Factors influencing Sexual Gender-Based Violence among female adolescents in Afar, Ethiopia.

A literature review

Figure 2 Afar teenage girl (1)

Figure 1 Region Afar in Ethiopia (2)

(1,2)

Matthea van Hennik
The Netherlands

Master of International Health

KIT (Royal Tropical Institute)
Vrije Universiteit Amsterdam (VU)

Factors influencing Sexual Gender-Based Violence among female adolescents in Afar, Ethiopia.
A literature review

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in International Health

by

Matthea van Hennik
The Netherlands

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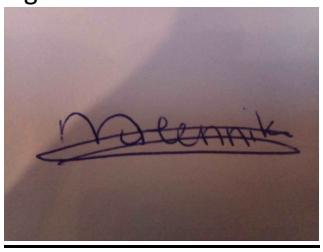

Master of International Health (MIH)
16 September 2016 – 4 September 2020
KIT (Royal Tropical Institute) / Vrije Universiteit Amsterdam
Amsterdam, the Netherlands

September 2020

Organised by:
KIT (Royal Tropical Institute)
Amsterdam, the Netherlands

In co-operation with:
Vrije Universiteit Amsterdam (VU)
Amsterdam, the Netherlands.

Acknowledgment

Before presenting you this thesis, I want to thank a few people. Without these people I would never have come this far and achieved what I have achieved now.

First of all, I want to thank my thesis supervisor, for having an enormous trust, patience and interest, reading and refining all the drafts over and over again. But she was not only doing that, through the process, she also inspired me in different areas of life. Her professional background, her personal background. She inspired me to reach further, and to enjoy the (professional) life God has given us. Thank you for pushing me forward in a nice way to improve myself. Thank you!

Second, I want to honor my parents, my brother and my sisters. My father inspiring me to enjoy an adventurous life and look beyond borders, telling me and my siblings stories since a young age. My sisters for teaching me how to read and write, always sticking with me until the end. My mother for monitoring me close. Without them I would not be writing anything. They are my companions, they always stick with me wherever I go.

Third, my Royal Tropical Institute 2019-2020 classmates and friends. I particularly enjoyed Ghassan, Makplang, Louisa, Oonno, Fiorella, and Merette. Without them, taking care of me, making it possible I could combine my clinical work in hospital with following courses at KIT, offering me their own houses and sleeping facilities, all this work would not have been possible. But most of all I enjoyed them sharing their personal stories and life, their background, their enjoyments, their tears and their laughters.

Fourth, my Dutch friends, my dear, dear, dear, friends. Due to the COVID-19 epidemic, we could not meet much, but for talking, on the phone, or in person, there was always time. Even though there was not much time for them, they supported me in my clinical work and last months in my writing. They did stick with me. I am grateful for that. ☺

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Abstract (max 350 words)

Introduction: From all countries worldwide, sexual and gender-based violence (SGBV), consisting of sexual, physical and psychological violence, bride abduction (BA), child marriage (CM) and female genital mutilation / cutting (FGM/C) for female adolescents is highest in Ethiopia. CM and FGM/C are high in Afar but knowledge and data about SGBV among female adolescents in Afar is not complete.
Objective: to explore the magnitude of SGBV, influencing factors and interventions addressing SGBV among female adolescents in Afar and best practices found addressing SGBV among female adolescents in pastoralist communities applicable to Afar.
Methodology: a literature study was done between January 2020 – August 2020.
Results: information on sexual and physical violence among female adolescents in Afar is found. Besides that, a pattern of continuous BA and CM and an increasing FGM/C is observed. An individual factor influencing SGBV is a low educational attainment. A relationship factor is the normalcy of (physical) violence. Community factors are strong patriarchic norms, a gap in connection between the government, justice, education and health sectors and Afar communities. Societal factors are political and economic marginalization and norms that 1) entrench male dominance over women and children, 2) support violence as an acceptable way to resolve conflict, 3) hinder acknowledgment of SGBV. Interventions on policy level, connecting education, health and justice sectors are conducted. Further recommended strategies are: developing an Afar linguistic and culturally appropriate education and health system (that is well connected with Bureau of Women Children and Youth Affairs), and develop a mobile health service to deliver Adolescent Youth and Sexual Reproductive Health (AYSRH) services in rural areas and track girls that dropped out of school or have come across justice sector.
Conclusion: evidence for SGBV is found and influenced mainly by factors at society and community level. When addressing SGBV for female adolescents in Afar, focus should be at securing education for girls, implementing Afar culturally and linguistic appropriate programs for education and health, connecting health, education and justice sector with BOWCYA, and empowerment programs involving religious and community leaders.

Key words
Afar, pastoralist, sexual and gender-based violence, female, adolescent.

Wordcount thesis: **13.028** words (**378** words tables and figures)

List of tables and figures

List of abbreviations

AYFS	Adolescent and Youth Friendly Services
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BA	Bride Abduction
BOWCYA	Bureau of Women Children and Youth Affairs
CBO	Civil Based Organization
CM	Child Marriage
CPR	Contraceptive Prevalence Rate
EDHS	Ethiopia Demographic Health Survey
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation / Circumcision
FMOH	Federal Ministry of Health
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GOE	Government of Ethiopia
HDA	Health Development Army
HEP	Health Extension Program
HEW	Health Extension Worker
HMIS	Health Management Information System
HTP	Harmful Traditional Practices
HSTP	Health Sector Transformation Plan
IDI	Indebt Interview
IPV	Intimate Partner Violence
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MOH	Ministry of Health
MOFD	Ministry of Finance and Economic Development
MOWCYA	Ministry of Women Children Youth Affairs
NGO	Non-Governmental Organization
NPV	Non-Partner Violence
PMA	Performance Monitoring and Accountability
RBs	Regional Bureaus
RBE	Regional Bureau of Education
REC	Research Education Center
RHB	Regional Health Bureau
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SRGB	School-related Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
VAW	Violence Against Women
WCYO	Women Children Youth Affairs Office
WEW	Women Extension Worker
WHO	World Health Organization
WHOs	Woreda Health Offices

Glossary of key terms

Sexual and Gender-Based Violence (SGBV) is defined as "any act of violence that is inflicted upon an individual because of his or her gender or sexual orientation." The violence can take different forms, physical, sexual, or psychological, and it encompasses harmful traditional practices, such a child marriage, sex trafficking, honor killings, sex-selective abortion and female genital mutilation & cutting (FGM/C) (3).

Violence Against Women (VAW): any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (4).

Physical violence: the use of physical force towards the woman with the purpose of causing injury, harm, disability, or death. It includes, but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, or use of a weapon (5).

Sexual violence: any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object (6).

Psychological violence: either psychological battering or emotional abuse without physical or sexual violence (7). (There is a lack of agreement on standard measures of emotional/psychological violence and the threshold at which acts can be considered unkind or insulting that cross the line into being emotional abuse (5).

Bride Abduction (BA): a phenomenon that a girl gets kidnapped by a boy, raped and forced into (early) marriage (8).

Child Marriage (CM): refers to any formal marriage or informal union between a child under the age of 18 and an adult or another child (9).

Female Genital Mutilation / Cutting (FGM/C): refers to all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons (10).

Pastoralism: nomadic lifestyle with livestock production (herding) as their main income generating activity. Pastoralism has a mobile aspect, moving the herds in search of fresh pasture and water (11).

Introduction

Worldwide, one in three women have or will experience physical and/or sexual violence (5). Regional estimates showed a prevalence rate ranging from 27,2% in Europe to 45,6% in Africa (5). Of all countries violence against women (VAW) is reported highest (71%) in Ethiopia (12). Moreover, of all Sub-Sahara African countries, violence among female adolescents and youth is highest (51%) in Ethiopia (13). Adolescent females are confronted with sexual violence (44.7%) the most, but physical and psychological violence are reported high as well (39.8% and 36.3 % respectively) (14). Next to VAW, female adolescents in Ethiopia regularly face traditional forms of sexual and gender-based violence (SGBV) such as bride abduction (kidnapping, rape and forced marriage), child marriage (marriage before 18 years of age) and female genital mutilation/cutting (15). In Afar region female adolescents experience the latter types of SGBV the most (15,16).

Because of the severe economic consequences and the severe costs in public health, improving adolescent and youth sexual and reproductive health (AYSRH) has a high priority on the (inter)national agenda (17). This is in line with the acknowledgment of VAW as a violation of rights in Beijing (1995) (18), the Maputo plan of action (19), the Millennium and Sustained Development Goals (20,21), the government installed national laws & policies, strategies and interventions to address SGBV for adolescents and youth (22). But although AYSRH is increasing in most regions of Ethiopia, in some regions, Afar in particularly, AYSRH is trailing behind (22).

Personally, while living and working as a young female doctor in a small maternity hospital in a dessert in Afar region I encountered adolescent women who experienced SGBV consistently. In the hospital most Afar' women were circumcised and had consequently genital-urinary tract problems. My youngest circumcised patient was a 2-year-old girl. But also, as most women are married in their adolescence they had their first delivery before 20 years of age, and many girls presented with obstructed labour, intra-uterine dead babies and obstetric fistula due to their immature pelvis during delivery. Next to that, girls and women presented with domestic, physical and sexual violence, with the most extreme cases of a 15-year-old married girl asking me a written proof of virginity for her husband after she refused sex and another 15-year-old unmarried 21-weeks-pregnant girl with her father asking me for an abortion.

Digesting the year working in Afar and the above written numbers found in the literature, my questions were numerous. What is the extent of SGBV these female adolescents are experiencing in Afar? And, what factors are influencing these types of SGBV? Are there strategies and interventions already implemented or is there room for adjusting? Are there strategies for SGBV among female adolescents from other equivalent (pastoralist) communities with lessons that can be applied to Afar? With this thesis I hope to contribute evidence and support for policy makers, health professionals, formal and informal justice officers, religious and community leaders to address SGBV for female adolescents in Afar.

Structure of the thesis

Chapter 1 describes the background of AYSRH in Ethiopia, and Afar in specific. Chapter 2 presents the problem statement, justification and research objectives. Chapter 3 explains the methodology and analytical framework. Chapter 4 explores the magnitude of SGBV in Afar, and Chapter 5 is focused on exploring factors influencing SGBV for adolescents in Afar. Chapter 6 interventions already done on SGBV in Afar are discussed and in Chapter 7 best practices for SGBV among female adolescents in (pastoralist) communities worldwide are presented. After the discussion in Chapter 8 the thesis concludes with a conclusion and recommendations (Chapter 9.

Chapter 1. Background

This chapter provides background information about Ethiopia in general and about Afar region in specific whereby geography, political and administrative structure, the demographic and socio-economic situation, health care system and financing and adolescent and youth sexual and reproductive health will be highlighted.

1.1 Geography, political and administrative structure

Ethiopia is a Sub-Saharan country, which forms the Horn of Africa together with Somalia, Djibouti and Eritrea. Ethiopia is surrounded by Somalia, Kenya, South Sudan and Sudan, Eritrea and Djibouti. In March 2020, 115 million people were living on 1.1 million km^2 surface, which makes Ethiopia the 2nd most populous country on the African continent (23,24). Ethiopia contains a plurality of ethnic groups of which the most prevalent ones are Oromia 34.4%, Amhara 27%, Somali 6.2%, Tigray 6.1%, Sidama 4%, Gurage 2.5%, Welayta 2.3%, Afar 1.7%, Hadiya 1.7% and Gamo 1.5%. Out of 86 existent languages, for long, Amharic was the first national language till March 2020 when Oromo, Somali, Afar and Tigrigna were officially added (24,25).

