INTERNATIONAL SOLIDARITY FOUNDATION

Violence Against Women and Girls and Gender Norms Analysis

FINAL REPORT

SUBMITTED TO:

INTERNATIONAL SOLIDARITY FOUNDATION (ISF)

SUBMITTED BY:

DAB DEVELOPMENT AND RESEARCH TRAINING PLC

dab development research and training

www.dabdrt.com

Addis Ababa, Ethiopia

June , 2024

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1. INTRODUCTION

1.1. Brief background and context

Compared with other countries in the Eastern and Southern Africa region, Ethiopia has registered remarkable change in its effort to end FGM/C. Although the country does not rank among the countries with the highest levels of FGM/C, it is home to the largest absolute number of girls and women (25 million) who have undergone the practice in the region. Overall, 65% of Ethiopian girls and women aged 15 to 49 have undergone FGM/C and of the four geographical areas under consideration for ISF operations, FGM/C prevalence for women in this age group is the highest in Somali at 98.5% (where 52% of women and 34% of men support the continuation of the practice; and 57% of women and 42% of men believe FGM is a religious requirement) followed by Afar at 91.2%, Harari at 81.7% and Dire Dawa at 75.3%[1],[2].

In the realm of Gender-Based Violence (GBV), it is highly prevalent, with 35% of ever-married women aged 15-49 experiencing physical, emotional, or sexual violence from their husband or partner, 68% of the women agree that wife-beating can be justified and about 65% of women aged 15-49 having undergone FGM, with the highest rate (99 percent) in the Somali region. It is evident that GBV disproportionately affects girls and young women. They bear the burden of GBV and suffer violations of their fundamental rights, particularly in contexts marked by conflict, insecurity, overcrowding in Internally Displaced Persons (IDP) camps, forced relocations and returns, as well as a lack of livelihood opportunities and community awareness on women's rights. Additionally, the absence of access to services exacerbates their vulnerability, leading to negative coping mechanisms that further expose them to risks such as Sexual Exploitation and Abuse (SEA) and engaging in survival sex (OCHA, 2022)[3].

Women's socio-economic standing plays a significant role in whether or not they undergo FGM. The rate of FGM/C prevalence is lower for women with some level of formal education compared to those with no education at all, women who are engaged in manual or other occupations compared with those who are unemployed, and women who come from the richest households compared to those from poorer families. The long-held traditional beliefs that circumcision is a necessary prerequisite for

[1] Doe-e Berhanu. (2021). Preparations for International Solidarity Foundation's Operations in Ethiopia, Final Geographical Analysis.
[2] ISF 2023 – 2025 Action Plan for operations in Ethiopia, ISF 2022 Report
[3] OCHA (2022). GBV AOR Ethiopia: Situation of GBV in Ethiopia: https://reliefweb.int/report/ethiopia/gbv-aor-ethiopia-situation-gbv-ethiopia-september-2022

marriageability and failure to adopt the Revised Family Code of 2020, which aims to tackle GBV, including child marriage and harmful practices such as FGM. Major resistance to adopting a family law comes from religious and community leaders who see the draft regional family law as divergent from cultural and religious norms and the society's acceptance of religious and customary justice systems over the formal legal system[4].

Gender-based violence response needs are very high in Somali Region and other drought and conflict-affected regions. The drought and conflicts are exacerbating GBV risks for women and girls with anecdotal reports of a rise in sexual violence and early marriages against a backdrop of communities practicing Female Genital Mutilation (FGM) (OCHA, 2022)[5].

Despite the prohibition of FGM/C in Ethiopia since 2005, the practice remains nearly universal in the Somali Regional State, with limited evidence indicating progress in combatting it, especially in pastoralist communities. Strong cultural and religious adherence to FGM/C persists in the region, hindering efforts to eradicate the practice (Nydal, 2020)[6]. Similarly, while marriage before the age of 18 is illegal nationwide, Somali and Afar regions have yet to revise their family codes to outlaw child marriage explicitly.

Restrictive gender norms, harmful gender stereotypes and traditional patriarchal structures, coupled with unequal power dynamics between men and women, contribute to the normalization of violence and the perpetuation of harmful practices such as child marriage, female genital mutilation/cutting (FGM/C), and domestic violence. These gender norms dictate women's roles and behaviors, often restricting their autonomy, mobility, and access to resources and opportunities (UNICEF, 2023)[7]. Moreover, socio-economic factors, such as poverty, lack of education, and limited access to justice and support services, exacerbate the vulnerability of women and girls to different violence. Rural communities and pastoralists, in particular, face additional challenges due to limited infrastructure, cultural traditions, and inadequate enforcement of laws protecting

[4] ISF 2023 – 2025 Action Plan for operations in Ethiopia, ISF 2022 Report
[5] OCHA (2022). GBV AOR Ethiopia: Situation of GBV in Ethiopia: https://reliefweb.int/report/ethiopia/gbv-aor-ethiopia-situation-gbv-ethiopia-september-2022
[6] Nydal, R. A. R. (2020). Understanding FGM/C in Ethiopia through looking at FGM/C interventions done by INGOs/NGOs and Ethiopian government policy (Master's thesis, OsloMet-Storbyuniversitetet).
[7] UNICEF (2023). PROMOTING MEN AND BOYS' ENGAGEMENT IN ENDING FEMALE GENITAL MUTILATION IN MENA:https://www.unicef.org/mena/media/20671/file/MENA%20Engaging%20Men%20and%20Boys%20-%20FULL%20REPORT.pdf

women's rights (UNICEF, 2023)[8].

Specific to FGM, though there is a slight decrease in prevalence over time, the recent studies conducted by Elizabeth P. et.al (2024) and Endale K. et.al (2022) identified that ensuring girls' good behavior, honouring the mother of the girl and marriageability are among the many ways in which FGM can be said to be a social norm and hence acceptable by both women and men. It can also be seen as a religious requirement (though it is not explicitly mentioned in either the Qur'an or the Bible), core to beliefs about adult femininity (and thus a rite of passage as well as important to women's status in the community), and a marker of cultural or ethnic identity (the implication of this is that laws and awareness-raising campaigns must be handled thoroughly and contextually lest they encourage entrenchment and/or provoke backlash).

FGM continues to be primarily practised during middle childhood but can be undertaken at any time prior to marriage. To make it more explicit in this regard, if one girl is circumcised, the neighbours and the community at large dignified her and her mother and vice versa. Despite the slow improvements in this regard, girls who have not undergone FGM are still subjected to community gossip, and mothers are shamed and ostracized for not bearing the expected responsibilities from the community. Another important finding revealed by this study (reference?) is that when a girl is circumcised, she feels that she is grown up.

As part of its endeavours to ensure the health and well-being of its people, including women and children, Ethiopia has committed to eliminating female genital mutilation (FGM) and early marriage by 2025. In line with this, the Ministry of Health banned the medicalization of FGM in all public and private medical facilities in the country. Per the circular passed on 4 January 2017, medical personnel who engage in any form of FGM in medical facilities will be subjected to legal action. However, though most girls are cut by traditional cutters –there is growing evidence of medicalization in the region. Though medicalization is officially banned, studies revealed that FGM is practiced in health centers or in the form of door-to-door by health professionals (trained TBAs/HEWs]. The main reasons cited were that girls are circumcised using a clean blade and to avoid the risk of excessive bleeding when it is conducted at home[9].

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[8] UNICEF (2023). GENDER, CONFLICT AND ENVIRONMENT ANALYSIS IN EAST SUDAN: Women Empowerment for Resilience, Inclusion, Sustainability and Environment in Eastern States Project: https://africa.unwomen.org/sites/default/files/2023-10/gender_conflict_and_environment_analysis_in_east_sudan.pdf

[9] Endale, K., Jones, N., Presler-Marshall, E., Woldehanna, T., Yadete, W., Abdisalam, A., Alemu, A.,

Another study carried out by Elizabeth P. et.al (2024) also indicated that almost all Somali girls can expect to undergo FGM before age 15 and that infibulation is nearly universal. However, the understanding of infibulation is rooted in traditional practice, and many girls are now "partially" infibulated by invasive procedures that girls nonetheless see as an improvement over the past. These shifts reflect religious leaders' efforts to eliminate traditional infibulation--and the health risks it entails--by promoting "less invasive" types of FGM as a requirement of Islam. This study further revealed evidence of emergent medicalization of the practice, as mothers are the primary decision-makers seeking to reduce risks further. Here, the importance of FGM is framed around social acceptance, whereas boys and men focus on FGM as a requirement for marriage as it allows families to control girls' sexuality[10].

These reviewed studies clearly showed two main conclusions: the incremental shifts in the type of FGM practiced in the region and the emerging medicalization of the practice (showing that some girls are undergoing FGM at health centres or hospitals with medically trained staff). Shifts in type and medicalization of the practice speak to the malleability of social norms and underscore how practices can be adapted as communities unwilling to abandon FGM work to balance new knowledge about its risks with traditional beliefs about its social and cultural benefits.

Addressing gender-based violence, early marriage, and female genital mutilation and improving the health of women and girls through protecting and investing in women and girls is necessary for building more productive and inclusive societies (USAID, 2017)[11]. Otherwise, no society can develop sustainably without transforming and amplifying the distribution of opportunities, resources, and choices for men and women so that they have equal power to shape their own lives and contribute to their families, communities, and countries (WB, 2023)[12]. Addressing gender inequality in general and **Violence against women and girls (VAWG)** in particular requires collaborative efforts by the government and other stakeholders [including international humanitarian and

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Gebeyehu, Y., Gezahegne, K., Murha, R., Neumeister, E., Tesfaye, A., Tilahun, K. and Workneh, F. (2022) *Exploring the patterning and drivers of FGM/C and child marriage in pastoralist Ethiopia: Baseline report from Afar and Somali regions.* Report. London: Gender and Adolescence: Global Evidence. (https://www.gage.odi.org/publication/exploring-the-patterning-and-drivers-of-fgm-c-and-child-marriage-in-pastoralist-ethiopia-baseline-report-from-afar-and-somali-regions/)

[10] Presler-Marshall E, Jones N, Endale K, Woldehanna T, Yadete W, Abdiselam A. [2024]. Exploring the patterning, drivers and gender norms around female genital mutilation in Ethiopia's Somali region.

