Understanding the Gaps in Delivering Comprehensive Sexual, Reproductive Health and Rights Services for Sexual and Gender-Based Violence Survivors in Humanitarian Settings in Ethiopia

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EXECUTIVE SUMMARY

Background: It is estimated that one in three women will experience gender based violence in their lifetime. According to the 2016 Ethiopian Demographic and Health Survey report, sexual violence was reported to be 10%, but recent studies showed a prevalence of over 40%. Despite the increase in prevalence, the reporting and care seeking behavior continues to be low. It has been known that Sexual and Gender Based Violence (SGBV) increases during conflict and the period following them, as it is used as a war tactic. During such times, the tendency to report and seek care is thought to decrease even more due to insecurity, displacement and the inability of the health system and other services to respond to these situations. Therefore, this study aimed to understand the existing gaps in disclosure and formal reporting of SGBV, barriers for SGBV care seeking and delivery to survivors exposed to violence during conflict or forced displacement from conflict. The finding provides evidence on how to offer, integrate and deliver SGBV care in humanitarian settings.

Methods: From May to July 2022, the research was carried out in four Ethiopian regions: Amhara, Oromia, Afar, and Somali regional states, and Addis Ababa city administration. A qualitative study using in-depth and key infomant interviews was conducted with 47 participants, including 19 survivors of sexual violence and 28 stakeholders, 7 service providers and 21 key experts. A semi-structured interview guide was used to gather data. The audio data was transcribed verbatim and translated into English before being entered into the Dedoose software for content analysis. The data was coded using the codebook created by the research team. The codes were then organized into a category and theme, which served as the framework for the presentation and discussion of the results. A desk review of relevant literature was conducted to supplement the findings from the primary data.

Results: All the survivors included in the study had been the victims of rape except one. The majority of those who were assaulted during an active conflict reported experiencing physical assaults, abductions, and forced detention. Social violence, such as community level stigmatization, threats, or isolation of a woman were experienced by some survivors of sexual violence. All participants claimed that the magnitude of SGBV increased dramatically during the conflict, despite the fact that it was underreported, implying that with a proper reporting system in place, the problem could be much larger. Some survivors had been abused by someone they trusted

and cared about, such as family members, or acquaintances. A significant of them were attacked by strangers, primarily by armed forces, during the time of active conflict and displacement. Following the assault, the survivors faced a range of consequences, including physical injury, pregnancy, and psychological effects, as well as financial losses.

Most survivors found disclosing the assault and seeking care difficult for different reasons. When they do, they almost always tell someone close to them, a family member, relative, neighbor, or friend. The major barriers identified were stigma, cultural influences, lack of awareness about SGBV services and where to seek assistance, economic dependence, displacement and instability, lengthy process to get the necessary health care and legal protection, poorly designed health care system that can provide comprehensive care, particularly in IDP sites, insufficient legal punishment for perpetrators and limited space at safe houses to serve the growing number of survivors.

Conclusions: Women and girls have suffered from chronic reproductive health, mental and psychological problems because of SGBV. Both governmental and non-governmental were involved in the provision of various care for survivors though it was not well coordinated. The SGBV survivors hardly accessed care and it was late for most of them. A significant of them received care post-conflict. There was delay in deciding to seek care as victims are not sure whether they have got care or because of fear of stigma/shame or not having the information where to obtain help; delay in reaching care as they had to travel far to seek care; delay in receiving care which is attributed to unavailability of trained health providers or shortage of supplies to render care. There was underreporting of incidents to understand the magnitude of the problem and plan for effective service provision and tracking of the existing data. There is a lack of clarity in the pathway in accessing care. There is no standard care and support as the role of each of the service delivery points and health professionals is not clearly defined.

Recommendations: More cases of SGBV are discovered post-conflict, hence, active search for survivors should continue. De-stigmatization of SGBV should be part of the community awareness program to have more survivors report and access care, services are made available closer to the victims. Comprehensive SGBV services which include medical care with forensic exam, psychosocial and legal services should be readily available to survivors. The health facilities should be equipped with the necessary medical supplies to deliver essential SGBV care putting a

good logistic system in place. Having the service closer and immediate would help survivors' benefit from the immediate medical care such as clinical management like emergency contraception, HIV PEP, STI treatment and safe abortion care.

The type of care that can be delivered at each of the service delivery or access points should be defined depending on the situation whether there is a humanitarian crisis or not. The role of the professionals should be outlined clearly. SGBV care should be part of the training in pre-service health profession education. SGBV awareness in the community and educating women and girls in particular on the prevention, the benefit of early reporting and information about the care and where to access it should be promoted. SGBV care which demands multi-sectoral engagement has to be led by the ministry of health and be part of the SRH programs. The ministry should bring stakeholders together to have an aligned plan and create a system which can respond to emergency situations such as this conflict with a clear mitigation, response and preparedness plan with a good data tracking system and document lessons from previous interventions. The root causes of all SGBV which is gender inequality should be tackled by strengthening the proven existing gender programs.