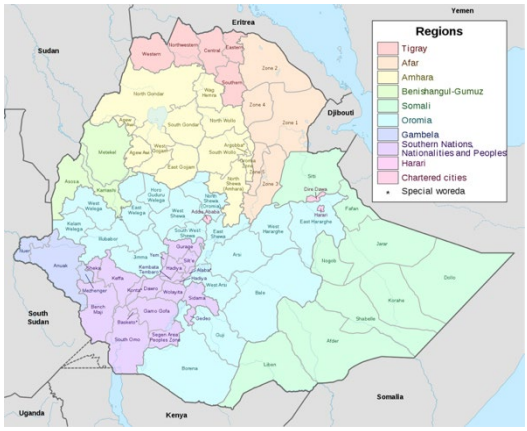

Figure 3 Administrative zones and regions in Ethiopia (26)

The Federal Democratic Republic of Ethiopia (FDRE) is divided in 9 regions (Oromia, Amhara, Tigray, Afar, Gambella, Benishangul-Gumuz, SNNPR, Harari, Ethiopia-Somali), and 2 administrative zones (Addis Ababa, Dire Dawa). See figure 3 (26). The regions are subdivided into 62 zones, which are subdivided into 532 "woredas" (districts) and these are further divided in kebeles (municipalities) (27). The region Afar is divided into 5 administrative zones, 32 woredas and 390 kebeles (28). See figure 4 (29). In 2019, in Afar region there were 1.9 million inhabitants living on 270.000 km^2 surface (30,31).

For its climate, Ethiopia can be divided into 4 areas: plateau, arid, semi-arid and dessert (32). Apart from the lush and green plateau and arid areas, two-thirds of the Ethiopian land is semi-arid and dessert. In Afar, the altitude ranges from 1600 m above to 116 m below sea level, the temperature ranges between 25 – 48 degrees (14) and an annual rainfall of 100 – 200 mm (32).

Figure 4 Zones and districts in Afar (29)

1.2 Demographic and socio-economic situation

In 2020, median age in Ethiopia is approximately 17.9 years, with 60% of the population below 25 years (24). With a growth rate of 3.02% per year, Ethiopia is one of the fastest growing countries in the world (24). With an expected 8.7 years of schooling (35), in 2016, 49% of women and 35% of men over 15 years were illiterate (15,24). In 2019, 79% of the population lived in rural areas (34) and Ethiopia has an agriculture-based economy (15,24). Around 57% of the rural population had access to improved clean drinking water, and 28% had access to improved sanitation services (24). In 2016, 24% of the population lived under $1.00 USD (poverty level). The Gross Domestic Product (GDP) in 2019 was low (96 billion US dollars) but in 2018 Ethiopia was among the fastest growing non-oil economies (annual growth rate of 9%) (36,37). In 2020, 63% was Christian (44% Orthodox) and 34% Muslim (24).

In Afar, in 2017 39% of the population was below 18 years (31). In 2004, Afar had a regional population growth rate of 4.11% (urban) and 2.23% (rural) (38). Around 90% lives in rural areas as

90% of the population are Afar pastoralists, nomads with livestock production (herding) as their main income generating activity (30,38,39). In 2016, literacy was lowest for women (no education 61.8%) and men (no education 48.2%) (15) and most people (74.2%) lived in the lowest wealth quintile (15). Due to El Nino, in 2017, there was a high deprivation in housing (92%), sanitation (88%), health (80%) and nutrition (85%) (31). In 2020, 95% of Afar population was Muslim (30,31).

1.3 Health care system and financing

Since decentralization (1991), the Federal Ministry of Health (FMOH) and the Regional Health Bureaus (RHBs) are responsible for health sector leadership and organizing policy matters and technical support (40). The woreda health offices (WHOs) are managing and coordinating the operation of the primary health care services (40). The health care system is a three-tier system consisting of primary health care units (health centers with satellite health posts) at the base, district hospitals in the middle secondary level, and specialized hospitals at the top third level (22,27,39).

In 2018, the physicians density was 0.077 per 1.000 (41), the nurses and midwives density was 0.712 per 1.000 (42). These numbers have increased since 2009 (physician's density 0.025 per 1.000 and nursing and midwifery density 0.252 per 1000) (43), but are still below the World Health Organization (WHO) threshold (2.3 physicians, nurses, and midwives per 1.000 population) to achieve coverage of primary health care (44). In Afar, in 2019, there were 6 hospitals, 86 health centers and 379 health posts reported by the RHBs (45). According APDAs report, there were 2 regional hospitals (Dubti and Awash), 3 doctors, 18 health officers, 128 senior nurses, 82 junior nurses (46). In 2015, the physician to population ratio was 1:132.140 (0.0076 per 1000 population) (47,48).

As a response to sparse human resources, in 2003, the FMOH introduced the Health Extension Program (HEP). Per kebele two females that spoke the local language, aged over 18, and completed grade 10 were selected by woreda education and health offices to become Health Extension Workers (HEWs) (49). After a 3-months-course they were educated to promote health and prevent disease with selected high impact curative interventions for mothers and newborns at community level (49–51). In 2020, around 40.000 - 50.000 HEWs were trained, accounting for almost half of the entire health workforce in Ethiopia (52). Since 2011, HEWs are creating systematic mobilization of model families in the community, called the Health Development Army (HDA) (50). The HDAs form groups of women that conduct regular discussions about health needs in the community (50). In the last decade, accelerated training of health officers and emergency surgery and obstetric officers were also conducted(44). Next to that, in 2014, the FMOH had delivered 1.247 ambulances across the country, linking health posts with health centers and health centers with primary hospitals (50,51).

Health services are financed by four main sources: government (federal and regional) 25%, development partners such as bilateral and multilateral donors (grants and loans) and non-governmental organizations (NGOs) 50% and private contributions such as households out-of-pocket payment 24%, private health insurance and community based insurance was 1% (27,40,53,54). In 2010, the absolute government expenditure on health was US$ 22.77 per capita, of which expenditure on sexual and reproductive health (SRH) per woman in reproductive age was US$ 12 (54).

1.4 Adolescent and Youth Sexual Reproductive Health

Over the last twenty years, Ethiopia has shown a significant progress in Sexual and Reproductive Health (SRH) outcomes. The total fertility rate (15-49 years) has dropped from 7.4 (in 1984) to 6.5 (in 2000) up to 4.2 (2018) total births per woman(55). Due to the HEWs, contraceptive prevalence rate (CPR) among married women had increased from 4.0% in 1990s to 44% in 2015 (50). Antenatal care coverage increased from 27% in 2000 to 62% in 2016 (15). However, the progress is not uniform across regions and population groups.

Even though female adolescent mortality, largely due to pregnancy related problems, has decreased from 4.89 in 2000 to 2.35 deaths per 1.000 in 2011, the adolescent birth rate was still high (22). Among all sexually active women of reproductive age, adolescents had the highest rates of pregnancy and unintended pregnancy (401 and 176 per 1.000 women). Of these unintended pregnancies about half (46%) ended in abortion (56), of which 65% in health facilities (57). This figure is concerning. However the low CPR (9%) among adolescents and the unmet need (30%) are explaining (22). HIV prevalence among adolescents was <1% and of new HIV infections among women (15-24 year) were more than double compared to new infections among young men (22,58). Comprehensive knowledge of HIV/AIDS among youth is relatively low 24% for girls and 35% for boys (22). Girls aged 15-19 years were seven times more likely to be HIV-positive than boys of the same age (54).

In Afar, the fertility rate was 5.5 per woman which is 2nd highest after Ethiopia-Somali (7.2 per woman) (15). Half of the women (50,7%) received antenatal care at least once and have the second lowest skilled delivery assistance rate (16%) (15). Maternal mortality in Afar was 720/100.000 life births in 2015, double of the national maternal mortality (48). According Mekonnen et al (2018) in 54,5% of female adolescents in Afar were childbearing at 15-19 years (59). The modern contraceptive prevalence rate among married women was increasing from 8.7% (2014) to 12.7% (2019) but still much lower than the national average of 41% (60). For female adolescents, CPR is unknown but is expected to be low. In 2014 the lowest unintended pregnancy rates are found (9%), rates on (unsafe) abortion are unknown (61). HIV prevalence among the reproductive age group is high (2%) (62). Comprehensive knowledge among adolescents about HIV/AIDS transmission and prevention is nearly half the national average (16% vs 30%) and has hardly improved since 2011(13.7%) (31).

Chapter 2. Problem statement, Justification, Objectives

This chapter will provide an overview of knowledge and justification of research on SGBV among female adolescents in Afar.

2.1 Problem statement: Sexual and Gender-Based Violence among adolescents in Afar

According the National Adolescent & Youth Health Strategy (NAYHS) 2016-2020, adolescent SRH and female adolescent mortality and morbidity are mainly influenced by risky sexual practices, harmful traditional practices (HTPs) such as bride abduction (BA) child marriage (CM) and early childbearing (22). Except risky sexual practices, these factors are all counted as SGBV for females.

Consequences of SGBV are extensive. For sexual, physical and psychological violence, physical consequences (trauma, teenage pregnancy, unsafe abortion, sexually transmitted diseases) and mental consequences (fear, low self-esteem, guilt, shame, depression and withdrawal from social contact, suicide) are described (17). See annex 1. For BA and CM, a higher likelihood of IPV, early childbearing, divorce and poverty are described (8). For FGM/C, consequences are divided into short-term (trauma, bleeding) and longer-term consequences (such as urogenital tract infections, sexual dysfunction and prolonged labor) (63).

In the NAYHS 2016-2020 it is stated further that in Ethiopia SGBV (stating only sexual, physical and psychological violence) among female adolescents and youth is high (22). In this literature review sexual, physical and psychological, but also harmful traditional practices (HTPs) such as Bride Abduction (BA), Child Marriage (CM) and Female Genital Mutilation / Cutting (FGM/C) are included in the definition of SGBV. Taking the latter definition, all these types of SGBV are high in Ethiopia (15,22).

From all Sub-Saharan African countries, female youth in educational institutions in Ethiopia experienced SGBV the most (51%) (13). Kassa et all (2019) showed that female students experienced sexual violence most (44.7%) followed by physical (39.8%) and psychological (36.3%) violence (14). Mulugeta et al (2016) found that physical and psychological violence is continuous throughout all reproductive-age groups, but for adolescent girls (10-19 years) as their bodies are maturing sexual violence is prevalent the most. Further, girls between the age of 14 and 17 are most vulnerable (64). Next to sexual, physical and psychological violence, two thirds of women are circumcised and 58% are married before 18 years of age (15). For abduction the national average was 69% with the highest average in SNNPR region (92%) (16).

