Good Practices and Lessons Learned from the UNFPA Supported

Prevention and Management of Gender Based Violence in Ethiopia

Programme

UNFPA

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Acknowledgments

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List of Acronyms

ADA - Amhara Development Association

AIDS- Acquired Immunodeficiency Syndrome

AWSAD – Association for Women's Sanctuary and Development

BIGA- Bright Image for Generation Association

CC - Community Conversation

DOC- Daughters of Charity

EDHS Ethiopian Demographic and Health Survey

ESOG - Ethiopian Society of Obstetricians and Gynecologists

FBOs– Faith Based Organizations

FGD- Focus Group Discussion

FGM- Female Genital Mutilation

GBV - Gender Based Violence

HIV – Human Immunodeficiency Virus

HTP - Harmful Traditional Practices

IRCE – Inter-Religious Council of Ethiopia

MLWDA – Mujejeguwa-Loka Women Development Association

MCRC – Mother and Child Rehabilitation Center

NCA - Norwegian Church Aid

NCWH - National Coalition for Women Against HIV/AIDS

ODA - Oromo Development Association

OSSA – Organization for Social Services, Health and Development

RH- Reproductive Health

SRH- Sexual and Reproductive Health

ToR- Terms of Reference

WAC- Woreda Advisory Committee

WDA- Women Development Army

UNDAF – United Nations Development Assistance Framework

UNFPA - United Nations Population Fund

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1. Background

Gender Based Violence (GBV), including different forms of harmful traditional practices, are widely practiced in Ethiopia with regional variations. Even if lack of data has been a hindrance to fully grasp the circumstances, reasons, consequences and impact of violence against women in the country, the limited studies conducted have shown that the problem exists in different forms both in rural and urban areas.

The government has adopted legal and policy frameworks to address the problem of GBV in Ethiopia. Furthermore, institutional structures including specialized units dealing with the problem of GBV have been established at different levels of government. However, because the practice of GBV is very much intertwined with long held and practiced cultural, traditional and religious beliefs, the problem still is quite pervasive.

GBV causes untold human suffering and has a profound effect on our communities. In addition to the health and human rights implications, violence prevents survivors from fully contributing to their communities. Survivors of GBV need access to support systems like legal aid, shelters, medical and psycho-social support. The policy framework in Ethiopia provides for a multi-sectoral approach whereby various sectors including non-governmental organizations can come together to provide the required package of support.

As part of the overall effort to improve the response and prevention mechanism, UNFPA has been supporting implementation of a programme entitled *Prevention and Management of Gender Based Violence* with the objective of strengthening community response to promote and protect the rights of women and girls in relation to harmful traditional practices and gender-based violence; strengthening institutional response to address harmful traditional practices and gender-based violence; and provide information and services to survivors of gender-based violence, including within a humanitarian context. This was aligned with the UNDAF Outcome that "by 2015, women, youth and children are increasingly protected and rehabilitated from abuse, violence, exploitation and discrimination". The programme funded by the Royal Netherlands Embassy was implemented together with implementing partners – 11 NGOs and 1 Governmental Organization operating in six Regions of the country (Amhara, Oromiya, SNNPR, Tigray, Benishangul-Gumuz and Addis Ababa). The time frame for the implementation of the programme – October 2012-December 2015 was used as the basis for the documentation of good practices and lessons learnt.

Although various programme are implemented through various actors in different parts of the country, studies[1] show that the coverage of the services (both governmental and non-governmental) is not adequate compared to the extent and gravity of the problem. Furthermore, the inadequacy also extends to the lack of documentation which captures what went into programmes towards achieving changes/positive results that can inform potential replication of programmes in different parts of the country.

With the conclusion of UNFPA's programme in 2015, it was imperative to undertake the documentation of good practices and lessons learnt in implementation of the programme so as to ensure that working strategies and approaches are adequately captured and recorded for potential use in other areas and in larger scale.

[1] See for instance, Assessment on the conditions of violence against women in Ethiopia, MOWCYA 2013; National Capacity Assessment for Prevention and Response to Gender Based Violence (GBV) in Schools, UNICEF, 2012.

2. Introduction

2.1 GBV and HTPS: the general picture in Ethiopia

The availability of adequate data and statistics on violence against women is crucial for designing and implementing effective prevention and response mechanisms. A review of secondary data shows that there are various studies on GBV covering various aspects of violence committed against women. Domestic violence is one of the most common forms of physical violence perpetrated against women in Ethiopia. It is widespread in Ethiopia. The UNFPA and Population Council conducted a study entitled *Ethiopian Gender Survey* in 2010 and found that out of a sample of 4,785 women, one out of ten had experienced physical violence from their husbands. The most common forms of physical violence include being slapped, pushed, shoved or thrown something at. Physical violence is often interlinked with psychological violence. A considerable percentage of women indicated having experienced psychological violence, in particular insults, reported among 7% of ever-married women.

The same study attempted to measure the prevalence of rape and coercion by asking respondents about the context of their first sexual experience. Their findings showed that one out of four sexually experienced women experienced sexual initiation under coercive conditions. In rural settings, this was the case of one woman out of three. Among these women, 17% were survivors of forced sexual intercourse/rape. The most common perpetrators of coercion or force were intimate partners in particular husbands. The study furthermore found that less than one out of ten survivors told someone about the unfortunate experience. Less than 3% sought medical assistance and 1.9% sought legal assistance.

CARE Ethiopia also conducted a study on the status of GBV and related services in four woredas in 2008 with a total sample size of 700 households where the household heads and the spouses were interviewed. Among the women, 36.6% have been survivors of physical violence, 76.6% have experienced sexual violence, 26. 4% were subject to emotional violence while 92% were survivors of violence related to household chores at the hands of their current or ex-partner. The most common act of violence reported by women was being slapped or having something thrown at them (34.7%), followed by being pushed or shoved (33.1%), doing something deliberately to scare her (12.8%), deprive the woman of food, water or sleep (5.7%) and threatening or actually using a gun, knife or any other weapon, and being tied up or blindfolded (4.9%). Sexual violence by partner was one of the focus areas of the same study. Findings show that 26.5% of married women have experienced some type of sexual violence in the 12 months preceding the survey. Among these women, 9% were physically forced to have intercourse.

Studies like the Ethiopian Demographic and Health Survey (EDHS) have national representation but cover limited aspects of GBV. From existing studies and national level reports, the picture shows FGM prevalence stands at 23% for the 0-14 age group in 2011 (welfare monitoring survey 2011), abduction is at 12.7% in 2009/10, and the prevalence of early marriage is at 8% in 2012/13 (Ethiopia Beijing 2014/15 report).

These and similar other studies have revealed that there is no systematic data/statistics that covers all aspects of GBV in the country. Furthermore, such a system for data/statistics collection and management is not in place yet. This has implications in terms of designing adequate response and prevention mechanisms, implementation of existing policy and legal frameworks and Furthermore prevents evidence based policy and legal revision in the country.

The underlying cause of GBV as well as the factors that increase the risk of its occurrence is ultimately attributed to the systemic gender based discrimination against women. Various studies attribute patriarchy and the systemic domination of women by men as the root cause of violence against women across

countries and cultures around the world. Other factors such as economic status, class, age, disability, and culture intersect or intertwine with patriarchy to give violence against women particular forms or manifestations. Furthermore, these factors act as immediate triggers or causes for GBV. These underlying as well as immediate causes of GBV are equally applicable in the Ethiopian context. Discriminatory practices embodied in cultural and other forms of social practices justify violence perpetrated against women in the country. Studies conducted in various parts of the country confirm this conclusion.

GBV has adverse consequences on the lives of women. These can broadly be categorized into the following: health impacts such as fistula and uterine prolapse, violations of human rights and limiting one's choices. The health impacts relate to adverse health at physical as well as psychological levels. Adverse physical health impacts include physical harm, bodily injury, and even death. The psychological impacts range from high level of stress, unhappy and unstable relationships to ostracizing by society. GBV may also have huge implications on the life choices that a woman and/or the girl child may have and exercise. HTPs such as child marriage and abduction lead to discontinuation of schooling, early pregnancy and too many children and exposure to HIV and AIDS. These occurrences tend to restrict the survivors to a pre-determined life cycle which may be difficult to change. The psychological violence also bars women from functioning to their full capacity/potential in society. GBV constitutes violations of human rights. This can be seen at different levels. The physical injury and associated health impacts amount to the violation of the security of the person. Some forms of GBV go to the extent of threatening the lives of women and children thereby affecting their right to life. Furthermore, GBV discriminates against women and the girl child and enforces their inferior status and the submissive role of women. The practice of GBV thus constitutes violations of human rights of women at multiple levels.

2.2 What is the general context under which the programme operated/was implemented?

A brief look at the context under which the programme was implemented/operated i.e. the available policy and institutional frameworks are important as these serve as either facilitating and/or barriers for adequate implementation. Furthermore, the knowledge and utilization of the available frameworks during the implementation of the programme is expected to have a bearing on the outputs.

The Ethiopian legal framework provides good level of protection against gender based violence. However, the scope of coverage of laws dealing with GBV falls short of internationally accepted

standards in some respects. Although the law addresses the major types of GBV: physical, sexual, psychological and economic violence, the coverage is not done in a comprehensive manner. For instance, in relation to physical violence, the law fails to take into account the gendered features of violence i.e. that it is violence perpetrated against women because they are women; it is committed repeatedly; it occurs in situations where the woman is under the influence of the man mainly where she is economically dependent; it is a manifestation of power of men over women etc.

In addition to the legal framework, the country has adopted the Strategic Plan for an Integrated and Multi-Sectoral Response to Violence against Women and Child Justice in Ethiopia in 2009. The strategic plan focuses on prevention, protection and response mechanisms. The plan intends to improve the situation by addressing gaps and challenges at the policy, institutional and practical level and by initiating a comprehensive multi-sectoral and integrated prevention and response to gender based violence including violence against women and children as well as child justice. In addition, the government has also adopted the National Strategy on Harmful Traditional Practices and the accompanying action plan on three major forms of HTPs: FGM, early/child marriage and abduction in 2013. The legal and policy frameworks criminalize all acts of violence against women, including all forms of harmful traditional practices and provide sanctions for their practice.

In terms of institutional framework, specialized structures within law enforcement bodies dedicated to addressing GBV have been established. The major ones are: child and women protection units in police stations responsible for handling cases of GBV; the GBV Investigation and Prosecution team (established by the Addis Ababa Bureau of Justice to handle GBV cases); and child and survivor friendly benches with the Federal First Instance Court that handle cases of GBV particularly where sexual violence cases occur in survivor friendly benches. Gender sensitive proceedings in the prosecution of GBV cases have been instituted in almost all the regional towns and Dire Dawa. In addition to law enforcement bodies, the Women and Children Affairs offices at various levels (federal, regional and woreda) level are manned with legal officers that provide advice for women on several rights related issues including GBV. The existence of these frameworks should translate into concrete measures of prosecution and punishment of perpetrators of GBV. However the situation on the ground leaves a lot to be desired.

Survivors of GBV need access to support systems like shelters, legal aid, and medical and psycho-social support. The policy framework in Ethiopia provides for a multi-sectoral approach whereby various sectors including non-governmental organizations can come together to provide the required package of support. In line with this, the government has established a one stop center. In addition, non-governmental organizations provide shelter as well as psycho-social support to survivors of GBV. Non-governmental organizations such as the Association for Women Sanctuary and Development (AWSAD), BIGA, Mother and Child Rehabilitation Center (MCRC), Mujejego Loka Women Development Assistance (MLWDA) and others go to the extent of providing skills training to enable survivors to engage in income generating activities after rehabilitation. Although the support service as stipulated in the policy framework is quite commendable, the coverage of the service (both governmental and non-governmental) is not adequate compared to the extent and gravity of the problem. Furthermore, the implementation of the multi-sectoral approach envisaged in the policy framework is quite weak. According to a study conducted in 2013 (Assessment of Conditions of Violence Against Women) key informants from participating woredas stated that there is a problem of coordination among the various sectors/stakeholders that are required to respond to GBV. One does not often see systems of cooperation and referral among the different sectors. Furthermore, women do not have adequate information regarding where they should go to/report when faced with GBV cases. As a result even where GBV is committed there is low level of reporting.

3. Approach and Methodology

At a very general/broad level, a practice is said to be 'good'[2] when it is found to lead to the desired results. It is important to note that the conditions/circumstances under which the desired results are achieved are as much important for the practice to be characterized as 'best'. The attribution of 'good' to a given practice requires standards and/or frameworks for assessment as well as adequate consideration of the prevailing local context in which the practice was undertaken.

The exercises of documenting good practices and lessons learned are very much interrelated. Examining what works i.e. what leads to the desired results is as much an investigation of why certain practices do not work. As such, documenting and applying lessons learned on what does not work and why it does not work is an integral part of a 'good practice' as it ensures that the same types of mistakes can be avoided by other programme s and projects. In light of this, this report, covers both aspects: good practices and lessons learned.

The literature on interventions targeted at reducing and/or eliminating gender based violence provides ample examples of standards/frameworks that can be used for assessing good practices. Some of the well-known standards include: transferability of practices from one intervention area to another, ease of adaptation of interventions to local particularities and available resources, establishment of and adherence to standards, principles underpinning interventions, coordination and integration of services provided by different sectors and stakeholders and the possibility of addressing all forms of violence against women.[3]

Similar to the literature, the ToR for this assignment also provides some guidance on identifying good practices. It in particular focuses on capturing practices with the most significant change. Accordingly, the standard of "what has been the most significant change in the beneficiaries as a result of their participation with prevention and management of GBV programme" has been provided as one guiding

[2] Alternatives like 'best practices' and 'promising practices' are often used in lieu of 'good practices' so as to ease the pressure of using the absolute superlative.

[3] United Nations Division for the Advancement of Women, Good Practices in Combating and Eliminating Violence against Women, Report of Expert Group Meeting, 2005.

point. This line of inquiry is set to probe into how the interventions influence not only gender based violence and its aftermath but also various aspects of gender relations that impact on prevention and response.

Taking these general guidelines in mind, the study begins by acknowledging that interventions are 'good practices' and possible 'lessons learnt' material due to a combination of factors. In light of this, it became important to examine different factors at different times and/or levels: at which level of programme implementation are the good practices to be documented (just outcome or process as well); Is the resulting outcome (and impact) due to programme inputs, activities, environment in which the project was implemented (local policy, culture, community, service providers, etc.); the experience/expertise of implementers, or other factors; is it a combination of some of these elements or is it the overall process that was inductive to resulting in the targeted outcome;what is/are the key success factor/s;are there commonalities between approaches/strategies?

With these questions in mind, the following were taken as general guiding standards/frameworks for identifying good practices and lessons learned:

- is the intervention (particular approaches/strategies employed) innovative;
- has it brought about most significant change measured not only in relation to gender based violence and its aftermath but also various aspects of gender relations that ultimately impact on prevention and response (the multiplier effect of the approach/strategy);
- is it easily replicable;
- is it efficient (value for money); and
- sustainability

The application of these standards/frameworks presupposes/requires a solid understanding of the context prior to intervention, what went into intervention and outcomes of the intervention so as to identify and document best practices vis-à-vis intended objectives.

The voices of implementing partners, beneficiaries as well as other stakeholders (for example institutions: government or non-governmental, working in coordination with implementing partners) contributed to determining what counts as good practices and possible lessons. Based on the indicative list of guiding elements above, the researchers documenting the good practices and lessons learnt also weighed in the final determination/identification for purposes of documentation.

Using a qualitative methodology, with appreciative inquiry as the guiding approach, the study looked into what worked/s well, instead of focusing on the negatives in an individual or community and trying to change them. The key data collection innovation of appreciative inquiry is the collection of people's stories of something at its best. These stories are collectively discussed in order to create new, generative ideas or images that aid in the developmental change.[4]It shifts away from the problem-oriented methods toward processes that build on community achievements, existing strengths and local skills. Appreciative inquiry allows room for emotional response as well as intellectual analysis, room for imagination as well as rational thought. The information that comes is often qualitative and in story form, but can be quite compelling. This approach is true to human nature because it integrates different ways of knowing. As such it is one of the best and preferred approaches for documenting good practices.

Qualitative methodology with the following data collection tools – document review with thematic analysis; key informant interviews and focus group discussions were employed. Key informants included: IPs

[4] See Cooperrider&Srivastva, 1987 and Bushe, G. 1998

(programme staff), beneficiaries (selected key informants), other partners like government sectors (health, justice, education, women and children affairs), grassroots operating in the intervention areas and focus group discussions targeted: women only, men only and mixed within each intervention areas.

Documenting Good Practices

What made the selected practices 'Good'? Combinations of the following elements were used to identify and document good practices.

The extent to which the interventions have been able to meet the goals/objective set out in the programme in terms of: prevention, provision/response and protection were used as a measure. In addition to the performance reports submitted by implementing partners, greater emphasis was given to the voice of beneficiaries at different levels – communities, structures and others.

Interventions may achieve their objectives but the extent to which they have been innovative, cost effective, and easily replicable as well as with the most significant change is what distinguishes the best practices from the ordinary ones. The assessment of the practices looked into these elements for the documentation.

Overall the following lists of good practices were selected for the documentation;

1. Community Conversation at work (ODA)
2. Integrating GBV in mainstream systems and structures: making the personal political (OSSA)
3. The youth as instruments of change within and beyond the Church (NCA)
4. Coordinated support services to survivors of violence (NCA)
5. Fighting GBV through grassroots structures (ADA)
6. Demystifying Fistula and Uterine Prolapse (NCWH)
7. Integrated support for survivors of GBV and HTPs (MLWDA)
8. Fighting GBV through the Media (Pro-pride)
9. Coordinated support service approach to address GBV The ESOG experience
10. Holistic shelter services for survivors as a means of rehabilitating and empowering of GBV survivors (AWSAD)
11. Schools as entry points in combating GBV sustainably (ODA , ADA &MLWDA)
12. The MCRC approach
13. The NCA Approach: FBOs as a means of raising awareness and preventing GBV

As the details of the practices show below, some of the interventions shared most of these traits while others shared some. For example, some of the interventions are strong in their innovative approach while others have scored high in bringing about most significant impact. Some of the documented practices share in all the traits in that they are also easily replicable and cost efficient.

Is the intervention Innovative? Religious focused approach by NCA and its partners and systems focused work by ESOG and OSSA were found to be innovative as both deviate from the usual approach in terms of avenues they used and final target that is regarded as sources of change. Has the intervention brought about most significant change? Results such as empowerment of women for example through the interventions of ODA, AWSAD, MLWDA, NCWH as well as changes in systems that would disrupt positively the status quo through the work of ESOG, OSSA, Pro-pride as well as ADA are documented as practices with most significant change. Is the intervention easily replicable? Where similar contexts obtain such as availability of existing youth in services etc. as is the case with the interventions of ODA, ADA and NCA interventions may be easily replicated in other areas. Is the intervention efficient, value for money? As the interventions of MLWDA, ESOG, OSSA, ODA, AWSAD, NCA, NCWH, ADA and Pro-pride show

efficient use of resources through using existing structures, good level of prior experience, effective exit strategy is possible.

4. Good practices

4.1 Community Conversation at work

Introduction

Gender based violence is one of the social ills in Oromia Regional State where ODA operated specifically Adama and the surrounding woredas - Adamitulu and Chiro. GBV in these intervention woredas takes different forms including physical violence both within the family and community context; sexual violence such as rape, psychological violence like sexual harassment and various forms of harmful traditional practices like child marriage and female genital mutilation. As is the case with the national level, getting accurate data on the prevalence and extent of GBV in Oromia is a difficult task. However, testimonials from community members as well as officials from sectors like women and children's affairs and justice in the region indicate that it is indeed a big problem.

The practice of GBV affects different sections of the population. Women constitute the major category adversely affected by the different forms of GBV. The category includes: school aged girls, married women, the elderly as well as disabled women. Men as well as boys have also been found to be targets of different forms of GBV, particularly sexual and physical violence. Although it is mainly men that are identified as perpetrators of violence, women are often cited as collaborators and enablers of the practice.

In Adama and the surrounding woredas, the practice of GBV has disrupted the normal functioning of the community. Community members described the situation as follows:

> "*We could not send our daughters on errands like to shops [small kiosks] because we could not be sure of them coming back in one piece";*

> "A day would not pass by without hearing about a dreadful attack"

"We had to plan well ahead of time regarding our travels to and from Wonji (one of the surrounding woredas) so that it would not coincide with nightfall because then it would be unthinkable to roam around safely";

"Our children (from Wonji) were frowned upon when they travelled to surrounding woredas, being referred to as the kids from the troubled area"

Representatives of responsible sectors i.e. Women and Children's Affairs and Justice Offices of Adama Woreda fully share the concerns of communities. They pointed out that cognizant of the problem and its impacts, the regional state, the concerned woredas as well as partners/stakeholders have been engaged in combatting GBV including HTPs in the said woredas. Different sets of strategies focusing on communities and implementers have been employed. While some of the interventions have been good others have not been as fruitful.

In Adamitutu and Chiro, discussions with community members revealed that the practice of different forms of GBV and HTPs have adverse impacts on the lives of women. Girls, due to the pervasive forms of violent practices, are often forced to drop out of school. GBV and HTPs are also responsible for the migration of women from their localities. Particularly in Chiro, these HTPs have resulted in heavy workload which in turn leads to uterine prolapse making it a widespread problem in the area.It is in this overall context that ODA came in with its community conversation strategy/approach to combat the problem of GBV.

ODA's Community Conversation: what went into it?

ODA started its intervention in seven woredas of the Oromia Region namely; Adamitullu, Adama, Sebeta-Hawas, Chiro and Haromaya, Karsa and Sekoru. Overall, one hundred and forty kebeles were reached through ODA's programme s. Community conversation as one of its overarching strategies was implemented in all of the intervention areas. During the life time of the project, the community conversation strategy/approach succeeded in directly reaching over 370,000 people in the intervention woredas. It is interesting to note that the overwhelming majority of those (over 225,000) that took part in community conversation sessions were women.

The process: ODA utilized women development army groups as principal entry points for its community conversations. Women development army groups constitute part of existing grassroots or community level structures that have been set up for promoting the interests of women in the economic, social and political arena. The structuring of these groups begins with the lowest level – often referred to as one-to-five groups – which are found at the lowest possible level i.e. within neighborhoods. The larger development army group consists of 25-30 households (women) which are Furthermore Furthermore organized into the "1 to 5" network of women where a model woman leads five other women within her neighborhood.

ODA recruited women leaders from development army groups. The recruits were then provided with extensive training on how to conduct community conversations in their respective localities. The trainings focused on: the basic elements of community conversations, how to target participants, and how to select topics etc.

In addition to the focus on the 'how' of community conversation, women development army leaders and members were provided training on GBV and HTPs. The training addressed identifying the different forms of GBV and HTPs in the area, the causes and consequences, response and protection mechanisms as well as advocacy towards prevention. Practical aspects in the training include, in the event of GBV and/or HTP, what are the practical steps that members of women's development army groups should take. Accordingly, development army members were taught on how to take steps to link survivors with service providers such

as Health Extension Workers as well as with sectors that provide protection like the police was all included in the training.