1. INTRODUCTION

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private (IASC, 2015). This can take on many forms such as physical, verbal (including hate speech), sexual, psychological, and socio-economic violence.

The humanitarian actors primarily use the Gender-Based Violence Information Management System (GBVIMS) Classification Tool which categorizes GBV incidents in to six core types of harmful acts: Rape; sexual assault; physical assault; forced marriage; denial of resources, opportunities and services; and psychological/emotional abuse (IASC, 2015).

GBV is rooted in gender inequality, the abuse of power and harmful norms and it is a serious violation of human rights and a life-threatening health and protection issue. The impact can include physical injuries that could range from disability to traumatic brain injury and death, adverse reproductive outcomes like unwanted pregnancies, fistulae, sexually transmitted infections including HIV, poor sexual health and chronic pain. In addition, it affects the survivors' future ability to learn and grow due to social rejection that increases their vulnerability to further abuse and exploitation and restrictions on daily activities (e.g., walking in certain areas) due to a fear of violence (Hossain and McAlpine, 2017).

Sexual violence is a form of gender-based violence and encompasses any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. Sexual violence takes multiple forms and includes rape, sexual abuse, forced pregnancy, forced sterilization, forced abortion, forced prostitution, trafficking, sexual enslavement, forced circumcision, castration and forced nudity (UNHCR, 2014).

SGBV Causes and Contributing factors

Known underlying causes for SGBV are inequitable power dynamics and patriarchal gender norms. Attitudes, beliefs, norms, structures, practices and sometimes laws can contribute to

gender-based discrimination at time of stability. Hence, the success of prevention of GBV can depend on how effective we are addressing these attitudes, beliefs, norms.

Conflicts or crisis in general contribute to increased risks of GBV due to displacement, family separation, disruption of relationships, not having the resources to care for basic needs, substance abuse, collapse of state-led protection systems, disruption of community norms and services, changes in cultural and gender norms, weakened infrastructure and increased militarization.

According to IOM, there are three levels of contributing factors: societal, community, family and individual (IOM, 2019). The societal level factors that contribute to GBV includes limited participation of women in leadership, not prioritization on persecuting sex crimes, failure to address the underlying cause of violence which is gender inequalities, lack of legal framework and criminalization of forms of GBV, or lack of awareness about the different forms of GBV that are considered as crimes. The community level contributing factors include poor shelter, water, sanitation and hygiene facility, lack of access to education for females, safe spaces for women and girls, community protections relating to GBV, reporting mechanisms for survivors, accessible and trusted multisectoral services for survivors, housing, land, and property rights for women and girls. "Blaming the victim" survivors of GBV, lack of confidentiality, community-wide acceptance of violence and lack of psychosocial support also count as community level factors. The individual or family level contributing factors include lack of basic survival supplies like food, water, shelter, cooking fuel and hygiene supplies, gender-inequitable distribution of family property and lack of resources for parents to provide for children and the elderly. Alcohol/drug use, age, gender, education and disability, family history of violence and witnessing GBV are also contributing factors.

SGBV consequences

Gender-based violence can have short- and long-term consequences impacting not only the survivors but also their families and communities. The commonly experienced consequences of GBV include death, physical, psychosocial and legal conditions.

Death can be as femicide, honor killings and suicide. The physical consequences can have immediate and long-term injuries including sexual reproductive health problems, unwanted

pregnancy and sexually transmitted infections such as HIV. The mental and psychosocial consequences may include post-traumatic reactions, anxiety, depression; suicidal or self-harming thoughts and behavior; sexual dysfunctions and disorders; stigma, isolation, ostracism, damaged reputation, divorce, loss of marriage opportunities and other sources of moral damage; damage to spiritual harmony; challenges related to delivering, accepting and nurturing children born out of rape; and transgenerational transmission of negative feelings and thoughts affecting entire families and communities. The socioeconomic consequences encompass loss of income and earning potential, lost opportunities including employment, education and social benefits, medical expenses incurred and costs of future rehabilitative care, including psychological services; costs of legal processes; costs of raising a child born of rape and of raising children by single parent survivor after losing marriage or remarriage opportunities, and ostracism from the family unit; and displacement. The legal consequences could be arrest, detention and punishment for sexual relations outside of marriage or adultery, lack of witness protection during investigations or trials.

Despite this, it is reported that the majority of SGBV cases go unreported due to the multifaceted causes discussed above, making the design of a suitable care system challenging, leaving many victims to live without help they need (UNHCR, 2018).