About SGBV among female adolescents in Afar, knowledge on SGBV types such as HTPs is large: in Afar most girls are circumcised and generally married off at 16 years (15,16). Knowledge on sexual, physical and psychological violence is limited, but there are suggestions that these types of violence among female adolescents are also high (30,65–68). However, for adolescents the exact magnitude of SGBV is not well described nor are the factors influencing these.

The causes of SGBV are usually multi-dimensional, including social, economic, cultural, political and religious factors (13,17). SGBV is particularly common in settings where low gender equality, women empowerment and highly patriarchal structures are present (12,69). In the gender-inequality index, Ethiopia ranks as 173 out of 188 countries, with features including HTPs such as BA, CM and FGM/C, domestic violence and fewer education and work opportunities (35). Causes for SGBV in Afar can probably be explained multidimensional as well, but in what way exactly is not known yet.

In Ethiopia, AYSRH services are designed to respond to the SRH needs of adolescents and youth (22). They are provided in public and non-governmental health care facilities, youth centers and schools (22). AYSRH services are available in 44.8% of public health facilities (22). In Afar, access to AYSRH

services is below the national average and said to be due to infrastructural problems and the mobility of the population (22). The NAYHS 2016-2020 described Afar as lacking most behind in addressing FGM/C, BA and CM, but knowledge on specific strategies on how the SGBV in Afar is addressed is not available (22). However, addressing SGBV for adolescent females in Afar would substantially decrease female adolescent mortality and morbidity.

2.2 Justification

Literature on the magnitude of sexual, physical and psychological violence for female adolescents in Afar is lacking. In surveys, such as EDHS, nationally lowest percentage of sexual and physical violence are reported (15). At regional bureaus (RBs) numbers of reported sexual, physical and psychological violence are low or absent (65). Apart from sexual, physical and psychological violence, HTPs in Afar have a special focus of governmental and NGO attention, but so far, programs and interventions did not significantly bring these down in Afar yet (16). Literature on reasons why is lacking.

For achieving SDG 5 (achieve gender equality and empower all women and girls) by 2030 in Afar, all types of SGBV should be identified and addressed, and (as UNICEF puts it) Afar should scale up efforts and should reduce the percentage of girls aged 15-19 years who have undergone FGM/C by 30% per year, and eliminate BA and CM 47 times faster (31,70). Even though it is clear that this acceleration scenario is highly unrealistic, it is also clear that identification and addressing SGBV for female adolescents in Afar needs attention and a plan of action.

Because of lack of evidence on the magnitude of sexual, physical and psychological violence among female adolescents in Afar, this literature review will focus first on finding the magnitude of SGBV as a whole among female adolescents in Afar. After this, exploring of factors influencing SGBV for female adolescents in Afar will be conducted. Further, existing interventions for SGBV for female adolescents in Afar and best practices international from other pastoralist communities addressing SGBV among female adolescents applicable to female adolescents in Afar will be discussed. This literature review is conducted to support different stake holders addressing SGBV for adolescents in Afar, such as the Government of Ethiopia (GOE), FMOH, RHB, BOWCYA, RBE, Civil Society Organizations (CSOs) and Non-Governmental Organizations (NGOs) that address SGBV for female adolescents in Afar.

2.3 Objectives

General objective: to explore factors and responses related to SGBV among female adolescents in Afar to support stakeholders addressing SGBV in policy and practice.

Specific objectives:

1. To estimate the magnitude of different forms of SGBV (with sexual, physical and psychological violence in specific) among female adolescents in Afar.
2. To explore factors influencing SGBV among female adolescents in Afar.
3. To explore existing health system responses for SGBV among female adolescents in Afar.
4. To analyze best practices to address SGBV among female adolescents in other pastoralist communities applicable to Afar.
5. To make recommendations for strategies and interventions and share these with stakeholders addressing SGBV for female adolescents in Afar.

Chapter 3. Methodology

This chapter gives an overview of the study type, the search strategy, the conceptual framework and limitations of the methodology.

3.1 Study type

The methodology of this study is a literature review and desk study, done between the period of January 2020 to August 2020. A literature review was selected because it gave opportunity to critically analyze and synthesize written evidence on SGBV among female adolescents in Afar and to draw conclusions and recommendations for stakeholders in addressing SGBV among female adolescents in Afar.

3.2 Search strategy

Literature was searched and extracted via websites, search engines and academic online databases. Websites of the Government of Ethiopia (GOE) and its authorities (Ministries of Women Children and Youth Affairs, Education, Finance and Economic Development, Health and Youth, Culture and Sport) and international authorities such as WHO, World Bank, World Population Review and CIA were visited to retrieve policy documents, reports, guidelines and researches. Reports of NGOs and CBOs working in Afar such as UNICEF, UNFPA, AMREF, Save the Children, APDA and CARE were used for information in the field.

Grey literature concerning SGBV among female adolescents in Afar and other pastoral communities was sought with a search engine i.e. Google Scholar. Academic online databases such as Pubmed (VU Library), were used for search of systematic reviews, and meta-analysis and other peer reviewed articles. Different authoritative journals such as BMC, Lancet, BMJ, Guttmacher institute were visited for their publications. Open access published and unpublished literature were reviewed. Throughout the whole research process, a snowballing approach was used to access cited papers in articles and reports. Keywords for search of literature were combined using the Boolean operator terms 'OR' and 'AND' to limit the search. See table 1.

Table 1 Literature search strategy

	Keywords used for search strategy			
Sources	**Objective 1** Magnitude of SGBV for adolescents in Afar	**Objective 2** Factors influencing SGBV for adolescents in Afar	**Objective 3** Health system response for SGBV for adolescents	**Objective 4** SGBV interventions applicable to female adolescents in Afar
Search engines and databases Google Scholar Pubmed **Websites** FMOH WHO World Bank World Population Review CIA Guttmacher **Journals** BMC Lancet BMJ Guttmacher institute	Main keywords: Afar AND Ethiopia AND adolescent AND sexual OR physical OR psychological OR gender-based violence OR (bride) abduction OR child marriage OR female genital mutilation / cutting	Main keywords: Afar AND Ethiopia AND education OR domestic violence OR child marriage OR female genital mutilation / cutting OR bureau of women children youth affairs OR regional health bureau Sub keywords: Pastoralism AND sexual OR physical OR gender-based violence Political situation AND Afar AND Ethiopia	Main keywords: Afar AND Ethiopia AND adolescent AND sexual OR physical OR gender-based violence AND Government OR CARE OR AMREF OR APDA OR UNFPA OR UNICEF	Main keywords: Pastoralism AND sexual OR physical OR gender-based violence AND interventions OR strategies

3.3 Inclusion and exclusion criteria

Retrieved literature was selected after reading the abstract or after scanning the literature first. To produce the most actual and relevant review, literature published between 2000 – 2020 was included. However, some of the literature that was published before 2000 was included because of information relevancy. Only literature written in English language was included.

3.4 Conceptual framework

This study reviews the magnitude and factors influencing SGBV for female adolescents in Afar, health system responses and exploration of best practices (worldwide) among pastoralist communities to address SGBV applicable to female adolescents in Afar. The conceptual framework suitable for analyzing factors influencing SGBV for adolescents in Afar is a socio-ecological model.

The socio-ecological model of Heise (1998) was considered (6). This model shows a framework that conceptualizes SGBV as a multifaceted phenomenon grounded in an interplay among personal, situational, and sociocultural factors. See annex 2. The socio-ecological model of Dahlberg and Krug from the World Report on Violence and Health (2002) has used the same core model as Heise and Jones with individual (both victim/perpetrator), relationship (microsystem: family & intimates or acquaintances), community (mesosystem: institutions & social structures, work, identity groups) and societal (exosystem: laws & policies, social norms, global trend, economic factors) factors (17). See figure 5. SGBV is a multi-layer problem and therefore this model fits best for this literature review. Also, as this model is depicting both victim and perpetrator side and is the most recent model, this model was chosen. The socio-ecological model of Jones et al (2019) was also considered but was too multifaceted with aspects such as change pathways and capability outcomes that were not applicable to the situation in Afar (66). See annex 3.

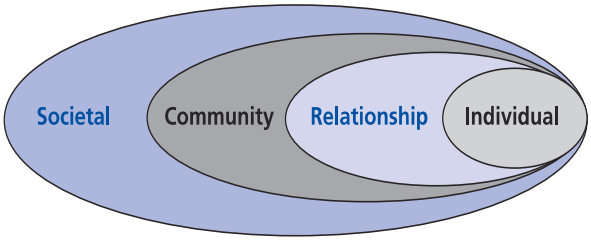

Figure 5 Socio-ecological model for factors influencing SGBV (17)

3.5 Limitations of methodology

The search was focused on existing published and unpublished articles and documents found. References were included from last twenty years because there were few articles written on SGBV among adolescents in Afar. This extended the resources of valuable literature but might have caused drawing an image that is not actually present anymore.

Most results had to be retrieved from qualitative data, as the sensitivity of the subject was high. Female adolescents nor key informants were interviewed for their perception and so triangulation was lacking. For psychological violence few data was found. Also, articles written in Amharic or other languages with possible valuable content could not be read nor added.

Chapter 4 Magnitude of Sexual and Gender-Based Violence among female adolescents in Afar

This chapter estimates the magnitude of SGBV among adolescents in Afar.

4.1 Sexual and Physical Violence

Even though in EDHS 2016 women in Afar reported nationally the lowest experience of physical (15.5%) and sexual violence (4.5%) (15), qualitative and quantitative research showed otherwise. In the GAGE study (2019), Afar girls expressed in interviews that there is a pronounced fear of strangers as they are the most likely perpetrators of rape (66). In interviews from Jones et al (2019) girls expressed that sexual harassment and rape was prevailing in the community. It was described that sometimes boys tried to have a sexual relationship by force and beat the girl or rape her when she refused his request (65). In the study of Save the Children Denmark (2008), out of all 9 regions, actual rape cases have been reported only by girls in Ethiopia-Somali (7%), Afar (6%) and Gambella (6%) (67). School girls within the 10-19 age group were most affected (67). Even though abuse by words or touching private parts were reported the lowest by students from these same three regions (67). In the other 6 regions in Ethiopia, adolescents reported to be afraid of rape, but did not report actual rape had happened (67). From all regions, teachers reported perceived violence and abuse among female students in school in Afar the highest (61%), parents 2nd highest (38%), compared with girls reporting this the lowest (24%) (67). Further, Woldab (2012) showed that students in Afar rate sexual attack in and on the way to school below average (71).

For physical violence, according EDHS 2016, adolescents in Afar are significantly less likely to have witnessed or experienced violence at home (38% Afar, 71% Amhara, 72% Oromio) (15). But, Focus Group Discussions (FGDs) from the GAGE study suggested that corporal punishment for adolescents at home is routine and often severe (66). A reason mentioned for this violence can be failing of an ordered task (for example losing a goat during herding) (66). Also, although spousal violence was reported least by Afar women, yet EDHS 2016 showed that married girls and women in Afar reported high percentages of acceptance of wife beating (15). In a UNICEF report (2012) about 30% of the female respondents from Afar experienced wife beating in their lifetime (16). Mohamed (2007) found that 94% of women in Afar were beaten by their husbands (72). Two thirds of boys told their mothers are beaten, so are their sisters. Adolescent girls married early had a higher likelihood of experienced beating by their husband (72). Among adolescent peers, violence was less reported in FGDs with adolescents from Afar (22%) than with adolescents from Amhara (44%) or Oromio (49%) region (66). Instead, adolescents from Afar reported bullying and spoke about the normalcy of violence between peers (66). Taken together this suggests that both sexual and physical violence are not openly discussed by adolescents in Afar.

