# Factors Associated with Sexual and Gender-Based Violence in the Somali Region of Ethiopia

## Results from a Qualitative Assessment

## Context

Sexual and reproductive health (SRH) is a human right for women and girls around the world. There is a significant need for SRH services in humanitarian settings, but also a severe dearth of rigorous evaluation of the effectiveness of sexual and reproductive health and rights (SRHR) programming in these contexts. The SRHR of internally displaced persons (IDPs) are particularly critical and require special considerations. While SRH services have increased for women in crisis situations broadly, these services have largely failed to reach IDPs.

IDPs are people who have been forced to leave their homes, but have remained within the borders of their country of origin. The needs of IDPs differ in meaningful ways from those of the general population. For example, IDPs frequently lack access to SRH services resulting in significant unmet need for contraceptive care, as well as comprehensive abortion care (Gebrecherkos et al. 2018). Host-country governments often lack the ability to effectively serve IDPs, as a result of needing to prioritize support in response to the conflict or disaster that has caused this displacement. Further, as IDPs lack the status of refugees and the associated protections, many multilateral agencies and nongovernmental organizations are unable to offer the same resources that they provide to refugee populations.

Sexual and gender-based violence (SGBV) is common in crisis environments. SGBV is one of the most widespread, underreported, and horrific human rights violations in the world, with girls and women being the most vulnerable to abuse and exploitation (Belay et al. 2020). Considering the physical, mental, and sociocultural impacts of SGBV, the World Health Organization has stated that "neglecting the offense is as equal as violating the fundamental right of human," which is not acceptable in any setting (2006). SGBV among IDPs in Ethiopia is prevalent; yet, SGBV services for this population are lacking (Feseha, G/Mariam, and Gerbaba 2012).

In Ethiopia, violence against women and girls continues to be a major challenge and a threat to a safe, equal, and dignified life. The Ethiopian Demographic and Health Survey reported that 23% of women aged 15 to 49 have experienced physical violence and 10% have experienced sexual violence (CSA and ICF 2016). Furthermore, 34% of ever-married women aged 15 to 49 have experienced physical, sexual, or emotional violence by their spouses and, of these women, 19% reported cuts, bruises, or aches and 10% reported deep wounds and other serious injuries (CSA and ICF 2016). Additionally, 65% of women have experienced female genital cutting (FGC) (CSA and ICF 2016).

The Ethiopian Demographic and Health Survey reported lower rates of physical violence, spousal violence, and sexual violence among women aged 15 to 49 years in the Somali regional state as compared to national rates (CSA and ICF, 2017). The Somali region has the lowest levels of physical violence (5.9%) and sexual violence (0.3%), but the highest reports of FGC, with 99% of women aged 15 to 49 having been circumcised (CSA and ICF, 2017). However, anecdotal data from the Somalia region present a somewhat different picture and suggest that rates of SGBV reporting for the region are indeed much higher. For instance, EngenderHealth's qualitative assessment of the Fafan zone of the Somalia region reported notable differences in the perceived prevalence of SGBV. While male responses cited no instances of SGBV, women commonly reported incidents of sexual assault and domestic violence (DRC and UNHCR 2019). Global evidence further suggests underreporting of SGBV is common and may be attributed to societal and structural barriers, including social stigma and shame, distrust of institutions, fear of retaliation

by the perpetrator, lack of awareness and access to referral services, and, in some settings, high levels of cultural and social acceptance of violence.

Our study sought to investigate the reasons for the potential underreporting of SGBV in the Somali region. Specifically, we assessed the perspectives of the community toward SGBV and engaged key informants to help identify factors associated with the relatively low prevalence rates of SGBV in the region.

# Methodology

## Study Context

The IDP crisis in Ethiopia is especially pronounced in the Somali region, where an estimated 896,000 climate-induced and conflict-affected IDPs reside across 419 displacements sites (UN-Habitat 2021). The largely rural Somali region spans over 350,000 square kilometers and is the second-largest region in the country. The region also presents complex resource issues and service delivery challenges.