[11] USAID (2017). EMPOWERING ETHIOPIANWOMEN

[12] https://www.worldbank.org/en/topic/gender/overview

development partners].

As part of the coordinated efforts by the government and other stakeholders to address the problem immediately [VAWG], ISF designed a development program (ISF 2022-25 Ethiopian program) to strengthen local civil societies by empowering women and their organizations, capacitating judicial and moral duty bearers, and strengthening local CSOs. To prepare for the ISF 2022-25 Ethiopian program, ISF and its three local implementation partners, CAAP, RDV, and HAVOYOCO, commission an analysis of violence against women and girls (VAWG) and gender norms in the Fafan and Jarar zones of Somali Regional State, Ethiopia. Thus, it's within this context that this VAWG and Gender Norms Analysis is prepared.

1.2. Objectives and geographic Focus

The purpose of conducting the VAWG and gender norms analysis was to shed light on the dynamics, causes, and triggers of VAWG—especially female genital mutilation/cutting and partner violence—as well as suggest alternative approaches to lessen its effects on the beneficiaries' lives and the communities in which they reside. Additionally, among community members (rights holders) and pertinent duty bearers, it seeks to clarify knowledge of the occurrence, severity, responsibility, and preventability of various types of VAWG. Geographically, the assignment covered one region in Ethiopia, namely the Somali Region, specifically the two districts/woredas of Harawo and Degahbour, which are in the two zones of Fafan and Jarar.

1.3. Scope of the consultancy

Thematically, the VAWG and gender norms analysis focused on [but not limited to]:

1) Gender norms analysis to explore the underlying gender stereotypes, norms, and ideals in the target communities;
2) FGM analysis to explore the local dynamics and understandings in the target communities;
3) Domestic/partner violence analysis to explore the local dynamics and understandings in the target communities
4) Non-partner sexual violence, abuse, and harassment analysis to explore the local dynamics and understandings in the target communities and
5) Stakeholder analysis to highlight the need for multi-sectoral prevention of VAWG

1.4. Research questions

The VAWG and gender norms analysis was aimed at answering the following interlinked

research questions, as listed under five categories:

A. **Gender norms analysis to explore the underlying gender stereotypes, norms, and ideals in the target communities:**

- ✔ What are typical characteristics and behaviors of women versus men in the community (gender stereotypes)?
- ✔ What characteristics and behavior are expected of women in the community? How about men? (gender norms and ideals)
- ✔ What positive consequences do traditional (rigid) gender norms and roles have for individual men/women/families/communities?
- ✔ What negative consequences do traditional (rigid) gender norms and roles have for individual men/women/families/communities?
- ✔ What is the role of family, religion, culture/tradition, media, etc., in imposing (or challenging) these gender norms? (see Stakeholder analysis guide below)
- ✔ In whose interest is it to support (or challenge) traditional (rigid) gender norms?
- ✔ What consequences are there for women if they do not assume the expected female gender roles and norms? For men?
- ✔ What options are there to renegotiate traditional gender norms and roles?

B. **FGM analysis to explore the local dynamics and understandings in the target communities:**

- ✔ Who are playing which roles in deciding, organizing, and performing the cut?
- ✔ Who are promoting FGM in the village/community?
- ✔ What are typical places and times of the cut?
- ✔ What are the main justifications for continuing the practice?
- ✔ Is FGM discussed openly? In families, in public, by duty bearers?
- ✔ Is there public FGM opposition locally? Led by whom?
- ✔ Is FGM believed to be widely practiced or disappearing in the near future?
- ✔ What do parents fear if they reject FGM?
- ✔ Who has authority/legitimacy regarding FGM in the village/community/wider society?
- ✔ Who do these opinion leaders listen to? What is their source of information

regarding FGM?

- ✔ What are the generally understood physical, psychological, and social consequences for survivors?
- ✔ Is FGM connected to early marriage? How?
- ✔ What referral mechanisms and institutions (reporting, investigation, and prosecution practices) are there to seek justice for FGM survivors (if illegal)? (use the template in ISF Ethics and safety guidelines for addressing VAWG to document and share)
- ✔ What referral mechanisms and institutions (medical, psychosocial, security/shelter) are there for FGM survivors? (Use the template in ISF Ethics and safety guidelines for addressing VAWG to document and share)

C. **Domestic/partner violence analysis to explore the local dynamics and understandings in the target communities:**

- ✔ What are the typical forms of domestic/partner violence (physical, sexual, mental, economic) in the community?
- ✔ Who are typically the perpetrators?
- ✔ What are typical triggers for partner/domestic violence?
- ✔ What justifications are given for domestic/partner violence? Are there signs of victim blaming?
- ✔ Is domestic/partner violence openly discussed or silenced?
- ✔ What are the generally understood physical, psychological, and social consequences for survivors?
- ✔ What locally available referral mechanisms and institutions are there for survivors or domestic/partner violence to seek justice (security/shelter, reporting, investigation, and prosecution practices)? (use the template in ISF Ethics and safety guidelines for addressing VAWG to document and share)
- ✔ What locally available referral mechanisms and institutions are there for survivors or domestic/partner violence to seek medical or psychosocial help? (use the template in ISF Ethics and safety guidelines for addressing VAWG to document and share)
- ✔ How are survivors of domestic/partner violence treated by local health/

police/judicial officials?

- ✔ What strategies do people identify for prevention and mitigation of partner violence?

D. **Non-partner sexual violence, abuse, and harassment analysis to explore the local dynamics and understandings in the target communities:**

- ✔ What are the typical forms of sexual violence, abuse, and harassment in the community?
- ✔ Who are typically the perpetrators?
- ✔ When and where do these violations typically take place?
- ✔ What justifications are given for sexual violence, abuse, and harassment? Are there signs of victim blaming?
- ✔ Is sexual violence, abuse, and harassment openly discussed or silenced?
- ✔ What are the generally understood physical, psychological, and social consequences for survivors?
- ✔ What locally available referral mechanisms and institutions are there for survivors or sexual violence, abuse, and harassment to seek justice (security/shelter, reporting, investigation, and prosecution practices)? (use the template in ISF Ethics and safety guidelines for addressing VAWG to document and share)
- ✔ What locally available referral mechanisms and institutions are there for survivors of sexual violence, abuse, and harassment to seek medical or psychosocial help? (use the template in ISF Ethics and safety guidelines for addressing VAWG to document and share)
- ✔ How are survivors of sexual violence, abuse, and harassment treated by local health/ police/judicial officials?
- ✔ What strategies do people identify for the prevention and mitigation of sexual violence, abuse, and harassment?

E. Stakeholder analysis

- ✔ To determine the interests and needs of different people and groups regarding the project.

2. METHODOLOGY

Concerned with the “why” and “how” questions, VAWG analysis used qualitative research by employing key informant interviews (KIIs) and focus group discussions (FGDs). The targets for KIIs and FGDs were selected using a purposive sampling technique. The maximum variation sampling technique was applied to examine various cases relevant to the VAWG analysis. It was helpful to pick informants with diverse opinions about VAWG's dynamics, causes, and triggers.

The KIIs were conducted both at the regional level (with focal persons from Bureau of Women and Children Affair (BoWCA), Bureau of Labor and Social Affair (BoLSA), Bureau of Education (BoE), Bureau of Health (BoH), Bureau of Justice (BOJ), NGOs Advocates for human rights and gender equality, and Anti-Female Genital Mutilation/Cutting (FGM/CM) alliances) and Woreda level (including Women and Children Affairs office, Labor and Social Affair office, Health office Education office, Justice office, GBV working group, School gender clubs, Parent-teacher association, Traditional institutes (Ugazi and Woyyo), Religious leaders and community leaders, Health extension workers, Traditional birth attendants (TBAs)). The KII began with a reminder about the objectives and activities of the VAWG and gender norms assessment. Special care was given that the sample respondents are individuals knowledgeable about the subject under study (VAWG and gender norms with good gender balance. The KIIs were purposively chosen based on their position, experience, or responsibilities and can provide information that fits the specific objectives of the VAWG and gender norms assessment.

The interviews were guided by semi-structured interview checklists translated into the region’s local languages (Afi-Somali). Furthermore, the task was carried out by experienced experts who could answer questions, explain, and stimulate discussions. While conducting the KII, sex-specific interviews (female interviewers for female respondents and male interviewers for men/male respondents) were assigned.

The FGDs were conducted with four types of FGD groups (adolescent girls, adult women, Adolescent boys, and adult men) at the Kebele level. The FGDs were begun with a reminder about the objectives and activities of the VAWG analysis. The discussions were guided by semi-structured questionnaires and conducted in separate sessions for women/girls and men/boy informants (hence, sex-disaggregated FGD sessions were arranged) to gather sex-specific experiences and avoid overshadowing females by males during the discussion.

The notes captured in the notebooks, questions, and recorders were transcribed by the note-takers and translated from local dialects into English. The team leader and project coordinator checked the transcriptions to ensure their quality. After fixing the inconsistencies, the transcribed and translated data were organized per theme and ready to facilitate data analysis tailored to the specific objectives of the assignment.