4.2 Bride Abduction

Bride abduction (BA) is a phenomenon that a girl gets kidnapped by a boy or man, raped after which usually early marriage and child bearing will follow (8). Marriage by BA is most common in the southern regions of Ethiopia (8,16,73). Save the Children (2008) found that in Afar abduction is non-existent (66). But contrary to this, Jones (2019) described that there is rape and abduction on those girls who are not promised to be wedded to a cousin or uncle (65). Kipury (2008) and Ahmed Mohamed (2007) explained that also cross-cousin marriage can involve abduction, as Afar girls may not be informed when they are to be married to their cousin. When the boy / man is ready, the girl is taken elsewhere without notice and forcibly raped by her new husband (72,74). This may occur over a period of weeks, as most Afar girls are infibulated, which creates a physical barrier and makes sexual intercourse extremely painful for the woman (74). The extend in which women are married off without notice and being raped by their new husband is not known.

4.3 Child Marriage

Different forms of CM are prevalent in Ethiopia. In Afar the "Absuma"-marriage is custom. Most girls were married according the "Law of Absuma", which means that girls were supposed to get married to one of their maternal cousins (son of mother's brother) or uncle (30,31,65,68,75). Families generally arrange their daughter's marriage at mid-adolescence (14-16 years old) (16,65,68,72). The minimum age for marriage in Afar was 9 years (72). In 2012, UNICEF found that approximately 80% of girls in Afar were married before reaching 18 years of age (16).

Through time there is no change in the median age at first marriage, as in the EDHS 2005 16.7 years, 2011 16.8 years and 2016 16,4 years was mentioned (15,66). This means that 67% of women aged 20-24 years were married before age 18 in 2016, which shows no difference from 69% in 1991 (15,31,66).

4.5 Female Genital Mutilation/Cutting

Nationally, FGM/C is common practice in Ethiopia, but according EDHS (2016) and OXFAM (2017) rates among women aged 15-49 years are highest in Ethiopia-Somali (99%), pocket areas in SNNP region (92%) and Afar (91%) (15,76). Systematic review by Cordon et al (2018) says infibulation, the most severe type of FGM/C, was found most common in Ethiopia-Somali (73%) and Afar (64%) (73). UNICEF (2017) showed with data of EDHS 2016 that in the younger age group (15-19 years) a higher prevalence rate (88%) of FGM/C was measured than in the older age group (20-24 years) (81%) which points to a rise in prevalence (31).

In most Afar communities, circumcision was usually done before daughters reached one year of age, in other communities circumcision is described around 12 or 13 years (30,66,72,77). However, at age of 15 years 86% of girls have been cut (15,76). One article mentioned that variation of age at circumcision was explained to be due to household's ability to cover the costs of the circumciser (traditional birth attendant) and related celebrations (66).

Chapter 5 Factors influencing Sexual and Gender-Based Violence among female adolescents in Afar

In this chapter factors influencing SGBV for female adolescents in Afar will be explored with use of the socio-ecological model of Krug et al (17).

5.1 Individual factors

Background characteristics

Individual factors related to physical and sexual violence, CM and FGM/C discussed in the EDHS 2016 are displayed in table 2 (15). Beside these factors, sexual violence increases with age (15-19 4% up to 40-49 14%), divorced/separated/widowed status and higher fertility (>5 children) (15). Employment of the woman is showing a little increased percentage (25%) of physical violence compared to non-employed (22%) (15). The study of Simister et al (2013) about 33 countries worldwide (including Ethiopia) found that women's education reduces risk of SGBV (78). Erulkar (2013) found that in Ethiopia, women married before age 15, 82% of them lived in rural areas and 79% had never gone to school (79). For FGM/C, women in rural areas, with low education attainment and lowest wealth quintile were most likely to believe that FGM/C is required by their religion (28%) and that FGM/C should be continued(15). In Afar, all the factors are represented. Women have nationally by far the highest percentages of not having any education (68,7%), rural residency (90%), lowest wealth quantiles (74,2%), lowest percentage of employment (22,7%), highest fertility status (5.5), and are predominantly Muslim(95%) (13,28,35).

***Table 2 Individual factors influencing SGBV* (15).**

Factor	*Physical violence*	*Sexual violence*	*Child Marriage*	*FGM/C*
Low educational attainment	*x*	*x*	*x*	*x*
Rural residence	*x*	*x*	*x*	*x*
Lowest wealth quintile	*x*			*x*
Low work opportunities	*x*			
Region			*x*	
Religion (Muslim)				*x*

Factors influencing education attendance

Afar boys and girls highest grade level attended is 2.46 (2.3 boys and 2.6 girls) (65). Their main barrier for attending school is the responsibility to take care of the flock (30,65,68,71). Because of the herding, most boys and girls enroll late (at age 10-12) cannot attend class on time, and drop out early (30,65,68,71). Inflexible educational calendars (to season) and geographic difficulties of reaching schools influence attendance further (71). Occasionally, school can be attended when the younger brothers or sisters take over the flock (65).

At school, a lack of human and material resources, ineffective teachings (due to a lack of materials, demotivated and not well trained teachers to teach in another culture and language), lack of school facilities (such as toilets), but especially curriculum irrelevance to the socio-economic and socio-cultural life of the Afar people where determining students motivation (71). Demotivation of teachers was caused by harsh living conditions, erratically paid salaries, social isolation, not being allowed to be transferred to other districts or highlands after specific years of services, and a lack of teaching materials (65,71).

In adolescence ruling gender norms are the cause that girls cannot contribute economically and thus will not go to school but conduct domestic duties at home and get married (30,65,68). These decisions are taken by the parents and her "absuma" (30). Generally, boys will be encouraged to go to school longer for future work and higher income opportunities (65).

5.2 Relationship factors: peers & family

Factors related to violence among family members

Violence among parents and parents in relation to their children is having a violence encouraging effect on children, adolescents and youth (17). For SGBV in Afar intergenerational transmission is manifest (80). Married men beat their wives and children, consequently older adolescent boys

punished their younger siblings and their own children as well, for same reasons, such as failing to do enough household work or adequately respect (age or gender) hierarchies (65). Reasons for spousal violence directed to early married adolescent girls are to ensure that the girl or women will be submissive (72). Nationally, acceptance of wife beating is highest in Afar (15). Common reasons for spousal violence are refusing sex, disobeying their husband, food burning, and simply due to culture (16), whereas in Afar for both women and men refusing sex was the main reason to accept wife beating (15,72). Wife beating was more acceptable in rural areas and decreases with increasing educational attainment (15).

Factors related to violence among peers

Among youths, research from Krug (2002) showed that young people are much more likely to engage in negative activities (and SGBV) when those behaviors are encouraged and approved by their friends (17). This is valid both for sexual, physical and psychological violence (17). Jones argued that Afar adolescents did not report but spoke about normalcy of violence among peers (65,66). In the GAGE study was found that peer violence was experienced higher in urban areas (57%) than rural (45%), and also the severity of the injuries and scale was larger in urban settings, where also the substance use was higher (66). Among the Afar adolescents, substances used were "khat", a green leafy plant that acts as a mild narcotic, which influences the likelihood of violence among peers (74,77). Boys in Afar use khat twice as much as girls (77).

Child Marriage

Absuma marriage is decided for daughters already before or at birth (30). The choice when to marry is made by the parents and the selected "Absuma". Financial and moral reasons are given: 1) by marrying off adolescent girls their parents have one child less to take care off and they receive a dowry and 2) parents avoid the risk of pre-marital sex and unintended pregnancy outside the wedlock (16,30,65,68,72). The cultural reasons for maintaining the "Absuma"-marriage are: 1) the kinship lines, kinship ties and clan identity are maintained 2) economic survival is higher, and 3) there is protection against violence (30,72). Through marriage, members of the clan agree to support and protect each other, both against financial constraints as violence (65,68). These reasons show the importance of parents to stick to this tradition. And cause the community rules to be considered more important than individual rights (81).

Mothers are in charge to know when her daughter started her periods and is ready to be wedded, but a mother has no authority to refuse to give her daughter away to the man who proposed (30,75). Some parents think that they have to marry their daughters before the age of 16 to make sure they have not reached the courage to be disobedient for "Absuma-marriage" yet (65,66). In 2012, an average of 39% of respondents in Afar stated they will marry of their daughters according "Absuma" before 18 years, with higher peaks in specific areas such as Elidar (60%) (16).

For the "Absuma" boy/man, he can negotiate with his parents to delay marriage and (if he has more female cousins) select the girl he wants to marry too (65). Usually, the boys are supported by the community to wait till late adolescence or early adulthood to marry so they can continue school, accumulate money for the wedding ceremony and cultivate their own livestock so they will be able to live an independent life (65). But the girls do not have the option to refuse or negotiate about time (30,65,66,68,72,74,75). Running away or attempts of suicide will not prohibit the marriage (30,65,66,68). If she refuses openly, the chosen "Absuma" can put a verbal prohibition ("Aqdi") for the girl to marry any man (68). This prohibition will be held until it will be undone by the same man putting it, so if the man dies before resolving this prohibition, she will never be able to get married for the rest of her life (68). Thus, even though marrying off girls at this young age is forbidden under Ethiopian law, the enforcement of the "Absuma"-marriage before 18 years old is very strong.

Female Genital Mutilation/Cutting

Reasons for parents to circumcise their daughters are that FGM/C is culturally and religiously necessary (65,66). Some imams preach that leaving girls uncircumcised is considered as "Haram" (which means wrong) (65,66). Culturally, women are not accepted to get married when left uncircumcised (65,81). And marriage is considered an important rite of passage for Afar women and is their path to community acceptance and adulthood (81). Others reasons for circumcision are: controlling sexual desire, hygiene (protection from dust), considering the clitoris as unclean, narrowing the "unpleasant wide vagina" for their husband (72). Even though some girls are aware of and wish for certain rights, because of community pressure and structure, they are unable to exercise them (81).

5.3 Community factors

Informal legal framework in communities

In Afar, people practice a traditional "Clan" administrative system. A clan is the lowest structural unit that has its own communal property rights, such as land-ownership and use of natural resources (30). Clan territories are usually marked by landscapes and natural water outlets such as rivers and lakes and contain strategic resources such as grazing areas including dry season evacuations and water points (30). In Afar there is the "Afar-Mada" or "Adda", which is the traditional authority given to the elders of clans and customary law. These elders regularly gather to make important societal decisions (72). The 'Finaa' is an institution serving as a sanction-executing unit (31,68). Whenever there are conflicts the elders solve the issues, either by negotiation, separation or fighting (68). Virginity of girls is most respected. When a girl becomes pregnant without a legal marriage, the elders encourage her to marry the man who impregnated her (30). In the case of rape of a girl with an "absuma", the family / clan affected is allowed to fight to reclaim honor (65,66,68).

Formal legal framework

Sexual or physical violence will usually first be reported to the elders and not reach the formal justice system (65,72). Therefore perpetrators are rarely prosecuted in the formal system, and the lack of reporting to the formal justice system drove the perception at district and regional level that there are no SGBV problems (65). Some women brought their complaints to the authorities, such as police and Bureaus of Women Children and Youth Affairs (BOWCYA), but were hampered in several ways: 1) the basic infrastructure, confidential reporting and testimonial spaces for girls to report forced marriage or violence were lacking; 2) there were very few personnel in the police and justice sectors who had been trained in child-friendly and gender-sensitive approaches; 3) after girls' reporting, follow-up was difficult due to migration of families. If a conflict occurred between families or clans, in response to elders, a family rather migrated to another place, than addressing SGBV and bringing perpetrators to justice via the formal legal framework (63,72,73). Another factor is that most parents and girls don't know about the existence of laws that protect girls from SGBV (65,72).

Formal health care response

Adolescents confronted with SGBV are usually not able to access good SRH services and adequate response to SGBV. Reasons for Afar girls and women not to meet qualitative good SRH services and an adequate SGBV response are numerous. Mentioned barriers for accessing SRH for girls and women in Afar are financial, geographical, and culturally not adjusted AYSRH services (39,47,62). Financial, as even though SRH services are free of charges, girls may not afford to buy drugs and pay for transportation and other travel-related expenses (39). Geographical, the provision of formal health care services in Afar are shown not to be enough to serve the mobile communities: two health extension workers per kebele, is not enough to reach the widely scattered households (39). Facilities and physicians are sparsely located and large geographic distances have to be overcome (47). AYSRH services are even more sparsely located and access is limited (57). Culturally, unfriendliness and non-acceptance of harmless traditional customs of some health workers discouraged women from

seeking care at health facilities (39). But also, for some health workers proper skills were thought to be lacking and so the confidence to handle. Lack of equipment, supplies, and drugs and lack of privacy were also mentioned (39). Both et al (2013) explained that many formal health care workers in Afar were not ethnically Afar themselves nor did they speak the language nor did they know the Afar customs which made it difficult to relate to them (82). Further, knowledge for health care workers on addressing SGBV in health facilities was generally not present (62). Jones (2020) wrote that at health clinics there was not a functional system of referrals to the BOWCYA (65).

Response of school in communities

For empowering girls averting child marriage, at schools there are girls' clubs where teachers teach girls that the minimal age for marriage is 18. Also, comprehensive sexual education (CSE) is taught at schools by teachers (66). But (fear of) violent reactions of the Afar communities towards teachers are described (65). And, girls explained that even if they understood the impact of early marriage, the problem was they had no capacity to say no to their parents when they had arranged to marry them (65). Also, the system of referrals from school to the BOWCYA for adolescent girls suffering from SGBV was usually not functional (65).

5.4 Societal factors

Pastoralist societies and SGBV

Around the world, tens of millions of pastoralists are found, which for 60% live in the African continent (83,84). In 2019, the pastoralist number in Ethiopia, was estimated to be 15 million, covering 60% of the total national landmass of Ethiopia (45). The most important pastoralist communities in Ethiopia are the Somali (53%), Afar (29%) and Borana (10%) (83). Pastoralists share common features all over the world. Pastoralists communities are usually politically and economically marginalized due to their way of life consisting of economic activities revolving around the herding and care of livestock and have the lowest access for basic public services such as education and human health services (72,74,83,84). They have a very low representation in national political processes (72,74,83,84). Infrastructures such as roads, telephone, markets etcetera are poorly developed. Poverty and food insecurity are wide spread (72,74,83,84). Also, access to SRH services is generally low and SGBV among pastoralists communities worldwide is high (74,81,84). Among pastoralists there are severe SGBV examples. They are described as patriarchal, displayed by women's marginalized roles, hardship, oppression and lack of power, in contrary to men's domination, ownership and power (81).

Political organization, marginalization and poverty

The Afar ethnic people were originally located in Afar region in Ethiopia, Eritrea and Djibouti (85,86). See figure 6 (85,86). Since the 20th century the Afar ethnic population was trying to restore the Afar unity across borders, but without success (85,86). After decentralization in 1991 (87) and establishment of the Afar Regional State, frequent interventions and control from the center, regional administrative incompetence and unwillingness to include Afar elites centrally have severely hampered the self-determination of Afar (85,86,88). Economically marginalization is shown in the following. Since the 1950s, the government led irrigation projects in the fertile Awash Valley were set up to encourage agricultural development, and later on more land was nationalized to create large state farms (82). Only a few Afar pastoralists were employed on the farms, many other Afar pastoralists were displaced from the riverside grazing plains that were the source of their livelihoods (82). The farms caused a substantial loss of communal pastures and increased food insecurity for a large number of pastoralists (82), especially after the El-Niño induced droughts. Food insecurity, malnourishment, internal displacement and loss of livelihood drove Afar into the lowest wealth quantiles even further (15,76).

Figure 6 Distribution of ethnic Afar population (85,86)

Both et al (2013) argued that the lack of resources in health result from a government logic that claims that the delivery of health education, health services, water and sanitation facilities are only worth investing in when pastoralists settle in sizeable permanent communities (82). Geographic isolation / remoteness, poor communication, logistical requirements and uncertain civil status makes the pastoralists often neglected (82). The political marginality hinders lobbying for better healthcare services, and cultural-linguistic marginality elicits that government installed health services are inappropriate for Afar pastoral communities as they conform to national language and culture policies (82).

Norms that support violence as an acceptable way to resolve conflicts
In Afar, physical violence to solve conflicts is an accepted way for the elders of clans in the informal administrative system (66), but also structures of hierarchy and dominance over women and children by men is supporting spousal violence and violence directed towards children (68). Because the informal system in Afar is stronger than the formal system, violent reactions from elders and clan decisions will be conducted by the (younger) adolescent men via intergenerational gender norms consistency (65).

Norms that hinder the acknowledgment of SGBV
Jones (2020) reports that in Afar there is no acknowledgement of sexual violence among girls and women themselves, among the peers, household and community members (65). If a girl reports, reactions of shame or blame come to her. She would generally not receive emotional support, but would rather be accused of exposing herself for rape, or that she had intercourse willingly (65,66). For physical violence, wife battering occurs because beating shows that a man loves a woman. Women expect to be beaten, otherwise they feel rejected (72). And acknowledgment of SGBV is haphazard in Afar society (65,66), but not different from nationally found norms. Shanko et al. found in a study done in Oromia region that only 60% of Ethiopian women in Oromia region do not recognize SGBV as a problem (89). Biftu et al (2019) showed the most common barriers to disclosure in Ethiopia were considering violence as normal/not serious for reporting, shame and embarrassment, fear of consequences of domestic violence related disclosure, perceptions that reporting does not help, lack of knowledge where to go and what to do (90). Concluding, in Ethiopia women and girls are expected to tolerate any violence and keep/maintain their partner. If she shares information to a third party, it will result in alienation, shame, embarrassment, or blame (90).

Norms that entrench male dominance over women and children
Among the clans in Afar norms are determined by the “Adda”-system. The “Adda” system restricts women in numerous ways, including decision-making, community affairs and entitlements (wealth) (31). Balehay (2018) describes that when a baby is born in an Afar family there will be gifts granted to the baby born, according the “Warsa”-practice usually animals (68). The ownership will strictly belong to the child to whom the animals were allotted at birth and things such as school accessories are bought by selling the animals given to them at birth. For female children usually half of the “normal” amount of animals will be assigned to them (68). When a girl gets married, the women herself will not own any asset: 1) all a woman owns before marriage (including animals) will be given to her husband, 2) all a woman earns by handcraft (floor mats, ropes and sacks) will be for her family, 3) at divorce a women is not entitled to share in household asset, 4) if the husband dies, the women will be married by a close relative and the household asset will go to her next husband (“Hixu-practice”) (65,68,91). Women should follow what is decided by men with submission, regardless whether it affects their well-being positively or negatively (31). Women and daughters have low capacity to decide in selling or buying animals or grains, mobility and health care decisions (30,68). For quality and quantity food, access is generally given with priority to boys and men (68,76). Women are sometimes considered unclean (menstrual period and after delivery), and then they are not allowed to eat or drink animal products nor look or touch animals (68).

Chapter 6 Health system response for Sexual and Gender-Based Violence among female adolescents in Afar

This chapter presents interventions found from government side, NGOs (AMREF, APDA, CARE, UNICEF and UNFPA) and Civil Society Organisations (CSOs) for addressing SGBV for adolescents in Afar.

6.1 Policies and legal framework at national level

In Ethiopia, in around 15 years' time, the government has implemented law frameworks, guidelines and strategies for adolescents and youth (10-24 years) (22). See table 3. For SGBV the Constitution (1995) describes children's rights (article 36), including the right to be free of corporal punishment. The Ethiopian Criminal Code of 2005 addresses human rights issues, in particular women's and children's rights including the criminalization and punishment of any act of SGBV. The National Child Policy (2017) calls for children to be protected from all forms of violence. For HTPs such as CM, FGM/C and BA "The Constitution (1995)" instituted mutual consent as a principle for marriage (article 34/2), and the federal Family Law in Ethiopia (2000) revised in 2005 set the legal age at marriage at 18 and calls for the elimination of HTPs (87). The national roadmap to end CM and FGM/C (2019) contains the government's plans for elimination (87).

Table 3 Law frameworks and guidelines and strategies for adolescents and youth (22).

Law Frameworks	
1995	Constitution
2000	Family Law
2004	National Youth Policy
2005	Criminal Code
2005	Abortion Law
2010	Youth Development Package
2013	National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia
2017	National Child Policy
Guidelines and strategies	
2000	Making Pregnancy Safer
2006	Minimum standards and Service Package for the Youth
2007	National Adolescent and Youth Reproductive Health Strategy
2010	Tools for Planning, Monitoring and Implementing AYFRH Services
2013	National Strategy and Action Plan on HTPs against Woman and Children in Ethiopia
2014	Revised Technical and Procedural Guidelines for Safe Abortion Services
2019	Roadmap to end CM and FGM/C

At national level, both UNICEF and UNFPA played a strong role in helping to set government agendas (92,93). For example, the National Strategy and Action Plan on HTPs against Women and Children in Ethiopia 2013 launched by the MOWCYA (92,93). For law enforcement, the Ethiopian Women Lawyers Association (EWLA) and the Ethiopian Human Rights Commission (the national human rights institution directly accountable to parliament) were installed (87). Gaps to address described by the Ethiopian Women Lawyers Association (2018) and Jones et al (2020) are: measures to proscribe marital rape, a comprehensive definition of domestic violence, economic and psychological violence, sexual harassment, and stalking. Also, the absence of civil remedies for victims of violence nor procedures to obtain protection (65,94).

6.2 Enforcing formal legal framework and awareness raising activities

In the 2000s APDA taught Traditional Birth Attendants (TBAs) who had stopped practicing FGM/C, to discuss and assist others to do the same. They were having discussions with religious leaders, local extension workers and community health workers. The TBAs visited all households they knew after childbirth and attend community celebrations such as weddings and funerals, to facilitate community discussions on the matter. The TBAs appreciated the importance given to them in this role as community members were often referring to them as 'women of wisdom' (81).

