The Prevalence and Contributing Factors of Sexual and Gender-based Violence among Women Somali Refugees in Addis Ababa, Ethiopia. The Case of Ethiopian Orthodox Church Development and Inter Church Aid Commission Refugees and Returnees Affairs Department (EOC-DICAC-RRAD)

MSW Dissertation Research Project
(MSWP-001)

Prepared By
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School of Social Work

Addis Ababa, Ethiopia
May, 2013

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DECLARATION

I hear by declare that the dissertation entitled *"The Prevalence and Contributing Factors of Sexual and Gender Based Violence among Women Somali Urban Refugee in Addis Ababa"* submitted by me for the partial fulfilment of the MSW to Indira Gandhi National Open University, (IGNOU) New Delhi is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirement for any other programme of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or others.

Place: _____ Signature: _____

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Name: _____

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CERTIFICATE

This is to certify that Mr. _____ student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for his project work for the course MSWP-001. His Project Work entitled *"The Prevalence and Contributing Factors of Sexual and Gender Based Violence among Women Somali Urban Refugee in Addis Ababa" which he is submitting, is his genuine and original work.*

Place: _____ *Signature:* _____

Date: _____ *Name:* _____

Address of the Supervisor: _____

_____

_____

_____

Dedication

I would like to dedicate this paper to all refugee women and girls who are forced to leave their homeland due to different reasons and become vulnerable and survivors of different psychosocial problems.

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Acknowledgement

First my deepest gratitude goes to the Almighty GOD who guided me all the way to reach this stage. I do believe that his protection will continue throughout my entire life.

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Abbreviations and Acronyms

EOC-DICAC-RRAD	Ethiopian Orthodox Church Development and Inter Church Aid Commission Refugees and Returnees Affairs Department
JRS	Jesuits Refugees Service
ARRA	Administration for Refugees and Returnees Affairs
MCDO	Mother and Child Development Organization
IOM	International Organization for Migration
SGBV	Sexual and Gender Based Violence
RCC	Refugees Central Committee
GBV	Gender Based Violence
NVAWS	National Violence against women survey
DHS	Demographic and Health Survey
IASC	Inter Agency Standing Committee
HTPs'	Harmful Traditional Practices
UNHCR	United Nations High Commission for Refugees
UNHCR/RLO	United Nations High Commissioner for Refugees Regional Liaisons Officer
IDP	Internally Displace Persons
FGoE	Federal Government of Ethiopia
URWS	Urban Refugees Women Association
ETB	Ethiopian Birr (Currency)

Abstract

Sexual and gender-based violence is a violation of human rights. This kind of violence perpetuates the stereotyping of gender roles that denies human dignity of the individual and stymies human development. The overwhelming majority of the victims/survivors of sexual and gender-based violence are women and girls. The root causes and consequences of sexual and gender-based violence must be understood before appropriate programmes to prevent and respond to this violence can be planned.

The main purposes of this study are to assess the prevalence and contributing factors for sexual and gender based violence and harmful tradition practices. It also attempts to investigate contributing factors for the prevalence of the problem especially among Somali urban refugees who are residing in Addis Ababa.

Methodologically, this study uses both qualitative narrative approach and quantitative method and the results are triangulated. Both primary and secondary data are used to collect relevant data for the study. The primary data are collected with the help of questioners and in-depth interviews with Somali women refugees, urban refugees' women association members, key informants and social workers working for the Ethiopian Orthodox Church Development and Inter Church Aid Commission Refugees and Returnees Affairs Department (EOC-DCIAC-RRAD).

The findings of the research indices that there is high prevalence of gender based violence and harmful traditional practices among Somali urban refugees community besides the deep rooted customs and traditions of the Somali community and the values attached to women and girls significantly contributed for the wide prevalence of the problem. The study recommends awareness raising workshops and trainings to Somali women, elders, religious leaders, urban refugees' representatives. Such trainings need to back up with monitoring to see the impacts. It also recommends that sending girls to school enable them to capacitate with knowledge.

Appendices

Appendix I:

Interview Schedule
On the Prevalence and Contributing Factors for SGBV among Women Somali Urban Refugees in Addis Ababa, Ethiopia.

Introduction

This questioner is designed to assess the prevalence and to identify contributing factors for sexual and gender based violence among Somali women urban refugees in Addis Ababa, Ethiopia.

The researcher would like to request you to give genuine answer to all the questions listed below. He would also like to remind you that your genuine answers are of paramount importance to the outcome of this research project and for that all the answers and your identity are kept anonymous.

Confidentiality and consent: The study will not ask your name and will not be recorded anywhere. The researcher will not tell to anyone your answers to any of these. You do not have to answer any questions that you do not want to answer. However, your honest answers to these questions will help the researcher to better understand the prevalence of the problem and to provide feasible suggestions to the different aspects of the problem.

The researcher would greatly appreciate your participation in this survey. It will take about 50 minutes to fill out this questionnaire. Thank you for your patience and participation in advance.

Are you willing to participate? [ ] YES [ ] NO. If yes, continue

I. Background Data

1. Respondent's Current address in Addis Ababa. Please put"√" mark against your choice)

1. Bole	[ ]	4. Yeka	[ ]	9. Arada	[ ]
2. Nefas-silk- Lafto	[ ]	5. Gulele	[ ]	10. Lideta Sub-city	[ ]
3. Kirkos sub-city	[ ]	7. Cherkos Su-city	[ ]		
4. Akaki sub-city	[ ]	8. Addis Ketema	[ ]		

No.	Questions in English	Response
100	Sex	1. Male 2. Female
101	How old are you?	_____
102	Marital status	1. married 2. single 3. divorced 4. separated 5. widowed 88. No response
103	If your answer for Q102 is "DIVORCED" OR "SEPARATED" what was the main reason? (more than one answers are possible)	1. Religious difference 2. External family members' interference 3. Economical problem 4. Ethnic difference 5. Working conditions 6. Sexual conflict 7. Addiction 8. Age difference 9. Others (please specify) _____ _____
104	If your answer for Q102 is "MARRIED", please tell us how you chose your marriage partner	1. By own choice 2. Parental Decision 3. By abduction 4. By inheritance 5. Others (please specify) _____ _____ 88. No response
105	Occupation	1. Farmer 2. Daily laborer 3. Merchant 4. Gov. employee 5. Private employee 6. Others (specify)_____ _____
106	Educational status	1. cannot read and write 2. read and write 3. Primary completed 4. Secondary school completed 5. College/University education,

		please specify
107	Religion	1. Muslim 2. Orthodox 3. Protestant 4. Catholic 5. Other (specify) _____ 6. 88. No response
108	Do all members in your household belong to the same religion?	1. Yes 2. No
109	If your answer is "No" for Q108, was there any major problems caused as a result in your HH? (more than one answer are allowed)	1. No problem observed at all 2. Conflict of interest 3. Divorce 4. Separation 5. Street life 6. Commercial sex work 7. Others (specify) _____ _____
110	Duration of the respondent's stay in Addis Ababa	_____ (years)

II. Socio-economic Data

200	Average Household income per month	Eth. Birr _____
201	What are the major income sources of the head of house?	1. Daily labor 2. Farming 3. Trading 4. Salary 5. Allowance from NGO/CBO/CSO 6. Self-employment 7. Other, please specify _____ _____
202	Does the head of house have any additional economic income sources?	1.Yes 2.No

III. Spouse Relationship

300	Does your husband have other wife?	1.Yes 2. No 88. No response
301	If the answer to Q300 is YES; how many wives does he have?	1. Two 2. Three 3. More than three
302	Are you the.....wife of your current husband?	1.First 2.Second

		3.Third 4. Fourth or above
303	Your current husband is the ...husband for you.	1.First 2.Second 3.Third 4. Fourth or above
304	How long have you stayed with your current husband?	_____years
305	Have you been in conflict with your husband or wife, since your marriage?	1.Yes 2.No 88. No response
306	If the answer to Q 305 is Yes; How frequent was the conflict?	1.Usually (daily) 2.Sometimes (3 times/week) 3.Occasionally(2 times/month) 4.Other (Specify)_____
307	If the answer to Q 305 is Yes; what was the cause?	1.It was not the marriage I wanted 2.Alcoholic husband 3. Husband has other wife. 4.Economical problem 5.You don't obey your husband properly 6.Initiated by Relatives 7.Husbands bad habit (cigarette, Khat) 8.Initiated by Neighbors 9.High tempered husband 10.Other (Specify)_____ _____

308	How was the conflict resolved?	1.Elderly people Intervention 2.Family Initiated 3.Friend Initiated 4.Parents 5.Neighbors 6.Yourselves 7.Still Not Resolved 8.Other (specify)_____ _____

IV. Harmful Traditional Practices

400	Have you ever heard about the Harmful Traditional Practices (HTP)?	1. Yes 2. No
401	If the answer is YES for Q400, how you heard about of HTPs?	1. Through media 2. Through community conversation 3. Training sessions 4. Religious teaching 5. Other (specify) _____ _____
402	Have you ever heard of female genital cutting or circumcision?	1. Yes 2. No
403	Have you yourself ever been circumcised?	1. Yes 2. No 3. 88. No response
404	How old were you when you were circumcised?	1. up to 1 years 2. 1-5 years 3. 6 to 10 years 4. > 10 years
405	Who performed the circumcision?	1. Traditional Circumciser 2. Traditional Birth attendant 3. Health profesional 88. No response

406	What is the place given by the family or community members for uncircumcised girl?	1. Neglected 2. Respected 3. Stigmatized 4. I don't know 88. No response
407	Can female circumcision be a criterion for good marital relations?	1. Yes 2. No 3. I don't know 88. No response
408	Which types of HTPs are most frequently practiced in your clan or kebele? Please specify the top five types of HTPs according to impact level, from highest impacting to lowest order.	1. _____ 2. _____ 3. _____ 4. _____ 5. _____
409	Do you think that the household members are at risk of HTPs?	1. Yes 2. No 88. No Response
410	If your response to Q 409 is No, what could be the reason? (more than one answer is possible)	1. God (Allah) protect us from all. 2. We are good with our neighbors and community 3. We are not exposed to HTPs 4. We use open discussion among family members. 5. Others (specify)_____ _____
411	What kinds of people are more likely to be highly vulnerable to HTPs? (more than one answer is possible)	1. Only children 2. Only girls and women 3. Only adults 4. Any body 5. Others (specify)_____ _____ 88. No response
412	Do you know how to prevent people from the impacts of HTPs in your household as well as in your sub-city or Wereda?	1.Giving education to the community, 2. Enforcing laws, 3. Isolating those who do the practice from the community, 4. Social Dialogue, 5. Others (Specify) _____

		_____ _____
413	HTPs have no effects on someone's life.	1. strongly agree 2. agree 3. neutral /have no idea 4. disagree 5. strongly disagree
414	Victims of HTPs/fistula / should not keep their status secret to household members.	1. strongly agree 2. agree 3. neutral 4. disagree 5. strongly disagree
415	Is any of your child has been circumcised?	1. Yes 2. No
416	If your answer for Q 415 is Yes, what was your reason for circumcising your female child? (more than one response is possible)	1. Just to keep the culture 2. To avoid bad effect on her future life 3. Wish her to have good marital relation 4. Thinking that her husband like it 5. For marriage 6. Others (specify) _____ _____ _____
417	Do you think it is safe to live with a person with fistula?	1. Yes 2. No 3. 88. No response
418	Would you stop being friend to child if she has a fistula?	1. Yes, I will stop 2. No, I do not stop 88. No response
419	A female child should be circumcised before marriage?	1. Strongly agree 2. Agree 3. Neutral /have no idea 4. Disagree 5. Strongly disagree
420	Have you ever thought of stopping female child circumcision?	1. Yes 2. No 88. No response
421	If your answer is No for Q420, why?	1. Fear of disrespect 2. Marriage delay 3. stigma 4. For rear of unwanted sexual behavior 5. Other (specify) _____ _____ _____

V. Magnitude of GBV

500	During the last months did you go out alone in the evening for different reasons?	1.Yes 2.No
501	Out of fear, do you generally avoid going out alone?	1.Yes 2.No
502	Out of fear, do you avoid in general using some streets, or areas in Addis Ababa?	1.Yes 2.No
503	Out of fear, do you generally avoid public transport services?	1.Yes 2.No
504	Should a husband be allowed to physically punish his wife?	1.Yes 2.No 88. No response
505	Is it common for men to beat their wives?	1.Yes 2.No
506	Is it common for other HH members to beat women?	1.Yes 2.No 88. No response
507	Are there traditions in the community that can help women recover from the bad affects of the conflict?	1.Yes 2.No
508	Please site some examples for ways for women to recover from violence?	_____
509	During the last 12 months, have you slapped, smacked or tapped a child?	1.Yes 2.No
510	During your childhood or teenage years, did you have any serious conflict with your parents or one of your parents?	1.Yes 2.No
511	Did anyone force you to undergo or perform sexual touching, tried or managed to have sexual intercourse with you against your will?	1.Yes 2.No
512	If yes to Question no. 511. How many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
513	Did someone force you to perform sexual touching? Did this occur several times?	1. Yes 2. No

514	During the last 12 months did anyone unsuccessfully try to force you to engage in sexual intercourse?	1. Yes 2. No
516	If Yes to Q 514, did this happen several times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
517	If Yes to Q 514, was it always the same person/persons?	1. Yes 2. No 88. No response
518	Was it a person (or people) totally unknown to you?	1. Yes 2. No
519	Among the acts we have just mentioned, for the last twelve months, you have reported that you have experiences:	1. Insults 2. Being followed 3. Assault for robbery 4. Exhibitionism 5. Threats or attack with a weapon 6. Being kissed or groped by force 7. sexual touching 8. Attempt of forced sexual intercourse 9. Forced sexual intercourse 88. No response
520	Among these incidents, which one, according to you is most serious?	(One possible answer) _____ _____
521	During the last 12 months, has your husband/spouse prevented you from meeting or talking to friends or family members or other people?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
522	During the last 12 months, did your husband/ spouse downplay the value of what you did?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
523	During the last 12 months, did your husband/ spouse make unpleasant remarks about your physical appearance (too big, ugly)?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
524	During the last 12 months, did your husband/spouse impose dressing styles, type of hair style on you, or how you were to behave in public?	1. Never 2. Seldom 3. Some times 4. Often

		5. Systematically
525	During the last 12 months, did your husband/spouse refuse to take your opinions into consideration, ridicule them or attempted to tell you what you should think (in private)?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
526	During the last 12 years, did your husband /spouse require to know with whom you were and where?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
527	During the last 12 months, did your husband/spouse stop talking to you; totally refuse to discuss issues with you?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
528	During the last 12 months, has your husband/spouse prevented you from having access to the household resources for your daily needs?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
529	During the last 12 months, did your husband/spouse threaten to beat your children or separate you from them?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
530	During the last 12 months, did your husband/spouse physically attack your children or separate you from them?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
531	During the last 12 months, did your husband/spouse insult you or abuse you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
532	During the last 12 months, did your husband/spouse throw an object at you, push you or brutally grab you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
533	During the last 12 months, did your husband/spouse slap you or inflict other physical brutalities on you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times

534	During the last 12 months, has your husband/spouse prevented you from going back home, lock you in or out, or in a car, and leave you on the roadside? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
535	During the last 12 months, did your husband/spouse threaten you with suicide? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
535	During the last 12 months, did your husband/spouse utter death threats against you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
536	During the last 12 months, did your husband/spouse threaten you with a weapon (knife, tool, revolver, etc)? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
537	During the last 12 months, did your husband/spouse attempt to strangle or kill you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
538	During the last 12 months, did your husband/spouse use force to have sexual intercourse with you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
539	Did he impose sexual acts that you refused? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
540	Among the incidents we have just mentioned and which occurred during the last 12 months, you declared that you have suffered from: (more than one answer is possible)	1. Being forbidden to have social relationships. 2. Undermining what you do. 3. Having your hairstyle, clothing criticized. 4. Having your physical appearance criticized 5. Imposed attitudes 6. Having your opinions criticized. 7. Being denigrated in front of a third party 8. Being denied the right to talk 9. Being denied access to money 10. Threats against a child 11. Violence against a child or forced separation 12. insults, abuses 13. Thrown objects at you 14. blows 15. confinement, being thrown out of the house, left on the roadside

