SIDRA INSTITUTE

SOMALI GENDER JUSTICE

BREAKING THE SILENCE:

A CONTEXTUAL ANALYSIS OF THE BARRIERS, LAWS AND POLICIES TO SAFE ABORTION FOLLOWING RAPE IN PUNTLAND, SOMALIA

Authors:
Hussein Yusuf Ali
Christopher Hook

Contributors:
Sareda Jayte Hassan
Dr.Yusra Mahamed Yasin
Teresa Durand Mazza
Abdulkadir Mohamed Muse
Kalinaki Lawrence Quintin

Cover Photo Credit: AFP

May 2021

The Somali Institute for Development Research & Analysis (SIDRA)
Garowe, Puntland State of Somalia

Cell Phone:
+252 5 846 044

Email:
info@sidrainstitute.org

Website:
https://www.sidrainstitute.org

This work is licensed under a Creative Commons Attribution
Non Commercial License (CC BY-NC 4.0)

Attribute to:
Somali Institute for Development Research & Analysis

“This research was provided through the generous and collaborative funding of the Safe Action Abortion Fund.”

Breaking the Silence:
A Contextual Analysis of the Barriers, Laws and Policies to Safe Abortion Following Rape in Puntland, Somalia

Somali Gender Justice (SGJ)

Mission: Somali Gender Justice links with the latest in research and programming, maintains strong connections among the gender justice community, works through a core set of hard-won principles, and constantly looking for opportunities to start crucial conversations necessary to achieve social change and promote gender equality.

Vision: Our vision for Somalia is a country and system where women enjoy the same liberties and opportunities as men. Our vision for our organization is to transform harmful attitudes and behaviors that belie gender equality, and be recognized as a thought leaders in advancing this vision.

Objective: Somali Gender Justice's objective is to bring the highest quality programs, research, education, advocacy and ethics to advance its vision.

Somali Institute for Development Research and Analysis (SIDRA)

Mission: SIDRA is a center of research that generates new knowledge that aims to be relevant, original and excellent. Our work co-constructs knowledge, alliance, dynamic policy environment and institutional capacity to fit for purpose.

Vision: SIDRA aspires to become the leading development research institute and center of excellence in Somalia.

Objectives

1. To conduct high quality research and policy analysis to inform evidence based effective policy making in Somalia.
2. To build a forum for debate public policy in Somalia.
3. To respond to the need to build external capacity for public policy research and policy analysis in Somalia.

TABLE OF CONTENTS

EXECUTIVE SUMMARY 5

DEFINITION OF KEY TERMS 7

1. INTRODUCTION 8
1.1 Background Information 8

2. METHODOLOGY 10
2.1 Data Collection and Analysis 10
2.2 Data Management and Storage 12
2.3 Content of the report 12

3. LITERATURE REVIEW 12
3.1 Sexual violence 13
3.2 Sexual and Reproductive Health / services 14
3.3 Abortion under social and cultural norms
3.4 Islam and Abortion 15
3.5 Legal and Policy Framework and Enforcement for Sexual Violence 15

4 RESULTS AND FINDINGS 17
4.1 Stories of survivors of rape 17
4.2 Rape Incidence 18
4.3 Safe Abortion 19
4.4 Laws, Policies and Protections 20
4.5 Challenges 20

5 CONCLUSIONS AND RECOMMENDATIONS 22
5.1 General conclusions 22
5.2 Recommendations suggested by the interviewees 24
5.3 General Recommendations 24

REFERENCES 26
ANNEX A: The Somali Sexual Offences Bill 29

EXECUTIVE SUMMARY

"The release of a Somali man on death row for the rape and murder of a 12-year-old girl after he paid 75 camels undermines a landmark law to curb gender violence and promotes a culture of impunity in the east African nation, women's rights groups said. Aisha Ilyes Aden was abducted from a market in northern Puntland's Galkayo town in February last year. She had been gang-raped and strangled to death and her genitals mutilated." Reuters, (February 27, 2020)[1]

Sexual violence is at epidemic proportions in Puntland, a semi-independent state located in the northeast corner of Somalia, though official data is not kept. Women and girls there face some of the most persistent and systemic gender inequities in the world. The absence of a strong central government and subsequent peace agreement following the Somalia Civil War in 1992 has led to the erection and recognition of a clan system of power, which relies on loose or well-organized collections of men, undemocratically elected and representing those in their clan in a sort of caste system, to make local decisions, collect money for insurance, and often, as in the story above, intervene in judicial matters. At the same time, survivors of sexual assault have limited recourse to sexual and reproductive health services after assault: in this officially Islamic state, abortion is only allowed to save the life of the mother, and based on the prevailing norms of the clinic or doctor performing the operation, can be refused; further, emergency contraception is not or rarely available.

The main goal for this research assignment was to collect data around the barriers of accessing safe abortion services experienced by survivors of sexual violence and whether Islam, as interpreted in Puntland's sharia law, allows for the exercise of a right to access abortion services following an act of sexual violence. Research questions include: what laws, policies and protections are in place for sexual violence survivors vis-à-vis abortion? How do these laws, policies and protections interact with social and gender norms? To what extent are these laws, policies and protections for sexual violence survivors vis-à-vis abortion enforced? And how can these laws, policies and protections be supplemented, revised or amended?

Data was collected from both primary and secondary data sources including desk review, key informant interviews (KIIs) and focus group discussions (FGDs). The desk review focused on searching available online resources on the links between sexual violence, sexual and reproductive health services including safe abortion, and social and gender norms related to sexuality. Two FGDs were conducted with community members and leaders, and two with health care professionals in an attempt to understand the barriers rape survivors experience in accessing safe abortion services in Puntland. KIIs were conducted comprising ministry officials (Ministry of Education, Ministry of Women and Human Rights Development, Ministry of Health), members of Parliament, judicial officials/ legal experts and relevant CSO executives to gain understanding on the relevant laws, policies and protections available for rape survivors to carry out safe abortions. In-depth interviews were conducted with rape survivors and those affected by rape (family relatives) to understand their experiences in accessing safe abortion services. This was very sensitive research to do – however, we felt very strongly that the voices of rape survivors themselves should drive the conversation.

Experts interviewed unanimously agreed that the incidence of rape in Puntland is high and has been increasing over the last few years. The health providers mentioned that in general women do not seek abortion services, attributing it to a culture of silence and shame among Somali women, even if she is in urgent need. They added that communities tend to be far away from medical centres and sometimes family members do not allow women to travel at all. If a woman does seek an abortion, they tend to resort to traditional abortions using service providers whose discretion they can trust not to report the service to the government.

Among the survivors interviewed, they report having received legal advice related to filing complaints with the police as well as seeking compensation and redress; medical care such as testing for sexually-transmitted infections (STI), pregnancy, maternal care, and psychological services (counselling, and family support mechanisms etc.). Two families expressed that they were tempted to search for the perpetrator themselves but, failed to do it as they did not have police support. Three out of the five interviewees clearly stated they sought an abortion following rape, though none managed to get the intervention. In two cases family members were also involved in the process of seeking options for interrupting the pregnancy.

The challenges present in Puntland in terms of access to health services in cases of rape and abortion were found to be; a lack of Rape Kits ('Kit Three') to prevent STI and unwanted pregnancy and even if available, a lack of awareness at community level in terms of services and laws, a lack of health services and a scarcity of trained staff to administer the drugs of the Rape Kit (Kit Three), and a rather arbitrary decision-making process about who offers Kit Three. Among the recommendations made were: providing legal recourse to safe abortion for pregnant survivors of sexual violence, changing social and gender norms by supporting the works of local feminist groups and gender rights and justice advocates, eliminating barriers that prevent women surviving sexual violence from receiving safe abortion services, provision of comprehensive services for rape survivors, applying a harm reduction approach for sexual violence survivors who meet hardships in accessing safe abortion services due to the social, economic and legal barriers, training of qualified police, medical, legal staff about rape, facilitating data collection and dissemination, and training of qualified police, medical, legal staff.

DEFINITION OF KEY TERMS

Abortion is the deliberate termination of a human pregnancy especially during the first 28 weeks of pregnancy.[2]

Harm reduction or harm minimization approach refers to a range of public health policies designed to lessen the negative social and/or physical consequences associated with various human behaviours, both legal and illegal.[3]

One Stop Medical Centre (OSMC) is a walk-in medical clinic with associated family and community practice and provides On-Site Services including reproductive health, ultrasound x-ray and pharmacy.

Rape is defined as any sexual intercourse or other forms of sexual penetration carried out against a person or persons without their consent.[4] It can be done by physical force, intimidation, abuse of authority, or against a person who is incapable of giving valid consent (unconscious, incapacitated, intellectually disabled or is below the legal age of consent).[5] Rape can occur anywhere and by anyone. It can be carried out by a person you know very well or some you do not know including; family member (husband, brother, uncle, relative etc.), friend, persons in authority (teacher, leader, police, elder etc.).

Rape kits (3 and 9) are UNFPA's post rape kits that contain essential lifesaving drugs and essential medical supplies to treat survivors of sexual violence. Kit number 3 contains drugs used to presumptively treat sexually transmitted infections (STIs) including post exposure prophylaxis (PEP) that can prevent the spread of HIV whereas Kit 9 contains medical supplies that can be used to suture cervical and high vaginal tears that might occur during a sexual assault.[6]

Safe abortion refers to the termination of a pregnancy by medical personnel or traditional practitioners with adequate skills within a medically safe environment. The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both.[7]

Sexual violence, according to the World Health Organization (WHO), is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.[8] Sexual violence may also take place when someone is not able to give consent, for instance, while intoxicated, drugged, asleep or mentally incapacitated.