2.1. Ethical considerations

The team leader developed informed consent and assent forms for key informants and focus group discussants. Before each KII or FGD, data collectors read a brief description of the objectives of the VAWG analysis and informed them that their participation was voluntary and that they could discontinue participating at any time. Informed consent was obtained from all respondents before conducting KII and FGDs. Participation in KII and FGDs was voluntary. Data collectors used pseudonyms or participant numbers during the FGDs and interviews.

3. FINDINGS OF THE VAWG ANALYSIS

3.1. Gender norms

Gender roles are behaviors, attitudes and actions that society feels are appropriate or inappropriate for a man or woman, boy or girl, according to cultural norms and traditions. To clarify, gender norms are social norms that relate specifically to gender differences. In this study, we use the term 'gender norms' to refer to informal rules and shared social expectations that distinguish expected behaviour based on gender. Bearing this in mind, this section presents findings about gender norms, focusing on exploring the underlying gender stereotypes, norms and ideals in the target communities.

When we inquired about the anticipated behaviours of individuals based on gender within the community and the repercussions for deviating from these expected gender roles and norms, the predominant response from study participants underscored the prevalence of deeply patriarchal customary and religious traditions, practices, and norms.

The informants underscored that the study woredas are predominantly inhabited by pastoralist and semi-pastoralist communities, particularly in the urban areas, characterized by deeply entrenched patriarchal social structures and norms. These norms often dictate strict roles and expectations for both men and women within the community. Men are typically seen as the primary decision-makers and providers, while women are expected to carry out domestic tasks and caregiving responsibilities within the household. Despite gradual shifts in gender norms, these communities persist in maintaining patriarchal systems where men wield primary authority in both private and public domains.

Despite governmental efforts, including policy enactments and initiatives by other stakeholders aimed at advocacy and awareness-raising, attempts to instigate positive changes in gender norms encounter resistance from religious and clan leaders, parents, and even from women themselves. Consequently, women and girls remain predominantly confined to gender-specific roles within the domestic sphere, with limited freedom of movement and largely restricted to traditional roles as mothers, wives, and caregivers. This situation also contributes to a lack of educational opportunities, as these societal norms often constrain external avenues.

The patriarchal dynamics within these communities significantly influence gender roles, where men traditionally hold authoritative positions. In such contexts, decisions made

by men are deemed final and unquestionable. Particularly in rural areas, women and girls often have limited involvement in decision-making processes, as men perceive themselves as the sole arbiters of major decisions, such as livestock sales and financial management. Biological distinctions between men and women are frequently cited to justify the segregation of gender roles. The responsibilities of childbearing and breastfeeding are predominantly assigned to women, reinforcing that childcare is primarily the domain of women and girls.

Inflexible gender norms in the study woredas contribute to the assignment of distinct tasks to girls and boys, even when they are working in the same environment. This results in a disparity in workload and responsibilities, particularly impacting women and girls who face time poverty and are burdened with double work duties. While men and boys are typically engaged in tending to livestock and participating in community affairs, pastoralist women are tasked with collecting fodder, caring for pregnant animals, and nurturing sick animals. This division of labour, combined with household chores, often falls more heavily on girls, leaving them with limited time to pursue other opportunities such as education. This is reflected in the educational gender parity; The national gender parity index (measuring equity between girls and boys) is currently 0.90 for primary and 0.94 for middle, or 0.76 and 0.75, respectively, for the Somali Region.

Gender socialization further reinforces these norms, particularly in remote areas where traditional expectations are more pronounced. Boys are encouraged to embody assertiveness, competitiveness, and independence, while girls are socialized to be nurturing, emotional, and compliant. These entrenched gender roles perpetuate inequality and restrict opportunities for both boys and girls, reinforcing existing power dynamics and limiting their ability to participate in various spheres of life fully.

"*The difference and treatment of boys and girls begin from the family. While they both come from school, the girl is expected to serve the family, and the boy can sit and be served. when they both go to school, they are expected equally. The more age increases, the burden of girls increases, while for the men, the load decreases as age increases. Even this will continue to the university level and achieve a father status. This is attached to culture and the religion even if people attach to it*". KII [Justice Bureau]

"As equal to or beyond the mothers' contribution, girls are responsible for caring for routine and tedious home-related activities in our community. Due to the deep-rooted gender stereotype, girls are expected to ensure that water and firewood for cooking are available, adequate food is prepared and served by them, the house and its environment

are clean, and the siblings are safe. interestingly, while girls bear all these roles and routine responsibilities, they are supervised by fathers, mothers and even their brothers/boys". -KII (Pastoral Concern)

The cultural and gender norms have their own effect on the utilization of maternal and reproductive health services. In Somali and other Muslim-majority regions, being assisted by a male attendant is perceived unacceptable by women; even the HEWs do not accept it. This study showed that except for a few mothers who have no specific sex preference, almost all mothers preferred to get maternal health care services from some female health care providers. Mothers attended by a male attendant would not be satisfied with the services they received. She may not revisit the facility for maternity services and may also influence others to not go to the facility. KII (Bureau of Health)

These gendered messages continue to shape children's self-concept, beliefs and expectations about themselves and others. In this regard, KII informants described that these restrictive gender norms often discourage children from pursuing interests that are "inappropriate" for their gender, limiting their potential and opportunities for exploration.

When boys and girls deviate from gender norms and societal expectations, they often experience a significant impact on their self-esteem and sense of identity. Non-conforming boys may be labelled as weak or effeminate, leading to bullying and social ostracization. Similarly, girls who do not adhere to traditional femininity may face harsh judgment and social exclusion, impacting their prospects for marriage and acceptance within their communities. This societal pressure to conform to gender norms can deeply affect adolescents' mental well-being and social integration. One participant said, "If you don't act like a 'proper' boy or girl, people will treat you differently, and it's hard to feel like you belong."

"Boys should not act as and look like (including wearing style) Girls, and Girls Shouldn't Act, behave and aspire like Boys. If they fail to do so, they should be ready to bear the social penalty after that". KII [Office of Women and Children Affairs]

The analysis revealed that rural parents, in contrast to their urban counterparts, remain influenced by traditional gender norms regarding the roles of girls in society. Consequently, they often prioritize assigning girls to domestic duties and caregiving responsibilities over sending them to school.

"Most pastoral parents continue segregating expectations and behaviors from their girls

and boys. Most parents encourage their boys to be masculine, contain/hold their emotions, work outside the home (including herding), or attend school. In contrast, girls prioritize raising a family, nurturing relationships, and being good wives in their future marriage lives. Even worse, the parents themselves may bully their children who do not conform to gender norms, such as boys who express interest or like traditionally feminine activities like domestic chores or girls who prefer to work outside the home and be exposed to public arenas". KII (Office of Women and Children Deghabur)

Key informants, in particular, highlighted that the slow progress in changing gender roles can be attributed to the government's concerted efforts and shifts in pastoral livelihoods. These shifts have disrupted the traditional gender norms deeply rooted in principles of patriarchy, which have long defined the role boundaries based on gender and age within traditional communities. Several participants in focus group discussions echoed similar sentiments, providing various justifications:

"*Though most women in our community [as a pastoralist] prefer to be a good wife and engage in giving birth, caring for children and serving their husband than working outside the home, there are situations where women are forced to bear dual responsibilities. During drought seasons or when husbands are addicted to chatting day and night, women/wives have to work in farming, trading, keeping herds and sell their labour to earn family income and hence for survival*"- Women FGD, [Deghabur].

In exceptional circumstances where no girls are in the household or if they are unavailable for consecutive days, boys may step in to assist their mothers out of sympathy. However, such occurrences are rare, and boys engage in these activities primarily due to their compassion for their mothers.

Despite some gradual changes, entrenched social norms concerning gender roles continue to hinder men's willingness to adapt. In several focus group discussions, both men and women discussed why men were reluctant to support their wives and involve them in decision-making processes. They revealed that if men spent too much time at home, they risked being labeled as feminine by the community and neighbors, leading to feelings of shame and a loss of status in the community. This social stigma discourages men from supporting women.

To support this idea with direct quotes;

"When neighbours (including women) see a man engaging in traditionally considered as "women-tasks" [the men supporting their wives at home in particular], they laugh at them,

and most say to them, 'don't interfere with women's businesses; men shall never spend much time at home; men should spend much time outside the home, no matter what".

FGD [Women, Harawo]

Suppose a man is involved in domestic activities like child care, cooking and fetching water. In that case, his neighbours [including women] often question why he gets married if he continues to engage in activities like child care, cooking and fetching water like a woman." ------FGD [Men Deghabur]

An intriguing finding from the analysis is that some of the younger generation, who are relatively more literate and aware than the older generation, are challenging entrenched gender-based task assignments. Despite the social stigma attached to it, younger men are taking the lead in sharing women's burdens of reproductive and domestic work and participating in all household activities and responsibilities. Additionally, they are engaging in joint decision-making on tasks or positions previously considered solely within the domain of men.

"Husbands have good support for their wives, especially during delivery. They bring their wives to the health centre & provide the necessary support (like if blood donation is needed and during immunization and after delivery, they will take their wives' home. In addition, Men/husband can support their wives by doing domestic work while they move to vaccinate their children in a health centre or nearby markets. Family-matter decisions, including selling cattle or camels, are made jointly. Now, things are changing". FGD (Women, Deghabur).

The study participants observed that culturally assigned women's tasks are arduous and burdensome. While some changes have occurred due to government policies, project interventions, the dissemination of new ideas, and information campaigns, the transition in gender roles faces opposition from clan leaders and men in remote rural areas.

