GENDER ANALYSIS AND GENDER BASED VIOLENCE (GBV) STUDY IN THE WOLAITA ZONE OF ETHIOPIA

Financed by:

Ayuda en Acción Ethiopia

Conducted by:

Grace Consultants

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ACKNOWLEDGMENTS

This assessment was undertaken by Grace Consultants. Grace would like to thank AeAE Ethiopia staff at head office and field office levels for their valuable input and regular follow-ups throughout the assessment process. Grace further extends its gratitude to the representatives of various government bureaus and offices, schools, health facilities and representatives of the community in the project area for providing valuable information for the assessment. Most importantly, Grace would like to thank the women, men, boys and girls, community and key staff at education, children and women and health office in the project area for participating as respondents in this assessment.

ACRONYMS

AYSRH	Adolescent and Youth Sexual and Reproductive Health
BoWCYA	Bureau of Women, Children and Youth affairs
CBOs	Community Based Organizations
CSO	Civil Society Organization
FBO	Faith Based Organization
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FMoH	Federal Ministry of Health
FP	Family Planning
GBV	Gender Based Violence
GTP II	Growth and Transformation Plan II
HEWs	Health Extension Workers
HTPs	Harmful Traditional Practices
HCPs	Harmful Cultural Practices
IE/BCC	Information Education/Behavior Change Communication
KAP	Knowledge Attitude and Practice
MoH	Ministry of Health
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TV	Television

EXECUTIVE SUMMARY

Overview of the project

Ayuda en Accion (AeA) is a Spain based international non-governmental humanitarian and development organization established in 1981 with a global commitment to eradicate poverty and exclusion. Since 2002 AeA has been supporting the development and humanitarian programs in Ethiopia in partnership with local and international NGOs. Cognizant of multi-dimensional poverty in the Wolaita Zone, Ayuda en Accion designed a long-term program (12-15 years) based on a territorial Development Areas approach committed to eradicating poverty and exclusions. As part of this program, the first three years were under implementation since 2018 with the overall objective to build resilient livelihoods for vulnerable people in the Boloso Sore and Boloso Bombe woredas of the Wolaita zone, targeting rural 11 kebeles and Wolaita Sodo town through AeAE's own structure and three development partners.

Aim of the study

The overall purpose of this study is to investigate and document gender analysis, the current prevalence and types of gender-based or domestic violence, their determinants, the knowledge, and response of the communities and to inventory any relevant responses that are occurring broadly and in the target areas. The study assessed and documented current response mechanisms and identified opportunities that exist based on an analysis of gaps in ensuring effective response and prevention methods.

Methods

Due to the multi-faceted nature of the subject and the multiple study objectives or questions, the study employed a mixed methods approach, i.e., a cross-sectional study designed using primary and secondary quantitative data (both national and regional reports on GBV and related areas) analysis mixed with an exploratory descriptive design (qualitative approach). Both the quantitative and qualitative approaches were conducted concurrently.

The study was conducted at Boloso Sore Bombe, Damot Fulassa, and Kindo Koyisha Woredas of the Wolaita Zone. The primary respondents of the study were the target beneficiaries of the project, namely men and women of reproductive age, boys and girls, and the community at large who are living in the project area. For the quantitative survey, men, women, boy and girl respondents (n=310) were interviewed using a structured questionnaire. The questionnaire contained a series of questions about socio-demographic, sexual and reproductive characteristics, contraception, life skill practices (for boys and girls), and related information. A qualitative study was conducted using key informant interviews with key government and development stakeholders at woreda and zonal levels, such as Health, Education, the Women, children, and youth affairs office, as well as FGD with community representatives, in order to triangulate the findings of the primary data collected through the survey.

Key Findings

GBV

- Gender-based violence (GBV) is violence that is directed at an individual based on his or her biological sex or gender identity. Both women and men experience gender-based violence, but the majority of victims are women and girls. Gender-based violence (GBV) includes physical, sexual, verbal, emotional, and psychological abuse, threats, coercion, and economic or educational deprivation.
- 73 percent of the respondents who are married, widowed, or separated reported that their marriage involved dowry or bride price. Knowledge of GBV is almost universal; 99% of them know about GBV. However, the respondents vary by the number of GBV types they know. In particular, more than 60% of respondents indicated the following GBV cases: girls' circumcision (99%), early marriage (82%), forced marriage (80%), sexual assaults on women and children (80%) , bodily harm inflicted by man on woman (73%), rape/sexual harassment inflicted by man (66%) and verbal abuse (63%).
- When we see the prevalence, 25 percent of respondents perceived that the level of GBV is high. Clearly, the rating varies by woreda. About the trend in the prevalence of GBV, 78 percent of the respondents replied "declining" while 14 and 8 percent replied "increasing" and "staying the same", respectively.
- The study results show that the main GBV perpetrators (according to survey respondents) are quite diverse, from parents to schoolboys. The top three perpetrators are partners (34%), neighbors (22%), and local authorities (15%). The results also indicate a variation by woreda: for instance, neighbors are the main perpetrators in Boloso Sore Woreda. However, the research team could not triangulate this, as we could not get any data on GBV cases (by type) at woreda and community levels. 66% of the respondents believed that GBV victims in the community usually reported to the police or local administration office. However, based on the FGD and KII we had, only a few cases are being reported due to the poor reporting and referral systems in place for GBV cases and the involvement of elders to arbitrate the perpetrators and victims using customary laws (usually the perpetrators will pay small amounts of money to the victims). Due to this, victims are not getting the proper legal services and other potential perpetrators are not learning from the cases. In addition, based on the consulting team's observations, we are unable to get any recorded or reported GBV cases at woreda and community levels.
- The percentage of people who have continuous access to information on GBV ranges from 35 % (Kindo Koysha) to 99 % (Boloso Sore). The top three main sources of information are TV (45%); radio and newspaper news (21%); and relatives, friends and workmates (10%).
- Based on our observations and on discussions we had with sectoral offices, there are poor GBV case recording and reporting mechanisms at woreda and community levels. In most cases the data collected are used for reporting purposes, particularly, for prosecution purposes by police and attorneys, but rarely for advocacy or policy dialogue or processes. In addition, based on our observations and interviews with key stakeholders, data are poorly reviewed and used for decision making.
- As we verified through FGD and KII, the other main challenge is that communities are not willing to report GBV cases to relevant government structures at kebele, woreda and zonal level because of fear of revenge from perpetrators and women's fear that there will be no one to take care of the family if the men are in prison due to their violent actions against women.

- At zonal level there are Rehabilitation and Staying Centers under the Women and children affairs administration. Lawyers employed by Women and children affairs give legal protection for the victims. In addition, psychosocial support, shelter, and food services are provided to the victims. The center has limited capacity in terms of human resources (with only one Lawyer and one Psychologist with seven administrative workers such as cooks, guards, janitors), basic infrastructures to accommodate a large number of cases, shortage of budget, and other administrative challenges. The other issue is the lack of such centers at woreda level, where there are more cases that are also a major challenge. Due to this, the maximum intake capacity of the center is not more than ten at a time.

Decision making power of women's

- Women's decision-making power is the ability to influence decisions that affect the household's life, such as control over resources including land, livestock, and crops, reproductive health rights, decisions to send children to school, clear divisions of labor, etc. The study showed that 55% of survey respondents agreed that men and women are the main decision-makers at the household level while 41% of them agreed that it is only men who have decision making power at household level, and the remaining 4% replied that only women had it.
- 59 percent of women and girls replied that they don't have the power to decide in any matters at household and community levels. By contrast, 12, 13, and 16 percent of women and girls have low, medium, and high levels of decision-making power, respectively. Women and girls with no decision-making power are the highest in Damot Pulassa (74%) while it is the lowest in Boloso Sore (37%). This could be attributed to the strong community structure and involvement of women in different political and economic activities in Damot Pulassa.
- When we see the decision-making power that women have, the top decision power that the women have includes: Sending boys to school (72%), selling livestock products (72%), selling livestock (66%), sending a daughter to school (59%), renting land (50%) and Spending their personal savings mainly Equib (50%). While they have less power on: Marriage of girls (28%), Medical expenses (25%), Number of children to have, use of contraceptives (21%), and personal savings (17%). Though they have low decision-making power to have personal savings, once they save the money (such as Equip) they have the power to spend it.
- Women's participation and representation in politics, economic and social events have shown improvement from time to time. For instance, women's nomination in the cabinet-level at zonal and woreda levels has shown an increment, though it has not yet reached 50%. Women's participation in joining cooperatives at the community level, social associations such as Edirs, has also shown an improvement.
- The gender equity and equality strategies that are implemented at zonal and Woreda levels in all sectors include gender focal person/unit in each sector per zone and woreda, Gender mainstreaming, affirmative action in education, recruitment, promotion etc., provision of free maternal health services, assignment of a minimum of one female Health Extension Worker at each health post level and ensuring rural women's equal access to and control over productive resources and services.

HCP/HTP

- Harmful traditional practices are those customs that are known to have bad effects on people's health and to obstruct the goals of equality, political and social rights, and the process of

economic development. These harmful traditional practices include female genital mutilation (FGM); early marriage; physical and physiological violence, the various taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices etc. In addition, women/girls are denied participation and decision making on matters that affect their lives, including providing relevant information without the consultation of their husband.

- When we see the knowledge of HCP/HTP, 83% of the respondents know HCP. The percentage ranges from 61(Kindo Koysha) to 100 (Boloso Sore). In addition, 19 and 64 percent of the respondents know 1-3 and 4-6 HCP types, respectively.
- HCP varies by woreda. It ranges from 6 % (Kindo Koysha) to 56 % (Damot Pulassa). The percentage of victims of HCP is 49%.
- When we see the legal awareness and information on HCP, 85% and 40% percent of the respondents are aware of the illegality of HCP and have got information on HTPs from different sources, respectively. In addition, 72% and 66% have heard of the law on the prevention and punishment of GBV and HTP in Woreda/Kebele/School; have attended community/school meetings where GBV and HTPs were discussed. 38% of them also replied as to know community or school-based structures that work on the prevention of GBV and HTP in their area.

SRH

- Sexual and Reproductive Health (SRH) is a state of complete physical, mental, social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health services include Family planning, HIV AIDS, maternal and neonatal health services, Sexually transmitted diseases etc.
- When we see the knowledge of SRH 89% and 91% of the respondents have knowledge of sexually transmitted diseases (STDs) and knowledge on HIV/AIDS. While 87 and 71 percent of them replied that they never had an HIV test/VCT and they or their partner are using family planning method, respectively.
- Based on the Woreda HMIS data, the total new and repeated acceptors for FP have been increasing since 2010 EC. On average, 74% of the total FP acceptors are accounted for as new acceptors from 2010 to 2011 EC in all woredas and 43% for repeat acceptors.

Life skills

- Life skills are abilities for adaptive and positive behavior that enable humans to deal effectively with the demands and challenges of life. 76 percent of youth and adolescents know about life skills. Knowledge of life skill ranges from 65 % (Boloso Bonbe) to 100 % (Kindo Koysha). When we see their specific knowledge on key life skills, though 76% of them replied as they know life skills, 57% of them identified communication while 21% goal setting, 8% (each) negotiation, conflict management, and decision making.
- As recommended by AeAE and other development partners, interventions should have capacity building components to ensure the enforcement of laws, coordinated interventions, strong reporting mechanisms and data use for GBV cases and the utilization of the existing elders and customary laws to reduce GBV and HTPs. In addition, it is also important to conduct targeted IEC/BCC campaigns, strengthen the inter-sector collaboration and coordination at woreda and zonal level, provide technical and in-kind support to local anti-HPT committees, CBOs, Eidrs,

women's associations and structures, and organize community-based education, awareness creation and mobilization sessions through religious leaders, elders, etc.

CHAPTER ONE: INTRODUCTION

Background about GBV and Gender

This section deals with the literatures review on GBV and Gender national and regional level which will show the current status, gaps and prospects. Since most of the studies are conducted nationally and less frequently, the data reflected mostly the national and regional specifics. The research team could not find any specific study conducted at Zonal and project woreda level in relation to GBV and Gender. Ethiopia is home to about 114 million inhabitants (Worldometer) from a variety of ethnic groups, with more than 80 different spoken languages. About 45% of the population is under the age of 15 years and women in the reproductive age group constitute 20% of the population. Like much of Sub-Saharan Africa, Ethiopia lags behind global targets to reduce levels of maternal and neonatal mortality, resulting in the deaths of under-five and neonatal mortality of 55 and 43 per 1,000 live births, respectively. On the other hand, the pregnancy-related mortality ratio (PRMR) for Ethiopia is 412 deaths per 100,000 live births.

Ethiopia is passing through a democratic political transition. By freeing political prisoners and repealing the previous CSO law, the country is widening the space for non-governmental organizations, including those working on women's rights and gender equality through its new law. The women focused policies, plans and declaration (such as National Policy on Women, Family Code, GTP I and II, Beijing Declaration and Platform for Action) on enhancing the participation of women in political, economic, cultural and social life, and the country has committed to eliminating child marriage by 2025. Ethiopia is one of the few countries that have achieved gender parity in the cabinet (50% in the cabinet), and women hold the positions of President and President of the Supreme Court.

Although in the legal and policy environment, such as commercial and criminal law, Ethiopia is yet to review its laws from a gender perspective and adopt a comprehensive law (integrated with criminal law) on gender-based violence that would include all forms of violence against women, including gang rape, acid attacks, marital rape and sexual harassment. The Constitution provided for affirmative action in public and private institutions, but a UN Committee on the Elimination of Discrimination against Women, in its eighth CEDAW periodic report (February, 2019), points out that a regulatory framework for the systematic implementation of this constitutional principle was lacking, and there was no engrained system for women's appointment to executive and decision-making levels.

And yet, the provisions in the FDRE Constitution, international instruments and national laws, policies and plans and existing women's associations and structures are enabling factors to promote and ensure the respect of the political, economic, social and legal rights of women in general and the realization of gender equality, women's empowerment and reduction of GBV in particular.

Despite progressive legal and policy frameworks, the long-standing and deep-rooted inequality situations and discriminations against women created due to the patriarchal social setting are unresolved. There is still a power imbalance in Ethiopian society and government structures, women's political participation at a lower level (such as Woredas) is low, and women are still discriminated. Gender-based violence in Ethiopia is still highly prevalent.
Reliable and current data on the magnitude and prevalence of GBV are hard to come by. Some studies are interested in showing the magnitude of GBV in different geographic regions of the country. Others are interested in revealing specific GBV types, such as physical violence, FGM, child marriage, sexual

violence, and so on. For that purpose, the latest DHS (2016) report is utilized to shed light on GBV prevalence in Ethiopia.

Data from the 2016 Demographic Health Survey (DHS) revealed that 33% of women ages 15-49 had experienced physical or sexual violence and that domestic violence is the most common form of violence that women experience. Data also shows that around 65% of women between the ages of 15-49 have been circumcised in Ethiopia and that child marriage is still a significant problem in the country, as around 58% of women ages 25-49 married before their 18th birthday.

The same report indicates that the prevalence of FGM/C varies greatly by region, with the highest prevalence in Somali (99%) and the lowest in Tigray (23%). Of the women who have undergone this procedure, 73% of them indicated that the cutting and removal of flesh occurred and 7% reported that their genital area was sewn closed, or "infibulated". Infibulation, the most severe type of FGM/C, was found to be more common in Somali (73%) and Afar (64%). More women living in urban areas (97%) had heard about FGM/C, compared to 91% of women living in rural areas. Knowledge of the prevalence of this practice differs by geographic region and is highest in Afar, Somali, Harari, Addis Ababa, and Dire Dawa, and is lowest in Gambela. The 2011 Welfare Monitoring Survey (WMS) shows that less than 25% of 0-14 years old girls were circumcised, while according to the EDHS 2016 report, 65% of women have been circumcised.

There are international and national policy environments that support to intervene in the practice of FGM. The UN general assembly resolution 34/180 declared the elimination of all forms of discrimination against women and set a plan of action for the elimination of traditional practices that affect women and children's health. This declaration is accepted and ratified by Ethiopia. The African Charter on the Right and Welfare of the Child (1999) entitles actions against the protection of harmful social and cultural practices. Similarly, there are several policy directions and laws that support the prevention and elimination of FGM practices, including the penal code and a national strategy for harmful traditional practices and reproductive health. Ethiopia envisages eliminating FGM by 2025 and puts strategic and multi-sectorial approaches through the national plan of action against the elimination of harmful traditional practices and national networks. Despite all these efforts, the practice of FGM has continued due to different reasons. Several personal, interpersonal, community/social, organizational factors, and the lack of an enabling policy environment can determine the prevalence of FGM/C. Female genital mutilation has been carried out among various communities in Ethiopia for similar reasons, such as issues related to virginity as honor of the family and the husband and mutilation as a criterion for marriage. However, psychosocial trauma and its health-related and other consequences are less understood among many communities in Ethiopia. Health facilities are providing Healthsource for victims of FGM/C while the legal and justice stakeholders (such as police, courts, etc.) provide legal protection services for the victims. The Women, children, and youth office also established survival centers to provide psychosocial, livelihood, and other related services. However, the main challenges are a lack of coordination among stakeholders, a shortage of enough survival centers at the lower level (woreda and Kebel), the limited capacity of the existing centers, and a low enforcement of the existing law to provide protection services.

Regarding child marriage, the 2016 Ethiopia DHS revealed that the average age at marriage was 17.1 for women ages 25-49. Around 58% of women in the same age group marry before their 18th birthday. Over 41% of women in the 20-24 age group reported getting married by the age of 18 and 16% of women in the same age group were married by age 15. The magnitude of child marriage differs by region. The prevalence of child marriage was found to be highest in the Afar region, as approximately 80% of women were married before reaching 18 years old. Prevalence rates were also high in the Amhara (43%), Tigray (43%), and Benishangul-Gumuz regions (50%) while in SNPP region it is 31%.

Sexual violence and rape: Findings from the 2016 Ethiopia DHS showed that among women aged 15-49, 10% have experienced sexual violence at some point in their lives, and 7% reported having experienced some form of sexual violence in the past 12 months.