Sexual violence is any sexual attempt to obtain a sexual act, or unwanted sexual comments or acts to traffic, that are directed against a person's sexuality using coercion by anyone, regardless of their relationship to the victim, in any setting, including at home and at work. Rape is the term that is commonly used for the first type of sexual violence mentioned above (forced/coerced intercourse).[9]

Violence against women refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[10]

1. INTRODUCTION

1.1. Background Information

For many years, rampant political and climatic insecurity have combined to create an unyielding crisis for many Puntland residents. Owing to poor rains for nearly four years, all of Puntland is either in "crisis" or "emergency" levels of food insecurity,[3] and as of February 2018, 600,000 people were in need of "urgent humanitarian assistance." Across Somalia, 1.2 million children are projected to be malnourished in 2018, a majority of whom are amongst displaced communities.[4] Further, a border dispute between Somaliland and Puntland have led to small clashes and threats of major conflict, exacerbating an already untenable security environment due to the presence of Al-Shabaab militants. Somalia is currently listed as the number two most fragile state in the world.[5]

Rampant political & climatic insecurity had combined created an unyielding emergency for many Puntland residents, with drought and the threat of Al-Shabaab militancy a constant factor. On February 2, 2020, Somalia declared a national emergency in response to the spread of fast-moving swarms of crop-eating desert locusts, which according to the UN are the worst swarms in 25 years. The resulting situation has exacerbated an already -tenuous food security situation: currently, all of Puntland is either in "stressed" or "crisis" levels of food insecurity (FEWS Net, 2020), and as of February 2020, 1.2 million were estimated to be in "urgent humanitarian assistance," affecting upwards of 690,000 children under the age of 5 the majority of whom are amongst displaced communities.[11] An estimated 2.2 million people live in IDP camps, of whom 70-80% are women.[12 13]

Somalia is one of the most gender unequal countries in the world. In leadership, women are underrepresented in every major Somali institution, especially clans and in government. In government, women only make up 25.8% of Parliament seats in Puntland, Somaliland and south-central Somalia (UNDP, 2018).[14] One of the primary drivers of these outcomes is lack of mobility and efficacy. Puntland has 535 primary schools with an overall primary enrolment of 107,907, 60% of whom were boys and 40% girls at 42,275.[15] As girls age, there are more likely to drop out of school than boys: the ratio of boys to girls fell from 0.59 in primary levels to 0.41 in secondary school.[16] The Somali clan system permeates political life and is a male-dominated institution. Clan elders are almost exclusively male, and clans themselves struggle to accept women as leaders. As one activist told the Institute for Security Studies (2018), "the clans would rather have a bad leader who is male, than a good leader who is female." The relationship of women to their clan is also a delicate subject, especially for those who marry into another clan. There are questions as to whether she represents her husband's clan, or that of her maiden family. Being unable to secure the full support of their clan puts these women at a financial disadvantage when it comes to political participation.[17 18]

Possibly as a result, reproductive and other rights suffer. Sexual violence is at epidemic proportions in Somalia. Many victims will not report rape and sexual violence because they lack confidence in the justice system, are unaware of available health and justice services or cannot access them, and fear reprisal and stigma should they report violence. As a result, women and young girls face what the UN's independent expert on human rights in Somalia refers to as "double victimization"— first the rape or sexual violence itself, then failure of the authorities to provide effective justice or medical and social support.[19]

Relatedly, Somali women have very limited access to sexual & reproductive health: estimates suggest that 4% of the overall Somali population use a modern family planning method[20] and the average family size is close to 7.[21] Inequitable gender norms discourage open discussion and many doctors in Puntland do not feel comfortable providing services to women without their husband's permission (Hook et al., 2017). 53% of Somali girls are married by the age of 18 and 98% of girls have experienced some form of female genital mutilation, most Type III.[22] Once pregnant, one out of every 12 women die from childbirth (ibid) with Save the Children in 2015 calling Somalia the "worst place in the world to be a mother."[23]

COVID-19 adds an additional, complicating layer to these issues. Somalia, the number-two most fragile state in the world[24] is just beginning to experience the pandemic. According to the Johns Hopkins Coronavirus Resource Centre as of December 30th, Somalia currently has confirmed 4,690 cases and 127 confirmed deaths[25], which is likely to be a severe undercount owing to weak testing facilities, among other factors[26]. From the researchers' daily interaction in the community, people are simply not contacting the Minister of Health or relying on healthcare facilities, and no public or private hospital has an ICU to receive severe cases. This deep uncertainty is likely to cause a significant spike in GBV in Somalia[27] especially among the estimated 1.55-1.77 million women and girls living in IDP camps.

Abortion is permitted in Somalia only to save the life of the mother basing on the 2012 Provisional Constitution of Somalia, the Somalia Penal Code (Legislative Decree No. 5 of 16 December 1962) and the Somalia Essential Drug List, 2003. In practice, this can be interpreted loosely or strictly, according to level of privilege enjoyed within Somali society. Clan affiliation, family wealth, and links with religious institutions as well as structural factors like rural/urban, pastoral/home-based and level of poverty can dictate the extent to which this rule is enforced. The more vulnerable you are, the higher possibility that you will not be able to access safe abortion services. Sexual violence survivors are extremely vulnerable, and require immediate support in the aftermath of assault. In a country where emergency contraception is non-existent, abortion services are absolutely critical.

The primary mechanism for inequitable access to safe abortion care is shame. Sharia is the official law of the land, and takes a Universalist, black and white, view of morality, rather than understanding how different groups of people enjoy different levels of vulnerability. In a country where shame and morality is engrained in legal codes, stigma prevents women and girls from accessing safe abortion services following an assault.

We call our report "Breaking the Silence" because this issue is quite under-studied, under-discussed, and therefore understood. It is our intention to use this research to bring to light some of these issues and create a platform for discussion. The main goal for this research assignment was to collect data around the barriers of accessing safe abortion services experienced by survivors of sexual violence, which was guided by the following questions:

1. What laws, policies and protections are in place for sexual violence survivors' vis-à-vis abortion?
2. How do these laws, policies and protections interact with social and gender norms?
3. To what extent are these laws, policies and protections for sexual violence survivors vis-à-vis abortion enforced?
4. How can these laws, policies and protections be supplemented, revised or amended?

This report presents the results of data collected through a range of sources: research studies, news published, blogs and online resources, key informant interviews, and focus group discussions.

2. METHODOLOGY

2.1 Data Collection and Analysis

The study drew on a wide range of sources: desk review, Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs).

The **desk review** focused on searching online resources (academic, journalistic, and grey literature, synthesizing the data found on three main categories: sexual violence, sexual and reproductive health services, and social and gender norms related to sexuality. Additionally, a relevant compilation of laws, policies and normative related to rape and abortion were also reviewed, aiming to identify shortcomings in those documents, and study any associated challenges to effective implementation. Keywords were identified and fed into Google, with key articles noted and read until the researchers felt a saturation point was reached.

Two **FGDs** (Table 1) were conducted with community members and leaders, and with health care professionals in an attempt to understand the barriers rape survivors experience in accessing safe abortion services in Puntland. The participants for the focus groups were selected purposively who were thought to provide the study with the best information and due to convenience.

Table 1 - Details of FDGs

FGD Discussants	Targeted	Actual
Community leaders (elders, clans, religious)	5	3
Influential women (women groups' leaders)	5	3
Influential youth (youth groups' leaders)	5	2
Community members	5	3
Total	**20**	**11**

KIIs (Table 2) were conducted comprising ministry officials (Ministry of Education, Ministry of Women and Human Rights Development, Ministry of Health), members of Parliament, judicial officials/ legal experts and relevant CSO executives to gain an understanding of the relevant laws, policies and protections available for rape survivors to carry out safe abortions.

Details of interviews with experts

List of interviews & FGD groups	Targeted	Actual
Interviewees		
Ministry officials (MoE, MoW-DAFA, MoH)	3	2
CSO executives	5	2
Members of parliament*	3	1
Judicial officials/ legal experts	3	1
Reproductive health service providers	5	5
Rape Survivors	3	5
Those affected by rape (family, relatives)	3	5
Total	**25**	**21**

** The Member of Parliament that participated in this research is a 47 year old woman who is serving her first term in Puntland Parliament.*

In-depth interviews (Table 3) were conducted with rape survivors and those affected by rape (family relatives) to understand their experiences in accessing safe abortion services. This information was analyzed and grouped in defined thematic categories to respond to the research questions stipulated in the scope of work.

Table 3 - Details of interviews with rape survivors

Respondents	Tool	Age of Rape Survivor	Family Member Interviewed
Respondent 1	KII	17	Mother
Respondent 2	KII	20	Mother
Respondent 3	KII	23	Older sister
Respondent 4	KII	25	Sister
Respondent 5	KII	19	Grand mother

Recruitment of Participants

According to the SIDRA's Research Protocol, approved by SGJ, all participants who participated in this research were purposively selected on the basis of their level of insight and knowledge of the barriers experienced by survivors of sexual violence in accessing safe abortion services. All were called in advance and given an introduction of the sensitivity of the subject matter to be discussed to gain their confidence and ensure their availability. All participants were provided with an anonymized consent form in English and Somali to sign or provide a thumbprint.

Recruitment of sexual assault survivors & family members

Somali Gender Justice, SIDRA and the Safe Action Abortion Fund were committed to relying in the voices of survivors themselves to 'tell the story.' While quite sensitive, this perspective is rarely heard in Puntland, and the power of the stories would be persuasive to shifting the policy and advocacy landscape. Every effort was made to recruit rape survivors in an ethical manner and according to precepts laid out in the Belmont Report[28]. The rape survivors and their families were found through a third party affiliate to SIDRA whose primary work is providing legal aid and psychological support to GBV and Sexual Violence Survivors in Puntland. Survivors were interviewed by themselves to minimize potential harm. Given the sensitivity of the subject matter, it was expected that some participants may experience distress. While always aiming to elicit detailed and thoughtful response, facilitators aimed to diminish harm to all involved individuals, and provided for the provision of mental health services should the need arise. All personal identity information has been anonymised and pseudonyms have been used for the participants. Ethical approval for the study was granted by the Puntland Ministry of Health.

