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DFS Jowhar GBV Rapid Assessment – Comprehensive Report

Location: Jowhar District, Middle Shabelle, Hirshabelle State
Period: 6th – 16th October 2025
Implementing Agency: *Dignity First Somalia (DFS)*
Focus: Gender-Based Violence (GBV) risk assessment across five IDP sites – Baarey 1, Tawakal 2, Towfiq, Bananey, and Kalundi.

1. Introduction and Context

Between **6 and 16 October 2025**, **Dignity First Somalia (DFS)** conducted a **Gender-Based Violence (GBV) Rapid Assessment** in **Jowhar District**, Middle Shabelle Region of Hirshabelle State.

Jowhar hosts large populations displaced by **recurrent Shabelle River floods, intermittent conflict, and livelihood losses** in surrounding rural areas. The five assessed IDP sites—**Baarey 1, Tawakal 2, Towfiq, Bananey, and Kalundi**—represent key displacement settlements experiencing overlapping humanitarian needs across protection, shelter, WASH, and food-security sectors.

Protection risks—particularly **GBV affecting women, adolescent girls, and persons with disabilities**—have intensified amid **overcrowded shelters, inadequate lighting, limited privacy, economic hardship, and weak enforcement of community protection mechanisms**. These factors have further compounded vulnerabilities within the already fragile social fabric.

The rapid assessment was undertaken to inform evidence-based planning and coordination among DFS, cluster partners, and government counterparts. Specifically, it aimed to:

- **Identify** the most pressing GBV risks and the profiles of vulnerable groups.
- **Map** available GBV and related protection services, including barriers to safe and confidential access.
- **Evaluate** the functionality of referral and coordination mechanisms among humanitarian and state actors.
- **Generate actionable insights** to strengthen survivor-centred programming and enhance collaboration with the GBV AoR members, Protection Cluster members, and Representatives from Ministry of Women & Human Rights Development (MoW&HRD).

Methodology

The assessment employed a **mixed-methods approach** integrating both qualitative and quantitative techniques to ensure a comprehensive understanding of GBV risks, service availability, and community perceptions across Jowhar's main IDP sites.

Data Collection Methods

- **60 Key Informant Interviews (KIIs):** Conducted with community leaders, women leaders, health facility staff, security personnel, representatives from the **Ministry of Women & Human Rights Development (MoW&HRD)**, GBV caseworkers, and social workers. KIIs captured institutional and experiential insights on GBV risks, service capacity, referral mechanisms, and coordination gaps.
- **20 Focus Group Discussions (FGDs):** Conducted across the five targeted IDP sites—**Baarey 1, Tawakal 2, Towfiq, Bananey, and Kalundi**—with disaggregated groups of **Elderly Women, Younger Women, Elderly Men, and Younger Men** (6 participants per group). FGDs explored perceptions of safety, community norms, access barriers, and accountability preferences.

All data collection tools adhered to **survivor-centred, do-no-harm, and informed consent** principles, emphasizing confidentiality, respect, and voluntary participation. No incident-level or personally identifiable data were collected. Triangulation of findings across KIIs and FGDs enhanced internal validity and contextual accuracy.

Table 1. Data Collection Matrix by Site and Group Type

IDP Site	Elderly Women (35+)	Younger Women (18–34)	Elderly Men (35+)	Younger Men (18–34)	Total FGDs
Baarey 1	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	**4**
Tawakal 2	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	**4**
Towfiq	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	**4**
Bananey	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	**4**
Kalundi	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	1 FGD (6 participants)	**4**
Total	**5 FGDs (30 participants)**	**5 FGDs (30 participants)**	**5 FGDs (30 participants)**	**5 FGDs (30 participants)**	**20 FGDs (120 participants)**

Sampling and Ethics

Participants were **purposively selected** to ensure representation across gender, age, and functional diversity.
Data collectors—trained GBV focal points—received orientation on **psychological first aid (PFA)**, safe referrals, and ethical interviewing. Supervisors ensured **daily debriefings**, **secure data handling**, and **non-identifiable record storage** in line with GBVIMS+ standards.

3. Demographics of Respondents

A total of **60 Key Informant Interviews (KIIs)** were conducted within **Jowhar District, Middle Shabelle Region of Hirshabelle State** between **6 and 16 October 2025**. All respondents were drawn from active actors in Jowhar / Middle Shabelle.

Of these 60 respondents, **the majority were women (approximately 70%)**, reflecting DFS's intentional emphasis on ensuring women's leadership and participation in GBV assessments and community protection dialogues. Male respondents accounted for roughly **30%**, primarily representing security personnel, health workers, and community leaders.

Professional and Institutional Representation

Respondents represented a cross-section of GBV service delivery and governance actors, including:

- **Community and women leaders:** 33%
- **Health and midwifery staff:** 26%
- **Security force personnel:** 11%
- **Line ministry department MoW&HRD focal points:** 10%
- **GBV/NGO caseworkers:** 9%
- **Other protection and social workers:** 11%

This composition provided a well-rounded perspective across health, security, social welfare, and community coordination roles, ensuring data validity and triangulation across institutional levels.

Geographic Coverage

All 60 KIIs were conducted **within Jowhar town and its five IDP settlements**, ensuring a consistent geographic focus and reducing contextual variability.
This concentrated sampling approach enhanced **data accuracy**, allowing DFS to draw site-specific insights on GBV trends, service accessibility, and referral system functionality within the Hirshabelle context.