EngenderHealth identified the Qoloji and Tuli Guled camps in the Fafan zone of the Somali regional state to serve as study sites. These sites are located southwest of the regional capital city of JigJiga. Operational since 2016, these camps house approximately 150,000 refugees and IDPs. Note, recognizing that these camps are highly restricted zones, refugees and non-refugees commonly intermix in these camps.

## Data Collection and Sociodemograpic Composition of Participants

EngenderHealth conducted a qualitative study between October and November 2021. We conducted in-person interviews and focus group discussions (FGDs) in Qoloji, Tuli Guled, and Jigjiga. The FGDs for our study population comprised consenting girls and women aged 15 to 49 years from these areas. Before beginning recruitment, we engaged staff from the regional health bureau and zonal health departments as well as district managers, camp managers, and public health emergency management teams to explain the purpose of our research and to garner their support for the study. We then used a convenience and peer-drive recruitment approach to identify participants.

After obtaining participant consent, we collected data through in-person interviews in spaces designated for privacy and confidentiality and through FGDs administered using a set of structured questions in local languages (Afan Oromo and Somali). The study team interviewed 15 key informants (9 male and 6 female) and conducted five FGDs engaging a total of 39 women and girls aged 15 to 49. By engaging key informants, we aimed to obtain an in-depth understanding of the context and the factors associated with the relatively low reported prevalence of certain forms of SGBV in the Somali region. These key informants included community and religious leaders, women's group leaders and representatives, youth, and government officials (primarily those from women and children affairs offices and legal enforcement bodies).

## Data Collector Training

Our study team trained four female research assistants (nurses able to speak Afaan Oromo and Somali) to recruit participants and to administer the survey. Our two-day training focused on research methods and ethics, survey administration, and confidentiality. We also engaged these data collectors to review every survey item for clarity and to refine and enhance the relevance of the survey measures for the local context and population.

### Survey Instrument

We based our FGD and key informant interview (KII) guide on other relevant SGBV studies. The questionnaire focused on the following topics: awareness and/or knowledge of SGBV, perceptions related to the acceptability of SGBV, use of SGBV services, and intention to use contraceptive methods. We developed the questionnaire in English and translated it into Afaan Oromo and Somali. We piloted the entire questionnaire with a sample of 20 respondents, examining internal consistencies and assessing the length required for each interview. Based on this pilot, we adjusted the survey to simplify the phrasing of select questions.

### Analysis

The study team transcribed the data using thematic analyses and narratives. We also used secondary data to complement and support findings from the primary data.

### Ethical Considerations

We submitted the study protocol to JigJiga University Research Ethics Committee for review and approval. Upon obtaining the clearance (Approval number: Ref# RERC/039/2021), the study team began collecting data. We informed participants of the purpose and procedures of the study, their rights related voluntary participation and confidentiality, and their right to decline or withdraw from the study without penalty. We asked participants to sign consent forms and provided copies of the form to them prior to conducting interviews. For participants under 18 years of age, we required consent from the participant as well as permission from an adult family member or guardian.

## Results

### Knowledge of SGBV in the Community

When we asked participants about their understanding of SGBV and to identify the different types of SGBV, responses were limited. Most commonly, participants only recognized two types of violence: rape and sexual assault.

> *"All women have experienced some form of violence at least once during their adult lives and more than one-tenth have suffered sexual violence involving the use of force. The majority of such violent acts are carried out by men in their immediate social environment, most often by marriage partners and ex-partners or strange men."*
> *FGD, JigJia*

Participants did not commonly identify and were less familiar with other types of SGBV, such as child, early, and forced marriage (CEFM); domestic violence; economic violence; and FGC.

### SGBV Perpetrators and Proponents

When asked about the types of SGBV perpetrators, respondents cited a range of types of individual—including husbands, parents, teenage boys, and strangers as well as policemen and other armed personnel. When asked about the gender of these perpetrators, respondents revealed that perpetrators could either be male or female, depending on the type of violence; however, participants commonly noted that men and adolescent boys commit acts of rape and domestic violence.