Facilitators

SIDRA has deep experience training KII and FGD facilitators to meet the needs of the research project proposed. Facilitators had previous training in facilitation including the use of probes to stimulate discussion and keep the conversation on track, as well as how to ensure that everyone in the focus group is speaking evenly. Facilitators' genders will match the gender of the key information interviewee. In case of interviews with survivors of rape, all facilitators will be women.

All facilitators were provided with a short training module on 'emotional first aid' for themselves and the interviewees/discussants. Such 'first aid' includes practical guidance on how to console a distressed individuals, how and when to proceed or stop an interview, how to provide words of guidance and support, and how to take care of yourself (e.g., not judging your emotions, not blaming yourself). Facilitators also had access to professional counselors at no cost to them should they have had the need.

Location of FGD/KII/IDI

Physical safeguards were used to provide the necessary privacy for the interviewers and interviewees.

- Qualitative research was held in secure private locations especially away from their own community where both interviewees and interviewers feel comfortable to speak their mind on such a sensitive topic in Somali culture. Interviews with the survivors took place in secluded conference rooms and SIDRA offices for those in Garowe.
- The location and time of the FGD/KIIs was communicated clearly and privately to all
- If the discussants for any reason did not wish to convene in a seclude place, they were given the opportunity to do them in a more comfortable and convenient location for them

Primary data collection

Primary data was collected through key informant interviews and FGD. This exercise was meant to take place between 5th March – 9th April according to the study plan, but due to the Covid-19 impact and preventative measures set in place, the first round of data collection took place in late April 2020 and second round of data collection happened in late May 2020. On average, KIIs lasted between forty-six minutes and one hour, and the FGDs lasted for two hours each. The three FGDs were;

- 1 with ministry officials, members of parliament and judicial officials/ legal experts,
- 1 with CSO executives,
- 1 with reproductive health service providers

2.2. Data Management and Storage

Data Recording: All primary data collection had an interviewer/FGD moderator and a note taker. As the interviews and focus group discussion took place, trained facilitators took notes according to the research protocol developed by Somali Institute for Development Research and Analysis (SIDRA & Somali Gender Justice (SGJ). Confidential and private information was omitted to make it impossible to track the results within this report to any specific respondent. All names, locations and dates recorded in the interviews/discussions were anonymized. No audio or video recordings were taken.

Data Storage: Hard copy notes were stored in an enclosed file folder and locked away in a file cabinet where only authorized personnel could access it whereas the softcopy data was stored on the main computer under a secured file folder both of which are only accessible to the head of research and the research coordinator. The detailed notes were transcribed into soft copy using Microsoft Word and the hardcopy notes destroyed.

Data Translation: A translator was commissioned to carry out translations of the questions from English to Somali and answers from Somali to English.

2.3. Content of the report

The report starts with contextual information regarding the prevalence of sexual violence against girls; reproductive health services; laws, policies and their enforcement; and socio-cultural, religious and gender norms in Somalia. The report further documents challenges experienced by a selected group of rape victims in accessing abortion services in the health sector. It also presents the data collected by KII and FGDs with experts related to barriers and challenges for accessing safe abortion services for women survivors of rape. The report ends by presenting recommendations and improvements to the legal frameworks and related policy to rape/sexual violence and abortion.

3. LITERATURE REVIEW

This chapter reviews and presents data, information and evidence resulted from an online search of existing literature, including journalistic outlets and online empirical sources for the major themes of this research.

3.1. Sexual violence

Sexual violence is widespread in Somalia. Two decades of conflict and the collapse of the basic functions of government have brought about a system where women and girls, many displaced and living in IDP camps, are inherently vulnerable to rape and other forms of sexual violence. The systematic use of sexual violence and rape has been a common feature of conflict perpetrated by all actors involved.

Women's rights and physical integrity are challenged by religious and customary practices such as polygamy, early and forced marriage, wife inheritance and female genital mutilation. In Somalia, rape survivors face harsh treatment from the community, sometimes including their own families who may stigmatize and blame them for what happened to her[30]. Girls are often subject to parental restrictions including keeping them out of educational opportunities. Often, in Somalia, sexual violence is reinforced by this type of exclusionary prejudicial social norms. Additionally, the reality of known cases of sexual violence, can prevent women from pursuing education and/or working.

According to UNHCR annual statistics reports, 2,086 incidents related to sexual violence were documented by its partners in 2017, and 1,202 incidents from January to August in 2018. However, the report covers only South-Central Somalia.

In a country where survivors of conflict-related sexual violence face exclusion and stigmatization, it is not surprising that most victims in Somalia do not report the crime. According to experts, it is estimated that for each rape reported in connection with conflict, between ten and twenty cases go unreported[31]. Victims of rape and their families face stigmatizing and ostracizing within their own communities and discrimination based on the attribution of "impurity".

When someone is accused of perpetrating rape, authorities allow families and traditional elders to settle rape cases out of court through customary laws (called Xeer) that do not accord due justice for the victims. This practice is perceived as an unfair justice outcome for the victims and has contributed to the prevalence of rape and sexual violence in Somalia.

There is a lack of confidence in the system due to the inability of the criminal justice system to hold the alleged perpetrators accountable. Many women are unaware of the health and justice services or they are not available (OECD Gender Index, 2019). There are neither no specialized referral centres, no safeguarding and, reporting processes and procedures in place nor standard codes of confidentiality and privacy in handling rape and sexual offences in the health facilities. Health facilities are not properly equipped to provide medical, psychological and emotional support to rape victims and witnesses.[32]

According to reports, barriers to health care include insufficient and poor facilities, inaccessibility, prohibitive costs, insufficient implementation capacities and constraints to service delivery.[33] Sexual violence services in Somalia include lifesaving medical support together with post rape treatment and care; protection, legal, psychosocial support; and livelihood assistance. These may however not be well structured and accessible; integrated response and multi-sectoral coordination have recently been given special emphasis to facilitate access by sexual violence survivors to basic needs (food, shelter, health care and water).[34]

3.2. Sexual and Reproductive Health / services

Between 2015 and 2019, on average, 73.3 million induced (safe and unsafe) abortions occurred worldwide each year. There were 39 induced abortions per 1000 women aged between 15–49 years. 3 out of 10 (29%) of all pregnancies, and 6 out of 10 (61%) of all unintended pregnancies, ended in an induced abortion.[35] Among these, 1 out of 3 were carried out in the least safe or dangerous conditions. Estimates from 2010 to 2014 showed that around 45% of all abortions were unsafe. Almost all of these unsafe abortions took place in developing countries.[36]

More than 97 percent of abortions in Africa are unsafe (up to 5 million unsafe abortions every year), and 1.7 million women are hospitalized annually for

complications arising from those procedures. In fourteen African countries[37] abortion is not permitted for any reason, including to save the woman's life or in cases of rape or incest. Where abortion is illegal, women may simply resort to unsafe methods to terminate pregnancies, such as inserting chemicals/herbs into the vagina, attempting to puncture the fetus with objects through the cervix, and ingesting toxic chemicals.[38] In many instances, such attempts clearly put these women at severe risk of facing social exclusion, destitution, isolation and extreme poverty from family and people close to them who ideally would have been at the forefront in offering support and care.[39]

In Somalia, abortion-related deaths are one of the contributing factors of the high maternal mortality rate in the country. A report from Somaliland indicates that 2.3% of maternal mortality death was abortion-related death.[40] A survey from the year 2000,[41] the last-available reliable data, indicates that 2% of the women in Somalia are reported to have at some point sought termination of pregnancy. UNICEF argues that most of these abortion attempts are likely to have been carried out in an unsafe environment.[42]

LIFOS´s report (2017) states that in Puntland, even though it is not accepted in the society, some women may turn to unsafe abortions, and claim that they have had a miscarriage. The abortion is in such a case carried out in what it is called a traditional way, with traditional methods such as using fat from sheep's meat and other herbal means that xaqitaan 'sweepers' (who provide abortion services for women in Somalia), without the presence of any skilled health care professional but instead with a traditional midwife.[43] In the same study, an UNFPA source states there official figures on abortion are not kept. If it occurs, then it occurs in an underground way.

The low contraceptive prevalence rate in Somalia is likely but not completely attributable to lack of awareness, misinformation, or cultural-religious opposition. Pregnancies contracted out of wedlock are more likely to lead to unsafe abortions.[44] With such statistics, ensuring access to safe and timely reproductive health care is critical.[45]

Somalia presents a complex scenario: lack of trained health personnel, lack of access to health and abortion facilities, inadequate rape kit for victims, and victimization and stigma strongly associated with religious and socio-cultural connotations around rape and abortion. Unsafe abortion puts a strain on the health care needed to treat complications arising from unsafe abortion on an already overstretched healthcare system in Somalia. Studies in other parts of sub-Saharan Africa clearly demonstrate that cost often serves as a major barrier to accessing reproductive health services, such as safe abortion services, post abortion care and counselling services. High rates of extreme poverty in Somalia mean that many women are unable to cover basic needs for themselves and their children thus likely to prioritize other necessities over health care.[46]

Overall, a diversity of factors affects health seeking behaviours of the Somali community: socio-demographic and economic factors, non-responsive bureaucratic system, shortages or absence of medical supplies and human resources, lack of supportive supervision, a shortage of water and electricity at the health facility and an unclean service delivery. Specifically, an additional identified barrier is present for women to seek sexual and reproductive services: male dominance in decision making in domestic spaces, and the influence of the husband and family in law in reproductive decisions. Being a patriarchal society, husbands take sole responsibility and charge of the family planning and reproductive health options and decisions.[47]

Globally, shortage of qualified health practitioners and facilities is often cited as one of the high-risk factors for survivors of rape. In Somalia, this is aggravated by the lack of proper reproductive health services, post abortion care, treatment and psychosocial support and counselling which has compounded the vulnerability of girls and women to infections, unwanted pregnancy, risks of death and permanent emotional trauma. Most health workers shy away from conducting safe and legally regulated abortion in Somalia citing societal pressures and threats to victimization strongly entrenched in the societal and cultural values.[48]

In this dire context, Somalia's administration has made efforts to set up structures and services within the available health facilities, for rape survivors. For example, they have made available the 'Kit Three.' Kit Three contains drugs used to treat sexually transmitted infections (STIs) including post exposure prophylaxis (PEP) which can prevent the spread of HIV whereas Kit 9 contains medical supplies that can be used to suture cervical and high vaginal tears that might occur during a sexual assault.[49] Kit (3 and 9) rarely contain any emergency contraceptives however. Over the last few years, One Stop Medical Centres (OSMCs) data shows that the demand of Kit Three medicine is extremely high. Increased number of young girls seeking a kit has been recorded in medical facilities, further providing evidence on the need to expand access to reproductive health services and post rape care for survivors.[50]
report.