4. Key Findings

4.1 Main GBV Risks and Patterns

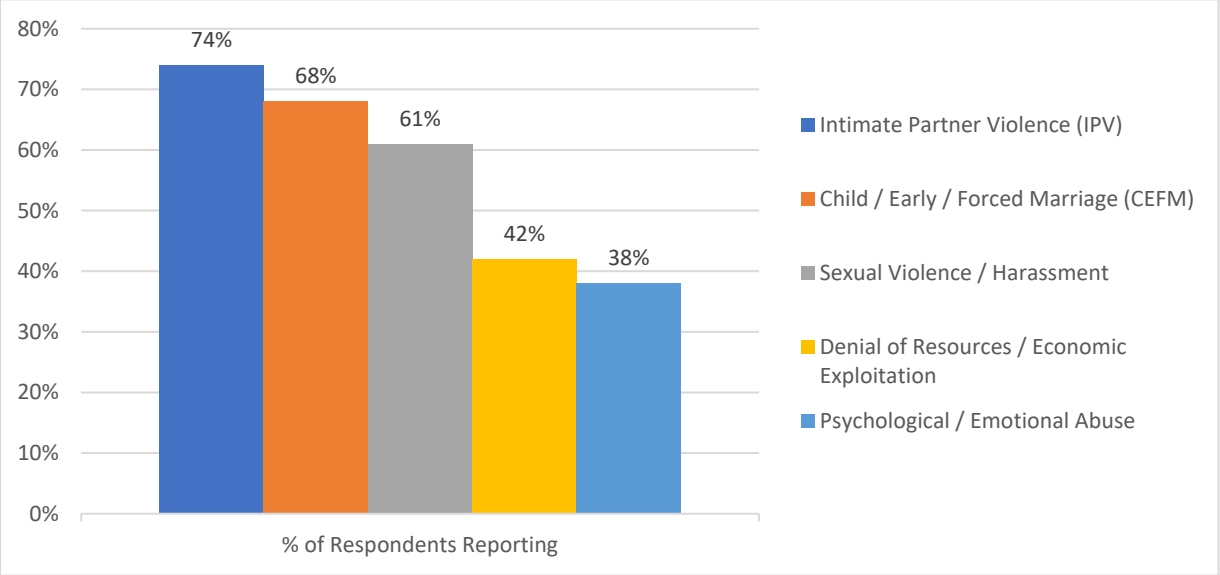
Findings from both **Key Informant Interviews (KIIs)** and **Focus Group Discussions (FGDs)** reveal persistent and multifaceted **Gender-Based Violence (GBV)** risks across all five assessed IDP sites in **Jowhar District**. Respondents consistently identified intimate partner violence, child and early marriage, sexual assault, and economic exploitation as the most prevalent forms of violence affecting women and girls, particularly within displaced populations.

GBV Type	% of Respondents Reporting	Severity Rating (1–5)
Intimate Partner Violence (IPV)	74%	5 – Very High
Child / Early / Forced Marriage (CEFM)	68%	4 – High
Sexual Violence / Harassment	61%	4 – High
Denial of Resources / Economic Exploitation	42%	3 – Moderate
Psychological / Emotional Abuse	38%	3 – Moderate

The most frequently cited GBV types include:

- **Intimate Partner Violence (IPV):** Physical, psychological, and economic abuse within households remains **widespread**. Women reported increased domestic tensions due to displacement-related stress, lack of income, and limited decision-making power at the household level.
- **Child, Early, and Forced Marriage (CEFM):** Reported in **over two-thirds (68%)** of interviews, especially among newly displaced or economically vulnerable families. CEFM is often used as a negative coping mechanism to reduce perceived financial burden or to secure protection and dowry income.
- **Sexual Violence:** Predominantly linked to **unsafe environments**, including poorly lit or unprotected routes to **latrines, water points, and markets**, as well as **lack of privacy** in makeshift shelters. Adolescent girls and women collecting water or firewood are particularly at risk of harassment and assault.

- **Denial of Resources and Economic Exploitation:** Women engaged in informal labor, petty trade, or domestic work reported **coercive control over income**, limited financial autonomy, and exploitation by employers or male household members.



These patterns highlight how **economic stress, displacement, and inadequate infrastructure** collectively exacerbate GBV risks and erode women's coping capacity.
The trends also underscore the intersectionality of vulnerabilities—where **gender, age, disability, and displacement status** converge to shape exposure to violence.

Community Narratives from FGDs

Direct testimonies from FGD participants provided vivid insights into lived experiences of insecurity and fear in daily life:

"At night the water points are unsafe; women fear harassment." — *Elderly Woman, Baarey 1*
"Most girls marry early because families have no income." — *Younger Woman, Towfiq*
"Our shelters are too close together; you can hear everything, but no one intervenes." — *Elderly Man, Bananey*
"There are no lights in the latrine area, so women wait until morning." — *Younger Woman, Kalundi*

These accounts reinforce the **urgent need for coordinated WASH–Protection interventions**, improved lighting and site planning, and strengthened community-based safety mechanisms.

4.2 High-Risk Groups

The assessment identified several population groups in **Jowhar IDP sites** who face **heightened exposure to GBV risks** due to social, economic, and structural vulnerabilities.
These groups consistently emerged across KIIs and FGDs as **most at risk of violence, exploitation, and exclusion from services**.

The key high-risk categories include:

- **Adolescent Girls (10–17 years):**
  Frequently exposed to **child and forced marriage**, **transactional sex**, and **school drop-out**.