> *"Rape always is perpetrated either by men or adolescent boys; if it is early marriage, family members (particularly both parents) can be the perpetrators; and when it is the case of FGC mostly mothers are the main perpetrators. Even though men are also advocating for the act of FGC, the violence is committed by a female. It is always females who are doing the act of cutting. Obviously, the perpetrators of domestic abuse are male members of the community." KII, JigJiga*

Furthermore, participants noted that some SGBV acts—including specifically CEFM, domestic violence, and FGC—are culturally acceptable and normal traditional practices and that community and religious leaders and community members may both perpetrate and advocate for the practices.

> *"Mothers and the fathers are the main actors for schoolgirl's to engage [in] forced marriages in exchange for financial income for their family; youths have been refusing to marry girls who are not practiced FGC." FGD, Tuli Guled*

## SGBV Causes and Risk Factors

When the study team enquired about the risk factors of SGBV, several themes emerged. The most common cause of SGBV identified is the entrenched religious beliefs and cultural attitudes within the prevailing patriarchal system, which perpetuate dangerous and discriminatory gender stereotypes and inequalities and in some cases legitimize violence against women and children to ensure the dominance and superiority of men. As previously acknowledged, traditional norms and beliefs can lead to religious leaders, elders, and parents perpetuating different types of SGBV.

> *"In our community, men are considered to be the head in the family, and this will be misunderstood to be he can do whatever he wishes to his family, and these harmful gender stereotypes or norms are often used to justify some types of violence against women, such as domestic abuse." KII, JigJiga*

Another important risk factor that respondents cited was financial stability and related issues, including poverty, lack of livelihood opportunities, and low female economic empowerment. Participants explained that a lack of economic resources in general makes women more vulnerable to violence given their reliance on men. Further, respondents noted that unemployment, a challenge for many men in the region, can also result in men's need to assert their masculinity through violence, which is often directed at their partners. Similarly, as previously noted, mothers and fathers are the main perpetrators of CEFM for the purpose of improving household financial stability.

> *"Women are economically dependent on men…most of the women in the study areas are housewives, dependent economically by their husbands. This creates patterns of violence and poverty that become self-perpetuating, making it extremely difficult for the survivors to extricate themselves, particularly from domestic abuse and psychological harm, which they suffer in the hands of their life partners." FGD, Tuli Guled*

Respondents also noted other factors, such as lack of education, lack of social support, substance abuse among men and adolescent boys, and impunity for crime and abuse as contributing to and reinforcing the culture of SGBV. All of these issues compound the cultural and economic factors that underlie SGBV prevalence in the region. Further, respondents noted that these factors were frequently aggravated in times of conflict and displacement, as rule of law is eroded and families and societies are subject to additional stressors.

## Perceived Prevalence and Reporting of SGBV Incidents

With regard to the question of underreporting of SGBV cases, several themes emerged from our study. Similar to the aforementioned causes and risk factors, respondents repeatedly cited established sociocultural norms as preventing survivors from reporting SGBV incidences. Key norms that prevent such reporting include the fear of repercussions, social stigma, and dishonor of the family. Participants also noted that SGBV survivors may be perceived by the community as shameful, weak, and in some cases at fault and deserving, for instance, in cases of a loss of virginity or promiscuous behavior. Indeed, participants acknowledged that in some cases, a woman may be forced to marry the man who raped to preserve her and her family's honor.

Other participants noted that while SGBV is a crime in the country, with legislation explicitly stating that women have the right to live free from violence, there is a lack of faith in the justice system and therefore many survivors fail to report. Respondents explained that this lack of trust is the result of perceptions of corruption, police failing to adequately investigate SGBV reports, law enforcement agencies dismissing or disregarding SGBV cases, and overall low levels of successful prosecution of SGBV incidents. Related to this distrust of the formal system is the reliance on informal, community-level systems to resolve SGBV matters. In such cases, there are no formal police records to demonstrate the number of incidences, thus resulting in underreporting of SGBV prevalence in national studies. Instead, many SGBV cases are mediated by traditional leaders and clan elders or directly by the families involved. For instance, in the context of the camp settlements, rapists are often brought to justice by the community, following negotiations between the survivor and her family and the rapist and his family. Thus, while rape is a criminal offense, cases are typically addressed by the community rather than the judicial system.

