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Structural Violence among Internally Displaced Persons (IDPS) Within Idp Settlements in Mogadishu Somalia

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ABSTRACT

Background: Gender based violence (GBV) remains a public health concern. Internally displaced persons (IDPs) and refugees have been shown to be at the highest risk of gender based violence. Somalia has been without a stable government for 26 years resulting in weak community and formal protection structures hence disproportionately increasing the vulnerability of females to gender based violence. Continued displacement of community members in South Central Somalia due to war, inters clan conflicts and the ongoing drought has resulted in more IDPs living in settlements along major urban areas. These IDPs continue to face violations such as forced evictions, discrimination and gender based violence.

Objective: This study was aimed at investigating the past and present forms of structural violence faced by IDPs in Mogadishu as well as their knowledge and perceptions regarding the same.

Methods: A descriptive cross sectional design was used in this study, in the month of May 2017. The study population for this survey was 320 IDPs in 10 IDP settlements in KM-11 and KM-13 regions of Mogadishu, South Central Somalia.

Results: The study established a 91.7% prevalence rate of female genital mutilation among the female respondents. World Health Organization (W.H.O.) type III was the most common form of FGM that female respondents in the two IDP settlements (38.9%) had faced, followed by W.HO. type 4 (23.1%) and W.H.O. type I and II (15.9%). The mean age at which FGM was carried out among this group was 7 years while forced and early marriages (mean of 16 years) are common among this population group. Sexual assault and rape were singled out as the most common forms of violence faced by females in the two IDP settlements with the risk factors for this violence being described as displacement, overcrowding in IDP settlements, poor lighting in the IDP settlements at night, unaccompanied females in the IDP settlements and female headed households. Respondents expressed their overwhelming preference for community protection structures in averting GBV and customary law in arbitrating gender based violence cases. There was low awareness on services available for GBV survivors and so was the knowledge on the urgency to seek medical services within the 72 hours window period following rape.

Conclusion: The study has established that structural violence is common among IDPs living in Mogadishu and it is constraining them from achieving the quality of life that would have otherwise been possible if they were not displaced. There is need to strengthen both community and formal protection units as well as raise awareness regarding the effects of the various forms of violence facing female IDPs, create awareness regarding services available for GBV survivors and ensure that these services are available and accessible to the IDPs.

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Keywords: Gender Based Violence, Female Genital Mutilation, Early Marriages, Forced Marriages, Rape and Customary Law.

Background

It is increasingly being recognized that gender based violence (GBV) is a public health problem with serious physical, mental and social well-being consequences [1]. The United Nations General Assembly's Declaration on the Elimination of Violence Against Women (1993) defines GBV as any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life W.H.O [2, 3]. Estimates that about 35% of females experience some form of physical and/or sexual violence at some point in their lives [4]. IDPs and refugees have been shown to be at the highest risk of gender based violence due to factors such as extreme poverty, minority status, lack of access to food, fuel and water, and disrupted family and community support structures [5, 6].

Somalia, a former British protectorate and an Italian colony collapsed into anarchy following the overthrow of President Muhammad Siad Barre's military regime in 1991 [7]. To date there are efforts to bring order and stability in the country through democratic processes but this is far from being actualized. The civil war fragmented the country into three zones: the South Central region, Somaliland, and Puntland. Puntland and Somaliland are relatively stable while the South Central region of Somalia is the epicenter of anarchy [7].

In addition, Somalia is currently facing a third famine in 25 years just 6 years after the 2011 drought crisis that killed about 260,000 people. Programming data from various organizations show that the current drought in Somalia has a negative impact on families, with women and girls bearing a heavier brunt because of prevailing negative gender roles and practices [8]. The over two decades of conflict, violence, human rights violations and natural disasters such as the current drought have triggered repeated waves of displacement and weakening of community and formal protection structures hence disproportionately increasing the vulnerability of women and children to gender based violence [9].

The Gender Inequality Index for Somalia is 0.776 denoting complete inequality and placing the country at the fourth highest position globally; hence the participation and role of women in politics and decision-making spheres is extremely limited [10, 11]. Family's wealth is traditionally the property of men in Somalia and across the country, customary law is preferred to state judiciary and this means that gender based violence offenders often go unpunished [12, 13]. Most importantly, response to GBV cases is hampered by low awareness regarding human rights issues, weak capacities among law enforcement agencies, a weak rule of law, traditional practices such as female genital mutilation (FGM) and fear of reprisals linked to clan protection dynamics [11].