Many adolescent girls reported limited access to reproductive health information and safe spaces, leaving them dependent on informal peer networks.

- **Women with Disabilities:**
  Often **isolated, stigmatized, and physically constrained** in accessing GBV or health services. Respondents emphasized that referral systems and outreach mechanisms rarely accommodate persons with mobility or sensory impairments.

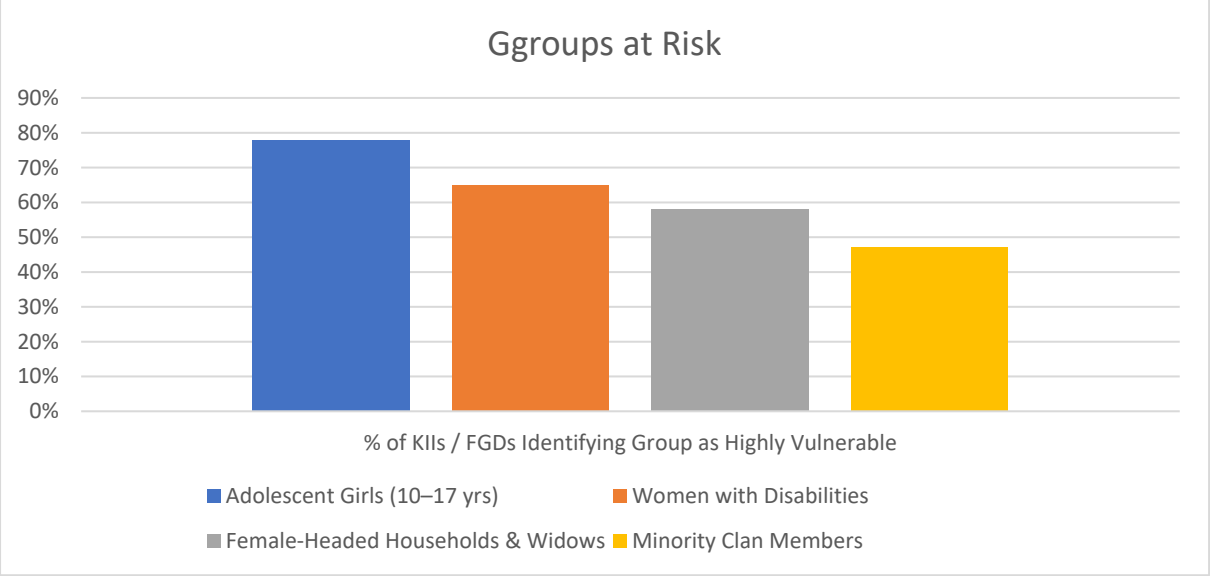
- **Female-Headed Households and Widows:**
  Identified as facing **economic exploitation**, **harassment**, and **high levels of insecurity** due to the absence of male protectors and limited livelihood options. Many rely on informal or precarious labor, which increases exposure to abuse.

- **Minority Clan Members:**
  Report **systemic discrimination and lower trust** in formal justice or law enforcement mechanisms. Their exclusion from leadership structures and camp committees limits their ability to report or influence GBV prevention and response decisions.

High-Risk Group	Key GBV Risks	Barriers to Protection / Services	Unique Needs / Recommendations
Adolescent Girls (10–17)	Early/forced marriage, sexual exploitation, transactional sex, school drop-out.	Stigma, lack of SRH information, absence of safe spaces, limited female mentors.	Establish youth-friendly spaces and education reintegration programs; engage parents and religious leaders.
Women with Disabilities	Sexual violence, neglect, psychological abuse, exploitation in aid access.	Physical inaccessibility, exclusion from outreach, low prioritization by service providers.	Disability-inclusive referral mechanisms, mobile outreach, and caregiver support programs.
Female-Headed Households & Widows	Economic abuse, harassment, exposure to GBV due to income insecurity.	Economic dependence, social isolation, weak community protection networks.	Targeted livelihood support, social safety nets, and inclusion in community protection structures.
Minority Clan Members	Discrimination, reduced access to justice, social exclusion, increased GBV risk.	Bias in leadership structures, lack of representation, distrust in institutions.	Inclusive community representation and legal awareness initiatives.

Across all sites, **gender, age, disability, and minority status intersect** to amplify risk and reduce access to protection.
GBV programming in Jowhar must therefore apply an **intersectional and inclusive approach**, ensuring **safe access, representation, and equitable service delivery** for marginalized and at-risk groups.

High-Risk Group	% of KIIs / FGDs Identifying Group as Highly Vulnerable	Main GBV Risks Reported	Relative Vulnerability Level
Adolescent Girls (10–17 yrs)	78%	Early/forced marriage, sexual exploitation, school drop-out	**Very High**
Women with Disabilities	65%	Sexual violence, neglect, exclusion from services	**High**
Female-Headed Households & Widows	58%	Economic exploitation, harassment, insecurity	**High**
Minority Clan Members	47%	Discrimination, reduced access to justice, exclusion	**Moderate–High**



4.3 Causes and Contributing Factors

Evidence from KIIs and FGDs indicates that **GBV in Jowhar's IDP settlements is driven by a combination of socio-economic stress, overcrowded living conditions, displacement, and entrenched gender norms**.
An overwhelming **92 percent** of respondents linked the increase in GBV incidents to **economic hardship, loss of livelihoods, and community disruption** following recurrent floods and displacement.