These trained community conversation facilitators conducted community conversations twice a month in their respective locations. People that can have influence in their communities were approached to participate in community conversations. These include: traditional leaders like Aba Geda leaders, religious leaders, women leaders, youth leaders, teachers, as well as representatives of the security sector and health extension workers.

During community conversations, coffee ceremonies are held to create the friendly and inviting environment. This practice, which used to be supported by ODA during the project's lifetime, has still continued after the phasing out of the programme. The communities prior to the ending of the programme voluntarily started to chip in their own resources to ensure continuity of the programme. Accordingly, monthly contributions were collected from participants so as to continue the programme. The money that was collected from community members is now used to sustain the community conversations

Achievements of Community Conversations

Community conversation was implemented in tandem with other strategies like house-to-house visit, referral services and making clear and direct attribution to these results a delicate exercise. However, both community participants and sector representatives are of the view that the reach of community conversation has been wide as well as transformative in challenging and disrupting long standing discriminatory gender relations which directly or indirectly impinge upon the practice of GBV including HTPs. It is this aspect of the achievement that makes community conversation stand out as one of the best practices in the fight against GBV.

Reports show that a number of planned HTPs like abduction, child marriage and FGM have been cancelled. Furthermore, reports of GBV cases have shown increase during the implementation period. Support to survivors has also been stepped up with reports showing increasing number of women receiving support ranging from health to psychological support.

In focus group discussions community representatives in Adamitulu and Chiro woredas revealed the following:

> *"In our area, FGM is done when the girl is about to get married. This is usually from age 14 onwards. But these days, due to the increase in the level of awareness in the community, the age of marriage has increased to 17 and 18. This has allowed girls to stay in school for a longer period of time. The influence of parents in pushing for early/child marriage and FGM has declined significantly. We cannot push girls to marry someone they are not interested in. They refuse. Similarly, we cannot push them to undergo FGM."*

Women that are members of development army groups and are part of the community conversation facilitators groups are taking leading a role by refusing to get their daughters circumcised. This sets good example in terms of fighting GBV and HTPs. The kebele found in Adami-Tulu woreda where the intervention has taken place has been awarded by the Oromia Region as a model kebele for its achievements in terms of having more and more girls uncircumcised.

The facilitators are also actively reporting on cases of GBV and HTPs. They create the necessary link with service providers to prevent an HTP from occurring. The following was raised as an example during focus group discussions:

> *"In Arbit village, a girl was about to get married. The parents had convinced the girl to get circumcised. While preparation was underway to get her circumcised, the village one-to five -group members came to know about it. They reported the case to the local administration. The leadership of women's development army groups and the local administration approached the parents and reasoned with them regarding the adverse consequences of HTPs like FGM. Fortunately, the parents were convinced and the planned FGM was abandoned."*

Community conversation as a vehicle for women's voice

As discussions with community members have revealed, women have been the primary victims of the practice of different forms of GBV and HTPs. Despite shouldering the pain, their voice in terms of narrating their experiences, the reasons behind as well as potential solutions to the problem has been quite minimal. This is largely due to the discriminatory traditions that deny women opportunities to participate in the public realm where changes may be initiated. Community conversation managed to break this cycle of silence and brought women to the forefront of the discussion on GBV.

ODA organized community conversation's take a particular form. At the very start of the intervention, ODA trained community conversation facilitators that would go out and facilitate the sessions within the community. These facilitators were deliberately chosen to be women. These women are members of women development army groups. As facilitators they play an important role in terms of targeting participants and facilitating community discussions. Having women at the apex has helped the process by bringing into light GBV issues that are usually regarded as private affairs. Women have begun to openly challenge accepted practices like FGM, early/child marriage, abduction and bring to justice perpetrators of different form of GBV. The following case is a good illustration.

> *"In Adama woreda, Wonji Kebele, a young man known for raping three women was roaming the kebele with no one coming after him. The community members were well aware of what he did. After raping women, he disappears from the area for a short period and surfaces again only to rape another one. In the fourth instance, he raped a girl and was about to do his disappearing act. This last incident infuriated the women in the kebele. They chipped in their own money and brought*

the raped girl at around 9pm in the evening to Adama Hospital to get medical treatment and to collect the required evidence. The women were members of community conversation facilitators. They also immediately reported the case to the local police. While they were waiting for a follow up of the case, some of the women saw the police that was assigned to investigate the matter with the families of the accused. He was negotiating to pay bribe and get away with rape for the fourth time. The women came together and called on the woreda women and children's affairs office, the woreda justice bureau head as well as the ODA contact person. The same police officer tried to threaten the women for reporting on him. However, the women were persistent in their efforts to get the accused apprehended. Their effort finally paid off and he was sentenced to eight years in prison."

GBV as a community concern (ownership)

As described above, community conversation sessions bring together community members that are said to be change agents/trend setters. These include: traditional leaders like Aba Gada, religious leaders, representatives of grass roots women's and youth associations such as WDA, members from girls' clubs in schools, and school directors/principals. As previous studies have proved time and again, these change agents have strong influence in their respective constituencies in shaping and reshaping socially acceptable behaviors and practices.

Bringing GBV as a discussion point/agenda in forums organized by change agents has ensured two things: first it expanded the potential reach of the message to different sections of the community and second it entrusted the issue of GBV as a legitimate community concern. Discussions with community members attest to these outcomes. In Wonji Woreda, FGD held with community members revealed the strong sense that GBV is no longer just a private matter but a concern for all. They explained this sense of community ownership of the issue as follows: "In previous times, even if we hear girls scream, we used to mind our own business but now everyone comes to the rescue and people are very vigilant in relaying information to the appropriate authorities."

Institutionalizing the issue: making it part of government agenda in a forceful way

Government laws and policies outlaw all forms of GBV including HTPs. Despite this, GBV is not often seen to be a priority issue. ODA's community conversation approach forced the institutionalizing of the issue and the responses to address the same. As such, it made the personal political (the private into a proper state/public affair). How did this come about? As the brief description of community conversation above shows, one of the primary instruments through which community conversation was tied to state structures was the 'Woreda Advisory Committee' (WAC). The WAC is composed of key sectors like health, education, women's affairs and justice and is chaired by the woreda administrator. The project coordinators from ODA's side as well as representatives of women's development army also sit in the WAC. The issue of GBV including HTPs was made to be the central agenda of the WAC. This implied that sectors which previously did not consider GBV to be part and parcel of their mandate were now made to take up the issue and address it. A typical example was given by the Justice sector. The Justice Office Head of Adama woreda shared the following in one of the discussions.

"Previously our main focus was on issues like peace and security, and conflict. We didn't consider gender issues to be part of our mandate. As such, when we were reporting on crimes (crime index) issues like FGM did not make it in the list because we thought it was not a priority issue. But now, we know that it is a problem and we do not dare say that as Adama woreda we do not have this problem."

The informant attributed this shift to the work of the WAC which has helped to clarify the responsibilities of the different sectors in combatting GBV and HTPs issues. It is Furthermore, credited for paving the way for systems of coordination and creation of forums for discussions as well as accountability within each sector.

Empowerment effect: prominent women leaders

One of the most significant contributions of ODA's community conversations approach has been its empowerment effect on women in the different intervention areas. Community conversation is credited for paving the way for women to become leaders in their community structures such as 'gere', 'ketena' and even kebele administrator. How did it produce women leaders?

Community conversation is spearheaded by women facilitators recruited and trained by ODA. These women prior to their role as facilitators were mostly home makers and confined to the domestic arena. One of the community conversation facilitators shared with us the following in one of the discussion forums "though I finished school (high school) in 1974 Ethiopian Calendar, I got married and stayed at home … not valued and appreciated much." Another participant shared "prior to the trainings, we were all staying at home, not doing much."

After the training, however, they shared in a focus group discussion, they got the chance to organize themselves and their communities so as to tackle social problems like GBV and HTPs that were causing havoc in their communities. The trainings, in addition to addressing basic community conversation facilitation skills like how to conduct community conversation and targeting of participants focused on building the capacities of the facilitators. Accordingly, the women were given assertiveness trainings and leadership skills. These skills enabled them to become public speakers, community organizers and office holders. The story of the first kebele administrator in the history of West Shoa Zone of the Oromia Region attests to this success. Yesunesh directly attributes her position as the first female kebele administrator to ODA's community conversation. She eloquently narrated her story as follows:

"I was born into a family of six boys. I was the only girl to my parents. I attended primary education in my neighborhood. As a child, I didn't enjoy going to school that much because it took time away from playing. I would at times go out and play all day long and come back home at the same time school ends. My mother desperately wanted me to attend school. She did not have any education but when I come home she would wait for me and check my books, just to see if I have been to school. She used to tell me, 'my girl, you have to be educated, the reason that your dad rules the house with an iron fist is because I am not educated.' My father was of the view that I would grow up and get married to a guy who will take care of me forever. Looking back, I am so grateful to my mother because had it not been for her persistence, I would not have continued with my school. I studied up to grade 11, the year I lost my father. I immediately got married thereafter and had 3 children. My husband ruled with an iron fist and he was also abusive. I stayed at home and raised my children. I kept to myself and my home; I didn't have much of a public life.

I joined 'ketena 3' women development army group when these grassroots were organized. When ODA came in with its community conversation strategy, I was selected to be a facilitator. I got the trainings on how to conduct community conversation, on how to be assertive as well as leadership skills. All of these trainings equipped me with skills necessary to take up responsibilities in public institutions. I was able to become the zonal leader of the women development army group in my 'ketena'. I was very active and attentive to the needs of the community. I mobilized the community and we managed to address our problems. My 'ketena' was selected to be 'model ketena'. This, I guess got me noticed and when the kebele administrator post became vacant, I was approached to take up the position. There was a lot of resistance. People that knew me in 'my ketena' were rooting for me. However, for the community at large, having a woman for kebele administrator was unheard of, hence the resistance. After a lot of struggles, I managed to prove myself. Now, community members, my colleagues and bosses all attests to the positive changes that have come about in our area. I think, a testimony for this is the recent award I got in a gathering that brought together leaders from various positions from all over the Oromia Region."

What has been the effect of women's empowerment? Women leaders like Yesunesh have been able to inspire as well as facilitate for other women to come to leadership positions. Under her guidance and support twenty women have become leaders of community level associations. Furthermore, more women have been able to assume positions within the kebele administrative structures.

Ability to address other social problems which expose women to GBV

ODA's community conversation has gone above and beyond its original calling in that it became a forum for discussing all types of social ills including governance as well as development challenges affecting the community. The manner in which the community conversations are held helped the community to tackle water supply challenges is a typical case. Community conversations serve as forums for discussing and solving community problems. Community members particularly women due to the lack of accessible water points have to travel long distance to fetch water. The long distance travel contributes to women's and girl's burden at the household level. Community members used community conversation to discuss about long planned but not delivered water points in their localities. The problems vary; in some cases the water points were constructed but were not operational; in other cases the problem related to management of operational water points. Interestingly, using community conversation to solving water supply problems goes a long way in reducing the exposure of women and girls to acts of GBV and HTPs.

What made Community Conversation work so well?

Community conversation is an age old approach for raising awareness among communities to tackle undesirable practices that adversely impact on people. Community conversation has become a household name for stakeholders engaged in tackling HTPs, GBV and other types of social ills all over the country. Despite its wide use, it's not always the case that community conversation is credited for positive changes particularly at the scale reported in ODA's intervention areas. So what made ODA's community conversation approach/strategy work well?

Properly diagnosed the problem and devised working strategy

The community conversation format allows community members to prioritize their problems, identify the causes, list out options and reach consensus on best strategies. This approach ensures full community ownership of the process. As such it has helped communities to tease out and recognizes factors which are exacerbating GBV and HTP situations. A typical example is the case of elders and religious leaders often intervening in legal procedures in GBV and HTP cases. Often, cases do not even get reported due to such interferences. Through community conversation, this interference has been identified as a major challenge and consensus has been reached so that elders and religious leaders would no longer interfere in GBV and HTP cases particularly in relation to grave cases like rape, abduction and early/child marriage.

Use of change agents

ODA's community conversation targets members of communities that are considered to be change agents. A typical community conversation brings together religious leaders, elders, school principals and teachers, and women leaders, among others. The participants are influential in their respective circles. They can relatively easily set examples through their behavior, teachings and the various forums their positions afford them. Furthermore, this approach of selection of community conversation participants has also meant that community conversation messages reach all segments of the population as participants are able to take back the message and share it in their circles.

Use of existing structures at community and state level

The community conversation strategy utilized existing structures at community level. It targeted women development army groups at various levels – for recruiting facilitators, participation in community conversations and Woreda Advisory Committee (WAC) and making the link between communities and sectors as well as ODA as project implementers. This strategy is quite efficient in that it uses already available societal structures and revitalized it for maximum result. Furthermore, it ensures sustainability as these structures have been there prior to the intervention and will continue to function after the phasing out of the project.

Creation of lasting structures

An innovative approach in the implementation of community conversation has been the creation of a structure that ties the state with the community, the WAC. The WAC created a forum whereby communities and the state/sectors can discuss GBV and HTP issues on a regular basis. The WAC is made up of community representatives, state sectors and ODA as implementing body of this project.

Non-graduation approach

Community conversation used to be implemented within time bound framework. Accordingly, the community conversation would be carried out for a period of time and then graduation follows. This was irrespective of whether the problem/issue under discussion has declined or not. ODA's approach changed this and introduced a new approach – non graduation. This way, until such time that the issue/problem is no more, communities will continue with their conversation and search for solutions. Given that the community conversation utilizes existing structures and hence is pretty efficient, the non-graduation approach is ideal for dealing with GBV and HTP issues that are deeply rooted in cultures/traditions of communities. To ensure sustainability, ODA brought on board and utilized grassroots community organizations which has ensured the continuity of the community conversations after the phasing out of the programme.

Accountability measures

Accountability mechanisms were put in place addressing different stakeholders such as sectors, those in positions of administration. As such work done to reduce gender based violence has been taken or adopted as one point of evaluating the activities of these different stakeholders.

Challenges /gaps

ODA's community conversation has been successful in many fronts. Project implementers, community members and stakeholders in government sectors point to certain challenges that weighed on their efforts to address the problem of GBV and HTPs in their intervention areas. Project implementers in ODA and community members are of the view that the process of change has been slow. They attribute this to the deep rooted nature of the various practices that affect women and girls. This essentially requires concerted and consistent effort for a sustained period.

A challenge/gap raised by sectoral stakeholders relates to the very loose involvement of regional level sectoral representatives in the work of the WAC. The current practice is that regional level government sectors usually receive reports rather than actively engaging in and following up on the work of the WAC. It was pointed out in key informant interviews that the work should not stop at woreda level. This is because actions at woreda level can only be effectively implemented when adopted and supported at regional level. Otherwise initiatives at woreda level may not progress much because of constraints like resource, mandate/decision making power and the like. Furthermore, it is also a missed opportunity in terms of creating the forum for replicating good practices in other woredas.

The resource limitation has meant that only limited number of woredas can be reached through this intervention. This is one challenge/gap that communities have underlined. In the focus group discussions, community members pointed out that there is a need to reach as many woredas and kebeles as possible. This would ensure common understanding and shared values among neighboring woredas thereby barring the possibility of reversal in gains.

Sectoral representatives point out that the involvement of Aba Geddas as owners of the issues remains short of the desired level. "Aba Geddas themselves should take on the stage and teach on the adverse impacts of GBV and HTPs. They should become teachers themselves"

4.2 Integrating GBV in mainstream systems and structures: making the personal political

Introduction

GBV is a major challenge in higher education institutions in the country. Studies show that it is one of the major reasons for the high level of attrition of female students.[5] The picture is no different in the implementation areas of OSSA: Mekelle and Axum Universities as well as Adwa Teachers' Training College. OSSA conducted a Knowledge, Attitude and Practice (KAP) survey into the situation and impacts of GBV prior to implementing the UNFPA supported intervention in the higher education institutions. The outcome of the study showed that 'gender related gaps' constitute one of the main reasons for the high level of attrition of female students. These 'gender related gaps' in terms of a lack of or limited understanding of the implications of gender roles, gender relations and associated expectations are responsible for the manner in which female students are being disadvantaged in different aspects of their lives. This includes their greater exposure to the problem of GBV. It is with this background and thorough understanding that OSSA started its implementation of the GBV programme in these institutions.

Discussions with students in a focus group discussion at Mekelle University revealed interesting findings on the challenges of students in higher education institutions. Students shared that their backgrounds influence how they behave and interact with one another in campus settings. Economic problems are cited as major challenges. Economic problems manifest in different ways. For the majority of the students, it is directly tied to their academic performance in that getting their hands on school materials like handouts and books cost money (to photocopy the materials). Inability to get copies costs them dearly in terms of grades. For female students, economic challenges manifest in additional ways; from the pressure to go to class in a relatively presentable manner to being locked up in the dormitory during menstruation. Female students shared their dilemma as follows:

> *"I know of female friends that missed class because they needed to wash and dry the rags they use during their period out of sight of their roommates and classmates. You should hear how 'better off' students make fun of us and say, are you still using rags when 'modes' is available? It is so*

[5] See for instance Girls' Education and Gender Equality Strategy, 2014, Ministry of Education.

demoralizing; even if you are good academically it makes you wonder if 'getting into campus is worth all this humiliation and embarrassment"

Sexual harassment is another challenge that students shared. Female students shared that harassment comes from teachers and male students. They particularly emphasized that it is mainly poor and vulnerable females that become targets of harassment. Male students also share in this assessment and cited cases where they have witnessed teachers picking on and discouraging female students in class for no particular reason.

It is not just harassment that victimizes female students. The FGD participants and gender office officials are of the view that due to low level of awareness even consensual relations among female and male students end up adversely affecting the academic performance of female students at times ending their college journey. The following story illustrates this point.

"A female student that fell pregnant shared that she would not have found herself in this situation if she had better knowledge of reproductive health particularly that of contraceptive services. She said she fell pregnant because she believed her boyfriend who told her that he has taken pills to prevent pregnancy."

University officials including gender office representatives concur that these are challenges that predominantly affect female students. The statistics in terms of high attrition rates among females attests to this fact. Though the challenges are known, addressing them in a meaningful manner has been difficult due to gaps in policy and academic frameworks. The gender office head opined that the lack of gender policy and anti-sexual harassment code of conduct has meant that we couldn't systematically address the different challenges and make a dent on the root causes. She furthermore stressed, although GBV is occurring within the teaching and learning environment, among teachers and students, the level of appreciation and understanding of the problem and its effects are not reflected in the teaching learning process. As a result, teachers and students have taken it as a norm.

OSSA's approach to address GBV: what went into it?

OSSA's intervention intended to address the various aspects of gender related challenges contributing to GBV through targeting three components: behavioral, bio-medical and structural. The behavioral component looked into raising awareness and creating consciousness through programmes like peer education; the bio-medical aspect targeted factors that expose females into GBV like economic problems and furthermore addressed the aftermath effects through the provision of different services like emergency contraception; the structural aspect sought to create the necessary policy framework as well as changes in curriculum bringing GBV from the periphery to the mainstream/system. Combined, the different components resulted in the implementation of a comprehensive approach to address GBV in the context of higher education institutions in Ethiopia.

The process: through strong (pre-existing) collaboration with gender offices of higher education institutions, OSSA proceeded to establish structures within the institutions that can directly reach students. These are mainly gender clubs and peer learning groups. These structures were used to reach large number of students for various end goals: capacity building trainings such as assertiveness, orientation and awareness programmes for incoming students and selection of beneficiaries for the provision of economic support like sanitary materials among others.

Through strong advocacy and collaboration effort with the gender office, OSSA managed to bring the lack of adequate policy environment i.e. lack of gender policy, lack of anti-sexual harassment code of

conduct and the knowledge gap as is evident in the gender neutral curriculum into the highest decision making table of Mekelle University. Following favorable decisions, OSSA together with the gender office developed the gender policy, the anti-sexual harassment code of conduct as well as the curriculum on 'Gender, Reproductive Health and HIV/AIDS' for the University.

To increase access to services including RH, OSSA established a toll free hotline service whereby students can get secure and confidential information on a variety of issues including reporting on GBV. Actual service dispensers i.e. university clinics were also equipped with the required materials to meet the demands of students.

Achievements

One of the challenges towards addressing different forms of GBV in the context of higher education institutions has been the lack of adequate policy and regulatory framework. The limited knowledge on gender differentiated needs and interests and their impacts on the teaching-learning process is another challenge. This has been raised time and again as one of the contributing factors for the exacerbation of the situation of GBV in Mekelle University both by students and the University administration. It is when students know that their rights are protected that they can challenge and stand up to such practices. Similarly, it is when the Universities have the means and structures in place that they can respond to the phenomenon of GBV. The fact that university policies have remained silent on this issue implies that this has not been taken as a mainstream concern – a concern for the well-functioning of the teaching-learning process. Bringing GBV issue into the policy framework – through the development of a gender policy and anti-sexual harassment code of conduct – OSSA has succeeded in changing this long-standing status quo.

The gender policy problematizes the situation of gender relations among students, teachers and generally the university community. It outlines and prioritizes the major gender related challenges affecting the teaching-learning process. It lists out strategies aimed at addressing these challenges. It further assigns duties and responsibilities to different bodies of the University community.

The anti-sexual harassment code of conduct defines various acts that constitute sexual harassment, recourse mechanisms for victims as well as punishments for perpetrators among others. It also assigns duties and responsibilities to different structures in the fight against sexual harassment. Copies were distributed to the student community.

Systematization through integration of GBV into policy and regulatory frameworks ensures sustainability in addressing the problem. This is because having the system in place is the first step towards taking any action. It serves as the corner stone. The roles and responsibilities placed on different actors through the policy frameworks would entail development of periodic work plans/actions/ activities towards fulfilling the objectives of the policy.

Another manifestation of systematization through OSSA's intervention is the adoption of a curriculum on gender, reproductive health and HIV and AIDS. The curriculum worth two credit points has been finalized and adopted by the Mekelle University Senate, awaiting now final approval for incorporation by the Federal Ministry of Education. Initial training targeting training of trainers from two departments, health and psychology, has been conducted. The lack of (limited) understanding of gender based differences is found to be one of the reasons for perpetration of GBV in higher educational institutions. This is a shared problem among students, teachers and administrators alike. This is a cycle of ignorance that will continue to expose females to GBV unless checked through intervention in the curriculum. OSSA's introduction of the ills of GBV and its causes and effects within the curriculum is a step in the right direction.

Over and above its work on raising consciousness among the university community and provision of services in the immediate aftermath of GBV including referral linkages, enabling the system to address GBV on its own (even after OSSA) is what makes OSSA's intervention one of the best practices in the fight against GBV. Equipped with the knowledge on the role of gender on GBV and RH through the curriculum and integration of gender issues into the mainstream through the gender policy and rights conscious and demanding student community through the anti-sexual harassment code, the University community is better positioned, now and in the future to combat GBV.