Over 1.1 million internally displaced people in Somalia continue to face violations such as forced evictions, discrimination and GBV [14]. The 2016 GBV annual report by the Somalia Gender Based Violence Sub-Cluster indicates that 9 out of every 10 GBV survivors were females with 76% being IDPs [12]. In light of these contextual gaps, this study aimed to investigate the past and present forms of structural violence among IDPs in Mogadishu as well as their knowledge and perceptions regarding the same.

Methods

Study Design: A descriptive cross sectional design was used in this study, in the month of May 2017.

Study Setting: The study was conducted in 10 IDP settlements in KM-11 and KM-13 regions of Mogadishu in Benadir region of South Central Somalia.

Study Population: The study population for this survey was IDPs in KM-11 and KM-13 regions. The respondent's included male and female youths of ages 15 to 25 years as well as male and female adults aged over 26 years all of whom had been living in the IDP settlements for less than one year.

Sample Size and Sampling Approach: With no accurate figures on the number of IDPs in the region due to the ongoing displacement resulting from drought, 320 respondents were sampled in 10 IDP settlements. These were 80 female youths, 80 male youths, 80 male adults and 80 female adults. Systemic random sampling was used to identify 32 respondents in each IDP settlement namely; 8 male youths, 8 female youths, 8 adult females and 8 adult males.

Data Management and Statistical Analysis: The instrument used for data collection in this study was a closed ended quantitative questionnaire that was translated from English to Somali language. Six research assistants (3 males and 3 females) were recruited and trained, performed the data collection. A questionnaire pretesting exercise and a sampling pilot testing exercise were carried out in KM-7 area of Mogadishu. SPSS (IBM version 23) was used for the data analysis, and the results were stratified by age groups and gender of the respondents.

Ethical Considerations: Following 26 years of conflict in South Central Somalia, most institutions have been run down; as such there were no ethical review committees in Mogadishu. Administrative permission to conduct the study was obtained from the camp leaders and camp gate keepers while written consent to participate in the study was sought from the respondents.

Results

Social Demographic Background of the Respondents

Respondents were 160 males and 160 females of ages 15 to 96 years with a mean age of 31.9 years (standard deviation= 16.58). The households included in the study had a minimum of two members, a maximum of 40 members with a mean of 7 household members (standard deviation=3). The duration of stay in the IDP camps by the respondents was 0.5 to 12 months (mean=3.47, standard deviation=2.2). Of these respondents, 97.8% of these IDPs were originally from South Central region of Somalia while 2.2% were from the other regions of Somalia. Education levels were low among the respondents with 58.8% of the respondents having never attended school in their life time (Figure 1).

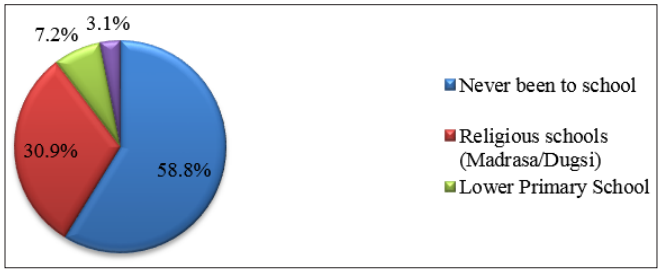

Figure 1: Education Levels

Female Genital Mutilation

A 91.7% prevalence of female genital mutilation was reported by the female respondents with 72.4% of the FGM survivors reporting that girls are usually circumcised in groups. The female respondents further reported that they underwent circumcision between the ages of 4 years and 16 years (mean=7 years, standard deviation=2.6). Upon further enquiry, 53.5% of female respondents who had undergone FGM reported that it was carried out by traditional birth attendants (TBAs), 42.1% reported that it was carried out by elderly women in the community while 4.4% reported that it was carried out by close family relatives. The predominant form of FGM that 38.9% female respondents were subjected to was *Firconi* (W.H.O. type 3) followed by *Sunna Saqira* (W.HO. type 4) and *Sunna Kabira* (W.H.O. type I and II) as illustrated in Figure 2.