It is reported that the magnitude of SGBV increases dramatically during humanitarian crises. These situations also exacerbate the already poor reporting trend due to instability, displacement, diversion of health and other services to address emergency situations mainly and in some cases due to destruction of these places due to conflict. (McAlpine A et al, 2014, Gupta J et al, 2012, Kuala L. et al, 2015).

Therefore, understanding the magnitude of the current problem and the existing opportunities and challenges associated with its disclosure, care seeking, and delivery is important, especially in the humanitarian setting, so that evidence-based assistance can be provided in the areas of sexual and reproductive health or women's protection services and to consider how to offer, integrate and deliver comprehensive SRH care in an accessible and appropriate manner in these settings.

2. OBJECTIVES

2.1. Main objective

- The main objective of the study was to understand the existing gaps in disclosure and formal reporting of SGBV or sexual exploitation, barriers for care seeking and SRH-SGBV care delivery to survivors exposed to violence during conflict or forced displacement from conflict.

2.2. Specific objectives

- To assess the availability and uptake of SRHR services in war affected and non-affected areas with a focus on SGBV care for survivors.
- To identify perceived barriers, facilitators, and characteristics associated with reporting of violent events and subsequent care-seeking.
- To identify preparedness, enabling factors, and barriers on SGBV and SRHR service delivery in humanitarian settings.
- To review government and stakeholders SRHR-GBV-MHPSS response efforts and its effect on maintaining GBV and SRHR services in humanitarian situations.
- To provide a systematic and comprehensive prioritized gaps and/or key needs to be addressed by the SRHR community, including practitioners, implementing partners, donors, researchers, and innovators.

3. DESK REVIEW

3.1. Magnitude of SGBV

It is estimated that, globally, one in three women experience gender based violence in their lifetime. Globally, nearly 7.2% of women report an experience of sexual violence from a non-partner; one out of three women, however, report an experience of physical or sexual violence from an intimate partner (Devries KM et al, 2013 and Abrahams N et al, 2014)

According to Ethiopian Demographic and Health Survey (EDHS) 2016 report of the previous five years trend, 23% of reproductive age women have experienced physical violence and 10% have experienced sexual violence. In addition, 4% of women have experienced physical violence during their pregnancy. The interview with married women indicated that 16% have experienced at least three types of marital control behaviors and 34% have experienced spousal physical, sexual or emotional violence. Furthermore, physical and emotional violence were experienced by 24% each, and sexual violence by 10%. From them, 22% have experienced injuries, including 19% who reported cuts, bruises, or aches and 10% who reported deep wounds and other serious injuries (EDHS, 2016).

Recent studies among high school and college students in various regions of Ethiopia have revealed that roughly half (46.6% to 57.7%) of the study population has experienced at least some form of GBV at some point in their lives (Duguma G. etal, 2022, Alemu B. etal, 2021 and Abubeker F. et al, 2021). There have also been reports of GBV as high as 63.7% and 71.1% (Tantu T. et al, 2020 and Habtamu G. etal, 2021). Sexual violence was reported to account for 27.9%, 37.2%, 46.6%, and 49.1% of these incidents in Debre Berhan, Wolaita Sodo, Harar, and Bahir Dar, respectively (Alemu B. etal, 2021, Tantu T. et al, 2020, Abubeker F. et al, 2021 and Habtamu G. etal, 2021).

Furthermore, during the COVID-19 lockdown, 36.2% and 21.3% of GBV and sexual violence incidents, respectively, were reported by a study from Debre Berhan (Alemu B. etal, 2021).

3.2. SGBV in humanitarian crisis

According to the Global report on internal displacement, there were a total 50.8 million Internally Displaced Persons (IDPs) by the end of 2019 globally. Amongst these 18.3 million were children under 15 years of age and 3.7 million were over 60 years. A staggering 45.7 million people were displaced because of conflict and violence in 61 countries and territories (GRID 2020).

It is reported that, during humanitarian crisis, SGBV increases dramatically leaving women and girls vulnerable to sexual violence, physical violence, and various forms of exploitation, including sex trafficking more than ever by strangers or people they know, including their husbands, boyfriends or other family members (McAlpine A et al, 2014, Gupta J et al, 2012, Kuala L. et al, 2015). Early and forced marriage and human trafficking are also reported to increase in disaster settings due to restricted options for livelihood and increased vulnerability. The problem is aggravated in the absence of a system to report and get assistance from as a result of breakdown of the health care and legal systems due to the crisis (Hossain and McAlpine, 2017).

Such violence is reported to continue even after the period of crisis. To date, estimates on reported rape and other non-partner sexual violence in conflict settings are wide, ranging from 0.2% to 72% among women reporting a lifetime experience (Hossain and McAlpine, 2017).