Decreasing gender-based violence, violence against women/girls, and harmful traditional practices demands a community-based, multi-pronged approach, and sustained engagement with multiple stakeholders at all levels, especially at grassroots. The most effective initiatives address societal attitudes towards gender/women's underlying risk factors for violence, including social norms regarding gender roles, the acceptability of violence, and the services.

Type of GBV	The proportion of women who have experienced violence	Source
Physical violence (from anyone) since age 15	23 %	DHS, 2016
Sexual violence in lifetime	10 %	DHS, 2016
Physical and/or sexual	26 %	DHS, 2016
Intimate Partner violence (IPV)	70 %	Jones, Gupta, & Tefera (2015)
IPV (among ever-married women)	34 %	DHS, 2016
FGM/C	80 %	DHS, 2016
FGM/C (15-49 years old)	65 %	DHS, 2016
FGM/C (0-14 years old)	16%	DHS, 2016
Child Marriage for women (among 25-49-year-old women) before age 18	58 %	DHS, 2016
Child Marriage among women 25-49 years old, before age 15	6 %	DHS, 2016
Child Marriage by age 18 (among 20- 24-year-old women)	41%	DHS, 2016
Child marriage by age 15 (20-24-year-old women)	16 %	DHS, 2016
Marriage by abduction (2003)	69 %	DHS, 2016

Table: National trends in the magnitude of GBV
Source: Systematic Literature Review of Gender Based Violence in Ethiopia Magnitude, Policies, and Interventions (2018), Social Impact.

Profile of the Wolaita Zone

The Wolaita zone borders to the south with the Gamo Gofa and Dawuro Zones; to the north east with Kambata Tambaro zone, to the North with Hadiya Zone; and to the south west with Sidama Zone. Wolaita Sodo town is the capital of the Wolaita zone; and located about 312 km south of the capital Addis Ababa. The northern tip of the boundary of Wolaita is at about 360 km south from Addis Ababa.

Based on the 2007 Census conducted by the Central Statistical Agency of Ethiopia (CSA), this Zone has a total population of 2,473,190. With an area of 4,208.64 square kilometers, Wolaita has a population density of 356.67, making it one of the most densely populated areas in the country. The population density in some parts of the Zone is as high as 781 ppkm² in Damot Gale Woreda; and as low as 168 ppkm² in Humbo Woreda. While 172,514 or 11.49% are urban inhabitants, 1,196 or 0.08% are pastoralists. Among the entire population, the productive group ranges from 15-64, which constitute 50.2% of the total, and the non-productive part (younger than 15 and above 65 years of age) make up 49.8%. A total of 310,454 households were counted in this Zone, which results in an average of 4.84 persons to a household, and 297,981 housing units. The largest ethnic group reported in this Zone is the Welayta (96.31%); all other ethnic groups made up 3.69% of the population. Welayta was spoken as a first language by 96.82% of the inhabitants; the remaining 3.18% spoke all other primary languages reported. 71.34% were Protestants, 21% of the population said they practiced Ethiopian Orthodox Christianity, and 5.35% embraced Catholicism.[1]

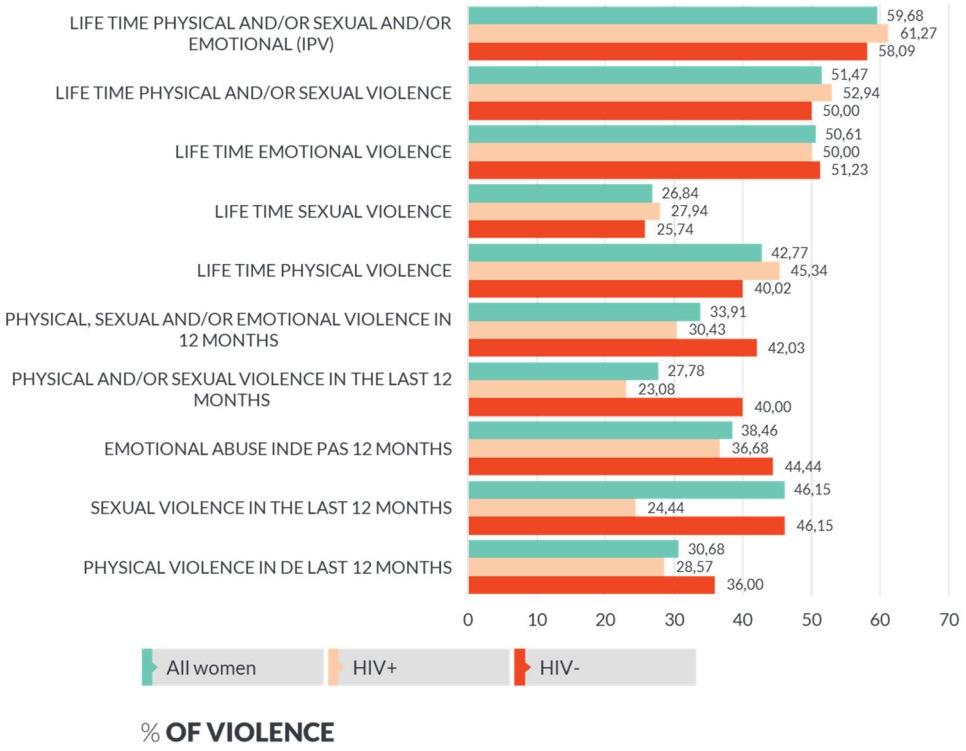
Wolaita is one among 14 zones (sub-regions) in South Nation Nationalities People Regional State (SNNPRS), Ethiopia. Agriculture is the livelihood of more than 90% of the population in the rural areas. Animal husbandry is complementary to crop production, and livestock. Mixed farming involving the production of cereals, root crops, Ensete, and coffee is practiced. The climate is stable, with a temperature variation between 24 and 30 °C during the day and 16 to 20 °C at night, all year round.

According to the 2019 Educational statistics, Wolaita zone has about 918 preschools (which includes Kindergarten, Established Centers, Fenced and Non-Fence O-Class and Child-to-Child Center), whereas the number of primary and secondary schools is 560 and 77 respectively. The net enrollment rate for preschool, primary and secondary is 53.1%, 87.4% and 25.6% respectively. The repetition rate for primary school is 9.2 (Male-9.4 and Female-8.9) whereas for secondary it is 5.9 (male-5.3 and female-5.7). When we see the pupil Section Ratio by Cycle: Primary Lower Cycle (1:74), Primary Upper Cycle (1:60), General Secondary (1:63), Preparatory (1:50) and Secondary (1:60). The pupil Trained Teacher Ratio (PTTR) by Cycle is as follows: Primary Lower Cycle-1:61, Primary Upper Cycle-1:33, Primary Total-1:46 and at general Secondary-1:84 and Preparatory Secondary-1:23.

According to a comparative study conducted on HIV Positive and Negative women in Wolaita zone, 204 or half of the women living with HIV (50%) had experienced lifetime emotional violence, with a similar proportion, 209 (51.23%), among HIV negative women. The overall lifetime prevalence of emotional violence among all women (n = 816) was 413 (50.61%). When we look at the lifetime prevalence of physical and sexual violence among all the women interviewed (n = 816), it was respectively 349 (42.77%) and 219 (26.84%). In addition, the lifetime prevalence of intimate partner violence (IPV) i.e. women who had reported at least one incident of physical, sexual, and emotional/psychological violence among all women surveyed (n = 816) were 487 (59.68%). In the 12 months preceding the survey, the prevalence of IPV (physical, sexual, emotional /psychological violence) among all women, n = 230, was 78 (33.91%). The prevalence of an overall positive attitude towards wife beating among all women was 393 (48.16%). In addition, the study also identified factors associated with IPV. According to it, women who were in the 29–39 age group were 2.86 times more likely to experience IPV than those in the 18–28 age group, women with low-income were nearly four times more likely to have experienced IPV than women with high income. Women whose bride price as requested by her parents was partially paid or

[1] CSA 2007 census report

not paid at all were 3.46 times more likely to experience IPV, than women for whom the requested bride price had been paid. In addition, women who indicated that a married woman has no right to refuse to have sex with her husband in some situations, such as sickness etc., were thrice as likely to experience IPV than women who believed a woman could refuse sex in some situations; and women whose partner drank alcohol were 2.36 times more likely to experience IPV than those whose partner did not drink alcohol. Similarly, women who had between two and nine sexual partners were 2.35 times more likely to experience IPV than women who had one sexual partner. Women whose partner had ever been involved in a physical fight with another man were 1.83 times more likely to experience IPV than those women who did not report this, and women who had experienced their behavior being controlled by their husband were 8.13 times more likely to suffer IPV than women who did not report this. Women whose partner's family arranged their marriage were also 2.82 times more likely to experience IPV, compared to those couples who chose marriage together[2]. A study among 462 female college students (ages 18-26) conducted at the Wolaita Sodo University in Southern Ethiopia found the likelihood of lifetime sexual violence to be 45.4%. Among them, 36.1% reported experiencing sexual violence since entering university[3].



[2] Mengistu Meskele and Nelisiwe Khuzwayo, Intimate partner violence against women living with and without HIV, and the associated factors in the Wolaita Zone, Southern Ethiopia: A comparative cross-sectional study

[3] Adinew YM, Hagos MA. Sexual violence against female university students in Ethiopia. BMC International Health and Human Rights. 2017; 17:19. https://dx.doi.org/10.1186/s12914- 017-0127-1.

Regarding the knowledge and attitude of the legal service providers in zone, according to the study[4] conducted by Bereket Tessema and Kidus Meskele, 89.5% defined rape as the forced penetration of a vagina by penis, while less than half considered forced anal and mouth penetration with a∫ penis as rape. The majority of legal service providers have a negative attitude towards rape victims. On the other hand, the majority of respondents literally indicated that they would reject the case of the compliant, if the victim willingly went to the suspect's house (48.4%), if the victim couldn't provide enough eye witness (56.4%), if there is no medical proof and other exhibits available (89.8%), and if the suspect is husband to the victim (42.5%).

In the Wolaita community there are several cultural practices associated to the status of women, such as polygamy, abduction, early marriage and female genital mutilation. According to the study by Mesele Woldemichael [5] , there are two basic justifications for the preference of polygamy in the Wolaita community. The first reason is the preference for a son or the husband's negative perception towards girls, by which girl children are giving a lower status. The second reason is levirate marriage, a type of marriage in which the brother of a deceased man is obliged to marry his brother's widow. FGM is also seen in the area as a practice valued by the community, since it is considered as a manifestation of cleanliness and beauty, and an important criterion to find a partner for marriage. Sometimes the community considers that mutilation is the best way to preserve virginity. When we see the role of women in economic activities and decision-making processes, the same study showed that, in families of low economic status, when a girl child grows up, she carries almost all responsibilities from an early age. Besides this, girl children have the great responsibility to feed their families. In addition, rural girl children move to the urban areas and other parts of the country in the dry season to look for jobs, because the dry season is a very challenging time for this area and food scarcity is common. In these cases, girls migrate to urban areas searching of work and are employed as home maids. In this situation, girls face great challenges from their employers. Demoralization, high workloads, harsh physical punishment and sexual abuse are common. In addition, the study showed that most housewives clearly explained that the community's perception towards women's decision-making capability is low, by which the community does not give women the chance to decide on issues by themselves. The reason is always the community perceiving that women are not capable of making the right decision, They are always supported or given directions by men to make decisions. According to the study conducted by Mihiretu Alemayehu and Mengistu Meskele [6], 58.4% of women in Wolaita have autonomy, while 40.9% of the study participants' healthcare decisions were made by their husbands. This showed that there are still husbands who play a role in making healthcare decisions about their wives.

[4] *Bereket Tessema Zewude , Kidus Meskele Ashine , Knowledge and Attitude of Legal Service Providers towards Rape Victim of Girls and Women: The Case of Wolaita Zone, SNNPR, Ethiopia, 2017*

[5] *Mesele Woldemichael, The Impact of Cultural Practices on Women Empowerment: The Case of Offa Woreda, Wolaita Zone, Southern Ethiopia*

[6] Mihiretu Alemayehu and Mengistu Meskele, Health care decision making autonomy of women from rural districts of Southern Ethiopia: a community based cross-sectional study

Purpose of the study

The main objective of this study was to conduct a Gender Analysis and Gender Based Violence (GBV) Study in Wolaita Zone that would help AeAE, its partners and the government to understand the magnitudes, causes, and effects of GBV, as well as to devise a strategy for women, girls and boys to be protected and to develop a long-term intervention plan. Further, the study will help AeAE to pursue an evidence-based planning and programming approach around its major thematic issues in the project area.

CHAPTER TWO: METHODOLOGY

Study assessment Design

The study was based on a mixed-method approach (using both quantitative and qualitative evaluation methods). Quantitative measures were obtained using a structured questionnaire applied on a sample of men, women of reproductive age, and boys and girls who were in schools and out of school selected using a statistical sampling procedure. Secondary data generated from sectorial office at national, regional and zonal level (prevalence data of the national and regional while zonal level data for educational and Health sector) were also synthesized and shown in the literature part. The qualitative information was collected using focus group discussions, interviews of key informants, and desk reviews of secondary sources, etc.

Study design

The study was a cross-sectional study designed with both quantitative and qualitative data collection methods. Desk reviews, key informants' interviews, and focus group discussions and observations were used as qualitative data collection methods. A cross-sectional survey and secondary data collection methods were used for the quantitative part of the study, involving data from women, men, youths, and adolescents.

Study Area

The gender analysis and GBV assessment study was conducted in Boloso Sore, Boloso Bombe, Damot Fulassa and Kindo Koyisha Woredas of the Wolaita Zone.

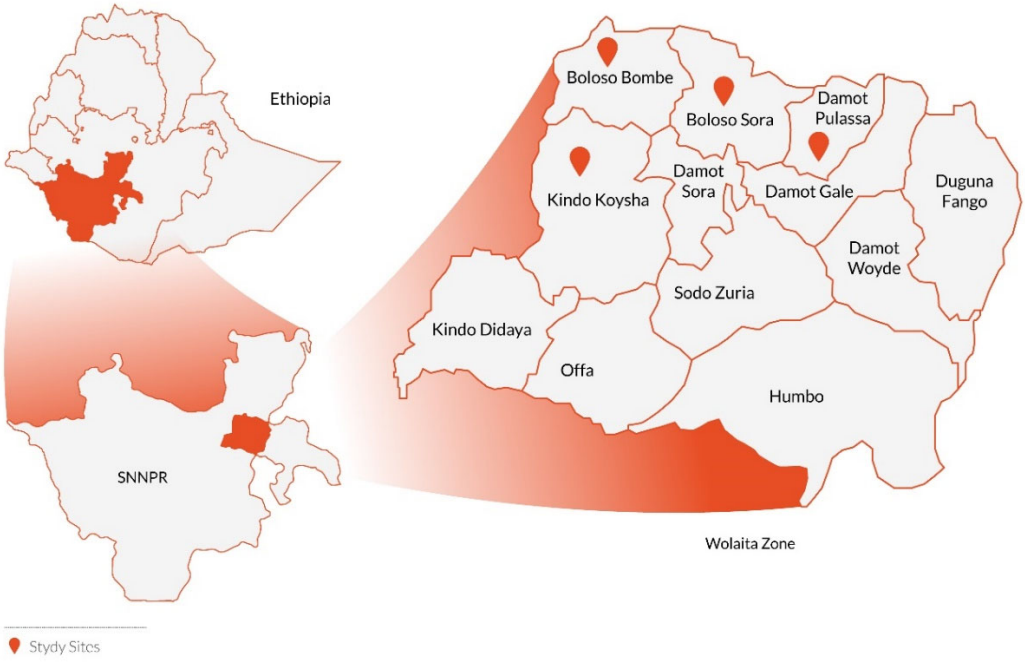


Figure 1: Map of study area

Study units

Quantitative Study/Survey: The study populations for the quantitative survey were boys, girls, men and Women who are vulnerable of GBV and live in the project's implementation areas. Reports and studies at regional and zonal education and health sectors were analyzed and presented in the literature part. Due to a lack of proper documented reports, studies and data, it is difficult to present the specifics of the prevalence of GBV at woreda level.

Qualitative study: Project stakeholders such as regional (SNNPR) Bureaus, Zone level departments and woreda level offices of Women, Children and Youth Affairs, Health, Education and Police were targeted as sources of qualitative information.

Sample Size and Sampling Technique for boys, girls, men and women

The unit of study for the quantitative part of the survey was the community: men and women who are of reproductive age and boys and girls who were in school and out of school. To determine the number of beneficiaries to be included in the study, a single population proportion formula for sample size calculation was used. The consultant used Kish Leslie's (1965)[7] formula to determine the total stakeholders to be sampled, which were proportionally assigned to each study woreda. According to the formula, the sample size (n) was calculated as

$$n = \frac{N.z^2.p(1-p)}{(N-1).d^2 + z^2.p(1-p)} \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots(i)$$

$$\approx \frac{z^2.p(1-p)}{d^2} \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots(ii)$$

As $N \to \infty$

Where;

n = estimated sample size

z = value on standardized normal distribution curve corresponding to a level of significance.

P = is the estimated proportion of an attribute that is present in the population (i.e. usually 0.5 that will offer the greatest sample size)

N = Population size. When N is large, the effect tends to be very minimal.

d = Selected accepted error (level of precision).

Assuming a margin of error of 5% and confidence level of 95% with prevalence of 23%[8] and 13% non-response rate, the total sample is allocated as follows:

[7] Kish, Leslie. 1965. Survey Sampling. New York: John Wiley and Sons, Inc.

[8] According to the 2011 Welfare Monitoring Survey (WMS) report and National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women in Ethiopia-MoCYA, 23 per cent of female experienced GBV

$$\approx \frac{1.96^2 x 0.23(1-0.23)}{0.05^2} = 273$$

=273 x13%+ 273 = 310

The total sample size, 310, were allocated to all the selected four woredas equally. Once the total population were allocated for the project districts, the respective sample respondents were selected using systematic sampling. The survey was conducted in three ways: house to house (for men and women), at health facilities (for men and women) and selected high schools in each woreda (for boys and girls).