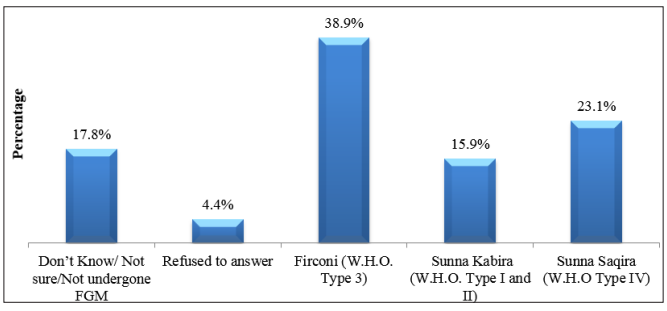

Figure 2: Forms of FGM Practiced

The major reason given for carrying out FGM was religious obligations (85.3%) followed by preservation of virginity (14.7%). A higher proportion of males (25%) than females (4.4%) were of the opinion that FGM is carried out to preserve virginity. Other reasons given for practicing FGM were sexual pleasure, promotion of faithfulness in marriage by reducing the sexual urge among females and a and a mandatory rite of passage before marriage (Figure 3). Knowledge on the effects of FGM was low with bleeding (67.2%), pain (82.5%) and infections (45.9%) being the most commonly perceived effects of FGM (Table 1).

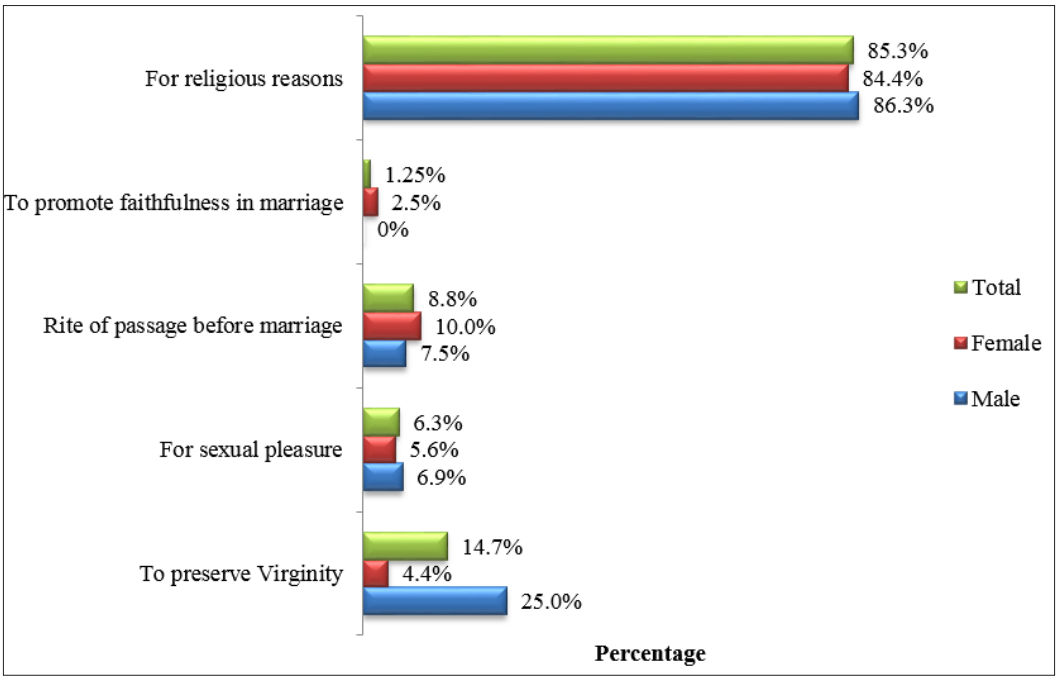

Figure 3: Reasons for Carrying out FGM

Table 1: Effects of FGM

	Male	Female	Total
Bleeding	60.0% (96)	74.4%(119)	67.2%(215)
Pain	78.1%(125)	86.9%(139)	82.5%(264)
Difficulties in giving birth	20.0 %(32)	23.85 (38)	21.9% (70)
Infections	32.5%(52)	59.4%(95)	45.9%(147)
Formation of cysts and abscesses	0.0%(0)	4.4%(7)	2.2%(7)
Menstrual and urinary disorders	28.8%(46)	10.0%(16)	19.4%(62)
Fistula	8.8% (14)	1.3%(2)	5.0%(16)
Infertility/Inability to get children	5.6%(9)	0.0%(0)	2.8%(9)
Scar formation	1.3%(2)	0.6%(1)	0.9%(3)