Overall, OSSA's approach addressed both prevention and response contributing immensely to the major outputs of the programme. The behavioral component contributed to increased knowledge on GBV as well as SRH issues among the student and teachers and generally the university community. University structures that are responsible for response such as the gender office as well as health providers were strengthened to respond to GBV and SRH issues. As a result, availability and accessibility of these services was strengthened. The capacity of concerned stakeholders was also built and strengthened for enhanced coordination and advocacy on issues of GBV in the universities.

What made systematization possible?

Proper diagnosis of the problem - realization on the need for system related changes

Prior to implementing the intervention, OSSA started with the process of diagnosing the problem through a KAP survey. The survey output showed where the problem lies – 'gender related gaps including GBV as the cause for high levels of attrition of female students in higher education institutions in the intervention areas'; and helped it prioritize solutions. In prioritizing solutions, sustainable solutions in terms of bringing about changes in systems – systematization of GBV issues –topped the list along with other measures that make the intervention comprehensive. This was also informed by prior experience.

Favorable local context

Although problems and solutions may be properly diagnosed, implementing them would be possible only where there exists a favorable environment. This is where the openness of Mekelle University to welcome partners becomes important. The University has open door policy to welcome those that wish to partner with it to address problems within the university. To this end, the University has established 'a University Management Taskforce' which brings together different partners from government (sectors), non-government such as OSSA and representatives of the community and led by the President of the University. OSSA has been a member of this taskforce for a long period. Through this partnership, OSSA plays the role of implementing University projects on behalf of the University and similarly, the University takes on implementing projects on behalf of OSSA. It is in such kind of favorable working environment that OSSA managed to take its intervention to the highest decision making body.

The openness also extends to the gender office within the University structure. The gender office is acutely aware of the problems and its limited capacity to bring about change on its own. As such, it opens its doors for collaborative efforts to implement its plans and programmes. Just as the work/activities are shared between the University and its partners, positive results and achievements are also shared with partners. The University and the gender office give due credit for the role of partners hence creating positive and favorable environment for collaboration.

Good level of commitment on the part of university management

Bringing about changes in systems through adopting gender policy and anti-sexual harassment codes all require decision at the highest level within the universities. The management within Mekelle University has shown good level of commitment in terms of opening the floor for debating the issues and adopting the policies within the required period. Similarly, the steps it has taken towards introducing the new curriculum on gender, RH and HIV has been possible due to the high commitment of the management. Furthermore, the university has committed its own resources towards training of trainers to integrate the curriculum into the teaching learning process in the university.

Strong prior experience

Prior experience of OSSA in addressing gender, RH and HIV and AIDS issues within the context of higher education institutions has been a good starting point for the design of the current intervention. The prior experience has meant that it was in a position to outline and prioritize potential and workable strategies to address the problem of GBV in the context of higher education institutions.

Challenges /gaps

The implementation of the three components of the intervention by OSSA namely behavioral, bio-medical and structural has faced certain challenges. Intervention measures such as material support are mainly targeted at female students. Furthermore, the distribution of policy documents such as anti-harassment code was limited to female students. While this is important to equip female students with the knowledge required to pursue their rights, its narrow focus on females may mean overlooking potential partners that can make the intervention work better. In this regard, targeting male students and perpetrators in future interventions may yield better results. It also helps to avert the feeling of being left out among male students.

4.3 The youth as instruments of change within and beyond the Church

Background

Studies from around the country show that religion is often cited as a reason among communities for the practice of different forms of HTPs like FGM. Even acts of GBV such as domestic violence are justified by the stand that a husband has to discipline his wife, a claim attributed to religion. In light of these and other erroneous claims, a religion focused approach/strategy has been necessary if the fight against GBV and HTPs is to show progress.

Cognizant of this, the Norwegian Church Aid (NCA) has been implementing the programme for the prevention and management of GBV in partnership with Faith Based Organizations (FBOs) through the Inter Religious Council of Ethiopia (IRCE). IRCE is an umbrella organization that brings together seven faith based institutions namely: the Ethiopian Orthodox Tewahedo Church, Ethiopian Islamic Supreme Council, Ethiopian Catholic Church, Evangelical Churches Fellowship of Ethiopia, Ethiopian Seventh Day Adventist Church, Ethiopian Evangelical Church Mekane -Yesus and Ethiopia Kal- Hiwot Church.

NCA's different partners, the FBOs, implemented the programme in their respective localities. As is the case with the other interventions in this programme, the religious approach has been successful in some areas but others have not been as impressive. This section looks into the experience of the Ethiopian Evangelical Church Mekane-Yesus in Hawassa, SNNP Regional State as an example of good practice.

Introduction

The Mekane-Yesus Church in Hawassa has a huge following within the city and beyond. The youth constitute one of the largest groups of followers. Church leaders and members agree that today's youth is faced with a number of challenges that influence their education and productive involvement in their communities. In a focus group discussion that brought together youth members, Church leaders and pastors, the discussion revealed drug addiction, unhealthy relations between boys and girls, sexual harassment and abortion as major problems affecting the youth of Hawassa.

Discussants pointed out how all of these issues, directly or indirectly, lead to GBV cases. Drug addiction for instance is attributed to be a significant factor for high levels of violence perpetrated against girls and women in the streets and in schools in the city. Sexual harassment is also reported to be rampant among the youth affecting girls in schools. Abortion, in most cases, is also said to be a direct outcome of sexual violence.

Unhealthy relations, defined in terms of lack of awareness or misunderstanding on how and when a boy and a girl should get into a relationship, are responsible for girls being abused by boys eventually leading to school dropout among others. This is also related to lack of awareness and preparation in terms of getting adequate information on sexual and reproductive health issues. Earlier experience of the Church working on FGM issues shows that girls start sexual activity at a very early age, around 11. By the time they reach age 13, they start to get contraceptive shots.

While these problems are common within the wider community, they are also problems within the church. A key informant interview revealed that Church leaders particularly those in positions of authority and entrusted with the care of the followers are found to be perpetrators of different forms of GBV including sexual violence. It is often young and trusting girls that are the victims of these acts of violence within the church. Often times, these acts of violence are kept in the dark. The girls are afraid to report believing that

it may be their fault. As the perpetrators usually have power within the Church structures, it may not even possible to push for any form of recourse.

Church leaders and youth members attribute these challenges to the lack of open discussion on relationship issues within the primary unit, the family, where the youth from young age should get adequate information on these issues. The lack of open discussion has meant that the youth approach the wrong sources for information: such as the internet and fellow friends.

Another related challenge is the generational gap between Church leaders and the huge number of youth followers. As times are changing, senior Church leaders have not been able to adapt and change their ways of approaching and understanding the challenges of today's youth.

These factors have pushed the youth towards acts which eventually harm the vulnerable i.e. young boys and young girls. Increase in the incidence of violence such as sexual violence leading to abortion, drug abuse, sexual harassment and abortion is a testament to this.

Youth focused approach to address GBV: what went into it?

The Church prior to implementing its intervention conducted a baseline assessment to understand the challenges of the youth including the situation of GBV within its membership as well as the wider community. This involved making inquiries within its members and gathering information from different sources including from its previous work on FGM. The discussion on what should be the role of the Church in addressing GBV culminated in adopting the family as the entry point for reaching the youth – the victims of the GBV crisis.

In order to adequately implement the plan of bringing the discussion into the family, it was necessary to get training on how to conduct family dialogue. The Church conducted family dialogue trainings to selected facilitators within the Church community. These trainings provided the opportunity for family dialogue forums within the church. According to one key informant, these dialogue forums opened their eyes to the generational difference which is preventing the youth from communicating and learning from their parents. From this finding, the Church created a mentorship programme whereby ten youth members were paired with one pastor to facilitate open discussion. In addition, a youth counseling departments was set up as part and parcel of the Church structure. Volunteer Church members from different walks of life serve as councilors for the youth members.

The youth being the ultimate target, a second set of training were conducted on organizing youth clubs within the church. These training equipped the facilitators with the necessary skills to navigate in the Church environment. The trainees also received leadership skills trainings.

The trainees proceeded to form a youth club known as '*yousakor club*'. The trainees were selected based on different criteria: their school performance so that they would be exemplary to others, their level of influence/having traits of being agents of change in their communities and gender composition so as to ensure equal representation among the sexes. The members of *yousakor,* after their trainings, proceeded to train and teach fellow youth members of the Church as well as other youths they can reach through school, in their neighborhoods and other networks. Different mediums were used for teaching: drama and writing, prayer service, worship service, testimonials and experience sharing.

The intervention produced a manual on how GBV issues are to be viewed and understood within the bible. Looking into the scripture, the manual provides guidance for trainers and family dialogue facilitators on how they should approach the issue biblically. The manual has been copied and shared with similar churches in the city. It is now used a reference for preachers.

Achievements of the youth focused approach

The most important achievement of the intervention is that it made the youth and their issues legitimate topics of discussion within the church, in its teachings and its various Church services. This is a break from the long standing tradition which had made the youth voiceless. This has meant that issues that were considered to be 'taboo topics' were discussed in the open. The major ones are: boy-girl relationships, and sexual and reproductive health issues. The lack of awareness as well as the lack of access to information which are among the primary causes triggering different forms of GBV can now be contained through open dialogue and open access to reliable sources of information.

Youth focused structures have been set up within the Church in order to support and sustain the breakthrough in addressing issues affecting the youth within the realm of the church. One of the main structures is the 'Yousakor' youth club. The club is a forum for the youth to articulate their own problems and challenges and come up with solutions. GBV related issues like abortion and drug abuse have been made the subjects of open dialogue and advocacy among the youth. The dialogue has helped youth followers to understand the link between these social ills and GBV; GBV being either a cause or consequence of the same. In order to ensure sustainability, currently, the structure has been made to be part of the Church budget supported structures. This ensures that the advocacy work will continue even after the phasing out of the programme.

Another achievement attributed to the intervention is the first youth pastor in the history of the city. In a focus group, the youth followers shared that having a youth pastor has meant that they are able to discuss issue like relationships, reproductive health related challenges and others openly. They are as a result able to get guidance on where to get adequate information and services. As a result, factors that may expose them to behavior and activities leading to GBV would be reduced.

Realizing the need for discussions on issues affecting the youth and providing them with adequate information and counseling services, the Church has established a youth counseling department. This is also another achievement of the intervention. The department serves as yet another source for informed decision making for the youth.

The youth focused approach is credited for paving the way for the inclusion/integration of social issues in Bible study programme s. Focus group discussion participants and Church leaders shared that prior to the

intervention, Bible study programs solely focused on the scripture. While this was important, the approach turned out to be a bit disconnected from the day to day realities. In the new approach, a social problem which is topical will be chosen for discussion during Bible study sessions. This approach has helped to create awareness on problems predominantly affecting the youth among the different sections of the congregation. It is also a good approach to ensure a sustainable way of addressing these problems.

The dialogue forums organized by the youth clubs are open to the wider community. This has helped to bring in non-Church members to the discussion forums. According to the club leaders, they have been able to invite and attract their school mates, students from different schools, youth from the neighborhoods and others to the forums organized by the club. As a result, the message and advocacy effort has been able to reach the wider community.

Another notable achievement is the ability to replicate this experience and approach to other sister Churches within the city. The Church, to expand its reach conducted experience sharing forums with four sister Churches in the city. According to a key informant from a sister Church, the youth in the respective churches formed their own youth clubs. The youth Pastor as well as well as youth club leaders have provided ongoing support to ensure successful replication. The manual produced by the Church has also been shared with the sister Churches.

Examining the overall picture in light of UNFPA's programme objectives, the youth focused approach has significantly contributed to increasing knowledge and response of communities and other stakeholders on GBV and SRH issues. It has also built in the stakeholders' capacities within the Church and sister churches for enhanced coordination and advocacy on issues of GBV and SRH.

What made the youth focused approach possible?

Focus on the youth as the main service direction of the Church

Focus on the youth is taken as the main service direction of the church. This came about as a result of the realization that the youth of today is challenged on many fronts. Church leaders shared the following in articulating this direction of the church, "we looked into the context under which the youth are operating today. The context forced us to look beyond spiritual issues and address the diverse needs of the youth." The project tapped into this service direction of the Church which made the intervention successful in shaping a youth focused approach.

Youth at the forefront of programme /intervention implementation

Early interventions of the programme i.e. towards problem diagnosis revealed that the youth are missing in articulating their challenges and coming up with solutions. The interventions then embarked on putting the youth in the driver's seat. A youth Pastor, youth clubs and youth counseling departments all headed and run by the youth have significantly contributed to the achievements of the program in terms of its wider reach and its ability to break the silence on taboo issues such as GBV.

Family as entry point for changing society and undesirable social behavior such as GBV

The youth focused intervention has used the family as an entry point for dialogue and advocacy. This is done by creating family dialogue forums whereby issues affecting the youth are discussed at family level. This approach has enabled the community at large to engage in dialogue and discussion on issues like GBV affecting the youth. This approach has thus been instrumental to reach wider sections of the population, within and beyond the church.

Use of change agents

The youth focused approach worked to bring on board youth members of the Church as well as youth from the wider community because it used youth leaders that are regarded as exemplary in their respective communities. Exceptionally well performing students with the capacity to act as agents of change in their school were used to pass on messages and advocacy campaign reaching many in the process.

Openness and willingness of Church leaders

The openness and willingness of Church leaders has been quite instrumental in pushing for a youth focused approach. Their willingness to allow youth structures and youth leaders to assume roles in different Church services such as having a youth Pastor has facilitated the smooth implementation of the intervention.

Challenges /gaps

One of the challenges in adopting a youth focused approach was the resistance from the establishment within the church. According to a key informant (the project focal person) resistance came in different ways. He shared "Prior to adoption of open family and youth dialogues, we had to show that the problems stated above do exist in our communities. We showed this through different ways. One method we used was to show a video on the ills of FGM. I remember distinctly how we were thrown out of churches for showing that video. Similarly, when we attempted to talk about reproductive health issues, we were accused of exposing the youth to issues they are not ready for. We were told not to bring in such issues to the church. This is a major challenge that we faced at the beginning of the intervention. It was through persistent discussion that we were able to break this resistance."

4.4 Coordinated support services to survivors of violence

Background

The interventions supported by NCA vary in approach and focus areas. While some of the interventions focused on using religion as an entry point for discussion and advocacy condemning GBV, others focused on providing support for survivors through coordinating the efforts of various stakeholders working on the issue. The following section looks into the experience of daughters of charity (DOC) in Mekelle city in Tigray Regional State.

Introduction

As is the case in many parts of the country, GBV is a major problem in Mekelle, the capital of Tigray Regional State. Different forms of GBV are reported to exist in the city. A key informant interview with the Women and Children Affairs Office of one of the Sub-cities of the city revealed that physical, economic and sexual violence are rampant in the city. Although the extent of the problem may differ, depending on the economic status of residents among others, the problem is said to be common across all localities.

According to the informant, physical violence usually occurs in the domestic context, men beating their wives and/or partners. Economic violence also occurs in the contexts of marriage and/or irregular unions. It takes different forms. For example, a husband or a male partner may deny a woman the means to support the family including children. Another common form is where the husband or the partner moves the common property to a third party without the knowledge of the wife or partner. This is a very common occurrence. Usually economic violence leads to physical violence, compounding the suffering of the women.

Sexual violence, particularly rape and harassment, are common among the youth and the student community. This is particularly true in high schools and universities. The use of drugs exacerbates the problem according to the informants.

The vast majority of the victims of these problems are women. According to a social court office in one of the intervention Sub-city, about eighty percent of the cases that come in the social court concern women. It is women that have been beaten by their husbands or partners, denied any means of living or raped that come and lodge their cases. He described the scene as follows:

> *"You know it feels like a house where there is fresh mourning, you hear loud sobbing and crying by the women. When you hear their stories of abuse, you ask yourself, where is the world going to? Why this much abuse and suffering?"*

Despite the gravity and extent of the problem, support services to survivors are quite limited. Focus group discussions with survivors revealed the same gap. They shared that:

> "Mostly women that go through such traumatic experience sit at home and cry. There is nowhere to go, so we just take the abuse"

The coordinated support service approach to address GBV: what went into it?

Daughters of Charity (DOC) has been operating in Tigary Region and specifically in Mekelle since the 1970s. It started with the relief operations for victims of humanitarian disaster back in the days. As an institution that has been in existence for quite a long period, DOC is quite familiar with the local context. Although the GBV programme is its first intervention in the realm of work on GBV areas, its knowledge of the local context has been instrumental in identifying the problems and devising a working strategy.

A two pronged approach – psychosocial and economic support –for survivors of violence: Discussions with programme staff and the head of the mission revealed that they have long years of experience working with less privileged women. They have worked with the motto of 'helping women to help themselves'. From this experience, they have gathered that where women are provided with some support they can be in a better position to support their families. As such, economic support formed a strong pillar of the intervention in the GBV prevention programme. Economic support (livelihood support) has different components: training targeting at building the business skill of beneficiaries and seed money given as loan.

Survivors are provided with five days of practical business skills and entrepreneurship training. The training exposes the women to practical things like: how to develop a business plan, how to balance books, how to attract business and customers etc. The trainers are professional people with long years of experience and

good level of awareness of the local context. To make the trainings relevant, examples from petty trade and small business operating in the area like vegetable trading, tea and biscuits selling are given as example. They also get the opportunity to exercise by developing their own business plans. Once they go through the training, the beneficiaries are provided with seed money in the range of five to six thousand birr. The repayment plan is quite conducive to the needs of the women. There is no interest payment on the loan. They are also given grace period. Even where they are unable to meet the monthly repayment, they are given breathing space whereby they can take a break. The repayment rate has been more than ninety percent according to the records of DOC.

The second component of psycho-social support was introduced as the second pillar of the intervention to address a specific need. DOC project staff shared that their interaction with survivors revealed that women that have been affected by violence do not often venture out seeking for help and engagement in livelihood activities because of the psychological trauma of the violence. Often times, they have difficulty in believing that they too can become productive citizens with the right help. To address this, DOC brought in a trained councilor from the local hospital to provide psycho-social support to the survivors. The women in the focus group discussion shared that:

> *"For the first time, we were able to openly speak of our problems and worries. More than the problem, it was the constant worry that crippled us. Getting this counseling service has opened the door for us to talk about all our challenges and encourage others within our localities to do the same."*

The survivors armed with the business skill and their seed money has ventured into different kinds of small businesses. It is through this support that they now support themselves and their children. The DOC support does not end with disbursement of funds. There is a strong monitoring and follow up support service provided by a social worker entrusted with this task. The social worker provides house- to-house visit. The visits allow the women discuss about their progress, any challenges and potential solutions.

DOC operates in close coordination with the intervention Sub-city Women and Children Affairs Office as well as the Labour and Social Affairs Office. These offices together with DOC are responsible for screening survivors. Support services like working places, further funding (loan) and the like are also facilitated by DOC in coordination with these offices.

In addition to the direct survivor focused work, DOC worked on general awareness raising campaigns through discussion forums and panel discussions that brought together different sections of the population.

Achievements of the coordinated support service approach

Empowerment of women

One of the main achievements of the coordinated support service is that the vast majority of the survivor women are now able to support themselves. In a focus group discussion, they shared that:

> *"We no longer need the support of extended family and friends; we can now support ourselves".*

Another participant shared:

> "I used to live in a small room with an extended family and I was afraid that I would be kicked out and my children would have no roof over their heads. Now, after the support, I have small business where I sell tea and biscuits from my new rented place. I can pay for my own house now."

Self-confidence and ability to avert further violence – In focus group discussion held with the women, one notes a feeling of confidence and assertiveness. They said, they would not allow anyone to violate them in any way in the future.

> "If he tries, I will show him myself [don't need anyone]"

This was how one of the beneficiaries expressed the confidence she got from the intervention. This is quite important because it shows that the intervention has equipped them with the necessary skills and confidence to avoid victimization in the future.

Sustainable approach through reuse of funds

The funds disbursed by DOC have seen high levels of return. The money which has now been pooled into one fund will be used for second round of support service for women affected by GBV. This has been possible through a careful design and implementation of the entire intervention. Particularly credited for this are the strong monitoring and follow up as well as the considerate repayment plan. In addition to availing potential resource, this approach has placed some kind of sense of responsibility of helping one another:

> "If we pay, the money will be used to help other women".

This feeling of community ownership of the problem and being able to influence the means for address it is an important achievement.

Women serving as support systems in their communities

A very notable achievement of the intervention is its ability to create a support system within the community. Women that have become beneficiaries are now taking the role of providing support to others in their community. The women in a focus group discussion shared:

> "We tell women that are suffering at home to go and seek help, to go and approach the authorities."

This support system encourages a broader fight against GBV.

A stepping stone for accessing government provided fund

The beneficiaries shared in one of the discussions that although women may be aware of the existence of services particular economic support through government structures, it is difficult to access the same due to the cumbersome requirements. These include the need to organize into groups, the ability to show prior saving etc. Through the fund that they secured from DOC, they were able to save and were contemplating approaching government agencies for more funding. This shows that the intervention has served as good complementary to underutilized government support services.

Overall DOC's approach has been instrumental in increasing the availability and accessibility of psycho-social services for vulnerable groups and survivors of GBV through its direct provision of such services, increasing knowledge and response of communities and other stakeholders on GBV and SRH through the network of community support provided by beneficiary women. Furthermore, through its intensive and collaborative work with the government and informal structures, it has contributed to increased stakeholders' capacity for enhanced coordination and advocacy on issues of GBV.

What made the coordinated support service approach possible?

Good level of understanding of local context

The long history of operation of DOC in the intervention area has enabled it to have good level of understanding of the challenges that women face in the area. The issue of economic violence is one that repeatedly came up in discussions with different stakeholders in government as well as the women. DOC properly captured this aspect of GBV in its intervention and sought to address it.

Proper diagnosis of the problem leading to a two pronged approach

DOC's good level of understanding of the local context has enabled it to effectively design a two pronged approach: psycho-social and economic support. In analyzing the problem and possible solutions, DOC programme staffs were able to articulate the connection between the different forms of violence i.e. economic violence exposing women to physical violence. Furthermore, for economic support to bear fruit, implementers recognized the need and invested on building the confidence of the women through psychosocial support.

The terms and conditions of loan disbursement

The women that benefited from the interventions have been successful in supporting themselves economically. This is made possible by the considerate terms and conditions attached to the disbursement of loans. The main features that made the economic support successful are: no interest payment, grace period, no collateral, breathing space where the women face difficulty in repayment and full recognition given to women that have successfully repaid their loan – through award of certificates of recognition.

The manner of delivery of training

Business skills trainings are usually provided as part of economic support programme s without much success. The approach of DOC is successful because it took into consideration the particular needs of trainees in terms of time, place, topics and manner of delivery. Training times are scheduled taking into account the convenience of the trainees. For instance, trainings are not conducted on market days as it adversely affects those that depend on markets for their daily income. Furthermore, trainees are given ample time to arrange their schedules prior to the commencement of the trainings. When trainees come for their trainings, they are encouraged to come with their children as they may not be able to come at all otherwise. The children are cared for including provided with tea and biscuits in the DOC facility while their parents get trained. Training topics including illustrative cases are selected based on the local context. Usually, trainers try and draw from the experiences of locally operated business in the area to encourage and show the women that business is indeed doable.