A 2014 meta-analysis of 19 studies on the prevalence of sexual violence among female refugees and IDPs across 14 countries affected by conflict suggested one in five (21.4%) experienced sexual violence. However, this is likely an underestimation of the true prevalence given the multiple existing barriers associated with disclosure including social stigma associated with rape, shame and fear of reprisal, inadequate justice systems, law enforcement systems that may mistreat and further victimize survivors, and health systems without the capacity to provide appropriate care (Vu, et al., 2014). The authors also highlight the importance of understanding who the range of perpetrators may be, as well as the physical locations and settings in which sexual violence is likely to occur. While rape as a weapon of war is perpetrated by armed actors and military personnel, other perpetrators may also include family members, NGO and humanitarian workers, trusted individuals, or strangers who take advantage of the heightened vulnerability of women and girls.

Three recent studies of the experiences and perspectives of adolescents affected by conflict and migration found poverty, and especially the lack of food, drove many adolescents to transactional sex and sometimes forced marriages (Fraulin et al., 2021; Iyakaremye and Mukagatare, 2016; Marlow et al., 2022). Rape, trafficking, sex work, and other forms of gender-based violence were also described by these studies. Lyakaremye and Mukagatare reported that adolescents in their study described sexual abuse by the government and rebel armies and continued abuse in the refugee camp by different perpetrators including family members, other youths in the camp, and people from outside the camp. Fraulin and colleagues found that adolescents facing poverty may perceive sexual exploitation as potentially protective through the gains of money and material support. Marlow and colleagues noted that participants had limited knowledge about contraception, and some information about SRH services available in the camp, and overall, knowledge and utilization of SRH services was low.

According to the Displacement Tracking Matrix (DTM), a total of 4.23 million IDPs have been identified as of September 2021 in Ethiopia. Of the total displaced population, the main causes of displacement were conflict which displaced 3.5 million IDPs (85%), followed by drought and seasonal floods which displaced 307,871 IDPs (7%) and 139,199 IDPs (3%), respectively. Among the total of 1578 IDP sites in Ethiopia, only ~19% have health facilities with GBV services.

Emerging evidence showed that the problem of SGBV is aggravated in Ethiopia due to the COVID-19 pandemic and internal displacements that are caused by conflict and natural disasters (GRID 2020). A national survey conducted in 2021 showed that GBV is rising, and poses special risks for girls. It is reported that 50% of women and girls have seen it rise. The most common increases in GBV are domestic violence and child marriage. Girls in all demographics (refugee, host community, IDP, and returnees) rank GBV as their primary concern during the pandemic. The problem is compounded by the compromised access to health care service. Despite the fact that the need for SRH services is likely to increase given the nature of humanitarian emergencies, the service has been suspended. This was due to the collapse of health systems, as a number of health centers were completely converted to COVID-19 centers, resulting in the interruption of basic health services such as sexual and reproductive health. More than half (55%) of women and girls say they are losing access to health services. In addition, the economic impact on the women

has led most to engage in transactional sex and unwanted marriage to maintain survival (Jayaweera et al., 2021).

Conflicts in Ethiopia overburden the primary health care systems, resulting in the disruption of basic primary healthcare provision among IDPs. Moreover, within IDP populations, women and children tend to be vulnerable with increased exposure to GBV, unwanted pregnancy, HIV infection, maternal and perinatal deaths and disability, early and forced marriage, rape, trafficking, sexual exploitation, and abuse. Additionally, considering that in every setting, from the total population, on average 25% are women of reproductive age, 4% are pregnant with needs for antenatal care and assisted delivery, 20% are sexually active with potential need for family planning and STI services and 15% of those pregnant face complications with about 5% potentially needing caesarian section, it is crucial that any response in these humanitarian disaster settings also addresses these unique needs.

3.3. SGBV disclosure/reporting and response strategies

The main issue associated with SGBV is the poor reporting rate which makes it difficult to design a better care and preventive service and policy based on the actual existing burden of the problem. In the face of that, different scholars have tried to understand the disclosure system.

A report by UNHCR showed that disclosure by survivors, especially in a humanitarian setting, is not as simple as it sounds. The problem arises at multiple levels; individual, social, and structural/ institutional factors which have to be dealt with in detail. The disclosure gap is heightened in a humanitarian setting due to high levels of mobility and insecurity that affects not only the survivors' capability, opportunity, and motivation to report but also the service providers ability to pursue disclosure due to overburdened work in the setting and also inability to make referral to additional support services (UNHCR, 2018).

A systematic review of SGBV reporting among survivors in 24 countries revealed that 40% have disclosed it to someone but only 7% have reported it to a formal system. And better reporting was observed among older age groups, urban residents and those not currently married. This implies that the program designed for the care and prevention of SGBV relies on the report of only a few that highly likely makes the programs less suitable for many (Palermo T., et al, 2014).