The top contributing factors were:

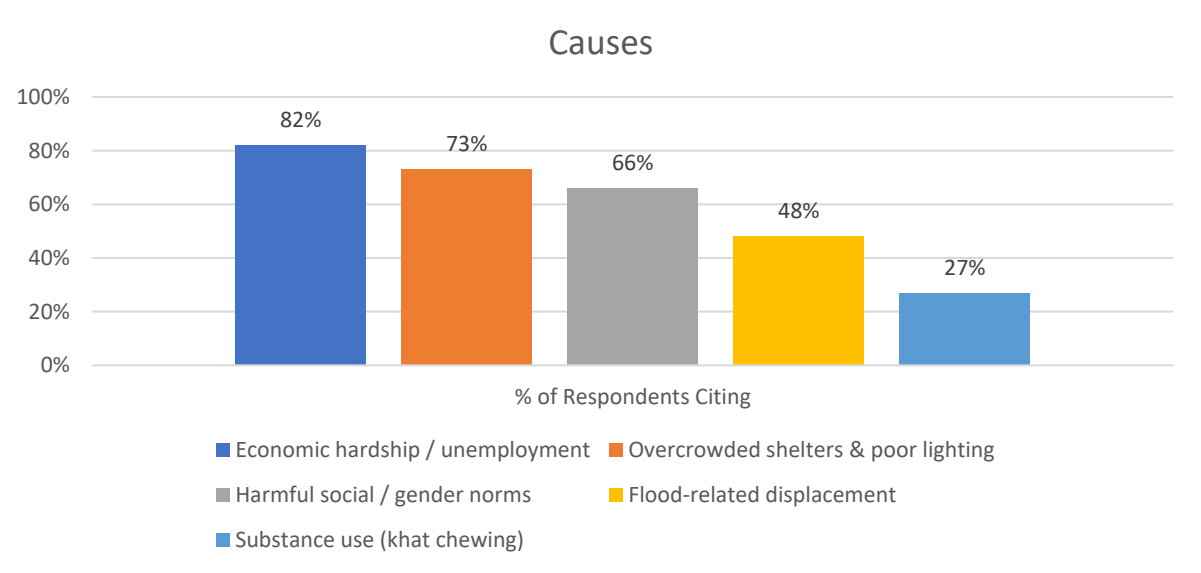
1. **Economic hardship and unemployment (82%)** – The erosion of income opportunities has heightened household tension, dependency, and resort to negative coping mechanisms such as early marriage or transactional sex.

2. **Overcrowded shelters and poor lighting (73%)** – Congested camps, lack of privacy, and poorly lit sanitation areas expose women and girls to harassment and assault.
3. **Harmful social and gender norms (66%)** – Persistent patriarchal beliefs normalize violence and discourage survivors from seeking help.
4. **Flood-related displacement (48%)** – Frequent flooding undermines family cohesion and disrupts community protection networks, forcing relocation to unsafe areas.
5. **Substance use (khat chewing) (27%)** – Reported mainly among unemployed men, khat chewing contributes to household tension, aggression, and neglect of responsibilities, increasing the likelihood of intimate-partner violence.

These drivers highlight that GBV in Jowhar is **rooted in structural and behavioral conditions**, requiring **integrated protection-livelihood-WASH interventions** to address both the causes and effects of violence.

Root Cause / Contributing Factor	Description	% of Respondents Citing	Impact on GBV Dynamics	Recommended Sectoral Linkage
Economic hardship / unemployment	Household income loss fuels stress, IPV, and early marriage as coping strategies.	82 %	Drives IPV and CEFM; promotes transactional sex.	Livelihoods, Cash for Work, VSLA support.
Overcrowded shelters & poor lighting	Privacy and security lacking in dense settlements and around WASH facilities.	73 %	Raises risk of sexual harassment and assault.	Shelter, CCCM, WASH (lighting, site planning).
Harmful social / gender norms	Patriarchal attitudes normalize violence and discourage reporting.	66 %	Reinforces IPV and limits women's agency.	Community dialogues, male engagement, gender-transformative approaches.
Flood-related displacement	Recurrent floods force relocations, separating families and weakening protection structures.	48 %	Increases exposure to violence in temporary sites.	DRR, CCCM, Early Recovery.
Substance use (khat chewing)	Linked to household tension, aggression, and	27 %	Escalates domestic violence and	MHPSS, Awareness campaigns, Community

Root Cause / Contributing Factor	Description	% of Respondents Citing	Impact on GBV Dynamics	Recommended Sectoral Linkage
	neglect by unemployed men.		economic abuse.	behavioral change programs.



4.4 Service Availability and Accessibility

While GBV service provision exists in **Jowhar District**, access remains **uneven, under-resourced, and limited by structural and capacity gaps**.
The assessment identified **five primary service categories**—GBV case management, clinical management of rape (CMR), psychosocial support (MHPSS), legal/security response, and safe shelter options—each facing constraints in coverage, staffing, and confidentiality.

Community perceptions reflect **mixed confidence** in available services.

- **47%** described services as *"available but inconsistent"*;
- **34%** as *"accessible and mostly safe"*; and
- **19%** as *"available but unsafe or not confidential."*

These findings suggest that while DFS and local partners maintain operational presence, significant investment is needed in **training, confidentiality, survivor transport, and facility preparedness** to ensure full service functionality.