3.3. Abortion under social and cultural norms

Addressing rape and abortion prevalence in Somalia points to the importance of considering sociocultural aspects.

In Somalia, female sexual modesty is especially important, with female virginity (and sometimes female genital mutilation) being essential for marriage. Hence, women traditionally carry greater expectations of social compliance than men and are often seen as particularly vulnerable targets that need to be protected. They are required to show modesty and not bring shame to their family by immodest or immoral behaviour.[51]

Marriages are traditionally arranged, but it is also becoming more common for parents to consider their child's love interest if the match is suitable.[52] According to UNICEF, 45% of women are married by the time they are 18 years old (35% urban, 52% rural). Boys generally marry at an older age, roughly 30 years old. The reasoning behind the age difference between men and women is that men are expected to financially provide for their wives. Thus, a man needs to be entirely self-sufficient and economically secure by the time he gets engaged.[53]

In a predominantly patriarchal system like in Somalia, gender inequality, cultural and religious norms, and poverty are key factors behind unwanted pregnancy for most vulnerable women. For many, the risks of social exclusion, expulsion from the family, abandonment and deepening poverty are high in front of a rape which terminates in a pregnancy. Most of rape and other sexual offences remains unreported due to the stigma, humiliation, and loss of honour, self-guilt and lack of support.

3.4 Islam and Abortion

Religion may play a significant role in a woman´s decision to have an abortion as well as in a country's abortion policy when the population is Islamic. An abortion, or Ijhad in Arabic, is the procedure for terminating an unwanted pregnancy before the foetus has attained viability, i.e. become capable of independent extra-uterine life. Though Islamic jurisprudence does not encourage abortion, there is no direct prohibition on abortion from the Quran and Sunnah, the two most authoritative biblical sources.

Muslim jurists have always viewed the fetus as the precious origin of human life. The womb is perceived as a fragile vessel that carries a unique human soul, and hence deserves safeguarding and careful treatment.[54] The Qur'an states:

"And it is not lawful for them to conceal what Allah has created in their wombs if they believe in Allah and the Last Day." [al-Baqara (2): 228].

By 120 days from conception, the scholars of all schools unanimously agree that ensoulment has taken place. This is based on a tradition in which the Prophet ﷺ mentions that the angel breathes the soul into the fetus by 120 days.[55 56]

Aborting the pregnancy becomes categorically forbidden at this point, as the embryo is now a fully-sanctified human life. Islamically-speaking, this would be murder—unless a physician determines that continuing the pregnancy would truly endanger the mother's life[54]. Only in this case can the pregnancy be terminated after 120 days. The logic behind this is an agreed upon legal maxim in Islamic law: certainty should not be overridden by doubt. In other words, a potential life (that of the infant) should not threaten a stable life (that of the mother). Although both are technically alive, the survival of the mother takes precedence because her life is evidently established, while survival of the fetus within her is relatively more doubtful[54]. Hence, doubt is trumped by certainty, and the lesser harm is endured to avoid the greater loss. Jurists also support this from another angle; the mother is the origin of the infant, so even if they have equal possibility of surviving, as long as the fetus is part of her and dependent on her, you don't cut the root to save the branch. When forced to choose, the branch should be sacrificed to save the root [54].

Between 40 and 120 days from conception, Muslim jurists disagree. According to Dr. Hatem Al Haj, "Abortion in the first forty days of pregnancy upon the mutual agreement of both parents is permissible for a legitimate cause, such as the woman's fear of not having the capacity to raise a newborn. Having said that, it is always preferable to avoid that, and if one relies on Allah's help and puts his/her trust in Him, He will not let them down. That fetus may become their favorite child one day.[57]

3.5 Legal and Policy Framework and Enforcement for Sexual Violence

In Africa, most countries have ratified legally-binding international treaties and conventions that protect fundamental human rights, including the right to non-discrimination and the right to the highest attainable standard of health. These rights are further recognized and defined in regional treaties and are also protected by the constitutions of many countries.[58]

The last decade has seen several milestones realized in the fight against human rights violations, protection of the girl-child and policy frameworks for law enforcement in Somalia. Violence against women is widely recognized as a form of discrimination and a violation of human rights under international and regional legal frameworks. However, the Federal Republic of Somalia has not ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Neither has Somalia ratified the Maputo Protocol, also known as the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, put into effect in 2005.

The UN Security Council Resolutions 1820, 1888 and 1889 note the need for access to comprehensive sexual and reproductive health services for women affected by armed conflict and post conflict situations. It has increasingly become imperative that comprehensive reproductive health issues be integrated into the Somali national agenda. [59]

With regard to Somali legal frameworks regarding apportion, Article 15 (5) of the Somali provisional Constitution in 2012 states that abortion is contrary to Shariah law and is prohibited "except in cases of necessity, especially to save the life of the mother."

Similarly, Somali's Penal Code (1962) criminalizes abortion, except to save the life of the woman (Article 418-422). Therefore, Somali laws are not in favor for abortion unless there is a reason and in this sense agrees with the Islamic view of abortion as we discussed above.

Under the international and regional human rights treaties named above, governments have the responsibility to protect women and girls from sexual violence and to respond effectively when violations occur. This responsibility to respond encompasses the duty to investigate and prosecute abuses, as well as to provide survivors with the necessary support and rehabilitation services. One of the conclusions of the experts consulted for this study clearly states that the country still has a long way to go in ensuring full compliance and conformity with the internationally set standards in regards to protection of rape survivors and prosecution of perpetrators of sexual violence.

Sexual violence in Somalia is widespread, pervasive and carried out without almost total impunity. It therefore required an immediate legal framework to conclusively address this matter considering the socio-cultural barriers to access to and provision of reproductive health

care information and services including but not limited to safe abortion, family planning, and psychosocial support (both at community and health facility levels).

In response to the dire situation facing survivors of sexual violence, the Ministry of Women and Human

Rights Development, and Legal Action Worldwide (LAW) oversaw the drafting and successful passing of the Sexual Offences Bill* and the Somaliland rape law. The Bill, lauded by experts as one of the most comprehensive of its kind, criminalizes a wide range of sexual offences and clearly sets out the duties of the police, investigators and prosecutors. It also sets out a clear guideline to a number of guarantees for survivors and victims of rape including the right to free medical care, to privacy in court and to support in securing housing.[60]

How it is effectively implemented is another complexity the administration must grapple with to manage the inevitable and foreseeable conflict arising from societal norms, religious and cultural misconceptions, and misinterpretations. The compliance of the Bill with Sharia Law has been confirmed on multiple occasions, a critical step towards the process of adoption and implementation in Somalia.[62]

A progressive sexual violence prevention and response act was passed in 2016 in Puntland, and has been in force since then in the courts. The law expands the definition of "rape" to be gender neutral, and criminalizes several sexual crimes including rape, gang rape, sexual assault, sexual harassment and sexual exploitation and abuse. The law punishes rape perpetrators with an imprisonment between 10 years to 20 years, in the case the crime is proven through circumstantial evidence, and the death penalty is given where the offender confesses or is proven to have used a weapon during the commission of the crime.

The law provides in article 21 (1) that the SGBV victims shall a "right to free medical, psychiatric, or psychological treatment services, psychosocial care, optional right to free medical, psychiatric, or psychological treatment services, psychosocial care, optional confidential testing for HIV and any other sexually transmitted diseases, at any stage before, during and after the legal proceedings". In the same article 21 (2) provides the right of the rape victim to some sexual and reproductive health remedies "An injured party has a right to receive and take safe emergency contraception after the occurrence of an unlawful sexual act." Abortion is not mentioned in this bill.

For Specifics of the Somali Sexual Offences Bill, refer to Annex A of the paper

4. RESULTS AND FINDINGS

The following section presents the data collected through interviews and focus groups with the following groups of respondents:

1. Survivors and their relatives (see Annex 1)
2. Key experts: legal, religious, civil society and public servants (see Annex 2)
3. Health service providers: Local Health Facility Managers, Medical Service Providers, Midwives, Traditional Delivery Service Providers and Front-Line Service Providers (see Annex 3)
4. Community members and leaders (see Annex 4)

The next section provides a description of events surrounding cases of rape and sexual violence which are taken from interviews with survivors and their relatives. These highlight the context of isolation a rape´s victim face (not only not reporting, but actually not informing their families), the stigma associated to being a rape´s survivor (hence the silence) and the impossibility of accessing the legal rape kit (Kit Three) for interrupting the pregnancy product of a sexual violence. We thank the survivors and willing family members for speaking with us.

4.1. Stories of survivors of rape

Survivor #1

She was 13 years old and was raped in own home when all family members were absent at that moment. The perpetrator was a man who was renting one of the rooms in the house. She remembers not telling anyone about the incident: "I kept quiet about it." Several weeks later, her grandmother noticed that something was wrong with her: "I was absent-minded, and was anxious and scared." She finally told her grandmother about the rape. Only then, a month after the incident, that she sought health services including psychosocial support. "Although she was shocked, I felt blessed to have my grandmother, who is old and experienced and gave me some advice".