Since 2006, UNICEF in partnership with Rohi Weddu Pastoral Women Development Organisation and BOWCYA had been implementing activities for the abandonment of FGM/C. They provided trainings in communities together with the regional advocacy group composed of Afar region Muslim Affairs Supreme Council, Women Affairs, Health and Justice Bureaus (16). Radio dialogues and spot messages on the radio were also supported (16). This resulted in a public declaration of the abandonment of FGM/C for nine woredas (including Gewane, Amibara and Awash Fentale) (16).

Mohamed described already in 2007 that involving religious leaders and connecting communities with health and justice bureaus prevented parents from performing FGM/C (72). The joint UNFPA – UNICEF program (2008-2017) and APDA still worked together with religious leaders, (former) circumcisers, local administrators, clan leaders, and the local judges in Afar (93). In the GAGE study (2019) infibulation was seen less due to religious leaders informing communities about FGM/C (66).

6.3 Health care response

In the first National Adolescent and Youth Health Strategy (2006-2015) the need for quality and tailored reproductive health services for young people was recognized and AYSRH services were an integral part of the Health Extension Package (HEP) (22). In the National Adolescent and Youth Health Strategy (2016-2020) reproductive, maternal, newborn, and child health interventions were added (22). And, as among adolescents unintended pregnancies, abortions and unmet contraception need were high (30%), the government committed to expand AYSRH services with family planning (Family Planning 2020 commitment) (22). However, in 2017 the coverage of AYSRH services in public health facilities was only 44.8% nationally and for Afar these services were lacking behind even more (22).

In 2010 woreda selected HEWs were not enough to serve the Afar communities (39), and in 2015, the Health Development Army (HAD) was not readily installed in Afar yet (50). In response to the human resource gap during the last decades APDA trained TBAs in Afar to become HEWs. APDA worked in cooperation with the RHB of Afar, and the RHB certified the 6-month course (81). At 2020, totally 139 HEWs were trained and still working for APDA in communities (46,81). The HEWs presence in the kebeles and provision of personalized services as a component of the HEP was highly valued by communities (51). Alongside, in 2019, totally 270 TBAs were trained and employed to teach in their communities about hygiene, sanitation, nutrition, safe motherhood, HIV prevention, and stopping HTPs. These women were called Women Extension Workers (WEWs) (51). WEWs worked alongside APDAs trained HEWs. Next to that another 450 traditional birth attendants (TBAs) were networked to the HEWs and WEWs (46,81). Jackson wrote in two evaluating qualitative studies that even though the level of education was less of the HEWs trained by APDA than the HEWs trained by the government, still the APDAs trained HEWs and WEWs had a higher retention rate they are happy to work in the Afar community (49,51,52).

In 2010, the SRHR alliance encompassing five Dutch organisations (Rutgers WPF, AMREF, Simavi, dance4life and Choice) formed the Unite for Body Rights program (UFBRP). Between 2011-2015 government trained HEWs and health professionals in health facilities were supported in their capacity to provide AYSRH services and improve the linkage between HEWs and health centers (48). Also, in health centers professionals were trained on SRHR / SGBV issues and counselling of victims of SGBV (48). In 2018, in the A'AGO project, EngenderHealth Inc and AMREF collaborated with RHBs (except in zone 2) to train government HEWs and health professionals in health facilities on AYSRH services and referral to BOWCYA (62). Also, health professionals received training on comprehensive contraception and comprehensive abortion care service (62). Baseline assessment identified the lack of availability of basic equipment for HEWs, power problems at health posts and shortage of delivery kits. As a response there were Philips backpacks (containing different equipment such as solar, mobile doppler) distributed. Health facilities were equipped with basic medical instruments (IUCD, implant and manual vacuum aspiration) (62).

6.4 One-stop center

The most widespread program that directly addresses IPV in Ethiopia is shelter provision for women and girl survivors of SGBV (73). At this time, there are twelve shelters in Ethiopia; five in Addis Ababa, two in Benishangul Gumuz, one in Amhara, two in Oromio, one in Dire Dawa and on in SNNP (73). All shelters provide basic food and shelter services, while services like healthcare, income-generating

activity training and legal aid vary between shelters (73). After UNWOMEN lobbied for more shelters in Ethiopia (95), a one-stop center was built and installed in Afar in 2020 (96). The one-stop center offers medical treatment, psychosocial and legal services for survivors of SGBV and is built at Dubti General Hospital (96). Partnership for implementation was with Project HOPE, Intra Health International, General Electric and USAID (96).

6.5 Education, school clubs and comprehensive sexual education

In order to reach equity of educational opportunities irrespective of distinction of sex, race, tribe or nationality, a national education and training policy in 1994 was created (71). To achieve the ultimate goal of universal primary education (8 years) by the year 2015 the policy allowed a localized curriculum and the use of local languages as a medium of instruction at primary education (71).
In Assayita the College of Teachers Education was established in 2007 with the vision of reducing the shortage of primary school teachers and equip them with skills and competencies and deliver on the job training to improve capacity (48). Unfortunately, a shortage of teachers is still there (71).
Also, in Afar teaching programs were not adapted to the Afar culture and language and most teachers in Afar were (culturally and linguistic) different, originating from other regions (71).

School clubs held by teachers were supported by different organizations. UNICEF and UNFPA (2008 – 2017) held activities consisting of peer education, school clubs and 'edutainment', focusing on HIV prevention, BA, CM, FGM/C, and rape (73). After evaluation the program had increased mutual respect between sexual partners and changed men's attitudes and behavior (73). Between 2011 – 2015, CARE worked together with AMREF on diverse strategies: 1) gender transformation school clubs with both joint and separate sessions for boys and girls. These clubs were managed by a female and male teacher, reporting the head of the school and with links to the parent-teacher associations and were used to discuss SRHR topics for adolescents; 2) providing separate latrines for girls in 4 schools, with one cubicle adapted for menstrual hygiene needs with sanitary products (reusable pads) were purchased and distributed to raise girls' awareness of options (62,97).

Since comprehensive sexual education (CSE) was incorporated in the NAYHS 2016-2020 in Ethiopia the CSE program was rolled out in all primary schools (22). The Sexuality Education Curriculum "the World Starts With Me" (WSWM) was adjusted and over 20.000 teachers were trained to teach the curriculum(22). The curriculum was designed to learn about the cognitive, emotional, physical and social aspects of sexuality and to equip children and young people with knowledge, skills, attitudes and values to realize quality sexual and reproductive health (98). In Ethiopia, since 2016, the Research Education Center (REC) trained teachers in Afar in the CSE program in zone 1 (Assaita) and 2 (Berhale) for 5-8 grade students. The CSE was culturally contextualized and the lessons were taught in Amharic and Afar (manuals). In 2018, the A'AGO program by EngenderHealth applied the WSWM curriculum in schools in zone 1, 3, 4 and 5 (62).

6.6 Intersectoral Partnerships

Although centrally laws and policies are installed, enforcement of these and connections between education, health and justice sectors are trailing behind (ie MOWCYA, MOE and MOH and its regional bureaus). Investments in delivery of (AY)SRH services at community level and in health facilities was done. However, in 2017 these services were still sparse, understaffed and undertrained and not well connected with BOWCYA. Also, some trainings of HEWs and in-facility health professionals (for example by AMREF) were based on national guidelines and not Afar cultural and linguistic adjusted.
In the education sector, the same phenomenon happens, teachers were sparse, mostly from other regions and the curriculum was not culturally and linguistic adjusted to Afar students. In the justice sector police is understaffed and not trained to handle SGBV cases enough. Also, where community and religious leaders that are included in programs which seems to be most effective in addressing diverse SGBV topics, the connections between these with the regional bureaus is sparse.

Chapter 7 Best practices and lessons learned for addressing Sexual and Gender-Based Violence among female adolescents in pastoralist communities

In this chapter best practices for SGBV among adolescents in pastoralist communities worldwide are explored.

7.1 Enforcing formal legal framework and awareness raising activities

In Ethiopia-Somali from February 2016 - March 2017 the Islamic Relief organization conducted a program for Combating GBV of Women and Girls (99). First, community volunteers and religious leaders were trained and were engaging with communities after. Discussed were the causes and consequences of SGBV and the rights of women and girls that are enshrined in the Holy Qur'an and within Ethiopia Family Law. The female volunteers received orientation on how to discreetly identify and report violence victims. Second, multi-stakeholder local meetings, reinforcing political commitment to end SGBV and building synergies with national legal frameworks were held. And health centers and health posts that supported information provision on SGBV prevention and how to respond to cases were linked with Woreda Women Children and Youth Affairs Office (WCYO) (99). The Woreda WCYO which was vacant at the start of the project, was running smoothly after the intervention (99). Positive reactions reported included: issues such as the act of a widowed woman marrying her husband's brother for inheritance purposes were refuted by religious leaders and women were claiming the dowry/wealth, they never received. And, after discussions on the importance of women's education, which dismantled the myth that women should not study, the women demanded adult literacy programs from the Woreda education office. FGM/C practitioners declared that they would stop this practice as deforming the human body is a major sin (99).

Another example where the entire community and later society was helping to tackle FGM/C was shown by the initiative of Tostan in the 1980s in Senegal. After a rural village empowerment program, women and men at grassroot level discussed with religious leaders (imam) the pros and cons about FMG/C. After discussions they jointly decided to stop FGM/C and have their own joint declaration of abolishment. This declaration was nationally publicized and more communities abolished FGM/C in the same way. In the held discussions FGM/C was not condemned but talked through, men where actively involved and imams were guiding discussions. Later when the government tried to prohibit FGM/C nationally there were more protest actions. Later it was abolished nationally but after discussions at grass root level again. The abandonment of FGM/C was made national and the program is even replicated in Sudan and Mali (81,100).

7.2 Health care response

For nomadic youths in Kenya AMREF launched the Nomadic Youth Reproductive Health Project. Creating safe environments where young women can share their concerns and ask questions about reproductive health is an effective strategy to improve perceptions about the services (101). Participatory tool mapping of nomadic populations was done in Chad to get insight into beliefs regarding reproductive health and could act as an essential tool to educate nomads about modern family planning (84).

A mobile healthcare system by AMREF and the Kenyan Ministry of Health had improved the needs of Maasai. The mobile health clinic provided essential drugs and services for treating common medical problems and moved between settlements in pastoral zones for 2 weeks at a time (102).

In Kenya, among pastoralist women, an increased desire for more mHealth resources was expressed. The increasing uptake of mobile devices among young people around the globe could open up opportunities to distribute reproductive health information, and link these populations to health care systems (103). However, even though a large proportion of nomadic families had access to mobile devices in northern Kenya, relatively few women could read, and therefore were more limited in their ability to use the devices to access health information (103).

7.3 Education and school clubs

A study of nomadic women in Tibet revealed that the more educated women were, women were more likely to seek modern reproductive healthcare (104). The ability to read can increase a woman's access to health materials in innumerable ways by enabling her to utilize written information about health care (104). Flintan (2008) argued that improved literacy, with increasing prevalence of mobile devices can be leveraged in many ways to provide reproductive health information to nomadic women. Increased education for girls can improve social conditions in communities in general and have positive effects on access to SRH services (84). Improved school attendance among nomadic youth and availability of income-generating activities for nomadic women increased autonomy and are among the recommended strategies to improve reproductive health for nomads (84).