Service Type	Availability Status	Main Service Providers / Facilities	Typical Barriers / Gaps Identified	Community Perception
GBV Case Management	Available through local	DFS, local CBOs, MoW&HRD focal points	Limited trained caseworkers, no	*Available but inconsistent*

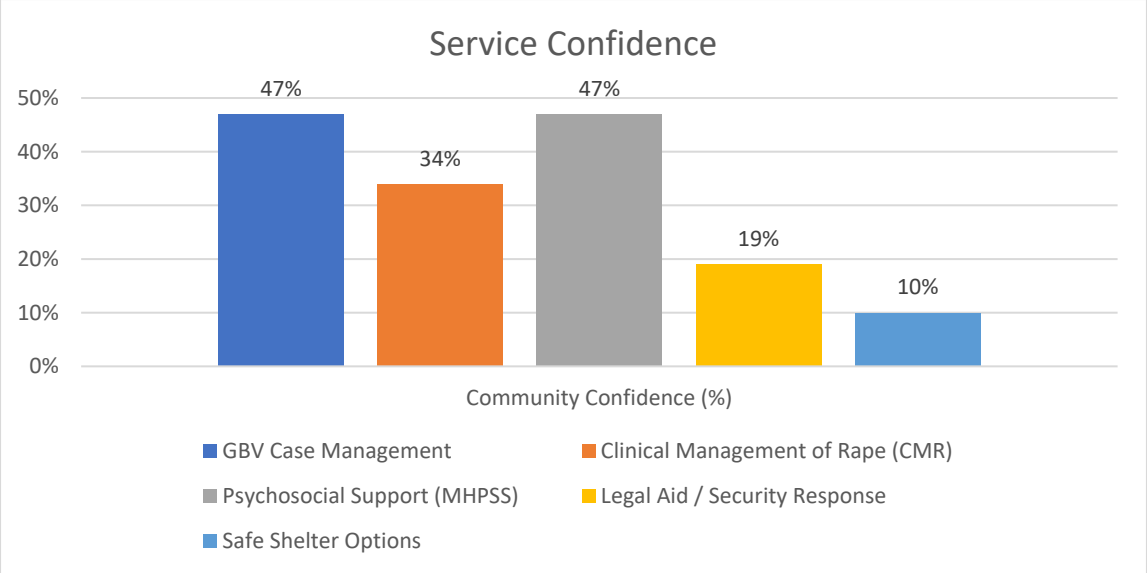
Service Type	Availability Status	Main Service Providers / Facilities	Typical Barriers / Gaps Identified	Community Perception
	NGOs (DFS and partners)		dedicated safe spaces for confidential sessions.	
Clinical Management of Rape (CMR)	Partial availability at Jowhar Hospital	Jowhar Hospital, MoH staff	Frequent stock-outs of PEP & emergency contraception; no night shifts; limited trained staff.	*Accessible but incomplete*
Psychosocial Support (MHPSS)	Ad hoc and project-based sessions	Health facilities, partner NGOs	Few trained counsellors; absence of private counselling rooms; short-term donor support.	*Available but inconsistent*
Legal Aid / Security Response	Available but inconsistent	Security personnel, paralegals, women leaders	Lack of privacy; fear of retaliation; weak survivor follow-up systems.	*Unsafe / low trust*
Safe Shelter Options	Very limited	Host families, informal shelters	No dedicated GBV safe house; survivors rely on short-term hosting.	*Unavailable or temporary*

Summary

- **Case management and psychosocial support** are the most consistently available services, but **confidentiality and continuity remain weak**.
- **CMR readiness** is partial—services depend on intermittent medical supply chains and staff availability.
- **Legal aid and security response** are hampered by fear of retaliation and limited trust, particularly among minority and displaced women.
- **Safe shelters** are virtually non-existent, forcing survivors to rely on host families—posing secondary protection risks.

Service Type	Availability Level (1–5)	Community Confidence (%)
GBV Case Management	4	47%
Clinical Management of Rape (CMR)	3	34%
Psychosocial Support (MHPSS)	3	47%
Legal Aid / Security Response	2	19%

Service Type	Availability Level (1–5)	Community Confidence (%)
Safe Shelter Options	1	10%



GBV service availability in Jowhar remains partial, with the strongest presence in case management and psychosocial support but major gaps in safe shelter and CMR preparedness. Survivors report limited confidentiality and inconsistent quality of assistance.

4.5 Referral Pathways and Coordination

Referral and coordination mechanisms in **Jowhar District** remain **partially functional** and fragmented across service providers.
Findings from KIIs and FGDs indicate that although some actors—including DFS partners, MoW&HRD focal points, and health workers—understand referral procedures, **formal documentation and follow-up mechanisms are weak or inconsistent**.

- **Formal and functioning referral systems:** 26%
- **Informal or verbal referrals:** 55%
- **No known referral mechanism:** 19%

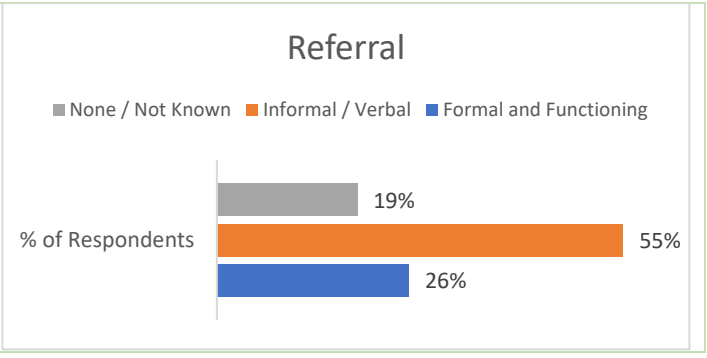
Coordination between service actors (health, security, NGOs, and government) occurs **quarterly (35%)** or on an **ad hoc basis (30%)**, reflecting irregular engagement and limited institutionalization of inter-agency collaboration.