Survivor #2

She was 18 years old and raped on a road close to her home at night and by three men who were stranger to her. Once she arrived home she did not tell anyone. Like Survivor #1, it took her one month to tell her mother: "At first, all of my family was angry with me, I was trying to explain what happened and that it was not my fault. After a long time, my mother understood and supported me to find medical aid from a hospital". They attended health services to receive medical, psychological and legal support two months after the rape.

Survivor #3

She was 16 years old and was raped by a man on the street. She did not anything, nor tell anyone. Eventually, she sought out health services where she got medical, psychosocial and legal support. She finally also informed her family: "they agreed with me this was a serious issue that we needed to address it in a proper way. They supported me very well."

Survivor #4

She was 19 years old and was raped by a man in a [internally-displaced persons] camp in which she was staying. She remembers being shocked and "did not do anything". She, eventually, told her sister and sought health services. "She was also shocked, but tried to help me to seek out any information about it and find medical support".

Survivor #5

She was 17 years old and was raped by a man while she was looking for firewood in a rural area. "We met accidentally, and he held me by force, then he did what he wanted". She remembers thinking a lot about the event until she told her mom "she supported me and brought me to a clinic". There she received medical and psychosocial support.

Synthesis

The five cases of rape explained by the interviewees (and their families)[63] happened either at home or on the streets. All the survivors were between 13 to 19 years old. They were alone either in their homes or on the s

streets. Only once case was a gang rape (three men), all the others were perpetrated by single older men.

Dramatically, but understandably, none of the girls informed their families immediately about the sexual violence. They refer to feelings of isolation, fear, and mental paralysis after the incident. They got to tell their stories and asked for help when, in some cases, a pregnancy was confirmed or, in others, when the family members noticed something wrong with them. The reaction of the relatives (mother, grandmother, sister mainly) have been supportive and that they jointly seek medical, criminal and psychological support for the rape incident. Only one case reports that the family at first blamed her and made her feel guilty. However, later they changed their positions, and became supportive.

All survivors interviewed ended up seeking health care for the rape. They report to have received legal (advice on filing complaints at the police, seeking compensation and redress), medical (testing for infections, pregnancy, neonatal attention and pain relieving) and psychological services (counselling, and family support mechanisms etc.). Two families expressed that they were tempted to search for the perpetrator themselves but, failed to do it as they did not have police support.

Three out of the five interviewees clearly stated they for an interruption of the pregnancy as it was a product of rape. None of them managed to get the intervention. Even though they tried, asked around, searched for services, pills and doctors, they could not get it. In two cases family members were also involved in the process of seeking options for interrupting the pregnancy.

4.2. Rape Incidence

The experts interviewed unanimously agreed that the incidence of rape in Puntland is high and has been increasing over the last few years: “92 cases were reported in Puntland between 2017 and 2020, this means that the cases are extremely high”. They also mentioned that reporting has increased which also shows the high incidence of rape in the region. An expert from the MoH mentions that “The medical centres data shows that the demand for the rape kit (Kit Three) used to prevent pregnancy and sexually transmitted diseases and infections has increased and that more girls have been serviced in these facilities”.

The health service providers who were part of the FGD were asked about their perceptions of the incidence of rape in their communities. They were asked to reveal whether they thought the rape incidence numbers were either high, moderate or low. Some of their responses were: “I think 10% of Somali women have experienced rape” and that “the incidence rate is less than 2% hence low”. However, these figures are based on personal guesses as none of them follow a registration and/or reporting procedure for rape survivors seeking medical services.

Members of the community interviewed have two opposite views regarding the incidence of rapes in their surroundings. On one hand, two of them mentioned that the incidence is high and situate the number of rapes between 250 (or less) and 540 (which “their documents are in the courts”). On the other hand, there is the opinion that the prevalence of rape is low and that “NGOs are lying to create demands for projects” and that “women are exaggerating.”

The experts interviewed mentioned a list of contributing factors for the increasing of cases of rape in the last few years:

1. **Changes in gender norms** related to unrestricted movement for women; higher number of girls in school where rapes have occurred in school canteens
2. **Rural context:** girls walk long distances to take animals out, usually alone and in isolated lands
3. **Judicial system:** the lack of coverage of the judicial system and the parallel traditional judiciary system
4. **Drug consumption:** men consume drugs like marijuana and khat and become violent. Also drug addiction relates to diaspora gangs
5. **IDP camps** related to lack of lighting, latrines and safety in the toilet zones which become a dangerous place for women and girls

The community members expressed that in front of a case of rape or sexual violence they tend to deal with it using traditional law processes and it is not brought to state based justice /jurisdiction. "We always solve this issue in traditional way. If he killed the woman, the family of that man is to give 50 camels to victim family. If the woman is alive, we decide that the man should give the lady's family some money or livestock or we force him to marry her."

4.3. Safe Abortion

According to both the Puntland Constitution and the Religious beliefs, Abortion is "illegal". However, this is vague and not clear because in the same paragraph illegalizing abortion, it is also allowed "only" in cases where the foetus brings complications and risk the life of the mother. The health providers mentioned that in general women do not seek abortion services following assault. "When Somali a woman is raped, she always keeps silent and is ashamed to seek health services. Even if she is in urgent need, she prefers death". They also claim that communities tend to be far away from medical centres and "sometimes family members do not allow women to travel".

If women seek an abortion service, the health providers believe they will resort to traditional or modern procedures and this will depend on several factors. Those seeking traditional abortion service providers will trust the privacy and discretion of those who provide this service: they "will not to report to the government". This service would also be cheaper and above all there is a cultural factor: lack of awareness and knowledge about modern forms of terminating a pregnancy and modern medical care "cannot do much due to the culture and context of this country". Those who will seek a modern abortion service will do it as they believe it is safe and easy to practice it, can be done without the consent of the husband, hence "privacy is always preserved."

The most common cultural factor named by the experts regarding rape and abortion refers to Islamic religion and laws. Unanimously, all of them conclude that abortion is prohibited for all circumstances: "The community will not support abortion after the sperm fused with the egg, which happens 72 hours after the intercourse." Abortion is against Islamic Sharia laws and cultural norms. "The community always obeys Islamic religion and they solve problems such as rape using Islamic law. No one can improve, revise, or amend the laws and acts to encourage safe abortions for especially rape survivors. Because it is against our culture and our religious beliefs" (Parliament member).

The religious expert interviewed is adamant in expressing his condemnation of rape "Rape is a serious sexual crime, since it consists of sexual intercourse which damages the dignity of women. Most of the Islamic sheikhs believe the Imam has a power to judge death sentence to perpetrator even if he did not kill someone." In terms of an abortion for a pregnancy product of rape, the expert noted that sheikhs have different opinions: "Most of the sheikhs agreed if the foetus is less than forty days and pregnancy was related to rape, abortion is allowed. Because still the foetus has no soul. But if the foetus is 4 months old or beyond, abortion is prohibited that was the time Allah gives the foetus soul. The third opinion is where the strongest difference lies, when foetus is older than one month and less than four months, some of them accept the abortion while others do not".

The religious expert interviewed clarifies that a rape survivor who becomes pregnant "has all the rights to do what she feels is right because she is the mother of the baby, and no one can dictate her what she will do with her baby. She will take responsibility of baby and she has to fulfil all his/her needs, such as food, shelter, clothing, education, and health." If the woman decides not to keep the baby born out of rape, it is the government´s responsibility to care for the needs of the child, according to the expert.

Community members interviewed tend to agree with these religious teachings. "The community believes that abortion is forbidden, and a crime and only non-Muslims practice it," one said. They therefore express that the advice to rape survivors is to carry on with the pregnancy … "to not terminate it because whatever happen it is your baby and you shouldn't kill this innocent foetus". Only one of the five members of the community interviewed expressed that they would advise to "seek a safe abortion and terminate the pregnancy, to be patient and not be ashamed to tell the truth".

4.4. Laws, Policies and Protections

The legal experts consulted have two visions regarding the laws related to abortion and rape. On one hand, some of them believe that the government of Puntland should not do nothing to promote safe abortion as it is a "sin in Somali culture and Islamic religion. The only thing they can do is to fight against rape and to strengthen justice for rape perpetrators". And that, "all types of abortions cannot be allowed in any institution after 72 hours of the rape".

On the other hand, a few legal experts mentioned that all rape cases should follow the guidelines of the Sexual Offences Bill "to support sexual violence survivors to redress them and provide medical support and legal aid" and that the government should provide resources for having more OSCM (One Stop Medical Centre) in rural areas."

All the legal experts agreed that a key recommendation is to include the religious leaders and the tribal elders as part of any policy and law concerning abortion and rape "to avoid religious and family problems". In this sense, they also express that the most important policy is to ensure the punishment of perpetrators in accordance with the Islamic law. An example of this kind of collaboration was given by the religious expert: "For example the last year 2019, there was a gang rape and a homicide incidence in Galackacyo, both government and communities backed the family, and government arrested and prosecuted the perpetrators who upon conviction got death sentences as a deterrent for others. After a long judicial process government executed the men and communities appreciated the process and the final judgment. Everyone planning to commit rape ever since is fully aware of the consequences."

One legal expert mentioned the importance of carrying forward the punishment "without considering his clan and community because he is a monster and he has to get what he deserves without mercy. Governments must capture the perpetrators to execute them". The religious leaders must support the government in the judgment of perpetrators by using the Sharia law.

The legal experts concluded as well that there is a need to do more work in terms of creating a safe and secure environment for women and children as well as raising community awareness to avoid further rape incidences and also provide avenues for survivors to access safe abortion services.

The legal experts present two clear personal opinions regarding access to abortion for a pregnancy product of a rape (the Kit Three in particular). First, there are legal experts who think that abortion should not be available for survivors. They refer to the fact that nothing "can be done without her husband's consent…. Without consent of the victim's husband can create problems". Another group of legal experts believed that survivors should get access to the One Stop Medical Centre within the first 72 hours and follow the guidelines of the Sexual Offences Bill/Act. "I believe the rape victim must get Rape Kit (Kit Three) for the first 72 hours to avoid unwanted pregnancy and sexual transmitted infections and diseases."