Increased domestic violence has been noted as men feel undermined, leading to a rise in divorce rates. Women advocating for changes in gender norms often face a loss of respect from their extended families, particularly from older female relatives who do not believe in gender equality. Pastoral men and influential figures like religious and clan leaders resist changes in gender roles, preferring that women and girls adhere to traditional household duties.

The majority of men feel a sense of degradation when gender roles begin to shift, as it challenges the patriarchal societal structure where they hold dominant positions. The

consequences of traditional gender norms are predominantly negative, as they contribute to gender inequality in decision-making, labor division, and access to resources. This inequality restricts women's development potential, limits opportunities, and hinders livelihood transformation for entire families. To support with selected quotes:

"Pastoral girls and women continue to bear the brunt of skewed gender norms, as they are more likely to experience restrictions of their freedom and mobility, they experience un-reported domestic violence and continue [with sluggish improvements in the younger generation and those living in adjacent to towns) to have fewer opportunities to choose how to live their lives and transform their livelihoods". KII [BoWSA]

When queried about gender norms, most respondents indicated that these norms remain deeply entrenched in pastoral communities, significantly impacting social and economic life, particularly for women and girls. However, in urban areas and among a few progressive youth-led households, there were reports of slow changes in gender norms.

This finding suggests that younger generations are adopting more gender-equitable attitudes, particularly regarding labour division, decision-making, and control of income, assets, resources, and services. Within these segments of the pastoral population, there is a noticeable divide between younger individuals embracing modernity and liberal thinking and older generations advocating for preserving cultural traditions, norms, and values to maintain cohesion and identity.

Moreover, the study also found out that mothers-in-law have a big part in keeping society's expectations and traditional gender roles in place inside households. They frequently impact decisions made in the home, especially those pertaining to women's roles and duties. Typically, mothers-in-law reinforce patriarchal norms and expectations by expecting daughters-in-law to carefully follow conventional gender roles, such as childcare and household chores. Their participation may limit women's agency and autonomy within the home and help to maintain gender inequality.

Despite the persistent efforts of influential figures, including older women, to uphold traditional gender norms and beliefs, a minority of the current generation, particularly those with higher education and exposure to urban areas, express beliefs in gender equality, highlighting a divergence in values.

3.2. FGM and child marriage analysis

3.2.1. Types of FGM practice

According to the study participants, there are two types of Female Genital Mutilation (FGM). The first type is known as the "pharaoh", which involves the removal of the labia majora and labia minora and suturing them together to form a scar. This practice is perceived as a protective measure against unwanted sexual activity and pregnancy until marriage. It is believed to have originated from the practices of the Egyptian Pharaoh, who would reportedly suture his wife in the morning when he went to work and open the sutures at night when he returned to safeguard her safety and exercise control.

The other form of FGM is referred to as Sunni, which involves the cutting of only the tip of the clitoris. Sometimes, it is called "dhiijin," where a small cut is made to make the clitoris bleed, believed to render the girl "clean" or "halal" and acceptable by the community. In the community, there was formerly a perception that if girls did not undergo this procedure (even if it was just Sunni), they were considered unclean (haram) and not preferred for marriage by males.

So, the first type of FGM, which is Pharaoh, is believed to be forbidden in Islam, but the second type, Sunni, is considered permissible to perform on girls. There are two distinct perceptions on this matter: one group believes it should be carried out, while the other group believes that females should not even be touched in the genital area, asserting that "she can live as Allah created her." However, in Somali culture, the practice of Sunni FGM is prevalent. Consequently, most of the FGD participants agreed that girls should undergo at least the Sunni type of FGM to gain cultural acceptance.

In conclusion, study participants from both woredas indicated the prevalence of two types of FGM practiced in the entire Somali region. The pharaonic type of FGM is predominantly practiced in remote areas, while its occurrence has decreased in urban areas. Conversely, the Sunni type of FGM is prevalent in urban areas. However, it is important to note that some families take their daughters to rural areas under the guise of visiting relatives when, in fact, they intend to subject them to the pharaonic type of FGM.

3.2.2. Promoters of FGM and Child marriage in the community

The study participant agreed that most of the time, the daughter's mother would propose and decide, then arrange the program and place of the cut and invite the Traditional Birth Attendant to cut them. Girls are cut from childhood any time up until

right before marriage.

In the case of child marriage, it is commonly observed that the decision-making process involves the entire family, particularly the father and other clan members related to the father's lineage. These family members play a significant role in deciding on marriage matters and are responsible for arranging and facilitating the child's marriage.

FGD participants highlighted that the primary supporters and promoters of female genital mutilation (FGM) within the community are typically women. In this regard, the FGD and KIIs further spelled out that in Somali society, mothers are responsible for matters related to females, and fathers are accountable for males. Accordingly, mothers continue to play a central role in female circumcisions, no matter the type of circumcision. In some cases, when the father is against FGM, mothers do that when her husband is not at home because of social pressure and stigmatization toward uncircumcised women or girls. Women know the physical and psychological pain of FGM because they experience it throughout their life. Due to the fear of being stigmatized and discriminated against, most mothers want their daughters to be cut and qualify for marriage.

Though it differs from context to context, study informants also reported that in most Somali communities, husbands are the heads of the family, and most decisions are in their hands. If a father decides to circumcise his daughter, no one can stand in his way. Therefore, fathers are also the most important decision-makers.

Some male informants, the adult one in particular, also revealed the difficulty of detaching FGM practices from the Somali community (in a short period of time), citing culture as the main reason. To support this with a specific quote:

"FGM is part of our identity culture. I am sure that if you ask any household head in the Somali community, the majority of them do not agree for FGM to be eradicated for good. They may instead tell you to stop the practice of infibulation and replace it by practicing the Sunna type of FGM practice, as it ensures lesser health risk than infibulation".

-FGD Male discussant (Sararka Kebele, Harawo)

Traditional Birth Attendants (TBA) also contribute to this practice, often motivated by financial gain as it provides income for them. Furthermore, it was observed that the majority of the Somali community members endorse FGM. However, the younger women had relatively negative attitudes toward female genital mutilation compared to the older women, who had favorable attitudes towards female genital mutilation.

When discussing with adolescent boys, there were varying opinions on FGM. Some participants expressed a preference for marrying girls who have undergone FGM due to cultural reasons and believing it ensures the girl's purity. Some participants mentioned the negative consequences of FGM and expressed optimism that it would eventually cease.

When it comes to the typical locations and timing of the procedure, girls are often taken to remote rural areas away from their usual residences to ensure secrecy. During Key Informant Interviews (KII), participants shared instances where families would bring their daughters from Western countries during the summer, disguising the visit as a family trip. Since schools are closed during this period, it provides an opportune time for the procedure to be carried out clandestinely.

The FGD participants shared that sometimes women do not disclose the secret even to their husbands or the fathers of their daughters, fearing that they might oppose the decision to perform FGM. Therefore, they often choose to carry out the procedure during summer. They mentioned that if FGM were performed in the same village where they lived, they would take the girl to a neighbor's house. Alternatively, they would wait until the father was away from the household so that he would not witness the procedure or the pain the girl endured. Sometimes, the father would not notice, as he would return home after she had completely healed.

3.2.3. Main justifications for continuing the FGM practice and child marriage

The finding from the regional level of KII shows that the community's first and most important justification is their attachment to their religion and culture. FGD participants of the study stated that they perform FGM practice as they believe that the girls will not find someone who will marry them if she is not circumcised. They also think that if they do this, girls cannot have sexual contact with males before marriage because their desire is reduced and painful, and it is important to keep family dignity.

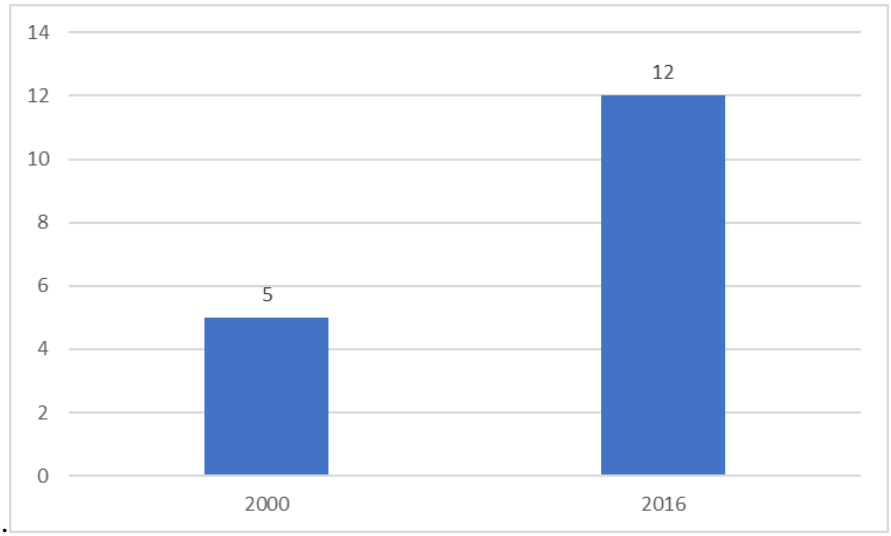
The TBA, on the other hand, does it for financial purposes. Most of the time, 1 to 5 girls are circumcised at one time, and the TBA would receive at least 1000 birr from each and a total of 5000 birr in total.

The other reason that participants reported as the reason for the continuation of FGM is that the community used to undertake FGM because they believe that if a girl is not circumcised, she will have strong sexual desire and might perform premarital sex and

which is unacceptable for the dignity of their family. Thus, they will undertake FGM to reduce sexual feelings and protect their daughter's safety until she gets married. Additionally, no men want an uncircumcised girl because men perceive that if she is not circumcised, a girl may have experienced sexual intercourse before marriage and not be considered a virgin. Boys think that she will be unfaithful in her married life also, so she is another important reason for them to cut girls.