Aspect	Current Status	Challenges Identified	Implications	Recommendations
Referral System Functionality	26% functional; 55% informal/verbal; 19% none	Lack of standardized tools, weak documentation,	Cases often referred verbally with minimal	Disseminate GBV referral pathway posters; train

Aspect	Current Status	Challenges Identified	Implications	Recommendations
		limited awareness among frontline staff.	follow-up or confidentiality.	community focal points.
Coordination Frequency	35% quarterly; 30% ad hoc	Irregular meetings, limited participation from MoW&HRD and health sector.	Fragmented service planning and delayed survivor support.	Institutionalize monthly inter-agency coordination led by MoW&HRD/GBV sub-cluster.
Information Sharing	Limited, mainly among NGO partners	Weak inter-sectoral communication and case tracking.	Overlaps and missed cases in assistance provision.	Develop shared referral reporting template under GBVIMS+.
Community Awareness of Referrals	Low	No visibility materials; limited outreach.	Survivors unaware of where or how to report.	Conduct community awareness sessions using local languages and pictorial IECs.

Community Narratives
"We try to refer survivors, but sometimes the hospital lacks supplies." — *Health Worker, Jowhar Hospital*
"There's no private place at the clinic for survivors." — *Nurse, Baarey 1 FGD*
"Some survivors go to the health post, but they're sent back because no one knows the procedure." — *Community Leader, Tawakal 2*
These accounts highlight that **referral functionality is hindered by gaps in resource availability, confidentiality, and clear communication channels**

Referral Type	% of Respondents
Formal and Functioning	26
Informal / Verbal	55
None / Not Known	19



Most GBV referrals in Jowhar are **informal or verbal**, reflecting limited institutionalized systems. Only one-quarter of actors reported having **formal and functioning mechanisms**, underlining the need for **standardized referral tools, joint case tracking, and regular coordination meetings**.

4.6 Accountability to Affected Populations (AAP) and PSEA Awareness

The assessment found that **community awareness of rights, complaint mechanisms, and protection from sexual exploitation and abuse (PSEA)** remains **limited but gradually improving** in Jowhar IDP sites.
Although DFS and its partners have introduced awareness sessions and focal point systems, overall understanding of **how to report misconduct or seek feedback** is still uneven across sites.

- **People unaware of rights or feedback channels:** 52%
- **Some awareness, limited trust:** 38%
- **Widespread awareness and trusted reporting routes:** 10%

The majority of respondents expressed **preference for in-person reporting**, particularly to **known female focal points**, citing comfort, confidentiality, and low literacy as barriers to hotline or written reporting.

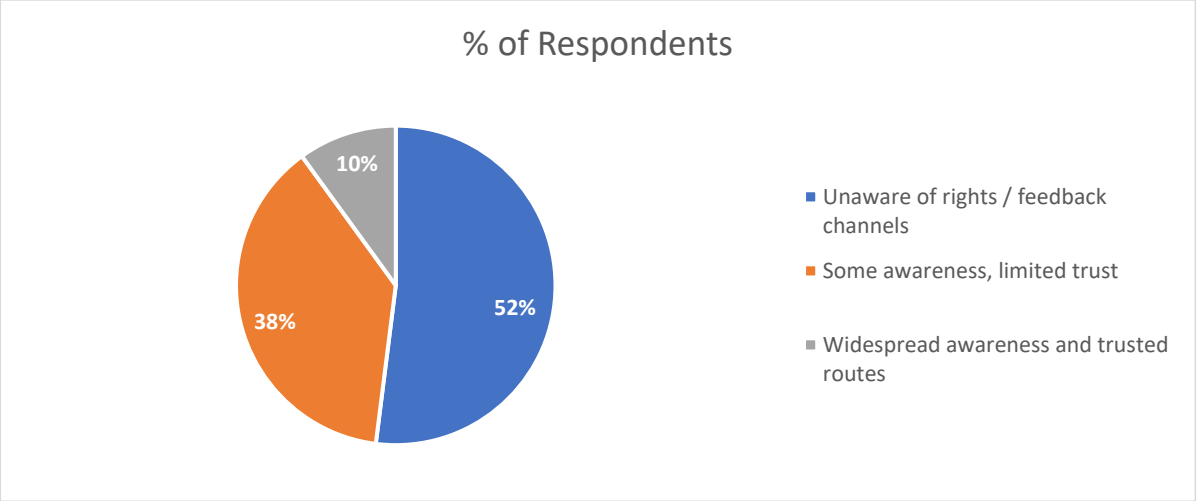
Awareness Category	% of Respondents	Description / Interpretation	Commonly Trusted Channels	Recommended Actions
People unaware of rights or feedback channels	52 %	Little or no knowledge of existing CFMs or reporting options; low engagement in awareness sessions.	None or indirect through community leaders.	Strengthen community sensitization; post visual complaint signs in Somali at service points.
Some awareness, limited trust	38 %	Aware of reporting options but uncertain about confidentiality or outcomes.	Female focal points, suggestion boxes.	Reinforce feedback loops; ensure follow-up and visible action on complaints.
Widespread awareness and trusted reporting routes	10 %	Clear understanding of how to report, strong confidence in existing focal points.	Female focal points, security helpdesks, hotline.	Expand trained focal points across all sites; link with GBV sub-cluster CFM systems.