Table 2: Forced and Early Marriage

2a. Decision on marriage age for girls	**Male**	**Female**	**Total**
The girl herself	6.9%(11)	23.8%(38)	15.3%(49)
Father	52.5%(84)	16.9%(27)	34.7%(111)
Mother	0.6%(1)	2.5%(4)	1.6%(5)
Both mother and father	38.8%(62)	53.8%(86)	42.3%(148)
Other relatives	2.5%(4)	2.5%(4)	2.5%(8)
Don't know	3.6%(6)	3.6%(6)	3.6%(6)
2b. Selection of marriage partners for girls	**Male**	**Female**	**Total**
The girl herself	85.6%(137)	59.4%(95)	64.4%(232)
Father	18.1%(29)	6.3%(10)	12.2%(39)
Mother	2.5%(4)	2.5%(4)	2.5%(8)
Both mother and father	3.6%(6)	28.1%(45)	16.0%(51)
Other relatives	2.5%(4)	2.5%(4)	2.5%(8)
Don't know	1.3% (2)	1.3%(2)	2.5%(4)

Early and Forced Marriages

The mean age of marriage reported among females was 16 years (standard deviation of 3.7) while the mean marriage among males was reported as 20 years (standard deviation= 3.1). Decisions on ages at which to marry off girls are largely made by both parents (42.3%) or unilaterally by fathers (34.7%) as illustrated in Table 2a. In addition, only 59.4% of the female respondents reported that marriage partners were chosen by the girls themselves, while 18.1% of the males reported that marriage partners were identified by fathers to the girls. A further 28.1% of females reported that both parents were involved in selection marriage partners for their daughters (Table 2b).

Violence against Women

When asked to identify the most common forms of violence faced by women in the IDP settlements, rape and sexual assault were singled out as the most prevalent types (41.3%) followed by physical assault (20.3%), emotional violence (19.4%) and forced marriage (16.3%) as illustrated in Table 3.

Table 3: Forms of Violence faced by females in the IDP settlements

	Male	Female	Total
Forced marriage	8.8%(14)	23.8%(38)	16.3%(52)
Sexual violence (rape and sexual assault)	36.3%(58)	46.3%(74)	41.3%(132)
Emotional abuse	23.1%(37)	15.6%(25)	19.4%(62)
Economic violence	11.3%(18)	1.9%(3)	6.5%(21)
Female genital cutting	1.3%(2)	3.8%(6)	2.5%(8)
Physical assault	24.4%(39)	16.3%(26)	20.3%(65)
Don't know	46.9%(75)	38.1%(61)	42.5%(136)

Several factors were identified as predisposing females to sexual violence and rape namely: displacement (32.5%), a high population density in the IDP settlements (34.7%), unaccompanied females in the IDP settlements (20.6%), lack of lighting in the IDP settlements at night (27.2%) and females headed households (18.1%) as illustrated in Table 4.

Table 4: Factors Predisposing Females to Sexual Violence

	Male	Female	Total
Displacement	31.3%(50)	33.8%(54)	32.5%(104)
Overcrowded camps	29.4%(47)	40.0%(64)	34.7%(111)
Use of *Khat* and other drugs	3.1%(5)	14.4%(23)	8.8%(28)
Poverty	19.4%(31)	0.0%(0)	9.7%(31)
Unaccompanied females	13.8%(22)	21.3%(34)	20.6%(66)
Lack of light	26.9%(43)	27.5%(44)	27.2%(87)
Drought	17.5%(28)	6.9%(11)	12.2%(39)
Lack of clan protection	19.4%(31)	5.6%(9)	12.5%(40)
Female headed households	22.5%(36)	13.8%(22)	18.1%(58)
Unsafe water and firewood collection points	18.1%(29)	5.6%(9)	11.9%(38)

Awareness regarding services available for violence survivors was low with 75.6% of the respondents completely unaware of even a single service (Table 5).

Table 5: Services Available to Violence Survivors in the Idp Settlements

	Male	Female	Total
Do not know any service available	75.6%(121)	75.6%(121)	75.6%(242)
Medical/ health care	5.6%(9)	5.6%(8)	5.6%(18)
Psychosocial support/ counseling	14.4%(23)	23.8%(38)	19.1%(61)
Material support	0.0%(0)	3.1%(5)	1.4%(5)
Legal information / assistance	6.3%(10)	0.0%(0)	3.1%(10)
Police	0.0%(0)	0.0%(0)	0.0%(0)
Livelihoods assistance	1.9%(3)	6.3%(10)	4.1%(13)
Safe shelter	0.0%(0)	0.0%(0)	0.0%(0)

Of those interviewed, 54.4% expressed their willingness to report rape cases occurring in their families. However, only 7.5% of those willing to report rape cases would do so to the police/military, with most respondents expressing their willingness to report such cases to community and religious leaders (Table 6).

Table 6: Reporting of Rape Cases

	Male	Female	Total
Religious leader/imam	13.8%(22)	8.8%(14)	11.3%(36)
Clan elder	35.0%(42)	9.4%(15)	15.8%(57)
Village leader	48.8%(78)	12.5%(20)	30.6%(98)
Camp leader/ Gatekeeper	40.6%(65)	32.5%(52)	36.6%(117)
Women's group	16.9%(27)	3.1%(5)	10%(32)
Social worker/ case worker	2.5%(4)	2.5%(4)	2.5%(8)
Health care worker	2.5%(4)	2.5%(4)	2.5%(8)
Police/Military	7.5%(12)	7.5%(12)	7.5%(12)

Knowledge on the correct timing in seeking medical services after rape was low with only 6.5% of the respondents reporting that health services should be sought within 72 hours after rape (Figure 4).

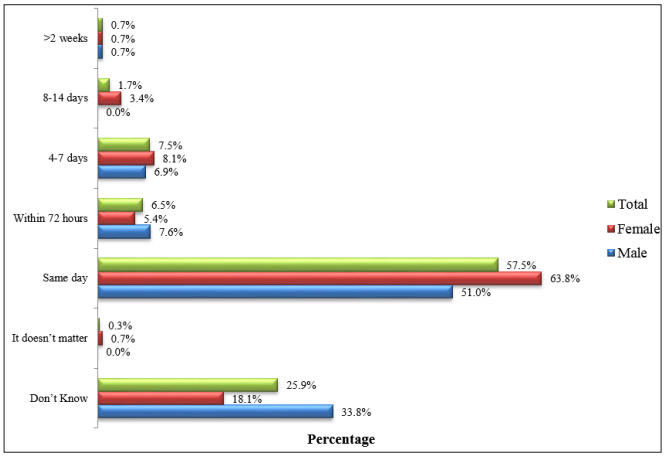

Figure 4: Seeking Medical Services after Rape

When asked to name all the reasons why medical treatment after rape is necessary, 36.2% of the respondents could not identify a single reason. Reasons given for seeking medical services after rape were treatment of physical injuries (35.6%), prevention of sexually transmitted infections (18.4%), prevention of pregnancy (46.3%) and post exposure prophylaxis against Human immunodeficiency virus (HIV)-37.5% as indicated in Figure 5.

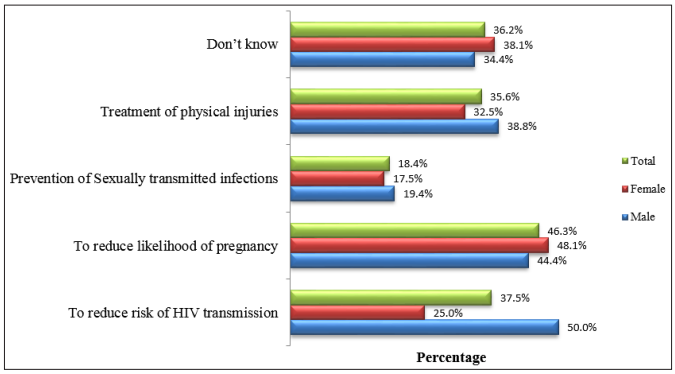

Figure 5: Reasons for Seeking Medical Treatment after Rape

The preferred justice system for physical violence by the respondents was predominantly customary law (90.3%). Customary law was also preferred by two thirds of respondents in cases of rape and forced marriage (Table 7).