> *"Most of the times women are too shy to seek help and find solution using the formal established system–both the legal as well as health providing institutions." KII, Tuli Guled*

> *"Most of the time women complain to their families, or to the elders of her family, and most of the time victims' and perpetrators' families try to solve the problem among themselves." FDG, Jigjiga*

> *"The communities know each other as they are affiliated from two Somali clans. Thus, the settlement and clan-based relations make [it] easy to identify and trace perpetrators or anyone who commit crime." KII, Qoloji*

> *"Most of the time cases are reported by the survivors informally… Families usually opt [for] the traditional establishments to report and resolve conflict related with SGBV, thus summon the traditional leaders to share the incidents and ensure justice." KII, Tuli Guled*

Finally, across all interviews and discussions was an overall theme related to the fragility of IDP's general safety and security. Participants noted IDPs experience multiple safety risks on a daily basis—from theft to fighting within the refugee camps and host communities as well as SGBV—which are often managed within the communities rather through formal channels.

## Referral Pathways and Quality of SGBV Services

When asked about referral pathways and SGBV centers, participants explained that there was little awareness of such systems and institutions. Further, participants noted that where services were known and available, survivors face multiple barriers in accessing SGBV support, including those which have already been discussed, such as fear of repercussions and social stigma.

> *"Even though medical and psychological services are accessible, due to traditions, the services and information are impeded to reach many victims in the community, as people are not confident to talk about particular service delivery concerning SGBV. Due to these, victims either fail to get proper information to get proper services or hide incidents instead of seeking help." KII, Jigjiga*

Some respondents also cited quality issues associated with existing SGBV services, including concerns related to provider compassion and confidentiality. Participants specifically highlighted concerns that information that survivors reported to providers could be shared among their communities, which could lead to victim blaming and other negative social outcomes. For instance, in one example, participants described a one-stop SGBV center that was located inside a referral hospital, and noted that SGBV survivors did not feel comfortable seeking services there due to the lack of anonymity. Participants also described service centers as generally ill-equipped to provide critical psychological, legal, and material support for SGBV survivors. Further, respondents explained that support services were also inaccessible for some women and that many providers lacked the required competencies for working with the IDP survivors of SGBV.

In addition to generally characterizing service provision centers as substandard, lacking quality service delivery, and incapable of managing and referring SGBV clients, respondents noted these issues are heightened by the ongoing political instability and crisis. Participants specifically described how the crisis in region, which has involved several episodes of forced displacement, abductions, and trafficking, has exacerbated the deteriorating quality of the service centers.

> *"In our camp, access to proper service is limited, the health center has limited staffs, drugs, facilities. The protection providers do not often attend service center on time due to [lack] of vehicle and the communications (phones) limitations, and sometimes they do not work regularly and effectively to respond to the dire and urgent needs of victims. In addition to this, the social workers have limited capacity and encounter difficulty in managing the cases with confidentiality." KII, Qoloji*

## Key Learnings and Recommendations

### Summary of Findings

The study revealed that overall knowledge about SGBV within the communities surveyed is limited and several types of SGBV—including CEFM, domestic violence, and FG—are considered normal cultural practices. The primary risk factors for SGBV in the region include socioeconomic inequalities, discriminatory cultural and religious beliefs, harmful traditional practices, and conflict and displacement. The patriarchal nature of the region also perpetuates certain forms of violence against women, including socializing domestic, economic, and emotional violence as acceptable, while limiting the opportunities of women for self-empowerment and collective action. The study also revealed that many SGBV cases are unreported, often due to fear of stigma and repercussions, lack of trust in the justice system, and the preference for family- and community-level mediation—in consideration of family honor and dignity issues and the effectiveness of tracing and disciplining of perpetrators through clan networks.

This study also explored the types of SGBV perpetrators, identifying a variety of different perpetrators, including armed personal. This finding is consistent with global evidence that widespread SGBV by armed groups during conflict is commonplace. However, while researchers attempted to probe further into the role of these specific perpetrators and types of violence inflicted, study participants provided little

information. Respondents' "silence" on this topic highlights the need for strategies to sensitize and train the health providers, law enforcement, and local administrators to create a survivor-centric response mechanisms, including for delivery of emergency support, prophylaxis, and treatment for survivors.