Trusted Feedback Channels (Ranked by Mentions)

1. **Female focal points** – Most preferred and trusted reporting pathway, often cited as confidential and responsive.
2. **Community suggestion boxes** – Increasingly recognized but limited by literacy barriers and inconsistent follow-up.
3. **Security helpdesks / hotline** – Trusted when staffed by familiar officers but underutilized due to phone access and gender sensitivities.

FGDs across all sites noted a consistent **preference for in-person reporting** to **a known and trusted female focal point**, reflecting both **limited literacy** and **restricted access to mobile communication** among women and girls.

"We feel safer telling someone we know, not calling a number we don't understand." — *Younger Woman, Tawakal 2*
"The box is good, but no one tells us if our complaint was read." — *Elderly Woman, Kalundi*



5. Cross-Analysis: KII vs FGD Findings

The triangulation of **Key Informant Interviews (KIIs)** and **Focus Group Discussions (FGDs)** provides a balanced view of both **institutional perspectives** and **community experiences** regarding GBV risks, service access, and accountability in Jowhar IDP sites.

Overall, KIIs tended to highlight **systemic and resource-related constraints**—such as stock-outs, lack of coordination, and confidentiality challenges—while FGDs captured the **lived experiences** of insecurity, stigma, and limited awareness among displaced women and men.
Together, these findings confirm that **service gaps and referral barriers persist** despite ongoing partner presence, and that **community trust** in formal mechanisms remains limited.

Theme	KII Consensus (Institutional View)	FGD Reflections (Community View)	Key Implication
Service Gaps	Inadequate CMR supplies; poor confidentiality; shortage of trained staff.	"No private room at the clinic."	Facility readiness remains partial; privacy infrastructure urgently needed.
Referral Functionality	55 % partial, 26 % functional; most referrals verbal.	Survivors rely on informal support from focal points or relatives.	Need standardized referral tools, awareness, and follow-up mechanisms.
Safe Shelters	60 % reported "temporary only" hosting arrangements.	"No dedicated space for women escaping violence."	Establish community-linked safe spaces and emergency accommodation.

Theme	KII Consensus (Institutional View)	FGD Reflections (Community View)	Key Implication
AAP Awareness	52 % low awareness of complaint mechanisms.	Communities request visible signboards and simplified reporting.	Expand CFM outreach through posters, female focal points, and radio messages.
Risk Zones	Latrines, water routes, markets identified as unsafe.	Latrines and dark paths most cited by both women and men.	Coordinate WASH-Protection actions on lighting, site layout, and patrols.

Synthesis

- **KIIs** reveal gaps in **institutional preparedness**, supplies, and coordination.
- **FGDs** emphasize **everyday barriers** such as privacy, trust, and language accessibility.
- Both data sources align on the need for **improved lighting, safe shelters, and visible feedback mechanisms** across all Jowhar IDP sites.

Bridging institutional and community perspectives will require **joint planning between NGOs, Line Ministry, and cluster partners** to ensure that survivor-centred standards translate into **practical, trusted services** on the ground.

6. Coordination and Institutional Context

The **Line Ministry** serves as the **lead coordination body** for GBV prevention and response in **Hirshabelle State**, operating through district focal points.
At the operational level, most **NGOs** work in close partnership with **health authorities, community-based organizations, and the GBV Sub-Cluster** to strengthen inter-agency coordination, harmonize referral pathways, and promote survivor-centred response across Jowhar IDP sites.

While coordination mechanisms are active, they remain **underdeveloped and unevenly implemented**. KIIs revealed several critical institutional gaps that affect the timeliness and quality of GBV response:

- **Limited regular data sharing and joint case review meetings:**
  Coordination is often reactive, with partners meeting primarily around new cases or project milestones rather than maintaining systematic, scheduled discussions.
- **Insufficient resource allocation for critical GBV response supplies and logistics:**
  Stock-outs of **Post-Exposure Prophylaxis (PEP)** and **Emergency Contraception (EC)**, coupled with a lack of dedicated survivor transport funds, frequently delay lifesaving care.
- **Weak integration of disability inclusion within GBV programming:**
  Existing service facilities are not fully accessible to persons with physical or sensory disabilities, and disability data are rarely captured in reporting systems.

NGOs, including DFS continues to **liaise with MoW&HRD, MoH, and the GBV Sub-Cluster** to address the gaps through:

- Regular **inter-agency coordination meetings and referral reviews** at district level;
- Enhanced **information management**; and
- Advocacy for **dedicated state-level GBV coordination resources** under Hirshabelle's Protection Working Group.

Strengthening institutional coordination in Jowhar will require **predictable scheduling, resource investment, and inclusive planning**, ensuring that **national GBV frameworks are localized** to meet the unique needs of IDP and host communities.

The assessment confirms **significant and persistent GBV risks** within Jowhar's displacement settlements, primarily driven by **economic hardship, harmful social norms, overcrowded living conditions, and weak protective infrastructure**.
These factors intersect to expose women, adolescent girls, persons with disabilities, and other vulnerable groups to multiple forms of violence, exploitation, and neglect.

Although **core GBV services**—such as case management, psychosocial support, and limited CMR—are available through DFS and partner organizations, service delivery remains **fragmented, under-resourced, and inconsistently coordinated**. Weak referral systems, irregular coordination meetings, and insufficient funding for transport, medical supplies, and safe spaces continue to constrain the effectiveness of the response.