4.5. Challenges

The legal experts mentioned a list of challenges present in Puntland in terms of access to health services in cases of rape and abortion:

1. Lack of Rape Kit (Kit Three) to prevent STD, STI and unwanted pregnancy in the OSMCs– particularly in rural or semi urban areas
2. Low awareness at community level in terms of available services for survivors and laws that protect them
3. Lack of health services and scarcity of trained staff to administer the drugs of the Rape Kit (Kit Three)
4. Discretionary decision making in terms of offer the Kit Three where the kits are given with or without deliberation

The health service providers believe that it is extremely difficult for rape survivors to access abortion services because there is shortage of trained staff and any kind of pregnancy interruption is prohibited in the country. Other issues mentioned were medical staff absenteeism, financial costs, family-related issues like family cohesion, socio-economic factors and the like, and fear that the provider will release this information to the community). They identified the main challenges faced by rape survivors in accessing proper health facilities for safe abortion procedures as:

1. Unavailability of adequate health services (remote area and distance)
2. Lack of confidentiality by health providers
3. Shortage of trained staff (unqualified health care providers)
4. Lack of knowledge and awareness of victims themselves
5. No specialized centres for rape survivors
6. Culture, religious and community perceptions ("abortion is shameful in our culture")
7. Lack of trust between health care providers and community

Also, the health providers highlighted the main challenges they confront in terms of interruption of a pregnancy:

1. Security (if they provide safe abortion, the family of the victim may threaten them)
2. Training and qualification gap amongst health providers
3. Service shortage or unavailability (distance)
4. Culture and religious perceptions and beliefs
5. Consent and official permission signed by the husband and some other family members is required.
6. Workload and small number of health care providers
7. Family barrier which prevent their victim from getting the required care

Members of the community face different challenges in the process of supporting rape survivors who are seeking safe abortion services. These are named as:

1. **Health services:** "service is limited, shortage and lack of specialized areas for this care"; distance of health care facility; and "health worker always not ready to support the victim".
2. **Culture and society:** family attitudes, traditional beliefs, community norms and security situation
3. **Legal framework:** barriers to "access legal protections also are not in place"

Rape survivors themselves mentioned two clearly spelled out barriers: one is religion and the other the lack of abortion services. The former speaks about the Islamic law being opposed to an abortion and in consequence, the girls need to accept the pregnancy (in fact, they use the word "tolerate" the children). Regarding the lack of services, it is simple as that, they do not exist, nor there were doctors available to perform the abortion, and neither could they have access to "pills" to terminate the pregnancy.

A third group of barriers mentioned by the interviewees were the "social blaming" or the possibility of the stigma to be attached to them. The girls and their relatives expressed a sense of resignation and acceptance in front of the bearing of children product of a rape. Only two of them recommended dissemination of information about access to abortion services and community awareness campaigns about sexual violence and abortion.

5. CONCLUSIONS AND RECOMMENDATIONS

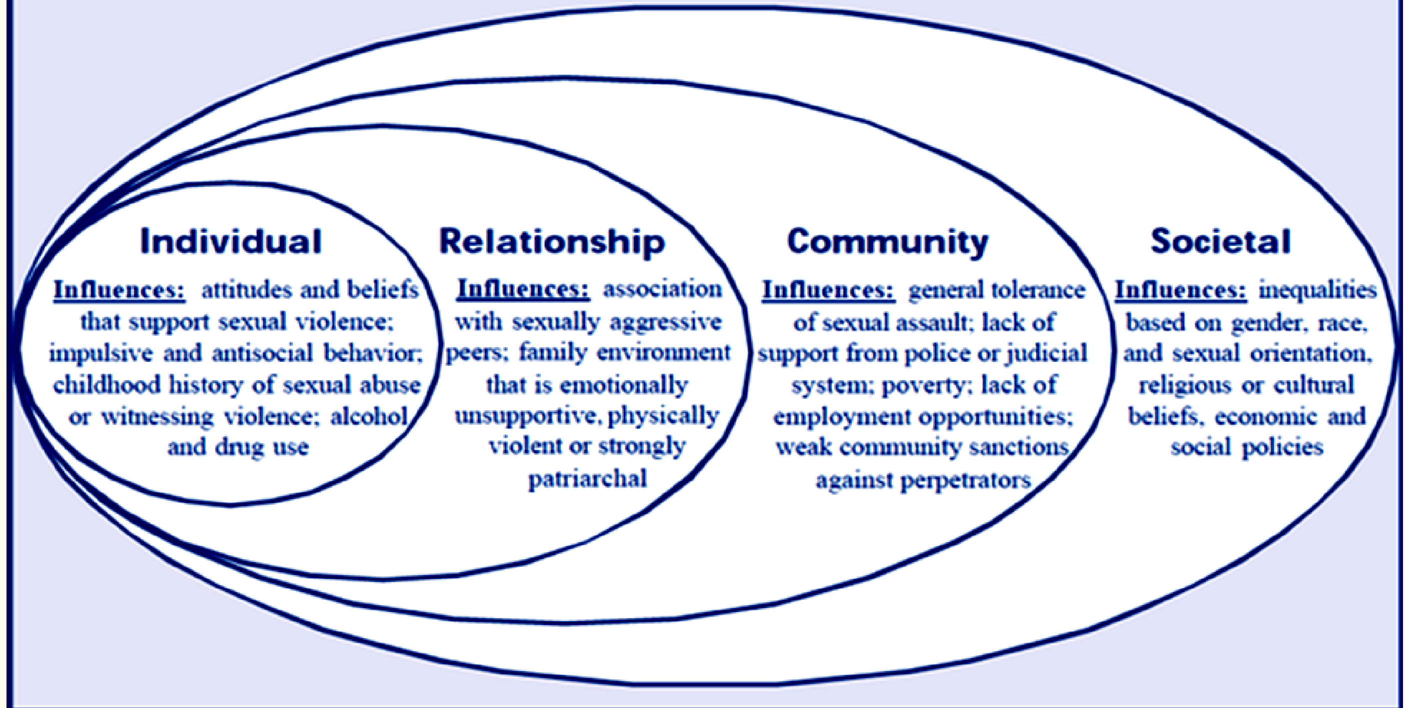
5.1. General conclusions

The factors behind a sexual violence are complex due to the multiple forms it takes and contexts in which it occurs. The ecological model,[64] which proposes that violence is a result of factors operating at four levels: individual, relationship, community and societal, is helpful in understanding the interaction between factors and across levels and could thus be adopted to better understand the experiences of rape and abortion retold by the interviewees.[65] The analytical emphasis of the interviews was put on the community and societal factors to shed light on the social, religious, and legal barriers surrounding access to abortion by rape survivors.

Community and societal factors were named as key for identifying ways to prevent rape and sexual violence before it happens. From the respondents' interviews, it can be concluded that the Somali society and culture support and perpetuate beliefs that disregard violence. They cited multiple conversations where victims have expressed fear of victimization, neglect, and risks of exclusion as the main reasons why they chose not to disclose their ordeals and thereafter seek medical services. Survivors of rape, in general, convey feelings of rejection and victimization from the people closest to them (family, friends and the community).

Traditional gender and social norms related to male superiority and patriarchy in the Somali society, such as that of women and girls are responsible for keeping men's sexual urges at bay or that rape is a sign of masculinity, have only enhanced the vulnerability of women and girls.[66] In addition, weak or sometimes non-existent community and legal sanctions against rape have further worsened the situation heightening the levels of stigmatization among survivors who have nowhere to turn to but their families and communities. Social exclusion, expulsion from the family, abandonment and deepening poverty have been cited as likely consequences facing victims and survivors of rape leaving them with limited life choices.

Despite recent calls from both women's rights groups and humanitarian agencies to legalise abortion in Somalia over the past decade, abortion is still only permitted in special circumstances where the safety of the mother's life is at extreme risk. Not even in the cases of rape or incest is it allowed. "Our provisional constitution prohibits abortion because it is contrary to Shariah law. The only special circumstance accepted in cases of necessity is to save the life of the mother" (interview with Ministry Official). He adds that, "due to ongoing calls to provide more room for sexual violence survivors to heal from trauma, Somali leaders are debating a new constitution amendment that will increase allowance for abortion than only saving the life of the mother but allow safe abortion under certain conditions as was the case with the banning of the circumcision of girls." Should this amendment be done, it will not only provide a degree of sense of relief for survivors and their families who wish not to carry unwanted pregnancies especially arising from sexual violence but it will also reduce deaths and disabilities that arise from unsafe abortion practices that survivors resort to due to the existing policies towards abortion.



Source: *Centers for Disease Control and Prevention (CDC)*

Principally, Islam protects the right to life of the unborn child in the womb. No abortion is permissible except in circumstances where it is done to save the life of the woman when complications of the pregnancy become severe. Religious positions and interpretations on abortion are notably variable, and many religious scholars permit abortion circumstances during specific stages of gestational development. In Somalia, the sharia law allows for abortion within 72 hours for unwanted pregnancies arising from rape and defilement. On paper, Islam prohibits the killing of a human being except in specific circumstances. However, with no clear mention of abortion, this has left the door open for misinterpretations further creating conflict and confusion with the country judicial system around non-conformity and inconsistency between the two jurisprudences. Local religious leaders expected to offer guidance have notably been influenced, when called upon to intervene or offer guidance on rape and abortion matters, by the societal expectations norms that barred survivors of rape from accessing safe abortion services or openly concealing their ordeal to the public.