Woreda Name	Total sample allocated
Boloso Bombe	78
Boloso Sore	75
Damot Pulassa	78
Kindo Koysha	79
Total	**310**

Data Source, Collection Methods and Tools

Data Sources

Both primary and secondary data sources were used for the assessment. Accordingly, as stipulated in the inception report, the evaluation team collected and analyzed relevant secondary documents, though obtaining zonal and woreda specific data is challenging. In addition, primary data sources were used so as to obtain in-depth qualitative information about the project area and to better understand the use of FP/RH services, education and sociocultural context of the woreda and the zone.

Data Collection Methods and Tools

Quantitative data were collected using a structured questionnaire from a sample of respondents (target beneficiaries: men, women of reproductive age, boys and girls). Secondary data generated from the sectorial office reports and databases were also used to see the health, educational and sociocultural situation of the zone and woredas. The qualitative information was collected using focus group discussions (focusing on prevalence of GBV, Gender roles, existing interventions in GBV and gender gaps, etc), interviews of key informants and desk review. The data collection tools are annexed to this report. The following data collection were used for the assessment:

- **Men, women of reproductive age, boys and girls:** For the quantitative aspect of the survey, a direct survey for program beneficiaries was conducted, and a total of 310 women, men, boys and girls participated (156 male and 154 female).
- **Key Informant Interviews:** Key Informant interviews were used to elicit in-depth reactions on the participants' knowledge, experience and opinion GBV, SRH and gender services. A semi structured interview guide was used to facilitate the key informant interviews with representatives of regional, zonal and woreda sectorial offices.
- **Focus Group Discussions (FGDs):** A total of 8 FGDs (2 FGD per woreda: one with community groups, which includes community representatives, elders, women development army and the other with key government sectorial office staff at Woreda).

- **Observation:** specific observations of healthcare and school facilities were conducted.

Data Quality Checks/assurance

The quality of data was assured by using properly designed questionnaires aligned with study tools, conducting pilot testings of the tools, offering appropriate and intensive training to interviewers and supervisors about data collection procedures and coding the questionnaire. Every day the completed questionnaires were viewed and checked for completeness and relevance by supervisors and the principal investigator. The necessary feedback was given to the survey/evaluation team every morning before the actual procedure and analysis. The following quality assurance measures were used:

- Data were collected using standardized tools
- Highly experienced data collectors with relevant educational background and language proficiency were employed
- Intensive training was offered to the data collectors and supervisors before data collection
- Ethical issues relating to consent, child protection, coercion, using accessible language and avoiding complex terms, confidentiality and data storage, checking quotations used from key informant interviewees
- Data collection issues including purposive and random participant selection, piloting and refining of the tools, consistent and rigorous recording, supervision and support of the enumerator team
- Data analysis issues including secure storage, confidentiality, triangulation of findings across stakeholder groups, focus group discussion and key informant interviews.

Methods of Data Analysis

All returned questionnaires were manually checked for completeness and consistency of response. Statistical analysis of quantitative data obtained from the structured citizens' perception survey was done using SPSS. Accordingly, appropriate descriptive and analytical (frequency, mean, standard deviation etc) methods were used to determine and explore associations between and/or across key evaluation variables. The analysis technique for qualitative data from key informant's interviews, focus group discussions and field observations was primarily text analysis. After the focus group discussion was completed, the note taker and moderator reviewed the notes and made a summary of the focus group discussions by referring to the notes and playing back the audiotape. Then quantitative findings were triangulated with the qualitative information/data.

Ethical considerations

Cognizant of the fact that ensuring the safety and security of survey subjects, the following ethical considerations were considered during the whole process of the end term survey.

- Prior to the survey the necessary communications about the overall purpose of the final evaluation assessment were made with woreda level administrative bodies
- All participation of the respondents was voluntary
- Participants were, as much as possible, interviewed privately and all necessary precautions were taken to maintain the confidentiality of the information obtained.

- Study teams were trained on how to handle and report specific cases to the local concerned institutions such as woreda level Women's Affairs Offices, in cases where the study team felt that the survivors needed to consult with local authorities.
- The data collectors obtained informed consent from respondents (oral and written)
- The study subjects were given complete information as to the objectives of the study and their benefits/risks
- Information gathering and documentation were done in a manner that presented the least risk to respondents, as methodologically sound, and built on current experiences and good practice
- The confidentiality of individuals and the information they revealed were and will always be protected.

Overview of Procedures Followed

Following the call for submissions of technical and financial proposals to undertake the assessment, our consultancy firm submitted a bid proposal. Accordingly, the AeAE bid team evaluated the proposal we submitted and awarded the assessment to our consultancy firm on a competitive basis. Accordingly, our firm signed a contract with AeAE and submitted an inception report for the overall assignment. Once the inception report was evaluated and finalized, the data collection was conducted as agreed on the inception report. To ensure data quality, the consultant applied different quality measures. Based on the data collected, a draft report was prepared and submitted to AeAE. Once AeAE provided comments on the draft report, the consultant finalized the report.

Structure of the Report

This assessment report comprises four chapters. The first chapter gives an overview of AeAE and the concept of the project. The second chapter deals with the study methodology that the consultant adopted, the third chapters deals with results and a discussion on the key findings of the study and finally the last chapter deals with the conclusion and recommendations that the study brought. Relevant study tools were annexed at the end of the report.

CHAPTER THREE: RESULTS AND DISCUSSION

Respondent Basic Socio - Demographic information

This section deals with the socio-economic and demographic characteristics of respondents. It includes their sex, age, religion, marital status and educational status. These characteristics are included to help the clients and readers to comprehend the results presented in the subsequent section in its proper context.

The tables in Annex 1 and 2 present the socio-demographic characteristics of the respondents of the survey. The survey collected data from a sample of 310. The number of samples ranges from 75 (Boloso Sore) to 79 (Kindo Koysha). When we see the sex ratio it is almost 50:50, where 156 and 154 of the respondents are male and female, respectively. The mean age of the respondents is 28 years. The mean age varies across woreda from 24 (Boloso Sore) to 33 (Damot Pulassa). The educational achievement varies by woreda. The respondents from Boloso Sore (illiterate, 23%) and Damot Pulassa (illiterate, 36%) are relatively less educated compared Boloso Bombe (illiterate, 7%) and Kindo Koysha (illiterate, 4%). These last two woredas have also larger proportions of respondents with relatively higher educational achievement. The majority of the respondents are Protestant (50%) and Orthodox (40%). 50 percent of the respondents are married while 41 percent have never married. The pattern of marital status is a bit different in Damot Pulassa, with the largest percentage of married and smallest percentage of never married, compared to other woredas. 73 percent of the respondents who are married, widowed, or separated reported that their marriage involved a dowry or bride price. The percentage ranges from 66 (Kindo Koysha) to 92 (Boloso Sore). The mean age at marriage of respondents is 28 years. The mean age at marriage ranges from 24 years (Boloso Sore) to 33 years (Damot Pulassa).

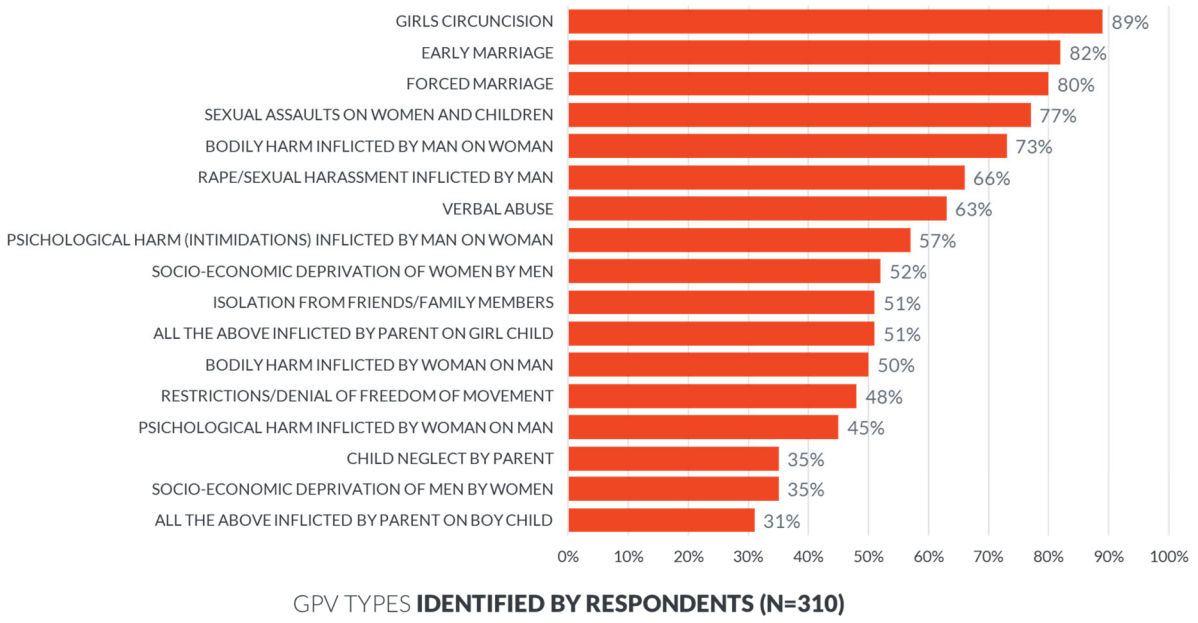
GBV Knowledge, attitude and practice

This section presents the study participants' knowledge, attitude and practice towards gender based violence. Their knowledge is assessed based on indicating 17 types of GBV, which includes but is not limited to FGM, physical, sexual and psychological abuse, early marriage, forced marriage, Rape/sexual harassment, socio-economic deprivation, child neglect by parent, verbal abuse, isolation from friends/family members, restrictions/denial of freedom of movement, etc. The table shows that knowledge of GBV is very good, where 99% of the respondents replied as to having knowledge on GBV. However, the respondents vary by the number of GBV types they know. In particular, more than 60% of respondents indicated the following GBV cases: girls' circumcision (99%), early marriage (82%), forced marriage (80%), sexual assaults on women and children (80%), bodily harm inflicted by man on woman (73%), rape/sexual harassment inflicted by man (66%) and verbal abuse (63%). According to the Zonal Women and Children Affairs experts:

"Sexual assault, beating of women in the home, psychological attack, attitudes that undermine women/girls, lack of good governance such as denying capital resources, denial of accepting ownership of children after the woman delivered are commonly faced by women in the area"

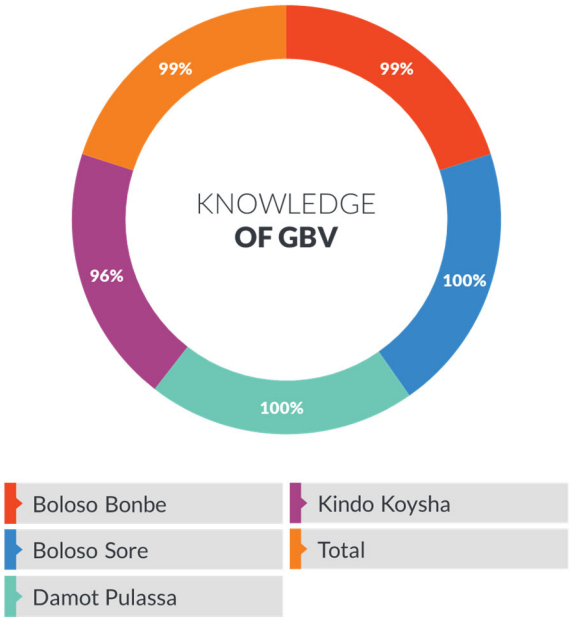
According to the Health office experts:

We are working with the zonal women and children affairs office. Still there is GBV occurring in this area. Physical abuse (beating of women and children, burning with fire or boiled water, cutting of body parts such as FGM), psychological abuse (including insulting, verbal attacks, using unnecessary words), child labor abuse and sexual assault are common.



GPV TYPES **IDENTIFIED BY RESPONDENTS (N=310)**

Figure 2: Knowledge of GBV



37% of the respondents agreed that there is GBV in the community, while 59% replied that they did not know and 5% replied negatively. When we see the level of GBV, which is constructed from their rating of 16 types of GBV (Very low to Very high)[9], the prevalence GBV was rated as high (among more than 50% of the respondents) for sexual assaults on women and children (58%), early marriage (53%) and psychological harm inflicted by man on woman (52%), while it was low for Socio-economic deprivation of women by men (56%), socio-economic deprivation of men by women (54%), verbal abuse (53%), child neglect by parent (52%) and bodily harm inflicted by man on woman (51%). The respondents were also asked the following "Would you say GBV in this community is increasing, declining, or staying the same?" Accordingly, 78 percent of the respondents replayed "declining" while 14 and 8 percent replayed "increasing" and "staying the same", respectively. Respondents' perceived trend of GBV varies by woreda. For instance, the percentage of respondents who perceived an increasing trend ranges from 1% (Boloso Sore) to 42% (Boloso Bombe). For the case of Boloso Bonbe, the responses identified a high prevalence of Early marriage, Psychological harm inflicted by man on woman, Sexual assaults on women and children and Bodily harm inflicted by man on woman. And hence for Boloso Bonbe, GBV and related interventions should be designed for this prevalence of GBV cases.

[9] For this analysis very high and high are grouped as high and very low and low grouped as low

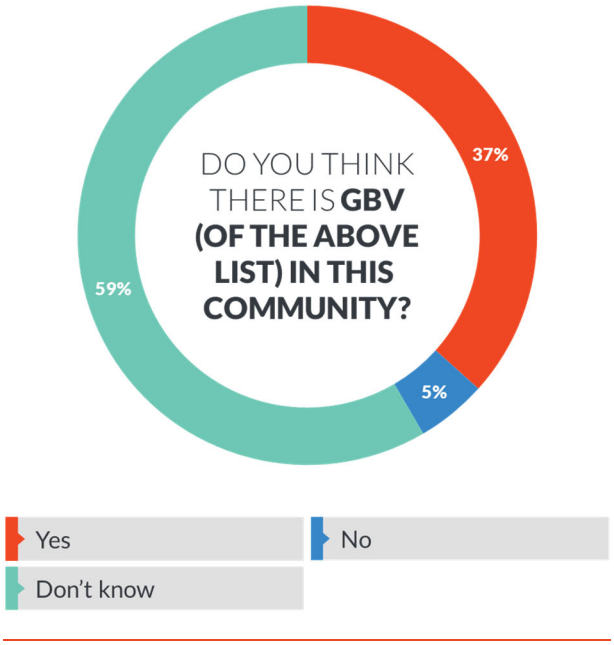
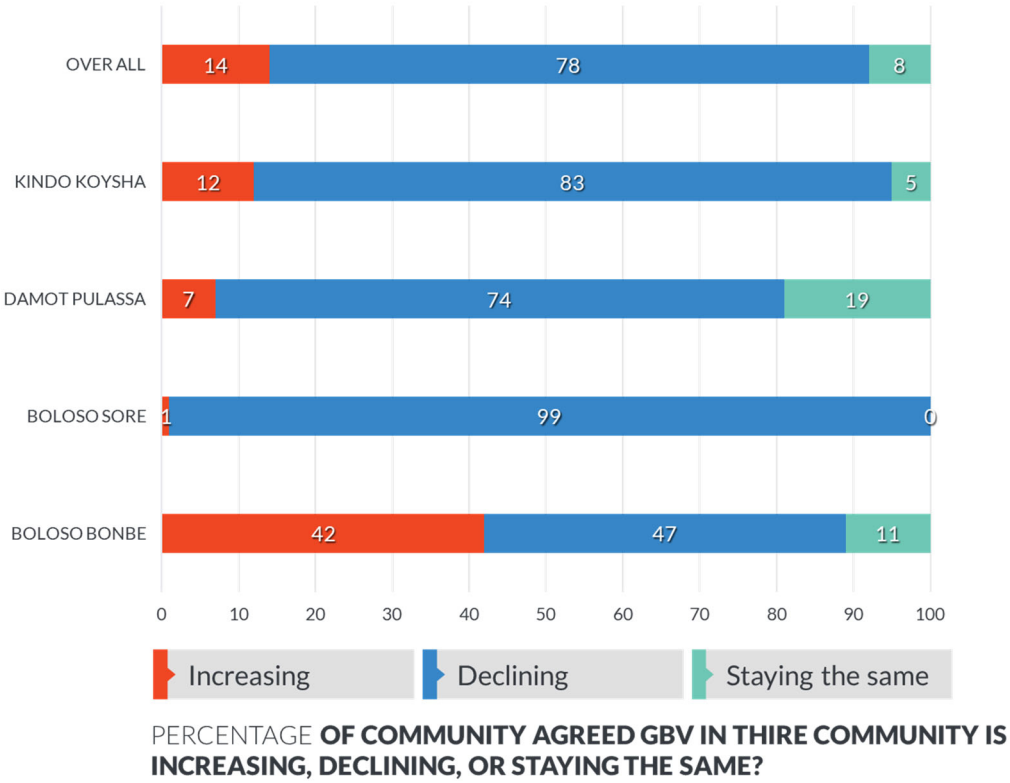


Figure 3: Prevalence and Trend of GBV



PERCENTAGE **OF COMMUNITY AGREED GBV IN THIRE COMMUNITY IS INCREASING, DECLINING, OR STAYING THE SAME?**

Type of GBV	High*	Low*	I don't know	Total
Sexual assaults on women and children	58%	35%	7%	100%
Early marriage	53%	36%	11%	100%
Psychological harm inflicted by man on woman	52%	37%	11%	100%
Rape/sexual harassment inflicted by man	47%	41%	12%	100%
Bodily harm inflicted by man on woman	42%	51%	8%	100%
Psychological harm inflicted by woman on man	38%	36%	25%	100%
Restrictions/denial of freedom of movement	35%	40%	25%	100%
Verbal abuse	34%	53%	13%	100%
Forced marriage	34%	39%	27%	100%
Socio-economic deprivation of women by men	33%	56%	11%	100%
All the above inflicted by parent on girl child	28%	42%	30%	100%
Isolation from friends/family members	27%	44%	30%	100%
All the above inflicted by parent on boy child	26%	38%	36%	100%
Child neglect by parent	25%	52%	24%	100%
Bodily harm inflicted by woman on man	25%	49%	26%	100%
Socio-economic deprivation of men by women	24%	54%	22%	100%

*High and low qualifications are based on the respondent's judgment on the occurrence of the specific GBV.