At the same time, **community engagement potential is high**. Women, adolescent girls, and youth participants expressed a **strong willingness to participate in prevention efforts**, including awareness sessions, community dialogues, and volunteer focal point roles—provided that such initiatives are inclusive, continuous, and linked to tangible livelihood opportunities.

The findings highlight an urgent need for **sustained, multi-sectoral investment** that connects GBV response with **livelihoods, WASH safety, site planning, and social norm transformation**. Strengthening accountability and coordination under the leadership of **MoW&HRD** and the **GBV Sub-Cluster** will be essential to translate policy frameworks into meaningful, survivor-centred action at community level.

Recommendations

Immediate (0–3 months)

- Deploy mobile GBV case management and MHPSS teams to Baarey 1 & Tawakal 2.
- Re-stock CMR supplies (PEP, EC, STI kits) and train night-shift staff at Jowhar Hospital.
- Establish multi-channel Complaint & Feedback Mechanism (CFM): hotline, boxes, focal points.
- Improve lighting and latrine placement in high-risk zones with CCCM/WASH partners.

Short Term (3–6 months)

- Sign referral MOUs among MoW&HRD, health, and NGO partners.
- Train security and community leaders on survivor-centred response.
- Create safe-space shelters integrated with livelihoods support.

- Launch SASA!-style social-norm sessions and male engagement dialogues.
- Develop and disseminate Somali-language IEC materials on GBV and AAP.

Lessons and Next Steps

1. **Community focal points** are the cornerstone of trust—future programs should institutionalize them under MoW&HRD supervision.
2. **Joint GBV-Health-Security coordination** must shift from ad hoc to structured monthly meetings.
3. **Inclusion of persons with disabilities** in safe-space and awareness activities is critical.
4. NGOs should maintain collaboration with the **Protection Cluster** and **GBV Sub-Cluster** for integrated reporting and resource mobilization.

Annexes

Annex 1: Key Informant Interview (KII) Guide

Purpose: To collect in-depth information from leaders, service providers, and authorities on GBV risks, response capacity, coordination, and challenges in Jowhar District.

A. General Information

1. Name of Respondent (optional): _____
2. Sex: ☐ Male ☐ Female | Role/Position: _____
3. Organization/Institution: _____
4. Date: _____ Location: _____

B. Community and GBV Context

5. What are the main protection and GBV-related concerns affecting women, girls, men, and boys in this area?
6. What changes have you observed in GBV risks over the past year (e.g., increase/decrease, new trends)?
7. Which groups are most at risk of GBV and why? (e.g., adolescent girls, widows, PwDs, IDPs)
8. What are the key causes or contributing factors of GBV in your community?

C. Services and Response Capacity

9. What types of GBV services are currently available (health, psychosocial, legal, safety, case management)?
10. Are these services accessible and confidential for survivors? What are the barriers?
11. Do health facilities have capacity to provide Clinical Management of Rape (CMR) within 72 hours?
12. Are there any safe shelters or temporary protection options available for survivors?

D. Coordination and Referral

13. Are there clear referral pathways for GBV survivors? How functional are they?
14. Which organizations or departments are involved in GBV response or coordination?
15. Are there regular coordination meetings or joint case discussions?

E. Prevention, Awareness, and AAP

16. What prevention or community awareness activities on GBV or PSEA are currently happening?
17. How do community members report GBV or misconduct? Are these mechanisms safe and trusted?
18. How could DFS and partners strengthen GBV prevention and survivor support in Jowhar?

F. Additional Comments

19. Any additional comments or recommendations?

Annex 2: Focus Group Discussion (FGD) Guides

Purpose: To explore community perspectives, experiences, and priorities on GBV risks, prevention, and access to services. FGDs should be segregated by age and sex: Women (18+), Adolescent Girls (10–17), Men (18+), Boys (10–17), and Persons with Disabilities (PwDs).

A. Introduction and Consent

1. Introduce the facilitators, purpose of discussion, confidentiality, voluntary participation, and the right to withdraw at any time.
2. Obtain verbal consent before proceeding.
3. Remind participants not to share personal experiences or identifiable survivor stories.

B. Guiding Questions

1. General Perceptions of Safety and Risk

a. What are the main safety or protection concerns faced by women/girls/men/boys/PwDs in your community?
b. Are there specific places or times where people feel unsafe (e.g., at night, water points, markets)?
c. Have these risks changed recently? Why?

2. GBV Awareness and Attitudes

a. What does the community understand by 'gender-based violence'?
b. What forms of violence are most common here (e.g., domestic violence, early marriage, sexual assault)?
What are the main causes of GBV in your community?

3. Reporting and Access to Help

a. If someone experiences GBV, where can they go for help?
b. What makes it difficult for survivors to report or seek help?
c. Are there people or institutions that survivors trust for support?

4. Prevention and Community Action

a. What can the community do to prevent GBV and support survivors?
b. What role can men and boys play in prevention?
c. What suggestions do you have for organizations like DFS to make your community safer?

5. Accountability and Feedback

a. Have you heard of ways to provide feedback or complaints about humanitarian services?
b. What channels would you trust most (e.g., hotline, focal point, suggestion box)?
c. How can organizations ensure confidentiality and respect when handling such feedback?

C. Closing

1. Summarize key discussion points.
2. Thank participants for their time and contributions.
3. Remind them of available confidential GBV support services or referral contacts.