5.2. Recommendations suggested by the interviewees

The health service providers interviewed suggested a list of actions that could be taken forward by government stakeholders, as follows:

1. Develop laws and policies for the protection of rape survivors
2. Provide resources for support centres for rape survivors
3. Train and capacity building for health care providers for counselling rape survivors
4. Implement programmes for increasing community awareness
5. Provide financial support to the victims
6. Finance essential and modern health services and systems
7. Implementation of Puntland anti-rape act to protect rape survivors and focus on providing emergency contraception for rape victims.
8. Develop guidelines for identifying pregnancy prevention as an essential element of sexual assault management and all include provisions on emergency contraception for eligible survivors.
9. Engage enlightened religious leaders in the fight against sexual violence against women and propagate Islamic view on apportion, especially those views that favours for aborting any pregnancy caused by rape in its first stages to avert further victimization.

The community members also proposed a series of actions for rape survivors seeking safe abortion services as follows:

1. Government´s actions: provide safe health services and facilities for interruption of a pregnancy due to a rape; pass laws that protect women survivors for rape; strengthen the system to provide health, psychological and legal care and services for women rape survivors.
2. Community actions: advocate for the right of rape survivors to have access to services they need, to contribute money for victim support, support community awareness, advocate to reinforce policies and regulations; ensure that the people do not discriminate rape survivors and their upcoming baby if any.

The evidence on rape and unsafe abortion provided by the interviewees cannot be ignored. The long term psychosocial, health and economic impact of sexual violence on girls and women is one that is immeasurable and require immediate action to protect them. This can be achieved by providing comprehensive abortion care, including counselling and contraceptive services, as allowed under the Constitution and the newly ratified Sexual Offences Bill.

5.3. General Recommendations

Changing social and gender norms: There is a need to support the works of local feminist groups and gender rights and justice advocates so that they can change attitudes and minds to stop the perpetuation of a culture of silence around the issue of abortion. Also the strengthening of education and exposure to new ideas and social mobilization to demand for relaxation of socioeconomic, religious and legal limitations surrounding abortion especially in cases of unwanted pregnancies arising from rape and defilement.

Pass legislation to allow survivors access to abortion services: We must eliminate those barriers that prevent women surviving sexual violence from receiving safe abortion. In an effort to save the lives of girls, and promote justice for survivors, we strongly recommend Puntland's government to pass a law supporting the rights of women and girls to safely access abortion following pregnancy that is a result of rape.

Provision of comprehensive services for rape survivors: Globally, there is a general movement towards a public health approach, away from the traditional criminal justice system approach, to addressing sexual violence and abortion. Recognizing violence against women and girls as a public health issue implies addressing its consequences with cross-cooperation from diverse sectors, including health, education, welfare, and the criminal justice system. Within this approach, it is critical to ensure that women and girls who experience rape have access to appropriate post rape and safe abortion services and support.[68] That said, provision of a comprehensive response to the needs of survivors is paramount and key to reducing the high mortality and morbidity rates associated with rape health consequences.[69]

Access to health services for victims of rape comprises medical support for injuries, sexually transmitted infections, pregnancy and other adverse health outcomes associated with rape.[70]

Applying a harm reduction approach: To discourage the incidences of sexual violence survivors who meet hardships in accessing safe abortion services due to the social, economic and legal barriers discovered in this study, traditional healers and midwives should be supported and mainstreamed to ensure that their procedures are safe and readily available especially to rural and poor rape survivors.

Training of qualified police, medical, legal staff: In addition, it is necessary to work towards sensitizing and training the local and law enforcement authorities, including police and judges, about rape – recognising that this means setting up essential structures and infrastructure and requires the goodwill from multi agencies towards improving the application of existing laws. International support is urgently needed for the range of multi-disciplinary service providers, justice actors and institutions necessary for the effective implementation of the newly ratified laws.

Data collection and dissemination: Data on prevalence and patterns, which have been lacking in Somalia, is an important tool to engage various government agencies, policymakers and international partners in addressing this issue through budgetary allocation and prioritization to support the efforts towards fighting sexual violence, rape and supporting women's right to an abortion.

Training of qualified police, medical, legal staff and popularizing among health and social services providers and the police, including integration into medical and legal training curricula, and among the general public, to heighten awareness of the rights of rape survivors to such services.

REFERENCES

1. https://www.reuters.com/article/us-somalia-women-crime/anger-as-somali-rapist-and-murderer-pays-75-camels-to-escape-death-idUSKCN20L2I2
2. Jansen, H. (2016). Violence Against Women Key Terminology - kNOwVAWdata. Bangkok: UNFPA Asia and the Pacific Regional Office.
3. https://en.oxforddictionaries.com/definition/abortion
4. https://en.wikipedia.org/wiki/Harm_reduction#:~:text=Harm%20reduction%2C%20or%20harm%20minimization,behaviors%2C%20both%20legal%20and%20illegal.
5. Krug, E.G. et al., eds. (2002). World report on violence and health. Geneva, World Health Organization
6. Krug, E.G. et al., eds. (2002). World report on violence and health. Geneva, World Health Organization
7. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/Somalia%20CMR%20Guidance%20Note%20for%20Service%20Providers.pdf
8. World Health Organization. (2012). Safe abortion: technical and policy guidance for health systems. Second edition. Geneva
9. Krug, E.G. et al., eds. (2002). World report on violence and health. Geneva, World Health Organization
10. https://www.who.int/health-topics/violence-against-women#tab=tab_1
11. UNSOM (United Nations Somalia). February 2020. “Somalia, UN seek humanitarian aid to avert food insecurity.” Available at: https://reliefweb.int/report/somalia/somalia-un-seek-humanitarian-aid-avert-food-insecurity
12. UN High Commission for Refugees (UNCHR). 2020. CCCM Cluster Somalia. Available at: https://data2.unhcr.org/en/situations/cccm_somalia
13. UNDP. 2015. “Gender in Somalia.” Available at: https://www.undp.org/content/dam/rbas/doc/Women's%20Empowerment/Gender_Somalia.pdf
14. UNDP. 2018. "Women leaders in Puntland are trained in political advocacy and campaigning."Accessed: www.so.undp.org
15. Puntland State Ministry of Education, 2017. https://www.globalpartnership.org/sites/default/files/puntla1.pdf
16. UNDP (UN Development Programme), 2012. http://www.undp.org/
17. EARF Policy Brief: Somali Women’s Political Participation And Leadership: Evidence And Opportunities. June 2017. East Africa Research Fund. Accessed: https://iknowpolitics.org/sites/default/files/somali_women_s_political_participation_and_leadership_evidence_29_sept.pdf
18. Mohamed, M. A. Factors Influencing Women Participation In Politics At Federal, State And Local Elections In Puntland State Of Somalia.
19. Human Rights Watch. 2014. “Here, Rape is Normal” A Five-Point Plan to Curtail Sexual Violence in Somalia.” Available at: https://www.peacewomen.org/content/report-somalia-women-shouldnt-live-fear-rape
20. Family Planning 2020, 2018. “Somalia.” http://www.familyplanning2020.org/entities/134
21. UNFPA (UN Family Planning Association), 2017. “August Newsletter.” Accessed: http://somalia.unfpa.org
22. Ibid, UNFPA 2017.
23. Save the Children. 2015. State of the World’s Mothers. Accessed: https://www.savethechildren.org
24. Haken, Nate. 2019. “Understanding Resilience: The Case of Somalia.” Fragile States Index. Available at: https://fragilestatesindex.org/2019/04/06/understanding-resilience-the-case-of-somalia/
25. Johns Hopkins Coronavirus Resource Center. December 30, 2020. Accessed December 30 at 11:22 PM. Available at https://coronavirus.jhu.edu/map.html
26. Ravelo, Jenny Lai. 2020. “With no labs for testing, Somalia braces for COVID-19.” Devex. Available at: https://www.devex.com/news/with-no-labs-for-testing-somalia-braces-for-covid-19-96882
27. Peterman, Potts, O’Donnell, Thompson, Shah, Oertelt-Prigione, and van Gelder, 2020. “Pandemics and Violence Against Women and Children.” CGD Working Paper 528. Washington, DC: Center for Global Development. https://www.cgdev.org/publication/ pandemics-and-violence-against-women-and-children