## Recommendations for Future Interventions

Building upon our findings, we have identified several priority recommendations for future programs aiming to address SGBV in IDP communities.

- Engage women and girls from the IDP sites to co-design survivor-centric SGBV interventions. This may include conducting safety, security, and mobility mappings and community-led site assessments for one-stop SGBV centers and other providers offering health, legal, judicial and other essential services.
- Facilitate SGBV awareness and sensitization activities within the community through multiple channels. Introduce (or strengthen) SRHR education programs for adolescents and youth to challenge harmful gender and social norms and to mitigate stigma facing SGBV survivors. Establish community-based networks, engaging community elders and religious leaders in particular, and conduct awareness campaigns that challenge social norms around the acceptability of CEFM, domestic violence, and FGC.
- Design and implement women's economic empowerment interventions, such as programs aimed at strengthening vocational skills, to promote self-reliance.
- Sensitize, strengthen the capacity of, and enhance coordination among law enforcement bodies and other key stakeholders, including informal justice mechanisms within communities and clans, to ensure recognition of, respect for, and protection of the rights of SGBV survivors.
- Strengthen existing survivor support services by ensuring availability of necessary equipment and privacy within facilities to support delivery of integrated, and effective health, psychosocial, legal, and material assistance to survivors. And, ensure staff are trained and supported to deliver compassionate, confidential, respectful care for SGBV survivors.

## References

Belay, H.G., T.M. Liyeh, H.A. Tassew, A.B. Ayalew, Y.A. Goshu, and G.N. Mihretie. 2021. "Magnitude of Gender-Based Violence and Its Associated Factors among Female Night Students in Bahir Dar City, Amhara Region, Ethiopia." *International Journal of Reproductive Medicine*. DOI: 10.1155/2021/6694890.

Central Statistical Agency (CSA) and ICF. 2016. *Ethiopia 2016 Demographic and Health Survey: Key Findings*. Addis Ababa: CSA and Rockville, MD: ICF. https://dhsprogram.com/pubs/pdf/SR241/SR241.pdf.

Danish Refugee Council (DRC) and UNHCR. 2019. *Protection Assessment of BIIQA, QOLOJI 1, Awajabur, Masle, Dugsi, and Kaliyal IDP Sites in Fafan Zone, Somali Regional State*. Addis Ababa: DRC and Geneva: UNHCR. https://www.globalprotectioncluster.org/wp-content/uploads/Fafan-Zone-Protection-Assessment.pdf.

Davidson, A.S., C. Fabiyi, S. Demissie, H. Getachew, and M. Gilliam. 2017. "Is LARC for Everyone? A Qualitative Study of Sociocultural Perceptions of Family Planning and Contraception among Refugees in Ethiopia." *Maternal and Child Health Journal* 21, no. 9 (September): 1699–1705. DOI: 10.1007/s10995-016-2018-9.

Feseha, G., A. G/mariam, and M. Gerbaba. 2012. "Intimate Partner Physical Violence among Women in Shimelba Refugee Camp, Northern Ethiopia." *BMC Public Health* 12, no. 1 (February): 125. DOI: 10.1186/1471-2458-12-125.

Garcia-Moreno, C., H.A.F.M. Jansen, M. Ellsberg, L. Heise, and C.H. Watts. 2006. "Prevalence of Intimate Partner Violence: Findings from the WHO Multi-Country Study on Women's Health and Domestic Violence." *The Lancet* 368: 1260–1269.

Gebrecherkos, K., B. Gebremariam, A. Gebeyehu, H. Siyum, G. Kahsay, and M. Abay. 2018. "Unmet Need for Modern Contraception and Associated Factors among Reproductive Age Group Women in Eritrean Refugee Camps, Tigray, North Ethiopia: A Cross-Sectional Study." *BMC Research Notes* 11, no. 1 (December): 851. DOI: 10.1186/s13104-018-3956-7.

UN-Habitat. 2021. *UN-Habitat Partner with Sister Agencies to Support Durable Solutions for IDPs in Somali Region, Ethiopia.* ReliefWeb. Accessed December 14, 2021. https://reliefweb.int/report/ethiopia/un-habitat-partner-sister-agencies-support-durable-solutions-idps-somali-region.

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