		16. suicide threat 17. death threat 18. Threat with a weapon 19. Attempted murder 20. Forced sexual intercourse 21. Other sexual abuses 22. Non
541	Among these incidents, which one is the most serious according to you?	*(One possible answer)* /____/
542	During the last 12 months, did one of your relatives prevent you from going out or locked you (in your home or in his house), chased you away or, during a ride by car, leave you on the roadside? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
543	Have you approached a police to report any incidents of violence?	1. Yes 2. No 88. No response
544	If your answer to Q 543 was Yes, what was the outcome?	_____ _____
545	During the last 12 months, did one of your relatives threaten you with a weapon, or a dangerous tool (knife, stick, revolver …), attempt to strangle or kill you? If yes, how many times?	1. Never 2. Once 3. 2 or 3 times 4. Between 4 and 10 times 5. More than 10 times
546	Was it the same person/people?	1. Yes 2. No
547	During the last 12 months, did one of your relatives force you to touch them sexually or oblige you to undress or attempt or manage to force you to have sexual intercourse with them against your will?	1. Yes 2. No
548	If yes, what was it?	1. Touching or undressing 2. An attempt of forced intercourse 3. A forced intercourse 4. No Response
549	Did this occur several times, and if yes, how many times?	1. Never 2. Once 3. 2 or 3 times 4. Between 4 and 10 times 5. More than 10 times
550	Following these incidents, did you suffer from troubles requiring psychological support?	1. Yes 2. No
551	Following these incidents, was your sexuality permanently impaired?	1. Yes 2. No 88. No response
552	Following this incident, did you get a sexually transmitted disease?	1. Yes 2. No 88. No response
553	Did you talk about the incident to someone? If yes, after how long?	1. Yes, immediately, in the course of the next few hours 2. Yes, later on, after some days or some months 3. No
554	After this event, did you or another person get in touch with EOC-DICAC-RRAD for any support?	1. No 2. Yes, I did

		3. Yes, another person did
555	Following these incidents did you yourself or someone else reports it to the police?	1. No 2. Yes, I did 3. Yes another person did
556	If your answer to Q 555 was Yes. How were you received upon your arrival?	1. Very well 2. Well 3. Moderately well 4. Badly 5. Very badly
557	Following your complaint was there any legal conclusion?	1. Yes 2. No

VI. Factors contributing to GBV

700	Is your culture downgrading the role of women or girls?	1. Yes 2. No
701	"Men are stronger than women".	1. Strongly agree 2. Agree 3. Neutral /have no idea 4. Disagree 5. Strongly disagree
702	"It is the duty of men to cook a meal".	1. Strongly agree 2. Agree 3. Neutral /have no idea 4. Disagree 5. Strongly disagree
703	"It is the duty of women to look after her children".	1. Strongly agree 2. Agree 4. Neutral /have no idea 5. Disagree 6. Strongly disagree
704	"Men are born to do hard work than women".	1. Strongly agree 2. Agree 3. Neutral /have no idea 4. Disagree 5. Strongly disagree

705	Do you use the following items (habits)? (more than one answers are possible)	1. Alcohol 2. Cigarette 3. Chat 4.Shesha 5. Other (Specify)_____
706	Does your husband use the following items (habits)? (more than one answers are possible	1. Alcohol 2. Cigarette 3. Chat 4. Shesha 5. Other (Specify)_____
706	Do you think that a certain age groups are more liable to Gender Based Violence?	1. Yes 2. No
707	Do you think that women with low income susceptible to Gender Based Violence?	1. Yes 2. No
708	Do you think that being divorced or separated increase the risk of sexual and gender based violence?	1. Yes 2. No
709	Do you think that living in a rent house increase the risk of sexual and gender based violence?	1. Yes 2. No
720	During the last 12 months, have you ever been bitten by your husband? If yes, what do you think the reason behind?	1. He is jealous 2. He has abusive character 3. He is dictator. 4. Other(Specify) _____ _____

Appendix II

Interview Guide
On the Prevalence and Contributing Factors for SGBV among Women Somali Urban Refugees in Addis Ababa.

FOCUS GROUP DISCUSSION (FGD) GUIDES

Let us discuss about existing situations in your community in relation to GBV/HTP and women's empowerment

1. Do you know what GBV is all about?
2. Do you know what HTP is all about?
3. What is the place given to women and girls in your community?
4. What are the most common types of violence and harmful practices occurred to women in the Somali community?
5. What are the deep causes or roots of the violence and harmful practices on women (social, cultural, economic, etc)
6. Can you tell me the consequences on women that may have witnessed or experienced gender based violence and harmful traditional practices?
7. What factors contribute to the spread of gender based violence and traditional practices among the Somali community?
8. What are the existing services rendered to prevent GBV/HTP by different organizations like DICAC-RRAD, UNHCR, ARRA, etc?
9. Do you think that refugee women are eager to share their harmful experiences to different organizations like DICAC-RRAD?
10. Is there any framework of cooperation between different organizations that provide different psychosocial supports to refugees?
11. What do you suggest to effectively control or minimize the prevalence of gender based violence?

Appendix III

Interview Guide

On the Prevalence and Contributing Factors for SGBV among Women Somali Urban Refugees in Addis Ababa.

KEY INFORMANTS INTERVIEW (KII) GUIDING QUESTIONS

1. How do you explain the prevalence of GBV in the Somali community?
2. How do you explain the prevalence of HTPs in the Somali community?
3. Please tell us the overall existing situations in the Somali community towards GBV/HTP in Addis Ababa.
4. Can you tell us some of the contributing factors for the spread of gender based violence and harmful traditional practices among Somali communities?
5. Would you please suggest the roles and responsibilities of different actors like the Somali community centers, community representatives, and religious leaders, different organizations like UNHCR, ARRA, DICAC, and JRS for the betterment of future interventions against GBV/HTP? What major activities do you suggest in order that optimal changes are brought for the Somali community here in Addis Ababa?

   (Would you please suggest any feasible intervention types that you believe to be most effective and efficient in the context?)

Appendix IV

Interview Guide

On the Prevalence and Contributing Factors for SGBV among Women Somali Urban Refugees in Addis Ababa.

EOC-DICAC-RRAD Social Workers interview Guide

1. What are the different kinds of gender based violence's reported from urban women refugees?
2. Do you think that refugee women are eager to share their harmful experiences to different organizations like DICAC-RRAD?
3. What kind of support do you provide to the SGBV/HTPs survivors?
4. Apart from your organization, can you name various organizations involved in the control of SGBV among urban refugees?
5. What do you think are contributing factors for the prevalence of gender based violence among refugee communities?
6. Is there any framework of cooperation between different organizations that provide different psychosocial supports to refugees?
7. Do you have standard operating procedures in place to mange and kinds of violence happing among refugees?
8. What do you suggest to effectively control or minimize the prevalence of gender based violence?

Appendix V

List of NGOs in the study Area that have direct relation to the study

1. United Nations High Commission for Refugees Regional liaisons office Addis Ababa.
2. Ethiopian Orthodox Church Development and Inter Church Aid Commission, Refugees and Returnees Affairs Department (EOC-DICAC-RRAD).
3. Jesuit Refugees Services (JRS)
4. Administration for Refugees and Returnees Affairs (ARRA)

Chapter one

1.1 Background of the Study

Two decades have passed since the collapse of the Somali Republic. However, the country is still suffering from chronic political uncertainty, violence and high levels of internal and external population displacement. Protracted displacement situations which began in the 1990s have been overlaid by new crises. By early July 2011, UNHCR estimated that a quarter of Somalia's population was displaced, either internally or as refugees Anna (2011). In terms of both the numbers of people affected and their humanitarian and protection needs, the current situation is widely acknowledged to be among the worst displacement situations in the world.

In 2011, the humanitarian crisis in Somalia continued to worsen due to a combination of generalized violence, conflict between the government and its allies and insurgent groups. Drought across the Horn of Africa contributed to famine conditions in south and central Somalia. Famine threatened the lives of many of the 1.5 million people displaced within Somalia by the conflict, and forced many more to flee again in search of lifesaving assistance(www.internal-displacement.org).

The number of internally displaced persons (IDPs) in Somali has remained between 1.4 and 1.5 million since 2007 (www.internal-displacement.org). UNHCR and its partners have collected information on the movement of populations in Somalia through the population movement tracking system. Most of the populations identified as displaced are believed to have fled their homes because of the conflict or violence, and many have been displaced a number of times (Ibid).

In 2011, IDPs in Somalia faced severe risks to their security and dignity due to their living conditions and the ongoing conflict. Parties to the conflict reportedly attacked IDP

camps, perpetrated widespread sexual and other gender-based violence, forcibly recruited internally displaced children and fought each other near camps. The fighting and deliberate obstruction by some parties to the conflict severely limited access to urgently needed protection and assistance of IDPs and others, and prevented the return of IDPs to their places of origin. The country also faced outbreaks of cholera, diarrhea, malaria, measles and pneumonia, most of them in the IDP hosting areas in the south (Ibid).

In 1993, the United Nations General Assembly defined violence against women as "any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women" (United Nations, 1993). The United Nations referred to "gender-based" violence to acknowledge that such a violence is rooted in gender inequality and is often tolerated and condoned by laws, institutions and community norms; it is not only a manifestation of gender-inequality, but often serves to enforce it (World Bank, 2005).

Sexual and gender-based violence (SGBV) is a violation of human rights and includes sexual violence, physical violence, emotional and psychological abuse, harmful traditional practices, and socio-economic abuses. SGBV involves the use of force, which includes physical force, threats, coercion, or manipulation. The overwhelming majority of the victims/survivors of sexual and gender-based violence are women and girls (Population Counsel, 2008).

Sex refers to the biological, anatomical and physiological characteristics of males and females. Gender is the term used to denote the social characteristics assigned to men and women. Gender is not static or innate, but is learned through socialization and varies widely among cultures. Women and children face additional risks of being subjected to SGBV when fleeing away from fighting and seeking asylum. During armed conflict, social structures are disrupted and hence both women and girls become highly vulnerable to violence.

Sexual and gender based violence occurs in all society and at all stages of a women's life cycle. For instance it can occur before a girl is even born, as with a sex selective abortion in Northern India, and continue to menace women in all age. Some type of GBV, for instance sexual violence and domestic violence, may occur in all culture, although they are more common in some societies than in others. Other manifestations such as dowry are specific to particular culture. Because of its nature GBV is hard to research, it is often enacted away from the public eye, and women and girls who experience it may be afraid to speak out, or may accept it as a "normal" part of life. Considering its apparent scale, there have been relatively few studies that attempt to measure the prevalence of different types of GBV in all societies.

Sexual and gender based violence against refugees is a global problem. It constitutes a violation of basic human rights, instilling fear in the lives of victims already profoundly affected by their displacement. Refugees from Bosnia and Herzegovina, Rwanda, Somalia and Vietnam have brought with them harrowing stories of abuse and suffering (UNHCR, 1995).

During violent conflicts, women and girls experience violent in different ways because of gender. During a recent conflict in Bosnia, Liberia, Democratic Republic of Congo, Northern Uganda, Burundi, Somali, Darfur in Sudan and elsewhere, rape has been used systematically as a weapon of war. In humanitarian context, such as displaced people's camp, women and children are especially vulnerable to GBV. For instance, a recent survey found that at least six out of ten women in Northern Uganda's largest camp for displaced people had been sexually and physically assaulted, threatened and humiliated by men in the camp (Geraldine Terry and Joanna Hoare, 2007).

The magnitude and atrocities of gender based violence among the Somali communities who are in their country and those who are hosted in neighboring counties like Ethiopia

or Kenya has not been studied in great depth and hence difficult to tell. Little documents are found written by UNHCR staffs that indicate the prevalence of gender based violence among Somali refugees who are hosted in few refugees' camps in Ethiopia. However the prevalence of gender based violence among Somali women urban refugees in Ethiopia has not been studied so far. Hence this project aims to investigate the prevalence and contributing factors of gender based violence among Somali women refugees in Addis Ababa.

1.2 Problem Statement

Globally, gender-based violence (GBV) is a pervasive public health and human rights problem. Women and girls are at higher risk and affected more frequently than men and boys. The term sexual and gender-based violence encompasses a wide variety of abuses including sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, involuntary prostitution or sexual bartering, and torture. Female genital cutting (FGC) and other harmful traditional practices, including early marriage, which substantially increase maternal morbidity and/or mortality, are also forms of sexual and gender-based violence among some nationalities in Africa.

Refugee women and girls are often subjected to specific forms of abuse such as rape, abduction, human trafficking and domestic violence during or prior to flight, and/or while in countries of asylum. In addition to the obvious psychological consequences, these abuses can result in unwanted pregnancy, unsafe abortion, sexually transmitted diseases (including HIV), sexual dysfunction, and trauma to the reproductive tract, and other chronic infections.

In conflict and post-conflict settings, there is high level of gender-based violence (GBV). This violence can then results disruption of social structures, men's loss of traditional roles, poverty, frustration, alcohol and drug abuse, and criminal impunity.

Harmful traditional practices (HTPs) as one form of GVB also posed threats to conflict-affected populations. The incidence of HTP increase in communities during and after conflict as affected communities have often responded by strengthening cultural traditions to deal with the loss experienced through the process of displacement.

Many forms of GBVs can occur during and after armed conflict. When communities are disrupted and uprooted, protection systems and social networks break down. During the emergency phase, most reported GBV incidents are cases of sexual violence involving female survivors/victims and male perpetrators (IASC, 2005). Rape is one of the most violent types of GBV occurring in conflict settings. Women and girl survivors of rape often experience long-term physical and psychological consequences, including chronic reproductive health problems, HIV infection and other sexually transmitted infections (STIs), unwanted pregnancy, depression, and marginalization from family and community due to stigma associated with sexual assault.

Urban Refugee Program in Addis Ababa started early 1960s for selected refugees who were demanding close medical attention and expertise due to their chronic health problems, security and protection reasons according to the information obtained from the Department of Refugees and Returnees Affairs office (RRAD, 2012). Currently, more than 2,500 refugee populations of different nationalities are getting different services from three organizations, namely; the Administration of Refugees and Returnees Affairs (ARRA), Jesuits Refugees Services (JRS), and Refugees and Returnees Affairs Department (RRAD).

Based on the information obtained from the Refugees and Returnees Affairs Department of the Ethiopian Orthodox Church, a good number of refugees have been referred from different refugees' camps in Ethiopia to the urban refugees' assistances, the majority of them are Somali. However, some of them are survivors of SGBV and are referred for physical protection, medical follow ups and for rehabilitation purposes. Therefore, as

there has no study conducted so far regarding the issue, this study will try to explore and to assess the magnitude of the prevalence and contributing factors for sexual and gender-based violence among women Somali urban refugees.

1.3 Objectives of the Study

The main objective of this study is to explore and to assess the prevalence and contributing factors for sexual and gender based violence among women Somali urban refugees in Addis Ababa.

Specific Objectives

- ➔ To assess the magnitude/prevalence of sexual and gender based violence and harmful traditional practices among the urban women and girls Somali refugees.
- ➔ To identify risk factors contributing to sexual and gender based violence among the Urban Somali refugee community;
- ➔ Look in to the measures taken by survivors to resolve the incidents before and after it happens;
- ➔ To recommend feasible interventions to address the identified gaps.

1.4 Operational Definitions

Refugees: A refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries. (http://www.unrefugees.org/site/c.lfIQKSOwFqG/b.4950731/k.A894/What_is_a_refugee.htm)

Urban Refugee: A refugee who has been allowed by a government to live in major urban centers in the country.

Non Governmental Organization: According to Wikipedia.org, a non-governmental organization (NGO) is a legally constituted organization created by natural or legal persons that operates independently from any form of government.

Sexual and Gender Based Violence (SGBV): Physical, sexual and psychological violence occurring in the family and in the community, including battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence, violence related to exploitation, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state. (Articles 1 and 2 of the UN Declaration on Violence against Women, 1993).

Intimate partner violence (IPV): It is "actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner" (Saltzman et al. 2003). The term intimate partner violence is increasingly replacing the synonymous term domestic violence (WHO, 2005a).

Sexual Violence: It is an umbrella term that includes, at least, rape, attempted rape, sexual abuse and sexual exploitation. It involves "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work" (IASC, 2005).

Rape: is an act of non-consensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of

force, and/or coercion. Any penetration is considered rape. Efforts to rape someone which do not result in penetration are considered attempted rape (IASC, 2005).

Sexual Abuse: Sexual abuse denotes other non-consensual sexual acts, not including rape or attempted rape. Sexual abuse includes acts performed on a minor (RHRCC, 2004).

Harmful Traditional Practices (HTP): According to answers.com, it is said to mean rituals, traditions and otherwise practices that have a prejudicial effect to the health, physical and psychological integrity, or the full exercise of human rights by persons partaking.

Post Traumatic Stress Disorder (PTSD): According to Merriam Webster.com, a psychological reaction that occurs after experiencing a highly stressing event (as wartime combat, physical violence, or a natural disaster) outside the range of normal human experience and that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event

Major Depressive Disorder (MDD): According to Merriam Webster.com, a mood disorder having a clinical course involving one or more episodes of serious psychological depression that last two or more weeks each, do not have intervening episodes of mania or hypomania, and are characterized by a loss of interest or pleasure in almost all activities and by some or all of disturbances of appetite, sleep, or psychomotor functioning, a decrease in energy, difficulties in thinking or making decisions, loss of self-esteem or feelings of guilt, and suicidal thoughts or attempts.

Psychosocial: According to Wikipedia.org, psychosocial means it relates to one's psychological development in, and interaction with, a social environment.

Gynecology: According to Merriam Webster on line Dictionary, it is a branch of medicine that deals with the diseases and routine physical care of the reproductive system of women and girls.

Chat/Khat: According to Wikipedia, a free on line encyclopedia, it is a stimulating plan which has evergreen leaves of 5-10 cm long and 1-4 cm broad. It is known by a variety of names such as qat and gat I Yemen, gaat and jaad in Somalia and chat in Ethiopia.

Shisha: According to the free dictionary.com it is an oriental tobacco pipe with a long flexible tube connected to a container where the smoke is cooled by passing through water.

Psychosocial support: is an approach to victims of disaster, catastrophe or violence to foster resilience of communities and individuals. It aims at easing resumption of normal life; facilitate affected people participation to their convalescence and preventing pathological consequences of potentially traumatic situations (IASC, 2005)

Stress: a physical, chemical or emotional factor that causes bodily or mental tension and may be a factor in disease causation (http://www.britannica.com/bps/dictionery)

1.5 Limitation of the Study

This research is focused on Somali communities where the majority of the study population neither speaks Amharic (the local language) or English. Hence, the issue of backward and forward translation was both challenging and time consuming. On top of that, the sensitive nature of the issue under discussion might prevent some of the study participants not to respond to some questions in the presence of a third party. Hence, the researcher used informed consent prior to in-depth interviews with key informants and to participants of focus group discussion to guarantee confidentiality. The researcher also

limits to gather data mainly from two sub-cities, where the majority of the community currently resides due to time and financial limitation.

1.6 Chapterization

This research paper has five chapters. The first chapter deals with the backgrounds of the study, statement of the problem, research question, objective of the study, hypothesis, universe of the study, study design, significance of the study, and delimitation of the study, tools for data collection, data analyses methods and eventually about the organization of the thesis.

The second chapter dealt about theoretical frame work and review of literature. The third chapter depicted the design of the study, site of the study, sources of data, information of the study, instruments of data collection, procedures of data collection and data analysis procedures.

The fourth chapter presents the narration, findings and discussion of the findings both from the quantitative and qualitative methods. The last chapter presents the conclusions and the recommendations from the researcher about the problem under investigation. In the end reference materials used in this research were indicated.

Chapter Two

2. Review of Related Literature

2.1 Theoretical Framework

Several international instruments specifically address sexual and gender-based violence against women and girls. The Convention on the Elimination of All Forms of Discrimination against Women adopted by the General Assembly in 1981, the United Nations Declaration on the Elimination of Violence against Women, adopted by the General Assembly in 1993, and the Beijing Declaration and Platform for Action, adopted in Beijing in 1995, include all forms of discrimination as violence against women and girls and reaffirm States' responsibility to work to eliminate them. Most recently, the 1998 Rome Statute of the International Criminal Court defines rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization or any other form Sexual and Gender-Based Violence against Refugees, Returnees and internally displaced Persons of sexual violence of comparable gravity as a crime against humanity. United Nations Security Council Resolution 1325 (2000) emphasizes States' responsibility to end impunity for crimes against humanity and war crimes, including sexual and other forms of violence against women and girls.

In 1993 the General Assembly of the United Nation ratified and approved the UN Declaration on the Elimination of Violence against Women. In the documents, it is indicated that physical, sexual and psychological violence within the family, child sexual abuse, dowry-related violence, marital rape, female genital mutilation, rape and sexual abuse, sexual harassment in the workplace and educational institutions, trafficking in women and forced prostitution constitute violation against women.

Following that, UNHCR, 2003 affirms that sexual Violence includes rape and marital rape, child sexual abuse, defilement and incest, forced sodomy or anal rape, attempted rape or attempted forced sodomy or anal rape, sexual abuse, sexual exploitation, forced prostitution or sexual exploitation, sexual harassment, sexual violence as a weapon of war and torture. Under physical violence acts like physical assault, trafficking and slavery are indicated, whereas emotional and psychological violence include abuse or humiliation, confinement. The following harmful traditional practices like female genital mutilation (FGM), early marriage, forced marriage, honor killing and maiming, infanticide and or neglect and denial of education for girls and women. The socio-economic violence also includes discrimination and or denial of opportunities and services, social exclusion or ostracism based on sexual orientation and obstructive legislative practice.

Gender Based Violence (GBV) is a widespread and critical aspect of armed conflict. Sexual and Gender Based Violence (SGBV), in its various forms, is endemic in communities around the world, cutting across class, race, age, religion and national boundaries. Exposure to gender-based violence and sexual coercion significantly increases girls' and women's chances of early sexual debut, experiencing forced sex, engaging in transactional sex, and non-use of condoms. Women make up high proportions of refugee and internally displaced populations, and they suffer unique consequences of war and conflict because of gender-based violence, discrimination, and caretaking roles. Refugee women are especially vulnerable to infectious disease, as well as threats to their mental health and physical safety.

UNHCR (2003) and UNHCR (2011) depict the magnitude and prevalence of sexual and gender based violence in the world as follows;

- *World-wide, an estimated 40 to 70 per cent of homicides of women are committed by intimate partners, often in the context of an abusive relationship.*

- *At least 60 million girls who would otherwise be expected to be alive are missing from various populations, mostly in Asia, as a result of sex-selective abortions, infanticide or neglect.*
- *Around the world, at least one in every three women has been beaten, coerced into sex, or otherwise abused in her lifetime.*
- *Trafficking of humans world-wide grew almost 50 percent from 1995 to 2000 and the International Organization for Migration (IOM) estimates that as many as 2 million women are trafficked across borders annually.*
- *More than 90 million African women and girls are victims of female genital mutilation.*
- *In South Africa, it is estimated that in every 83 seconds one woman is raped; only one in twenty of these cases is ever reported to the police.*
- *At least 60 million girls who would otherwise be expected to be alive are missing from various populations, mostly in Asia, as a result of sex-selective abortions, infanticide or neglect.*
- *More than 90 million African women and girls are victims of female circumcision or other forms of genital mutilation.*
- *In recent years, mass rape in war has been documented in Bosnia, Cambodia, Liberia, Peru, Somalia and Uganda. A European Community fact-finding team estimates that more than 20,000 Muslim women were raped during the war in Bosnia.*
- *Ninety-four percent of displaced households surveyed in Sierra Leone have reported incidents of sexual assault, including rape, torture and sexual slavery. At least 250,000, perhaps as many as 500,000, women were raped during the 1994 genocide in Rwanda.*

From the above information we can deduce that there is high prevalence of sexual and gender based violence throughout the world. However, the magnitude becomes severe in conflict prone areas of Africa and the Middle East.

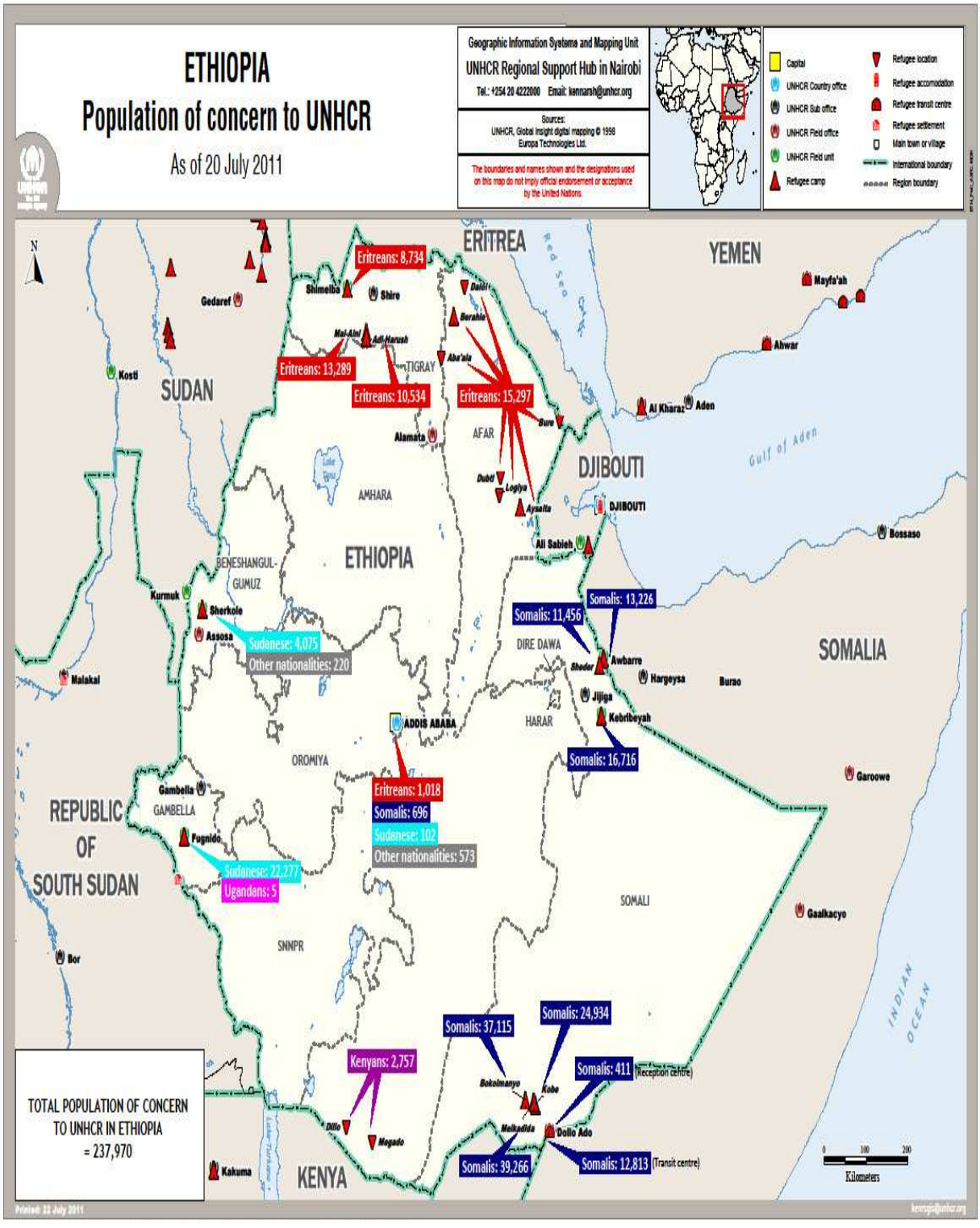
Being home to 6.7 million refugees, Africa particularly continues to be the heart of exodus and the heart of refugee (Kibret Markos, 1997). Environmental degradation, famine and armed conflicts have tormented the continent's population and have resulted in enormous forced population movements. Refugee flows have for long overwhelmed the Horn of Africa, with the Somali refugee crisis clearly being the centre of this situation

for the last nearly 20 years. Devastated by political instability, total collapse of government and clan warfare, Somalia has at present around half a million of its citizens seeking refuge in neighboring countries. (ibid).

Ethiopia currently hosts a total of 392,096 refugees and asylum seekers from many African countries including Somalia, Sudan, Eritrea, Rwanda, Burundi, Mozambique, Liberia, Nigeria, Djibouti, Uganda, and Yemen (UNHCR-RLO Addis Ababa, 2012). However, refugees from Somalia, Sudan, and Eritrea make up the majority. Currently there are eighteen refugee camps located in the east, west, south and northern parts of the country and the number is on the rise due to political instability and natural crises in the horn of Africa. Urban refugees are also found in major towns, especially in Addis Ababa.

The government of Ethiopia is signatory to the 1951 Convention and incorporated most of its rights and provisions in the Ethiopian Refugee Proclamation of 2004 (Federal Negarit Gazeta July, 2004). However, Ethiopia maintains a reservation to providing access to employment to refugees. The national refugee law also confirms the government's encampment policy for refugees. Local integration, therefore, is presently not possible for refugees in Ethiopia.

According to UNHCR-RLO, by July 2011, some 67 percent of the refugees within Ethiopia, or 160,000 people, were of Somali origin. Six new refugee camps have been opened to accommodate Somalis in the past five years (2007-2012), with three camps in eastern Ethiopia (Kebrebeyah, Sheder and Aw-Bare), near Jijiga, and four in the south-east, around Dollo Ado (Bokolmayo, Malkadida, Kobe and Halaweyn). (Please refer to the map on the next page).



Map I: The location of Refugee camps in Ethiopia

The number of new arrivals from Somali increased dramatically in 2011 due to the combined effects of drought, famine and insecurity in Somalia, with up to 23,000 people arriving per month during the year 2011 (UNHCR-RLO Statistical Abstract 2012).

Most often some of these refugees are referred from different camps to urban centers for better care and management of their well identified medical and security issues. Currently, nearly 977 registered Somali refugees are hosted in Addis Ababa, Adama and Dire Dawa (DICAC/RRAD, 2012). The majority of these are women and girls with complicated psychosocial problems. Many of them develop medical problems and are now under continuous and close follow up in different hospitals and clinics in Addis Ababa. The Ethiopian Orthodox Church Development and Inter Church Aid Commission, Refugees and Returnees Affairs Department (EOC-DICAC-RRAD) and Jesuit refugee service (JRS) are involved in providing different assistances to these and other urban refugees along with the government agency the Administration for Refugees and Returnees Affairs and The United Nations High Commissioners for Refugees, Regional Liaisons office of Addis Ababa (UNHCR-RLO).

According to EOC-DICAC-RRAD, urban refugees referred from different camps around the country based on one or more of three possible criteria. These criteria are all risk-related; refugees with 1) health, 2) protection or 3) security risks may be referred to the Urban Programme where they may avail of different services more appropriate to their specific needs.

According to the current data (19/03/2013) from EOC-DICAC/RRAD, the majority of the urban refugees are Somali (45.83%), Eritrean (20.51%), Congolese (17.49) and Sudanese (6.41%), with the remaining individuals made up primarily of Great Lakes Region, Yemeni, Djiboutian refugees. 50.12% are under the age of 18. 46.20% are female and 53.80% are male.

According to EOC-DICAC-RRAD, within Somalia, various forms of gender-based violence (GBV) are widespread. Newly arrived Somali refugees report chronic and acute medical problems that cannot be addressed at the camp level as their primary reason for urban refugee assistance while some cite violence as contributing factor. Among the different age and sex groups, Somali women and girls are facing an even greater risk of GBV, both during their journey out of Somali, up on arrival in different camps in Ethiopia and in their current residences in Addis Ababa. EOC-DICAC-RRAD is one of the organizations responsible to provide care and support to survivors of gender-based violence. The organization indicated that among the many reported cases of GBV incidents Somali holds the majority. Hence, this paper tries to identify the prevalence and contributing factors for sexual and gender-based violence among Somali urban refugees in Addis Ababa.

2.2 The prevalence of SGBV in North America

Gender based violence is one of the most challenging issues in North America. According to the National Violence against Women Survey (NVAWS) in United States, about 1.5 million women were raped and/or physically assaulted by an intimate partner annually. According to the Bureau of Justice Statistics Crime Data Brief, which measured only physical assaults, "there were 691,710 nonfatal violent victimizations committed by current or former spouses, boyfriends, or girlfriends of the victims during 2001. Of these, 85% were against women. The NVAWS also found that 22.1 percent of women surveyed, compared to 7.4 percent of men, reported being physically assaulted by a current or former partner in their lifetime. (Violence against women online resource, 2010)

The situation in Canada is also more or less similar. According to the information obtained from the Canadian' Women Foundation, on average, in every six days a woman in Canada is killed by her intimate partner. In 2009, 67 women were murdered by their current or former spouse or boyfriend, in any given day in Canada; more than 3,000

women (along with their 2,500 children) are living in an emergency shelter to escape domestic violence. Each year, over 40,000 arrests result from domestic violence—that's about 12% of all violent crime in Canada. Since only 22% of all incidents are reported to the police, the real number is much higher; as of 2010, there were 582 known cases of missing or murdered aboriginal women in Canada. Both Amnesty International and the United Nations have called upon the Canadian government to take action on this issue, without success; in just one year in Canada, 427,000 women over the age of 15 reported they had been sexually assaulted. Since only about 10% of all sexual assaults are reported to the police, the actual number is much higher. From the above information it can be concluded that gender based violence is a common problem in America despite their technological advancement and educational statuses. (http://www.canadianwomen.org/facts-about-violence).

2.3 The prevalence of SGBV in Latin America

Violence, especially sexual and gender based violence is also common in Latin America. According to Population Counsel (2011), intimate partner violence is the most common sexual violence, often occurs with physical violence. The population based survey conducted by population Counsel in 2011 shown that 5-47% of women reported ever experiencing forced sex by a partner. The World Health Organization Multi-country study (Brazil, Peru) found out that 6-23% of women with the age group 15 to 49 reported forced sex by partner in 2010. Sexual Violence by non-partner is also a common problem in Latin America but less documented. With regards to forced sexual debut a Nicaragua survey found out that 26% of women reporting sexual abuse before age 19. Concerning migration violence in the region, it is found that 70% of female migrants reporting that they experience violence, 60% of which was sexual violence (Population Council, 2011).

2.4 The prevalence of SGBV in Europe

Karin Nordmeyer, Chair of the Gender Equality Transversal Group is cited as saying that "Violence against women exists in all Council of Europe member states and occurs at all levels of society" (IPPE, 2009). A draft report by the European Parliamentary committee on Women's Rights and Gender Equality indicated that around 500,000 women and girls living in Europe have been subjected to female genital mutilation.

During the last decade, national prevalence studies have been carried out in many European countries, such as Finland, Sweden, France, Germany, England and Norway. On the whole, the results have been similar, and the figures confirm much of the knowledge from qualitative studies on the consequences of violence, but above all, there is now knowledge of the prevalence and geography of violence in Europe. According to the research conducted 46 percent of women in Sweden over the age of 15 have experienced violence, and more than every third woman who has been married or cohabiting with a partner have been exposed to violence by a former husband/cohabitant partner. More than every third woman who has left a violent partner has experienced systematic violence. One out of four women within the youngest age category (18-24 years) has been exposed to violence in 2009. Every third woman has been exposed to violence before her fifteenth birthday (IPPF, 2009). The above data clearly shows that gender based violence is still a major problem in many European countries

2.5 The prevalence of SGBV in Asia

According to Oxfam Briefing Paper (August, 2004), in South Asia, one in every two women experiences violence in her daily life. Social, cultural, political, economic, and legal factors in the region combine to leave women and girls vulnerable to community-sanctioned violence. In a region affected by a high level of volatile human conflict, violence against women is viewed as just 'another form of violence' in Asia. There is no

acceptance that violence against women is a serious human rights issue; that it impacts on women's socio-economic wellbeing, health, sexual and reproductive rights; and, significantly, that it reduces women's contribution to the gross domestic product (Ibid).

According to NFHS-2(2000), 21% of ever-married women in India have been physically mistreated by their husbands, and husband in-laws or other persons since age 15. In the same documents it was indicated that the prevalence rate shows some variations across the states in India. Tamil Nadus shows the highest prevalence, with 40 percent of women reporting experiencing physical violence since age 15. Andra Pradesh, Karnataka, Meghalaya, Arunachal Pradesh, Mizoram, Orissa, Bihar and Jammu and Kashmir have prevalence rates higher than 20 percent. Himachal Pradesh shows the lowest prevalence rate at 5.8 percent, followed by Kerala (10.1 percent) and Gujarat (10.2 percent) (IIPS and ORC Macro, 2000).

According to the National Family Health Survey 2000, in every six hours, somewhere in India, a young married woman is burned alive, beaten to death, or driven to commit suicide. It is estimated that more than 15,000 women suffer from dowry-related violence ever year. In a nation-wide survey in India, nearly 50 per cent of women reported at least one incident of physical or psychological violence in their lifetime (NFHS-2(2000).

In Pakistan, 80 per cent of women experience violence within their homes (Oxfam Briefing paper, 2004). Despite the fact that many incidents of 'honor killing' are not reported, in 2002, more than 450 Pakistani women or girls were killed by relatives in so-called 'honor killings', and at least as many were raped.

Forty seven per cent of Bangladeshi women also experience some physical violence at the hands of their intimate partners. If psychological violence were included, the figure would be much higher. Every week, more than ten women in Bangladesh suffer from an acid attack that leaves them brutally disfigured, and often blind and disabled. A study in

Bangladesh shows that 32 per cent of women working outside their homes experience disruption of their work due to incidents of domestic violence (Ibid). as can be concluded in south Asia where harmful traditional practices still prevails women and girls suffer as a result of rampant sexual and gender based violence.

2.6 The Prevalence of SGBV in Africa

In Africa natural and man made calamities are very frequent. Consequently, the majority of the people of Africa, particularly women and girls experience the consequences. In some African countries Gender-based violence and forced sex are highly prevalent (Population Council, 2008). The following data clearly explains the above fact.

- *In Zambia, DHS data indicate that 27 percent of ever-married women reported being beaten by their spouse/partner in the past year; this rate reaches 33 percent of 15-19 year-olds and 35 percent of 20-24 year-olds. 59 percent of Zambian women have ever experienced any violence by anyone since the age of 15 years.*
- *In South Africa, 7 percent of 15-19 year-olds had been assaulted in the past 12 months by a current or ex-partner; and 10 percent of 15-19 year-olds were forced or persuaded to have sex against their will.*
- *In Kenya, 43% of 15-49 year old women reported having experienced some form of gender-based violence in their lifetime, with 29% reporting an experience in the previous year; 16% of women reported having ever been sexually abused, and for 13%, this had happened in the last year.*
- *In rural Ethiopia, 49% of ever-partnered women have ever experienced physical violence by an intimate partner, rising to 59% ever experiencing sexual violence.*
- *In rural Tanzania, 47% of ever-partnered women have ever experienced physical violence by an intimate partner, while 31% have ever experienced sexual violence.*

Population-based studies conducted among adolescents in Africa indicate that 3.4% of males in Namibia and 13.4% in Tanzania have experienced a sexual assault. 11% of male

adolescents in South Africa and 29.9% in Cameroon reported forced sexual initiation (Ibid).

2.7 The prevalence of SGBV in Ethiopia

The FDRE Constitution, Proc. No. 1/1995 disapproves all Harmful Traditional Practices (HTPs) that result in bodily injury or mental harm. In Ethiopia, women usually experience harmful practices like female genital cutting (FGC) and early marriage. These practices are prohibited by the Constitution of the Federal Government of Ethiopia. In addition, the modified Penal Code of Ethiopia punishes any acts of HTPs in order to protect the mental and physical health of children. The 1998 Baseline Survey (BLS) of Ethiopia (CSA, 1998), which collected data from 65 ethnic groups in all parts of the country, is perhaps the most important study on HTPs. Out of 88 practices, 20 HTPs were selected and considered to cause harm to the body and the mind of the children, including FGC and the early marriage of girls.

The prevalence of gender based violence, including domestic abuse, harmful traditional practices (HTP) and general negative perceptions, attitudes and beliefs about women and their abilities and roles abound throughout Ethiopia (Tsegahun Tesemma, 2008). According to Tesemma, over the past few years, the Federal Government of Ethiopia (FGoE) has issued a relatively large amount of gender-friendly legislation and policies, including the 'National Women's Policy', which was issued in 1993. This was based on the concept of respect for human and democratic rights without distinction, as set forth in the Charter on International Agreements and Conventions. Despite this case, as well as other legislative acts, judicial and educational policies and efforts to address the situation by government agencies, non-governmental organizations and civil society organizations, clearly, women remain highly vulnerable in Ethiopia and continue to suffer from violence and denial of their rights in one form or another. In rural Ethiopia, 49% of ever-partnered women have ever experienced physical violence by an intimate

partner, rising to 59% ever experiencing sexual violence (WHO, 2005). The situation is very serious when we look at the information published by the National Statistics Agency (CSA) in 2000 where 85% of women in Ethiopia believe that a husband is justified in beating his wife for at least on reason (CSA, 2000).

2.8 The prevalence of SGBV among Somali refugees in Ethiopia

Cornell International Law Journal (2011) stressed that "In recent times, there have emerged extensive accounts of violence against women in times of armed conflict. Systematic rape and other forms of gender based violence are increasingly used as weapons of war in armed conflicts in different regions of the world. Furthermore, the use of rape to reinforce policies of ethnic cleansing and the establishment of camps explicitly intended for sexual torture and the forcible impregnations of women are tragic developments which mark a definite escalation of violence against women in situations of armed conflicts."

GBV in conflict and post-conflict areas can take many forms including rape, slavery, forced impregnation/miscarriages, kidnapping/trafficking, forced nudity, and disease transmission, with rape and sexual abuse being among the most common. Rape in conflict settings is often violent and brutal, frequently involving gang-rape and rape with foreign objects such as guns and knives. In addition to rape, sexual abuse is also prevalent, particularly in the forms of forced nudity, strip searches, and other publicly humiliating and violating acts. These acts and other acts of sexual violence, such as forced impregnation or forced miscarriages, are often part of an intentional strategy of war, used to destabilize the civilian population and violate the honor of the opposing force (Ibid).

According to UK boarder Agency Country of Origin Information Service May 2010, Somalia had one of the highest maternal mortality rates (14-17% face mortal birth risk) due to the collapse of public medical institutions. The rate of women literacy is around

12-14% and 80% of young girls got married early. Although the Somali constitution of 1991 criminalized Female Genital Mutilations (FGM), 97% of young girls still face the phenomenon.

"There are no credible statistics on violence against women in Somali. Cases of gender based violence (GBV) recorded by women's organizations, support programmes and others show that reports of rape are increasing in some areas in Somali, though this could be due in part to more willingness to report. As Somali women are more dynamic in the market place since they have to earn a living and support the family, they are exposed to vulnerable situations. Women are often victims of rape from the warlords (Ibid).

The situation of Somali refugees arriving in Ethiopia is more or the same. These refugees have had little if any support for health, psychological, and social consequences of experiences with GBV. It is likely that newly arriving refugees are not yet aware of the support services available to GBV survivors, including post-rape medical care, as well as other vital information regarding gender and violence.

United Nation Population Fund (UNFPA) in 2007 conducted an assessment in one of the oldest camp in Ethiopia called Kebre Beyah where Somali refugees and asylum seekers are hosted. On the assessment it was pointed out that discussion were held with all stakeholders of the camp including refugee community, UNHCR, different implementing partners and the local police with regards to the magnitude, intensity and interventions on sexual and gender based violence.

The finding revealed that sexual violence, domestic violence, harmful traditional practices (Female Genital Cutting), early marriages and sexual exploitation and abuse were all forms of GBV that were prevalent in the camp. Most stakeholders stated that youth gangs were to blame for the insecurity and rapes in the camp. According to the those interviewed the lack of opportunity for education, jobs and the lack of possibility to

earn an income are the main reasons for the disillusionment of the youth who eventually end up forming gangs that fight, harass, intimidate, steel and seek out women (UNFPA, 2007).

2.9. The Prevalence of Sexual and Gender Based Violence in an Emergency

In situations of armed conflict and displacement, women and children face additional risks and vulnerability. According to Susan (1995), the different cycle of violence against women and girls refugees during emergency and post emergency time are clearly indicated in the following table.

No.	Phase	Type of Violence
1	During Conflict, Prior to Flight	❖ Abuse by person in power ❖ Sexual battery of women ❖ Sexual violence by "soldiers"
2	During Flight	❖ Sexual Attack by bandits, border guards, pirates ❖ Capture for trafficking by smugglers, slave traders
3	In the country of asylum	❖ Sexual attack, extortion by persons in authority ❖ Sexual abuse of fostered girls ❖ Domestic violence ❖ Sexual attack when collecting woods, water, etc ❖ Sex for survival
4	During repatriation	❖ Sexual abuse of women and girls who have been separated from family ❖ Sexual abuse by persons in power, sexual attack by bandits, border guards
5	During reintegration	❖ Returnees may suffer sexual abuse as retribution ❖ Sexual extortion in order to obtain legal status

Table 1. Sexual Violence cycle during emergency and post emergency time.

In an emergency situation, social bond looses and different psychosocial problems prevail. However, the magnitude and intensity of such problems become serious especially in vulnerable groups of communities where women and gild hold the majority. As can be

observed from the tale above, different kinds of sexual and gender based violence can occur to women and girls in case of conflicts, during flight to a safe environment, in the country of asylum or temporary resident places, during their journey back home and even in the time of social reintegration in the home country.

Heise(1994) also indicated the type of violence that may be experienced at separate and multiple stages of the life cycle of an individual in the following table.

No.	Stages of Development	Type of Violence
1	**Prenatal**	Prenatal sex selection, battering during pregnancy, coerced pregnancy (rape during war)
2	**Infancy**	Female infanticide, emotional and physical abuse, differential access to food and medical care
3	**Childhood**	Genital cutting; incest and sexual abuse; differential access to food, medical care, and education; child prostitution
4	**Adolescence**	Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, forced prostitution
5	**Reproductive**	Abuse of women by intimate partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities
6	**Old Age**	Abuse of widows, elder abuse (which affects mostly women)

Table 2: Types of Violence commonly experienced at various phases of the life cycle

2.10 Contributing factors for SGBV against Refugees

There are many factors contributing to acts of sexual and gender-based violence in any setting. In general, the overriding causes are gender inequity, assertion of power, and lack of respect for human rights. Since refugees live in different camps in many African countries most of which are far from major population settlement, they are highly vulnerable to different socio-economic problems that includes sexual and gender based violence. The following causes and/or circumstances are well identified as causes that initiate sexual attacks against women and girls refugees (UNHCR, 1995).

A) Society (of refugees, and surroundings)

- Sexual violence in the country of origin may have a political motive, for example where mass rape of populations is used to dominate, control and/or uproot, or where sexual torture is used as a method of interrogation. Sometimes sexual violence is used as a weapon of warfare, to humiliate or cause the disintegration of another community, as a part of "ethnic cleansing".
- Attacks by neighboring groups may occur in areas where refugees are considered materially privileged compared with the local population. Within camps, women who are economically successful have been targeted.
- Attacks by the local population because of the consequences flowing from refugee presence, such as fear of criminal activities, racism, xenophobia and other concerns including degradation of the environment and depletion of natural resources.
- Traditional tensions and feuds between various clans/groups may also give rise to sexual violence.
- The collapse of traditional societal support mechanisms (social sanctions, norms for proper behavior, etc.) when refugees were forced to flee or to live in camp surroundings. In particular, the communal support systems for the protection of vulnerable individuals may no longer be present, for example, due to the absence of many male members from the community.
- Male attitudes of disrespect towards women may be instrumental in causing incidents of sexual violence. For example, camp guards and male refugees may look upon unaccompanied women and girls in refugee camps as common sexual property. Husbands or other male family members may also abuse a victim of a previous attack because they believe she is no longer "virtuous".
- Psychological strain on refugee men in not being able to assume normal cultural, social and economic roles, may cause aggressive behavior towards women. Many other aspects of refugee life can aggravate this, including idleness, anger at loss of control and power, uncertainty about the future, and frustration with living conditions.
- Alcohol and drug abuse can result in violent behavior within families and communities. Such abuse is often linked to boredom, depression and stress.

B) Vulnerability

- Sexual violence during flight or in the country of asylum can occur because of the special vulnerability and powerlessness of refugees, including the need for "safe" passage. This is underlined by the common misconception held by people who come into contact with refugees, such as members of the military and police, that they are not legally protected outside their country of origin.
- Females who are on their own for whatever reason, whether they are single, widowed, abandoned, unaccompanied minors, lone heads of households, or women who have been separated from male family members by the chaos of flight or during voluntary repatriation, are all particularly at risk of sexual violence.
- Where foster care placement of children occurs without proper screening of families or monitoring of the child's welfare, the refugee child may be exposed to sexual abuse.
- Incarceration in closed detention facilities may compound the problems of sexual violence. In a number of countries, all individuals who enter illegally or without authorization are subject to detention regardless of age, sex, or their status as asylum-seekers. In some cases, asylum applicants are incarcerated with criminals, children with unrelated adults, females with males.
- Refugee women without proper personal documentation are susceptible to sexual exploitation and abuse. In many refugee situations, women are not routinely provided with documents showing that they are legally in the country. The male family member may have been designated as the head of household and given the relevant documents; he may not be present to produce these documents before the authorities as and when required. Similarly, refugee women may not be given individual registration cards or documents with which they collect food rations, shelter material and qualify for other forms of assistance.
- Male responsibility for distribution of goods and necessities may expose women to sexual exploitation. In camps where male authorities or male refugees have this responsibility, women may be coerced into sexual acts. For example sexual favors may be demanded in exchange for food rations.

C) Camp design and location

- The geographical location of a refugee camp may increase the likelihood of sexual violence, if the camp is located in an area which has a serious crime problem for example, or is geographically isolated from the local population.
- The design and social structure in many refugee camps and settlements may contribute to the likelihood of protection problems. Camps are often overcrowded. Unrelated families may need to share communal living and sleeping space. In effect, such refugees are living among strangers, perhaps among persons who could be considered traditional enemies.
- Poor design of services and facilities may also contribute to security problems. Communal latrines and washing facilities may be at some distance from the living quarters, thereby increasing the potential for attacks. Many camps are not lit, or poorly lit, compounding these risks at night. Night patrols exist in some camps, but not in others. The distance refugees must travel to food, water and fuel distribution points or collection areas may also expose them to danger. Also, where refugees are housed in centers and camps, sleeping rooms and washing facilities usually cannot be locked.
- The lack of police protection and general lawlessness in some camps is also a factor. Police may accept bribes in exchange for not investigating complaints, or for releasing the alleged perpetrators from custody. Police officers, military personnel, camp administrators or other government officers may themselves be involved in acts of abuse or exploitation.

D) UNHCR/Other presence

- The lack of UNHCR or NGO access to, or presence in, camps, particularly at night can be a contributing factor. The absence of an independent presence in camps is thought likely to increase the risks of attacks on personal security, including sexual violence. At the same time, the security situation might not allow for this presence.

2.11 Consequences of Gender Based Violence

Such violations of bodily integrity and freedom from violence are of concern as adverse outcomes in and of themselves, and because they are correlated with poor reproductive

health. Studies from diverse settings – e.g., China, Peru, the USA, and Uganda have found that girls and/or young women who had previously experienced sexual coercion are significantly less likely to use condoms, and more likely to experience genital tract infection symptoms, unintended pregnancy and a higher incidence of unsafe abortion (Gazmararian et al., 1995; Campbell & McPhail, 2002). Lack of sexual autonomy and control stemming from actual or threatened violence, together with fear of repercussion from use of condoms or contraception, are direct pathways to unwanted pregnancy and increased risk of STIs (Kishor & Johnson, 2004). Moreover, intimate partner violence has been found to be independently associated with HIV infection (Fonck et al., 2005; Auerbach et al., 2005). The following table outlines the potential physical, reproductive health, psychological and behavioral consequences of sexual and gender-based violence:

Non-fatal outcomes			Fatal outcomes
Physical injuries and chronic conditions	Sexual and reproductive consequence	Psychological and behavioral outcomes	• Femicide • Suicide • AIDS-related mortality • Maternal mortality
• Fractures • Abdominal/thoracic injuries • Chronic pain syndromes • Fibromyalgia • Permanent disability • Gastrointestinal disorders • Irritable bowel syndrome • Lacerations and abrasions • Ocular damage	• Gynecological disorders • Pelvic Inflammatory disease • Unsafe abortion • Unwanted pregnancy • Pregnancy complications • Sexual dysfunction • Miscarriage/low birth weight • Sexually-transmitted infections, including HIV	• Depression and anxiety • Eating and sleep disorders • Drug and alcohol abuse • Phobias and panel disorder • Poor self-esteem • Post-traumatic stress disorder • Psychosomatic disorders • Self harm • Unsafe sexual behavior: • High-risk views on sexual violence & HIV infection • less likely to use condoms & contraceptives	

Table 3: Fatal and non-fatal outcomes of SGBV

2.12 Social Responses to Sexual and Gender Based Violence

Prevention of and response to sexual and gender-based violence are directly linked to the protection of human rights. Human rights are universal, inalienable, indivisible, interconnected and interdependent. Every individual, without regard to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or status, is entitled to the respect, protection, exercise and enjoyment of all the fundamental human rights and freedoms. States are obliged to ensure the equal enjoyment of all economic, social, cultural, civil and political rights for women and men, girls and boys.

Acts of sexual and gender-based violence violate a number of human rights principles enshrined in international human rights instruments. Among others, these include:

- ✓ The right to life, liberty and security of the person.
- ✓ The right to the highest attainable standard of physical and mental health.
- ✓ The right to freedom from torture or cruel, inhuman, or degrading treatment or punishment.
- ✓ The right to freedom of movement, opinion, expression, and association.
- ✓ The right to enter into marriage with free and full consent and the entitlement to equal rights to marriage, during marriage and at its dissolution.
- ✓ The right to education, social security and personal development.
- ✓ The right to cultural, political and public participation, equal access to public services, work and equal pays for equal work.

Several international instruments specifically address sexual and gender-based violence against women and girls. Over the last few decades, gender-based violence (GBV) has been recognized and discussed as a public, rather than a private problem. As a result, hundreds of potential responses have been identified within the state and civil society.

Though some approaches are more effective than others, the key to eliminating GBV lies in the participation of multiple sectors and entire communities. When GBV is addressed

from all angles, the possibility of prevention becomes a reality, social networks are created which ensure that victims of GBV get the care and protection they need, and fewer women fall through the cracks. Creating these networks involves integrating GBV prevention and care into existing systems and services, as well as designing new responses. Social responses to GBV fall under several categories: health care services, victim assistance services, media information and awareness campaigns, education, legal responses, community interventions, faith-based programs and international conferences and conventions (Pan American Health Organization, 1999). In the same document, on women, health and Development Programme fact sheet, it was stated that the social response to different forms of gender based violence should include the following.

A. Health Care - Training health care providers to recognize and respond to gender-based violence is one of the most important ways of identifying and assisting victims. Not just obstetrician/ gynecologists but all health care professionals must learn to recognize the signs: hospitals (especially emergency room staff); public and private health clinic staff; general/family practitioners; internists; pediatricians; psychiatrists; nurses and the staff of family planning clinics.
B. Victim Assistance Services - These are services created or incorporated to respond to gender-based violence, such as: battered women shelters; homeless shelters; financial assistance programs; women's police stations or services; victim advocacy programs; rape crisis, domestic violence and suicide prevention hotlines; legal services; runaway programs; social welfare programs; psychological support services (including individual counseling and support groups) and teen sexuality programs/health services.
C. Support Groups - While support groups can fall under the heading of victim assistance services, they merit special mention because they are not always externally organized services. Support groups can be a important way for victims themselves to organize pro-actively and take charge of their own situation. Beyond emotional support, group members can also provide one another with a sense of security and even, if needed, a place to go.

D. Working with Perpetrators - Working with the perpetrators of violence (batterer-intervention programs) has been a controversial and occasionally successful response. While victim assistance services are a useful band-aid to address an existing problem, this approach targets efforts at the source of the problem, attempting to change violent men's behavior.

E. Exploring Masculinities - Programs which address masculinities attempt to explore what "makes a man". The central idea is to educate boys from the earliest age that violence (against anyone) is wrong, that the prevailing definition of masculinity in any society is not the only alternative, and that even though they are physically different, girls are entitled to the same rights and opportunities as men.

F. Media Information and Awareness Campaigns - The media is a key conduit for making GBV visible, advertising solutions, informing policy-makers and educating the public about legal rights and how to recognize and address GBV. Newspapers, magazines, newsletters, radio, television, the music industry, film, theatre, advertising, the internet, posters, leaflets, community notice boards, libraries and direct mail are all channels for providing information to victims and the general public about GBV prevention and available services.

G. Education - School systems are instrumental to stopping GBV before it starts. Regular curricula, sexuality education, school counseling programs and school health services can all convey the message that violence is wrong and can be prevented, suggest alternative models of masculinity, teach conflict-resolution skills and provide assistance to children/adolescents who may be victims or perpetrators of violence. Integrating GBV as a subject into psychology, sociology, medicine, nursing, law, women's studies, social work and other programs enables providers to identify and tend to this problem.

H. Faith-Based Programs and Services - Religious counseling, support groups, education programs, study groups and assistance programs can address GBV with their participants/worshippers. Most religions emphasize the importance of peace and tolerance. Framing a discussion of GBV in the context of religious tenets is one way to foster awareness and discussion of the problem. It may also be a way to identify and assist victims who do not feel comfortable talking to a health care provider or police officer.

I. Legal Responses - The criminalization of all forms of GBV - domestic violence, rape, sexual harassment, psychological violence etc. has been an important step in eliminating it. What remains is the consistent application of these laws, the implementation of penalties, and a greater focus on rehabilitating convicted perpetrators. Other legal responses to GBV have included: legal aid services; training of police and judicial personnel; women's police stations; legal advocacy and lobbying; training of family, criminal, immigration and juvenile court lawyers and bar association advocacy.

J. International Conferences and Conventions - The international community has come together to address gender-based violence through a variety of conferences, conventions and agreements. Though these do not have the same binding force as domestic law, international conventions such as the Declaration on the Elimination of Violence against Women and the Convention of Belém do Pará (see links) can be demonstrative of a state's willingness to acknowledge the problem of GBV and seek solutions. International conventions also hold states accountable to an international and externally monitored standard. International conferences on GBV bring together groups and actors from all over the world, giving them the opportunity to share their own experiences, and learn from others.

K. Community Networks and Interventions - A number of studies have shown that involving entire communities in recognizing, addressing and working to prevent GBV is one of the surest ways of eliminating it. To be optimally effective, community networks must bring together all of the responses outlined above, integrating members from all sectors of the community: families; businesses; advocacy groups/civil society; public services such as police, fire fighters and medical examiners; social services such as welfare, unemployment, public housing and health; education; the media and officials from national, state/provincial and local/municipal governments. Community interventions must send a clear message about what gender-based violence is, the different forms it can take, why it is wrong and how to prevent it.

2.13 Summary

Sexual and gender based violence is the violation of the fundamental human rights. Many states are signatures to the different declarations, conventions and resolutions to the elimination of any forms of gender based violence. However, the prevalence of gender based violence is very high through out the world. The problem is, however, very rampant in countries where political instability is vey common. During conflict a large part of the community, especially women and girls who are the most vulnerable part of the community will be exposed to different types of violations by warlords and militants in time of emergency, during exile and in the asylum counties. The consequences of such violations will have physical, gynecological and psychological effects. To protect women and girls from such atrocities a multi-functional approach that involves all segments of the community, government and non-government organizations, and community based organizations is important.

Chapter Three

3.1 Research Design and Method

The social reality and situational knowledge of the respondents of this study are the bases for this research. For the purpose of exploring the prevalence and psychosocial impacts of gender based violence, exploratory qualitative and quantitative methods have been employed. Exploratory qualitative research method employs in-depth interviews, projective techniques; key informants' discussion, focus group discussion and observation (Ethnography). These approaches give a wide range of rooms for the informants of the research to express their thoughts and beliefs on the subject under discussion.

The quantitative data from the respondents were first cleaned, edited and entered in to the IBM statistical package for social science (SPSS) software version 20 for statistical analysis. The frequency distribution and percentages of the variables (outcome and independent variables) were computed. Bivariate analysis was done to see any association between variables. The data were described and presented using tables and graphs.

3.2 Description of the Study Area

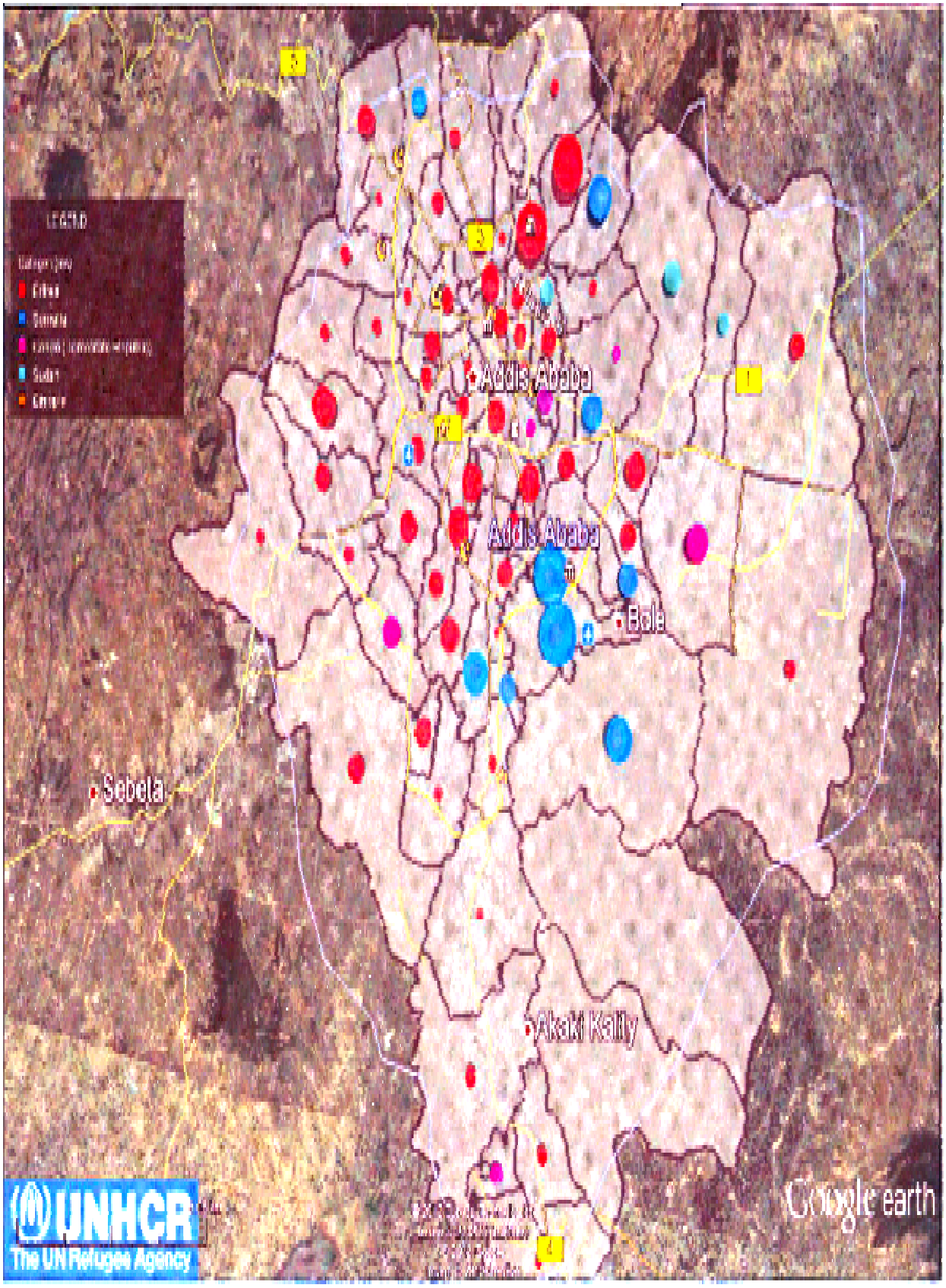
The site of this study was at the office of the Ethiopian Orthodox Church Development and Inter Church Aid Commission, Refugees and Returnees Affairs Department (EOC-DICAC-RRAD) in Addis Ababa. EOC-DICAC-RRAD is one of the organizations in Addis Ababa that provides different psychosocial assistances to urban refugees. It is located at the center of Addis Ababa, Arada Sub-city.

Since the study tried to investigate the prevalence and contributing factors for sexual and gender based violence among Somali urban refugees, the study area is Addis Ababa, the capital city of Ethiopia. However, due to the low assistances they get from some non-governmental organizations on the one hand and the high cost of living in Addis Ababa currently, these refugees are found very scattered in the outskirt of Addis Ababa. Based

on the the information the researcher got from the EOC-DICAC-RRAD social workers concerning the site where the majority of Somali urban refugees reside, the study was focused in both Bole Michael and Yeka sub cities to collect the qualitative data. (Please refer Map II on page 38). During the process of data collection, the researcher had the chance to observe the living condition of some of the Somali urban refugees who are residing in those two sub-cities.

3.3 Universe of the Study

According to the Administration for Refugees and Returnees Affairs (ARRA, 2012), nearly 187,344 Somali refugees are hosting in Ethiopia and among which 797 individuals are currently recognized as urban refugees and are getting assistances from different humanitarian organizations. The population of Somali refugees and asylum seekers who are residing in Addis Ababa without the assistance from UNHCR and other humanitarian assistances is also expected to be involved in this study. Hence, this study project involved all Somali urban refugees with or without financial and material assistances from different humanitarian organizations and are allowed by the Federal Government of Ethiopia to live in Addis Ababa.



Map II. Refugees and Asylum seekers in Addis Ababa, 2011

3.4 Sampling Method

To effectively conduct the study, the researcher delimited the sample size to the recognized Somali urban refugees by the FGoE. The study sample were 75 who filled in the questioners; 5 key informants, the majority of whom were survivors of gender based violence; 10 focus group discussion participants, all of them were members of either Urban Refugees Women Association (URWA) members or members of refugees central committee; and 2 social workers of EOC-DICAC-RRAD. The method of sampling was purposive sampling for the reason that Somali refugees tend to settle very close to their own clans and families. To this end, out of the total recognized and assisted Somali families were included in the study.

3.5 Data Collection Tools and Procedures.

The data used to for this research was collected from two main sources namely primary and secondary sources. The primary data was collected using self administered questioners and discussion with key informants and interview with survivors of different gender based violence, focus group discussion and from social workers who were on psychosocial supports at EOC-DICAC-RRAD. Structured and semi-structured questionnaire were developed from different literatures. The questionnaire included socio-demographic characteristics of respondents, Spouse relationship, magnitude of both gender based violence and harmful traditional practices and impact of the problems and interventions done by different stakeholders. The questions and statements were arranged according to particular objectives that they intended to measure and questions in a logical flow.

As Leedy and Ormrod (2001) pointed out, that interview helps the researcher to establish rapport with potential participants and therefore, gain their cooperation. Hence, interview was the first tool that allowed the researcher to dig out trustworthy and valid data. Thus, semi-structured and structured interview questions were administered to collect data for it allowed the researcher to some extent be flexible in generating questions that could come out of the response of the interviewees. Interview Questions were also used to gather data from humanitarian agencies; key informants drawn from

the Urban Refugees Women Association members, Somali refugee community, community leaders, and urban refugee women association members to gather relevant data. Besides, the researcher observed the standard of living of some of the Somali families while collecting data. Generally, both quantitative and qualitative data collection methods were utilized through questioners, in-depth interview with key informants and focus group discussion, observation and interviews with social workers of the EOC-DICAC-RRAD and the data collected were triangulated and analyzed to arrive at the result that addressed the objectives of this study.

Primary data has been collected from a total of 75 registered Somali Women Urban Refugees who are residing in Bole and Yeka sub-cities. The questioner was prepared to include all the aspects of sexual and gender based violence and harmful traditional practices. Later on the data was analyzed with the help of IBM SPSS software version 20. Later on the result was triangulated with the result of the qualitative data to strengthen the findings.

3.5.1 Data analysis procures

The quantitative data from the respondents were first cleaned, edited and entered in to the IBM statistical package for social science (SPSS) software version 20 for statistical analysis. The frequency distribution and percentages of the variables (outcome and independent variables) were computed. Bivariate analysis was also done to see any association between the quantitative and qualitative variables. The data were described and presented using tables and graphs.

For the qualitative data, semi-structured and structured interview guides and questions were developed and used. Besides to better analyze the issue, relevant document were reviewed. The qualitative data collected were coded to look for themes to be merged. Through the coding process all the text and other data that they have associated with some thematic idea were retrieved and collated together to examine different cases that

can be compared. Then, by descriptive summaries, respondents' saying or practices were described and triangulated with the result of the qualitative data.

Chapter 4

4. Data Analysis and Interpretation

4.1 Introduction

Gender based violence includes physical, sexual, or psychological aggression or coercion and is a pattern of behavior employed by one person in a relationship to control the other. The violence may include battering, burning, emotional blackmail, mockery or ridicule, threats of abandonment, confinement to the home, and the withholding of money and other family support.

In this part the qualitative and quantitative data are analyzed close look at the prevalence and contributing factors for sexual gender based violence among Somali urban refugees was made to scrutiny the magnitude of the problem.

I. Socio-demographic features

A total of 75 study subjects responded to the questions and it makes the response rate 94 percent of the planned sample size. All participants were female Somali urban refugees who are residing in Bole (78.7 percent) Yeka (21.3 percent) sub cities in Addis Ababa. The study participants' marital status was married (48 percent), separated (21.3 percent) and widowed (21.3 percent) while the rest were divorced and single.

Among the types of marriage experienced by respondents', those who marry by the parents' decision and preference were 42 (59.2 percent) while those who marry by their own choice/preference accounts 29(40.8 percent). The information from the focus group discussion pointed out that the majority of Somali girls marry their husband through the preferences and decision of either their father, elder brother or their uncle. The mother and the girl have no right to involve in such issue.

Regarding, the reasons mentioned for marital divorces, economic problem accounts 8 (47.1percent), ethnic difference 6 (35.3 percent) and others from external family members

interference and working conditions. This finding is also stressed during both the key informants' discussion and the focus group discussion. They indicated that being as refugees in Ethiopia, only very few are assisted by humanitarian organizations. The majority are living by a small remittance their get from their relatives abroad. Besides, many Somali men are addicted to Chat or Khat (a green stimulating leaves) and hence they demand their wives to give them money everyday. Hence, many marriages end up with divorce.

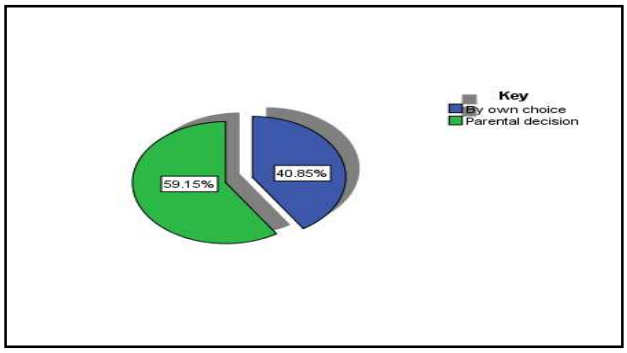


Fig 1: Choice of partners by respondents

All respondents were followers of Muslim religion and 92 percent of their households families belong to the same religion while some 8 percent household members have different religion other than Muslim. Regarding their educational level, as shown in the figure 2 below those who can read and write 24 (32 percent), Can't read and write 23 (30.7 percent), primary level 18 (24 percent) and the rest 13.4 percent were secondary and tertiary level education. Results from the focus group discussion also reveals, that women and girls education is given very low attention by the Somali community. The main reason cited was that girls eventually belong to another many and hence spending money for girls' education is wastage for the parent. Most of the study participants (78.1percent) have no occupation while 29.9 percent of them were merchants/traders. This result was also conformed during the focus group discussion where they indicated that almost many of the Somali refugees in Ethiopia completely rely on either humanitarian organizations or remittances. Only very few are engaged in small petty trade activities on the main roads of Addis Ababa.

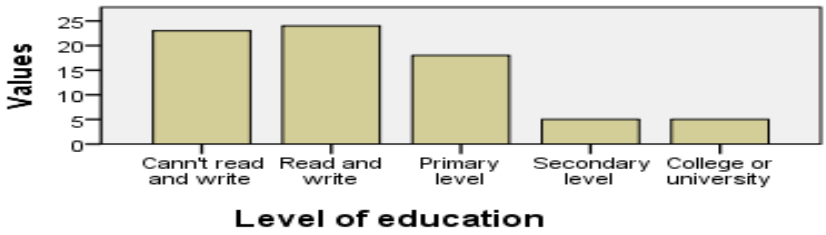


Figure 2: study respondents level of education

As depicted in the table 4 below 53.4 percent of the study participants stayed less than seven years, while the remaining 46.6 percent stayed more than eight years in Addis Ababa as urban refugees.

Duration		Frequency	Percent
	1-7 years	40	53.4
	8-10 years	16	21.3
	>10	19	25.3
	Total	75	100.0

Table 4 Study Respondents' duration of stay in Addis Ababa as urban refugee

Regarding refugee monthly income, most respondents' average monthly income lays between ET birr 2,001.00 to 3,000.00 while 34.6 percent of refugees got less than 2,000.00 ET birr and some 13.3 percent got more than ET birr 3,000.00. Their main source (54.3 percent) of monthly income was assistances obtained from NGO followed by self-employment earnings (21.4 percent). From all study subjects 38 (50.7 percent) have an additional source of monthly income, remittance from their relatives who are abroad while the rest depends only from monthly allowance got from NGOs. Concerning income participants of the focus group indicated that EOC-DICAC-RRAD provided monthly subsistence allowance to very few recognized urban refugees including Somali based on their family size. According to the social workers of the agency currently, monthly a single urban refugee receives ETB 1,510.00, a family with two receive ETB 1,785.00, a family size of three get ETB 2,060.00, a family size of four get ETB 2,610.00, a

family size of five get ETB 2,841.00, a family size of six get ETB 3,160.00, a family size of seven also get ETB 3,435.00, and a family size of eight and above get ETB 3,710.00. During the focus group discussion the indicated that many Somali have extended family like seventeen and above. However, they get the same amount with a family size of eight. This put them in an awkward situation to support their families.

II. *Spouse Relationships*

Study participants responded that 18 (24 percent) their husbands have another wife, while 18 (24percent) their husbands do not have additional wife. However, 39 (52 percent) of the respondents' did not want to respond to the question. The result was also conformed through the focus group discussion by saying that as long as a man is rich he can marry more wives. The reality, however, according to the respondents is that those men with low financial statuses marry more than one wife. From those whose husbands marry more than one, 41 (57.7 percent) of the study subjects were the first wives of their last husband, 18 (25.4 percent) second wives of their husband, and 12 (16.9 percent) were the third and above wives for their husbands. On the other hand, at the time of this data gathering 40 (56.3 percent) of the respondents' were living with their first husband, with their second husband 22 (31 percent), with their third and fourth husbands 9 (12.7 percent).

Furthermore, 46 (64.8 percent) of the respondents' live for less than or equal to five years while 25 (35.2 percents) live between six to ten years with their last husbands. Most of the respondents' 57 (80.3 percent) experienced conflict with their husbands while the rest live relatively peaceful. Of those who have conflict experience with their counterparts, the frequencies were, sometimes/three times per week 25 (43.8 percent), occasionally (two time per week) and daily 8 (14 percent). Among the causes for the conflict economic problem, and husband's bad habit like cigarette, chat, Shisha, etc. addiction takes the lead responses. From the discussion with the focus group and key informants, it was disclosed

that since men consider their wives as their property they always beat them even with minor thing. Hence, conflict is a very common phenomenon.

III. *Harmful Traditional Practices*

About 50 percent of respondents' heard about harmful traditional practices (HTPs) and their source of information was training and workshops organized by different NGOS. On the other hand, more than 90 percent of the study participants heard about female genital cutting (FGC) and/or circumcision. As well 50 (66.7percent) of them reported that they have been circumcised and the remaining 25 (33.3percent) didn't want to respond. According to the respondents' most of the 59 (78.7 percent) of them had FGC before their 1st year and about 15 (20percent) of respondents' didn't know when the FGC performed. Participants of the focus group discussion also pointed out that the level of awareness among the Somali community with regards to HTPs is also high but despite the reality many of them considers some of such practices like female genital cutting, early marriage, denial of education to girls and women are very common. The other finding with HTPs during the focus group discussion is that not only girls genital mutilation.

According to the study participants, FGC was conducted by traditional birth attendants and traditional circumcises 39 (52 percent) and 36 (48 percent) respectively. And those who did not perform FGC become neglected 54 (72 percent) and stigmatized 21 (28 percent). Concerning the practice of FGC, the discussion from the focus group indicated that not only those Somali in different camps in Ethiopia but also those who are in Addis Ababa take their children back to camps for genital cutting. The other finding is that after the cutting the girls' genital organ will be closed with thread to guarantee sexual intercourse before marriage. This horrible act usually put the girls to great danger in time of marriage and birth. More often they develop fistula.

From the study respondents' 38 (50.7 percent) believe that their households are at risk of HTPs while 27 (36 percent) did not believe and the rest did not want to respond. Of those who have a fear of the HTP risk of their family members believe that girls, women and

children have higher risk than other family members. The result for the focus group discussion also conformed that the prime victims of such act are women and girls. As shown in the table 5 below giving education, law enforcement and social dialogue were respondents' better HTPs prevention mechanisms. On this issue the key informants and the participants of the focus group discussion explained that the main reason for the wide prevalent of HTPs among the Somali communities is the deep rooted tradition and customs. Hence, they indicated that to minimize the problem the awareness level of the community need to be enhanced. They cited the example of EOC-DICAC-RRAD's awareness raising workshops on SGBV become a good topic of discussion among the Somali women. The social workers who work for EOC-DICAC-RRAD also observed that the number of reported GBV incidents is on the increase among the Somali women community.

HTPs prevention methods		Frequency	Percent
	Providing education to the community	27	36.0
	Enforcing the law	23	30.7
	Isolating those who do the practice	10	13.3
	Social Dialogue	15	20.0
	Total	75	100.0

Table 5: Respondents' knowledge on how to prevent HTPs

Most respondents 62 (83 percent) agreed the negative health consequences of HTPs, while some 13 percent of them were in support of the HTPs. On the other hand 57 percent of study participants agree in disclosing the HTP survivor status to their family members. The remaining 21 percent did not support this idea of disclosing HTP survivor status. And a similar number of respondents' have a neutral idea about the issue. The participants of the focus group also agree the harmful effect of some of the traditional practices on women and girls.

Of all respondents of this study, 31 (41. 3 percent) of them circumcised their children while the rest responded not. Most respondents (46.7 percent) believe that it is not safe to

live with a person affected with fistula while 34.7 percent believe it has no problem living with a person of fistula. Besides, 68 percent of the study subjects decided to stop the friendship with fistula victims. This finding is also correlated with the discussion result of the focus group where they indicated that almost all women believe that their female children should be circumcised not only to keep the culture but also to make them preferable for marriage.

IV. Gender Based Violence

During the last one month, the majority of respondents (70.7 percent) didn't prefer to go outside of their home at the evening time due to fear of gender based violence. As a result 83.6 percent of them did not go outside in the evening to avoid sexual violence risks. According to most respondents (80 percent) a husband should allowed to punish his wife. Similarly, 78.7 percent of participants responded that it is common for men to beat their wives.

During the last 12 months, 77.3 percent of respondents have slapped, smacked or trapped a child. And during their childhood/teenage 86.7 percent of the study subjects had any form of serious conflict with either of their parents. Besides, 76 percent of them experienced forced sexual violence between four and ten times frequency (39.7 percent), and with similar percentage between one to three times. Results from the focus group also indicated that women and girls are very vulnerable for any forms of sexual and gender based violence. They also indicated that it is not safe for women and girls to go and stay outside in the evening. With regards to domestic violence, respondents form both group i.e. key informants and focus group participants indicated that the community has accepted the male dominancy and hence they are free to do what every the husband want against their wives and their female children.

According to respondents sexual violence perpetrators were varied at different times. And in most cases (68.8 percent) the perpetrators were unknown by the respondents and the rest were known by them. Among the acts of GBV for the last twelve months, threat or

attack with weapons (37.3 percent), exhibitionism (17.3 percent) and assault by robbery and being kissed or groped by force were the most common reported acts. Of these, assaults by robbery, exhibitionism and threat or attack with weapons were identified as the most serious acts to the respondents. All the participants of the focus group indicated that life is very challenging especially for women and girls in Addis Ababa for they are easily exposed to different types of gender based violence both at home and even on some streets in Addis Ababa.

During the last twelve months, more than 40 and 70 percent of respondents reported that their husbands prevent them from talking to their friends and downplay what they did respectively. According to the study participants, during the same period, 66 percent of respondents' husband made unpleasant remarks about their wife's physical appearance. Furthermore, more than 85 percent of respondents reported that their husbands impose dressing styles and /or how to behave to the public. And more than 69 percent of husbands require knowing with whom and where their wives were.

On the contrary, about 40 percent of respondents reported limited household resource access. A similar number of respondents reported that they have been attacked by an object and/or brutally grabbed. During the last twelve months, about 42 percent and 39.5 percent of study participants were at least once their husbands/spouse use force to have sexual relations and strangled or attempted to be killed by their husbands/spouses respectively. But the remaining 52 percent of respondents never have such experience with their husbands/spouse. Among the common incidents inflicted on wives, insult and sexual abuses were identified as the most frequent acts.

Results from the focus group discussion and the key informants also strengthen the remark that domestic violence is very rampant in many Somali families both in the camp and here in Addis Ababa. Concerning property possession, the participants indicated that any property in the house is fully controlled by the husband. Some participants indicated that the life of divorced or separated women is much better than those in marriage.

In terms of seriousness of the violence suicide, death threats and forced sexual intercourses were identified as major threat for respondents. After the violent incidents 84.3 percent of the respondents' have acquired health problem which requires attention of psychosocial services but impairment of their sexuality wasn't reported by 67.6 percent of the respondents and the remaining 32.4 of them did not want to respond to it. About 60 percent of respondents who have experienced sexual violence, sooner or later communicated the incident with their close relative and/or friends. 38.4 the victims report their case to EOC-DICAC/RRAD with self and support from other colleagues. However, 35.6 percent of the respondent did not report the incidents to EOC-DICAC/RRAD.

Following the violence more than 60 percent of the respondents at least once reported their case to the police. And most of the respondents (81.9 percent) who report their case to the police either they didn't get or know the outcome of their cases. In addition, according to the respondent information, following their complaint of violence act in 85.3 percent of the cases there was no legal action/conclusion. Results from the focus group discussion, key informants and social workers indicated that most of the time women and girls who experienced violence develops psychosocial problems and alienate themselves from the community. They pointed out that any women who become pregnant out of bed lock will be automatically out cased by her clans and the community in general. Hence, the survivors are forced to leave their residence and find a new place to live, more preferably away from the Somali communities. Hence, for fear of such isolation they tend to hide and keep their secrets even though they suffer psychologically. They also pointed out that few of them tried to report the incidents either to EOC-DICAC-RRAD or police the perpetrators was not put in justice.

V. *Contributing factors for Gender Based Violence*

According to 81.3 percent of respondents, the role of women was downgraded by their culture. As shown in table 6, most respondents agree that men are stronger than women.

Almost the majority (97.4 percent) of the respondents disagrees on men's involvement in cooking a meal and half of the respondents agree that it is the role of women to look after her children. As shown on table 6, 71.6 percent of respondents believe that men are born to do hard work than women.

		Frequency	Percent
	Strongly agree	8	10.7
	Agree	42	56.0
	Neutral or have no idea	4	5.3
	Disagree	9	12.0
	Strongly Disagree	12	16.0
	Total	75	100.0

Table 6: Comparison on men is stronger than women

		Frequency	Percent
	Strongly agree	27	36.5
	Agree	26	35.1
	Neutral/ have no idea	5	6.8
	Disagree	4	5.4
	Strongly disagree	12	16.2
	Total	74	100.0

Table 7: Responses on men are born to do hard work than women

As can be observed from Table 8, more than 50 percent of respondents indicated that their husbands used Chat, Shisha or other forms of addictions, while 44.6 of them did not use either of these substances. The discussion result from the focus group also conformed that almost all household management is the responsibility of women. Men usually go to their house to get food and to sleep. During day time men spend their time with their friends by talking, chewing chat or smoking Shisha. Concerning social engagements the respondents indicated that it is the duty of men.

Substances		Frequency	Valid Percent
	Cigarette	10	13.5
	Chat	34	45.9
	Shisha	15	20.3
	He uses neither of them	15	20.3
	Total	74	100.0

Table 8: Husbands' substances use habit

Most (74.7 percent) of respondents believe that women with low income are susceptible to GBV. On the other hand, 84.9 percent of respondents believe that being separated/divorced increases the risk of GBV. On other hand 45.9 percent of the respondents believe that living in a rent house also increases the risk of GBV. One of the issue of discussion during the focus group was to mention contributing factors for gender based violence, it was indicated that the customs and tradition of the Somali community that give men the upper hand both in his family and in the community is the main reason for the high prevalence of GBV. They also mention financial constrains contributed to the problem.

In-depth interviews were carried out with key informants who were randomly selected and asked if they were interested to participate in the discussion. Initially the numbers of participants were eight and three of them express their frustration to participate in the discussion and hence the actual number was limited to only five participants. Their age ranges from 18 to 37. All of them were urban refugees legally registered by the Federal Government of Ethiopia and the UNHCR. They were fully assisted by EOC-DICAC-RRAD.

With regard to in-depth interviewees of the key informants, three of them were victims of violence and they narrate their experiences as if it happened recently. One of the women was crying while narrating her traumatic experiences and an effort was exerted to cool her down and continue her story.

Each participant had some difference in their perception of what is meant to sexual and gender based violence and harmful traditional practices. Hence, a clear clarification about them was provided. After the clarification each participant narrates some of the most common types of gender based violence prevalent among the Somali communities.

Instances of physical violence included slaps, punches, kicking; beating with a stick, burning, and use of weapons were mentioned as some of the violence against women and girls in the Somali communities. The respondents indicated that such kinds of violence occur in the country of organ, on the way to Ethiopia, in different refugee camps and in Addis Ababa.

They indicated that the women are the property of men and they should tolerate to offences inflicted from the husbands. One of the survivor of sexual and gender based violence indicated that she was living in Shedder refugee camp along with her parents. She later falls in love with one Somali boy. She stayed with him some time until the parents discover that she had an affair with a boy. She was chased away from home and all her clan members rejected her. She was later went to Jijiga, a nearby town and administrative city of the Ethiopian Somali region. She gave birth to a baby girl and stayed in the house of the local as maid servant.

One day, she took a taxi to go to a market place to purchase household materials. She indicated that there was one man in the taxi who covers his head with a scarf. Later the taxi went to a wrong road and she asked the driver why the taxi turned to the wrong direction. The driver replied that he had to take the man to his place first. She asked him to park that car but he continue to drive. After a while the taxi went in to a certain house and the man who stood besides her dragged her from the car and took her in to the house. She was forced to stay three days in the house and later she escaped. After a few months she discovered that she was pregnant. She informed to the house owners about all that happened. They were sympathetic about the incidents and promised to help her. She stayed in the house for nearly two years and later went back to Shedder camp while she

was a seven month pregnant. She approached to UNHCR and the Administration for Refugees and Returnees Affairs office and explained them all that happened. Realizing her complicated problems she was relocated to Addis Ababa for physical protection. She said that she do not know the where about of her boy friend and now taking care of two kids.

The other informants also disclosed similar experiences. They all indicated that the violation of women in the Somali refugee community is very serious and part of their daily life. They also cited the deep rooted traditions and customs of the Somalia community and the economic problem as the major contributing factors for the wide prevalence of gender based violence.

Concerning traditional practices, they indicated that female genital cutting, closing the vaginal valve with tread to protect they from any sexual intercourse before marriage, early marriage, giving girl to old but rich man, denial of education to girls and women thinking that they will belong to someone else later are more rampant among the Somali communities. They all indicated that the husband may use even a silly thing to beat his wife. Hence, fore fear of such physical violence the women should keep themselves busy in making the house more attractive and makes money to fill the persistent demand of their husband. During the discussion it was pointed out that the magnitude of harmful traditional practices is declining among the urban Somali refugees. However, the practice is widespread in different camps.

During the discussion it was indicated that some organizations like EOC-DICAC-RRAD initiated awareness raising trainings to different segments of the urban refugee communities including Somali. Such trainings paved the way for women to talk openly about their fundamental rights and have started to come to their offices for counseling. The key informants from the agency (EOC-DICAC-RRAD) indicated that problem of gender based violence and harmful traditional practices are very common and deep rooted among the Somali communities. Hence, they planned to continue to provide

similar awareness raising campaigns as a major tool to fight against any form of violence and harmful traditional practices.

All the participants indicated that the deep rooted traditions and customs of the community is the major cause behind the wide prevalence for the sexual and gender based violence and traditional practices.

Chapter 5

5. Conclusion and Recommendations

5.1 Conclusion

Based on the data presented and discussed in chapter four the following conclusion can be made.

A. Divorce and Separation:

Concerning the marriage experiences of respondents, the majority was based on family decision. Such type of marriage eventually ends up with either long lasting suffering or divorce. The finding reveals that a good number of marriages end up with divorce and economic problem was the major reason followed by ethnic differences.

B. Educational Status

The majority of the respondents' educational level is either primary or lowered than primary level of education. This clearly indicated the value given by the community to educate women and girls. Even those who had better opportunity could not attend education due to the great responsibility they shoulder in their family.

C. Spouse Relationship

The study result reveals that their husbands have additional wives. This clearly paves the way for sexually transmitted diseases. Besides, their husbands could not effectively manage their families. Consequently, the majority of the respondents' experiences conflict with their husbands more frequently. The major reasons of the conflict were economic problem followed by their counterparts' addiction to different drugs.

D. Harmful Traditional Practices

The knowledge level of the majority of the respondents concerning gender based violence and harmful traditional practices were minimal. Among the respondents almost all of them were circumcised during their childhood either by traditional birth attendants or traditional circumciser. Likewise, the majority of the respondents made their children circumcised even while they were in Addis Ababa. This clearly indicates how deep is the prevalent of female genital cutting among the Somali urban refugee community. The majority of the respondents, however, agree that HTPs has negative consequences on those who were undergone through the practice.

On the other hand due to early marriage many Somali women develop fistula. However, the majority of the respondents do believe that it was not safe to live with a person that develop fistula hence they prefer to cut any relationship with them. The study identified harmful traditional practices are very common among the Somali community and hence women and children are at risk harmful traditional practices.

E. Domestic Violence

Somali women refugees experience violence at home in the form of physical and verbal assaults. Different forms of physical assaults such as slapping, beating, committing forced sexual intercourse; twisting arm or pulling hair; punching with fists; and kicking, dragging, were experienced during the last 12 months from the time of the study. In a similar development, some women suffered from verbal abuse and assaults from their spouses/couples over the last 12 months of the survey. Most frequent types of assaults/abuses were blown; forbidding having social relationships with others; denial of the right to talk; denial of access to money; undermining one's reputation; imposition of ideas; and forced sex. All these indicated that there is high prevalence of violence against women among the Somali communities.

F. Prevalence of SGBV and HTPs

Data from both quantitative and qualitative sources revealed that both sexual and gender based violence and harmful traditional practices are more common in the study area. The majority of the respondents indicated that they feel insecure to manage their day to day activities in the study area. Equally, early marriage, FGC and closing the vaginal openings with thread, denial of education for their female children were still very rampant and accepted the Somali community as norms.

G. Contributing Factors for SGBV and HTPs

The study results obtained both from the quantitative and qualitative indicated that the main reasons that contributed for SGBV and HTPs are the traditions and customs of the Somali community towards the role of women and girls in the communities, economic problem and substance abuses i.e. frequent use of alcohol, Chat, Shisha and jealousy or distrust.

H. Service provision/delivery and quality of services

NGOs and other stakeholders are providing some services which are not actually commensurate to the existing needs in the area in terms of depth and width. Care for survivors of SGBV/HTPs and the unaccompanied minors, children born as a result of rape, and vulnerable women, awareness creation trainings for few community members and skill trainings and income generating activities for survivors SGBV/HTPs in the study areas are some of the services some organizations like EOC-DICAC-RRAD are providing. However, the services are fragmented, shallow, not well coordinated and inconsistent. There are no tailored and hands-on trainings and services for GBV/HTP survivors in the area.

The majority of the respondents indicated that they were not aware of the services provided to survivors of GBV/HTPs by some organizations like EOC-DICAC-RRAD. This

is basically due to the fact that the community is unaware of the services existed in such organizations.

Generally, the result obtained from both the qualitative and quantitative methods is that gender based violence and harmful traditional practices are very rampant among the Somali community in general and the refugee community in particular. The major cause behind this problem is the community's attitudes towards the role of women and girls.

5.2 Recommendations

Based on the aforementioned conclusions, the following recommendations are forwarded:

1. *Increased community mobilization and sensitization*: it is disclosed in the study that community awareness and knowledge on GBV/HTPs is very minimal. Therefore, it is imperative to enhance community mobilization and sensitization activities to raise the level of demand creation capacity through workshops and trainings that target community representative, elders and religious leaders.

2. *Encouraging grass-root community centers involvement*: During the discussion with key informants and social workers of EOC-DICAC-RRAD it was indicated that there were Somali community centers in different parts of Addis Ababa. These community centers were run by respected community elders. It was also indicated that a good number of Somali community frequently visit the centers everyday. Hence, a due attention should be given by different organizations working with refugees to target such centers to create and raise awareness in different topics.

3. *Post-training follows up, monitoring and evaluation:* it is evident that different stakeholders conduct different trainings at different times. Most often, however, different organizations consider trainings as an end by itself. As a result change is

not traced. Therefore, to ensure incremental change over time and sustain on-going positive practices and experiences in the study area, conducting post-training monitoring, follow up and evaluation is important. In other words, put in place strong and systematic monitoring, evaluation and follow up of the proper implementation of deliberations of past trainings and significant gains from the past interventions. Key stakeholders working in the area against GBV/HTPs and women's empowerment need to plan and monitor implementation of and gains of past trainings so that they can measure changes and plan for the future accordingly. EOC-DICAC/RRAD is supposed to augment this practice.

4. *Schooling for girls:* one of the major findings of this study is that the community gives low status for girls' education. This attitude makes women and girls complete dependants on men. Hence, concerned organizations like EOC-DICAC-RRAD should exert maximum effort to increase girls' school participation by arranging different incentives. Schools consist of a large number of youth as students. The youth and students are active groups of the society and can carry out several activities to enlighten the community. Once girls get the chance for education they will be automatically empowered to decide their own fate.

5. *Link the intervention strategy with the FGoE Policy and Strategy:* The Federal Government of Ethiopia works to eliminate any forms of gender based violence and harmful traditional practices in all of its regions. Since refugees live together with the host communities, organizations like EOC-DICAC-RRAD should strengthen their interventions with regional women, children and youth bureaus and other such offices. In such collaboration the magnitude of the problem can better be addressed.

6. *Inter-institutional cooperation and collaboration for better service delivery:* fragmented and piecemeal services and interventions of organizations were mentioned as a major weakness. Instituting and aligning gender related activities

within an organization alone does not guarantee a success. Inter-sectoral collaboration and cooperation is critical to boost effective and uninterrupted service and support to women and girls. Strengthening partnership building initiatives and re-aligning institutions in the study area and in every refugee camp is a necessary precondition to better plan women-friendly services. This must start with the existing community mobilization and awareness education activities already in place to some extent. To this end, partnership with all the implementing partners of UNHCR like EOC-DICAC-RRAD, JRS, ARRA needs to be re-oriented in such a way that essential service providing activities is planned and implemented to change women's life in a better way. A good development on this regard is the signing of the standard operating procedures by all the organizations to mange and mitigates gender based violence among the urban refugees' communities. This operating procedure helps to systematically address the issues. However, continuous follow ups and evaluation of the implementation of the procedure is also equally important.

7. *Making male as a center of intervention:* One of the findings of the study is the conventional acceptance of women and girls inferiority by the community. Conscientizing male adolescents brings changes in young men's behaviors, and can be taken as a way to hold the young men accountable to the project/intervention for the commitments that they make to change harmful attitudes and behaviors. The idea is that men can be mobilized to support gender equality by relating their own best experiences of oppression to women's experience of gender-based oppression. Working with men, not only as 'objects' but also as 'subjects'; working with men as potential allies to women can include working across the program policy spectrum for a change at household, community and societal levels, seeking to change behaviors, attitudes, norms, policies and laws that harm sexual and reproductive health and that promote gender equity. Therefore, engaging men in GBV/HTPs interventions need to be accompanied by a scheduled and

systematically planned education activity. Education programs that are not mere indoctrinations of gender equality, but rather recognize male involvement as a strategy and associates gender equality with development and growth. On this attitude the place of men is crucial. Hence, in every intervention strategies to combat the prevalence of GBV/HTPs in the Somali communities the involvement of men is crucial. Hence, it is a strong recommendation that men should be involved in every intervention strategies.

8. *Capacity building of Agencies:* Institutional and technical capacity of stakeholders thought to participate in women centered interventions has been a question. From the perspective of service provision at the expected level capacity of institutions becomes of paramount importance. From the standpoint of providing adequate services for the intended groups of the society, institutions are required to possess the requisite capacity.

9. *Support to GBV/HTPs survivors:* It was disclosed that services for GBV/HTPs survivors in the study area are inadequate and haphazard. To this end, it is recommended that those survivors need to get the right rehabilitative psychosocial services including skill training on different marketable income generating schemes. As a result their quality of life gets improved and they also be part of the educator/activist members to end GBV/HTPs from the community.

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Appendices

Appendix I:

Interview Schedule
On the Prevalence and Contributing Factors for SGBV among Women Somali Urban Refugees in Addis Ababa, Ethiopia.

Introduction

This questioner is designed to assess the prevalence and to identify contributing factors for sexual and gender based violence among Somali women urban refugees in Addis Ababa, Ethiopia.

The researcher would like to request you to give genuine answer to all the questions listed below. He would also like to remind you that your genuine answers are of paramount importance to the outcome of this research project and for that all the answers and your identity are kept anonymous.

Confidentiality and consent: The study will not ask your name and will not be recorded anywhere. The researcher will not tell to anyone your answers to any of these. You do not have to answer any questions that you do not want to answer. However, your honest answers to these questions will help the researcher to better understand the prevalence of the problem and to provide feasible suggestions to the different aspects of the problem.

The researcher would greatly appreciate your participation in this survey. It will take about 50 minutes to fill out this questionnaire. Thank you for your patience and participation in advance.

Are you willing to participate? [ ] YES [ ] NO. If yes, continue

I. Background Data

1. Respondent's Current address in Addis Ababa. Please put"√" mark against your choice)

1. Bole	[ ]	4. Yeka	[ ]	9. Arada	[ ]
2. Nefas-silk- Lafto	[ ]	5. Gulele	[ ]	10. Lideta Sub-city	[ ]
3. Kirkos sub-city	[ ]	7. Cherkos Su-city	[ ]		
4. Akaki sub-city	[ ]	8. Addis Ketema	[ ]		

No.	Questions in English	Response
100	Sex	1. Male 2. Female
101	How old are you?	_____
102	Marital status	1. married 2. single 3. divorced 4. separated 5. widowed 88. No response
103	If your answer for Q102 is "DIVORCED" OR "SEPARATED" what was the main reason? (more than one answers are possible)	1. Religious difference 2. External family members' interference 3. Economical problem 4. Ethnic difference 5. Working conditions 6. Sexual conflict 7. Addiction 8. Age difference 9. Others (please specify) _____ _____
104	If your answer for Q102 is "MARRIED", please tell us how you chose your marriage partner	1. By own choice 2. Parental Decision 3. By abduction 4. By inheritance 5. Others (please specify) _____ _____ 88. No response
105	Occupation	1. Farmer 2. Daily laborer 3. Merchant 4. Gov. employee 5. Private employee 6. Others (specify)_____ _____
106	Educational status	1. cannot read and write 2. read and write 3. Primary completed 4. Secondary school completed 5. College/University education,

		please specify
107	Religion	1. Muslim 2. Orthodox 3. Protestant 4. Catholic 5. Other (specify) _____ 6. 88. No response
108	Do all members in your household belong to the same religion?	1. Yes 2. No
109	If your answer is "No" for Q108, was there any major problems caused as a result in your HH? (more than one answer are allowed)	1. No problem observed at all 2. Conflict of interest 3. Divorce 4. Separation 5. Street life 6. Commercial sex work 7. Others (specify) _____ _____
110	Duration of the respondent's stay in Addis Ababa	_____ (years)

II. Socio-economic Data

200	Average Household income per month	Eth. Birr _____
201	What are the major income sources of the head of house?	1. Daily labor 2. Farming 3. Trading 4. Salary 5. Allowance from NGO/CBO/CSO 6. Self-employment 7. Other, please specify _____ _____
202	Does the head of house have any additional economic income sources?	1.Yes 2.No

III. Spouse Relationship

300	Does your husband have other wife?	1.Yes 2. No 88. No response
301	If the answer to Q300 is YES; how many wives does he have?	1. Two 2. Three 3. More than three
302	Are you the.....wife of your current husband?	1.First 2.Second

		3.Third 4. Fourth or above
303	Your current husband is the ...husband for you.	1.First 2.Second 3.Third 4. Fourth or above
304	How long have you stayed with your current husband?	_____years
305	Have you been in conflict with your husband or wife, since your marriage?	1.Yes 2.No 88. No response
306	If the answer to Q 305 is Yes; How frequent was the conflict?	1.Usually (daily) 2.Sometimes (3 times/week) 3.Occasionally(2 times/month) 4.Other (Specify)_____
307	If the answer to Q 305 is Yes; what was the cause?	1.It was not the marriage I wanted 2.Alcoholic husband 3. Husband has other wife. 4.Economical problem 5.You don't obey your husband properly 6.Initiated by Relatives 7.Husbands bad habit (cigarette, Khat) 8.Initiated by Neighbors 9.High tempered husband 10.Other (Specify)_____ _____

308	How was the conflict resolved?	1.Elderly people Intervention 2.Family Initiated 3.Friend Initiated 4.Parents 5.Neighbors 6.Yourselves 7.Still Not Resolved 8.Other (specify)_____ _____

IV. Harmful Traditional Practices

400	Have you ever heard about the Harmful Traditional Practices (HTP)?	1. Yes 2. No
401	If the answer is YES for Q400, how you heard about of HTPs?	1. Through media 2. Through community conversation 3. Training sessions 4. Religious teaching 5. Other (specify) _____ _____
402	Have you ever heard of female genital cutting or circumcision?	1. Yes 2. No
403	Have you yourself ever been circumcised?	1. Yes 2. No 3. 88. No response
404	How old were you when you were circumcised?	1. up to 1 years 2. 1-5 years 3. 6 to 10 years 4. > 10 years
405	Who performed the circumcision?	1. Traditional Circumciser 2. Traditional Birth attendant 3. Health profesional 88. No response

406	What is the place given by the family or community members for uncircumcised girl?	1. Neglected 2. Respected 3. Stigmatized 4. I don't know 88. No response
407	Can female circumcision be a criterion for good marital relations?	1. Yes 2. No 3. I don't know 88. No response
408	Which types of HTPs are most frequently practiced in your clan or kebele? Please specify the top five types of HTPs according to impact level, from highest impacting to lowest order.	1. _____ 2. _____ 3. _____ 4. _____ 5. _____
409	Do you think that the household members are at risk of HTPs?	1. Yes 2. No 88. No Response
410	If your response to Q 409 is No, what could be the reason? (more than one answer is possible)	1. God (Allah) protect us from all. 2. We are good with our neighbors and community 3. We are not exposed to HTPs 4. We use open discussion among family members. 5. Others (specify)_____ _____
411	What kinds of people are more likely to be highly vulnerable to HTPs? (more than one answer is possible)	1. Only children 2. Only girls and women 3. Only adults 4. Any body 5. Others (specify)_____ _____ 88. No response
412	Do you know how to prevent people from the impacts of HTPs in your household as well as in your sub-city or Wereda?	1.Giving education to the community, 2. Enforcing laws, 3. Isolating those who do the practice from the community, 4. Social Dialogue, 5. Others (Specify) _____

		_____ _____
413	HTPs have no effects on someone's life.	1. strongly agree 2. agree 3. neutral /have no idea 4. disagree 5. strongly disagree
414	Victims of HTPs/fistula / should not keep their status secret to household members.	1. strongly agree 2. agree 3. neutral 4. disagree 5. strongly disagree
415	Is any of your child has been circumcised?	1. Yes 2. No
416	If your answer for Q 415 is Yes, what was your reason for circumcising your female child? (more than one response is possible)	1. Just to keep the culture 2. To avoid bad effect on her future life 3. Wish her to have good marital relation 4. Thinking that her husband like it 5. For marriage 6. Others (specify) _____ _____ _____
417	Do you think it is safe to live with a person with fistula?	1. Yes 2. No 3. 88. No response
418	Would you stop being friend to child if she has a fistula?	1. Yes, I will stop 2. No, I do not stop 88. No response
419	A female child should be circumcised before marriage?	1. Strongly agree 2. Agree 3. Neutral /have no idea 4. Disagree 5. Strongly disagree
420	Have you ever thought of stopping female child circumcision?	1. Yes 2. No 88. No response
421	If your answer is No for Q420, why?	1. Fear of disrespect 2. Marriage delay 3. stigma 4. For rear of unwanted sexual behavior 5. Other (specify) _____ _____ _____

V. Magnitude of GBV

500	During the last months did you go out alone in the evening for different reasons?	1.Yes 2.No
501	Out of fear, do you generally avoid going out alone?	1.Yes 2.No
502	Out of fear, do you avoid in general using some streets, or areas in Addis Ababa?	1.Yes 2.No
503	Out of fear, do you generally avoid public transport services?	1.Yes 2.No
504	Should a husband be allowed to physically punish his wife?	1.Yes 2.No 88. No response
505	Is it common for men to beat their wives?	1.Yes 2.No
506	Is it common for other HH members to beat women?	1.Yes 2.No 88. No response
507	Are there traditions in the community that can help women recover from the bad affects of the conflict?	1.Yes 2.No
508	Please site some examples for ways for women to recover from violence?	_____
509	During the last 12 months, have you slapped, smacked or tapped a child?	1.Yes 2.No
510	During your childhood or teenage years, did you have any serious conflict with your parents or one of your parents?	1.Yes 2.No
511	Did anyone force you to undergo or perform sexual touching, tried or managed to have sexual intercourse with you against your will?	1.Yes 2.No
512	If yes to Question no. 511. How many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
513	Did someone force you to perform sexual touching? Did this occur several times?	1. Yes 2. No

514	During the last 12 months did anyone unsuccessfully try to force you to engage in sexual intercourse?	1. Yes 2. No
516	If Yes to Q 514, did this happen several times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
517	If Yes to Q 514, was it always the same person/persons?	1. Yes 2. No 88. No response
518	Was it a person (or people) totally unknown to you?	1. Yes 2. No
519	Among the acts we have just mentioned, for the last twelve months, you have reported that you have experiences:	1. Insults 2. Being followed 3. Assault for robbery 4. Exhibitionism 5. Threats or attack with a weapon 6. Being kissed or groped by force 7. sexual touching 8. Attempt of forced sexual intercourse 9. Forced sexual intercourse 88. No response
520	Among these incidents, which one, according to you is most serious?	(One possible answer) _____ _____
521	During the last 12 months, has your husband/spouse prevented you from meeting or talking to friends or family members or other people?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
522	During the last 12 months, did your husband/ spouse downplay the value of what you did?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
523	During the last 12 months, did your husband/ spouse make unpleasant remarks about your physical appearance (too big, ugly)?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
524	During the last 12 months, did your husband/spouse impose dressing styles, type of hair style on you, or how you were to behave in public?	1. Never 2. Seldom 3. Some times 4. Often

		5. Systematically
525	During the last 12 months, did your husband/spouse refuse to take your opinions into consideration, ridicule them or attempted to tell you what you should think (in private)?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
526	During the last 12 years, did your husband /spouse require to know with whom you were and where?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
527	During the last 12 months, did your husband/spouse stop talking to you; totally refuse to discuss issues with you?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
528	During the last 12 months, has your husband/spouse prevented you from having access to the household resources for your daily needs?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
529	During the last 12 months, did your husband/spouse threaten to beat your children or separate you from them?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
530	During the last 12 months, did your husband/spouse physically attack your children or separate you from them?	1. Never 2. Seldom 3. Some times 4. Often 5. Systematically
531	During the last 12 months, did your husband/spouse insult you or abuse you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
532	During the last 12 months, did your husband/spouse throw an object at you, push you or brutally grab you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
533	During the last 12 months, did your husband/spouse slap you or inflict other physical brutalities on you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times

534	During the last 12 months, has your husband/spouse prevented you from going back home, lock you in or out, or in a car, and leave you on the roadside? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
535	During the last 12 months, did your husband/spouse threaten you with suicide? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
535	During the last 12 months, did your husband/spouse utter death threats against you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
536	During the last 12 months, did your husband/spouse threaten you with a weapon (knife, tool, revolver, etc)? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
537	During the last 12 months, did your husband/spouse attempt to strangle or kill you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
538	During the last 12 months, did your husband/spouse use force to have sexual intercourse with you? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
539	Did he impose sexual acts that you refused? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
540	Among the incidents we have just mentioned and which occurred during the last 12 months, you declared that you have suffered from: (more than one answer is possible)	1. Being forbidden to have social relationships. 2. Undermining what you do. 3. Having your hairstyle, clothing criticized. 4. Having your physical appearance criticized 5. Imposed attitudes 6. Having your opinions criticized. 7. Being denigrated in front of a third party 8. Being denied the right to talk 9. Being denied access to money 10. Threats against a child 11. Violence against a child or forced separation 12. insults, abuses 13. Thrown objects at you 14. blows 15. confinement, being thrown out of the house, left on the roadside

		16. suicide threat 17. death threat 18. Threat with a weapon 19. Attempted murder 20. Forced sexual intercourse 21. Other sexual abuses 22. Non
541	Among these incidents, which one is the most serious according to you?	*(One possible answer)* /____/
542	During the last 12 months, did one of your relatives prevent you from going out or locked you (in your home or in his house), chased you away or, during a ride by car, leave you on the roadside? If yes, how many times?	1. Once 2. 2 to 3 times 3. Between 4 and 10 times 4. More than 10 times
543	Have you approached a police to report any incidents of violence?	1. Yes 2. No 88. No response
544	If your answer to Q 543 was Yes, what was the outcome?	_____ _____
545	During the last 12 months, did one of your relatives threaten you with a weapon, or a dangerous tool (knife, stick, revolver …), attempt to strangle or kill you? If yes, how many times?	1. Never 2. Once 3. 2 or 3 times 4. Between 4 and 10 times 5. More than 10 times
546	Was it the same person/people?	1. Yes 2. No
547	During the last 12 months, did one of your relatives force you to touch them sexually or oblige you to undress or attempt or manage to force you to have sexual intercourse with them against your will?	1. Yes 2. No
548	If yes, what was it?	1. Touching or undressing 2. An attempt of forced intercourse 3. A forced intercourse 4. No Response
549	Did this occur several times, and if yes, how many times?	1. Never 2. Once 3. 2 or 3 times 4. Between 4 and 10 times 5. More than 10 times
550	Following these incidents, did you suffer from troubles requiring psychological support?	1. Yes 2. No
551	Following these incidents, was your sexuality permanently impaired?	1. Yes 2. No 88. No response
552	Following this incident, did you get a sexually transmitted disease?	1. Yes 2. No 88. No response
553	Did you talk about the incident to someone? If yes, after how long?	1. Yes, immediately, in the course of the next few hours 2. Yes, later on, after some days or some months 3. No
554	After this event, did you or another person get in touch with EOC-DICAC-RRAD for any support?	1. No 2. Yes, I did

		3. Yes, another person did
555	Following these incidents did you yourself or someone else reports it to the police?	1. No 2. Yes, I did 3. Yes another person did
556	If your answer to Q 555 was Yes. How were you received upon your arrival?	1. Very well 2. Well 3. Moderately well 4. Badly 5. Very badly
557	Following your complaint was there any legal conclusion?	1. Yes 2. No

VI. Factors contributing to GBV

700	Is your culture downgrading the role of women or girls?	1. Yes 2. No
701	"Men are stronger than women".	1. Strongly agree 2. Agree 3. Neutral /have no idea 4. Disagree 5. Strongly disagree
702	"It is the duty of men to cook a meal".	1. Strongly agree 2. Agree 3. Neutral /have no idea 4. Disagree 5. Strongly disagree
703	"It is the duty of women to look after her children".	1. Strongly agree 2. Agree 4. Neutral /have no idea 5. Disagree 6. Strongly disagree
704	"Men are born to do hard work than women".	1. Strongly agree 2. Agree 3. Neutral /have no idea 4. Disagree 5. Strongly disagree

705	Do you use the following items (habits)? (more than one answers are possible)	1. Alcohol 2. Cigarette 3. Chat 4.Shesha 5. Other (Specify)_____
706	Does your husband use the following items (habits)? (more than one answers are possible	1. Alcohol 2. Cigarette 3. Chat 4. Shesha 5. Other (Specify)_____
706	Do you think that a certain age groups are more liable to Gender Based Violence?	1. Yes 2. No
707	Do you think that women with low income susceptible to Gender Based Violence?	1. Yes 2. No
708	Do you think that being divorced or separated increase the risk of sexual and gender based violence?	1. Yes 2. No
709	Do you think that living in a rent house increase the risk of sexual and gender based violence?	1. Yes 2. No
720	During the last 12 months, have you ever been bitten by your husband? If yes, what do you think the reason behind?	1. He is jealous 2. He has abusive character 3. He is dictator. 4. Other(Specify) _____ _____

Appendix II

Interview Guide
On the Prevalence and Contributing Factors for SGBV among Women Somali Urban Refugees in Addis Ababa.

FOCUS GROUP DISCUSSION (FGD) GUIDES

Let us discuss about existing situations in your community in relation to GBV/HTP and women's empowerment

1. Do you know what GBV is all about?
2. Do you know what HTP is all about?
3. What is the place given to women and girls in your community?
4. What are the most common types of violence and harmful practices occurred to women in the Somali community?
5. What are the deep causes or roots of the violence and harmful practices on women (social, cultural, economic, etc)
6. Can you tell me the consequences on women that may have witnessed or experienced gender based violence and harmful traditional practices?
7. What factors contribute to the spread of gender based violence and traditional practices among the Somali community?
8. What are the existing services rendered to prevent GBV/HTP by different organizations like DICAC-RRAD, UNHCR, ARRA, etc?
9. Do you think that refugee women are eager to share their harmful experiences to different organizations like DICAC-RRAD?
10. Is there any framework of cooperation between different organizations that provide different psychosocial supports to refugees?
11. What do you suggest to effectively control or minimize the prevalence of gender based violence?

Appendix III

Interview Guide

On the Prevalence and Contributing Factors for SGBV among Women Somali Urban Refugees in Addis Ababa.

KEY INFORMANTS INTERVIEW (KII) GUIDING QUESTIONS

1. How do you explain the prevalence of GBV in the Somali community?
2. How do you explain the prevalence of HTPs in the Somali community?
3. Please tell us the overall existing situations in the Somali community towards GBV/HTP in Addis Ababa.
4. Can you tell us some of the contributing factors for the spread of gender based violence and harmful traditional practices among Somali communities?
5. Would you please suggest the roles and responsibilities of different actors like the Somali community centers, community representatives, and religious leaders, different organizations like UNHCR, ARRA, DICAC, and JRS for the betterment of future interventions against GBV/HTP? What major activities do you suggest in order that optimal changes are brought for the Somali community here in Addis Ababa?

   (Would you please suggest any feasible intervention types that you believe to be most effective and efficient in the context?)

Appendix IV

Interview Guide

On the Prevalence and Contributing Factors for SGBV among Women Somali Urban Refugees in Addis Ababa.

EOC-DICAC-RRAD Social Workers interview Guide

1. What are the different kinds of gender based violence's reported from urban women refugees?
2. Do you think that refugee women are eager to share their harmful experiences to different organizations like DICAC-RRAD?
3. What kind of support do you provide to the SGBV/HTPs survivors?
4. Apart from your organization, can you name various organizations involved in the control of SGBV among urban refugees?
5. What do you think are contributing factors for the prevalence of gender based violence among refugee communities?
6. Is there any framework of cooperation between different organizations that provide different psychosocial supports to refugees?
7. Do you have standard operating procedures in place to mange and kinds of violence happing among refugees?
8. What do you suggest to effectively control or minimize the prevalence of gender based violence?

Appendix V

List of NGOs in the study Area that have direct relation to the study

1. United Nations High Commission for Refugees Regional liaisons office Addis Ababa.
2. Ethiopian Orthodox Church Development and Inter Church Aid Commission, Refugees and Returnees Affairs Department (EOC-DICAC-RRAD).
3. Jesuit Refugees Services (JRS)
4. Administration for Refugees and Returnees Affairs (ARRA)