When it comes to child marriage, notwithstanding recent slow declines, Somali region continue to be among the pastoral regions where nearly half or more of all girls are married before age 18. But in areas affected by droughts and emergencies [refuges], multiple reports revealed that child marriage is increasing[13].

Incidence of child marriage for girls aged 15-17



Source: Exploring the patterning and drivers of FGM/C and child marriage in pastoralist Ethiopia

Baseline report from Afar and Somali regions, 2022

As most FGD participants mentioned, several factors contribute to child marriage. One such factor is the community's belief that if girls do not marry early, they will struggle to find a husband later. Additionally, families sometimes promise their daughters to their friends as a social bond. Economic factors also play a significant role, with families marrying off their daughters to receive bride price, particularly during times of hardship like droughts, or to attain wealth and resources. Peer pressure and influence from social media further exacerbate the issue, as teenagers aspire to emulate what they see online.

[13] Exploring the patterning and drivers of FGM/C and child marriage in pastoralist Ethiopia Baseline report from Afar and Somali regions, 2022

FGD participants also mentioned that, despite pressure from their parents, most married girls decide on their own marriage. The community also holds the belief that if a girl menstruates at the age of 13 or 14, it is referred to as "Qangadh," signifying that she will develop sexual desires and feelings for the opposite sex. Child marriages affect not only girls but also young boys, often leading to school dropouts and early entry into the workforce.

Another prevalent cause of child marriage is the family's own belief that their daughters should marry before the age of 15 or 16. However, if a girl reaches around 18, the family will actively seek a husband for her.

Concerning marriage arrangements, although non-arranged marriages are slowly increasing in general and in the urban and semi-urban areas in particular, sources indicate that arranged marriages are more common in the region.

When the participants were asked about the interlinkage of FGM and child marriage, there was a divergent view. Some FGD participants said there is no interlinkage, whereas others said there is a linkage. The justification provided by the latter group is that parents want their daughter to get married so that the cut won’t stay with her for a long time. Moreover, according to the key informants, there is a connection between FGM and child marriage because both FGM and child marriage are bad traditional practices which may result in difficulty to the girl's future life psychologically and physically; for instance, if the girl goes under FGM and at the same time she gets married at an early age or before appropriate age of marriage, she will experience double-burden of the complication of FGM and child marriage which may make her life more miserable compared to uncircumcised girl and a girl who get married at her normal age or after she reaches the age of 18 and physically and psychologically well mature.

Regarding open dialogue regarding FGM and child marriage, participants in focus group discussions noted that, previously, there has been limited discussion on these topics within the community. However, a gradual shift is occurring, with increasing willingness among community members to address these issues openly. Families and community members are beginning to convene discussions on FGM and child marriage, both within households and at community forums, often in collaboration with health extension workers and NGOs focused on addressing these harmful practices.

The religious leader also informed us those lessons were being taught in the (masjid) religious space about the negative effects of child marriage and female genital mutilation, as well as the necessity of marriages occurring at the appropriate age and

time for both genders.

TBAs engage in these practices primarily for financial gain. Key informant interviews (KIIs) from the regional pastoralist office in Jigjiga reported that efforts are being made to address this issue. These efforts include establishing one-stop centres, providing alternative economic opportunities for traditional midwives involved in circumcision, raising awareness in the community, and offering financial support for transportation for victims. Positive changes resulting from these activities have been observed empirically.

When discussing the concerns of parents who reject FGM and child marriage, study participants emphasized that families often fear social repercussions and cultural non-acceptance if their daughters do not undergo the pharaoh type of FGM. They worry that without this practice, their daughters may struggle to find a suitable husband, leading families to resort to such measures to ensure their daughters' marital prospects.

The FGD participants expressed that they have heard about the negative implications of practices such as FGM and child marriage and acknowledge that these are harmful traditional practices that need to be stopped. However, they also mentioned that they fear social discrimination, stigma, and social sanctions from the community if they defy these practices. Additionally, the study found that opinion leaders, particularly religious and community leaders, hold significant influence over community members' beliefs and behaviors regarding these practices.

Though not always, there are some circumstances in which the two harmful practices are linked and co-exist. As mentioned earlier, a girl’s marriageability in the pastoral community is tied to whether she has undergone the cut. As the time or FGM is performed as a ceremony of passage into womanhood and as a predecessor to marriage, often carried out in early adolescence. The low levels of education, deep-rooted gender norms, rural residence, and living in poorer households are among the factors that make these two harmful practices reinforce each other.

On the other hand, and as noted by KIIs in particular, these two harmful practices have their own unique driving forces. Child marriage is more likely to be triggered by absolute poverty and humanitarian crises (like drought and conflict). To make it more explicit, economically destitute households may choose to marry off a daughter [in her early adolescence] as a coping mechanism to financial stress or in the belief that it will secure for her a steadier future livelihood and marriage life. In this regard, child marriage is considered an optimal solution when other livelihood options for the particular girls seem very challenging and unattainable. On the other hand, practising FGM is closely

related to a community's ethnic identity and inclusivity and is a symbol of shared values.

"In the pastoral community, child marriage is mostly associated with low levels of education and more often driven by economic pressure resulting from climate change, drought and conflicts. This means that interventions, including financial support, livelihood transformation, and women's economic empowerment, can sustainably address the problem. On the other hand, since FGM is linked to traditional beliefs and customs, concerted efforts at household and community levels by all stakeholders [including local leaders, elders, TBAs] are needed. All concerned bodies should work to increase efforts to secure full enforcement of existing laws against FGM practice in general, FGM in its worst form in particular". KII (Bureau of Women and Social Affairs]

The analysis sought to understand the community's perception of the physical, psychological, and social consequences faced by survivors of FGM. FGD participants reported witnessing numerous complications experienced by women who have undergone FGM, including immediate bleeding, recurrent urinary tract infections, and significant difficulties during childbirth, sometimes resulting in death due to obstructed labor. Furthermore, early marriage among survivors exacerbates reproductive health issues, as their reproductive organs may not be fully developed for pregnancy, and their narrow birth canals can lead to obstructed labor, fistula, and other serious complications stemming from the scarring caused by FGM.

Most FGD participants acknowledged the significant health effects of FGM and recognized its serious consequences. One participant shared a personal experience, stating, "For example, I have a wife who constantly suffers from pain and illness due to FGM performed during her childhood. So, I have made a solemn oath to Allah that my daughter will not undergo circumcision."

KII participants also highlighted that FGM can lead to divorce and the dissolution of families. They explained that girls who have undergone FGM may lack sexual desire when they get married. Consequently, if a wife does not desire sex, her husband may feel offended and choose to file for divorce.

3.2.4. Response and referral mechanisms and institutions

FGD participants and KII reported that the TBAs initially provide basic health services if a person experiences other related health issues when undergoing FGM. Subsequently, they report the case to the police and support the survivor. The referral system is well-established, with clear steps outlined. If a girl undergoes circumcision and experiences

bleeding, the community takes her to the nearest health center or hospital. From there, the case is reported to the Women and Child Affairs office, which informs the local police. The police collect evidence and proceed to file a case in court. However, participants noted that the referral mechanism could be complex, and anyone in the community who witnesses such cases might not report them to the police, as both FGM and child marriage are considered criminal offenses.

KII from various bureaus discussed the presence of one-stop centers that provide comprehensive medical treatments, including legal and justice services. Both the community and religious leaders are involved in handling such cases. In addition, NGOs like Pastoral Concern have also been working with the centers (and with the regional Bureau of Women and Social Affairs in general) since their establishment. Pastoral Concern continues to finance interventions related to encouraging reporting of FGM/C cases, medical treatment and care for physical bruises, clinical management of FGM/C, psychosocial counseling, and referrals support for legal assistance and prosecution. According to KII from BoWSA, other NGOs like ISF also provide skills training and financial incentives for the survivors to be reintegrated.

3.3. Domestic/partner violence

This section delved into the issue of domestic or partner-related violence, examining its various types, perpetrators, local dynamics, and community understandings within the target areas. It also explored the availability of referral mechanisms and institutions for survivors, along with strategies for preventing and mitigating domestic violence in the study woredas.

3.3.1. Nature and forms of Domestic violence

According to the insights shared by the informants, domestic violence remains a common occurrence in the pastoral community, albeit with slight variations across different woredas. Despite a gradual decline, it persists due to entrenched gender inequalities, where women and girls face fewer rights compared to men and boys in various spheres, especially during non-emergency periods. These disparities are exacerbated during systemic shocks like droughts and related economic crises.

Consistent with existing literature, both Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) highlighted physical and sexual violence as the most prevalent forms, followed by emotional and psychological abuse. Unfortunately, such abuses are often brushed aside as internal family matters rather than criminal offences.

Informants from both KIIs and FGDs noted that many victims hesitate to report their experiences due to feelings of shame, fear of repercussions, or a sense of familial loyalty, which could result in social ostracization. In severe cases where physical harm is evident, community arbitration led by close relatives or religious/local leaders may be sought as a resolution method, further contributing to underreporting and perpetuation of the issue.

3.3.2. Common perpetrators and typical triggers for partner/domestic violence

The study's findings shed light on the diverse range of perpetrators and triggering factors of domestic violence within the community. Perpetrators identified included husbands, parents (particularly targeting girls), boys (perpetrating violence against their sisters), and sometimes even extended family members like mothers-in-law.

One key triggering factor identified was the deeply ingrained gender norms prevalent in the community. These norms, deeply intertwined with cultural attitudes, perpetuate harmful stereotypes and unequal power dynamics between men and women. As a result, domestic violence against women and girls may be normalized and even justified within the context of these patriarchal systems.