In the Islamic relief program also gender clubs were installed supporting girls' protection from violence and abuse and providing culturally and linguistic adjusted material and psychosocial support. They worked together with their school principals and the Woreda education office. Girls that had dropped out from school were identified and after discussion with school and Woreda education office they were able to bring girls back to school (99).

7.4 Integration in the Afar society

Improving intersectoral connections between woreda education offices and school principals had been encouraged already by AMREF in Afar, but identification of girls that had dropped out and bringing them back to school was not yet described (62,97). In the example of Islamic Relief connections where made between health and education sector and the Woreda WCYO. By this cooperation dropped-out girls where tracked, WCYO talked with parents and caused girls to come back to school (99). Looking at this example it showed that integration and connection of BOWCYA with the health and education sectors could possibly improve AYSRH in Afar. Also, making use of a mobile health clinic could connect the adolescent girls through the health sector with the Woreda WCYO. It could contribute to less "losing sight of families that have moved after conflict situations". Strategies on investing in more culturally and linguistic appropriate education and health sector programs has not been found in the literature in other pastoral societies. But, as Afar representatives in the Ethiopian government are integrated and Afar language is acknowledged as an official language, developments in education and health sector programs and a better connection of Afar to the central government can be expected.

In the example of the Tostan initiative an empowerment program created opportunity for men and women to have discussions with religious leaders and decide their own agreements about FGM/C (81). As religion seems to be playing a big role for norms change at society level in Afar, engagement of religious and clan leaders in discussion plays a key factor. UNFPA, UNICEF, APDA and Islamic relief all engaged religious leaders and community leaders in changing norms at societal level (16,81,93). The Islamic Relief in Ethiopia-Somali region communicated in Somali language and culturally adjusted and with help of religious and community leaders addressed also the interrelational position between men and women. For communities in Afar this could be investigated for applicability. Interventions on the change of the acceptance of wife beating in pastoral societies has not been found in the literature yet. But discussions have been held about the age at marriage for adolescent girls. Local empowerment programs could be encouraged further to discuss HTPs more at community and societal level. As interventions (such as school clubs) only intervene at the individual level and are described earlier as non-effective as a single intervention to stop girls dropping out of school, addressing gender norms at community level could enhance a change of gender norms at individual, interrelational and societal level.

Chapter 8 Discussion

In this chapter findings of previous chapters, interventions and recommendations will be discussed.

8.1 Magnitude and influencing factors of SGBV among female adolescents in Afar

Proof of rape for female adolescents and sexual relationship by force is described. Also, physical violence (even though by adolescents in Afar less reported), seems to be normal. For HTPs: incidence of BA is unknown, CM is omniprevalent and not decreasing, FGM/C is increasing in the younger age-group. In general we have seen that SGBV among adolescents is underreported due to 1) the type of studies done 2) the normalcy of violence among adolescents in Afar 3) the consequences of reporting SGBV for female adolescents. Questionnaires (such as those used for the EDHS) instead of interviews were not appropriate to identify physical or sexual violence due to the sensitivity of the topic. Such questionnaires might be useful measuring age at marriage and FGM/C, but not for sexual physical or psychological violence among adolescent girls. Also, the consequences for girls to acknowledge SGBV and report might be destructive for her own (mental) health. As long as SGBV is not readily acknowledged at society level, adolescent girls in Afar might acknowledge SGBV themselves, but they will not have enough tools to defend themselves. In the following section the factors influencing SGBV among female adolescents in Afar will be discussed according the conceptual framework of Krug.

Individual factors

Individual factors influencing SGBV among female adolescents in Afar are low educational attainment, rural residence, lowest wealth quintile, low work opportunities and religion (Muslim). All factors are common among most female adolescents in Afar. Education attainment opportunities and rural residence are affecting all types of violence. But in Afar, rural residency and nomadic life style are not easily addressed. With the tentative goal to achieve universal coverage for education the government built many schools in Afar and teachers are placed in rural areas. But the migrating life style prevents children from going to school, as this can be geographically impossible. Inflexible school schedules increases this further. Then, as the education system is not sufficiently responding to the cultural needs and occupations of Afar communities, the parents and children will even be less motivated to make sure the children attend school. Taken together with the gender norms that parents find it more important for girls to be working on their chores in the house, not acknowledging the importance of education for girls as a passport for wealth and economic power, attainment of education for girls in Afar is extremely difficult.

Relationship factors

Relationship factors influencing SGBV among female adolescents are norms accepting violence between husbands and their wives, between parents and children, children and their younger siblings, but also among peers. Reasons given are that hierarchy (determined by gender and age) should be respected. The use of physical violence as a tool to create this hierarchy is accepted.
The age for marriage and circumcision for adolescent girls is determined by the parents, but are actually more influenced by the community and “Absuma” himself. Marriage is connected with social status and before being able to get married, circumcision needs to be done. Although different “lighter” forms of FGM/C are accepted, religious ideas and norms in the community and relationship overtake individual rights. The same is relevant for CM. Even though some girls know (e.g. via school clubs) that they are legally not allowed to marry before 18 years, and they want to attain education longer, they have no authority to negotiate with the parents on their age of marriage.

Community factors

Religious leaders and community leaders are the most important influencers in the communities. But these leaders are influenced by the patriarchic “Adda”-system where the elderly men determine the woman’s authority and entitlements. Reporting SGBV will be at the religious and community leaders

side and will not easily pass to the BOWCYA. As acceptance of individuals and families by their communities is highly important and functional for physical and financial protection, there is a higher pressure for families to respond and obey to the religious and community leaders. Therefore, reporting at the formal justice system is hardly done, as this may possibly have severe consequences for the girl and her family. But íf reporting is done, and if the families are strong enough to bypass their community leaders, then other problems are described. Experiences of lacking basic infrastructure, few child-friendly and gender-sensitive approaches trained staff and difficult follow-up due to migration of families (as mostly decided by their community leaders) are reported. Then, when formal health care nor education is well connected with the Afar communities nor was there a functional system of referrals described between them and BOWCYA, female adolescents confronted with SGBV have no place to go. The cultural and linguistic gap between health workers or teachers and female adolescents is increasing the problem even further.

Societal factors
Economic and political oppression and marginalization by the Ethiopian government in the last decades is contributing to SGBV for female adolescents in Afar even further. Attempts of the Afar population to raise a unified Afar nation (including Afar in Djibouti and Eritrea) has not succeeded (85,86). And last decades in the Ethiopian Government chairs for Afar representatives were officially assigned but representatives were not present (88). (AY)SRH issues and needs could not be advocated for at central level. For decades pastoralist communities in Ethiopia were marginalized and oppressed and government led programs for education and health and its interventions were not culturally and linguistic sensitive and created a larger gap in SRH for female adolescents in Afar. Norms that entrench male dominance over women and children and support violence as an acceptable way to solve conflicts and hinder acknowledgment of SGBV increased this gap even further. However, last two years the change has come that Afar (and female) representatives are included in the government and Afar language is acknowledged as an official language in Ethiopia. This created opportunities to invest in decreasing this gap.

8.2 Interventions for SGBV among adolescents in Afar and best practices in pastoralist communities applicable

Policies and legal framework at national level
Although politically the government of Ethiopia has set out quite a number of laws addressing SGBV, supported by UNICEF and UNFPA. However, there are still a few gaps described (such as domestic violence and marital rape) and progression is needed to address these as well.

Enforcing formal legal framework and awareness raising activities
Gaps in the formal justice system in Afar such as the lack of basic infrastructure, few SGBV trained personnel in police and justice sectors, and difficult follow-up of cases due to migration of families are mentioned before. The positive example from Islamic relief example in Ethiopia-Somali showed investment in capacity building of police and Woreda Women Children and Youth Affairs Offices (WCYO). Also, health workers and teachers were effectively linked with BOWCYA. These measures instantly increased the number of girls attending school. But moreover, what has shown to be effective already was involving religious leaders and community leaders to address CM and FGM/C. A change of type of FGM/C (less severe form) due to teaching of religious leaders was already described in some articles. From the Tostan Inititative one can learn that initiating change should preferably not be forced by the government but come from discussions at grass root level. The Islamic Relief did the same by stimulating discussions on education and wealth for women. Including religious and community leaders in these discussions is trivial.

Health care response in communities and health facilities
The HEP implemented by the government in 2003 and elaborated on later was a strong attempt to reduce the human resource health care gap in the rural areas, but unfortunately in Afar this still results in not enough HEWs to cover the mobile society in Afar. Also, the HDA was not implemented by government trained HEWs yet. It can be debated whether this was caused by a cultural and linguistic gap between governmental HEWs and Afar ethnic population. To fill the gap, APDA has trained TBAs into WEWs, that are more trusted and accepted by the Afar communities, and HEWs in cooperation with the RHB. Even though the level of education of APDA trained HEWs was reported to be less than government trained HEWs, the cultural and linguistic gap between the HEWs and Afar ethnic population was small and attainment of these HEWs high.
For training of the HEWs, physicians, midwives and nurses, the SRHR alliance UFBR and EngenderHealth A'AGO projects were conducted. Even a one-stop center is built. Learning point described by EngenderHealth on the A'AGO project was to include Afar ethnic health care workers in the future to identify needs better (participatory tool mapping), and to use culturally sensitive approaches. Another strategy learned from AMREF Kenya are that mobile clinics travelling around connected with the formal health care could improve health care outcome for public health and in this case opportunities for delivery of (recent expanded) AYSRH services. Also, the mobile clinics could support tracking families that have been migrating and connect them with BOWYCA.

Education, school clubs and comprehensive sexuality education
Because of the lack of teachers and school facilities and geographic distances, the Assayita College of Teachers was installed. However, human resources were still lacking and school programs were not flexible nor applicable to children / adolescents with Afar pastoralist lifestyle. Now the Afar language is officially acknowledged, delivering linguistic and culturally appropriate teaching programs that are flexible to the Afar lifestyle could increase the attendance rate at school. Smooth cooperation between the education sector with the BOWCYA could help to track dropped out girls and get them back to school (such as in the example by Islamic Relief). Also, delivering information and support at school clubs in Afar language and with Afar IEC materials could empower Afar adolescents, together with CSE in Afar language. Although education of adolescents at individual level alone will not be effective enough to tackle SGBV (as community and society norms are more important to them and should be addressed at these levels first), still these are essential in strategies.

8.3 Limitations and strengths

Limitations and strengths of conceptual framework
Using the conceptual framework of Krug made it possible to distinguish between the size of influence of different factors related to SGBV among female adolescents in Afar. By splitting them up in different layers it was easier to analyze them. Limitations are the missing options of analyzing and discussing strategies and interventions to tackle the SGBV. In the framework of the GAGE study these were added, but in a less applicable way.

Limitations of researcher
Even though the researcher has worked in Afar for a year, she has no Afar ethnic background, nor could documents in Amharic or Afar language be read. This means that for validation of information restrictions were found. Due to internet connection blockage by the government in Ethiopia during data collection process, information could not be validated by key informants or professionals working in Afar.