Strong monitoring and follow up even after the phasing out of the project

Perhaps one significant factor that made the DOC approach work is the strong monitoring and following up of the beneficiaries. Through a dedicated social worker, DOC beneficiaries get house to house follow up service. The service includes provision of advice, linking up with appropriate government structures. The follow up is also done with the relevant government structures. This has ensured strong collaboration among the different stakeholders to come to bear as a result of the intervention.

Challenges /gaps

The major challenge DOC faced in the implementation of this intervention relates to the manner in which the programme fund is disbursed. The disbursement of funds was very much near to the reporting period. This barely leaves adequate time to implement the planned activities in an orderly fashion. The timing of disbursement of funds and reporting – not leaving much time for the actual implementation of the activity – would have compromised the implementation had it not been for the utilization of others sources of funding for filling the time gaps.

4.5 Fighting GBV through grassroots structures

Introduction

GBV is a major social problem in the Amhara Regional State where the Amhara Development Association (ADA) operated the UNFPA supported intervention. Different forms of GBV and HTPs are practiced in the region. HTPs, mainly early/child marriage and FGM, are wide spread in the selected areas of the intervention. In addition, physical violence like wife-beating, heavy workload including labour exploitation, economic violence mainly seen in terms of depriving women the decision making power in economic resources of the household, and sexual violence mainly rape are practiced. It is women and children that are victimized by the different forms of GBV and HTPs.

In the intervention woredas of Kobo, Enarj-Enawga and Derra the practice of early marriage affects girls in the age group of 12-14 as well as those that are younger. These girls are exposed to forced sexual intercourse which has led to numerous complications such as fistula and uterine prolapse. Economic and physical violence perpetrated against women also lead to the disintegration of families. When the women are no longer in a position to look after their children and the family due to extreme and continuous violence, families disintegrate with adverse impact on children. Early/child marriage is also the major culprit for school dropout among young girls thereby affecting their life choices.

Key informants as well as focus group discussants from the community raised an interesting connection between the different forms of violence and the high levels of migration witnessed in their localities. The practice of early/child marriage, the different forms of violence women face such as physical, sexual and economic violence are all seen forcing women to leave their families behind and embark on migration. The destinations differ; while some opt for urban centers many choose to go abroad, mainly to countries in the Middle East and Sudan.

These practices have been there for quite a long period of time. As such, they have been intertwined with culture and different forms of customary beliefs. This has meant that the practices as well as the adverse consequences are usually explained in light of culture, tradition and in some cases religion. For instance, when women are faced with fistula, the women and the community at large see it as punishments from God rather than as an outcome of early marriage and as a treatable condition. As a result, women affected by the consequences of these practices hide themselves from the community and potential sources of services. This has proved difficult and challenging to break the practice.

Fighting GBV through grassroots structures: what went into it?

Community conversation using local or grassroots structures

The main strategy used by ADA to implement the UNFPA supported intervention was sustained community conversations in the selected intervention woredas and kebeles of the Amhara Region. ADA, prior to embarking on community conversation to reach the communities, conducted an assessment towards establishing available resources in terms of structures that can reach the broader community. This assessment which was also informed by previous experiences of ADA working in communities revealed the existence of rich resources in terms of grassroots/local structures that exist the community and can be used as instruments for passing on the message of preventing and responding to cases of GBV and HTPs.

These structures constitute formal government as well as informal structures. The main structures that were used for conducting successful community conversations from the formal/government structures included: kebele level government structures, namely police in particular community police, health extension workers, schools and kebele administration. At community level, women's and youth grassroots associations/organizations, development army groups, religious organizations, and elders were directly involved in community conversations.

The role of overseeing community conversations was given to community policing structures at kebele levels. All of the above mentioned organizations/associations played important supporting role to ensure effective conduct of community conversations.

Community conversations were facilitated by trained facilitators. The facilitators were initially recruited from among the communities as well as members of community policing structures. A total of 222 facilitators were trained using professional trainers as well as manuals prepared for this purpose. The facilitators were then assigned to the respective intervention kebeles to spearhead the conversations.

Typically community conversations brought together different sections of the community. Health extension workers, teachers as well as kebele administration also took part in every community conversation. Grassroots organizations like development army groups take active part in the conversations. Leaders of development army groups organized into the one to five groups play active role in community conversations. They also serve as important entry points for reaching the broader community as they pass on the message from community conversations to their group members in their respective localities.

Agenda setting for community conversations is the role of the participant community members. They select issues for discussion looking into topical issues and problems in their areas. According to ADA officials, experience has shown that cases of early/child marriage, FGM, rape, unequal distribution of property during divorce, and migration are among the top ranking discussion points in many of the intervention areas. About 50-60 people take part in one community conversation. Community conversations are conducted twice a month for the duration of 30-60 minutes.

Produced and distributed manuals for community conversation: In order to efficiently conduct community conversations, ADA contextualized and adapted manuals that guide community conversations. The manuals are prepared by professionals. Furthermore, the manuals are prepared taking into account the local needs and contexts thereby making them relevant to the community conversations. The manuals have been distributed to trained community conversation facilitators so that they can have hands on guidance while conducting the conversations.

Strong and regular monitoring and follow up on the intervention: ADA has structures that are present at woreda and kebele levels. The presence of ADA at the lowest administrative levels where actual community conversations take place has meant that ADA is able to do regular follow up on the conversations, the progress and possible outcomes. A quarterly meeting of all stakeholders – government representatives of different sectors and community/grassroots organizations evaluates the conduct of the community conversations. In these meetings, controversial issues that may have arisen during community conversations will be reviewed. The meeting also provides opportunity for cross checking of achievements as reported by different stakeholders. These meetings are part of the initiatives of ADA's intervention.

Direct support to survivors of violence: ADA also provided support to survivors of violence including HTPs. The main support provided for survivors relates to provision of medical service. This has been the case for the survivors of cases of fistula and uterine prolapse. Women affected by these problems were sent to referral hospitals for treatment with ADA covering medical and associated costs.

Achievements of fighting GBV through grassroots structures approach

Established effective communication channel

Effective communication channel whereby cases of GBV and HTP are reported to the appropriate authorities and survivors get adequate support services has been created thanks to the effective community conversation and associated support services. The communication strategy brings on board household members, neighbors, villagers as well as formal and informal structures at grassroots level. The communication strategy that ADA instrumented looks as follows:

How does this work?

At household level, one or more family members have been made aware of the adverse impacts of GBV and HTPs through their participation in development army groups, women's associations, and through health extension workers - all of which are structures effectively taking part in community conversations. Accordingly, if and when a women/girl faces GBV or HTPs she is aware of her rights and who to approach including the how in order to redress the situation. The person in question usually approaches the leader of her one to five groups, teachers if she is a student, or her neighbors all of which are direct participants of the community conversations spearheaded by the community police in the area. The information is then immediately relayed to the police or health extension workers or to the kebele administration. Depending on the severity of the violence, the survivor is then immediately connected with structures that can provide direct support – ADA and hospitals for example for medical support, the justice bureau for protection etc.

The information relay system described above is effective in many ways. As these structures are permanent government structures, with or without the intervention, they will continue to serve the same purpose. This makes it cost effective and sustainable. Furthermore, the structures are found close to the community hence

increasing accessibility to vulnerable sections of the community. With accessibility comes the possibility of taking immediate measures to avert planned GBV and HTP cases as well as to respond to survivors in a timely manner.

The following story illustrates how the system works efficiently:

> *"A woman in Yweyenenchet kebele suffered from fistula due to complications during child birth. She lived with the problem for over ten years, hiding herself in her home. Community members attributed the fistula to her weight – she was very thin while pregnant and hence ended up with fistula. Due to the awareness created through community conversations, the one to five group leader in her locality informed of her situation to the health extension worker, and the information was relayed to ADA. ADA facilitated for her to get medical service from the local referral hospital. The coordinated effort of these structures and information flow helped her to get her health back. She is now teaching in different community conversation forums about the ills of practices that lead to fistula."*

Improved level of awareness

Due to the community conversations, there is increased level of awareness about the ill impacts of GBV and HTPs. This is noted from the key informant interviews and focus groups discussions held with community members. Key informants from sectoral bureaus of women and children as well as the police reported that one measure of assessing increased level of awareness is the action that community members begin to take in the fight against GBV and HTPs. The most prominent of such actions include: communities providing evidence on perpetrators of violence and HTPs which was quite challenging in previous times; communities supporting and encouraging those affected by fistula and uterine prolapse to get treatment to women that were previously ostracized from the society; the high number of cancelled early marriages (67 in a single woreda – Derra- this fiscal year alone); and reporting cases of abduction and sexual violence.

A focus group discussant shared her personal story as follows:

> *"I live in Derra Woreda. I have taken part in consecutive community conversations in my kelebe. I have two daughters aged one and five. My daughters have not been circumcised. This made me the laughing stock of the community. I was told, left and right, that I am ruining their future as uncircumcised girls would have difficulty during intercourse in later years. I, however, did not budge from my decision. This is because I have learned about the adverse effects of FGM as well as the fact that the said consequence of circumcision is untrue thanks to the many community conversations that I took part."*

An informant from the Women's Affairs Office also shared the following:

> *"As our woreda is along the border with Afar, we are facing a problem with young girls crossing over with the intention of migrating out of the country. These are young girls between the ages of 13-14. While these are clearly too young to travel, they usually get fake IDs showing that they are 18 and above. They also take Muslim names so as to be able to travel to their destination countries. These illegal acts are done by brokers with the help of corrupt kebele administration officials. It is through community conversations that we were able to pinpoint where the problem lies and address it accordingly."*

Strong and sustainable coordination among sectors

One of the achievements of ADA's grassroots focused community conversation approach is the strengthening of coordination among different stakeholders within government as well as informal structures. As the discussion above points out, different government and community structures are necessary for the intervention to succeed. These structures are actively involved in the conduct of community conversations. Their involvement also extends to responding to acts of GBV and HTPs either in the form of direct support or protection. It is the manner in which the community conversation is designed that has brought in all these structures to work in a coordinated manner.

Adoption of community wide stands to fight different forms of GBV and HTPs

Community conversation in ADA intervention areas have resulted in the adoption of community wide stands in the fight against GBV and HTPs. Good examples in this regard are declarations made to end practices such as early/child marriage and FGM; agreement with elders not to handle GBV and HTP cases through negotiations entailing ostracizing of elders and community leaders that intervene in legal process relating to GBV and HTP cases. These serve as important ways of holding communities accountable in the fight against GBV and HTPs.

Bringing men on board in the fight against GBV and HTPs

A notable achievement of the community conversation approach of ADA has been its ability to bring men on board in the fight against HTP and GBV. Although GBV and HTP cases used to be major topics of discussion in forums organized by women for women, it was not a mainstream forum topic of discussion. It is the community conversations that bring together men and women from all walks of life that made GBV and HTPs mainstream agenda items. Attesting to this, male FGD participants in Enarge-Enawga kebele shared:

> *"In the past, I used to tell my wife, 'you have no right to decide on money related issues, it is my prerogative alone. But now we usuallyconsult with one another before making decisions."*

> *"In the past, without my consent let alone going to meetings she could not even attend funerals. But now we usually talk about all issues and she goes to meetings and engages in different kinds of activities."*

Community conversation has helped to address other social problems

Community conversations have been used to discuss a variety of issues affecting the community. In this regard issues that relate to other social problems including governance related issues have made it to the discussion table. HIV testing and counseling prior to marriage is one such issue. Helping destitute women through labour contribution for instance to build them shelter has also been the result of community conversation.

What has been ADA's contribution in terms of contributing to the overall programme outputs? Increased knowledge and response of communities and other stakeholders on GBV and SRH has been brought about through community conversations. Furthermore, the capacity of stakeholders to engage in coordinated advocacy has been strengthened.

What made fighting GBV through grassroots structures approach possible?

Use of existing local or grassroots structures

ADA's community conversation utilized existing grassroots structures as the main instruments of change. The structures are both formal government structures representing relevant sectors including schools, health extension service providers, women and children affairs as well as justice sector including community police and informal structures representing communities. In the latter category fall women's and youth grassroots associations/organizations, development army groups, religious organizations, and elders. Using existing grassroots structures has contributed significantly for the success of the programme. First, it has enabled ADA to conduct cost effective interventions relying on what already exists. Second, it ensures sustainability because the structures will continue to function even after the intervention. Third, it is quite effective in reaching the broader population as these structures are found quite close to the community.

Capacity assessment and building both internally as well as for stakeholders/partners

Prior to implementing the community conversations, ADA conducted a capacity assessment exercise. The capacity assessment exercise looked into the capacity of all collaborators at government and informal structures. The capacity exercise was instrumental for two ends: first it enabled ADA to identify capacity gaps as well as potential (unused resources). Second, based on the identified gaps, it designed capacity building interventions. These took the form of targeted capacity building exercise for grassroots structures. For instance, 2,664 health army groups were provided trainings on GBV and HTPs. The trainings also included those provided to ensure effective community conversations. Third, once the respective resources of all stakeholders have been identified, ADA was able to divide responsibilities along the expertise of the different stakeholders and use them accordingly. Overall, this exercise has enabled ADA to use its resources effectively to produce best results.

Locally relevant and convenient community conversation mechanisms

Adopting generic forms of community conversation may not be suitable in contexts where local realities and specificities dictate certain approaches. Cognizant of this, ADA adopted community conversation manuals that took into consideration the local context and reality. These were made readily available to facilitators in all kebeles. Community conversations also brought in community members that are regarded to be influential and are well respected. In terms of timing and duration, the conversations were scheduled during periods that are convenient for the community and did not take up too much time.

Incorporating/integrating GBV issues in social discussion forums

Community conversation has created the opportunity for GBV and HTP issues to be included in different discussion forums at various levels. Discussions are now seen taking place at family dialogues, in coffee ceremonies that gather neighbors, in Idirs and Ekub gatherings among others. This is important in that it has made GBV and HTP issues a concern for all and an everyday discussion issues.

There are attempts to introduce family dialogue which is at its pilot stage. The idea here is to take issues that form the subject of discussion in community conversations and make them subjects of discussion at family level. Initial indications show that it is quite beneficial but more work needs to be done.

Gender balanced participation in community conversations

ADA adopted a policy of ensuring gender balance in the representation of women and men in community conversations. As such the representation of men and women in community conversations was balanced. Out of the 11,312 community members that took part in 277 community conversation sessions, 5,379 were women. In addition to individual representation, structures that promote the interests of women such as women's associations, women's affairs offices etc. were also equally represented. This policy and approach plays significantly in the promotion of the principle of gender equality. It sets the example for future interventions within and outside of government.

Using testimonials of beneficiaries of the intervention

A practical approach of teaching and awareness raising were employed in the community conversations. This approach advocated for using the testimonials of women with experience (for example survivors) for raising important issues at community forums. Testimonials coming from survivors embolden others in similar situations to take steps to remedy their circumstances. Furthermore, it helps to dispel beliefs that tend to attribute wrong reasons for some of the after effects of GBV and HTPs.

Graduation mechanism

It is interesting to note that ADA has managed to reach quite a huge number of people, over 100,000 through a system of graduation which allow resources for community conversation to move from one area to underserved areas in time. After a thorough conduct of community conversation in a certain location (intervention area), graduation takes place where the community declares that it has sufficient awareness about the ills of GBV and HTPs and reaches consensus on how to address the same. ADA's representative believes that graduation ensures adequate use of resources to reach wider communities.

Challenges /gaps

Imbalance between the high demands created through good level of awareness and the limited response capacity

Community conversation has been very successful. One of the measures has been the increase in the level of reporting of GBV and HTP cases to various structures that take part in the conversations. Although this is quite an important achievement, one that the programme set out to achieve, it has not been accompanied by an equally growing capacity to respond as well as provide protection to survivors.

This problem is typically illustrated in the justice sector. According to key informants from the sector as well as ADA, women are coming in large numbers to report on cases of GBV and HTPs. However, said the police representative, "our capacity to provide services such as provision of immediate help is quite

limited. We cannot even interview them in a secure/confidential manner as we do not have the space." ADA similarly has at times been forced to use its own resources to ensure survivors get medical support.

Limited focus on the youth

Adequate targeting of participants is important for community conversation to work. ADA's approach has attempted to bring in as many sections of the population as possible. However, the participation of the youth has not been at the desired level. Focus group discussants among the communities pointed out the following in this regard:

> *"A lot has been done to address early marriage in our communities. We are convinced of the problems and are abandoning the practice. But what we are seeing today is the teenagers themselves opting to marry before they come of age. They go to the extent of falsifying their documents and adding onto their real age so as to get married. What we are saying is, early/child marriage is also a decision by the young boys and girls. So interventions like community conversations should target them as well."*

4.6 Demystifying Fistula and Uterine Prolapse

1 Introduction

The Benishangul-Gumuz Regional State, where the National Coalition for Women against HIV and AIDS (NCWH) implemented the UNFPA supported prevention and management of gender based violence programme, is home to diverse ethnic groups with similarly diverse cultural and traditional practices. The three intervention woredas constituting more than one hundred kebeles altogether are home to the Berta and Mao Como people as well as settlers from the highland regions of the country. The diversity has meant that a wide range of cultural and religious practices are prevalent in the area. Different forms of GBV and HTPs are practiced owing to cultural dictates of the communities.

While some forms of GBV and HTPs are prevalent in all the intervention areas, others are peculiar to some of the communities. Women carry the entire burden – in and outside the house – in the Berta and Mao Como communities. The burden of providing for household provisions lies on women. This extends to building a house, providing food on the table and taking care of children and the elderly and family members in general. The heavy work burden has severe health consequences for women.

While women carry the entire burden of caring for the family, they have little decision making power both at the household and community levels. They are not allowed to speak in most cases and decide on matters that affect them dearly. The lack of decision making power among women is a shared problem in all intervention areas. Women in all communities of the three woredas are excluded from engaging in matters that affect their wellbeing.

Early/child marriage is another common practice in the intervention woredas. The practice is common among all the communities. Early/child marriage and heavy work burden is a lethal combination severely jeopardizing the health of women.

As discussions with representatives of NCWH as well as focus group discussions with community members has revealed, it is these cultural practices that are adversely affecting women. They shared the following:

> *"Girls are married off at a very young age. This fact by itself leads to detrimental health impacts as the girls do not have the physical maturity to handle pregnancy and childbirth. This often leads to cases of fistula. Combined with heavy workload inside and outside of the home, they often face the problem of uterine prolapse. Fistula and uterine prolapse are the major challenges women face in our areas."*

These adverse health consequences are often associated with cultural and religious explanations rather than being attributed to practices like early/child marriage and heavy workload on women. This makes the effort to combat HTPs and different forms of GBV quite challenging. Women that have been affected by fistula and uterine prolapse usually hide themselves from the community believing that they have done something wrong to deserve this punishment. According to a key informant at NCWH, "in our intervention, we have found women that have been in hiding for over twenty years." "Our main challenge," the informant reiterated "is to drill the message through that these adverse health consequences can directly be traced to harmful practices like early/child marriage and unfair division of work burden inside and outside the home."

Demystifying Fistula and Uterine Prolapse: what went into it?

As the brief discussion above illustrated, GBV and HTPs are directly attributed to fistula and uterine prolapse. These conditions tragically end the lives of women. Once afflicted, the women hide themselves and society ostracizes them for good. Accordingly, the fight against this unfortunate situation has to be waged on different fronts: changing societal attitude that these afflictions are not due to bad karma but rather society's own doing of early/child marriage and heavy workload on women; healing the women through adequate medical care; integrating them in society to completely dispel the views surrounding fistula and uterine prolapse and in so doing address the root causes i.e. GBV and HTPs.

Cognizant of this, NCWH devised a three pronged approach to implement its intervention in the selected woredas. The three elements of the intervention are: community focused awareness creation; care and rehabilitation for survivors; and facilitating livelihood opportunities for survivors.

Community focused awareness creation

The community focused awareness creation approach was informed by the prevailing wrong beliefs associated with fistula and uterine prolapse. As a strategy community conversation was carried out at a large scale. Existing structures were used to reach the community through community conversations. Women's associations such as the one-to-five groupings and the larger women development army groups, anti-GBV and HTP committees at kebele levels, religious leaders, kebele administration representatives and community elders took part in the conversations. It is women's associations that were used to

spearhead the community conversations. Furthermore, trainings were provided to community conversation facilitators. Conversations were held twice a month for the duration of thirty to sixty minutes. The community conversation has been instrumental for communities to understand the link between GBV and HTPs on the one hand and the ill fate of women afflicted by fistula and uterine prolapse on the other.

Care and rehabilitation for survivors

The major activity undertaken under the intervention relates to provision of care and rehabilitation to survivors. This aspect of the intervention involved the collaboration of a number of stakeholders and community mobilization.

The first task involved locating those affected by fistula and uterine prolapse. As problematized above, these women hide themselves and communities are not keen on interacting with them. It is the community conversation messages that helped sensitize community members so as to reach as many survivors as possible. The care and rehabilitation services are done in a series of campaigns. Accordingly, prior to the launch of a campaign where women get medical and rehabilitation service, a lot of effort goes into locating and identifying survivors. The most effective instruments to this end are participants of community conversations namely leaders of women's groups as well as anti GBV and HTP committee members. These groups play an important role in locating affected women in their respective localities and bringing this to the attention of the kebele Women and Children Affairs Offices as well as the health extension workers in the village. NCWH also used mass mobilizations employing announcement of campaigns using loudspeakers in villages.

Once women affected by fistula and uterine prolapse have been identified and their list taken, medical service is provided through either of the following modalities. The first and usual modality is to use one off campaigns whereby specialist doctors go to the Assossa Hospital and the women receive the required medical service. This is done through the coordinated effort of UNFPA and ESOG. Women go through prior screening to ensure that they qualify for the medical service provided. Another modality is where a specialist doctor from Assossa Hospital goes around the different woredas and carries out the screening so that ESOG appointed specialists can provide the services in an efficient manner. In this case, the women are gathered in the woreda health centers for the procedures. In both modalities, NCWH covers the necessary expenses for the women to travel to the locations where the medical services are provided.

Livelihood opportunities for survivors

Survivors of GBV and HTPs, particularly fistula and uterine prolapse, are usually ostracized from society and as such are not engaged in livelihood activities to support themselves. Many are out of productive activities for relatively long period of time. As such, the support service includes livelihood intervention so that they would be in a position to support themselves.

To address this, the intervention collaborated with the woreda Women and Children Affairs Office as well as the micro-finance agency. The women and children affairs office assisted with identification of potential beneficiaries while the micro enterprises agency administers the fund. The funding comes from the NCWH. A revolving fund set up through this collaboration has gone operational helping survivors as well as those at risk of GBV and HTPs. The women are given between 2,500 to 3,000 Birr. The will have immediate access to half of the funds and when they save as much, they will have full access. They are given a grace period of up to one year before repayment begins.

Achievements of 'Demystifying Fistula and Uterine Prolapse' approach

Increased demand for care and rehabilitation services

One of the main achievements of the intervention has been its ability to demystify the problems of fistula and uterine prolapse. This can be seen in different ways. At the launch of the programme, let alone for there to be a demand for this aspect of the intervention, it was quite difficult to get women who come out in the open and receive medical service. "It was through quite a lot of effort that we were able to get 23 women to get medical treatment," shared a key informant at NCWH. Another manifestation was how it was difficult to get the cooperation of service providers like transporters, hotels and others in helping these women receive medical care.

After sufficient level of awareness on the causes, effects and possibility of treatment and cure has been gained through community conversations, communities started to open up. The women too were keen on taking up the services. Things have dramatically changed during the course of the intervention that now there is a waiting list for women to get medical services. The data is telling of this dramatic shift in thinking: at Assosa woreda during the first campaign 23 women received treatment; in the second the number doubled into 45 and the third campaign saw 65 women in the list. Even after the phasing out of the programme some months ago in Bambasi woreda there was a waiting list of 510 women that are currently waiting to receive the medical service. Similarly, in Bambasi woreda alone, 74 women affected by fistula and 244 women that suffered from uterine prolapse got medical services.

Changes are also evident among different service providers and collaborators. Now, they no longer shun the women that are seeking medical service. Service providers like hotels and transporters are willing and open to help the women in need.

Increased levels of awareness in the communities

Community conversation has been instrumental in changing perception of communities and mobilizing them into action to fight HTPs and GBV. A focus group discussion in Assossa woreda revealed the following case illustrating this point.

> *"Fetena is a thirteen years old girl living in Gambella kebele of Assossa woreda. Her parents entered into an agreement with another family to give her hand in marriage. While they were preparing for the wedding, information reached the local police station through a community conversation participant that early/child marriage is about to take place in their locality. The kebele police shared the information with the kebele women and children affairs office. Together, the two approached the family. They told the family that this practice is detrimental to the girl child, it is illegal and it should stop. The girl then intervened stating that she has consented to get married. The police and women affairs office representatives were not convinced of the situation. They took the girl to the hospital to check her age. The hospital confirmed that she cannot be more than thirteen years of age. The parents were then made to face the law – they were imprisoned. In the meantime, the police and women affairs worked towards changing the views of the girl on early marriage. Upon release, the parents signed an affidavit promising not to marry off the girl."*

Empowerment of women

The livelihood support component has been instrumental in enabling the women to protect themselves from further victimizations. Women that have been affected by GBV and HTPs do not wish to go back to their previous lives which have exposed them to various adverse impacts. The livelihood support is vital to break this cycle. The women in a focus group discussion revealed that the livelihood support not only empowers

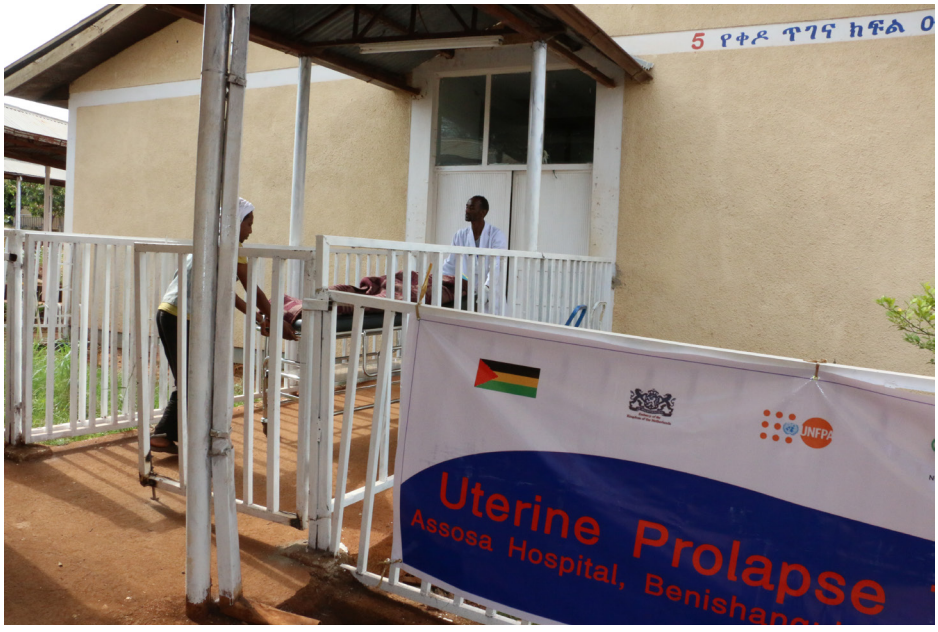
them economically but also provides the opportunity for them to be engaged thereby leaving little time and room for worry. One woman shared the following:

> *"Fatuma Oumer lives in Ashebora kebele. She has lived with fistula for 19 years. The family has built a separate hut for her. No one in the community comes near her. When community conversation was being held in a neighboring woreda, word reached the facilitators on the situation of Fatuma. The Women's Affairs Office in the woreda went to her locality to ascertain the situation. When they approached her hut, Fatuma screamed and said 'no one comes near me, do not approach me.' The women's affairs people tried their best to convince her – that her situation can be treated. They also approached her family and children so that they can understand and help convince her. Finally, she was convinced to go for treatment. As her condition was complicated, she had to come to Gandhi Hospital and after seven months of treatment she got a clean bill of health. She got back to her village and through the livelihood support provided by NCWH, she now engages in poultry. Business is booming, she sells about 200 eggs per week to support herself and her family."*

In terms of contributing to the overall programme outputs, the intervention by NCWH has contributed to increased knowledge and response of communities and other stakeholders on GBV and SRH; increased availability and accessibility of SRH and psycho-social services for vulnerable groups and survivors of GBV; and increased stakeholders' capacity for enhanced coordination and advocacy on issues of GBV.

What made the 'Demystifying fistula and uterine prolapse' approach possible?

Well integrated/ packaged approach



Demystifying the wrong perceptions associated with fistula and uterine prolapse in terms of the causes, effects and possibility of treatment required an approach that targets all aspects of the sources of the problem. Proper diagnosis of this was the first step in designing an approach that targeted the different aspects of the problem.

Accordingly, the design included raising the awareness and consciousness of the community through community conversation – quite instrumental in understanding the causes thereby condemning GBV and HTPs as the culprits of these undesirable consequences. Secondly, the design of the intervention provided adequate medical care to survivors – in addition to responding to their needs, this served to showcase that the conditions are treatable. Thirdly, the design provided livelihood interventions – this is important to ensure that the women will be not in a position that may expose them to further violence.

Bringing in all relevant stakeholders into action

A variety of stakeholders took part to make the intervention a success. The stakeholders constitute both government and non-governmental (informal) structures. The availability of structures at grass roots level made the approach work well. The contribution of stakeholders such as sectors and community structures has helped significantly in many ways. First it has been instrumental in making the intervention cost efficient as stakeholders contribute their time, expertise and resources to bring about the intended results. This has been seen for instance in relation to sectors providing transport services, taking care of daily expenses of the women etc. Secondly, as these structures are already parts of the existing system they can carry on with the activities contributing to its sustainability. The structures have incorporated fighting GBV and HTPs as part of their regular work. As a result, GBV and HTPs constitute one of the checklists in the work of cadres in the villages. Furthermore, GBV and HTPs are made part of the discussion in any forum that brings together communities.

Commitment

The strong commitment of those that are engaged in the day to day operations has contributed significantly to the achievements. The commitment is seen in different ways: where road networks are poor, workers had to travel long distance on foot to locate the affected communities; where road networks make it difficult to get in cars, they used donkey drawn carts to transport the women; where hotels refuse boarding affected women, the workers open their homes. Survivors attest to this strong commitment in different forums thereby encouraging others to come out of hiding and seek help. Today after the phasing out of the programme over 500 women are in the waiting list to receive treatment thanks to the persistent awareness creation work and commitment to support those in need manifested by the workers.

Challenges /gaps

The approach that combined awareness creation, care and rehabilitation for survivors and livelihood interventions are all important to addresses all aspects of the problem. However, challenges were noted in successfully pursuing all aspects of the intervention. Particular challenges were noted with respect to the livelihood support approach. The evidence shows that of the total beneficiaries of this programme it is quite a small percentage that managed to return the funds from the revolving fund in Assosa woreda. Though funds are provided to help the women, what is required to make them succeed has not been fully provided. These include: trainings on managing money, business skills etc. A stronger coordination whereby full package of support services are provided ensures effective results.

4.7 Integrated support for survivors of GBV and HTPs

Introduction

The Benishangul- Gumuz Regional State where the Mujejeguwa-Loka Women Development Association (MLWDA) operated the UNFPA supported prevention and management of gender based violence programme is home to diverse ethnic groups with similarly diverse cultural and traditional practices. The intervention woredas, Pawe and Bullen, are home to the Gumuz people as well as settlers from the highland regions of the country. The diversity in the inhabitant populations has meant that a wide range of cultural and religious practices are prevalent in the area. Justified by the various cultural and religious practices of the communities, different forms of GBV and HTPs are practiced.

The common forms of GBV and HTPs practiced in the intervention areas are wife exchange, early/child marriage, FGM, wife beating, heavy workload on women, isolation during childbirth, food taboo, and isolation during menstruation as well as denying women to exercise decision making power. Wife

exchange is a common practice in the Gumuz community. FGM and early/child marriage are commonly practiced in settler communities. Wife beating and excluding women from decision making power is a common practice among all the communities in the intervention areas.

Discussions with communities as well as key informant interviews with project implementers revealed that women are faced with multiple forms of GBV and HTP situations. A good example of this problem is seen when young teenage girls are married off through exchange marriage and are forced on to take an entire household responsibility as well as engage in work outside of the home. In the majority of cases, when these girls get pregnant, they often face the problem of fistula. Another complication that arises is that of uterine prolapse. The problem is not limited to these physical and health related hazards. These girls are often psychologically scarred for life due to the trauma they face at a very young age.

The integrated support approach: what went into it?

Community conversation

Community conversations were the primary instruments used to reach large sections of the population in the intervention woredas. Community conversations that were conducted twice a month and consisting of different sections of the population reached over 45,000 people. Community conversation facilitators were recruited and trained with the skills of facilitation. Furthermore, the trainings equipped facilitators with basic knowledge on law, communication and other relevant topics.

MLWDA established/formed grassroots structures to fight GBV and HTPs at kebele levels. These structures bring in men and women: the Women's Advisory Group (WAG) and Men's Advisory Group (MAG), as they are referred to, are the main structures used to reach the community. Membership of these structures is drawn from teachers, health extension workers, development agents and the police. Membership is on a voluntary basis. The advisory groups come together on a quarterly basis for review and experience sharing meetings.

MLWDA conducted extensive capacity building exercise

The capacity building exercise focused on building the capacity of these groups in terms of: their role, their contribution, and their understanding and awareness on GBV and HTP issues. The advisory groups provide advice on the intervention. They also provide information on cases of fistula and uterine prolapse to the appropriate bodies. The advisory group provides both preventive action as well as remedial measures where GBV cases happen. In the prevention aspect, they collaborate with community conversation facilitators towards successful holding of community conversations, providing information before GBV attacks occur, and teaching and awareness creation in their communities. In terms of facilitating for survivors to access services such as medical and legal services, they also assist women to engage in income generating activities.

Livelihood support for survivors and those at risk

Organizing survivors and those at risk into self-help groups constituted one of the interventions. The purpose of the intervention is to empower vulnerable sections of society so as to protect them from GBV practices. The intervention constituted establishing the groups and building their capacity to support themselves. Once they have formed their groups, they come up with their own rules of engagement, take stand against any practice of GBV and HTPs and adopt bylaws to fight GBV and HTPs. The self-help groups are also provided with material support to help them engage in economic activities.

Establishing and strengthening of clubs in schools

Another structure that is used to reach communities is school club. MLWDA established and/or strengthened school clubs in the various schools in the intervention woredas. All school club members were provided with trainings on GBV and HTPs. Teachers that support the running of school clubs also benefited from the trainings. Gender clubs in the target schools were provided with material support – school materials. Furthermore, it also provides female students with sanitary materials.

Safe house services

The response and protection aspect of MLWDA's intervention was provide through its safe house service for survivors of GBV and HTPs. The safe house provides comprehensive services including food, accommodation and clothing. Survivors are also provided with medical and psycho-social support. Survivors are also provided with trainings which equip them with skills that would enable them to support themselves once they leave the safe house. The safe house also doubles as a place of stay for those receiving medical service for fistula.

Achievements of 'integrated support 'approach

Increased awareness

The intervention by MLWDA has resulted in increased level of awareness among the communities directly targeted by the community conversations. The regularly executed community conversations have resulted in a shift in community wide practices. This is very evident in relation to the long held practice of sending women into isolation during menstruation and childbirth among the Gumuz people. There is evidence that shows that Gumuz communities no longer adhere to these harmful practices that put women in harm's way. The evidence is in part seen by an increase in the number of women giving birth in facilities as well as at home.

Institutionalizing prevention and response to GBV and HTPs

The intervention by MLWDA has targeted institutional structures at various levels to fight GBV and HTPs. This approach has integrated the work within the plans and work programme s of the structures. Accordingly structures like advisory committees, schools clubs, and self-help groups have all integrated GBV and HTP related work as part of their regular programme s. This goes a long way in terms of ensuring sustainability of the work.

Building response capacity

The safe house provision has been instrumental in filling the gap in terms of responding to the various needs of survivors of HTPs and GBV. Institutional structures that work as front line service providers for

survivors such as the police and Women's Affairs Offices have been made aware of the availability and accessibility of the safe house service in a timely and adequate manner. This has resulted in smooth flow of cases from one provider to the other with women getting adequate response and protection. Towards ensuring sustainability, MLWDA has received land and funding and is now in the process of building the safe house.

Zewede Banja is a 12 years old girl living in Bullen woreda. She is the seventh child in her family. She grew up leading a hard life just like other Gumuz girls, busy all day doing household chores too difficult to handle for her tender age. She never had the chance to go to school. Her family decided to marry her off to someone who was much older than her and already had two wives. He agreed to pay two oxen and 2, 000 Birr as dowry. After marriage she started leading a miserable life. Her husband beat her all the time. She also served as a maid to his older wives. Zewde couldn't take it anymore and finally left her husband and went back to her family traveling long distance. But her family members were not happy to receive her except her mother. Her husband eventually came to her family's house accompanied by some people who were armed. He asked the family to return her to him and took her by force. She started leading that miserable life again. She tried to kill herself so many times. Zewde escaped for the second time and eventually found her way to the shelter run by the Mujejeguwa-Loka Women Development Association with the help of the Bullen Woreda Police. She received medical and psychological treatment and other important support including food, clothing, and accommodation. She started going to school after some time and is now leading a new life with the support of MLWDA.

She said, "When I finish my education I want to stand against child marriage and GBV and I also fight for the equality of women. I hope I will return the power of women taken by the men in the region. I would like to thank MLWDA for saving of my life and returning it back to me. I saw the light because of your light"

Empowering women

The interventions that targeted to address the immediate needs of survivors and increase awareness of the public have resulted in the empowerment of women. The interventions have recorded impacts in the social, economic and political aspects. In the economic front, the livelihood interventions have been instrumental in allowing women to have income that they can exercise control. In the political front, through the leadership experience and skills they have acquired in the self-help groups and other associations, women have been able to assume positions in kebele cabinets and water committees. It has also helped them to build their negotiating capacity. In the social aspect, women have been enabled to have access to social capital that they can draw on – for example helping one another during crisis. It has also increased their decision making and negotiating capacity in the household context.

Looking at the overall picture, MLWDA contributed to increased availability and accessibility of SRH and psycho-social services for vulnerable groups and survivors of GBV; increased knowledge and response of communities and other stakeholders on GBV and SRH; and increased stakeholders' capacity for enhanced coordination and advocacy on issues of GBV through its targeting of grassroots structures.

What made the 'the integrated approach' possible?

Well integrated/ packaged approach

The provision of well integrated measures – response through safe house, prevention through community conversation – is instrumental in addressing the different aspects of the problem. This integrated approach is particularly necessary in the context of the Bensihagul-Gumuz Regional State. This is because the region as a developing regional state has particular challenges in terms of gaps in the delivery of social services,

limited uptake of available services, and scattered nature of settlement of the population as well as diverse cultural and traditional practices representing the diversity in the population.

For instance, even if health services are available, the likelihood of a Gumuz woman affected by fistula going directly to health centers is low given the limited experience and exposure. The provision of safe house service provides a good transition point whereby such women would have a chance to acclimatize to different surroundings and get psychological support prior to proceeding for direct medical care. Similarly, the provision of different packages of services is quite important in the region where the availability and accessibility of such services is rather limited.

Making GBV work attractive

The usual approach of teaching towards prevention takes the form of conversations at community level. While this is important, as stated by participants of such conversations and representatives of sectors, at times it tends to be repetitive and hence may not be able to grab the attention of communities as desired.

The approach MLWDA employed to break this is to include messages of teaching in structures like self-help groups that it has set up for empowering women. The women come together in these groups to promote economic goals. Incorporating or integrating messages of teaching on GBV and HTPs in such forums and gatherings has made it possible for the participants to keep interest in the discussion.

Practical teaching method

MLWDA employed practical teaching methods to reach all sections of communities in its intervention areas. The practical method mainly employs survivors that have gone through treatment and are now in a position to support themselves. These women come out and share their experiences. In so doing, they show others that are perhaps in hiding, to come forward and get the necessary support to change the direction of their lives.

Some of the practices of GBV and HTP in the area tend to exclude women from active engagement in different activities during their menstruation. To dispel this belief, MLWDA set up a separate farm in the area for women – while one area of the farm was cultivated by women during their monthly period, another area was cultivated by women that were not in their monthly cycle. The results which were quite similar showed the community that menstruating women are as effective. This helped to dispel the view that menstruating women would spoil things unless they are isolated during their monthly cycle.

Similarly, to dispel the belief that women should be isolated during childbirth, MLWDA used model women such as wives of clan leaders to give birth at facilities or at home under the care of a skilled birth attendant. This showed communities that the belief that something bad would happen if women give birth at home is wrong.

This practical teaching approach has been quite instrumental according to key informants from MLWDA as well as focus groups discussants in the communities.

Engaging men and women

One approach that made MLWDA's intervention succeed in making communities own the issue of GBV and HTPs is the engagement of both men and women in the various aspects of the intervention. Through the men's and women's advisory groups that MLWDA established to fight GBV and HTPs, men have been active participants in their advisory roles in their respective communities. This approach is instrumental for the sustainability of the interventions as it has managed to bring onboard all sections of the population.

Challenges /gaps

The sustainability of interventions depends on the exit strategies that they embed into their programme s. While some of the components of the MLWDA programme s have integrated well thought out exit strategies well ahead of the conclusion of the UNFPA support, some weaknesses have been noted in the other components. This gap is noted particularly in relation to tapping into the mandates, resources and influence of structures such as Women and Children Affairs Offices. These offices in the intervention areas are one of the influential structures with the mandate to influence activities geared at promoting and protecting the rights of women. Tying in the work of MLWDA with the activities of these offices, for example directly engaging their experts in the activities of self-help groups, community conversations, getting a registry of those supported by MLWDA into women's affairs records for follow up would have been instrumental in continuing with the work started by MLWDA. In light of this, joint planning and execution with the mandated institution would have ensured continuity.

4.8 Fighting GBV through the Media

Introduction

The media has been used as an important instrument for reaching the public with messages of social change. In the fight against GBV and HTPs, different stakeholders have used the media as an important outlet for reaching the public at large. Print, radio, TV and other mediums carry messages of the adverse impacts of GBV and HTPs as well as preach that it is a violation of human rights and an immoral act among others. To the extent that some of the mediums like radio are accessible to quite a large section of the population in the country, the media approach in the fight against GBV and HTPs appears promising. Cognizant of this and its rich prior experience, Pro-pride utilized the media with its messages of fighting GBV and HTPs. This section examines Pro-pride's experience in two intervention areas: Amhara and Oromia Regional States.

Pro-pride used radio as a medium. In the Amhara Regional States, the radio program covered large areas in Gojam and Gonder. Similarly, in Oromia, it reached areas in West Hararghe and some areas of the Somali Regional State.

Though there may be some distinctions, in both Regional States where Pro-pride implemented the UNFPA supported prevention and management of gender based violence programme, different forms of GBV and HTPs are widely practiced. The major forms of GBV and HTPs include FGM, early/child marriage, and sexual violence like rape, polygamy, wife beating, trafficking and heavy workload on women.

While the majority of these practices are perpetrated against women, other sections of society are not spared. Children, the youth and the elderly are also affected.

These practices in and of themselves expose women to different kinds of health hazards. It is usually the case that a woman suffers from multiple forms of GBV and HTPs. In such instances, the consequences both in terms of physical and psychological health are so severe. Women exposed to multiple forms of GBV and HTPs have suffered adverse health consequences such as fistula and uterine prolapse.

Similar to other regions where the problem exists, the causes attributed to the adverse health outcome are not usually associated with GBV and HTPs. The society rather attributes them to cultural and religious reasons. As such beliefs are widely shared in the communities, the women themselves subscribe to the same belief. As such, they condemn themselves for their ill fortune and hide from their families and neighbors for years. The communities also ostracize them.

Fighting GBV through the Media: what went into it?

Pro-pride used the following components in its media focused intervention:

Design of radio programs

The main intervention constituted the design and delivery of a radio program. Different activities went into the design of the radio program. First Pro-pride started with identifying the most topical and relevant GBV and HTP issues that are affecting the society at large. This exercise, in addition to identifying major issues that should be the targets of radio program, showed that although women are disproportionately affected by the practice, they do have the space to articulate their challenges, sufferings and generally their voice in relations to GBV and HTP cases. To address this major gap, the radio program was titled

"*Esemashalehu*" (I listen to you). The name itself is indicative of the fact that the program is one that is meant to serve as a voice for women.

Under this umbrella term, different kinds of programs that address particular issues that affect women were designed. Some of these issue specific programs include: "Enat", "TemarLije", Women and HIV/AIDS, "BergetimYechalal", what does the law say?, "Endihimyenoral", and "Enemyedershayen". These programs get 30 minutes air time three times a week.

The program design used different approaches. While some capitalized on existing women friendly values and practices, others attempted to create awareness on rights, still others showed the strength of women to overcome all odds to succeed in life. These approaches combined have succeeded in showing the different dynamics that shape our lives.

One approach focused on capitalizing on already existing favorable/desirable societal values towards promoting women's rights against the practice of GBV and HTPs. The program on motherhood is a good example in this regard. Motherhood is a value that is shared among members of society. Tapping into this, the program preached on the need to love and respect women, to care for women – the mothers of society. Another approach focused on making women aware of their rights and making others (men, different sectors and stakeholders) aware of their responsibilities towards respecting and protecting women's rights. The program on "What does the law say?" as well as "Chilotwillo" typically represent this approach. Yet another approach used was to show the resilience of women against all odds. The program entitled "BergetimYechalal" and "Endihimyenoral", did exactly this. This approach empowers other women by showing them that 'it is doable and possible' according to stakeholders that took part in the key informant interviews.