Ethiopia has designed a number of policies and strategies that are decentralized to the local level to guide the system that is responsive to harmful acts targeted based on gender difference. These include; Anti-Harassment Code of Conduct for Technical Vocational Education and Training (2013), Code of Conduct on Prevention of School Related Gender-based Violence in Schools (2014) and the Gender Strategy for the Education and Training Sector (2015) among others.

In order to minimize the barriers of care seeking, the first One Stop Centre, that provides a comprehensive service including medical and psychological treatment, legal aid and shelter, was opened in 2011 in Gandhi hospital in Addis Ababa. This is a big initiative that solved a number of problems but it is still insufficient to meet every victim's demand (Jenny P. et al, 2017).

But, due to the varying socio-cultural norms, socio-economic conditions and inadequate integration of the reporting system from national to local level and between concerned stakeholders on top of the underdeveloped health care system, the policy implementation has faced a number of challenges. That calls for a well-designed and integrated service provision at every level by both the government and non-governmental humanitarian responders.

3.4. SGBV care

Recent evidence from the DRC and Somalia highlights the gaps in access to safe abortion for survivors of sexual assault (Ali and Hook, 2020; Burkhardt et al., 2016; and Rouhani et al., 2016). Somali women are reported to have low care seeking tendency due their culture, which has led them to prefer silence and avoid the shame of being attacked, in addition to a lack of or inaccessibility of services (Ali and Hook, 2020). Survivors in DRC also had limited access to safe abortion services, and most attempted pregnancy termination with medicines and herbs not recognized as evidence-based methods and sought these methods outside of the formal healthcare sector (Burkhardt et al., 2016; Rouhani et al., 2016).

According to EDHS 2016, about one-quarter (23%) of women who have ever experienced any type of physical or sexual violence by anyone have sought help. Notably, 66% have never sought help nor told anyone about the violence. Women who have experienced both physical and sexual violence are more likely to have sought help (27%) than women who have experienced only sexual violence (7%) or only physical violence (23%).

Among women who have experienced physical or sexual violence and sought help, the most common source for help was neighbors (34%). Other common sources were the woman's own family (31%), and her husband's/partner's family (14%). Only 8% of women seek help from the police. It is not common for women who have experienced physical and sexual violence to seek help from service providers such as lawyers, doctors/medical personnel, and social work organizations: only 2%-3% have ever sought help from each of these sources (EDHS, 2016).

Overall, there has been considerable work invested in mitigating the risks of GBV, responding to cases and preventing violence. However, gaps remain and the needs facing the sector are vast – particularly given the increases in GBV due to IDPs and increasing pressures on already limited resources to respond to SRHR services.

Furthermore, at the highest level, there is a lack of prioritization, commitment, and accountability throughout the humanitarian sector. Other sectors do not prioritize integrating GBV in IDPs and SRHR risk mitigation activities into their own work, and there are few accountability mechanisms to ensure this essential work is implemented effectively. Likewise, prevention activities for vulnerable women and children in IDPs are not often prioritized, even within the humanitarian sector, and there are few initiatives that seek to address gender and power imbalances within humanitarian organizations and the sector at large.

3.5. Interventions

One of the global key actors in SBGV, UNFPA recommends different strategies ranging from work that could be in community to policy level advocacy. Some of the community interventions include raising awareness on GBV. It emphasizes on the need to developing capacities in reporting GBV, integrating GBV in pre-service training curricula for health professionals and ensuring all health providers have received the training on Clinical management of rape and intimate partner violence survivors. It also recommends on the need to equipping health centers to have separate rooms for private consultations and medical exams in cases of rape. Services should include emotional support, post-exposure prophylaxis (PEP) in order to prevent HIV transmission for all women and adolescent girls who have been raped and others who have engaged in unprotected sexual intercourse, ensuring the availability of emergency contraception supplies, presumptive

treatment for STIs, psychosocial support, providing follow-up care and referring for additional support.

Addressing GBV against women and girls requires a multi-sectoral approach. Establishing or strengthening multi-sectoral networks for the prevention and management of violence against women and girls and responding to their needs including legal, safety, health, economic and cultural considerations is paramount.

Intervention in humanitarian setting

Key actors in addressing all forms of GBV during emergencies recommend multisectoral and holistic approaches to preventing and responding to SGBV and to establishing systems for coordinating response efforts. They have different approaches depending on the type of emergencies and country context.