Chapter 9 Conclusions and recommendations

In this chapter conclusions and recommendations for addressing SGBV for female adolescents in Afar will be given.

9.1 Conclusions

Even though identification of sexual, physical and psychological violence is complicated and few (mostly qualitative) data is published, evidence for sexual and physical violence among female adolescents is found. For HTPs the literature is clear: nationally these are among the highest.

Indeed, the causes for SGBV in Afar are multi-dimensional, including social, economic, cultural, political and religious factors. In Afar, low gender equality, low women empowerment and high patriarchal structures are equally prevalent but culturally not expressed the same as in the other ethnic groups in (the highlands of) Ethiopia. In Afar, on individual level, especially low educational attainment, is determining a higher risk for sexual and physical violence, CM and FGM/C. However, the low educational attainment cannot be tackled at individual level as this is connected with factors in the relationship, community and societal spheres. At relationship level, families and peer groups use violence to set out hierarchy rules. At community level, the rules are determined by elders and community leaders and consecutively engrained in the Afar (pastoralist) society. The traditional administrative system is stronger than the formal legal framework and gaps between the central government (and education, health and justice sector) and the Afar society are enormous.

For interventions, laws and policies are nationally installed and progressing. Programs on improving human resources and quality in delivery of AYSRH services are conducted and religious and community leaders are engaged in these programs and have shown to be effective in addressing AYSRH for female adolescents in Afar. However, some of the programs were not yet culturally and linguistically adjusted to the Afar communities and intersectoral connections trailing behind.

At this point, politically, Afar representatives are now present in the government. Also, Afar is acknowledged as an official language. The programs can be adjusted now in health, education and justice sectors and can be taken a step further by improving the connections between health, education and justice sectors with BOWCYA at regional level and Woreda WCYO. In the health sector mobile clinics and use of mHealth (as all families have cellphones) could address the human resource gaps, deliver AYSRH services in the most rural places, and connect " lost" families back to Woreda WCYO or BOWCYA. In the education sector, Afar adjusted programs could facilitate more children and adolescents for school. School clubs would be more functional when teachers would be more connected with Woreda WCYO and dropped out girls could be brought back to school. This is also applicable to the justice sector.

Empowerment programs for addressing HTPs at grassroot level involving community and religious leaders could direct into a further change of norms at society level. APDA, Islam Relief, and Rohu Wedda initiatives showed already a change in their communities. Connecting community and religious leaders with Woreda WCYO could elicit a tremendous change.

9.2 Recommendations

Short term:

- Justice sector/NGOs (UNFPA/UNICEF/EWLA): collaborate on implementation of missing laws such as on domestic violence and marital rape.
- Education sector/NGOs (UNFPA/UNICEF/AMREF/Rohi Weddu): develop culturally and linguistically adjusted program and train teachers to teach these programs adjusted to Afar seasonal occupations (i.e. herding).

- Education sector/NGOs (UNFPA/UNICEF/AMREF/Rohi Weddu): connect teachers effectively with Woreda WCYO to address drop-outs.
- Health sector/NGOs (AMREF): participatory tool mapping, training workers how to deal with SGBV and improve connections with Woreda WCYO and BOWCYA.
- Health sector/NGOs (AMREF/APDA): install mobile clinics that are connected with Woreda WCYO and BOWCYA.
- Justice sector/NGOs (AMREF/APDA/Rohi Weddu): participatory tool mapping, training workers how to deal with SGBV and improve connections with Woreda WCYO and BOWCYA.
- Empowerment programs (UNFPA/UNICEF/AMREF/APDA/Rohi Weddu): conduct programs at grass-root level involving men, women, and trained religious leaders to address HTPs, gender norms. Improve connections between community and religious leaders and Woreda WCYO and BOWCYA.

Medium/long term:

- MOH/MOE/MWCYA: Oversee programs, anticipate and design plan for expansion of programs from woreda to zonal level up to regional level in Afar.
- MoH/MoE/MWCYA: Oversee improved connections and governance at Woreda WCYO and BOWCYA.

Long term:

- MOH/MOE/MWCYA: report from regional level and influence advocacy at central level for health, education and justice at regional and woreda level in Afar.
- MOH/MOE/MWCYA: take feedback of report to evaluate expansion of feasible strategies to other pastoral societies in other regions of Ethiopia.

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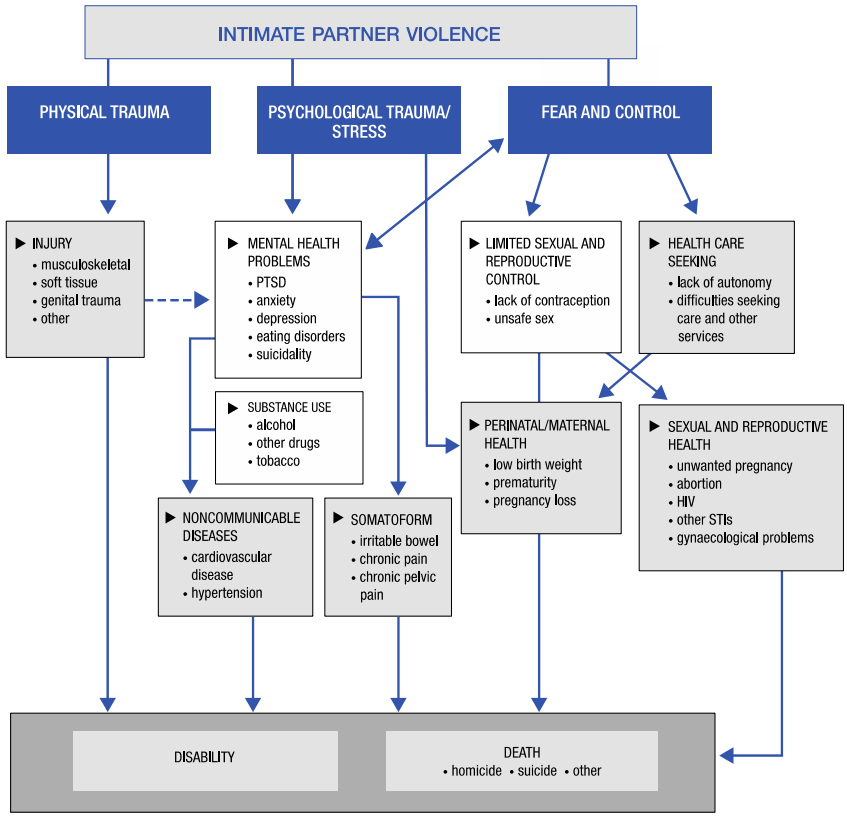
Annexes

Annex 1: Consequences of violence

Figure 1. Pathways and health effects on intimate partner violence

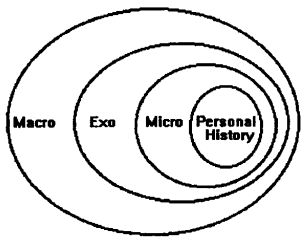


There are multiple pathways through which intimate partner violence can lead to adverse health outcomes. This figure highlights three key mechanisms and pathways that can explain many of these outcomes. Mental health problems and substance use might result directly from any of the three mechanisms, which might, in turn, increase health risks. However, mental health problems and substance use are not necessarily a precondition for subsequent health effects, and will not always lie in the pathway to adverse health.

Source: Garcia-Moreno, 2013 (5)

Annex 2: The socio-ecologic model of Heise (1998) (6)

The innermost circle represents personal history factors. The next circle, the micro-system, represents the immediate context in which abuse takes place – frequently the family or other intimate or acquaintance relationship. The third level, exo- or mesosystem, encompasses institutions and social structures both formal and informal such as extended family, network of peers, work, neighborhood, social networks, identity groups, but also, police, courts and social services. The macrosystem represents the general views and attitudes that permeate the culture at large.



Personal History

- o Witnessing marital violence as a child
- o Being abused oneself as a child
- o Absent or rejecting father

Microsystem

- o Male dominance in the family
- o Male control of wealth in the family
- o Use of alcohol
- o Marital/verbal conflict

Exosystem

- o Low socioeconomic status/unemployment
- o Isolation of woman and family
- o Delinquent peer associations

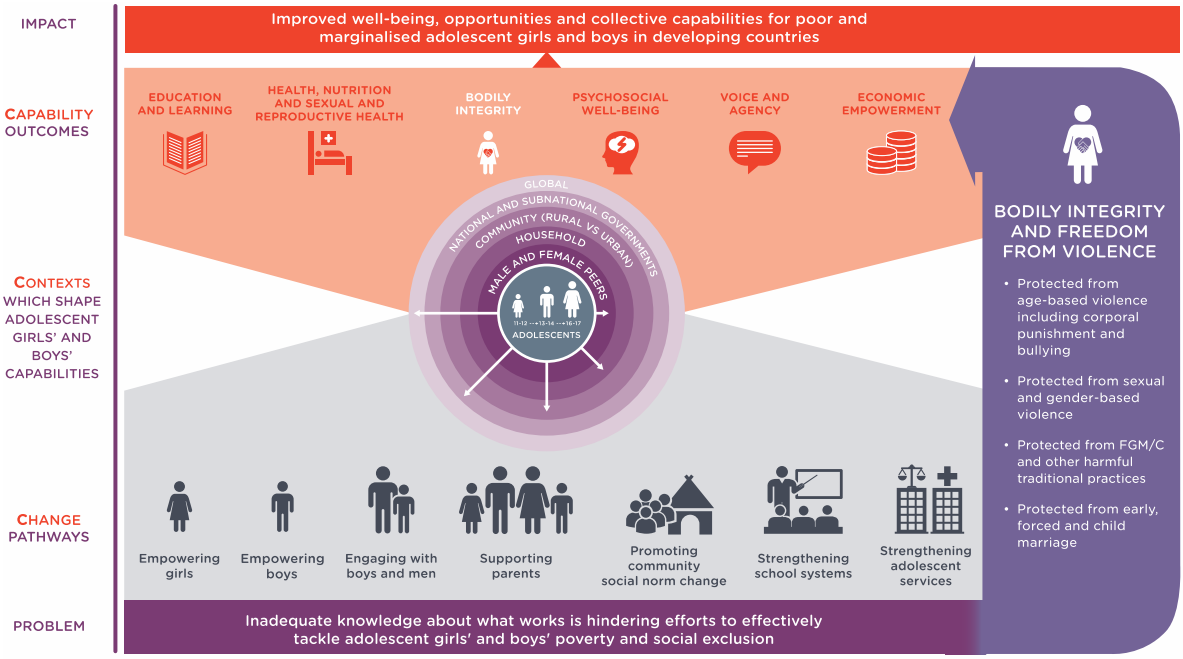
Macrosystem

- o Male entitlement/ownership of women
- o Masculinity linked to aggression and dominance
- o Rigid gender roles
- o Acceptance of interpersonal violence
- o Acceptance of physical chastisement

Figure 1: Factors related to violence against women at different levels of the social ecology

Annex 3: the socio-ecological model of Jones (2019) (66)

Figure 1: GAGE conceptual framework



Source: GAGE Consortium, 2019 forthcoming