Created a network of all relevant stakeholders

For every single show, quite a number of partners should come together and contribute for the successful delivery of the thirty minutes radio program. Starting from getting air time which is quite an expensive, depending on the topic for discussion the right kind of information/data coming from experts in the field, presenters that are charismatic and trained etc. are needed. This calls for identifying partners, getting them on board and keeping the partnership intact.

To this end, Pro-pride invested on conducting baseline assessment to identify potential partners and proceeded to form a network of all relevant partners. The network brought together radio stations, experts in health, law, psychology and other relevant fields, drama clubs operating within intervention areas, schools and government sector bureaus. The availability of the network provided the necessary pool that can easily be utilized on demand for the different topics in the radio shows.

Capacity building of partners

Given its extensive experience in media work, Pro-pride was able to add a capacity building component to its various partners for the successful delivery of the radio programs. To this end, it used trainings, experience sharing forums, facilitated information sharing and exchange among partners and embarked on advocacy campaign to empower its partners.

Achievements of 'Fighting GBV through the Media' approach

Increased awareness

One of the most significant achievements of the media intervention is the increased level of awareness among communities where the radio program reaches. Awareness with regards to the different forms of GBV and HTPs, their adverse impacts, who can do what to address these problems including the role of society are all issues that communities have become aware of through the radio programs.

There are different markers of the increased level of awareness. In Haromaya for example, there are increased levels of reporting of GBV and HTP cases as illustrated by the legal aid officer within Haromaya University legal aid office:

> *"Since the start of broadcast of the radio program, the number of women that come to our legal aid office seeking legal help has been increasing tremendously. We are finding it difficult to cope with the increasing number of women. The women attribute their knowledge of their rights to the radio program"*

A key informant interview from the Pro-pride office shared that:

> *"We receive anywhere between 30 and 50 phone calls in every show. This is quite a lot given that it is just a 30 minutes show. It shows that people are listening and responding to the issues that are raised."*

Listeners' clubs and groups have been established in the different intervention areas where the program reaches. For instance in Amhara Regional State, in Chlga and Takusa woredas, these clubs are very much active. In addition to coming together to listen to the programs and conduct discussion forums, the members chip in resources and their time to help survivors of violence in their localities. Similarly, wealthy people call into the radio station and pledge to provide support to survivors of violence. A focus group discussion with listener's club members shared the following story:

"I was listening to the case of one survivor and the problems she is facing to get on with her life after the attack. I was so touched by the program. I shared what I heard with my office mates. They asked how I came to know about the case and I told them about the radio program. We all chipped in some money and we ended up paying her house rent."

The radio program also serves as a forum for reporting on cases of GBV and HTPs. A case in Oromia Regional State shows this:

"In Fedis woreda, a father threw out his wife from their family home leaving her three girls behind aged 12, 8 and 7. The father sexually abused the girls one after the other. Neighbors that saw this called on the radio show and reported on the father. Law enforcement intervened based on this tip off and the father was given 15 years prison term."

Provision of direct support to survivors

The radio program brings in diverse audience. People that listen into the programs occupy different positions that allow them to provide assistance to survivors. After the shows are aired people call in and offer to provide different kinds of assistance to survivors. While some provide money, others offer to give professional assistance like legal representation, medical care and even livelihood support. In areas where established care and support mechanisms for survivors do not exist, the radio program provides the medium through which different resources can be put to use to provide response and support for survivors of violence.

In Haromaya, a key informant shared the following experience:

"We were broadcasting the case of three women that have been severely affected by different forms of violent acts. After the show business people called and offered to help these women get on with their lives through livelihood support. The business people followed through with the offer and came over to our station to meet the women. They have now opened bank accounts in the name of these women and deposited seed money for them to engage in activities to support themselves."

Built the capacity of stakeholders working on GBV and HTP issues

The capacity building of partners and stakeholders working on GBV issues came about in different ways. While some like clubs in schools and those working in radio stations received training and participated in experience sharing forums, others received a more indirect support to strengthen their capacity. Typical examples in this regard are courts. The progress of cases that have been reported to the justice administration bodies are followed up and reported on radio programs. This enables people to know that the system is indeed working. Survivors that use the judicial system also provide feedback on the challenges they faced particularly as it relates to gaps in the workings of the court system. This system has been particularly helpful for the courts. There are times when courts have taken on records of shows to examine their gaps and improve on delivery of justice.

Bringing topical issues to the attention of policy makers

One of the achievements of the radio program relates to its approach in raising topical issues. Issues that are taking center stage in terms of their prevalence and impact on the society are made topics of discussion. For instance, migration particularly as a feminized phenomenon has been raised as one

important topical issue in the programs. The discussion brought in interesting issues: extent of the problem in different areas of the country, shared the plights of individuals that have migrated and returned home, gaps in policy measures to address the problem as well as gaps in implementation of the law to protect vulnerable sections of the population from exploitation by traffickers. It is discussions like this that would inform policy makers to respond to policy gaps and issues affecting the citizens at large.

The interventions contributed to increased knowledge and response of communities and other stakeholders on GBV and SRH, increased stakeholders' capacity for enhanced coordination and advocacy on issues of GBV and strengthened capacity of the law enforcement bodies to effectively handle and respond to GBV cases.

What made the 'Fighting GBV through the Media' approach possible?

Women focused program

This is the first program that focused on the plight of women in relation to GBV and HTP issues in many of the intervention areas. GBV and HTPs though known to exist and practiced by many, looking at them from the perspective of their adverse impact, as violations of rights etc. is a new approach. The women that participated in focus group discussions shared that they feel that for the first time their issues mattered enough to become part of the mainstream media program. It provided voice for the voiceless and the vulnerable. The program's stand with the vulnerable made it attractive to many that identify with such position and even those in privileged positions as it became an eye opener.

Attractive programming

The radio programs do not just follow the conventional approach. Different kinds of components are packaged into the show including drama, poetry as well as real life stories of people. This makes the program attractive to listeners. The programs are described as 'attention grabbers' by listeners' clubs in different parts of the intervention areas. This aspect is quite crucial as it ensures that the intervention reaches its targets.

Participatory approach

The radio program made provisions to ensure high level of participation by the public. This was done through opening telephone lines. The telephone lines were made open during the show so that people can call in and participate in the discussions. The lines were also left open for a relatively long period after the airing of the shows. The participatory nature of the shows extends to encouraging and brining into the show different stakeholders. Accordingly, representatives of sectors like justice regularly participated informing people of their rights and recourse mechanisms in the event of violence. The participatory nature of the show has made it possible to create a sense of ownership of the issues up for discussion among the public.

Coverage of topical issues

The radio shows have been able to capture the attention of large sections of the population as audience because they were able to respond to topical issues affecting communities. Some of the issues such as migration and trafficking, and exploitation of child labour are matters that communities see on a day to basis. Getting the forum for discussion and looking for solutions for these budding problems has made the program attractive for people from different walks of life.

Involvement of all necessary stakeholders

All stakeholders that have direct or indirect engagement with issues of GBV and HTPs were made to take part in the radio programs. The participation took different forms. Some of them like the police and courts made appearance in the shows and shared their experiences, what the law provides, recourse mechanisms and others. This is quite instrumental in empowering women and the general public on what they can and should do to prevent GBV and HTPs. Others like philanthropists participated by offering direct support to survivors. Still others participated through offering professionals support for survivors. This goes a long way in terms of making GBV and HTP issues to be owned by all.

Challenges /gaps

The issues raised through the radio programs are important and topical to the public. Listeners' clubs and key informants from partner/stakeholder structures have confirmed this. Despite this, the stations through which the programs are aired do not reach as many areas. Reaching large sections of population requires getting airtime in the bigger radio stations that have wider coverage. Accordingly, though all agree that the messages are quite important due to resource limitations, they have not been able to reach as many listeners and areas as desired.

The timing of the airing of the programs may be challenging. The broadcast at 6 P.M. may exclude employees that may not make it home from work. This is also a time when women in rural settings are busy preparing dinner. The timing may thus be challenging to reach the intended population.

The programs focus on the youth can be improved so as to address populations at risk. While focus on survivors and adults is important for sharing experiences including coping mechanisms, equipping the youth who are at risk is also important.

4.9 Coordinated support service approach to address GBV

Introduction

The Ethiopian Society of Obstetricians and Gynecologists (ESOG) operation through the UNFPA supported prevention and management of gender based violence programme covers the Amhara, Oromia and Tgray Regional States. It focuses on bringing about system-wide changes through its policy focused work and direct support to survivors of violence and HTPs.

In the process of the documentation of good practices and lessons learned, the field trip covered ESOG's intervention in Jimma, Mekelle and Gonder. Although there are differences in the types and prevalence of the forms of violence and types of HTPs perpetrated, there are also similarities. One common problem that is quite prevalent in all intervention areas is sexual violence in the form of rape. It predominantly affects women and girls. Those in the age group 5 to 20 are the major category of survivors.

The manner in which communities view and address sexual violence cases differ from one intervention area to another though the survivors usually tend to keep quiet about their ordeal. When families come to know about it, they usually try to force the girls to marry the perpetrators. This has been the case for instance in Gonder.

Attempts to address the problem through the legal system – prosecuting perpetrators and according protection to survivors – are usually frustrated by interference from community members like elders and lack of evidence as potential witnesses refuse to cooperate. An important obstacle in the legal process is the lack of adequate evidence due to failure to gather medical evidence at the right time. This is because institutions i.e. medical institutions that can provide the required evidence within the required time frame are lacking or quite limited in number and efficient service.

The coordinated support service approach to address GBV: what went into it?

The primary focus of the intervention in the areas visited was the provision of adequate services for survivors of sexual violence. This was delivered through the following modalities.

Focused service provision through model clinics

ESOG established model clinics that are specifically dedicated to survivors of sexual violence, rape. The model clinics were established in government run health institutions like hospitals in Gonder, Mekelle and Jimma. The major services include psychosocial support, provision of emergency contraception to sexually abused women, dealing with unwanted pregnancy with the consent of the survivor and doctors, testing for HIV and Hepatitis B and giving preventive medicine in the early stages, and vaccinating survivors and providing medical certificate upon the request of the survivor and the police.

Survivors do a six months follow up on a bi-weekly basis, then three months and finally at the end of the sixth month period receiving the different packages of services. This is necessary to ensure that the women get comprehensive support service.

Looking at it from the perspective of the health of survivors of sexual violence, immediate medical attendance would enable them to get treatment for sexually transmitted diseases and to deal with possible unwanted pregnancy. From the perspective of protecting their rights, the clinics can provide the required type of medical evidence within the right time frame so that survivors can pursue their cases.

Large scale training targeting lower level providers through training of trainers

In addition to opening the model clinics, ESOG has put in place the required personnel, for example qualified nurses, to run the clinics. In terms of materials, the clinics have been well equipped.

ESOG has also conducted training through the capacity building component of the intervention. In line with this, doctors and nurses in the respective hospitals where the model clinics have been set up have received training. For instance, in Jimma, in close collaboration with the Jimma Town Health Office a number of trainings were provided on sexual reproductive health (SRH) to health professionals. Furthermore, training on Basic Emergency Obstetric and Newborn Care (BEmONC) was given to health professionals working in Kerrsa and TricoareftaWoredas. In Jimma alone, 31 health professionals working in six woredas of the Jimma Zone have been trained.

At macro level, ESOG is credited with its work on influencing the knowledge and behavior of service providers through changing systems. This comes mainly in the form of introduction of new curriculum as well as the development of standard operating procedures in the treatment of survivors of violence and HTPs.

Achievements of the coordinated support service approach

Establishment of model clinics – responding to immediate needs

The first achievement of the ESOG intervention relates to the successful establishment of model clinics in the intervention areas. The model clinics have been able to respond to the medical needs of survivors. The clinics equipped with the required resources both in terms of human resource and materials have become operational in all the visited intervention areas. In this regard in Jimma alone, the model clinic has provided service close to 300 survivors of sexual violence.

The clinics are instrumental in providing immediate response to the needs of survivors. Prior to the establishment of the clinics in every area visited, survivors were treated along with other patients. This meant they would be forced to wait in line and do not get secure and protected environment to speak of their ordeal. With the setting up of the clinics, however, survivors got immediate treatment within a short period of time and in a more confidential and secure environment. During the field visit in Gonder, in the

space of one hour, we were able to witness two survivors between the ages of 14-15 and 8-10 receiving medical service.

The model clinics have been set up in wings that are out of sight from the main service area of the hospitals. This is done so that survivors would get some level of protection and privacy. All of the required services are provided in the clinics thereby saving survivors the trouble of going from one location to another.

Model clinics contributing to protection

The model clinics have been instrumental in providing the required medical evidence to pursue the legal avenue to protect the rights of survivors. This is an important achievement in that prior to the setting up of the clinics, securing the required medical evidence at the right time and in the right format was a challenge. This was a problem for survivors as well as law enforcement bodies. The clinics have managed to address this challenge.

Increased awareness

The establishment of the clinics has increased the awareness within the medical community of the importance of evidence for protecting the rights of survivors. Previously, medical professionals used to focus on providing help without giving much attention to their role in providing the required kind of evidence within the required period. The clinics are also attracting students (graduating students) to get hands on experience on the treatment of violence survivors.

Training of service providers at woreda levels which are easily accessible to survivors

Another notable achievement of ESOG's intervention relates to its reach of lower level service providers through its capacity building component. Those that are directly recruited from hospitals and trained at central level have gone down and cascaded the training at woreda levels. Training of service providers at woreda level have several advantages. First, it ensures knowledge transfer to a large number of beneficiaries. Second, it helps service providers that are very near to the majority in rural areas be better equipped to serve the people. Where services are accessible in their own areas, survivors would not be forced to come to cities.

Introducing changes in systems

The ESOG approach is comprehensive in that it targets directly service provision at the ground level and changing of systems at macro level. At macro level, the integration of standard GBV curriculum in medical school curriculum as well as the preparation and adoption of standard operating procedures are notable achievements.

What made the coordinated support service approach possible?

Policy focused approach

The policy focused approach has contributed to mainstreaming GBV and HTP issues in policy and curriculum documents. This policy focused approach resulted from examination of the issue of GBV and HTPs at various level i.e. service provision, assessment of regulatory frameworks and the challenges of different stakeholders working on GBV issues. This produced a strategy aimed at influencing and bringing about changes in systems. This approach also ensures sustainability.

Working with existing institutions/structures

Working with existing structures has helped ESOG both in terms of efficient use of resources and ensuring sustainability. Model clinics were established within government hospitals. This has meant that the hospitals have taken over these clinics after the phasing out of the programme and have continued providing the services.

Good track record and networking with relevant stakeholders

One factor attributed to the success of ESOG's interventions in the different locations relates to its good track record in terms of implementing similar programme s in the past. ESOG has successfully established, operated and transferred similar model clinics to government hospitals in the past. This has helped it to have smooth relations with all the relevant stakeholders in its current operations.

Challenges /gaps

One challenge/gap observed is that although the services are available, the awareness level among the general public is not at the desired level. The low level of awareness also exists among the members of the hospital community. This requires work in terms of putting word out about the clinics and their services.

Even where communities are aware of its existence and receive services, some challenges have been noted in terms of survivors not following through with their treatment. In Jimma for example, many of the survivors have not received the required treatment on time. Almost all the survivors that come from the farthest Woredas or Kebles are not willing to come and take the second and third vaccination for Hepatitis B administered after the first and six months of occurrence of the rape. Transportation and other costs bar them from coming to continue with the services.

The model clinics have been instrumental in contributing to the protection of the rights of survivors. However, some challenges have been noted as regards to delivering the required medical certificate which serves as evidence in legal proceedings in some areas. In Gonder for instance, the signature of three people – the senior doctor that treated the survivor, department head and the medical director of the hospital – is required to get medical certificate for survivors. This is cumbersome in that some of these people may not be available at all times particularly given that they are in position of authority. This has led to delays and at times required survivors to come repeatedly to get their certificate.

4.10 Holistic shelter services as a means of rehabilitating and empowering of GBV survivors

Introduction

Comprehensive institutional support to survivors of GBV and those who are at risk of violence is a major challenge in Ethiopia. Survivors of GBV often have nowhere to go to escape their attackers. Survivors either go back to their persecutor or seek other solutions and sometimes end up in the street, exposing themselves to other forms of violence. Safe houses are the only alternative for such victims and very critical to secure protection and provision of secure accommodation for survivors and those who are at risk of violence. This is particularly true for survivors who are aged under 18 and those abused by family members.

> *"…this young girl aged around 16 endured threats and beating at the hands of her uncle. Eventually her teacher saw her bruised hands and brought her to the police…..her uncle was called to the police station to give his words and unbelievably he was telling us how he is an educated person and that he knows how to give manner lesson to a young girl… we asked him to bring her mother as she was living in close proximity… her mother was defending her brother saying its none of our business and*

he can raise her the way he wanted to. After hearing her mother we were not willing to give the girl to her mother…we took her to AWSAD, as she has to be protected and we then opened a case against the uncle…then we got justice. Without AWSAD this case would have failed. There is no safe house in the police station. If we had returned her back to either her mother or her uncle, she would have suffered a much severe injury" **Deputy Inspector Alganesh**

"… the girl was 15 when she came to the police station. She was repeatedly raped by her own father. She couldn't tell her mother as she was scared… she was absent from class most of the time and her teacher noticed this and asked her if there was something wrong with her but the girl was not speaking up, that's when her teacher brought her to the police station" **Inspector Sisay of Arada Police Station**

Such structures do not exist in the government institutions that are the first points of contact for survivors. Often, public servants in these offices contribute money to pay for a hotel room and food for survivors until an alternative solution is found. They also contribute money to pay for bus tickets for those women who have been tricked to come to Addis Ababa under false promises and who wish to go back home.

Safe houses are currently the only safe haven for the most vulnerable survivors. The UNFPA programme has shown that safe houses and shelters are key to an effective response to GBV. Shelters help survivors and the vulnerable to recover from their traumatic experiences, rebuild their self-esteem and take steps to lead an independent life. The experience of the Association for Women's Sanctuary and Development (AWSAD) is used to document good practices in the area of rehabilitation and empowerment of GBV survivors.

AWSAD's holistic approach to address GBV: what went into it?

AWSAD is one of the pioneers in setting up safe houses in Addis Ababa. It was founded in 2005. AWSAD's intervention intended to increase availability and accessibility of SRH, psycho-social and protection services for vulnerable groups and survivors of GBV. AWSAD also aimed at increasing knowledge and response of police on GBV and SRH. Its main activity is the provision of safe house for survivors of violence and their children. 67% of the survivors are under 18 years of age. The majority of survivors (59.15%) were raped while 16% were victims where the fathers did not accept the babies as

their own. Others were victims of expulsion from home, attempted rape, battery, trafficking and abduction. Survivors are able to access a comprehensive service in this safe house beyond the protection and security aspects. AWSAD has a case management system comprised of several clearly defined steps followed for each of the survivors – from their arrival at the safe house, throughout their stay and up to the time they leave.

AWSAD has a strong collaboration with the Addis Ababa Police Commission and Sub-city police, Addis Ababa and Sub-city Women's Affairs Offices and the one stop centre at Gandhi Memorial Hospital. Survivors are referred to AWSAD mainly through theses three structures, in particular the police. Survivors who got the safe house services are also referred from the Federal Supreme Court Children Justice Project Office, the Ethiopian Women Lawyers Association (EWLA), schools, Pro-Gynist, OPRIFES, women's associations, the Addis Ababa Labor and Social Affairs Bureau, and *Kichene* orphanage.

Once at the safe house, survivors have access to a comprehensive service which includes the following:

- A safe environment: Survivors tend to sleep quite a lot in the first few days after their arrival at the safe house as it is an environment where they feel secure.
- Respect to survivors: The attitude of the staff is respectful, welcoming and caring. Furthermore, one of the first things they do when they arrive at the safe house is to take a shower, get clean clothes and some food.
- A shelter free of discrimination: Equality between all religions, ethnic groups, background and origin is a rule by which all abide.
- Health counseling from the safe house nurse: their physical condition is assessed and it is determined whether they need further health care either in a health centre or in a hospital. Pregnant survivors get antenatal and postnatal care.
- Psychological counseling: Beyond the physical abuse survivors have been through, AWSAD gives great attention to the psychological dimension. Some survivors may be in such condition that they may attempt to commit suicide and are closely watched. Most survivors are psychologically damaged and an assessment is undertaken to determine the extent of the support and counseling required for rehabilitation. Serious cases are referred to psychiatrist counseling at a mental hospital.
- Legal support: Survivors of GBV may have ongoing police and court cases. This is an aspect deemed important by AWSAD in its effort to bring justice to survivors. It accompanies and counsels survivors in this process.
- Empowerment sessions: Such sessions focus on reproductive health and women's right issues to enhance survivors' self-esteem and confidence.
- Skill training: Empowerment through skill development is one of the services provided by AWSAD. During their stay at the safe house, survivors have the possibility of acquiring skills in sewing and embroidery, leather, catering and hair dressing within the compound.
- Startup capital and covering living costs: When survivors are rehabilitated and ready to leave the safe house after successful completion of skills training, they are provided with a certain amount of money which allows them to pay rent for three months; they are given provisions such as food and other basic commodities including some furniture.
- Basic education for children of survivors and day care within the compound: These services are provided to the children of survivors during their stay at the safe house. While mothers are in training or have to leave the compound to follow up their court cases, the children remain in the small day care play room or attend class next door.

- Permanent residence and education for under aged survivors until they finish high school: Currently, the safe house has a second house where 17 girls live. These survivors are given a new home and the opportunity to go to school.

  'This resident was born in Arsi. She was abducted at the age of 14. She pretended she was very sick so that her abductor would take her to a clinic where she met a nurse to whom she told her story. The nurse contacted the police and her abductor was arrested. The Adama Women's Affairs Office referred her to the AWSAD safe house in Adama. As there were no witnesses to her abduction, her abductor was freed. She couldn't go back to her village where the abductor also lives. She would have been ostracized at best and made to marry her abductor at worst. Because of her special situation, she was transferred to Addis Ababa to live with other children like her and pursue her education. She was asked if she wanted this, it was not imposed upon her. It has now been three years since she is living at the second compound of the AWSAD safe house with 16 other children and teenagers. She is in the tenth grade and took the national examination a few months back.'

- Follow up after survivors have left: Ex-residents are visited by the safe house staff on a quarterly basis and once a month. Ex-residents visit the centre once a month. This visit is an opportunity for them to share their experience with current residents.
- Capacity building and training to police officers: police officers who are directly working in the Women and Child Department in Addis Ababa Police Commission were trained on counselling skills and burn out management.

Achievements

Saving the lives of women and young girls is the most important outcome. Beyond this, the physical and psychological rehabilitation of survivors has been achieved for women and children who have been in the safe house. Legal cases have been closed and perpetrators have been punished by the justice system.

'This ex-resident is now 19 years old. She is from Merabite. After her parents passed away, she lived for some time with her aunt who used to mistreat her. She ran away to Addis Ababa and was attacked and raped and left for dead in the street when police found her. She stayed with the police for a period of 6 months following up her case. The police rented her a room and gave her food allowance during this period. As she was pregnant and physically handicapped, police and the Women's Affairs Office referred her to AWSAD safe house. She stayed in the safe house for 2 years. She got training on food preparation during her stay there. When she was ready, she left the safe house with her child. AWSAD helped her find a place to rent, gave her food, groceries, furniture and accompanied her in her new life. AWSAD also provided her a start-up capital to buy a frying machine. She is now selling fried food during the day when her child goes to school."

Empowerment of survivors through gaining self-esteem and confidence, knowing their rights and responsibilities and economic empowerment through skill development has given a chance to survivors towards financial independence.

'One of the ex-residents of the safe house shared her story with us. She had been physically, sexually and psychologically abused by her brother for many years. This started when her brother divorced with his wife who left taking her kids with her. She used to go to school when they lived in Holeta but her brother took her out of school when they moved to Addis Ababa and she was not allowed to leave her brother's home. She was saved by her neighbor who hid her and took her to the police. Her

brother believed she had run away while her case was being investigated. She was 16 when she arrived at the AWSAD safe house. She says the safe house gave her a home, physical and psychological healing. She was given psychological counseling for one month after her arrival. She says that her counselor, Fantu, saved her life. She benefited from training in hair dressing while her case was being handled by the law. She also learned Taekwondo during this period. Because her brother holds a powerful position (a police commander himself), her court case was closed. She stayed in the safe house for over one year. Although she did not get justice, she decided to move on. This was three years ago. She found a job, rented a room and started all over again. After working in some renowned hair salons, she returned to AWSAD as a trainer in hair dressing for other survivors. When asked what made it possible for her to start over and succeed, she says it is due to the services she got in the safe house. Beyond this, she states that it is her own willingness.'

The project has allowed establishing and strengthening collaboration and referral system between different bodies engaged in the response to GBV. This avoids duplication of efforts and enabled better handling of cases as well as more efficient physical and psychological rehabilitation of survivors.

Earning people's trust is very difficult; as a result we have to keep the survivors safe. This is what this safe house is providing to us. When the survivors go to the safe house, at first the survivors are not willing to talk. They feel uncomfortable sharing their problems with you because they don't feel safe. With the process they undergo, they are able to overcome that, and they start talking because in addition to the psychological therapy they receive, they also feel that people who are there have passed the same road they passed. **Deputy Inspector Alganesh**

The importance of safe houses in the response to GBV has been shown to the government and other stakeholders. It is clear to government counterparts that shelters are an important partner in the response to GBV.

Training and capacity building has brought attitudinal and behavior change in police officers and other frontline service providers to GBV survivors.

"Police are at the forefront of the criminal justice system. They are often called upon to intervene when an act of violence is in progress or shortly after it has occurred. Police works with survivors, offenders, witnesses and various forms of evidence. Their attitude and response to all involved can have a dramatic impact on ensuing developments, including the prevention of future violent acts and the protection of survivors," says **Inspector Sisay**

The training provided to police officers did not only focus on survivor handling and improved service provision. It also paid much attention to service providers who encounter victims and their terrifying experience every day. These public servants face psychological stress due to the nature of their work. The provision of training on stress management has enabled them to stay on the job.

Numerically, the following have been achieved:

- Capacity building and training for 82 police officers
- Provision of safe house services for 290 survivors and 97 children
- Training on self-defense and vocational skills to 60 survivors each and provision of startup capital to 40 survivors
- Coverage of living costs for 20 survivors who left the safe house
- Provision of psychological support to 10 perpetrators

What made this approach possible?

The most important success factor is team work and staff commitment. Most of the safe house staff has been working at AWSAD for several years. They are committed to the cause. Although they have a heavy workload and the nature of their work can be psychologically challenging, witnessing the rehabilitation of survivors is an essential motivational factor. Furthermore, the director of the safe house is as committed and serves as an example to the rest of the staff.

Strong prior experience and learning by doing: These achievements are a result of trial and error. It took several years to come up with this comprehensive approach. AWSAD recognizes gaps and challenges in the services it delivers and tries to address them with the available human and financial resources.

Inclusive approach of all major stakeholders: The director of AWSAD believes that the fight against GBV and its response can only be successful if all relevant stakeholders are involved in a collaborative manner. AWSAD holds a strong relationship with government actors and works through a referral system between these different bodies. It has established a good working relationship with major government actors based on trust and common approach to rehabilitation and empowerment of survivors. To strengthen this approach and ensure justice is served for survivors, it is in the process of establishing working relations with prosecutors.

Good track record, management and transparency: This has allowed AWSAD to continue its activities. Financial support from UNFPA and other donors is key to the very existence of AWSAD. Technical support from UNFPA on project management, reporting, etc has allowed AWSAD to document its activities and seek funding from other donors.

Challenges /gaps

Skills training alone is not sufficient: The market is competitive with many challenges ahead. For survivors with children, they have difficulty to engage in employment or in income generating activities as they do not have a place where they can leave their child. Once they leave the safe house, survivors have to become financially independent and this is one impediment to their economic empowerment and advancement.

Insufficient space to handle all demand: Due to the shortage of safe houses or shelters in Addis Ababa, it is difficult to turn away new comers who are also desperate. This tends to create an overcrowded environment in particular during the rainy season. For the survivors, the safe house is still better than other alternatives, if any. This increases the workload of staff and may affect the quality of services to a small extent.

High rental costs: The shelter is housed in a rented residence. Due to increases in rent or unwillingness of landlords to renew rental lease, the safe house has moved 4 times since its foundation in 2005. Several unsuccessful requests have been forwarded to government land authorities to acquire a parcel of land so as to build permanent structures for the safe house. The rent is very costly. Many survivors could be helped with the money spent on rent and moving.

Scarcity of resources: The safe house would be able to provide even better services to its residents if it had additional resources. Donation of used clothes especially for babies and children, and financial and technical support from volunteers is important but not sufficient.

4.11 Schools as entry points in combating GBV sustainably

Introduction

There are various considerations that justify using schools as entry points for GBV prevention and response programmes. One such justification relates to the high level of GBV cases affecting female students at various levels of schooling. The problems occur within schools and when commuting to and from schools. Another important justification relates to the fact that interventions targeted at school- going children are quite instrumental in bringing about lasting changes in communities as students are the future generation.

Discussions held with students where the implementing partners namely ADA, ODA and MLWDA worked directly with schools, different forms of GBV are perpetrated against female students. The common ones are: verbal abuse, harassment including asking for sexual favors, abduction and rape. These acts are committed both within school premises as well as while commuting to and from school. Teachers, fellow male students and community members are often reported as perpetrators. A female student shared the following experience:

> *"We rent rooms around our school as we live very far from our homes. When we are about to leave for our families at the end of the school week, it is quite a worrying time for us. We are terrified of being abducted and raped on our way home"*

Teachers that took part in the study also share these challenges. They are of the view that although the problem is showing some declines it is still a major source of worry, causing underperformance and even dropout among female students.

School based intervention: what went into it?

ADA, ODA and MLWDA all implemented school focused programmes in the different interventions areas. Three types of interventions were implemented in tandem. These are: creating/strengthening gender clubs within schools; providing different facilities whereby students can freely express their concerns such as secret boxes; and provision of rooms where female students can freely use during their monthly cycle.

Gender clubs within schools: this intervention mainly targeted secondary schools. Through the instrumentality of these clubs, awareness creation and training programmes on GBV were organized and provided to teachers and students. Furthermore, clubs were provided with materials as well as money to allow them to carry out their day to day functions.

School clubs also serve as forums where students can help each other. Students that took part in FGDs in Woyneenhet kebele in Derra woreda shared that club members and teachers contribute two birr every month so as to help the neediest students among them. Female students are the primary beneficiaries of this initiative.

Secrete boxes: secret boxes are safe places where students can express their concerns and receive support and solutions to their problems. Students utilize the secret boxes not only to get help for themselves but also to report on what is happening in their homes and their neighborhoods. Teachers shared that some students that may otherwise feel ashamed, report through the secret boxes about conditions of fistula and uterine prolapse that affect their mothers and sisters. The boxes play both preventive as well as response roles. The following story illustrates the importance of secret boxes in helping female students:

"The story happened in 2006 Ethiopian Calendar. In Wonji town Geferssa primary school, a seventh grader girl was being followed by a potential abductor. The girl lives with relatives around the school as her home is a bit far from the school. At the end of the school week she travels home to be with her parents. In one of those weekends a man together with his friends was planning to abduct her. This information was put in the secret box. When the gender club and school authorities became aware of the hovering harm, they called the girl and told her to cancel her trip to the family that weekend. The girl did as advised and avoided the unfortunate situation of abduction. Come Monday, the man came to the school looking for her. School authorities approached him and asked him what he wanted. He tried to lie his way through. The school authorities informed the local police and he was apprehended. Had it not been for the information found in the secret box, the life of this girl would have been ruined. The secret box provided the safe space whereby those with information can use it to prevent GBV cases."

What made this approach possible?

Using innovative approaches

Using secret boxes is one of the most interesting and innovative approaches witnessed in school related interventions. It serves as a safe space where female students can share their concerns in the safest and private manner possible. It is also cost effective. Once put in place, it can easily be utilized for quite some time. Information shared in the secret boxes is quickly acted upon by the school administration and gender club members.

Using multifaceted approaches

As the approaches discussed above show, those implementing partners that used schools as entry points combined the use of clubs and facilitating safe spaces in an integrated manner. Where information is shared through safe spaces like secret boxes, gender clubs take the responsibility of linking the services/solution to the students. This has meant that solutions are easily facilitated due to the integrated approaches.

Collaboration with other stakeholders

Schools are seen working in collaboration with other sectors to solve the various GBV related challenges of female students. A primary example of this is the collaboration between police and schools. Schools call upon law enforcement bodies when female students are faced with violent situations. Similar collaborations are also noted with Women and Children's Affairs Offices as well as health sectors. These collaborations ensure that students would get all the required services when faced with a situation of GBV.

Challenges/gaps

One of the challenges raised in relation to secret boxes is that though they provide the required safe space for female students, as very often they are used by female students, there are fears that female students may not openly talk about their problems and demand their rights in the open. Furthermore, a sense of alienation and indifference may also develop among male students as they are not made to be part of the discussion.

A related challenge is in the work of these implementing partners using schools as entry points, the role and place of male students in the fight against GBV does not appear to be strong. The gender clubs are usually for female students. Interestingly it is mainly female teachers that take part in such clubs. Support systems such as direct material support only focuses on female students leading at times to resentment among male students.

4.12 The MCRC Approach

The Mother and Child Rehabilitation Center (MCRC) is an organization that benefited from UNFPA funding mainly working on assisting survivors of GBV in Addis Ababa. It provides shelter for survivors of GBV with a particular focus on children, either victims themselves or whose mother is a survivor.

Supporting future generations: what went into it?

MCRC provides safe house for women and children who benefit from counseling and psychological rehabilitation services, renting housing for mothers and their children. Its approach is innovative in that it not only focuses on mothers, but strives to rehabilitate children. MCRC provides nutritional services, formal education support, counseling and psychosocial services and therapeutic programme s.

Support to victims and survivors of GBV may tend to overlook the damages to children. MCRC fill this gap by channeling much of its resources towards children. These children are provided with a nutritionally balanced diet. MCRC has different therapeutic programme s designed to help children cope with trauma of violence and sexual, mental, physical and emotional abuse/deprivation and lack of education. Therapy programme s include music, dance, exercise/sport and photography, which help to improve survivors not only to deal with their personal issues but also with their social interactions and the manner in which they deal with everyday obstacles. When medical care is required, MCRC accompanies children throughout their physical and psychological convalescence in different private and public hospitals.

One of the barriers to mothers' economic empowerment is their reproductive role. In the case of survivors of GBV, a woman often ends up being a mother without having any clue where and how to raise her child and work to provide for herself and her child. MCRC lifts this challenge faced by single mothers. It provides a day care service and a home for children of survivors allowing mothers to have time for training and/or work without having to worry about the safety of their child. A monitoring system is also established to follow up on survivors after they have left the organization.

Achievements

Saving the lives of women and children is the major outcome. Physical and psychological rehabilitation as well as economic empowerment have been achieved through this project as reflected by testimonies of direct beneficiaries.

Testimony 1: Her parents died at a young age so she was raised by her aunt. When she was 18, she got married and moved to Mekelle. After living there for 3 years, she got into a big fight with her husband and they divorced. 'I came to Addis after separating with my husband and found a job as a house maid… I met a man and he tricked me into having sex with him and I got pregnant. He denied that the baby was his and called me different names… I got very worried; it was like the sky was falling on me; I even attempted to commit suicide…the women in the compound where I used to work told me about MCRC. That's how I came to know about the centre.' After she stayed in the safe house of the centre for about 2 years, MCRC rented her a house and gave her 800 birr food allowance per month. As part of the centre's intervention of engaging the survivors in income generating activities, she started hair dressing training after which she found a job in a hair salon. 'When I started earning money, the centre cut the house rent allowance but kept my daughter at the centre as I was a full time employee…from all the service the center provides, for me the most satisfactory is the safe house; knowing that my daughter is in good hands, getting education and eating 3 times a day is the best thing any mother wishes to give for her child and the centre is actually providing all those… now I am concentrating on my work.'.

Testimony 2: She was born and raised in Gayent, Gonder. She attended school up to grade 7 but she discontinued as she came to Addis to help out her parents. She got a job as a house maid in Addis. '…I met this guy when I was a maid, fell in love and got married. I gave birth to two boys… My husband left for his mistress, leaving me and the kids empty handed…I started solid waste collection to bring income to the family but raising two kids and paying house rent was very difficult … my friend told me that if I went to MCRC, they would give my children an exercise book; but when I paid a visit to the centre I came to know there is more to it than exercise books.' After examining her case, the centre provided her with accommodation, paid for her children's school fees and materials. She also got training in sewing but after she graduated from the sewing school, her monthly salary was only 850 birr, which can't even pay the house rent. Because of her low income, she still seeks help from the MCRC. 'My children are in grade 8 now, they are top students… the centre has done lot of things for us and I wish I could stand on my own but I am handicapped as the salary I am getting right now is not even enough for myself let alone my children.'

Testimony 3: She was born in Hawassa. She lost her parents at the age of 4 due to a car accident. As she had no siblings, her friend's parents took custody of her. She was only 15 when she got raped on her way home from school. 'I felt like people who know about it will judge me in a way about it, I felt like maybe they will think it is my fault, that's why I wanted to just keep it to myself, but as the days went by, people in the house started to notice a change in the way I walk and on my behavior. Because I refused to talk they took me to the hospital. That is how I came to know about my pregnancy…the police tried to find the person who raped me but they didn't succeed as the reporting was too late.' Once they knew she was pregnant her foster parents forced her to quit school and when her pregnancy started to show, they took her to Hawassa referral hospital to give birth. 'I requested the Hawassa referral hospital to take my child and they referred me to MCRC. The centre took me in. When I came to MCRC, I looked pale and drawn. When I was interviewed, I was humiliated to tell my story. I labeled myself ill-fated and worthless… I really wanted to kill my baby. It's after a lot of counseling that I was calmed… I am so grateful for what the centre has done for me this far. If I hadn't joined this centre I would have ended up on the street.' MCRC has provided her with postnatal care, accommodation in safe house of the centre, and all the necessary material for her infant and psychological therapy. She is now in grade 10 attentively following her school. The social worker closely follows up all her progresses.

What made this approach possible?

Commitment is the major success factor for this approach. In particular the commitment of the founder and director of MCRC is the driving force of the organization. Funding is also a crucial element of the activities of MCRC.

Challenges /gaps

Skill training alone is not sufficient: When they leave the safe house, survivors have to become financially independent and this is a serious impediment to their economic empowerment and advancement. It is also a source of dependency syndrome.

Funding is essential to maintain the activities of MCRC. Most staffs that were part of the UNFPA funded programme left after the latter phased out. Furthermore, because of scarce funding, such services can only be provided to a limited number of survivors.

The referral system through which victims/survivors are channeled to the safe houses is not fully functional. MCRC's activities are not well known by government service providers such as the police and Women's Affairs Offices. Few survivors have reported their case to the police and this can be the result of lack of coordination between the centre and the police.

4.13 FBOs as a means of raising awareness and preventing GBV

Introduction

Faith and religion play an important role in Ethiopia. Faith based organization (FBOs) have a wide reach and influence. They are firmly rooted in community. As trusted institutions, FBOs have the capacity to affect knowledge, attitude and behavior of their constituencies. Religious leaders are often relied upon for guidance on intimate and personal issues. FBOs can therefore be powerful agents of change in the prevention and response to GBV.

Recognizing this, UNFPA partnered with the Norwegian Church Aid (NCA) in support of collaboration with different FBOs to prevent and improve response to GBV. The Programme aimed at building the capacity

of FBOs at national and regional levels to increase awareness on GBV, and its consequences for women, girls and families. Through this project, NCA facilitated dialogue at various levels with the aim of engaging FBOs in addressing Sexual and Reproductive Health (SRH) and GBV issues through their existing structures.

The programme e was implemented in collaborations with Inter-Religious Council of Ethiopia (IRCE), an umbrella organization that brings together the Ethiopian Orthodox Church Inter-Church Aid Commission, Evangelical Churches Fellowship of Ethiopia, Ethiopian Catholic Church, Ethiopian Evangelical Churches MekaneYesus Development and Social Services Commission North Area Work and the Ethiopian Muslim Development Agency.

NCA approach to address GBV: what went into it?

The following activities were undertaken:

- Organize religious leaders' dialogue forums at national and regional level
- Commemoration of the 16 days of activism against gender based violence
- Awareness creation activities at congregation level
- Use FBO media to disseminate information/ publication of print media
- Capacity building of theological and marriage counselling training institutes for integration and strengthening model marriage and family counseling centers
- National FBO engagement workshop and Exhibition

These activities were aimed at raising the awareness of religious leaders on GBV. FBOs were also provided with material to disseminate their knowledge and conviction in regards to prevention and response to GBV. NCA provided technical support to its partner FBOs throughout their different activities and the project life.

Achievements

Overall understanding by religious leaders of GBV, its causes and consequences: Religious leaders' awareness was demonstrated through their commitment and engagement ranging from integrating GBV issue as one area of teaching in the action plan for the Church and institutionalizing the response in different ways. As a result of this, some churches established a counseling center for GBV and family related issues in their Church compound and assigned volunteer professional counselors from the congregation. Establishing marriage and family counseling centers helped to address the issue of GBV particularly intimate partners' violence within the faith setting. Youth clubs were set up at the Ethiopian Orthodox Church and Evangelical Church.

High level religious leaders' dialogue was initiated and resulted in a joint statement. This interfaith dialogue at the top leadership level is an achievement as it allowed religious leaders from different faiths to discuss on the impacts of GBV on individuals, on the society and the country as a whole. In their joint statement, they have condemned GBV and HTPs, committed to teach ethics and moral values to prevent GBV in their religious teachings and exert utmost effort to bring about change, and agreed to support and rehabilitate victims of GBV and work closely with law enforcement bodies to bring justice to victims.

FBOs' efforts in dealing with the issue of GBV proved that faith leaders could be an essential and effective mechanism to raise awareness and bring about attitudinal and behavior change in the community. The fact that FBOs can reach their constituencies with such messages easily makes this approach efficient in

the fight against GBV.There is a higher level of awareness and commitment. Counseling services have also seen increased demand.

What made this approach possible?

Long years of partnership with FBOs have enabled NCA to hold constructive relationships marked by trust. Its long term commitment in working with FBOs created a platform for close collaboration and discussion with high level religious councils. As a result, NCA was able to address sensitive or taboo forms of GBV and HTPs such as female genital mutilation.

The multiplier effect: Using FBOs is a cost effective approach as structures already exist and are fully operational. No additional human resources and limited financial resources are necessary for addressing GBV in the teachings. Key persons within each religious institution participating in the project were given training. They in turn trained other members of congregations and heads of Community Based Organizations (CBOs). Finally the message reaches the followers. The structure of FBOs is conducive to getting the message through.

Endorsement by the highest level of religious institutions and religious leaders was an important factor. The very fact that the process towards the issuance of joint statement has brought together various religious leaders has created an enabling environment for dialogue and understanding.

Exposing the suffering of GBV victims and survivors to the top level religious leaders has opened their eyes on the importance of addressing the issue as part of religious teachings. Giving a face to GBV has been a key approach that made it less of a utopia.

Challenges /gaps

This approach is sometimes challenging to transmit the FBOs message as followers have many other means (in particular media) of hearing about GBV in Addis Ababa. Sometimes messages from different sources are not totally aligned with that of the preacher.

The budget allocated was very limited and did not allow a greater number of religious leaders to be trained. Although the FBO approach uses existing structures, project activities have costs (transport, communication, organizing training, producing training and preaching materials, etc) that are not all covered by the project budget. This also limits the activities of FBOs to prevention while it could expand its reach to address response to GBV.

There is a lack of coordination among the different faiths leading to duplication of efforts. If two FBOs are focusing on the same area, they could coordinate efforts. In particular in material development, some aspects of integrating GBV issues in preaching do not differ from one faith to the other. For instance, the definition of GBV, its causes and consequences are common across religions.

5. Lessons learned

As highlighted in the introductory section of this document, the exercise of documenting good practices and lessons learned are very much interrelated. Examining what works i.e. what leads to the desired results is as much an investigation of why certain practices that have been put to use do not work. In looking into why some of the practices employed by the Implementing Partners (IPs) have not worked or have not worked to the desired level, one is able to draw lessons on how to approach similar interventions in the future.

The data collection has revealed certain challenges and gaps in the course of the implementation of the interventions by the IPs. These challenges and gaps have detracted from what could have possibly been achieved had it not been for the challenges. In the worst case scenario, the gaps have been insurmountable that intended results/outcomes have been compromised.

Lessons are not just associated with gaps and challenges. Lessons are also about the possibility of maximizing results by fine-tuning what works. Accordingly, even the documented good practices may have the potential to yield more with fine tuning of working approaches and strategies.

In light of these, this section draws on lessons learned from observed challenges as well as documented good and working practices to draw a general picture with specific interventions used as points of illustrations.

5.1 Limited understanding of the local context/implications of violence is a huge cost:

Sufficient understanding of local context is a very important first step towards designing a working approach and strategy. Similarly, a lack of understanding of the implication of violence on the lives of women is detrimental to the success of the intervention. All the best practices documented for this study clearly confirm this. Good level of understanding of the local context may come in different ways. It may come from strong prior work experience in the area of intervention as has been the case for instance for OSSA in Mekelle and ODA in Oromia. It may also come from partnering with and engaging actors that have strong presence in the intervention areas, again ODA and MLWDA can be good examples – particularly their strong ties and use of existing structures.

The understanding of local context contributes to the successful implementations of the intervention in many ways. First, it helps to accurately diagnose the problem on the ground. Second, it can easily identify potential stakeholders/partners that can be brought on board for successful implementation. Third, effective ways of reaching communities can easily be identified. Fourth, it can tap in existing resources in terms of materials and human resources to efficiently implement the programme.

When implementing partners do not have sufficient understanding of the local context/situation in which they operate, the entire intervention is put at risk. The problem begins with the inability to accurately diagnose the problem that is being addressed. Although the UNFPA supported programme has outlined the umbrella objectives, activities that can effectively address these objectives are left to implementing partners. Implementing partners in turn are expected to design activities that can respond to the problems on the ground. With limited understanding of the local context, the activities designed suffer from a mismatch between what is needed and what is implemented. Furthermore, although the planned activities may be able to address the problems, the implementation may suffer due to lack of understanding of the local dynamic. Either ways, the implementation will end up not fulfilling its intended outcome.

The implementation of the intervention by OSSA in Adama is a good illustration of this gap. OSSA in its work with Adama University Gender Office implemented a programme that targeted the following sets of activities: increased awareness through activities like orientation, increased access to SRH services through for example provision of sanitary materials among others and increased capacity for stakeholders. Discussion with beneficiaries and partners at the gender office revealed that although resource i.e. money wise it is one of the big projects in their University; in terms of actual contribution to the intended goals it is quite minimal.

Discussions with the representatives of the Gender Office revealed different shortcomings as to why the intervention did not contribute as expected. First of all, the intervention did not have a particular target group. Other similar projects would start with identifying a target group – based on their objectives and the group would become x's (the funder's) group. The formation of a target group helps to do follow up and progress on the impacts of the intervention. Beneficiary students also identify with the goals and objectives of that particular intervention. This bond leads to follow up on both sides – the gender office follows upon the performance of the beneficiaries and how the support is helping them; students also report on their performance, make suggestions to improve the services and also hold the gender office accountable for gaps.

Related to this, there was no discussion forum that was created between OSSA Adama and the Gender Office that was overseeing the implementation of the intervention. OSSA opted for the approach of buying and delivering supplies to the University with no feedback loop to assess effectiveness, a match between the needs of students and its intervention etc. Documentation on the process was also lacking.

Students also shared that there was no predictability in terms of the support services provided through OSSA Adama. This is particularly true in terms of timing of the support services – sanitary and cleaning materials supplied to students. Furthermore, according to female students' association representatives, the

life skills trainings provided as part of the intervention did not introduce something new for students. As such the benefits from that aspect of the intervention were quite minimal.

The challenges/gaps identified above have in part resulted from the limited understanding of the context – the needs of students and the manner in which interventions should be designed and implemented. This could have been addressed either through a quick assessment of what the problems are – similar to what OSSA did in Mekelle or through forging strong partnership with the gender office – that has very good understanding of the context i.e. needs of students and how a GBV prevention and response programme should address the same. Instead OSSA opted for a one sided approach of supplying resources.

Another example of limited understanding of local context frustrating the objectives of the intervention comes from Mekaneyesus Church in Mekelle. The gap here relates to one aspect or component of the activities of the Church namely the livelihood intervention approach to help survivors of violence become self-sufficient.

According to discussions with the representative of the church, this component of the intervention targeted fifty-one women survivors. The main gap comes in the manner in which funds were disbursed to the women including the conditionality attached. Women survivors of violence are among the most vulnerable sections of society – they have very limited social capital in terms of support system, resources etc. This is one of the reasons why they need different kinds of support – medical, psychological, material and livelihood combined so that they can get out of the cycle which may expose them to further violence. Despite this the women that eventually became beneficiaries were asked to provide collateral to receive the seed money. The key informant from the Church shared the ordeal that the women went through to bring in the said collateral. At times, the nurse that served on the project presented herself and her family members as collateral so that the women would be able to access the fund. Many that could not provide the collateral were left out. On the part of the church, this was justified by the need to have proper paper work for the auditing of the project.

The loan gave the beneficiaries three months of grace period, after which they were required to pay monthly installments towards meeting their obligations. Despite all the stringent conditions attached to the disbursement of the loan, it is only three women that are said to be well with the seed money. The Church has not been able to follow up on the remaining beneficiaries as some have disappeared, changed their address etc.

This can be compared to similar intervention done by DOC in Mekelle. The livelihood intervention component of DOC did not impose all of these cumbersome conditions on the women and yet has been successful in terms of helping the women earn a leaving out of the seed money and have also been able to record higher percentage of repayment (refer to the best practice case of DOC above for the details).

The difference in understanding of the situation of women affected by violence among the IPs has seriously compromised the outcomes of similarly intended interventions. The impact has been not only a costly experience for Mekaneyesus Church it has also unnecessarily burdened women survivors of violence.

5.2 Weakness of Implementing Partners

The success of interventions is as much a reflection of the strengths of the implementing partners. Strength of implementing partners can be measured through different variables: institutional/structural strength including sufficient human resource in quality and quantity; well defined mission including high level of

commitment to the work; strong leadership and direction; prior experience in GBV and HTP related work and strong presence in networks that can facilitate one's work are among the major factors.

As the documented good practices above show, success is very much related to the presence of these factors. Weaknesses of some of these variables compromise potential results from the interventions. Examples that can illustrate this point can be drawn from the Federal Police and BIGA. While BIGA has been a strong partner in the implementation of this intervention providing much needed support for survivors in a region where similar support system does not exist, it was severely affected by a leadership crisis midway through the implementation of the programme. The crisis has resulted in uncertainties both for staff and survivors that are beneficiaries of the intervention.

The intervention with Federal Police illustrates a similar point. While the intervention under the direction of Federal Police has shown success in some of the areas, in the majority of places results have not been as desired. There was limited communication between the implementing partners at woreda level and the parent IP i.e. Federal Police which left some of the woreda police partners at a loss as to what to do with the money transferred. In some instances, authorities have banned the use of the transferred resource as there was no clarity on its use. In other woredas, the implementers couldn't use the money to address glaring needs as they were not to assume responsibility of the consequences. These shortcomings contributed to a less than desirable outcome from including the police within the programme. The lack of qualified personnel to direct the intervention coupled with limited prior experience and follow up have all contributed to this outcome.

Vetting of implementing partners should thus take into account these variables/elements prior to engaging them in the interventions. While vetting can provide initial assessment, similar assessment during the implementation of the programme is also vital to take corrective measures during the lifetime of the programme.

5.3 Rarity of similar level of success in all components of interventions

The good practices documented above have focused on the most viable approach or strategy that the IP has employed to bring about its 'headline' achievement in the intervention. It should however be noted that each implementing partner implemented several strategies/approaches to address the different components of the programme. This is particularly true given that prevention and response constituted the main components of the programmes of implementing partners. This approach is necessitated by the fact that one can effectively address GBV and its consequences through combined interventions targeting prevention, response as well as protection. This approach is one that can break the cycle that exposes vulnerable women to a repeat of violence in their lifetime.

While the overall framing of the programme as described above is noble, the rate of success in the implementation of the different components by the implementing partners shows differences. Reports of implementing partners as well as discussions with beneficiaries at community and state structure levels reveal that it is rare for an implementing partner to show similar level of success in all of the components of the intervention. Again, while this may not be out of the natural in implementation of programme s, at times gains in one component could be maximized if time and resources are focused in that component rather than being thinly spread across many. This would have positive implications on overall efficiency and effectiveness of the programme.

For instance, the MLWDA intervention attests to this point. MLWDA's approach that combined awareness creation, care and rehabilitation for survivors and livelihood approach are all important to addresses all

aspects of the problem. However, challenges were noted in successfully pursuing all aspects of the intervention. Particular challenges were noted with respect to the livelihood support approach. The evidence shows that of the total beneficiaries of this programme it is quite a small percentage that managed to return the funds from the revolving fund. Though funds are provided to help the women, what is required to make them succeed has not been fully provided. These include: trainings on managing money, business skills etc. A stronger coordination whereby full package of support services are provided ensures effective results.

Similarly, the intervention by Mekanyesus Church in Mekelle faced similar shortcomings. While the prevention aspect of the intervention is credited for innovative approaches like men's and youth involvement in GBV work, the performance of the livelihood approach was dismal. It was poor both in terms of meeting its target of enabling women to support themselves but also ended up burdening women survivors of violence through its cumbersome procedure.

What can be done to address this? One possible mechanism for future interventions may be to divide components to different implementing partners based on their area of effectiveness. Accordingly, for implementing partners working in the same region, components of prevention, protection and response may be divided along their strengths. In situations where an implementing partner is effective in addressing all of its components in a relatively reasonable manner, the three pronged approach may still be maintained.

5.4 Differences among similar IP's interventions in different locations

The same implementing partner operates in different location/regions. This has been the case for instance with OSSA, ESOG and Pro-pride. An interesting picture in relation to success of interventions is that while an implementing partner may be successful in one area, it may not be able to repeat the same success in another area. This outcome is perfectly natural in that success is a combination of many factors, local context being one.

A good example in this regard may be the implementation of similar package of interventions by OSSA in Mekelle and in Adama. While the intervention in Mekelle is among the best practices of the programme, the intervention in Adama has net been quite successful in fully meeting its objectives. Similarly, the intervention of ESOG in Jimma has been successful thus counting as a best practice while that of Amhara has been as successful.

A question that should arise here however is the extents to which implementing partners that operate similar interventions in different regions/areas as well as UNFPA take note of these differences and the factors behind and how this informs their implementation in the course of the intervention. Understanding the differences and associated factors may go a long way in terms of fine-tuning approaches in different locations.

5.5 Limited forum for engagement/discussion among IPs at least at regional level

Different implementing partners operate in a given region. This has been the case in Amhara, Oromia, SNNP as well as Tigray Regions with an average of two or three implementing partners operating in a given region. While some of the implementing partners have forged a link whereby they created forums of experience sharing and exchange of information as well as leveraging of a forum created by one for the benefit of another, this has not been a uniform approach or exercise in all of the regions.

During the field trips for data collection, questions were raised to the different implementing partners whether they were aware of others operating under the same programme in their areas. While some acknowledged that they were aware of others operating under the same programme, they reported they did have working relations. Still others stated that they did not know of others that work under the same programme. The following interesting case illustrates this point.

ODA operated in Adama in Oromia Regional State. The Adama Woreda Police was also a partner. Discussions with the gender focal person at Adama Woreda Police revealed different challenges for addressing GBV and HTPs. She shared that while they were able to address different aspects of the problem, addressing the root cause required bringing in all important community members such as elders, religious leaders, Geda leaders, etc. in one big conference whereby they can discuss the roots causes and pass on strict and binding messages to their respective followers. They couldn't do this as they do not have sufficient resources from the programme. Interestingly, ODA that operated under the same programme exactly did the kinds of interventions that the police were unable to do due to resource limitations. The most interesting aspect of this story is that ODA and the Adama Police station are located next to each other in the same neighborhood. Asked whether they are aware of ODA's activities, the gender focal person confirmed that they were not aware of that and if they had this information at the beginning of the intervention, they would have partnered with ODA to maximize the results.

One way of addressing this gap is in future programme s; forums that bring in different implementing partners may be built into programme plans. At least, regional level forums can be ideal as they are not costly and can be left to the management of the partners.

5.6 Who is present at the table for review meetings

Periodic review meetings are built into the programme. Review meetings are important for taking stock of what has been done, what works and what does not work and take corrective measures. Review meetings are as good as the information that participants can bring in. If participants are far removed from actual implementation on the ground, their inputs for review cannot be as effective.

Review meeting participants have been chosen by head offices. While some head offices have called on implementers on the ground, others have not done so. This has had some implications. Firstly, implementers at ground level being left out, the review meetings miss important details that can make or break the interventions. Secondly, implementers at ground level do not seem to get answers to their challenges (particularly as it directly relates to UNFPA) as they are not afforded opportunities to share the same. The latter has had impact on the drive and initiative of implementers on the ground.

In future programming, mechanisms that can ensure the participation of ground level implementers may need to be built into the programme. This stand should also get the buy-in of head offices so as to run smooth operations.

5.7 Limitations in involving men in the programmes

The various projects implemented under the UNFPA supported programme either directly or indirectly had women as the primary and in many instances exclusive beneficiaries. While this approach is in part necessitated by the immediate impacts of violence on the wellbeing of women and the need to support them in the aftermath, active targeting of men which are actually part of the problem as well as the solution is necessary.

A good illustration of this dilemma is seen in the school based/focused interventions. In the projects of implementing partners using schools as entry points, the role and place of male students in the fight against GBV does not appear to be strong. The gender clubs are usually for female students. Interestingly it is mainly female teachers that take part in such clubs. Support systems such as direct material support only focus on female students leading at times to resentment among male students.

Similar dilemma is noted in the intervention by OSSA in higher education institutions particularly in Mekelle. Intervention measures such as material support are mainly targeted at female students. Furthermore, the distribution of policy documents such as anti-harassment code was limited to female students. While this is important to equip female students with the knowledge required to pursue their rights, its narrow focus on females may mean overlooking potential partners that can make the intervention work better. In this regard, targeting male students and perpetrators in future interventions may yield better results. It also helps to avert the feeling of being left out among male students.

5.8 Exit strategies

Sustainability of interventions even after the phasing out of support programmes is one marker of good practices. The interventions have built in different kinds of exit strategies into their programmes. While some of these strategies are promising others have not been found to be adequate. A measure of the success of exit strategies is the continuation of the work after the phasing out of the programme. In some of the interventions, it was noted during data collection that the work has not continued in the desired manner. For instance, the failure to tap into the mandates, resources and influence of structures such as Women and Children Affairs Offices that are influential to influence activities geared at promoting and protecting the rights of women has meant that MLWDA's work particularly in relation to livelihood activities has not continued as desired. Similarly, the work of OSSA in Adama could not be sustained in any way after it exited.

Promising strategies include the use of existing structures for implementation of the interventions which guarantees continuation of the work after the programmes (ODA for example provides a good case in point) as well as work on changing systems that will continue to shape future interventions (OSSA is a good example in this regard). Another good example relates to MLWDA's intervention as it relates to the response component of the programme. Accordingly, its ability to secure land and start the building of its own safe house is important in terms of sustainability as it cuts out one of the largest costs of running a safe house service.

The exit strategy of ESOG is also mentionable as promising strategy. ESOG handed over its model clinics to the respective health institutions upon the phasing out of the programme s. This has ensured the continuity of services. In a similar note, NCA's approach of institutionalizing GBV and HTP issues through faith based organizations serves the same purpose.

5.9 Disbursement of funds and reporting: clarity in expectations and associated consequences

A challenge raised by all implementing partners relates to the timing of disbursement of funds and submission of timely report to UNFPA. Implementing partners complained of the complications that arise from quarterly disbursement of fund. Complications relate to delay, difficulty in utilizing funds within the short period, and difficulty in producing reports within a short period are some of the challenges. Implementing partners shared that due to these difficulties, at times they are forced to leave certain planned activities.

The main challenge on the part of UNFPA relates to delays in submission of performance reports. These reports are conditions for the timely release of funds every quarter. The fact that all implementing partners should submit their report before their release of funds has ended up punishing those that submit their reports on time. In time though, UNFPA has attempted to devise strategies whereby the delay in reporting by one will not affect others.

Annex-1 - List of respondents

No	Name	Organization	Position
	ODA		
	Taddesse Lema	ODA	ODA East Showa Coordinator
	Azeb Taddesse	Adam Zureya Wo Justice Office	Head
	Kumele Guadissa	Adam Zureya Wo WCA Office	Head
	YesuneshTakele	WonjiGefersa 01 Kebele	Chair person
	Gelana Ayana	WonjiGefersa 01 Kebele	Cabine member
	Negash Seberekle	WonjiGefersa 01 Kebele	Cabine member
	Feteya Mohamed	East Hareregе Zone WCAO	Head
	Emebete Mengstu	Chiro Woreda WCAO	D/Head
	Melese Lema	ODA-Chiro	Chiro representative
	Meko Yesu Yemer	Chiro Woreda	Beneficiary
	Misra Mohamed	Chiro Woreda	Beneficiary
	Fate Mohmaed	Adami-Tulu wor(Habene Kebele	1/30 leader
	Bekelech Yasin	Adami-Tulu Wor WCAO	Head
	Fatuma Yassin	Adami Tulu (Geremame Kebele)	Beneficiary
	OSSA		
	Yirga G/Mariam	OSSA(Mekele)	Head
	Kiros Tesfaye	OSSA(Mekele)	Programme Coordinator
	Gere G/Michel	OSSA(Mekele)	Programme Coordinator
	Mebrit Yohans	Mekele University	Gender office Head
	Abebe Getachew	Mekele University	Expert
	----------	OSSA (Adama)	
	----------	Adama Univ Gender office	
	------	Adama Univ (student represe)	
	---------	Adama Univ (student represen)	
	NCA		
	Selamu Belay	NCA-Awssa	Project coordinator
	Pastor Tsegaye	Mekanyesus church-Awwsa	Pastor
	Pastor Welde-	Mekanyesus church-Awwsa	Pastor
	Pastor Derege	Mekanyesus church-Awwsa	Pastor
	Melat Yakobe	MC- Awssa(Yaskor group)	Member
	Betelheme Lema	MC- Awssa(Yaskor group)	Member
	Yohans H/Mariam	Catholic Church- Mekele (DOC)	Project coordinator
	Eyerusaleme Yared	Catholic Church- Mekele (DOC)	Beneficiary
	Gebreselasse/G	Ayeder K/k WAO	Expert
	Debas Halefom	Ayeder K/k LSAO	Head
	------	Mekanyesus che (Mekele)	-----
	ESOG		
	Mulutsega Fiseha	ESOG	Office head, Gonder
	Dr. Getachew Shifera	ESOG	ESOG rep. Gonder
	Sister Atseda Berhan	ESOG	Senior nurse, Gonder

	Dr. KiroseTefera	Gonder Hospital/University	Resident Gynecologist
	Sister Selam Bohonge	Gonder Hospital/University	ESSOG clinic nurse ,Gonder
	Birtukan Zewde	3rd Police Station	Police officer, Children &Women Unit
	C/I Mekam Mengesha	Gonder City Police	Zonal police WCAO affairs unit head
	Sister Roman Asrat	Mekele Aydar Hospital	Senior nurse
	Sister Sara Bahta	Mekele Aydar Hospital	Senior nurse
	Feven Kasaye	ESSOG- Mekele	Office head
	Fedila Teyibe	Essog- Jimma	office head
	Sr. Rhael Getcahew	ESOG's Model clinic	Nurse
	Sr. Marta Tolossa	ESOG's Model clinic	Nurse
	Dr. Webshete Gream	Jimma Hospital	ESSOG focal person
	Solomon Tesfaye	Jimma (*Tirra-afeta* Woreda HC	Midwifery
	Sa/ Abente Gelana	Woreda 02 Police Unit	Head
	Kedeja Hussen	Jima city WAO	Head
	MLWDA		
	Gemechu Nemera	MLWDA	Programme coordinator
	Henok Gebeyewe	MLWDA	Project officer
	Hadri Worku	MLWDA	Gender expert
	Arega Alamrew	Pawe wor women's & chi office	Expert
	Meryiam	Pawe wor women's & chi office	Expert
	Mohammed	Pawe wor women's & chi office	Safe house coordinator
	Medenek Tessema	Gligele Beles Prison cell	women prisoner's representatives
	ZenebeTadesse	MLWDA	Facilitator
	Pro-Pride		
	Dereje Demeke	Pro-Pride- Baher Dar	Editor
	Smauel Sendeke	Pro-Pride- Baher Dar	Reporter
	Mulugeta Mitiku	Bahirdar woreda court	Juge
	Asmamaw Belay	Amhara mass media	Jornalist
	Yesmawe Chane	Bahirdar	listener
	Chale Mare	Bahirdar	youth center
	Mehelete Tilahun	Bahirdar	mother to mother organization
	Meskerem Abebe	Bahirdar	listener
	Lidya Asmamawe	Bahirdar	Fasilo secondary school
	S/ Werke Semachew-	Bahirdar	1st police station
	Tiruwork Yasin	Bahirdar	listener
	Belaynesh Lema	Bahirdar	listener
	Belaynshe Fantahun	Diredawa	Reporter
	Wondemagene Yeme	Diredawa	Reporter
	Zekareya Ameya	Diredawa	Editor
	Yesufe Useman	Diredawa	station head
	Momina Negwo	Damota Keble(Haremaya)	Beneficiary
	Madie Yesufe	Damota Keble(Haremaya)	Beneficary
	Zeyida Ahemed	Seadie Keble(Haremaya)	Beneficiary
	Senaite Tilahun	Adele Keble	Beneficiary
	Erukia Ibrahim	Efabatie Keble	women asso representative

	ADA		
	Hamid Mohamed	ADA	Director
	Tadeele Asegedew	ADA	North Wollo Coordinator
	Genet Meteku-	Kobo woreda	Head of women & children affairs off
	TigabuTegene	Kobo woreda	one to five members
	BejuguAsefa	Kobo woreda	one to five members
	YeshiArgea	Kobo woreda	one to five members
	SemachenTeme	Kobo woreda	one to five members
	S/ SitotaweTeshome	Kobo woreda	Community police
	Tizazu Tessema	ADA (Dera)	Coordinator
	Ethiopia Gegade	WCAO/ Dera	Head
	Aregash Ayalew	Weyenichet Kebele WCAO	Head
	Tsgereda Athsede	Weyenichet Kebele	Student
	Yeshi Mare	Weyenichet Kebele	Student
	Getenet Ayalew	Weyenichet Kebele	Beneficiary
	Engocha Lemlem	Weyenichet Kebele	Beneficiary
	Andwalem Worekneh	Enarge Enawga Woreda (ADA)	Coordinator
	C/S. Mamo Netsanet	Dejagmena Kebale	Community Police
	Ememe Gete	Dejagmena Kebale	1/5 group member
	Asagash Seid,	Dejagmena Kebale	Beneficiary
	Ayaleneshe Lema	Dejagmena Kebale	Beneficiary
	NCWH		
	Aleme Tadesse	NCWH(B/G)	Coordinator
	Beletech Asemare	NCWH(Assosa Woreda)	Coordinator
	Desalene Mengstu	Assosa Woreda WCAO	Senior Expert
	Shambele Gudeta	B/G WCAO	Senior Expert
	Zenebe Gudeta	Assosa	Beneficiary
	shemsi Ahemed	Assosa	Beneficiary
	Menene Ali Belachwe	Banbasi -NCWH	Focal person
	Zeynebe Ibrahim	Banbasi Woreda WA	D/Head
	Abdul Fetahe	Banbasi Woreda WCAO	Expert
	Meriam Nejib	Banbasi woreda	Beneficiary
	Kemise Ayana	Banbasi woreda	Beneficiary
	Zeynyia Ahemed	Banbasi woreda	Beneficiary
	Police woreda/city		
	In/ Brehanu Alemay	Dera woreda	Police Head
	C/ S Yewyin Hareg	Enarge Enawga woreda	W/C unit head
	S/r Bogalech Tessa	Adama Woreda	W/C unit head
	Ins. Sntayew Betola	Adama woreda	W/C unit officer
	S/I Yefit Eshet Tades	Awassa city	Tabor sub city police
	S/I Abeba Demese	Assosa Woreda	W/C unit head
	C/S . Mulu Tesahger	Kobo Woreda	W/C unit head
	C/S . Aminat Mohame	Banbasi Woreda	W/C unit head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