Table 7: Preferred Justice System

		Customary law	Formal justice	Don't know/ Not sure
Physical Violence	Male	89.4%(143)	0.0%(0)	10.6% (17)
	Female	91.3%(146)	2.5%(4)	5.2%(10)
	Total	90.3%(289)	1.3%(4)	8.4%(26)
Rape	Male	69.4%(111)	11.9%(19)	18.7%(30)
	Female	62.5%(100)	13.8%(22)	23.7%(34)
	Total	65.9%(211)	12.8%(41)	21.3%(64)
Forced Marriage	Male	73.8%(118)	3.1%(5)	23.1%(37))
	Female	60.6%(97)	10.0%(16)	29.4%(47)
	Total	67.2%(215)	6.6%(21)	26.2%(84)

Discussion

The study established a 91.7% prevalence rate of female genital mutilation which is consistent with estimates of 99% among females aged 15 to 49 years in South Central Somalia [15, 16]. W.H.O. type III was the most common form of FGM among the female respondents in the 2 IDP settlements (38.9%) followed by W.HO. type 4 (23.1%) and W.H.O. type I and II (15.9%). This is in contrast with W.H.O. global estimates that 90% of FGM cases include either types I, II or IV and about 10% are type III but in agreement with the United States Department of State, Bureau of Democracy, Human Rights, and Labor who observe that type III FGM is the most prevalent in Somalia [17, 18]. Similarly, the mean age at which FGM was carried out amongst female respondents was 7 years which is in concurrence with programming data from United Nations Children's Fund (UNICEF) which indicates that FGM in Somalia is primarily performed on girls aged 4 to 11 years [19].

Early and forced marriages in Somalia appear to be largely driven by cultural norms with parents playing a key role in not only deciding the age at which their daughters are married off but also the selection of their marriage partners. It is for this reason that this study established the mean age for marriage among females to be 16 years an observation that is coherent with available literature suggesting that 8% of the females in Somalia are married by the age of 15 while 45% of the females in this country are married by the age of 18 [20].

Sexual violence was singled out as the most common form of violence that females faced in the two IDP settlements which is in contrast with the 2016 GBV annual report by the Somalia Gender Based Violence Sub-Cluster which indicates that the GBV cases reported were physical violence (52.5%), sexual violence (rape at 16.8% and sexual assault at 13.9%), economic violence (6.9%), psychological violence (6.7%) and forced marriage at 3.3% [12]. Displacement, overcrowding in IDP settlements, poor lighting in the IDP settlements at night, unaccompanied females in the IDP settlements and female headed households were cited as the main factors predisposing females to violence.

In addition, both male and female respondents expressed their overwhelming preference for community protection structures and customary law in arbitrating physical violence cases, rape cases and forced marriage cases a finding that is consistent with the United Nations Fund for Population Activities (UNFPA) and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) publications on handling gender based violence cases in Somalia [12, 13].

Despite these alarming figures on violence in the IDP settlements, knowledge on services at the disposal of GBV survivors was very low as depicted by over thee quarter of the respondents who could not single out services for survivors in the IDP settlement; this is an indication of either low awareness or unavailability of these services in these two IDP settlements. Similarly, the urgency to seek medical services within the 72 hours window period following rape was poorly understood by the respondents alluding to preventable consequences of rape due to this knowledge gap.

Limitations

This study was carried out on a displaced population group in two IDP settlement camps with a continuous influx and outflow of IDPs. Their exposure to humanitarian and government interventions was unknown; as such the findings may have been subject to exposure to GBV interventions. Every effort was made to ensure that only IDPs who had lived in the settlements for less than a year were included in the study. Similarly, the actual population size in the two camps was unknown hence compromising the sample size estimation. The study also relied on quantitative data with no qualitative data insights to some of the key observations.

Conclusion

The study has established that structural violence is common among IDPs living in Mogadishu and it is constraining them from achieving the quality of life that would have otherwise been possible if they were not displaced. This study further that Somalia still has one of the highest FGM prevalence rates globally. Awareness regarding services available to GBV survivors as well as their timely utilization is low. There is need to strengthen both community and formal protection units as well as raise awareness regarding the effects of the various forms of violence facing female IDPs, create awareness regarding services available for GBV survivors and ensure that these services are available and accessible to the IDPs.

Declaration

Ethics: Following 26 years of conflict in South Central Somalia, most institutions have been run down; as such there were no ethical review committees in Mogadishu. Administrative permission to conduct the study was obtained from the camp leaders and camp gate keepers while written consent to participate in the study was sought from the respondents.

Competing interests: The authors declare that they have no competing interests.

Consent: Consent for publication has been granted by the two co-authors.

Availability of data and materials: The complete dataset used in this study is in the custody of Dr. Cosmas Mugambi and is available to upon written request.

Funding: Self-funded.

Author contributions: Dr. Cosmas Mugambi, conceived and designed this study under the guidance of Karin Michotte.

Acknowledgements: Not applicable.

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