Economic factors also played a significant role in triggering domestic violence. Economic hardships, unemployment, and financial stressors were highlighted as exacerbating tensions within households, leading to an increase in violent incidents. Additionally, substance abuse, such as excessive chewing of chat, was mentioned as contributing to violent behavior among men.

Moreover, certain forms of domestic violence, including verbal abuse, stalking, and physical violence, were described as culturally acceptable and even tolerated within the community. Despite their detrimental effects, these behaviors may be overlooked or dismissed by family members, religious leaders, and other community members, perpetuating a cycle of violence and reinforcing gender inequalities. To support this selected quote:

"As this community embodies patriarchal thinking and gender norms, domestic violence is a learnt behaviour that is passed from generation to generation and has an inter-generational effect of violence. For example, if a boy witnessed inter-parental violence as a child, he can be more likely to inflict domestic on his wife during his adult life. Likewise, a girl who witnessed violence inter-parental violence as a child is more likely to develop attitudinal acceptance and normative understanding of domestic violence". KII [Bureau of Women and Social Affairs)

The study's findings highlight additional concerning aspects of domestic violence within the community. One particularly alarming observation is the normalization of self-preparation for violence among some women, who may resort to preparing a stick for their own beatings by their husbands as a form of punishment for perceived transgressions. These transgressions can range from seemingly minor infractions, such as failing to perform household tasks adequately or leaving the house without permission, to more serious offences.

Economic factors emerge as another significant triggering factor for domestic violence, particularly the poverty status of households. Women from lower socioeconomic backgrounds are identified as being more vulnerable to experiencing violence from their husbands or partners. This vulnerability is exacerbated in households with a high dependency burden, where economic stressors can lead to increased tensions and conflicts within the family.

The excessive use of chat, a stimulant substance, by partners in poor households is also linked to heightened levels of domestic violence. The consumption of chat can contribute to increased stress and aggression among men, leading to violent behavior towards their families. Moreover, the financial strain caused by expenditure on chat further compounds economic difficulties within the household, fueling conflicts and contributing to the cycle of violence.

Overall, these findings underscore the complex interplay between economic factors, substance abuse, and cultural norms in perpetuating domestic violence within the community. Addressing these underlying issues is crucial for developing effective strategies to prevent and mitigate domestic violence and promote gender equality and social justice.

"Due to the traditional beliefs, norms and practices, women continue to be economically dependent on men. In remote rural areas, most women are housewives, dependent economically on their husbands. This creates patterns of violence and poverty that become self-perpetuating, making it extremely difficult for the survivors to detach themselves, particularly from domestic abuse and psychological damage, which they suffer in the hands of their husbands."-KII [Women and Children Affair, Harawo]

The study's participants provided further insight into the factors contributing to domestic violence within the community. They highlighted the significance of economic empowerment and livelihood opportunities for women in reducing their vulnerability to violence. Women's economic dependence on men increases their susceptibility to abuse, particularly in contexts where unemployment among men is prevalent. In such situations, men may resort to violence to assert their masculinity and maintain control over their partners and children.

The lack of decision-making power for women in households also emerged as a risk factor for domestic violence. In households where husbands make all decisions unilaterally, there is a higher likelihood of conflict and violence, especially when women challenge their husbands' decisions. These dynamic underscores the importance of promoting gender equality and women's empowerment to mitigate the risk of domestic violence.

Few men FGD participants also reported that men become aggressive or violent against their women/wives due to peer pressure and in order to maintain their number one/patriarchy place in the household.

Furthermore, the study identified the impact of female genital mutilation/cutting (FGM/C) on spousal relationships. Women who undergo FGM/C, particularly in pastoral communities, may experience dissatisfaction with their marital and sexual relationships. These feelings of dissatisfaction can contribute to frequent disagreements and conflicts between couples, leading to various forms of violence, including sexual, physical, and psychological abuse. Additionally, polygamous relationships were highlighted as exacerbating factors, as they can intensify existing tensions and conflicts within marital relationships.

Overall, these findings emphasize the complex interplay of economic, cultural, and social factors in perpetuating domestic violence. Addressing these underlying issues requires a multifaceted approach that addresses gender inequalities, promotes women's empowerment, and challenges harmful cultural practices such as FGM/C. By addressing

these root causes, communities can work towards creating safer and more equitable environments for all individuals.

Last but not least, study informants at the grassroots level, in particular, also emphasized other factors contributing to and reinforcing domestic violence against women and girls. These include limited control over productive resources and assets, economic position, limited access to education and awareness creation training, underreporting of cases, and impunity for crimes and abuse. All of these triggering and risky factors compound the cultural and economic factors underlying domestic violence prevalence in the study woredas. An important finding is that these risk factors are frequently exacerbated in emergencies, including drought, conflict, and displacement of internally displaced persons (IDPs).

3.3.3. Rape, death report after raping Justifications given for domestic/partner violence [including victim blaming]

The study findings revealed a divergence in perspectives regarding the causes and discussions of domestic violence within the community. While FGD participants primarily attributed domestic violence to women's failure to adhere to stereotypical gender roles, such as proper household duties and behavior, KII informants provided a more nuanced understanding. KII respondents highlighted additional factors contributing to domestic violence, including suspicions of infidelity, pathological jealousy, sexual dissatisfaction, and coping mechanisms for stress and past trauma.

This disparity suggests a need for comprehensive education and awareness-raising initiatives to address the root causes of domestic violence and challenge harmful gender stereotypes. While FGD participants may benefit from understanding the broader context of domestic violence, KII findings underscore the importance of acknowledging and addressing complex psychological and social factors influencing perpetrators' behavior.

Moreover, the reluctance to openly discuss domestic violence, particularly among FGD participants, underscores the pervasive stigma and cultural taboos surrounding the issue. The entrenched sociocultural norms and patriarchal principles identified by KII informants contribute to this taboo, inhibiting survivors from reporting incidents and seeking assistance. Efforts to combat domestic violence must, therefore, prioritize challenging these norms, fostering open dialogue, and providing safe spaces for survivors to come forward without fear of stigma or retribution.

Overall, addressing domestic violence requires a multifaceted approach that includes challenging harmful gender norms, promoting gender equality, and creating supportive environments where survivors feel empowered to seek help and support. By engaging both community members and key stakeholders in open discussions and awareness-raising activities, communities can work towards preventing and mitigating the impact of domestic violence.

"Usually, women and girls do not have the courage to report the case to a formal system [police and women affair]. Instead, they take the issue to their close friends or elders of the family, if not solved, the case is directed to traditional leader [as a last resort] and solve the problem." -KII (GBV Working group)

The study findings highlight a range of complex factors that contribute to the underreporting of domestic sexual violence cases. These factors underscore the significant barriers victims face in seeking help and justice, as well as the pervasive societal attitudes and structural challenges that perpetuate silence and impunity.

- Firstly, fear of stigmatization emerges as a central deterrent to reporting IPV cases. Victims and their families may internalize societal judgments and derogatory labels, such as being labelled as "losers" or facing social ostracization, which can have profound psychological and social consequences. This fear of stigma not only affects survivors' willingness to come forward but also perpetuates a culture of silence and victim-blaming.
- Secondly, economic dependence exacerbates survivors' vulnerability and reluctance to report incidents. Many victims, particularly housewives, fear the financial repercussions of divorce and lack the means to support themselves independently. This economic insecurity further traps survivors in abusive situations, as they feel unable to leave or seek help without jeopardizing their financial stability.
- Thirdly, concerns about privacy and confidentiality in legal proceedings deter survivors from seeking justice through formal channels. Detailed investigations and court proceedings can expose victims to further harm, including public scrutiny and social humiliation, reinforcing their reluctance to report incidents.
- Additionally, cultural norms and perceptions of IPV as a trivial family matter perpetuate silence and discourage survivors from seeking help. The shame associated with family dishonour and community judgment further compounds

survivors' hesitance to come forward, as they fear bringing further shame upon themselves and their families.

- Moreover, illiteracy and lack of awareness about reporting procedures contribute to underreporting, as many women may not know how to access support or navigate the legal system effectively. This lack of knowledge and information further isolates survivors and perpetuates their vulnerability to abuse.
- Finally, survivors may decline referrals to health services due to concerns about mandatory reporting requirements and potential involvement of law enforcement. This fear of legal consequences and loss of autonomy deters survivors from accessing essential healthcare and support services, further exacerbating their isolation and vulnerability.

The study findings reveal significant gaps in the availability and awareness of local referral mechanisms and institutions for survivors of domestic/partner violence. While efforts are being made to address this issue, particularly through the allocation of resources and establishment of coordinated responses, challenges persist in ensuring survivors can access the support they need. As one practical solution, coordinated efforts aiming at linking the community directly to the referral mechanisms should be in place, thus not only reinforcing the community dialogue and the stakeholder cooperation separately but also building bridges in between.

One key challenge highlighted by informants is the lack of awareness among both survivors and community members about available services and referral mechanisms. This underscores the need for targeted awareness-raising initiatives to educate individuals about their rights and their support options. Increasing public knowledge about the criminal nature of domestic violence and the range of services offered, including healthcare, shelter, and legal assistance, is essential for empowering survivors to seek help.

Additionally, barriers to accessing support services were identified as a major concern. These barriers include logistical challenges, such as geographic distance to service providers or transportation limitations, and systemic barriers, such as bureaucratic hurdles or lack of culturally sensitive and responsive services. Addressing these barriers requires comprehensive approaches that prioritize accessibility, affordability, and cultural relevance in service delivery.