REFERENCES

28. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html
29. OECD Gender Index 2019 https://www.genderindex.org/wp-content/uploads/files/datasheets/2019/SO.pdf Accessed on 19-04-2020
30. SIDRA, 2019. Rape: A rising crisis and reality for the women in Somalia. Accessed on https://media.africaportal.org/documents/Sidra_Abuse.pdf
31. Gure, F., Dahir, M. K., Yusuf, M., & Foster, A. M. (2016). Emergency contraception in post-conflict Somalia: An assessment of awareness and perceptions of need. Studies in family planning, 47 (1), 69-81.
32. SIDRA, 2019. Rape: A rising crisis and reality for the women in Somalia. file:///C:/Users/teres/Downloads/Sidra_Abuse.pdf Accessed on 19-04-2020
33. OECD Gender Index 2019 https://www.genderindex.org/wp-content/uploads/files/datasheets/2019/SO.pdf Accessed on 19-04-2020
34. https://somalia.unfpa.org/en/news/clinical-management-rape-rolled-out-somalia
35. Bearak J, Popinchalk A, Ganatra B, Moller A-B, Tunçalp Ö, Beavin C, Kwok L, Alkema L. (2019). Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. Lancet Glob Health. 2020 Sep; 8(9):e1152-e1161.
36. Ganatra B, Gerdts C, Rossier C, Johnson Jr B R, Tuncalp Ö, Assifi A, Sedgh G, Singh S, Bankole A, Popinchalk A, Bearak J, Kang Z, Alkema L. (2017). Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. The Lancet. 2017 Sep
37. Angola, Central African Republic, Congo-Brazzaville, Democratic Republic of the Congo, Egypt, Gabon, Guinea-Bissau, Lesotho, Madagascar, Mauritania, Mauritius, São Tomé and Principe, Senegal, and Somalia.
38. https://www.populationconnection.org/article/women-urgently-need-safe-abortion-services-in-africa/ Accessed on 19-04-2020
39. Hord, C. and Merrill, W. (2004). Breaking the Cycle of Unsafe Abortion in Africa, in African Journal of Reproductive Health, Vol. 8, No. 1, April, 2004 pp. 29-36. Available on http://www.bioline.org.br/request?rh04006
40. http://www.emro.who.int/images/stories/somalia/Somaliland_WRA_mortality_surey Final report 1_Dec.pdf?ua=1
41. Please note that official (and unofficial data) is not available on abortion rates in any region of the country. (Abortion is prohibited, given it does not comply with Sharia law as practiced in Somalia, but it is possible in cases of necessity such as to save the life of the mother)
42. United Nations Children's Fund (UNICEF): Somalia – A situation analysis of reproductive health, 2009, https://www.unicef.org/somalia/SOM_resources_finalRHSanalysis.pdf
43. Faduma Gure, Marian Yusuf & Angel M. Foster (2015) Exploring Somali women's reproductive health knowledge and experiences: results from focus group discussions in Mogadishu, Reproductive Health Matters, 23:46, 136-144, DOI: 10.1016/j.rhm.2015.11.018
44. LIFOS (2017) Women in Somalia. Pregnancies and children out of wedlock https://www.ecoi.net/en/file/local/1401860/1226_1497947430_170601300.pdf Accessed on 19-04-2020
45. ICPD Somalia Country Implementation Profile (2012) Accessed at https://www.unfpa.org/sites/default/files/resource-pdf/FINAL_Somalia.pdf
46. E. Gay, M. Lee. Reproductive health and economic well-being in East Africa [Internet]. Feb. 2015; Population Reference Bureau: Washington, DC. (Available from: http://www.prb.org/pdf15/poppov-reprohealth-econ-eastafrica brief.pdf). [Google Scholar]
47. Jalu MT, A. A. (2019). Exploring barriers to reproductive, maternal, child and neonatal (RMNCH) health-seeking behaviors in Somali region, Ethiopia. Plos One, 2019 Mar 15;14(3):e0212227. doi: 10.1371/journal.pone.0212227. eCollection 2019.
48. World Health Organization. (2015). Health worker roles in providing safe abortion care and post-abortion contraception. Geneva, Switzerland. 2015
49. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/Somalia%20CMR%20Guidance%20Note%20for%20Service%20Providers.pdf
50. This will be discussed in further detail later in the report.
51. Cultural Atlas, Somalia Accessed at https://culturalatlas.sbs.com.au/somali-culture/somali-culture-family#somali-culture-family

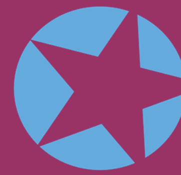
REFERENCES

52. UNHCR, 2016 Culture, context and mental health of Somali refugees Accessed at https://www.unhcr.org/5bbb73b14.pdf
53. Cultural Atlas, Somalia Accessed at https://culturalatlas.sbs.com.au/somali-culture/somali-culture-family#somali-culture-family Accessed on 19-04-2020
54. Suleiman, Omar. (2017). Islam and the Abortion Debate. Yaqeen Institute, 2017
55. See: al-Burhân al-Kâshif (p. 275) by Ibn az-Zamlakâni.
56. See: Tafseer Ibn Katheer; Surat al-Mu'minoon (23); Ayah 14.
57. Suleiman, Omar. (2017). Islam and the Abortion Debate. Yaqeen Institute, 2017- Omar Suleiman (2017. Islam and apportion debate. https://yaqeeninstitute.org/omar-suleiman/islam-and-the-abortion-debate/.
58. Union, A. (2003). Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa
59. Article 15 (5) of the Somali provisional Constitution in 2012 states that abortion is contrary to Sharia law and is prohibited "except in cases of necessity, especially to save the life of the mother". Similarly, Somali's Penal Code (1962), based on colonial-era Italian laws, and criminalizes abortion, except to save the life of the woman (Article 418-422).
60. http://www.legalactionworldwide.org/somalia-2/sexual-offences-bill/ Accessed on 19-04-2020
61. Medical certificates are written documents from a physician who affirms to the medical examination result of a certain patient.
62. Mulvey, A. (2018). By balancing Sharia law and the new Sexual Offences Bill, Somalia is legislating for the 21st century. Accessed at https://blogs.lse.ac.uk/wps/2018/06/14/by-balancing-sharia-law-and-the-new-sexual-offences-bill-somalia-is-legislating-for-the-21st-century/
63. For more details, please see Annex 1 with extracts from the interviews with rape survivors and their relatives.
64. Socio-ecological model by the CDC (US) Accessed at http://wiki.preventconnect.org/socio-ecological-model/
65. Fulu, E., & Miedema, S. (2015). Violence against women: globalizing the integrated ecological model. Violence against women, 21(12), 1431-1455
66. GARDNER, JUDITH and el-Bush, JUDY. (2017). Somalia: A state of male power, insecurity and inequality Findings from the inception study on the impact of war on Somali men. RIFT VALLEY INSTITUTE
67. SIDA, 2015 Preventing and Responding to Gender-Based Violence: Expressions and Strategies Accessed at https://www.sida.se/contentassets/3a820dbd152f4fca98bacde8a8101e15/preventing-and-responding-to-gender-based-violence.pdf
68. UNFPA, 2015 Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies Accessed at https://www.unfpa.org/sites/default/files/pub-pdf/GBVIE.Minimum.Standards.Publication.FINAL_.ENG_.pdf
69. European Parliament, 2013 Overview of the worldwide best practices for rape prevention and for assisting women victims of rape Accessed at https://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/493025/IPOL-FEMM_ET%282013%29493025_EN.pdf
70. World Health Organization, & World Health Organization. Reproductive Health. (2015). Health Worker Role in Providing Safe Abortion Care and Post Abortion Contraception. World Health Organization

ANNEX A: The Somali Sexual Offences Bill

Sexual Offences defined as	• Rape • Gang rape • Sexual violence by penetration • Sexual violence • Causing a person to engage in a sexual activity • Sexual slavery • Sex tourism • Sex trafficking • Forced marriage • Sexual harassment • Administering an intoxicating substance with intent to commit a sexual offence • Abduction for sexual purpose • Unlawful detention for sexual purpose • Unlawful recording, sharing or distributing sexual photographs or recordings • Offences committed against children, including the above offences and some offences specifically relating only to children, such as: – Causing or inciting a child to engage in a sexual activity – Child marriage – Meeting or grooming a child for sexual purposes – Production, sale, distribution and possession of child pornography
Support to survivors	Survivors have the following protections and support mechanisms: • Any delay in filing a complaint by the survivor will not be used against them • Any medical facility can issue a medical certificate[61] that may be used in court • No need of a police referral to get a medical certificate • Protection of the survivor(s)' identity • The court may grant a protection order to protect the survivor, family members, witnesses, medical practitioners, lawyers or humanitarian workers related to the case. • The survivor has a right to free medical care, including counselling, and other necessary assistance. Survivors and witnesses have the right to confidentiality and privacy. • Children have all the rights of other survivors, as well as additional rights, including to special care and attention. • Persons with a disability have all the rights of other survivors, as well as additional rights, including with regard to accommodation, education, medical treatment and care. • Survivors of sex trafficking have a right to lawfully reside in Somalia, or may alternatively request assistance to be safely repatriated to the country of their lawful residence or citizenship. • The survivor may initiate civil proceedings to damages suffered by him or her as a result of a sexual offence.

Sexual Offences defined as	• The bill does not provide any reference to sexual and reproductive health services including safe abortion
Roles & responsibilities for police and prosecutors	• The Police shall preserve the identity of the survivor and or witness at all times especially from the community in which the crime occurred and from the accuser and if they disclose it they commit an offence • Police and prosecutor have the responsibility to protect the survivor, family members, witnesses, medical practitioners, lawyers, or humanitarian workers related to the case • Police will not arrest, or prosecutors try or sue a complainant for reporting a sexual offence unless they knew the complaint was false • Police and prosecutors should start investigations after receiving a report even without a medical certificate. It may be adduced as evidence but is not necessary to opening an investigation, prosecuting a case or convicting an offender • Prosecution shall not be barred due to failure in producing forensic evidence as long as the survivors' testimony is deemed factual and can be substantiated • The police and prosecution shall protect the constitutional and human rights of the accused. If the accused cannot afford a defense lawyer, he or she should be provided with free and impartial legal aid.



About SIDRA
SIDRA is a registered independent Research and Policy Analysis Think Tank based in Garowe, Puntland, Somalia.

Our Vision
A Somalia in which social justice prevails and inclusive economic growth benefits all and improves the well being of all people.

Our Mission
A center of development and research that generates relevant and original knowledge for dynamic policy environment support, institutional capacity development and alliance.

Contacts

www.sidrainstitute.org

info@sidrainstitute.org

SIDRAInstitute

The Somali Institute for Development Research and Analysis SIDRA

SIDRAInstitute

Contacts

www.somaligenderjustice.org

sgj@somaligenderjustice.org

SomaliGenderJustice

somali-gender-justice

+252 907 754 912 (Som)
+1-330-357-2841 (US)

About SGJ
SGJ works to achieve gender equality and social transformation by partnering with government and NGOs to ask the hard questions, to support the marginalized and to advance gender equality through unlikely partners, all by using evidence-backed approaches and state-of-the-art program design.

Our Vision
A country and system where women enjoy the same liberties and opportunities as men. Our vision for our organization is to transform harmful attitudes and behaviors that belie gender equality, and be recognized as a thought leaders in advancing this vision.

Our Mission
Somali Gender Justice links with the latest in research and programming, maintains strong connections among the gender justice community, works through a core set of hard-won principles, and constantly looking for opportunities to start crucial conversations necessary to achieve social change and promote gender equality.

ADDRESS
Office: Garowe, Puntland State of Somalia
Telephone: +252 5 846 044
Website: www.sidrainstitute.org
Email: info@sidrainstitute.org
Facebook: SIDRA Institute
Linkdin: The Somali Institute for Development Research and Analysis SIDRA
Twitter: SIDRA Institute

“This research was provided through the generous and collaborative funding of the Safe Action Abortion Fund.”