Table 1: Level of gbv

According to a women's network member:

"General GBV is decreasing. Because different networks are also established at different levels through which women can empower themselves and continue to be respected. People are reporting incidences of GBVs such as early marriage, FGM since the establishment of different women networks in the community. Based on my observation, polygamy and early marriage are still common in my community while FGM and early marriage seem to be decreasing".

The table below presents the responses of several questions related to respondents' exposure to GBV. One of the most important questions is understanding the prevalence of GBV. The study asked participants "Have you personally ever been victim of any violence related to gender (GBV) in your lifetime?" Accordingly, 31 percent of the respondents responded "Yes". The percentage of respondent who responded "yes" is lowest in Boloso Sore (9%) while it is highest in Kindo Koysha (42%). Respondents were also asked the question "Have you heard of or met a GBV victim in your community in the last 12 months?" 48 percent of the respondents responded "Yes".

Women from Kindo Kosha woreda said. We heard one rape case, while a girl was on the way from school to home. Nobody knows who raped her. Unfortunately, she did not show up at school after that event and we do not know who raped her.

Respondents were asked their recent (for the last 12 months) exposure to specific GBV types. 31% of them (39% at Boloso Bonbe, 9% at Boloso Bonbe 32% at Damot Pulassa and 42% at Kindo Koysha) have been victims of some kind of violence related to gender (GBV) in their lifetime. In addition, 85% and 72% of the respondents (in all woredas) heard of a girl or woman beaten by a man/boy/friend and heard of cases of rape in the community in the last 12 months respectively, while 74% of them heard of cases of sexual abuse in the community in the last 12 months. There is little to some variation by woreda to the above responses. In particular, the result suggests that levels of sexual abuse are prevalent in Kindo Koysha, where 91% of them replied that they had heard of cases of sexual abuse in in their community in the last 12 months.

Variable	Boloso Bonbe		Boloso Sore		Damot Pulassa		Kindo Koysha		Over all	
	#	%	#	%	#	%	#	%	#	%
Have you personally ever been victim of any violence related to gender (GBV) in your lifetime?										
Yes	30	**39**	7	**9**	25	**32**	33	**42**	**95**	**31**
No	47	**61**	67	**91**	53	**68**	46	**58**	**213**	**69**
Have you heard of or met a GBV victim in your community in the last 12 months?										
Yes	27	**35**	68	**92**	33	**42**	21	**27**	**149**	**48**
No	51	**65**	6	**8**	45	**58**	57	**73**	**159**	**52**
In the last 12 months, have you heard of a girl or woman being beaten by a man/boy/friend?										
Yes	30	**75**	69	**95**	43	**81**	9	**75**	**151**	**85**
No	10	**25**	4	**5**	10	**19**	3	**25**	**27**	**15**
Have you heard of cases of rape in your community in the last 12 months?										
Yes	36	**73**	48	**70**	32	**65**	20	**87**	**136**	**72**
No	13	**27**	21	**30**	17	**35**	3	**13**	**54**	**28**
Have you heard of cases of sexual abuse in in your community in the last 12 months?										
Yes	31	**70**	47	**67**	37	**76**	31	**91**	**146**	**74**
No	13	**30**	23	**33**	12	**24**	3	**9**	**51**	**26**

Table 2: Individual experience with GBV

The table below presents results related to GBV perpetrators and actions taken. The results show that the main GBV perpetrators are quite diverse, ranging from parents to schoolboys. The first top three perpetrators are partners (34 %), neighbors (22) and local authorities (15%). The result also indicates variation by woreda — for instance, Neighbors are the main perpetrators in Boloso Sore Woreda. 66 % of the respondents said that GBV victims in the community usually reported to the police or local administration office. The results indicate some variation by woreda. Police, teachers and local authorities are also mentioned as GBV perpetrators. In particular, the highest (74%) and lowest (56%)

percentages of GBV victims reporting to police or local administration are in Boloso Bonbe and Kindo Koysha, respectively. The FGD participants at community level confirmed that access to legal services is available even at kebele level. There are community level committees that are working on prevention of and response to GBV. The prevention part includes awareness raising through different community dialogues and meetings, through religious leaders and elders. The response is mainly focused on providing legal services in collaboration with the police and the women and children office of the woreda. However, getting the community to report cases of GBV is still a challenge.
According to zonal women and children office experts:

It is difficult to get the necessary information about the supervisors and perpetrators due to different pressures in the community. Even if a family wants to report the sexual assault crime on their child or girl, neighbors and other community segments discourage the family from reporting the case with comments such as: "you are going to shame your child, you are going to disqualify the future opportunities of your child if you make it a legal issue, it is shameful for the witness to stand in front of the court for such a shameful incident". And hence even the family of that specific victim will hide the information. Then the family of that victim will negotiate culturally with the perpetrator's family guided by elders in the community.

Respondents were asked about their willingness to report GBV cases. 73 percent of them are willing to report to police and other responsible bodies. Willingness to report cases of GBV ranges from 59 % (Kindo Koysha) to 99 % (Boloso Sore). However, in reality GBV cases are not well reported by the community, mainly because of a fear of the revenge from perpetrators and intervention of elders for arbitration with prosecutors before they took the case to the police. One of the key challenges faced by the policy on GBV is the silence of the community committees to report the GBV cases. Most of the girls are often reluctant to report violence, for fear of repercussions, or because they do not recognize particular acts as violence, specially in the case of verbal abuse and assault.

Variable	Boloso Bonbe		Boloso Sore		Damot Pulassa		Kindo Koysha		Over all	
	#	%	#	%	#	%	#	%	#	%
Who are the main perpetrators of GBV in your community? (ONLY ONE ANSWER)										
husband/partner	24	**31**	1	**1**	24	**31**	3	**4**	**52**	**17**
wife/partner	1	**1**	1	**1**	18	**23**	32	**41**	**52**	**17**
Parent	11	**14**	8	**11**	1	**1**	2	**3**	**22**	**7**
Neighbor	11	**14**	38	**51**	11	**14**	7	**9**	**67**	**22**
Teacher	5	**6**	0	**0**	5	**6**	5	**6**	**15**	**5**
A local authority	13	**17**	1	**1**	10	**13**	21	**27**	**45**	**15**
A policeman/woman	2	**3**	0	**0**	3	**4**	0	**0**	**5**	**2**
An unknown person	10	**13**	20	**27**	6	**8**	8	**10**	**44**	**14**
School boys	1	**1**	6	**8**	0	**0**	0	**0**	**7**	**2**
Are the GBV victims in your community usually reporting to the police or the local administration										

office?										
Yes	46	**74**	53	**71**	37	**65**	40	**56**	**176**	**66**
No	16	**26**	22	**29**	20	**35**	31	**44**	**89**	**34**
If you heard about a case of GBV occurring in your community, would you report the case?										
Yes	41	**66**	72	**99**	36	**63**	41	**59**	**190**	**73**
No	21	**34**	1	**1**	21	**37**	28	**41**	**71**	**27**

Table 3: GBV perpetrators and action taken.

Table 7 presents exposure to GBV information and sources of information on GBV prevention. 66 percent of the respondents indicated that they received information on GBV in the past three months. The percentage exposed to information ranges from 35 % (Kindo Koysha) to 99 % (Boloso Sore). The top three main sources of information are TV (45%); radio and newspapers (21%); and relatives, friends and workmates (10%). The main sources of information vary by woreda. For instance, TV is the top main source in all woredas except for Damot Pulassa. And hence the project interventions should use appropriate communication channels to disseminate information on GBV. In addition, some of the cost-effective sources of information, such as the church/place of worship and peer educators, are not widely used in the study areas. For instance, the role of the church/place of worship at Damot Pulassa and Kindo Koysha is very low.
According to the woreda health office:

Different networks in the community are used to raise awareness. There is a women development army (WDA) and 1-to-5 group in the community linked to each kebele. Women, children, youth affairs is closely supporting them. We also use other strategies, such as health education for clients at healthcare facilities before routine activities are started, during graduation of model kebeles and meetings.

Variable	Boloso Bonbe		Boloso Sore		Damot Pulassa		Kindo Koysha		Overall	
	#	%	#	%	#	%	#	%	#	%
Have you received any information on GBV in the past three months?										
Yes	30	**64**	68	**99**	22	**49**	15	**35**	**135**	**66**
No	17	**36**	1	**1**	23	**51**	28	**65**	**69**	**34**
What is your main source of information on GBV Prevention? (ONE ANSWER ONLY)										
TV	38	**50**	35	**47**	7	**9**	59	**76**	**139**	**45**
Radio Newspapers News	7	**9**	18	**24**	37	**47**	3	**4**	**65**	**21**
Relatives Friends	2	**3**	7	**9**	23	**29**	0	**0**	**32**	**10**

Church/place of worship	11	**14**	13	**17**	4	**5**	0	**0**	**28**	**9**
Peer educators	2	**3**	2	**3**	4	**5**	3	**4**	**11**	**4**
Health workers	11	**14**	0	**0**	3	**4**	13	**17**	**27**	**9**
Other Specify	5	**7**	0	**0**	0	**0**	0	**0**	**5**	**2**

Table 4: Information about GBV

GBV data collection and reporting

There is a need to collect GBV data for informed decisions. It is generally understood that the information collected serves three main purposes: to ensure appropriate patient care, for program monitoring and for advocacy. The study tried to understand the level of GBV data collection and sharing initiatives at all levels: Kebele, woreda, zone and regional. In all woredas registration of GBV cases (such as FGM) is mostly carried out at healthcare centers/ health offices where those cases are treated, and confidentiality is respected but utilized for recording and reporting purposes, not for policy advocacy and action.

However, not all stakeholders working on GBV (specially the police and Women and Children Affairs Offices) have standardized registration and reporting mechanisms. Each sector keeps a register by using their own handwritten format and reported zero cases most of the time for many reasons, such as under-reporting, lack of proper recording and documentation, etc. This has to be strengthened in terms of developing a standard data collection template or format and reporting mechanisms from community to woreda, zonal and regional level. The other main challenge is that the communities are not willing to report GBV cases to relevant government structures at kebele, woreda and zonal level because of fear of revenge from perpetrators. In most cases the GBV data collected are used mainly for prosecution purposes by police and attorneys. Whenever GBV cases are reported to the police by the victims (most of the time) and families (rarely reported), the police will document the full story from the victims so as to open the case at court. However, if the GBV victims or families fail to follow the case, the police are less likely to reinstate the case. In addition to the victims and communities, sectorial offices and woredas also report to the police so that the victims can receive justice services. The main challenge for the justice bodies to provide a prompt decision is obtaining the right evidence in a timely manner. In addition, data are poorly reviewed and used for decision-making and advocacy or policy dialogue by the woredas, zones and regions.

In general, GBV data collection efforts are geared towards providing evidence for the courts rather than to make a case for campaigns and advocacy. Data are available at different sectors and providers such as the police, the courts (criminal prosecutions; applications for protection orders, civil cases), hospitals and health facilities and schools. The details on the services provided for victims are shown in the following section on service provision for GBV survivors.

Service provision for GBV survivors

Survivors of GBV need to be able to access care and support to reduce the impact of such violence. There are different types of assistance that GBV survivors look for. These include psychosocial support, such as emotional support and case management, livelihood support, temporary shelter, primary healthcare services, such as the provision of medications, counseling and reintegration with families.

The study assumes that the police, relatives, health facilities, support groups, friends and places of worship are some of the systems that respond to GBV survivors whenever there is a case. At zonal level there is one Rehabilitation and Staying Center under the Women and children affairs administration. Lawyers and psychologists employed by Women and children affairs give legal protection and psychosocial services to the victims. These centers are serving women and children who are victims of violence by giving them legal (through police) and psychological support until they receive other, advanced healthcare services. The following services were provided by the center in collaboration with other stakeholders;

Service	Provider	Remark
Shelter and food	By the center	
Psychosocial support	By the center	
Free Healthcare service	In collaboration with the hospital	
Free Legal service	In collaboration with the police	
Family reunification	In collaboration with the woreda	
Children court system and evidence gathering system	In collaboration with the police	Since collecting evidence from children is difficult, separate investigation and evidence gathering rooms are established

The main challenge for the center includes shortage of budget, shortage of logistics to transport victims and survivors from and to woredas and communities, shortage of staff (only one social worker and one psychologist plus 7 administrative workers such as cooks, guards, janitors, etc), space problems, lack of dedicated healthcare service providers for the center. The capacity of the center is of no more than 14 people at a time. During the assessment there were 10 survivors in the center who came from different woredas.

In terms of the referral mechanism for the community, the different structures in the community that work on the prevention of GBV (i.e. women development army, 1-to-5 group, Justice Forum in the community) will bring the victim to kebele, then Children's Right Conventions at kebele, in cooperation with the police, will bring the victim to district, then the district's Children's Right Conventions, with the woreda police, will bring the victim to the zonal Women and children affairs office. The victims also come to the center by themselves. The Women and children affairs office will keep the victim in the rehabilitation center to give psychological, medical and legal support.

There is no formally established center for GBV survivors at woreda level where survivors can access the service freely. Whenever there is a GBV case, the woreda Women and children office, in collaboration with the police and different community level structures that work on the prevention of

GBV (such as women development army, 1-to-5 group, Justice Forum in the community), provides some support to survivors. Informally friends provide support for the survivors.

The consulting team was able to understand some initiatives undertaken to improve referral linkages from the community to the zone. However, interviews with government stakeholders indicate that the referral pathways available to survivors are not robust. Survivors typically have multiple and complex needs that require a comprehensive set of services including health, psychosocial, security and protection, legal, and/or economic, reintegration support. Due to the continuing lack of these integrated services at Woreda level, GBV victims are not receiving proper services at lower level.

In terms of the role of religious leaders and religious institutions in creating awareness on GBV and reporting GBV cases at community level, despite the diversity and large number of religious followers in the area, their role is found to be very low in all woredas.

In an effort to scale-up prevention and response services to protect children from violence, the Regional Government is allocating a budget for medical and legal support to children and women survivors of violence. The budget will support government hospitals to provide free medical, legal and psycho-social services to survivors of sexual violence through establishing and strengthening One Stop Centers. The One Stop Center standard includes a trained and dedicated social worker, prosecutor, police officers, a nurse, a clerk, a doctor, and a professional psychiatrist. The Center will link with the Bureau for Women and Children Youth Affairs, the Attorney General's office, the police, the Special High Court, and local NGOs. However, the implementation of this center has not yet started in the case of Wolaita.

According to the zonal Women and children office:

In most woredas of the Wolaita zone, the justice office and court gives priority to GBV cases. A team formed by justice, police, women affairs and health representatives and attorneys collaborate on the case. Most often the procedures for GBV cases are handled as follows: The survivor lodges a complaint to women's associations or Women and Children Affairs. These institutions refer the client to the police department. The police request medical reports and summon potential witnesses and send documents to the justice office to initiate a court case. However, the services provided at local health centers are not adequate and some serious GBV cases are referred to hospitals in major regional towns.

Harmful Traditional practices (HTP)

When we see the knowledge of the community of HTP, 82 % of the total respondents know FGM (which ranges from 60% in Kindo Koysha to 100% in Boloso Sore). The second most common forms of HTP that the respondents have knowledge of is marriage by abduction (79%) and early marriage (77%). Polygamy and wife inheritance is also known by 63% and 61% of the total respondents in the study areas. The community have the least knowledge of the dowry, where only 45% of them know of dowry as a Harmful Traditional practice.

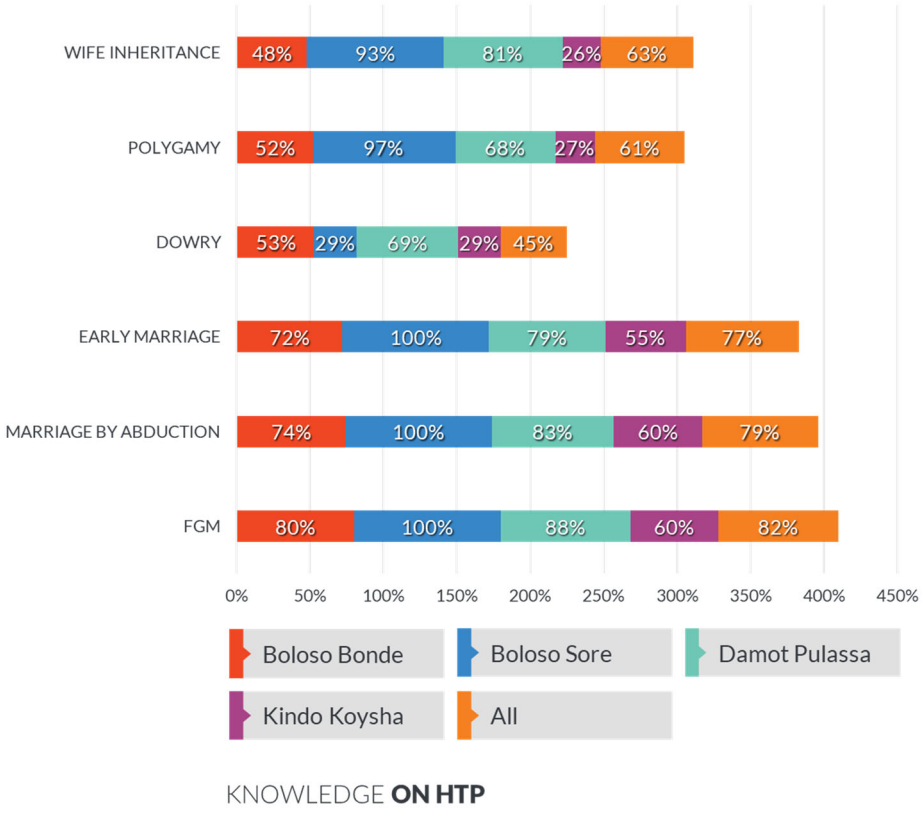


Figure 4: Knowledge of HTP

When looking at the levels of HCP in the study area, 40% of the respondents agreed that HTP is high whereas 19% rated it as low and the remaining 11% did not know. In terms of HTP by type, dowry is high (rated by 57% of the respondents) followed by FGM (54%), early marriage (46%), Marriage by abduction (35%) and polygamy (30%). Wife inheritance is the lowest one (18%). 69% of them agreed that they were circumcised at some point in their life while the remaining 31% did not undergo FGM.

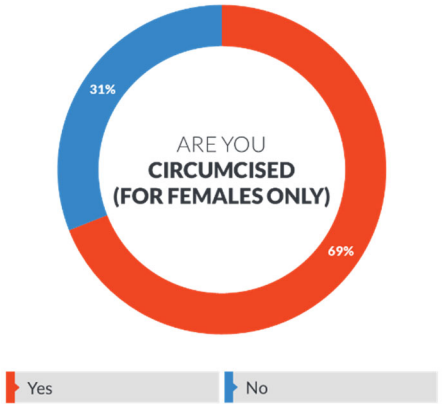
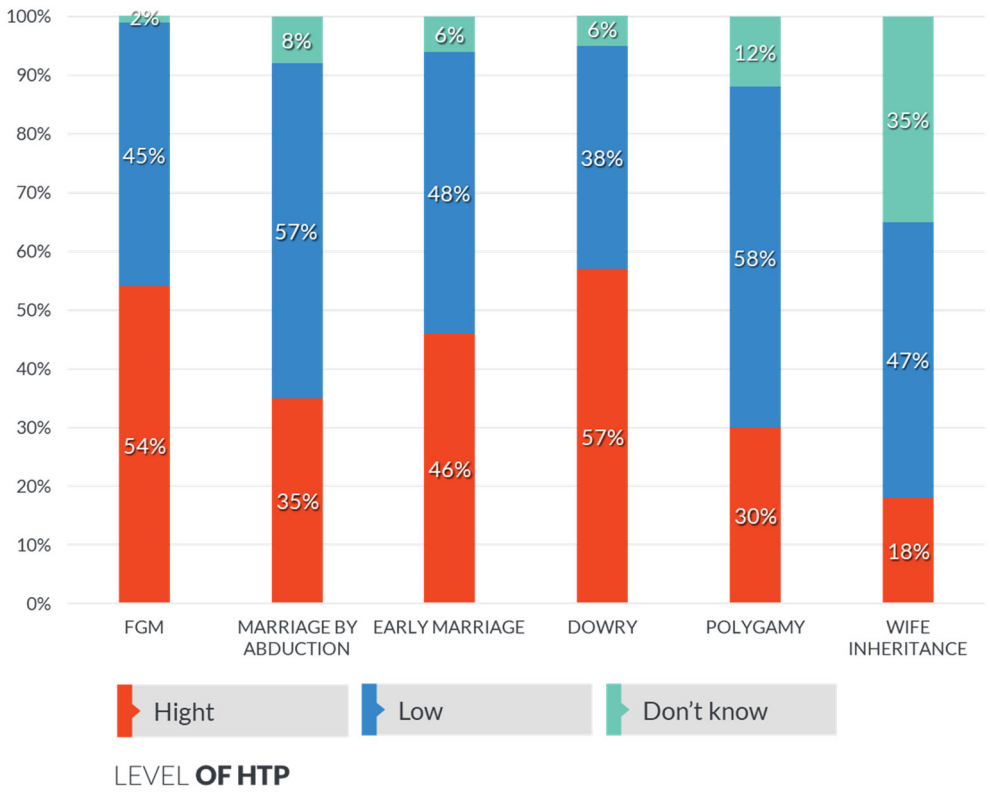


Figure 5: Level of HCP and practice.



LEVEL **OF HTP**

The table below presents results related to legal awareness and information on HCP. According to it, 85, 79, 72, 66, and 38 percent of the respondents are aware of the illegality of HCP; have got information on HTPs; have heard of the law preventing and punishing GBV and HTP in Woreda/Kebele/School; have attended a school meeting where GBV and HTPs were discussed; and know community or school based structures that work on the prevention of GBV and HTP in their area, respectively. The results vary across woreda for all the questions.

Variable	Boloso Bonbe		Boloso Sore		Damot Pulassa		Kindo Koysha		Overall	
	#	%	#	%	#	%	#	%	#	%
Are you aware of the illegality of HCP such as FGM, abduction										
Yes	50	**66**	74	**100**	56	**74**	77	**100**	**257**	**85**
No	26	**34**	0	**0**	20	**26**	0	**0**	**46**	**15**
Have you got information on HTPs?										
Yes	42	**58**	72	**100**	49	**64**	73	**96**	**236**	**79**
No	31	**42**	0	**0**	28	**36**	3	**4**	**62**	**21**
Have you ever heard of the law on the prevention and punishment of GBV and HTP in your Woreda/Kebele/School?										
Yes	46	**60**	74	**100**	47	**60**	53	**68**	**220**	**72**
No	31	**40**	0	**0**	31	**40**	25	**32**	**87**	**28**
Have you ever attended a community/school meeting where GBV and HTPs were discussed?										
Yes	41	**53**	71	**96**	44	**57**	46	**60**	**202**	**66**

No	37	**47**	3	**4**	33	**43**	31	**40**	**104**	**34**
Do you know any community or school-based structure that works on the prevention of GBV and HTP in your area?										
Yes	24	**31**	10	**14**	37	**47**	45	**58**	**116**	**38**
No	53	**69**	64	**86**	41	**53**	32	**42**	**190**	**62**

Table 5: Legal awareness and information on HCP and GBV.

The following specific HTP issues were raised by FGD participants and KII informants at woreda and zonal levels:

- FGM is continuing, especially in rural areas, due to different reasons, including socio-cultural and psychosexual: (1) the main reason is that it is an inherited cultural practice (2) parents think that their daughter will be calm and accepted in society, they practice it to ensure her virginity so that their own honor/dignity will be respected, they fear that she will destroy the household objects. Even the girl herself is inclined to be incised because she might be insulted and disrespected by her friends if they think that she is not clean.
- Early marriage is practiced rarely and it is more common among girls than boys. We call it early marriage if it occurs from 13-18 years of age for girls. Girls are early married either due to a poor economy status or to a lack of awareness of its harmful consequences.
- Men practice polygamy because (1) they have better farmland and capital than women, (2) in some cases, if their first wife is becoming older, they try to marry a younger wife, even if they have limited economic resources. This may lead to conflict among the family and to economic crisis for the first wife if she is ignored by the husband.
- People are practicing newly emerging *extravagant ceremonies*, which are *leading to economic crises*. These include wedding ceremonies, postpartum ceremonies, student graduation ceremonies and house graduation ceremonies. Even though these ceremonies strengthen social interaction among the community, poor people are forced to practice them by borrowing unavailable materials and borrowing money from others. These events include different gifts such as: gathering money for the host of the ceremony, giving cattle, bringing cereals/teff and other materials. If they do not have enough income to face these events, they exchange their valuable farmland for money in order to host them. E.g. a friend woman visits a mother after delivery during the postnatal period with different gifts that may include money, cattle/sheep and cereals accompanied by 15-50 women (i.e. at least 15 women). The friend woman collects the gift from other people; otherwise, she will have to put in the difference herself. People who are not celebrating these events are not acceptable by any means in society, they are undermined economically, discriminated and spoken of as not sociable in the community; finally, they may be marginalized socially and economically.
- Funeral ceremonies are very prevalent in this zone, which is leading to economic crises. The dead body remains at home for four days and then a final burial celebration is held the next day. Until the body is buried, no one is allowed to work on any productive jobs in that community. The relatives will take huge gifts.

Vulnerable groups

The study also tried to identify the groups most vulnerable to GBV. The following groups are most at risk of GBV in the project areas as identified by experts at Woreda and zonal level:

Group	Description	Justifications
Age	Children at lower ages and teenage girls, especially 10-15 age group Women of reproductive age Girls (school and out of school ages)	Lack of resources, decision making power and being minors are some of the reasons for their vulnerability
Sex	Mainly women	Women are more vulnerable than men since the do not have full access to resources and cultural values
Educational level	Uneducated or less educated groups	They have lesser access to information and less awareness of their rights and related issues
Poverty status	Poor of the poorest	Poor people on low incomes are highly influenced by those who have resources.

Knowledge of SRH

Table 15 presents respondents' knowledge of SRH. 89, 91, 87 and 71 percent of the respondents, respectively, know about sexually transmitted diseases (STDs); know of HIV/AIDS; have had an HIV test/VCT; they or their partner are using a family planning method. The results vary across woredas for all questions.

Variable	Boloso Bonbe		Boloso Sore		Damot Pulassa		Kindo Koysha		Overall	
	#	%	#	%	#	%	#	%	#	%
Do you know about sexually transmitted diseases (STDs) which are diseases that can be passed on through sexual contact?										
Yes	45	**68**	73	**99**	68	**91**	75	**95**	**261**	**89**
No	21	**32**	1	**1**	7	**9**	4	**5**	**33**	**11**
Do you know about HIV/ AIDS										
Yes	48	**70**	74	**100**	71	**96**	75	**95**	**268**	**91**
No	21	**30**	0	**0**	3	**4**	4	**5**	**28**	**9**
Have you ever had an HIV test/VCT?										
Yes	55	**80**	67	**92**	61	**84**	64	**94**	**247**	**87**
No	14	**20**	6	**8**	12	**16**	4	**6**	**36**	**13**
Are you or your husband using any family planning method when you want to limit or space the number of children you have?										
Yes	23	**59**	30	**97**	53	**77**	21	**51**	**127**	**71**
No	16	**41**	1	**3**	16	**23**	20	**49**	**53**	**29**

Table 6: SRH knowledge and practice.

Despite the above findings, SRH services in the study areas are still challenged by: (1) lack of awareness about SRH services among the community (2) cultural factors around the use of family planning methods, (3) lack of youth friendly SRH service provision centers (4) shortage of supplies (mainly test kits), (5) absence of sustainable school based interventions for students, 6) lack of appropriate and up to the standard youth centers in the project woreda. According to the KII result, husbands are still resistant to accept that their wives use of FP. According to one of the Healthcare workers interviewed,

"There are men who do not want their wife to use FP without their knowledge. Some of the women come to the facility for FP services without the knowledge of their husband mainly because they fear resistance from their husband. We try to counsel some of the women with their husbands, though women have full right to use methods of family planning of their choice without consultation with their husband. Nonetheless, male involvement in FP will bring significant changes in our area."

Use of Family Planning methods

According to EDHS 2016, more than one third of married women (35%) want to delay childbearing (delay first birth or space another birth) for at least two years. Additionally, 24% of married women do not want any more children. Women who want to delay or stop childbearing are said to have a demand

for family planning. The total demand for family planning among married women in Ethiopia is 58%. Oromia region had the highest percentage of unmet needs at 29% followed by Gambella at 23%. Unmet needs continue to skew towards older, rural, and less educated women. In addition, there was a notable (10 percentage points) decrease in unmet need among women 15 - 19 years of age from 2011 to 2016, possibly because women at these ages are now staying in school and/or delaying marriage.

Based on the HMIS data of the Woreda, the total new and repeated acceptors of FP has been increasing since 2010 EC. On average, 74% of the total FP acceptors are accounted for as new acceptors from 2010 to 2011 EC in all woredas and 43% as repeat acceptors.

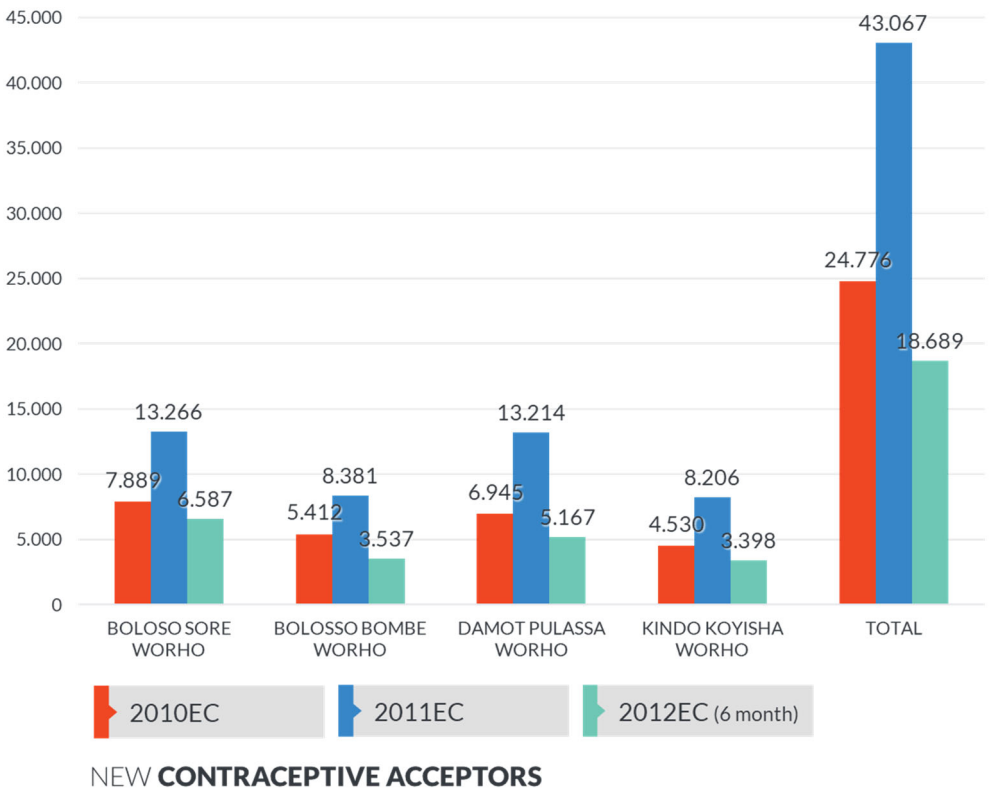
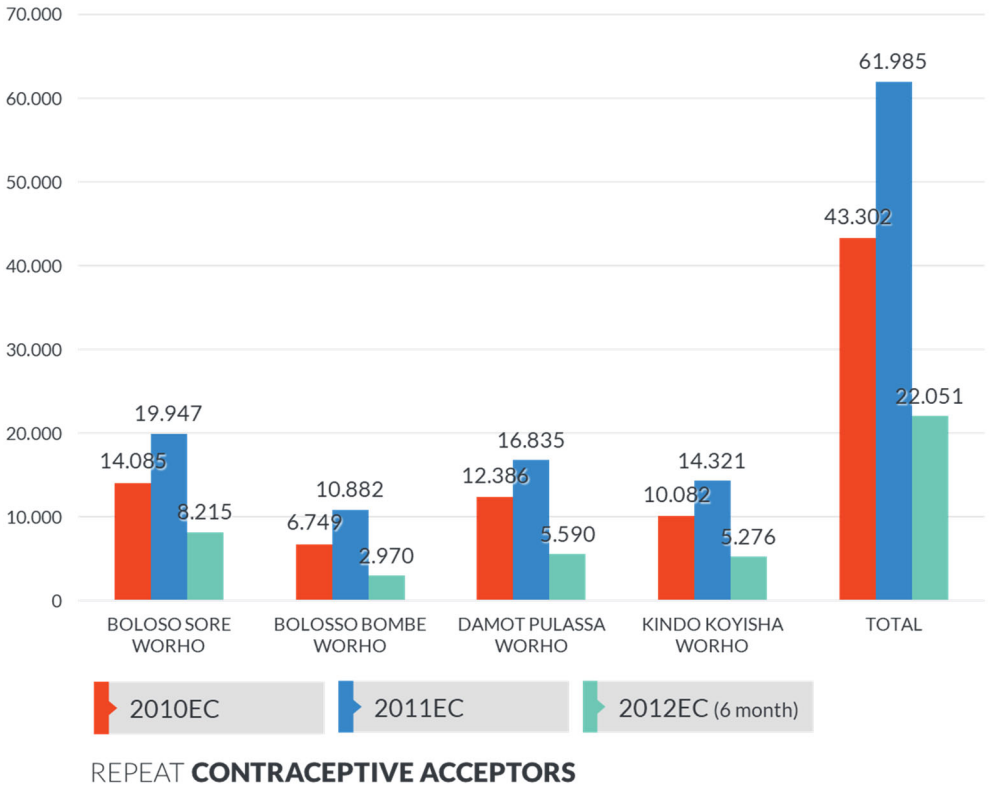


Figure 6: FP Acceptors-new (based on HMIS data)



**The dates correspond to the Ethiopian calendar*

Figure 7: FP REPEAT AcceptorS (based on HMIS data)

Based on key informant interviews, observations and FGD with the community, the major barriers for the supply of SRH/FP in the health facilities of the four woredas are:

- Lack of supplies and commodities such as Implanon
- High trained staff turnover
- Lack of dedicated and reliable ambulances for pregnant mothers
- Lack of youth friendly ASRH service provision centers
- Shortage and poor quality of medical equipment
- Limited outreach to the community and less support to health extension workers from the facilities
- Inadequate monitoring and/or follow up and support from local government health offices.
- Weak and intermittent support from NGO partners.
- Poor readiness of facilities in terms of access to roads, water, and electricity, which is an issue to expand the SRH services.
- Lack of maternal waiting area and low usage of the existing maternal waiting area (in the facilities that have a maternal waiting area)

The other challenge is the common myths and misconceptions around FP. As per the key informant interviews with health facilities heads and health offices, the following myths and misconceptions around contraceptives were also common in the study area:

- Contraception (especially long-acting methods) causes infertility
- Contraceptives could end in hair loss
- The government is promoting family planning to reduce the size of certain populations
- Oral contraceptives cause congenital disabilities or multiple births.
- Oral pills build up in a woman's body.

Gender analysis

Gender roles and Power relations between women and men

The table in annex 3 presents responses related to several questions on power relations between women and men, attitudes towards violence against women, and gender roles. The first question asks respondents to express their agreement with the statement that "***A man should have the final word about decisions in his home***." 50% and 31% of the respondents indicated to agree and partially agree with the statement, while 8% and 12 % of the respondents disagreed and strongly disagreed, respectively. This shows that male dominance is still there in the community, as about 81% of them agree on the male final saying on HH decisions. The response pattern is quite similar for all woredas except for Kindo Koysha. In particular, the respondents in Kindo Koysha relatively disagreed with the statement (disagree: 26 %, strongly disagree: 14 %). 67% and 12% of the respondents expressed their agreement and partial agreement with the statement "***Women have the same right as men to study and work outside the home***", while the remaining 18 and 3 percent disagreed and strongly disagreed with the statement, respectively. This is positive in terms of understanding the right to study and work outside the home, though in practice there are challenges. The respondents were also asked to express their agreement with the following similar statements: "***A couple should decide together if they want to have children"*** and "***A man and a woman should decide together what type of contraceptive to use***". Surprisingly, the overall response pattern is quite similar to the previous statement. This goes in line with reproductive health rights in the country, where men and women have equal rights to use family planning methods (type, timing, etc). The respondents were also asked to express their agreement with the statement "**A woman should be able to choose her own friends even if her husband disapproves**." Accordingly, 50% and 14% of them responded as agreeing and partially agreeing with the statement, while the remaining 20% and 17% of them disagreed and strongly disagreed with the statement, respectively.

The respondents were asked to express their agreement with statements on sexuality: "It's a wife's obligation to have sex with her husband even if she doesn't feel like it" and "A wife has no right to ask her husband to use a condom." Their response for these two statements is almost 50:50 where half of them agreed and half of them disagreed. This goes against reproductive health rights in the country, by which women should have sex according to their feeling and willingness. The survey also asked respondents' agreements with wife beating: "There are times when a woman deserves to be beaten" and "It is the husband's right to beat his wife whenever she fails to obey him". 51% and 28% of the respondents agreed, respectively. This shows that there is still a gap of understanding women's rights, as half of them still agreed that there are times when a woman deserves to be beaten.

The respondents were also asked the four final questions related to gender roles. 84% and 75% of the respondents believe or think that "***if women are given equal opportunities they can be as successful as men***" and "***women can be more successful than men***", respectively. This shows that there is a great improvement regarding the roles and capacities of women among the community.

In terms of the respondents' perception on women and leadership, about 77% and 78 % of them agreed with "women can lead men"; and "except for the reproductive (childbearing) function the difference in roles between men and women is created by society not by GOD", respectively. Here also the community shows a good understanding of women's leadership capacities and of gender difference being socially established.

Variable	Boloso Bonbe		Boloso Sore		Damot Pulassa		Kindo Koysha		Overall	
	#	%	#	%	#	%	#	%	#	%
Do you believe that if women are given equal opportunities they can be as successful as men?										
Yes	56	**82**	75	**100**	55	**87**	52	**67**	**238**	**84**
No	12	**18**	0	**0**	8	**13**	26	**33**	**46**	**16**
Do you think that women can be more successful than men?										
Yes	38	**63**	72	**99**	39	**71**	42	**64**	**191**	**75**
No	22	**37**	1	**1**	16	**29**	24	**36**	**63**	**25**
Do you think that women can lead men?										
Yes	48	**75**	66	**93**	43	**75**	38	**63**	**195**	**77**
No	16	**25**	5	**7**	14	**25**	22	**37**	**57**	**23**
Do you think that Except for the reproductive (childbearing) function the difference in roles between men and women is created by society not by GOD?										
Yes	40	**70**	64	**93**	46	**85**	36	**62**	**186**	**78**
No	17	**30**	5	**7**	8	**15**	22	**38**	**52**	**22**

Table 7: Gender rolEs

Regarding who made the most decisions in the household (such as HH expenditure and other related issues), more than half of them (55%) replied that man and woman have equal decision making power, while 41% still think that only men do and the remaining 4% think that only women do. Woreda-wise, there is high male decision making dominance in Damot Pulassa (men only 64 %) and Kindo Koysa (men only 55%).

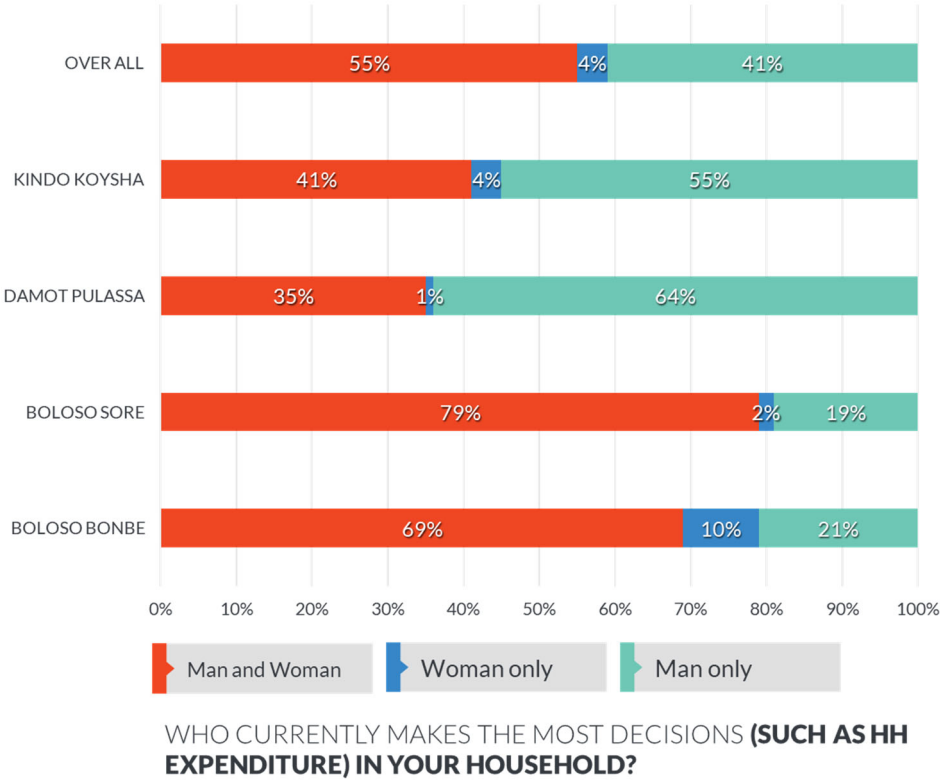


Figure 8: Decision making power roles

Gender Mainstreaming

Ethiopia's diversity poses huge challenges to policy enactment on SRGBV. With varying socio-cultural norms and socio-economic conditions, forms of violence, perspectives on the causes, solutions and even what is violence, vary between groups and regions. Decentralization can be a means both to ensure that national policies reach across populations, and to guarantee responsiveness to this variability through meaningful policy dialogues at all levels. The government has addressed these challenges through mainstreaming gender at macro level (federal), meso level (regional and zonal) and micro level (woreda, sub-city or kebele). Increasingly GBV has become a central focus of the gender work.

At Zonal and woreda level Gender Units or a focal person are assigned (not a dedicated person) to coordinate, support and monitor the work on gender across sectors. In addition, they will work with planning departments at zonal and woreda level so that gender issues are mainstreamed and budgeted. The zonal and Woreda Women, Youth and Children's Affairs office leads the overall coordination and provides support for each sector's gender focal unit/person. Through their membership in regional and woreda administration councils, heads of BoWYCA ensure that issues relating to gender, youth and children are incorporated within regional and local development plans.

According to a gender expert in a regional education office:

Through the GEQUIP II program the education bureau produces a directive on safe learning environments in schools and colleges. In addition, we are closely following up with schools and colleges on the implementation of school SRGBV codes of conduct. GEQUIP II also allocated a school budget based on the enrollment of students which took gender into account.
At local levels, the woreda education bureau also have staff designated to be gender focal points, who are the key people supporting school administration on SRGBV work. They liaise with schools in supporting the most vulnerable students, and promoting awareness of girls' education and safe, secure learning environments in schools and communities. Serious incidents of violence against girls are reported to the woreda women's affairs bureau, with their interventions including financial assistance or advice to victims and reporting to the police or justice bureau. However, the implementation is not uniform across all zones and woredas in the region.

Girls' and Women's Decision-Making Power and Participation in Societal Institutions

The study assesses the decision-making power that women have. In these terms, decision-making power is classified into three levels: Green (with better power), Yellow (medium) and red (low). The aspects in which they have top decision power include: Sending boys to school, selling livestock products, selling livestock, sending daughter to school, Renting land and Spending personal savings (mainly saving from Equib). While they have less power on: Marriage of girl, Medical expenses, Number of children to have, use of contraceptives and personal savings. Though they have low decision-making power about having personal savings, once they save the money (through means such as Equip), they have the power to spend it.

According to a woreda's Women and children affairs officer:

"Thanks to the rural land certification in Ethiopia, most of our women have full rights in terms of land. This means that they have equal rights to rent the land. In terms of selling crops and livestock, it is showing improvement so far."

Which of the following decision making power do you have (for Women) ?	Yes	No
Sending boys to school	72%	28%
Selling livestock products	72%	28%
Selling livestock	66%	34%
Sending daughter to school	59%	41%
Renting land	50%	50%
Spending personal savings	50%	50%
Selling crops	49%	51%
Marriage of son	38%	62%
Saving selling livestock and crop products	34%	66%
Marriage of girl	28%	72%
Medical expenses	25%	75%
Number of children to have	24%	76%
Use of contraceptives	21%	79%
Having personal savings	17%	83%

Table 8: women's decision-making power

Note: Green is above 50% (inclusive), Yellow between 34%(inclusive) and 50%, and red below 34%

Women and girls were asked about their participation in different community associations. 51, 36, 18, and 52 percent of the women and girls who interviewed were participating (as members) in women's associations, cooperative associations, farmers' associations, and "Ider", respectively. The results indicate that their participation varies across woredas for all the types of associations. According to a Zonal cooperative office; *"Due to different awareness raising activities, these days the number of women headed households participating in different established cooperatives."*

Variable	Boloso Bonbe		Boloso Sore		Damot Pulassa		Kindo Koysha		Overall	
	#	%	#	%	#	%	#	%	#	%
Womens' association										
Yes	10	**59**	22	**100**	0	**0**	8	**38**	**40**	**51**
No	7	**41**	0	**0**	18	**100**	13	**62**	**38**	**49**
Cooperative association										
Yes	8	**47**	18	**82**	0	**0**	1	**5**	**27**	**36**
No	9	**53**	4	**18**	18	**100**	18	**95**	**49**	**64**
Farmers association										
Yes	7	**41**	4	**18**	1	**6**	2	**11**	**14**	**18**
No	10	**59**	18	**82**	17	**94**	17	**89**	**62**	**82**
Iders										

Yes	12	**71**	19	**86**	1	**6**	8	**40**	**40**	**52**
No	5	**29**	3	**14**	17	**94**	12	**60**	**37**	**48**

Table 9: Level of decision making and participation in different associations for women and girls.

Gender is deep-rooted in socio-cultural, economic, and political structures and thus, gender Equality and equity is closely linked to every development agenda, ranging from the elimination of poverty to the promotion of peace and democratic rights. The following are the key gender equity and equality strategies that are implemented at zonal and Woreda levels in all sectors;

- Establish a gender focal person/unit in each sector at zonal and woreda levels and meet on a regular basis for joint planning, supervision, review meetings and evaluation. It is led by the Women, youth and children office at other zonal and woreda levels.
- Gender mainstreaming is the main agenda of the cabinet at all levels, where all sectors are gender mainstreamed on their day to day activities. Though sectors have zonal or woreda level specific mainstreaming manuals, they are using their national office's manuals.
- They are giving special attention to the participation of women in recruitment, training, promotion and assignment in all sectors.
- Giving priority to women in political assignments at Zonal and woreda levels
- Giving women a chance to participate in the Productive Safety Net Programme (PSNP)
- Provide a special loan package for women to engage in income generating activities.
- Basic maternal health services are provided for free in all public facilities of the study area
- The establishment of rural savings and credit cooperatives is part of the Government strategy and implemented at community level. Some of them are also established in women's self-help groups.
- Under the Health Extension Workers (HEW) program, each health post has a minimum of one female Health Extension Worker. HEWs regularly participate in Community Conversation sessions to provide information about reproductive health and harmful traditional practices. Women and girls have separate groups, where they discuss family planning, gender-based violence, HIV/AIDS, maternal health, seeking anti-natal and post-natal care and safe delivery.
- To enhance rural women's equal access to and control over productive resources and services (land, oxen, extension, credit) in order to make them food secure and come out of the poverty trap, a rural land certification program is almost covered in all the woredas. This also helped women in accessing credits and inputs by using land as collateral.

YOUTH AND ADOLESCENTS' LIFE SKILLS

In Ethiopia, the proportion of young population is very large. Most young people are vulnerable to various types of problems, including addiction, unemployment, HIV/AIDS, harmful traditional practices, poverty, gender-based violence, reproductive health problems, shortages of recreational centers and participatory forums. A life skills approach has been found to enhance adolescent transitions by building skills that are essential components of a healthy development and which define a resilient child. Evidence suggests that the life skills approach promotes social, cognitive, emotional and behavioral competencies that are critical in reducing negative or high-risk behaviors (delay the onset of drug use, prevent high-risk sexual behaviors, reduce anger and violence), as well as numerous positive attitudes, social adjustments, healthy lifestyles, and even academic performance among adolescents. The subsequent section presents life skills related questions for youth and adolescents (10-24 years). The result indicates that 76 percent of youth and adolescents know about life skills. Knowledge of life skills ranges from 65 % (Boloso Bonbe) to 100 % (Kindo Koysha).

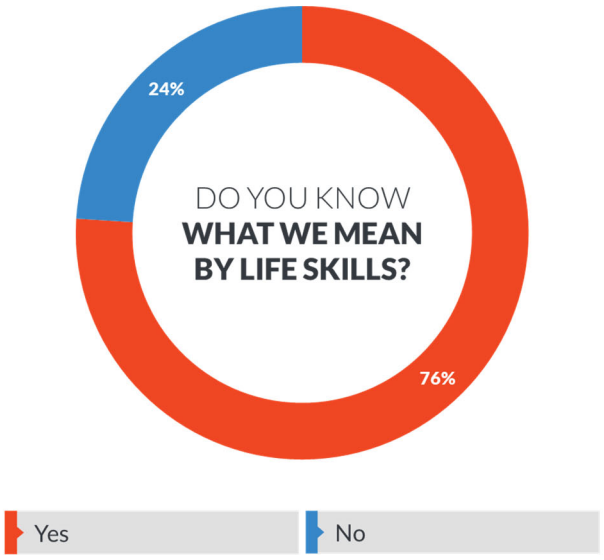


Figure 9:Life skillS of youth and adolescents (10-24 years).

In terms of their specific knowledge on key life skills, though 76% of them replied as knowing what they are, 57% of them identified communication, while 21% goal setting, 8% (each) negotiation, conflict management and decision making.

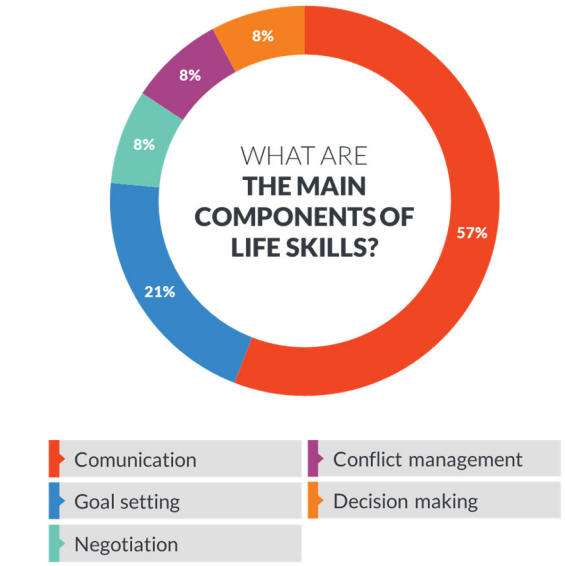


Figure 10:Components of life skillS

47, 28 and 25 percent of youth and adolescents talk about love and sex with parents often, sometimes, and never, respectively. 46, 35 and 19 percent of adolescents responded to the question "How often do you challenge an issue raised by your teacher or parents in school?" often, sometimes and never, respectively. 74 and 46 percent of youth and adolescents have vision or goal for their life and been trained in life skills, respectively. 50, 38 and 13 percent of youth and adolescents responded to the question "When someone abuses your rights do you quickly get angry" often, sometimes, and never, respectively. 41, 44 and 15 percent of youth and adolescents responded to the question "Do you feel that you can make friends easily?" often, sometimes and never, respectively. 43, 30 and 28 percent of youth and adolescents responded to the question "How often do you get bored while listening to others?" often, sometimes and never, respectively. 44, 38 and 18 percent of youth and adolescents responded to the question "Do you care what other people say about you?" often, sometimes and never, respectively. Generally, youth and adolescents' response to the above questions varies by woreda.

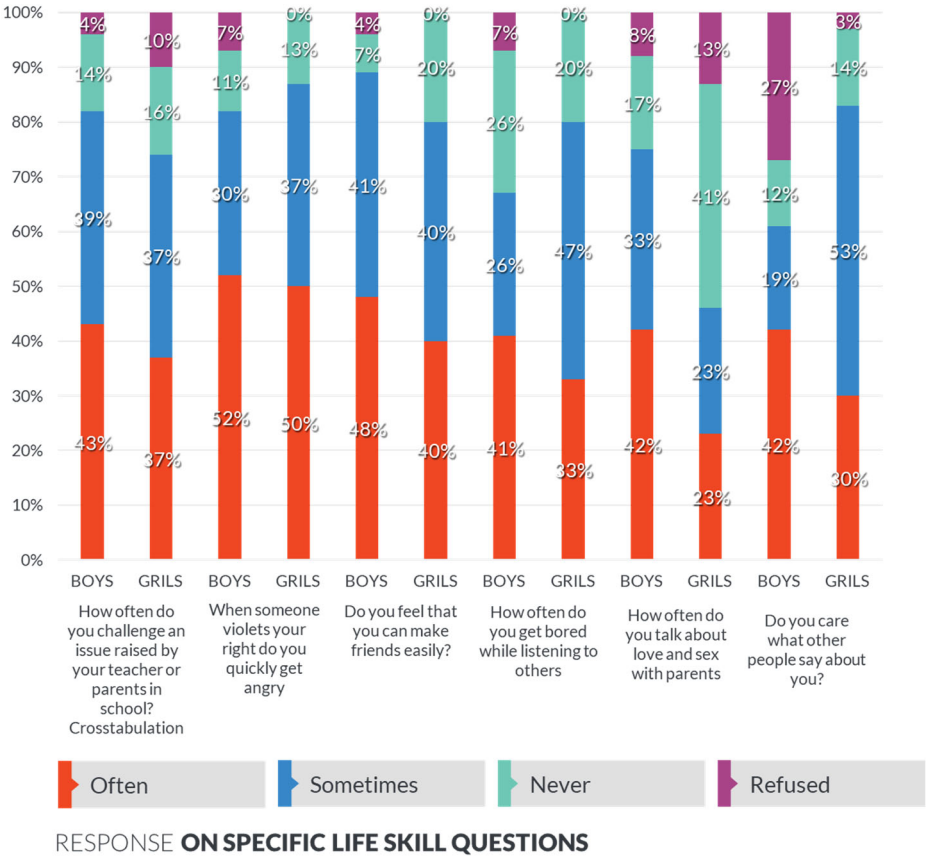


Figure 11:Response on specific life skill questions_1

Youth and adolescents were asked about how they make decisions. 74, 57 and 74 percent of youth and adolescents answered that they rarely make important decisions without consulting others; generally decide quickly; and make important decisions at the last minute, respectively. Generally, youth and adolescents' response to the questions above varies by woreda.

The last two questions concern youth and adolescent's participation in school health or SRH clubs. Accordingly, 55 and 45 percent of youth and adolescents are members of school SRH clubs and in leadership roles in health or SRH clubs, respectively. Generally, youth and adolescents' response to the questions above varies by woreda.

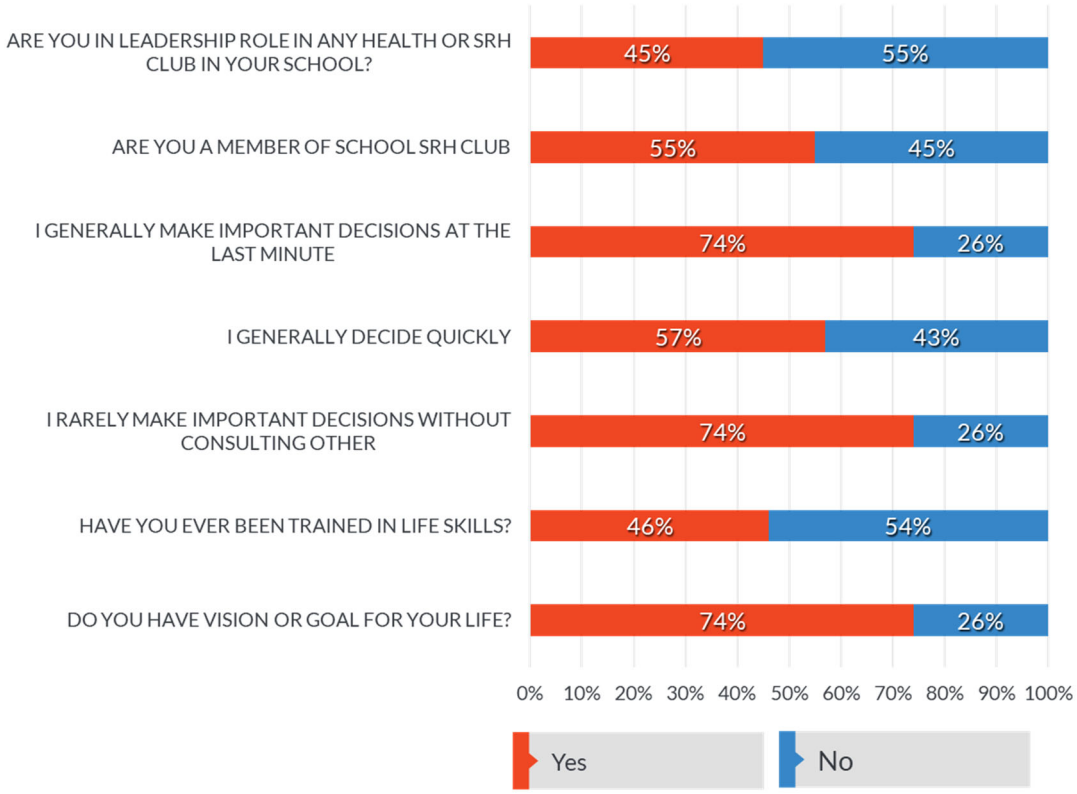


Figure 12:Response on specific life skill questions_2

According to the Gender expert of the zonal Education office

There are different clubs that include the issue of GBV in all schools. These clubs are monitored by the school administration, monitored by experts of the woreda education office, which in turn is accountable for the zone education department. For example, we send virtual team with a checklist to assess the situation at school level and to create awareness among school clubs. Some obstacles complicating addressing the problem in schools include: lack of roads to remote woredas and schools, poor road construction (if road is available), lack of budget to run the process, shortage of manpower.

A 38 year old teacher, who was acting as an HIV/AIDS club organizer, witnessed the following:

"Our school doesn't have any system that can provide SRH information to the student, except for brief sessions during biology classes (which is inadequate). Even if a problem with family planning and other health issues exist, due to manpower and budget constraints, we do not provide proper SRH information through our clubs. I heard that a school health program is being piloted in some schools in the country. If the Ministry of Education collaborates with the Ministry of Health, the problems mentioned earlier can be solved easily, and students can access the reproductive health service."

According to the KII at education office:

"We have schools with strong mini media that are trying to address health (STIs, HIV, etc.) and related topics such as motivational words and issues pertinent to good citizenship. However, they are facing different problems. For instance, they do not have appropriate audiovisual equipment. Furthermore, they need different training on health (STIs, HIV, etc.), life skills, etc."

The following are key challenges in relation to life skills, as identified through KII and FGD:

- Awareness gap in the community on the needs of boys and girls
- Illegal migration
- Lack of appropriate youth centers and recreational places
- Limited access to different life skills training to youths, boys and girls
- Youth unemployment
- Poor access to or lack of washing facilities, especially for adolescent women during menstruation, toilets without doors, etc.
- Lack of hygiene and sanitary material support for students from families of low socioeconomic status.

Comparison of male and female responses for selected variables

The table below presents results of knowledge about GBV, HCP and their levels disaggregated by sex. The table also provides information on statistical tests of difference in the responses between females and males. The results indicate that knowledge of GBV significantly differs between females and males at the 0.05 level of significance. The percentage of females who know about GBV (97%) is quite close to that of males (100%). The test might not be reliable because the cell frequencies are quite unbalanced. The results also indicate that there is no significant difference in knowledge of HCP between females and males.

The levels of perception of GBV and HCP differ very significantly between females and males. Looking at the results, the percentage of females who perceived high levels of GBV is 33 compared to 14 for males. Surprisingly, the corresponding percentages are quite similar to HCP levels. In particular, 34 percent of females perceived high levels of HCP compared 13 percent of males who did the same. Clearly there is a disagreement in the level of GBV and HCP between the sexes. Generally, in a patriarchal society, male are the perpetrators of GBV and females are the victims. So it might be partly attributed to this power structure.

Variables	Male		Female	
	#	%	#	%
Knowledge of GBV				
Yes	121	**97**	185	**100**
No	4	**3**	0	**0**
Level of GBV**				
Low	107	**86**	124	**67**
High	18	**14**	61	**33**
Knowledge of HCP				
Yes	105	**84**	153	**83**
No	20	**16**	32	**17**
Level of HCP**				
Low	109	**87**	123	**66**
High	16	**13**	62	**34**

*Significant at 0.05 level
** Significant at 0.01 level

Table 10: Knowledge of GBV, HTP and perceived levels by sex

The table in the annex 4 presents sex disaggregated results related to several questions on power relations between women and men, attitude towards violence against women, and gender roles. The table also provides information on statistical tests of difference in the responses between females and males. The results indicate that the views of females and males are only significantly different in 4 out of 13 questions. One of the questions for which there is a statistical difference is “A woman should be able to choose her own friends even if her husband disapproves”. For this statement, females tend to agree, while males do not. The other three questions for which there is statistical difference are the following: “Do you think that women can be more successful than men?”; “Do you think that women can lead men?” and “Do you think that except for the reproductive (child bearing) function the difference in roles between men and women is created by society, not by GOD?” Females respond more positively than males to all three statements.

Coordination mechanism for Partners

There are different stakeholders who are working on HCP, GBV, health, education and other developmental areas at community level and government level (zonal and woreda). The table below shows the list of stakeholders and potential areas of coordination at both levels:

Government level (zonal and woreda)

Actors	Potential areas of Coordination and Key roles	Yes	No	Remark
Zonal and Woreda Women and Children affairs office, Youth and sport office	▶ Joint planning, supportive supervisions and review meetings		X	It is not regular and consistent
	▶ Guidelines for coordination		X	
Justice bodies such as Police, court, etc.	▶ Joint planning, supportive supervisions and review meetings	X		
	▶ Support victims to receive justice services	X		
Education office and schools	▶ Joint planning, supportive supervisions and review meetings		X	They have annual planning but not jointly with others
	▶ Collaborate on life skills training	X		
	▶ Strengthen SRH/Health clubs and mini media	X		
	▶ Guidelines for coordination		X	
Zonal and Health office and health facilities (including health care workers, HEWs)	▶ Joint planning, supportive supervisions and review meetings		X	Training on different areas has been given to HCWs in collaboration with regional health and NGOs. However newly recruited staff needs training
	▶ Create awareness among community members	X		
	▶ Provide SRH services			
	▶ Staff capacity building	X		
	▶ Guidelines for coordination	X		
NGOs such as AMRFI, Link Community Development	▶ Joint planning, supportive supervisions and review meetings		X	They did not have dedicated office or staff at Woreda level
	▶ Collaboration capacity building and other aspects of the projects	X		
School Clubs	▶ Joint planning, supportive supervisions and review meetings	X X		
	▶ Collaboration capacity building and other aspects of the projects	X	X	
	▶ Awareness creation on SRH			

Community level

Actors	Potential areas of Coordination and Key roles	Yes	No	Remark
Religious leaders and Elders	▸ Joint planning, supportive supervisions and review meetings		X	
	▸ Bring awareness to the community around SRH and related areas		X	
	▸ Community mobilization		X	
	▸ Guideline for coordination		X	
Women development army (WDA)	▸ Awareness creation	X		
	▸ Reporting GBV and HTP cases		X	
	▸ Referral of victims		X	
CBOs and Edirs	▸ Awareness creation		X	
	▸ Supporting victims (psychological, economical, etc)		X	
Anti HTP committee	▸ Awareness creation	X		
	▸ Reporting GBV and HTP cases	X		
	▸ Referral of victims		X	
Cooperatives	▸ Awareness creation		X	
	▸ Supporting victims (psychological, economical, etc)		X	

According to zonal and Woreda women and children office experts:

We are working with churches, where religious leaders teach members of their respective churches that FGM, early marriage, polygamy and abduction are illegal. For example, if FGM occurs in the community, WDA leaders report the case to the kebele, the kebele, in cooperation with the police, brings the case to women and children affairs, women and children affairs will take it to the concerned bodies, such as further health services and court. In that case both the family and the person who performed the FGM are brought to court.

The woreda's Education office expert:

A stream committee at kebele level that is composed of health extension workers, a kebele representative, an agriculture representative, an education representative and the women's league. This committee reports the case to kebele, then the kebele reports to the woreda and the woreda reports to the zone's Women and children affairs office

The woreda's Women and children officer;

There are different structures in the community that work on the prevention of GBV. These include the women development army (WDA), 1-to-5 group, Justice Forum in the community, Children's Right Conventions at district and kebele levels, and different clubs at school to protect children from violence.

The following are key challenges observed and reported by respondents concerning coordination mechanisms among stakeholders:

- Duplication of efforts
- Lack of regular supportive supervision and review meetings
- Lack of consistent Go-NGO forums and review meetings
- Lack of coordination and a referral system among stakeholders
- Funding shortage of NGOs
- Many organizations are not effective in working with a lower community structure;
- Gender composition is weak;
- Majority of staff does not know the laws and policies;
- In most cases, there is limited budget to support and provide services, specially addressing HTP/GBV.
- There is a poor data and information recording system, and the M&E system is not systematic for an informed decision-making process. There is no mechanism to report back to the community;
- Key governmental stakeholders have a busy schedule;
- High turnover or reshuffling of Woreda and facility heads
- Lack of sustainable support for SRH by development partners

CHAPTER FOUR: CONCLUSION AND RECOMMENDATIONS

Conclusion

The findings of this study are believed to add new insight into the existing knowledge in the areas of gender, GBV, SRH and HCP. It is assumed that the findings of the current study will improve the understanding of policy makers, service providers and program implementers about the prevalence, knowledge, attitude and practice of community and stakeholders towards gender, GBV, SRH and HCP. The findings further highlighted challenges and opportunities for service institutions to integrate the issue of women and girls affected by GBV, SRH and HCP in the public sectors. It also indicated barriers to stakeholders' collaboration to address the issues of GBV, SRH and HCP practices effectively.

Based on the data collected and analysis made, it is possible to conclude that the relevant local government offices, including Women, Children and Youth Affairs, Justice, Police and Health Offices know their mandate in promoting gender equality, and prevention and control of gender based violence and harmful traditional practices. Based on the key informant interview we held at zonal level offices and FGD with woreda offices, we have understood that each sector has activities in relation to GBV and gender. They have also meetings at woreda and zonal levels, though meetings are not frequent and the delay in taking action as per the meetings is an issue. The assessment has also proved the existence of a women development army, women forum, 1-5, etc. in all woredas that are working on GBV.

The assessment has identified the presence of survivors' service centers at zonal level where survivors can easily get medical, legal, psychological and other kinds of support. However, such types of centers are not yet established at woreda level. The lack of appropriate data collection, reporting and data review mechanisms for cases of SGBV is still a challenge at all levels.

The study explicitly found out that tradition or attitude is the major challenge in fighting GBV/ HTPs, in which almost all sector offices and women structures are engaged in one way or another. There are communities still who believe that a woman should undergo FGM before marriage. About 69% of the respondents believe that FGM is high and 54% of the female respondents have undergone FGM. There are even men who are still interested in marrying circumcised women. Unnecessary weddings and other cultural ceremonies are still prevalent in the community. There are efforts to bring awareness to the community about HTP through the anti HTP communities established at Kee, woreda and zonal levels. However, the awareness and community mobilization efforts are sporadic and uncoordinated. As a result, the GBV cases reported have been settled by negotiations by elders, which has given more power to the perpetrators/ with financial capacity and disempowered the victims. HTPs have gone into hiding via excuses, such as birthday celebrations for FGM, early/ child and exchange marriages are being excused in the name of culture, fear of societal stigma and discrimination sponsored by "elders" and perpetrators. Hence, the assessment revealed the profound need for coordination, partnership building and networking among all stakeholders to address such challenge.

These situations in the target woredas have contributed to having less effective local sector offices in providing services to the needy, women's structures in relation with advocacy for the implementation of existing laws, policies etc in the fight against GBV/ HTPs.

The specific findings for each section are the following:

- 73 percent of the respondents who are married, widowed, or separated reported that their marriage involved a dowry or bride price. Knowledge of GBV is almost universal, where 99% of them know about GBV. 16 %, 36 % and 46% know 1-5, 6-10 and > 10 GBV types.
- When we see the perceived prevalence, 25 percent of respondents perceived that the level of GBV is high. Clearly, the rating varies by woreda. The percentage of respondents who perceived a high level of GBV ranges from 0 (Boloso Sore) to 58 (Damot Pulassa). With regard to the trend in the prevalence of GBV, 78 percent of respondents replied "declining" while 14 and 8 percent replied "increasing" and "staying the same",
- The result shows that the main GBV perpetrators are quite diverse, ranging from parents to schoolboys. The first top three perpetrators are partners (34 %), neighbors (22) and local authorities (15%). The result also indicates a variation by woreda; for instance, neighbors are the main perpetrators in Boloso Sore Woreda. 66 % of the respondents said that GBV victims in the community usually report to the police or local administration office
- The percentage exposed to information about GBV ranges from 35 % (Kindo Koysha) to 99 % (Boloso Sore). The top three main sources of information are TV (45%); radio and newspapers (21%); and relatives, friends and workmates (10%).
- Poor GBV case recording and reporting mechanisms at woreda level. In most cases the data collected are used for reporting purposes, particularly, for prosecution by police and attorneys, but rarely for advocacy or policy dialogue or processes. In addition, data are poorly reviewed and used for decision-making.
- The other main challenge is that the communities are not willing to report GBV cases to relevant government structures at kebele, woreda and zonal levels because they fear revenge from perpetrators.
- At zonal level there are Rehabilitation and Staying Centers under the women and children affairs administrations. Lawyers employed by Women and children affairs give legal protection to the victims
- 55, 4 and 41 percent of the respondents responded that man and woman, woman only, and man only, respectively, are the main decision makers at household level. The results indicate that 59 percent of women and girls don't have the power to decide. By contrast, 12, 13, and 16 percent of women and girls have low, medium and high levels of decision-making power, respectively. Women and girls with no decision-making power are highest in number in Damot Pulassa (74%) and lowest in Boloso Sore (37%).
- In terms of the decision-making power that women have, the top decisions in which they have power include: Sending boys to school, selling livestock products, selling livestock, sending daughters to school, renting land, spending personal savings and Selling crops. While they have less power on: Marriage of girl, Medical expenses, Number of children to have, use of contraceptives and having personal savings. With regard to ownership of land, according to the zonal agricultural office, the majority of the households have secured land certification.
- When we see the knowledge of HCP, 83 % of the respondents know HCP. The percentage ranges from 61(Kindo Koysha) to 100 (Boloso Sore). In addition, 19 and 64 percent of the respondents know 1-3 and 4-6 HCP types, respectively.
- HCP varies by woreda. It ranges from 6 % (Kindo Koysha) to 56 % (Damot Pulassa). The percentage of victims of HCP is 49.
- When we see the legal awareness and information on HCP, 85, 40, 72, 66, and 38 percent of the respondents are aware of the illegality of HCP; have got information on HTPs; have heard of the law in preventing and punishing GBV and HTP in Woreda/Kebele/School; have attended a

school meeting where GBV and HTPs were discussed; and know of a community or school based structure that works on the prevention of GBV and HTP in their area, respectively.

- Knowledge of SRH. 89, 91, 87 and 71 percent of the respondents know about sexually transmitted diseases (STDs); know about HIV/AIDS; have had an HIV test/VCT; they or their partner are using a family planning method, respectively.
- Based on the HMIS data of the Woreda, the total of new and repeated acceptors of FP has been increasing since 2010 EC. On average, 74% of the total FP acceptors are accounted for as new acceptors from 2010EC to 2011 in all woredas and 43% as repeat acceptors.
- 76 percent of youth and adolescents know about life skills. Knowledge of life skills ranges from 65 % (Boloso Bonbe) to 100 % (Kindo Koysha). When looking at their specific knowledge on key life skills, though 76% of them replied that they know life skills, 57% of them identified communication, 21% goal setting, 8% (each) negotiation, conflict management and decision making.
- The lack of proper coordination mechanisms for stakeholders working at zonal and woreda levels is also challenge.

Recommendations

Based on the major findings of the study and concluding remarks given above, the research team would like to forward the following recommendations for government and development partners including AeAE Ethiopia.

For AeAE Ethiopia and other development partners

1. **Capacity building to local government:** The assessment findings show that there is an urgent need to increase and strengthen the capacity of local government and women's associations and structures to improve the effectiveness in protecting, reducing GBV, HTPs, enhance advocacy, enforce existing laws / policies and responsiveness in services rendered to GBV survivors.
2. The study showed that local arbitrations through elders and customary laws are still prevalent at local community level, especially for rural parts. Due to this, GBV and HTP victims are not receiving legal action. And hence it is important to provide orientation to the community-based structures, local kebele administrators and stakeholders, law enforcement bodies etc on national laws/ policies, (criminal code, family laws) and international instruments with a focus on GBV/ HTPs.
3. The study identified a lack of reliable data and reporting system for GBV cases as a challenge. And hence it is important to establish and guide the experts of the relevant sector offices, women's associations and structures on registration, data collection, confidentiality and consent, reporting of GBV cases and producing analysis for informed policy decisions.
4. **Conduct Targeted Campaigns:** there are specific events and timings for some of the GBV and HCP cases. For instance, FGM is conducted during the end of schooling (summer season till mid September) and during wedding ceremonies (mostly January to April). Thus, organizing targeted awareness creation and attitudinal change campaigns during these occasions would help avert parents'/guardians' decision to circumcise their daughters. For this, AeAE Ethiopia and other development partners should organize different events, such as awareness creation sessions on market days, school openings, celebration of womens' days etc. In addition, it is important to develop appropriate ICC/BCC materials which considerer the local culture,

language etc. It can be done using the local TV and FM channels, posters, billboards, leaflets, brochures etc.

5. **Strengthen inter sectoral collaboration and coordination at woreda and zonal levels:** Most of the challenges were related to a lack coordinated sector offices and partners and a lack of functional platforms. BoWCYA offices should take the initiative to have a common regular forum to discuss GBV, SRH an HCP issues among all partners. Implementing partners should also support (technically and functionally) the functionality and regularity of GO-NGO forums. AeAE Ethiopia and other development partners should ensure the continuity of such forums and coordination mechanisms by sponsoring the regular review meetings, joint planning, supportive supervisions and review meetings.
6. It is important to train experts of relevant sector offices and women's associations and structures on project cycle management (planning/ monitoring and reporting), leadership, networking, referral systems, communication and advocacy strategy to address gender equality as well as GBV/ HTPs. A detailed assessment on training needs should be conducted at the time of the intervention, which will identify the total number of experts who need the training, its duration and associated costs.
7. Based on the assessment, the local anti HTP committees, CBOs, Edirs, women's associations and structures face a shortage of stationery and other office materials to identify, record, report and advocate against GBV and HCP. And hence it is important to capacitate this structure through the provision of stationery and other office materials.
8. It is important to organize community-based education, awareness creation and mobilization sessions through religious leaders. The role of these religious leaders in the Wolaiyta community is tremendous and hence the project should engage religious leaders in awareness raising activities.
9. Strengthen the existing community-based referral systems for the reporting anti GBV actions between the established anti –GBV/HTPs committees, HEWs, Agricultural developmental agents with women's associations, women's affairs office, health institutions and survivor centers, and create access to services. This can be done through developing referral directories that show where to refer to, how and when, and supporting the implementation of the system.
10. It is important to strengthen school-based clubs and the school community using mini media equipment and capacity building for teachers and club leaders (on life skills, ASRH, GBV, HTP etc) and support them to implement the school health program interventions.
11. Women's place in society is determined by their economic status, economically dependent women are always undermined and discriminated. And hence, livelihood intervention for the women who are victims of HTP/SGBV is important.

For Government and policy makers

1. **Engage Multiple Channels of Communication:** The current survey found out that community dialogue and the dissemination of anti-GBV and HTP messages are the key channels of communication to reach the community with messages of anti- GBV and HCP. The current study showed that the driving forces for GBV and HCP are related to psychological and gender related reasoning, social reasoning, one's faith, peer pressure, myths, and personal factors such as cleanliness and aesthetic values. Factors affecting GBV and HCP acts at individual, social and community, environmental, and legal/policy framework levels. Thus, engaging multiple channels of communication such as peer education, media outlets (community radio), and tailored and targeted information, and formal education could contribute a lot in reaching the

community at grassroots level, and in tackling the myths and misconceptions and eventually changing the behavior and practices of GBV and HCP.

2. Capacitate health centers and hospitals to adopt / strengthen the one-window service strategy for survivors of GBV/HTPs, and assign counsellors and lawyers in sector offices to handle GBV cases appropriately;
3. **Strengthen Customary/Traditional laws such as arbitration through elders:** Different studies showed that in areas where customary/traditional laws are strong, the prevalence of GBV and HCP is low. However, there are barriers and challenges that reduce the effectiveness of customary laws (mainly **arbitration through elders)** from supporting anti- GBV and HCP endeavors. Interventions need to overcome such problems and challenges and create adequate awareness before the establishment of anti GBV and HCP declarations and bylaws. Obligations should emanate from the community, and punishment needs to focus on social sanction, rather than on large amounts of financial punishment that exceed those of statutory laws. Hence, strengthening and revising customary/traditional laws in consultation with justice offices in all target woredas could help in addressing the aforementioned challenges and meaningfully reducing the prevalence of GBV and HCP. The revision will include the arbitration process, sanction levels, compensation to victims and integration with the routine legal system.

ANNEX

Annex tables

Annex: 1: Respondents' basic socio-demographic characteristics

Variable	Boloso Bonbe		Boloso Sore		Damot Pulassa		Kindo Koysha		Total	
	#	%	#	%	#	%	#	%	#	%
Sex										
Male	39	**50**	40	**53**	40	**51**	37	**47**	**156**	**50**
Female	39	**50**	35	**47**	38	**49**	42	**53**	**154**	**50**
Total	78	**100**	75	**100**	78	**100**	79	**100**	**310**	**100**
Age Category										
<= 19	28	**36**	19	**25**	2	**3**	17	**22**	**66**	**21**
20-24	21	**27**	20	**27**	8	**10**	24	**30**	**73**	**24**
25-29	10	**13**	25	**33**	20	**26**	21	**27**	**76**	**25**
30-34	8	**10**	11	**15**	13	**17**	4	**5**	**36**	**12**
35-39	1	**1**	0	**0**	19	**24**	4	**5**	**24**	**8**
40-44	4	**5**	0	**0**	10	**13**	2	**3**	**16**	**5**
>=45	6	**8**	0	**0**	6	**8**	7	**9**	**19**	**6**
Educational status										
No education/illiterate	5	**7**	17	**23**	28	**36**	3	**4**	**53**	**17**
Only writing and reading	7	**9**	18	**24**	5	**6**	29	**37**	**59**	**19**
Primary	10	**13**	11	**15**	25	**32**	11	**14**	**57**	**19**
Secondary	37	**49**	26	**35**	12	**15**	11	**14**	**86**	**28**
Technical/vocational	1	**1**	1	**1**	4	**5**	5	**6**	**11**	**4**
Higher	15	**20**	2	**3**	4	**5**	19	**24**	**40**	**13**
Religion										
Orthodox	22	**28**	35	**47**	31	**40**	37	**47**	**125**	**40**
Catholic	4	**5**	3	**4**	3	**4**	7	**9**	**17**	**5**
Protestant	40	**51**	37	**49**	44	**56**	33	**42**	**154**	**50**
Muslim	1	**1**	0	**0**	0	**0**	2	**3**	**3**	**1**
Other (specify)	11	**14**	0	**0**	0	**0**	0	**0**	**11**	**4**
Marital status										
Married	38	**49**	37	**49**	46	**59**	35	**44**	**156**	**50**
Never Married	39	**51**	37	**49**	11	**14**	41	**52**	**128**	**41**

Divorced or separated	0	**0**	0	**0**	7	**9**	0	**0**	**7**	**2**
Widowed	0	**0**	1	**1**	14	**18**	3	**4**	**18**	**6**
When you got married was there a dowry or bride price (if you are married)?										
Yes	26	**70**	34	**92**	35	**67**	23	**66**	**118**	**73**
No	11	**30**	3	**8**	17	**33**	12	**34**	**43**	**27**

Annex: 2:Respondents' Age and Age at marriage.

Variables	Boloso Bonbe			Boloso Sore			Damot Pulassa			Kindo Koysha			Overall		
	Mean	STDV	#	Mean	STDV	#	Mean	STDV	#	Mean	STDV	#	Mean	STDV	#
Age	27	17.5	78	24	5.1	75	33	7.9	78	29	18.0	79	**28**	**13.8**	**310**
Age at marriage	22	3.9	27	21	1.9	36	17	3.8	62	23	4.5	32	**20**	**4.3**	**157**

Annex: 3: Power relationshipS between women and men, attitude towards violence against women, and gender roles.

Variable	Boloso Bonbe		Boloso Sore		Damot Pulassa		Kindo Koysha		Overall	
	#	%	#	%	#	%	#	%	#	%
A man should have the final word about decisions in his home										
Agree	39	**61**	27	**61**	49	**68**	3	**5**	**118**	**50**
Partially Agree	13	**20**	12	**27**	16	**22**	32	**55**	**73**	**31**
Disagree	0	**0**	0	**0**	4	**6**	15	**26**	**19**	**8**
Strongly Disagree	12	**19**	5	**11**	3	**4**	8	**14**	**28**	**12**
Women have the same right as men to study and work outside the home										
Agree	53	**71**	68	**91**	45	**59**	36	**48**	**202**	**67**
Partially Agree	10	**13**	6	**8**	18	**24**	2	**3**	**36**	**12**
Disagree	8	**11**	0	**0**	8	**11**	37	**49**	**53**	**18**
Strongly Disagree	4	**5**	1	**1**	5	**7**	0	**0**	**10**	**3**
A couple should decide together if they want to have children										
Agree	49	**65**	67	**89**	51	**66**	41	**55**	**208**	**69**
Partially Agree	12	**16**	7	**9**	10	**13**	0	**0**	**29**	**10**
Disagree	6	**8**	0	**0**	13	**17**	33	**45**	**52**	**17**
Strongly Disagree	8	**11**	1	**1**	3	**4**	0	**0**	**12**	**4**

A man and a woman should decide together what type of contraceptive to use										
Agree	50	**71**	69	**92**	48	**62**	39	**51**	**206**	**69**
Partially Agree	11	**16**	5	**7**	18	**23**	1	**1**	**35**	**12**
Disagree	7	**10**	0	**0**	10	**13**	36	**47**	**53**	**18**
Strongly Disagree	2	**3**	1	**1**	2	**3**	1	**1**	**6**	**2**
A woman should be able to choose her own friends even if her husband disapproves										
Agree	39	**60**	27	**38**	38	**60**	28	**43**	**132**	**50**
Partially Agree	14	**22**	5	**7**	13	**21**	4	**6**	**36**	**14**
Disagree	8	**12**	2	**3**	9	**14**	33	**51**	**52**	**20**
Strongly Disagree	4	**6**	37	**52**	3	**5**	0	**0**	**44**	**17**
It's a wife's obligation to have sex with her husband even if she doesn't feel like it										
Agree	31	**53**	0	**0**	6	**12**	7	**14**	**44**	**24**
Partially Agree	16	**28**	5	**17**	20	**40**	3	**6**	**44**	**24**
Disagree	3	**5**	2	**7**	19	**38**	31	**63**	**55**	**29**
Strongly Disagree	8	**14**	23	**77**	5	**10**	8	**16**	**44**	**24**
A wife has no right to ask her husband to use a condom										
Agree	30	**57**	1	**2**	10	**19**	9	**21**	**50**	**25**
Partially Agree	12	**23**	10	**19**	15	**28**	0	**0**	**37**	**18**
Disagree	4	**8**	7	**13**	21	**40**	34	**79**	**66**	**33**
Strongly Disagree	7	**13**	35	**66**	7	**13**	0	**0**	**49**	**24**
There are times when a woman deserves to be beaten										
Agree	30	**53**	0	**0**	7	**15**	0	**0**	**37**	**22**
Partially Agree	10	**18**	10	**63**	15	**31**	15	**30**	**50**	**29**
Disagree	5	**9**	0	**0**	17	**35**	25	**50**	**47**	**27**
Strongly Disagree	12	**21**	6	**38**	9	**19**	10	**20**	**37**	**22**
It is the husband's right to beat his wife whenever she fails to obey him										
Agree	23	**32**	0	**0**	11	**15**	9	**13**	**43**	**15**
Partially Agree	12	**17**	0	**0**	11	**15**	15	**22**	**38**	**13**
Disagree	10	**14**	0	**0**	16	**22**	20	**29**	**46**	**16**
Strongly Disagree	27	**38**	75	**100**	35	**48**	24	**35**	**161**	**56**

Annex: 4: Power relationshipS between women and men, attitude towards violence against women, and gender roles disaggregated by sex

Variables	Male		Female	
	#	%	#	%
A man should have the final word about decisions in his home				
Agree	45	**44**	73	**54**
Partially Agree	33	**32**	40	**29**
Disagree	7	**7**	12	**9**
Strongly Disagree	17	**17**	11	**8**
A woman should be able to choose her own friends even if her husband disapproves*				
Agree	48	**46**	84	**53**
Partially Agree	12	**11**	24	**15**
Disagree	18	**17**	34	**21**
Strongly Disagree	27	**26**	17	**11**
There are times when a woman deserves to be beaten				
Agree	16	**24**	21	**20**
Partially Agree	24	**35**	26	**25**
Disagree	13	**19**	34	**33**
Strongly Disagree	15	**22**	22	**21**
It's a wife's obligation to have sex with her husband even if she doesn't feel like it				
Agree	18	**23**	26	**24**
Partially Agree	16	**21**	28	**25**
Disagree	18	**23**	37	**34**
Strongly Disagree	25	**32**	19	**17**
A wife has no right to ask her husband to use a condom				
Agree	24	**28**	26	**23**
Partially Agree	15	**17**	22	**19**
Disagree	23	**26**	43	**37**
Strongly Disagree	25	**29**	24	**21**
A couple should decide together if they want to have children				
Agree	81	**68**	127	**70**
Partially Agree	13	**11**	16	**9**
Disagree	19	**16**	33	**18**
Strongly Disagree	6	**5**	6	**3**
A man and a woman should decide together what type of contraceptive to use				
Agree	80	**68**	126	**69**
Partially Agree	13	**11**	22	**12**
Disagree	21	**18**	32	**18**
Strongly Disagree	4	**3**	2	**1**
Women have the same right as men to study and work outside the home				
Agree	80	**66**	122	**68**
Partially Agree	13	**11**	23	**13**
Disagree	23	**19**	30	**17**
Strongly Disagree	5	**4**	5	**3**
It is the husband's right to beat his wife whenever she fails to obey him				

Agree	21	**18**	22	**13**
Partially Agree	14	**12**	24	**14**
Disagree	15	**13**	31	**18**
Strongly Disagree	68	**58**	93	**55**
Do you believe that if women are given equal opportunities they can be as successful as men?				
Yes	105	**87**	133	**82**
No	16	**13**	30	**18**
Do you think that women can be more successful than men?*				
Yes	76	**68**	115	**80**
No	35	**32**	28	**20**
Do you think that women can lead men ?*				
Yes	75	**71**	120	**82**
No	31	**29**	26	**18**
Do you think that except for the reproductive (child bearing) function, the difference in roles between men and women is created by society, not by GOD?*				
Yes	72	**71**	114	**83**
No	29	**29**	23	**17**

*Significant at 0.05 level

** Significant at 0.01 level

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Financed by:

Ayuda en Acción
Ethiopia

Conducted by:

Grace Consultants