Some of the key intervention areas suggested include: advocacy and support to incorporate GBV in humanitarian condition when planning, assessment and program design, promote GBV data collection and gender analysis, improve capacity of health facilities including competencies of health providers to render SGBV care which includes counselling, prevention and treatment of sexually transmitted infections, HIV PEP, emergency contraception, treatment and care for women with traumatic fistulas, pregnancy-related care, as well as the collection of forensic evidence as part of legal procedures to bring perpetrators to justice and document human rights violations.

Other interventions suggested are sensitizing uniformed personnel on zero tolerance for violence against women and girls, supporting civil society networks working to address SGBV and building capacity within the humanitarian community for effective SGBV programming and coordination. Deploying gender experts who can ensure appropriate coordination, planning and action so that SGBV can be well integrated into the emergency response and training of humanitarian coordinator in SGBV issues are also key interventions indicated.

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) is SRH services that are implemented at humanitarian setting starting as early as 48 hours following the crisis or emergency with the aim to prevent SRH related morbidity and mortality ensuring women's right. The priority objectives includes identifying lead organization for implementation

of the MISP, preventing sexual violence and responding to the needs of survivors, preventing STIs including HIV and unintended pregnancies, and planning an integrated SRH services into primary health care and facilitate access to safe abortion care.

To prevent sexual violence and respond to the needs of survivors, the lead organization which in most cases are the ministry of health and health sector work with other clusters to put in place preventative measures at all levels. It also works to make clinical care and referral available for survivors of sexual violence ensuring privacy and confidentiality. The MISP for SRH activities may not be limited to the health sector. It also includes sectors such as food/nutrition, education, water, sanitation and hygiene, and housing (Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2018).

4. METHODOLOGY

4.1.Study area and design

This study was conducted from May to July 2022 in 5 regions of Ethiopia namely Amhara, Oromia, Afar and Somali regional states and Addis Ababa city administration. To achieve the study objectives, a qualitative content analysis approach was employed.

4.2.Population and recruitment

The study population comprised GBV survivors, SRHR-SGBV service providers, community health workers and implementing partners and key experts working at federal and regional, district levels to mitigate and respond to SGBV.

19 GBV survivors were included in the study; 13 from conflict areas (10 from Amhara and 3 from Afar regions) and 6 from non-conflict areas (3 from each region; Addis Ababa and Oromia). Purposive sampling was used to include participants who had experienced SGBV, particularly in the context of conflict and displacement, and who could provide better information about SRHR service needs. Eligible participants were selected and interviewed until the required information was saturated.

Furthermore, 28 key informant interviews were conducted with stakeholders. An expert from MOH, 3 SRH-GBV service providers (1 from each region; Amhara, Oromia and Somali), 4 health extension workers (1 from each region; Amhara, Afar, Oromia and Somali), 2 IDP site representatives (1 from each; Amhara and Afar), 4 SRH program experts (2 from Afar, 1 from Oromia and 1 from Amhara), 4 experts from Women's affair who is in the SGBV task force (1 from each; Oromia, Amhara, Afar and Somali), 3 police (1 from each; Oromia, Amhara, Afar), 7 implementing partners (AWSAD, UNICEF, ESOG, AWSA Women mobilization and enhancement officer, New millennium women Empowerment Organization, FGAE and ODA) were involved in the study. The key informants were also selected purposively based on their level of involvement in the program and knowledge of the subject matter.

4.3.Data collection and quality assurance

The study primarily used a primary data to identify gaps in SGBV reporting and in Delivering Comprehensive Sexual Reproductive Health and Rights Services for Sexual and Gender-Based Violence Survivors in Humanitarian Settings. Data was collected using semi-structured interviews to perform the IDIs and KIIs (**Annex III**). Data from desk review of relevant literature was made before and after the data collection to complement the finds from the primary data.

To assure the quality of the collected data, competent supervisors and data collectors with the required professional background were trained adequately. After the commencement of data collection, the research team reviewed sample interviews and provided adequate feedback before moving on to the next interview. Daily night sessions with data collectors and supervisors were organized to address gaps in the collection of the data and how to proceed with data collection the following day. When data collectors encountered difficulties identifying survivors or potential key informants, assistance was provided through ongoing engagement with regional and woreda offices so that respondents who could provide more information were included.

4.4.Data Management and analysis

The audio recorded data was transcribed verbatim and translated into English. The translated document and short notes taken from observation during the interview were all recorded and archived on a password-protected hard drive to be confirmed by supervisors for quality and consistency in order to ensure the quality of the data.

Dedoose software was used to code and analyze the data. Two team members worked independently to create a codebook based on key themes related to the research objectives. The final codebook was created by comparing the two codebooks. All English transcripts and field notes were coded line by line against the set codes using the final codebook.

4.5.Ethics approval

The study was conducted after obtaining ethics approval from the Institutional Review Board of St. Paul's Hospital Millennium Medical College. Further consent was obtained from the Association for Women's Sanctuary and Development (AWSAD). In addition, verbal informed consent was received from all participants. Safehouses and IDP centers were used to access and

identify SGBV survivors and interviews were conducted in the presence of known counselors at the request and consent of all participants. Before the initiation of the interview, counselors were given the chance to review the sensitivity of the questions and necessary amendments were made to keep the survivors comfortable.

Interviewees were assured that participation is voluntary and refusal to participate will not affect them in any way in their daily lives in the community. Interviews conducted in a location with visual and auditory privacy to ensure confidentiality of the respondents' answers. Additionally, all interviews are conducted in a location that ensures participants' physical comfort during the interview.

Participants were informed that if they experience any physical discomfort during the interview, to please let the interviewer know and the interview will be stopped. Given the sensitive nature of this research, all interview questions asked with compassion and respondents were informed that they are free to refuse to respond to any question that makes them uncomfortable. There was no remuneration or incentive provided for participation in the study except acknowledgment. Data collectors were oriented on trauma informed care and how to provide support and referrals to participants after completion of the interviews, as needed.

All recordings and notes from the IDIs and KIIs were kept in a secure location when not being used by the study team. The data were used for research purposes only and will never be presented in a way that permits identification of any respondent. The data will be kept confidential until the study is completed.

5. FINDINGS OF THE STUDY

5.1. Characteristics of the study participants

More than half of the survivors (10/19) are from the Amhara region and three survivors were from Afar region, where there has been active conflict and many people have been displaced. During the interview, three-quarters of the survivors were living in safehouses, and one-fifth were living in their own homes. The mean age (SD) of the participants was 24.9 (± 9.8) years, ranging from 10 to 45 years. More than half of the survivors (10/19) are married, either now (6/9) or in the past (4/9), and more than three-quarters of these survivors had at least one child (ranging from 1 to 6) living with them at the time of the attack. Most of the participants have not completed their primary education. Followers of the Orthodox faith makeup 84.2 percent of the survivors and the remaining were Muslims (**Annex I).**

According to the characteristics of the survivors included in the study as well as the interviews with service providers and SGBV experts, the majority of the survivors were mostly adolescent girls and young women with little education, no jobs and low socioeconomic status. Most lived modest lives, waiting tables, running small businesses, and toiling on subsistence farming; however, there were few who made a decent living. Some had children and were staying with extended family.

The service providers and key informants' median (interquartile range) age was 35 years (28-42 years), with 11 being male. Most of them were from Amhara region (8/28), followed by Oromia (7/28) and Afar (5/28). Seven of the key informants are involved in direct SGBV-SRH service provision at health centers and hospitals, while the rest are experts working at various SGBV related institutions, both national and international. The median length of work experience of the participants was 7.5 years, ranging from 1 year to 22 years. **Annex II**

5.2.SGBV Experience and Magnitude

5.2.1. Magnitude and Type of Violence

The interview with service providers and experts revealed that the magnitude of SGBV has increased as a result of the conflict in the country. Those who have worked in the field for over a

decade claim that this is the most significant increase they have ever seen. Sexual violence was employed as a tactic of war, torture and abuse.

> *"During the conflict, I was assaulted by the armed forces, and my neighbors witnessed the incident. I'm also aware of the other people who were assaulted. It happened to the majority of the women in our neighborhood, and we all witnessed it. Even if we don't talk about it, everyone is aware of it." [Survivor 06, from Amhara region safe house]*

> *"There are lots of speculation that most studies bring to us, for example, whenever there is war, people use SGBV as a weapon, so whenever there is conflict, it is expected that there is going to be an increase in SGBV particularly sexual assault because of the fact that it will humiliate women, and any of the opponents want to have superiority over the other side, so they start to use SGBV." [Key informant, ESOG]*

A SGBV service provider and focal person mentioned that she encountered at least four cases per month in their facility alone. Because of community instability and displacement, which hampered full-scale policy implementation and law enforcement on top of limited resources, this increase has persisted even after the active war ended. According to these service providers, some were also assaulted on their way to safety by individuals who provided them with transportation. According to the IDP site representatives, there were numerous reports of sexual assault at IDP sites. Women were victims in the very place where they thought they would be safe.

Furthermore, a service provider from the Somali region reported that the increase in magnitude is attributable to a recent increase in drug abuse among adolescents, which they witnessed while providing services and also observed from the perpetrators' characteristics in the region in recent times.

> *"Drug use among young people in our town has recently increased. In the community and in clinics, we see a lot of cases. This has led to these individuals engaging in gang rape, particularly when they come across strange girls from another kebele. Some even collaborate with bajaje drivers to bring girls who are using the transportation service on their own." [Service provider from Somali region]*

All participants claimed the vast majority of victims never report their cases. If proper reporting systems were in place and survivors were enabled to report, the magnitude could be strikingly high. Some were seen months after the assault when seeking medical attention for safe abortion services or complications such as fistula. Even at this point, most do not reveal that it was the result of an assault unless professionals suspect and question the reason, which is rarely done due to the large flow of patients and professional burnout. In extreme cases, they go to a health facility after delivery to see if they can connect them with donors for financial assistance.

In terms of the type of violence, all the survivors included in the study, with the exception of one who sustained a physical violence by her husband, had been the victims of rape. The majority of those who were assaulted during an active conflict also reported experiencing physical assaults, abductions, and forced detention. This was also evidenced by the service provider interview, who also claimed to see a large number of cases with FGM/C and early/forced marriage.

Additionally, the majority of survivors faced social violence, such as community level stigmatization, threats, or isolation of a woman, to the point that some families made the decision to move to another town.

> *"It was in my parents' interest to leave the town and go anywhere else far away as there was gossip and a sign of discrimination in the village. I also wanted that. Even children of my age were talking about me every time they saw me, including at school. It was very difficult to lead the same life as before." [Survivor 16, from Oromia region safe house]*

5.2.2. Perpetrators and context

Nearly two-thirds of survivors (women not from conflict area) said they had been abused by someone they trusted and were close to, such as their husbands, family members, and acquaintances. Most were unable to disclose the incident when they should have done so due to one or more of the following factors: some were very young and didn't know what to do, others lived alone or with distant relatives, making it difficult to report due to the feeling of not having a close family member to protect; and for the remainder, cultural barriers were the most significant factor. Conversely, for those assaulted by first-degree family members like father and brother, being young and shy facilitated the event, in addition to the poorly spaced living conditions that

made siblings share the same bedroom, which enabled the incident to go unnoticed. In both situations, a single offender continually assaults the victim.

The remaining were attacked by strangers, primarily by armed forces, during the time of active conflict and displacement, which left the majority of women vulnerable because they did not have a husband or other person around to protect them. The men had either joined the army or flee for safety. Hence, the women had to walk for long distances in search of food and other goods. These attacks were reported to be an isolated event, the majority of which involved gang rape.

> *"I was on my way to my family's home, which was an hour away on foot. The armed forces found me on the way, and they ordered me to follow them. On our way, they took me to an empty home, and then they started drinking beer. When it got dark, they locked the house and started raping me; they did it the entire night and I lost consciousness." [Survivor 02, from Amhara region safe house]*

Even those who preferred to remain in their own homes and live with their families during the conflict could not rely on them for protection since they were outpowered by the armed forces.

> *"It was very painful as three individuals raped me. At the time, I just had my first baby and was recovering and needed some food and care. . I have no words to describe my situation during the rape, so I shall say simply that it was a horriblepain that no woman should experience. My husband was in the house, hiding somewhere. He couldn't help me because they would have killed him if they knew he was there. So, he had to save himself." [Survivor 04, from Amhara region safe house]*

> *"During the incident, there were two children, aged 3 and 7. My elder brother also witnessed the scene, but couldn't do anything. Since they saw him, I was afraid they might return and kill him." [Survivor 05, from Amhara region safe house]*

Similarly, service providers reported that armed forces were the most common perpetrators during active conflict. However, they claimed that after the active war, the assaults continued with the same or even increased magnitude but with different perpetrators, primarily long-distance truck drivers, employers (particularly among domestic workers), and a gang of drug-addicted youths attacking stranger women on the street and mass gatherings such as weddings.

"After the active conflict, a mother brought her child to our clinic. She was assaulted by a truck driver who asked her to show him a way and forced her to go with him. Similar incidents are reported by others as well." [Service provider, from Amhara region]

5.2.3. Consequences of the assault

Following the assault, the survivors experienced multifaceted consequences, encompassing anything from physical injury to psychological effects to financial losses.

Most of the survivors became pregnant following the assault. Some of them experienced physical injuries like genital tears, pelvic pain, bleeding, and fractures. One victim of gang sexual assault experienced a misacrraige after the attack.

"When I relocated to Gashena and divorced my husband, I was four months pregnant. In the hometown of my family, I was living alone. I was attacked by three people inside my home. It made no difference to them if I disclosed my pregnancy. I started bleeding immediately after the incident, and I miscarried." [Survivor 05, from Amhara region safe house]

Owing to their youth, unstable living conditions, and the time of war, the majority of survivors had suicidal thoughts and depression after the assault. Some women experienced severe mental breakdowns, necessitating psychiatric treatment. Though some had recovered well, there were some women who still had nightmares and were suffering from post-traumatic stress disorder, indicating that they had not fully recovered from their trauma. