enumerator Deployment

- Team composition: 8 enumerators (4 female, 4 male), trained in GBV case handling, LIVES, and PSEA.
- Coverage: All 11 target IDP camps were reached (Buusley, Babado, Tirka, Hareeri Jiroon, Xafata, Lowforar, Buula Gomaar, Abbey, Cadaan Qaboowe, Weelbuurow, Wanini).
- Daily workload: Each enumerator conducted on average 2 KIIs and 1 FGD per day, enabling completion of 80 KIIs and 40 FGDs in five days.
- Language: Data collection was conducted in Somali (Maay and Maxaa dialects), ensuring accessibility for different communities.

Tools and Instruments

- KII guides explored GBV risks, barriers to services, coping strategies, and service availability.
- FGD guides used participatory methods to identify unsafe spaces, barriers, and potential solutions.
- Observation checklists documented settlement-level risks in WASH and shelter infrastructure.
- Service readiness tools verified stock availability (PEP/EC), staffing (especially female staff), privacy measures, and referral systems.

Ethical Safeguards

- Informed consent was obtained from all participants, with clear explanations of voluntary participation and confidentiality.
- No incident probing was done; the focus remained on perceptions and community-level dynamics.
- Enumerators applied LIVES principles (Listen, Inquire, Validate, Enhance safety, Support) and adhered to PSEA standards.
- FGDs were conducted in gender- and age-segregated spaces, and deliberate steps were taken to include PWD and minority groups safely.

Limitations

- **Short timeframe:** Five days limited opportunities for deeper probing in some camps.
- **Perception-based:** Findings rely on self-reported perceptions, not case data, which may under- or over-estimate prevalence.
- **Male survivor perspectives:** Underrepresented, as discussions prioritized women and girls in line with GBV AoR priorities.
- **Service verification gaps:** Some facility readiness findings were based on informant reports rather than direct inspection.

Strengths

- **Breadth and inclusivity:** The assessment covered **80 KIIs and 40 FGDs with 408 participants**, spanning all major demographic groups.
- **Consistency in data:** Service awareness levels averaged **about 48%** across both KIIs and FGDs, showing reliability of triangulated findings.
- **Accessibility insight:** Reported average travel time to services was **55–62 minutes**, consistently highlighting barriers faced by survivors.
  Together, these strengths ensure that the assessment provides a **robust and representative picture** of GBV risks and service gaps in Baidoa's IDP camps.

3. Key Findings

3.1 Risks and Trends

The assessment confirmed that **Intimate Partner Violence (IPV)** is the most widespread form of GBV in Baidoa's IDP camps. IPV was identified in **45 out of 80 KIIs (56%)**, making it the most cited risk overall. While it appeared less frequently in FGDs (**12 out of 40 groups, or 30%**), facilitators observed that IPV is often under-reported in group settings because it is normalized within households and clouded by stigma. Women in discussions described IPV as a "hidden but daily reality," particularly affecting married women in overcrowded shelters where stress, economic pressure, and displacement amplify tensions.

Child and early marriage also emerged as a significant and growing concern, raised in **27 KIIs (34%)** and **20 FGDs (50%)**. Participants explained that displacement-related poverty drives families to marry off daughters as a coping mechanism — either to reduce household expenses or to seek perceived protection. Both KII informants and adolescent girls in FGDs noted that such practices are becoming more common in the past year, with girls as young as 13–14 being affected.

Sexual assault was reported in **31 KIIs (39%)** and **19 FGDs (48%)**. These incidents were most often linked to unsafe physical environments, especially unlit camp peripheries and pathways to water points. Adolescent girls were highlighted as particularly at risk, as they are frequently tasked with collecting firewood and fetching water in areas lacking community watch structures.

Sexual exploitation was identified in **22 KIIs (28%)** and **16 FGDs (40%)**, underscoring its systemic nature. Survivors and community members associated exploitation with humanitarian aid distribution, where women and girls face pressure to exchange sexual favors for access to food, water, or basic services. Several KIIs pointed out that these exploitative dynamics persist due to weak accountability and the absence of formal complaint mechanisms within camps.

Harassment at WASH facilities was cited in **21 KIIs (26%)** and **15 FGDs (38%)**. Women and girls consistently described water points and communal latrines as unsafe, especially after dark. Long queues, the absence of locks, and poor lighting increased risks, and adolescent girls in particular reported harassment while waiting in line for water or attempting to use latrines at night.

Finally, **denial of resources** was reported in **14 KIIs (18%)** and **18 FGDs (45%)**. This form of violence primarily occurred at the household level, where men withheld food, cash, or other essentials, leaving women and children vulnerable to neglect and exploitation.

Across all 11 camps, **high-risk settings** were consistently identified. Communal latrines lacked functioning locks or lighting, water points were overcrowded and unsafe, and shelters on camp peripheries left women and girls isolated and exposed to attacks. The analysis also shows clear vulnerability patterns: **economic stress** was repeatedly cited as a driver of early marriage, sexual exploitation, and denial of resources. Minority women and adolescent girls were particularly

highlighted as facing multiple overlapping risks, illustrating how GBV in Baidoa is shaped not only by gender but also by poverty and social exclusion.

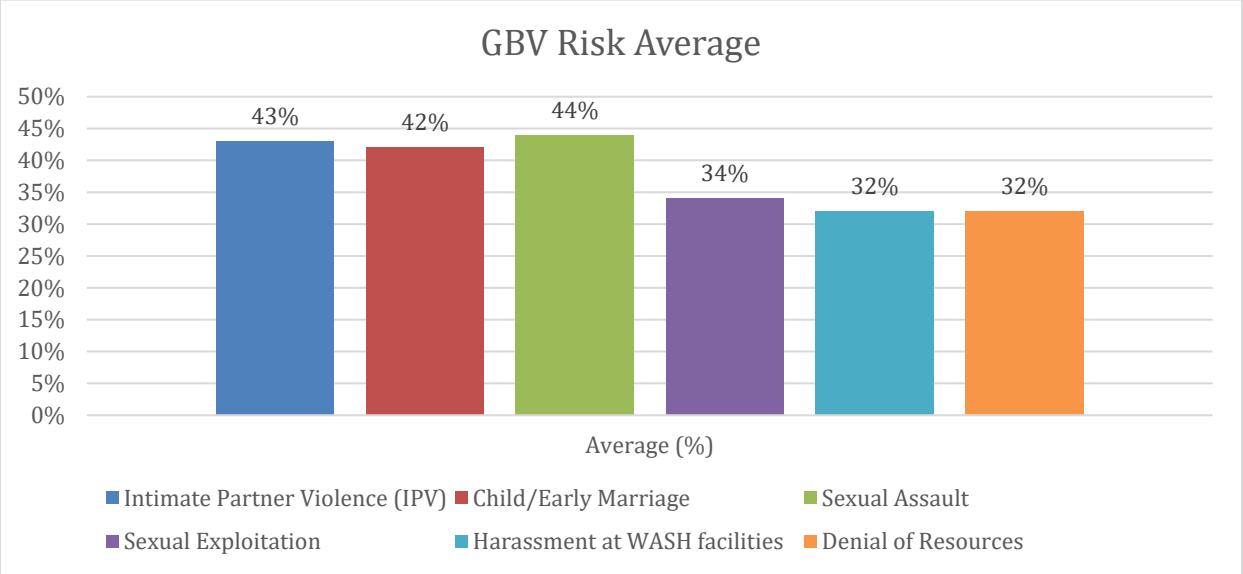
Table 1. Reported GBV Risks – KIIs and FGDs

GBV Risk	KIIs (n=80)	KII (%)	FGDs (n=40)	FGD (%)
Intimate Partner Violence (IPV)	45	56%	12	30%
Child/Early Marriage	27	34%	20	50%
Sexual Assault	31	39%	19	48%
Sexual Exploitation	22	28%	16	40%
Harassment at WASH facilities	21	26%	15	38%
Denial of Resources	14	18%	18	45%

The disparities between KII and FGD findings highlight the different ways risks are **perceived, reported, and discussed** in **individual** versus **group settings**.

- For Intimate Partner Violence (IPV), prevalence was higher in KIIs (56%) than FGDs (30%). This reflects the sensitivity and stigma surrounding IPV; survivors and community members are more likely to acknowledge it in confidential one-on-one interviews than in group discussions, where cultural norms discourage disclosure.
- In contrast, Child/Early Marriage was reported less often in KIIs (34%) but much more frequently in FGDs (50%). This suggests that while individual informants may hesitate to present child marriage as a personal concern, group discussions — especially with adolescents and women — create space for participants to speak collectively about the growing practice and its impact on girls.
- Sexual Assault and Sexual Exploitation show relatively consistent patterns across both methods (39% vs. 48% and 28% vs. 40% respectively). This alignment suggests that these risks are widely recognized and affect the community in visible ways. Slightly higher reporting in FGDs may reflect the shared validation effect, where participants feel more confident to disclose when others raise the same issue.
- Harassment at WASH facilities and Denial of Resources were also more frequently raised in FGDs (38% and 45%) compared to KIIs (26% and 18%). These risks are often collective experiences that women and girls face in public or household spaces. Group discussions may make it easier to highlight these shared problems, whereas KII respondents may downplay them or prioritize other risks when interviewed individually.
- Overall, the data underscores that KIIs capture sensitive, individualized experiences, particularly IPV, while FGDs are more effective in surfacing community-wide risks such as child marriage, harassment, and denial of resources. Using both methods together provides a more holistic understanding of GBV dynamics in Baidoa, balancing private disclosures with collective perceptions.

Average Reported Prevalence of GBV Risks (KIIs + FGDs)



3.2 Service Availability and Gaps

The assessment revealed major gaps in GBV service provision across Baidoa's 11 IDP camps. While some limited services are technically present, their accessibility and reliability remain inconsistent, leaving survivors underserved and at risk.

On **clinical management of rape (CMR)**, only **48% of KII informants** reported that nearby health facilities were adequately prepared to provide CMR services. Even where facilities were reported as technically "ready," there were frequent complaints about **stockouts of Post-Exposure Prophylaxis (PEP) and Emergency Contraception (EC)**, which were confirmed by only **36% of KIIs** as consistently available. Survivors in FGDs described situations where they were referred to health centers only to find that essential supplies were missing, delaying timely treatment and increasing health risks.

Psychosocial support (PSS) was available only in a limited and fragmented way. Communities explained that small-scale PSS services were mainly provided through NGO-led initiatives, often dependent on short-term projects. These were not present inside the camps themselves and were seen as **sporadic, underfunded, and difficult to reach**. Several women noted that informal gatherings often became the only accessible form of peer support, highlighting the absence of structured psychosocial interventions.

With regard to **Women and Girls' Safe Spaces (WGSS) and One-Stop Centers (OSC)**, the assessment confirmed there are **no formal facilities inside the camps**. All 80 KIIs (0%) indicated that WGSS presence within camp boundaries was absent. Instead, NGO-run centers exist outside the camps, but their resources are limited, and survivors described barriers of **distance, stigma, and lack of transport**. The average reported travel time to reach such services was **56 minutes**

from KIIs and 62 minutes from FGDs, making them inaccessible for most women and girls in urgent need.

Finally, referral pathways were found to be outdated and inconsistent. Only about 48% of informants demonstrated awareness of existing services or could identify clear referral options. Both KII respondents and FGD participants highlighted that referral posters and leaflets were either missing or outdated, and frontline staff were often unclear about referral protocols. This not only hinders survivors from accessing help quickly but also undermines trust in formal systems.

Overall, the data demonstrates that while some elements of a GBV response system exist in Baidoa, they are fragmented, under-resourced, and inaccessible. Survivors continue to rely on informal networks, face long travel times, and encounter frequent barriers to accessing lifesaving care.

Table 2. Service Availability and Gaps

Service Indicator	Value
Facilities CMR-ready	48%
PEP/EC consistently in stock	36%
WGSS/OSC presence inside camps	0%
Average travel time to services	56 min (KIIs), 62 min (FGDs)
Awareness of referral pathways	48%
Psychosocial support availability	Minimal, mostly informal peer support

3.3 Accessibility and Barriers

Access to GBV services in Baidoa is heavily constrained, not only by the limited availability of facilities but also by multiple barriers that discourage survivors from seeking support. The data show that even when services exist, survivors face overlapping challenges of distance, stigma, cost, discrimination, and disability exclusion.

The first and most frequently reported barrier was distance and travel time. According to KIIs, 37 out of 80 respondents (46%) identified distance as a major constraint. Survivors reported average travel times of 56 minutes in KIIs and 62 minutes in FGDs to reach services. These journeys were especially difficult for women with children and persons with disabilities, who required additional support and often abandoned attempts to reach help due to exhaustion or insecurity.

The second barrier was stigma and fear of disclosure, raised in 33 KIIs (41%). Survivors worried that reporting violence would lead to shame, rejection, or retaliation, especially in close-knit camp communities where confidentiality is difficult to maintain. Women noted that stigma not only prevented survivors from seeking formal support but also reinforced silence within families.

The third key barrier was the **cost of transport and treatment**, highlighted in **23 KIIs (29%)**. While services themselves were often free, indirect costs such as hiring a vehicle, purchasing medicines, or paying clinic fees created insurmountable financial obstacles. For displaced families already facing severe poverty, these costs were prohibitive, effectively cutting them off from life-saving services.

The fourth barrier was **privacy and safety within services**, mentioned in **19 KIIs (24%)**. Health facilities and service points were described as lacking confidentiality — for example, consultation rooms without doors or overcrowded waiting areas where others could overhear sensitive disclosures. Survivors feared that a lack of privacy could expose them to stigma or further harm.

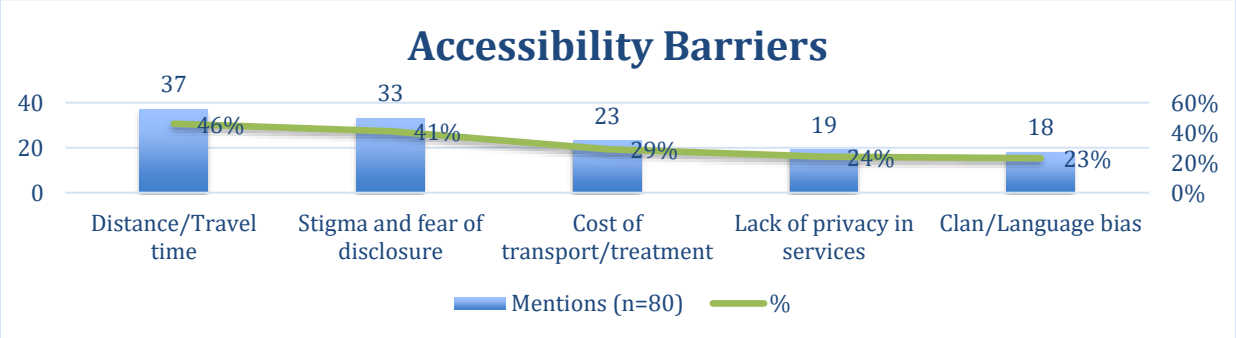
The fifth major barrier was **clan and language bias**, cited in **18 KIIs (23%)**. Minority women in particular reported being dismissed or discriminated against by providers, sometimes due to their clan affiliation, and at other times due to language differences. In some cases, services were only available in Maxaa, excluding Maay-speaking survivors from minority groups.

Additional challenges included the **lack of disability-friendly facilities**, reported during FGDs with persons with disabilities, who highlighted the absence of ramps, adapted latrines, or tailored communication tools. This left women and girls with disabilities doubly excluded, facing both high exposure to GBV and systemic barriers to care.

Overall, the findings demonstrate that barriers are not isolated but cumulative. Survivors in Baidoa face **long distances, deep stigma, prohibitive costs, poor privacy, and social discrimination**, which together severely restrict access to already limited GBV services.

Table 3. Accessibility Barriers (from KIIs)

Barrier	Mentions (n=80)	%
Distance/Travel time	37	46%
Stigma and fear of disclosure	33	41%
Cost of transport/treatment	23	29%
Lack of privacy in services	19	24%
Clan/Language bias	18	23%



3.4 Coping Mechanisms

In the absence of reliable GBV services, communities in assessed camps have developed a range of coping mechanisms. These strategies reflect both resilience and adaptation but also reveal how survivors are forced to manage risks in ways that may compromise their safety and dignity.

The most commonly cited strategy was **restricting movement**, reported in **43 KIIs (54%)**. Women and girls explained that they often avoid leaving shelters unless absolutely necessary, particularly after dark, to reduce the risk of harassment or assault. While this strategy provides a sense of immediate safety, it also **limits access to education, markets, and social participation**, reinforcing isolation.

A second strategy involved **seeking informal women's gatherings**, mentioned in **35 KIIs (44%)**. These gatherings, often held discreetly within camps, provide spaces for women and girls to share experiences, offer emotional support, and exchange advice on staying safe. Participants described these as the only available form of psychosocial support, compensating for the absence of formal safe spaces.

Communities also reported **relying on elders and respected leaders**, cited in **29 KIIs (36%)**. Elders were seen as mediators in cases of violence or conflict, often providing advice or attempting informal resolutions. However, participants noted that such mediation frequently prioritized family or community harmony over survivor needs, sometimes resulting in survivors being pressured to reconcile with perpetrators.

Avoiding night movements was another coping measure, highlighted in **23 KIIs (29%)**. Women and girls deliberately avoided using latrines or fetching water after dark due to fear of harassment and assault. Some families designated male relatives to fetch water at night, though this shifted household burdens and did not fully address risks.

Finally, while not always explicitly framed as "coping," both FGDs and KIIs indicated that **child and early marriage** was being used by some families as a negative coping mechanism. Although not listed as frequently in the KII coping responses, it was repeatedly discussed in FGDs — especially with adolescent girls — as a way parents attempt to reduce economic pressure or provide perceived protection. This practice exposes girls to long-term harm, cutting short their education and exposing them to IPV within marriage.

Together, these findings illustrate that coping mechanisms in Baidoa are shaped by **scarcity of services and lack of safe infrastructure**. While strategies like restricting movement or informal women's gatherings provide some protection, they also **reinforce exclusion and risk**, highlighting the urgent need for formal, accessible, and survivor-centered GBV services.

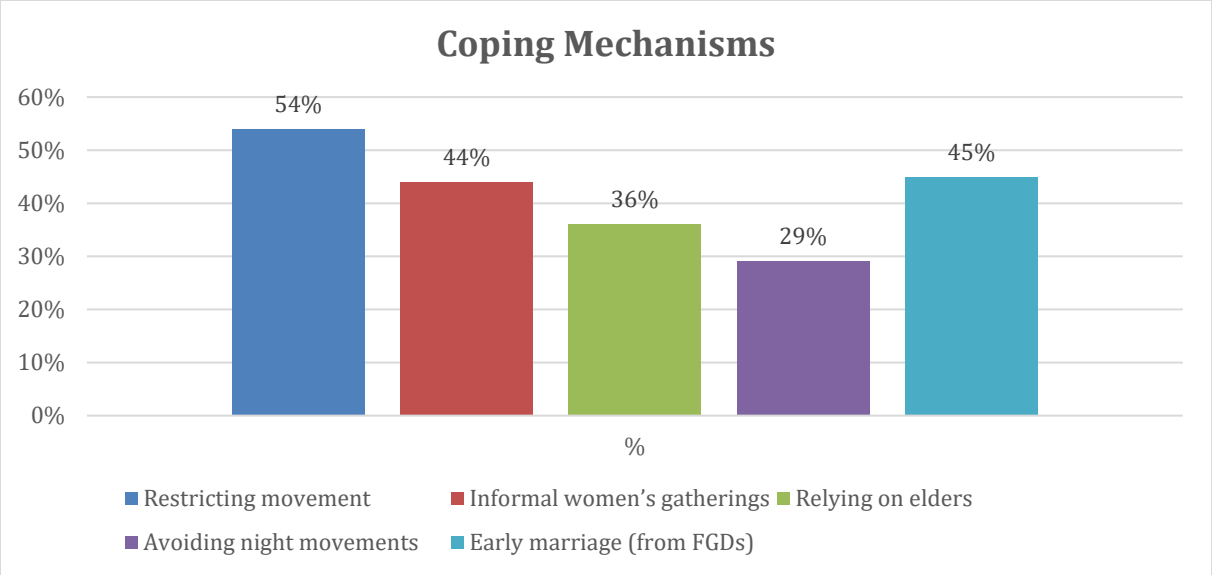


Table 4. Coping Mechanisms (from KIIs)

Coping Mechanism	Mentions (n=80)	%
Restricting movement	43	54%
Informal women's gatherings	35	44%
Relying on elders	29	36%
Avoiding night movements	23	29%
Early marriage (from FGDs)	18	45%

4. Camp-Level Highlights

The assessment revealed important variations across the 11 IDP camps in Baidoa, showing how GBV risks and service gaps manifest differently at the settlement level.

In **Buusley and Babado**, reports of **intimate partner violence (IPV) and child marriage** were frequent. Service awareness remained low, with only **51% in Buusley and 44% in Babado** of informants able to identify available services. CMR readiness was particularly weak in Buusley, where only **20% of KIIs** reported nearby facilities prepared to provide clinical management of rape, compared to **57% in Babado**. Both camps highlighted the need for stronger awareness-raising and closer service proximity.

Tirka and Hareeri Jiroon faced critical accessibility challenges. Average travel times were **56 minutes in Tirka and 56 minutes in Hareeri Jiroon**, with many participants describing trips exceeding 70 minutes when walking from camp peripheries. Both camps reported **high risks of harassment at water points**, where overcrowding and lack of lighting created unsafe environments for women and girls.

In **Xafata and Lowforar**, informants frequently described **gatekeeper interference** as a barrier to accessing aid and services. While Xafata recorded relatively high service awareness (**54%**) and strong CMR readiness (**75%**), survivors described intimidation and exploitation in accessing these services. Lowforar had weaker indicators, with **47% awareness**, **33% CMR readiness**, but comparatively better PEP/EC stock availability (**83%**), which was offset by governance-related barriers.

Buula Gomaar and Abbey both acknowledged the existence of **offsite Women and Girls' Safe Spaces (WGSS)** operated by NGOs, but access was severely constrained. Awareness levels were moderate (**49% in Buula Gomaar, 53% in Abbey**), yet PEP/EC stocks were either absent (**0% in Buula Gomaar**) or unreliable (**50% in Abbey**). Travel times of **55–57 minutes** to reach services made these spaces inaccessible for most women and girls in urgent need.

In **Cadaan Qaboowe and Weelbuurow**, the most striking concern was **exclusion of minority women from services** due to clan bias and language barriers. While service awareness was above 50% (**53% in Cadaan Qaboowe, 43% in Weelbuurow**), survivors from minority groups reported being turned away or not taken seriously. CMR readiness was relatively higher (**60% and 57% respectively**), but PEP/EC stocks were unreliable (**0% in Cadaan Qaboowe and 14% in Weelbuurow**).

Wanini presented some of the weakest indicators overall. Although CMR readiness appeared high (**71% of KIIs** reported readiness), community members emphasized that services were not consistently accessible. Average awareness was only **46%**, one of the lowest among camps, and stigma was strongly reported in FGDs as a barrier preventing survivors from seeking care.

Overall, camp-level analysis shows a consistent pattern of **weak awareness, fragmented readiness, and systemic barriers** across all sites. The findings reinforce that while some services exist, **none of the camps currently provide fully functional, accessible, and inclusive GBV services**, leaving survivors reliant on informal coping strategies.

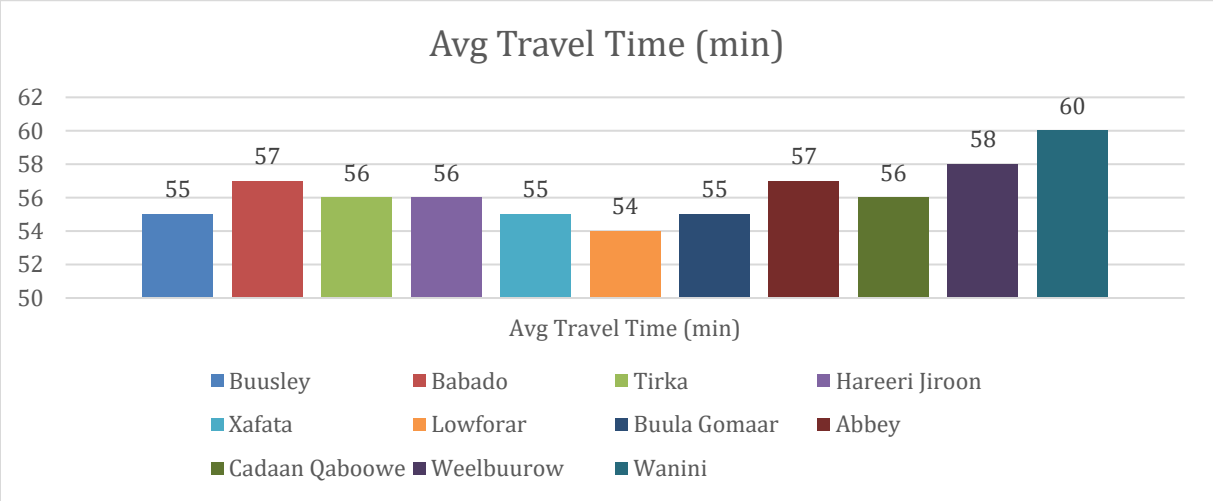
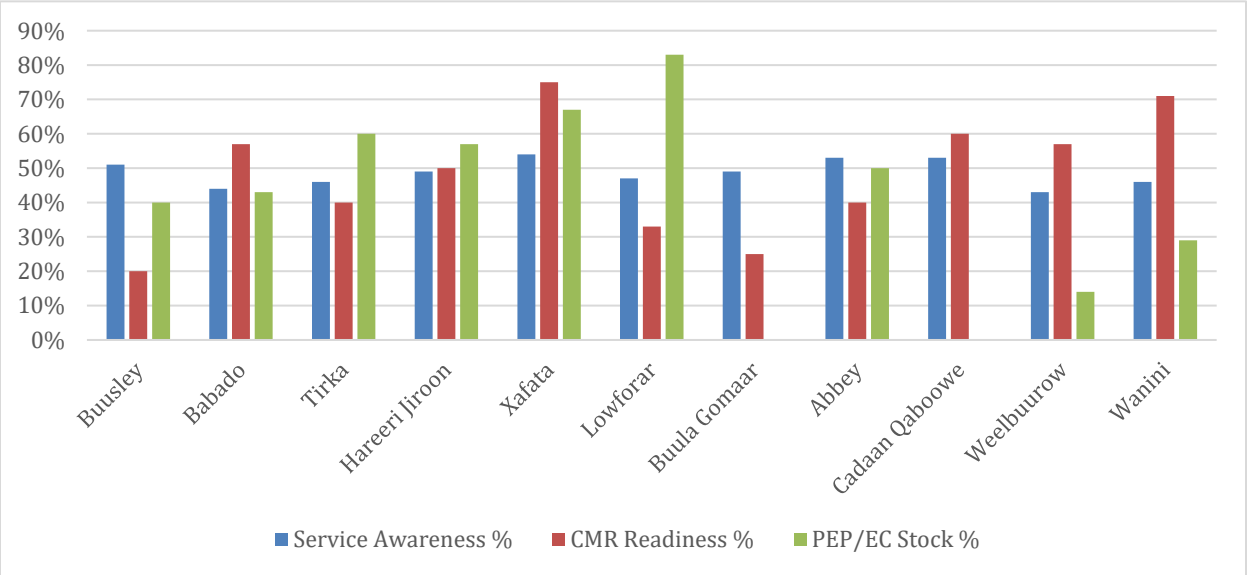


Table 5. Camp-Level Service Indicators

Camp	Service Awareness %	CMR Readiness %	PEP/EC Stock %	Avg Travel Time (min)	Notes
Buusley	51%	20%	40%	55	IPV and child marriage frequent
Babado	44%	57%	43%	57	Low awareness, some readiness
Tirka	46%	40%	60%	56	Harassment at water points
Hareeri Jiroon	49%	50%	57%	56	Similar challenges as Tirka
Xafata	54%	75%	67%	55	Gatekeeper interference reported
Lowforar	47%	33%	83%	54	High PEP/EC stock, weak readiness
Buula Gomaar	49%	25%	0%	55	Offsite WGSS noted, not accessible
Abbey	53%	40%	50%	57	Similar to Buula Gomaar
Cadaan Qaboowe	53%	60%	0%	56	Minority women excluded
Weelbuurow	43%	57%	14%	58	Similar exclusion as Cadaan Qaboowe
Wanini	46%	71%	29%	60	Lowest awareness, high stigma



5. Immediate Recommendations

The findings of this rapid assessment point to a number of urgent, low-cost interventions that can be implemented within two weeks to significantly reduce GBV risks in Baidoa's IDP camps. These recommendations focus on practical steps that improve safety in high-risk areas, strengthen access to information, and bring critical services closer to survivors.

- Installing solar lighting at water points and latrines should be prioritized across all 11 camps. The lack of lighting was consistently identified as a driver of harassment and assault, particularly at night. Affordable solar-powered lamps can create safer access to communal facilities, reducing risks for women and girls who must fetch water or use latrines after dark.
- Repairing and securing locks on communal latrines is another immediate action that directly addresses identified risks. Broken or absent locks were repeatedly observed during field visits and cited in both KIIs and FGDs as contributing to feelings of insecurity. Quick repairs and provision of durable locks will restore privacy and reduce exposure to violence in these facilities.
- Deploying temporary community watch groups or night guards can provide a visible deterrent against harassment and assault in camp peripheries. Community members expressed strong interest in such measures during FGDs, suggesting that locally recruited and trained volunteers, with clear accountability mechanisms, could provide interim protection while more sustainable solutions are developed.
- Disseminating updated referral pathways in Somali (both Maxaa and Maay dialects) is critical to improving survivors' access to existing services. Only 48% of KII respondents were aware of service options, reflecting the urgent need for clear, accessible, and language-sensitive communication. Posters, leaflets, and community awareness sessions should be prioritized to ensure that survivors know where to seek medical, psychosocial, and legal support.
- Activating mobile psychosocial support and legal aid desks within camps can fill urgent gaps until permanent safe spaces are established. Survivors repeatedly emphasized the absence of psychosocial care and legal assistance in the camps. Deploying mobile teams for scheduled visits would ensure that survivors can access confidential support without traveling long distances, reducing both barriers and risks of stigma.

Together, these immediate actions target the most pressing risk factors highlighted in the assessment: unsafe infrastructure, lack of visibility and accountability, weak awareness, and absence of in-camp services. Implementing them swiftly would provide tangible protection benefits for women, girls, and other at-risk groups in Baidoa.

6. System-Level Actions (1–3 months)

While immediate measures can help reduce risks in the short term, the assessment findings highlight the need for systemic and sustained interventions that address structural barriers and service gaps in Baidoa. Over the next one to three months, the following actions are

recommended to strengthen the protection environment and align with humanitarian response priorities.

- Establishing formal Women and Girls' Safe Spaces (WGSS) or One-Stop Centers (OSC) inside Baidoa's IDP camps or in nearby catchments is a priority. The assessment confirmed that none of the 11 camps currently have such facilities, with 0% of KIIs reporting WGSS presence. Survivors currently rely on offsite NGO centers, often located more than an hour away and poorly resourced. Establishing permanent, accessible safe spaces within or near camps will provide a confidential environment for survivors to access psychosocial, legal, and referral services without facing long travel times, stigma, or safety risks.
- Strengthening Clinical Management of Rape (CMR) readiness is equally urgent. Only 48% of informants reported that facilities were CMR-ready, and just 36% confirmed consistent availability of PEP/EC supplies. Investments are needed to ensure that health facilities have uninterrupted stocks of PEP/EC, female clinicians trained in survivor-centered care, and private consultation spaces. This will not only improve medical response but also restore trust among survivors that care is available when they need it.
- Integrating disability and minority inclusion into service provision must be central to all GBV response efforts. Persons with disabilities reported barriers due to the absence of accessible infrastructure, while minority women reported exclusion linked to clan and language bias. Service providers should be trained on inclusive approaches, materials should be available in both Somali dialects (Maay and Maxaa), and facilities should be adapted to meet the needs of PWDs. Without deliberate action, these groups will remain among the most excluded.
- Expanding community-based protection structures and training GBV focal points can improve both prevention and response. FGDs showed that communities already rely on elders and informal networks for mediation, but these approaches often prioritize community harmony over survivor needs. By building community protection committees, training GBV focal points, and linking them to formal referral systems, the response can become more survivor-centered while leveraging local structures.
- Finally, all efforts should align with the Somalia Humanitarian Response Plan (HNRP) and protection priorities, which call for scaling up GBV and CP case management, clinical response, and the use of targeted cash assistance to reduce protection risks. Embedding Baidoa's interventions within this broader framework will ensure coherence, attract funding, and reinforce accountability to affected populations.

Taken together, these system-level actions aim not only to fill urgent service gaps but also to lay the foundation for a sustainable, inclusive, and survivor-centered GBV response system in Baidoa.

7. Conclusion

The Baidoa rapid assessment provides clear evidence that GBV risks are widespread, severe, and systemic across all 11 IDP camps. Intimate partner violence, child and early marriage, sexual assault, harassment at WASH facilities, and denial of resources were consistently reported, with

adolescent girls, minority women, and persons with disabilities emerging as the most vulnerable groups.

These risks are **compounded by critical service gaps**. Only 48% of health facilities were reported as CMR-ready, just 36% had consistent PEP/EC supplies, and there are no functioning Women and Girls' Safe Spaces (WGSS) or One-Stop Centers (OSC) within the camps. Survivors are forced to rely on offsite NGO-run facilities that are resource-limited and often more than an hour away. Awareness of referral pathways remains low (48%), further limiting survivors' ability to seek help.

Accessibility barriers — including long travel times, stigma, cost, lack of privacy, clan discrimination, and exclusion of PWDs — combine to create an environment where even the limited services that exist remain largely out of reach. As a result, communities continue to depend on negative or fragile coping mechanisms such as restricting movement, avoiding night activities, relying on elders for mediation, and resorting to early marriage.

The findings underscore the urgent need for a **dual-track response**. On the one hand, **immediate, low-cost actions** such as installing solar lighting, repairing locks, deploying community watch groups, disseminating referral pathways, and activating mobile psychosocial and legal aid desks can reduce acute risks. On the other hand, **system-level investments** are essential: establishing formal WGSS/OSCs, ensuring consistent CMR readiness, integrating disability and minority inclusion, and strengthening community-based protection structures.

Without decisive action, **women, girls, PWDs, and minority groups in Baidoa will remain at heightened risk of violence, exploitation, and exclusion**. With coordinated investment and community-driven solutions, however, it is possible to safeguard dignity, expand access to lifesaving services, and begin addressing the root causes of GBV in Baidoa's displacement settings.

Key Messages

- **Severe GBV risks** were confirmed in all 11 Baidoa IDP camps, with IPV, child/early marriage, sexual assault, and harassment at WASH points most frequently reported.
- **Service gaps are critical**: only 48% of facilities are CMR-ready, just 36% have PEP/EC consistently in stock, and there are **no WGSS/OSCs inside camps**.
- **Barriers are overlapping**: survivors face long travel times (average 56–62 minutes), stigma, cost, lack of privacy, clan discrimination, and exclusion of PWDs.
- **Communities rely on fragile coping mechanisms**, including restricting movement, avoiding night use of facilities, informal women's gatherings, and early marriage.
- **Urgent action is needed**: low-cost mitigations (lighting, locks, community watch, mobile services) must be combined with system-level investments in safe spaces, CMR readiness, and inclusive referral pathways.