Furthermore, the fragmented nature of service provision and coordination presents a significant challenge to effectively addressing domestic violence in pastoral settings. Efforts to establish coordinated responses must involve collaboration among various stakeholders, including government agencies, civil society organizations, healthcare providers, law enforcement agencies, and community leaders. By fostering partnerships and enhancing coordination mechanisms, it becomes possible to streamline service delivery and ensure a more holistic and integrated approach to supporting survivors.

Overall, while progress has been made in recognizing and responding to domestic violence in pastoral communities, significant efforts are still needed to strengthen referral mechanisms, improve service accessibility, and enhance coordination among stakeholders. By addressing these challenges, it becomes possible to better support survivors and combat domestic violence effectively in pastoral settings. These barriers include fear of divorce, social stigma, and discrimination. To substantiate this quote:

"Even though local referral mechanisms and institutions for survivors or domestic/partner violence to seek justice (security/shelter, reporting, investigation, and prosecution practices) are functioning, the victims prefer either silent or seeking justice from the religious or traditional leaders".

The disclosure that survivors lack trust in existing formal services due to concerns about confidentiality and anonymity underscores a critical issue that must be addressed in efforts to combat domestic violence. Without trust in the confidentiality of their information, survivors may be reluctant to seek help or report incidents of violence, perpetuating a cycle of underreporting and inaccessibility to support services. To address this challenge, it is essential to prioritize protecting survivors' privacy and confidentiality through robust confidentiality protocols and training for service providers. Additionally, efforts should be made to build trust with survivors through transparent communication, empathetic support, and consistent adherence to ethical standards.

The partial functioning of one-stop centers and the lack of critical resources to provide comprehensive support for IPV survivors highlight gaps in service provision that must be addressed. Ensuring that one-stop centers are adequately resourced and staffed with trained professionals is essential for providing survivors with the holistic support they need to recover from violence and rebuild their lives. This may involve investing in training programs for service providers, increasing funding for support services, and improving infrastructure and facilities at one-stop centers to enhance their effectiveness and accessibility.

Weak coordination and partnerships with other stakeholders, high staff turnover, and ineffective information management systems are additional challenges that must be overcome to improve the implementation of local referral mechanisms and institutions for survivors of domestic/partner violence seeking justice. Strengthening coordination mechanisms among stakeholders, including government agencies, civil society organizations, healthcare providers, and law enforcement agencies, is critical for ensuring a cohesive and integrated response to domestic violence. This may involve establishing formalized coordination mechanisms, such as inter-agency working groups or task forces, to facilitate collaboration and information sharing among key stakeholders. Additionally, efforts should be made to address staff turnover through measures such as providing adequate training and support for personnel and implementing retention strategies to promote job satisfaction and longevity.

Overall, addressing these challenges requires a multi-faceted approach that prioritizes survivor-centered care, trust-building, resource allocation, and coordination among stakeholders. By addressing gaps in service provision and strengthening coordination mechanisms, it becomes possible to enhance the effectiveness of local referral mechanisms and institutions for survivors of domestic/partner violence seeking justice.

3.4. Non-partner sexual violence

The revelation of mixed views regarding the types of non-partner violence in the study areas underscores the complexity of understanding and addressing this issue. While some informants reported a lack of adequate evidence about non-partner violence, others indicated an increasing prevalence of such violence over time. This variation in perspectives highlights the need for more comprehensive data collection and analysis to accurately assess the extent and nature of non-partner violence in the region.

The acknowledgement that non-partner violence against women and girls can have multiple adverse health outcomes, including fatal, physical, sexual, psychological, or behavioural consequences, underscores the urgency of addressing this issue. Non-partner violence poses significant risks to the health and well-being of women and girls, and efforts to prevent and mitigate its impact are essential for promoting gender equality and safeguarding the rights of all individuals.

Moving forward, it is important to prioritize research and data collection efforts to understand better the prevalence, patterns, and drivers of non-partner violence in the study areas. This may involve conducting surveys, interviews, and focus groups to gather information from survivors, service providers, and community members about

their experiences and perceptions of non-partner violence. Additionally, efforts should be made to raise awareness about the issue and provide support services for survivors, including access to healthcare, counselling, legal assistance, and other forms of support.

Addressing non-partner violence requires a comprehensive and multi-sectoral approach that involves collaboration among government agencies, civil society organizations, healthcare providers, law enforcement agencies, and community leaders. By working together to raise awareness, strengthen support services, and advocate for policy and legal reforms, it becomes possible to prevent and respond effectively to non-partner violence and promote the safety and well-being of all individuals in the study areas.

Rape and attempted rape, especially prevalent during economic hardships, emergencies, and in IDP centers, are significant concerns. This type of non-domestic violence is followed by sexual harassment, particularly notable in IDP centers and schools, according to the majority of informants. The main perpetrators identified by these informants were youths and adults addicted to drugs and alcohol, as well as mentally ill individuals. To support this with quotes:

"Rape, death report after raping, sexual violence, abuse and harassment are increasing in the region from time to time. the most common violence is the rape of girls and boys. For instance, the last 9 months report there are 105 and 75 cases of actual rape of both girls and boys in the city of Gode and Jijiga, respectively. The cases are now being reported to the Women and Children Affairs Bureau since the community now understands that justice services exist". (KII from BoWSA)

3.4.1. Triggering factors and justifications

When discussing triggering factors and justifications, the majority of informants highlighted economic hardships (such as poverty and unemployment due to limited economic opportunities and livelihood loss from drought), social norms condoning men's use of violence for control and discipline, low awareness levels, and substance misuse as reinforcing gender inequality and perpetuating non-partner violence against women and girls in pastoral communities. Unlike domestic violence, informants noted that victim-blaming attitudes are low, indicating that the community generally condemns rape and attempted rape seriously.

"The common triggering factors are attached to easy access to the drugs and behavioural problems attached to the mafia group called China group. Usually, such incidents happen at night time from 4.00 to 6.00 in dark corner areas. In addition, un-

wise access and use of social media and the loss of one's religious and cultural identity as other potential factors, as well as feeling hopelessness (due to inflation, unemployment and absolute poverty) are the main factors exacerbating such violence in the community"-KII (BoLSA)

"*In the IDPs, it has been reported the high risk of sexual abuse and exploitation. In some areas of the IDPs, the neighbourhoods are very densely populated with residents who are mixed of male/female-headed households and single male youths. As there were no toilets and bathrooms in tents, many women faced sexual abuse because of the toilets or because they didn't have money to pay for their basic needs, such as food and shelter. In such episodes, victims do not report to formal systems because they worry about their reputation and fear retaliation. Another reason is that the ultimate concern of women providing for their family's basic needs at all costs and scarification*". KII (Traditional birth attendants, Deghabur)

When asked about prevention and response measures in place (referral mechanisms and institutions for survivors of domestic/partner violence to seek justice (security/shelter, reporting, investigation, and prosecution practices), participants' views are summarized as follows.

The informants disclosed that inclusive trainings, targeting local and religious leaders, parents, school teachers, youths, and women groups, as well as traditional birth attendants, are provided aiming at prevention of such violence. Regarding response mechanisms, one-stop centers have been established in Jijiga and Degahabur cities to cater to the needs of rape survivors, effectively offering health and legal services for the victims. According to informants from the Bureau of Women and Social Affairs and Justice Bureau, the demand for such services is very low due to the high rates of under-reporting of non-domestic violence (rape) in the pastoral communities.

To support these direct words of one KII;

"Instead of seeking services and justice from formal systems, most rape survivors prefer to handle the case through the locally available mechanisms (by engaging religious and local elders) to protect the victim from stereotypes. In this case, the perpetrator is expected to marry the victim with compensation or take the case to the court if he failed to accept the offer". KII (Religious leader, Harawo)

"To handle the case locally, a man who raped a girl (if he impregnated her in particular) will be her husband in our culture. Many women married to men who raped them because it is a way of covering shame and the rape victim stereotype. In addition, for the sake of social harmony and community stability, we do not believe in monetary compensation and sending to jail the perpetrator as an atonement for rape." KII (Traditional leader, Deghabur)

The reasons for under-reporting [hiding of rape and attempted rape cases] include: Victims often deny being survivors of rape due to the perception that they are seen as "losers" and exposed to bullying. Detailed investigations of rape cases can cause further psychological and sometimes even social injuries to the victims. Seeking justice through formal systems may result in the victim's name and personal details being made public, leading to repeated social damage. Victims may fear retaliation by the perpetrator, who could bribe the police and judiciary personnel. Additionally, survivors may fear revenge from the offender or their associates if they are convicted and sent to jail. Some rape survivors decline referrals to health services due to the fear of mandatory reporting requirements to the police and justice system.

Regarding the legal framework, informants from justice and women's affairs stated that the criminal code clearly stipulates that actual rape results in 25 years imprisonment and sometimes a life sentence. In comparison, attempted rape carries a punishment ranging from 7 to 8 years imprisonment. Once an incidence occurs and all medical and psychological support is provided at the one-stop centre, with the medical evidence, the case is referred for legal measures through the facilitation of police and justice bureau experts within the one-stop centre for further enforcement.

3.5. Stakeholder analysis

Table 1: Stakeholder Analysis

Stakeholder[14]	The interests, objectives, and priorities regarding VAWG and gender norms.	Mechanisms used to address VAWG	Availability of resources	Collaboration with others	Challenges
Government agencies (Health, Justice, education, WSA…)	• Justice Buruea indicated that their interest was to support victims legally. • The Women's Affairs Bureau mentioned that their interest was to maintain gender equity and protect women and girls from violence. • To do so, they are working with. Their challenges are cultural attitudes, lack of resources, and commitment from men. Similarly, • The Education Bureau's interest is to create access to girls and manage girls dropping out due to child marriage. • The Health Bureau's interest is to ensure the health centre provides service to the survivors	• Wider community attitudinal change • Capacity building of the woreda-level focal persons related to the issue. • Referral to a one-stop centre for further treatments and legal protections.	• Lack of resources both human and financial resources • Lack of expertise on the subject matter	• Stakeholders working in the one-stop centre • Concerned regional bureaus and NGOs	• lack of resources • Cultural beliefs, lack of commitment from men
non-governmental organizations	• UNICEF, GIZ, IRC, Save the Children, Pastoralist Concern, ODA, and WHO are some NGOs working in VAW. Their interest is to decrease girls' school dropout because of child marriage, provide the necessary service for the survivors of VAWG in the health centre, decrease FGM	• Supporting government sectors • Establishing the one-stop center • Creating alternative economic options for the traditional midwives involved	• Lack of human and financial resources to cover a large area	• Government sectors, community-based organization	Cultural beliefs

[14] Include both duty bearers and rights holders

Stakeholder[14]	The interests, objectives, and priorities regarding VAWG and gender norms.	Mechanisms used to address VAWG	Availability of resources	Collaboration with others	Challenges
		in mutilation, Financial support for transportation for survivors			
Healthcare providers	• Decrease FGM and child marriage	Awareness-making and health education for the community and health workers	• Lack of resources (transportation cost…) • Few areas of coverage	• Keele leaders	No strong stakeholder collaboration
Religious institutions	• The objective is to end this VAWG and all things that affect the health of individuals and communities, including bad norms and practices related to cultures	Give general advice and raise awareness for the community at masjids and other places	• No resources to create awareness across the board	• Government sectors	Lack of resources
Traditional institutes (Ugazi)	• The main objective is to prevent any harm before it happens	Create awareness	• Limited resources	• Government	Old men's beliefs and their addiction to the harmful norms and how they are influencing the people, and how some people still believe them. Lack of resources to help the affected victims
PTA	• Preventing this harmful tradition	Teaching the community about the consequences of harmful traditional practices	There is no resource	Community leaders	
TBAs	• To make people more educated about FGM and child marriage	• Creating awareness		Community leaders	Resistance from the community

4. CONCLUSION AND RECOMMENDATIONS

4.1. Conclusion

The study employed a qualitative research approach, collecting data through Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) with a wide array of informants from regional, woreda, kebele, and institutional levels. Primary data was gathered through face-to-face interactions at both individual and group levels.

While the regional government, in collaboration with other stakeholders addressing Violence Against Women and Girls (VAWG), has made efforts to combat the issue, there remain significant challenges. The prevalence of VAWG, including Female Genital Mutilation/Cutting (FGM/C) and Intimate Partner Violence (IPV), continues to pose serious public health concerns for the lives of women and girls in the study areas. The findings underscore the ongoing need for concerted efforts by the Ethiopian government and its development partners to fulfil commitments to eliminate FGM/C and child marriage and to reduce IPV and non-domestic violence, particularly instances of rape.

Triggered by both traditional and religious justifications, a large majority of girls continue to be victims of Female Genital Mutilation/Cutting (FGM/C), often performed by traditional cutters, although there is growing evidence of medicalization and shifts in the type of FGM being practiced. Though mothers are the main promoters of FGM to continue, TBAs, religious leaders and [old men in particular] also consider FGM as part of their culture and religion.

Additionally, the pastoral community, particularly mothers, often perceive FGM/C as beneficial, primarily for controlling girls' sexuality and ensuring their marriageability, despite the associated negative consequences.

In terms of both domestic and non-domestic violence, the primary risk factors include deeply entrenched gender norms, patriarchal principles, socioeconomic inequalities, discriminatory cultural and religious beliefs, harmful traditional practices, and economic hardships exacerbated by droughts and floods. The patriarchal nature of the community perpetuates certain forms of domestic violence against women, such as physical, psychological, and emotional abuse, which are often considered acceptable and tolerable, leading to victim-blaming and social exclusion of women survivors.

In terms of non-domestic violence, rape and attempted rape were identified as the most prevalent types, followed by sexual harassment in internally displaced persons (IDP) camps and schools. The main perpetrators were youths and adults addicted to drugs and alcohol, as well as mentally ill individuals. The primary triggering factors cited included economic hardships, such as poverty and unemployment resulting from a lack of economic alternatives and the loss of livelihood due to drought shocks. Additionally, social norms that condone men's use of violence as a form of discipline and control, low levels of awareness, and substance misuse were identified as contributing factors.

Unlike domestic violence, informants noted that victim-blaming attitudes regarding non-domestic violence were low in the community, with condemnation rather than justification or tolerance of rape and attempted rape. However, many acts of violence against women and girls, both domestic and non-domestic, are under-reported due to

various reasons, including fear of stigma and labelling, retaliation by the perpetrator, and mistrust in the police and justice system's confidentiality and reporting requirements.

Another noteworthy finding is the reluctance to openly discuss violence against women and girls (VAWG) within families, public forums, and among duty bearers. This silence was observed among the majority of focus group discussion (FGD) participants and some key informants (KII) at the local level, underscoring the necessity for strategies to sensitize and train health providers, law enforcement personnel, and local administrators and gatekeepers, including religious leaders, traditional birth attendants (TBAs), and community leaders. These efforts aim to raise awareness and encourage open discussions about VAWG within the community.

Regarding response mechanisms, it was observed that most cases of VAWG are handled through locally available mechanisms, primarily involving engagement with religious and local elders, rather than seeking formal services and justice through established systems. This preference for family- and community-level mediation is influenced by considerations of family honor and dignity and the perceived effectiveness of tracing and disciplining perpetrators through religious doctrines and clan networks.

4.2. Recommendations

Building upon our findings, we have identified several priority recommendations for future coordinated interventions to address VAWG in the study woredas and IDP centres.

- ✔ Establish community-based networks, engaging community elders and religious leaders in particular, and conduct awareness campaigns that challenge social norms around the acceptability of IPV, non-domestic violence, and FGM/C
- ✔ Because restrictive gender norms prevent girls and women from accessing education, employment or decision-making – and drive VAWG– the Women and Social Affairs Bureau must prioritize efforts to tackle these beliefs and practices directly.
- ✔ Promote income-generating activities for women. Provide capacity building for women (both soft and technical skill) training, create access to credit and market, using role models [pastoral women who have succeeded in combining family responsibilities and out-of-home livelihood activities], equal access to formal education, encouraging and facilitating networking between successful women and focal women [like TBAs]…etc.
- ✔ Promote inter-household and intergenerational dialogue around VAWG and male engagement. Recognize model households/ champions in a fight against VAWG.
- ✔ There should be periodic coordination between agencies working on VAWG to review, assess, monitor, evaluate and follow up on handling reported cases of VAWG in general and during economic hardships and emergencies.
- ✔ Non-government actors work closely with gatekeepers [such as religious and

local leaders, TBAs, and teachers) to promote the negative consequences of VAWG in general and the abandonment of these harmful practices.

- ✔ Utilize school clubs to encourage interactive learning on various topics, including promoting equitable division of household chores and out-of-home responsibilities between girls and boys and men and women. In addition, role models shall be invited to share their life stories with girls to inspire them to fight for gender equality and change the gender norms and roles that reinforce VAWG. The role models can be selected from the schools or outside the schools/community. The activities in GC and role models to be in place shall use learning approaches involving groups, drama and role-play, peer-led activities involving group discussions…etc.

- ✔ Because knowledge of the law banning FGM/C and child marriage remains limited, and enforcement appears all but non-existent, the justice sector needs to scale up efforts to promote and enforce regional laws on harmful practices.

- ✔ Engage women and girls from the IDP sites to co-design survivor centric SGBV interventions. This may include conducting safety, security, mobility mappings and community-led site assessments for one-stop VAWG centers and other providers offering health, legal, judicial and other essential services.

- ✔ Facilitate VAWG awareness and sensitization activities, including the response mechanism within the community through multiple channels.

- ✔ Introduce (or strengthen) SRHR education programs for adolescents and youth to challenge harmful gender and social norms and to mitigate stigma facing VAWG survivors.

- ✔ Provide training for health service providers about VAW and how to treat survivors

- ✔ Adopt a survivor-led approach: this means listening, reporting (with the victim's consent) and long-term support

- ✔ Strict requirements for medical service providers, kebele leaders, and families of victims to report any rape and other forms of violence expose women, girls and children to the risk of stigma, shame, and social pressure during emergencies in particular

- ✔ Identify a clear referral pathway supported by standards for the various stakeholders involved and Create awareness of the referral mechanism available as an effective strategy to address identified gaps in the referral linkages. This could increase the reporting rate of incidence of VAWG;

- ✔ Establish linkages between private and public health referrals for VAWG survivors who report to private clinics.

- ✔ Ensuring the availability, accessibility and inclusiveness of shelters [including a One-Stop center with skilled training and seed money for the reintegration of survivors]

Specific to FGM and Child marriage, the following approaches shall be implemented

- ✔ Social norms approach to address collective behaviour changes, foster community empowerment, and create positive social norms.
- ✔ Gender transformative approaches, which promote gender equality (the shared control of resources and decision-making) and women's empowerment, are central to interventions addressing the root causes of child marriage and FGM/C, with due focus on the worst forms.
- ✔ Multi-sectoral approach to address the different drivers and the common causes of child marriage and FGM/C through coordination of mandates to empower girls and work with communities, and strengthen health, education, child protection and legal system and services.
- ✔ In pursuant of girls at the center, the social ecological framework shall be applied to reach all those who play a role: families, religion and communities and their structures, service providers [including referral mechanisms and institutions] and policy maker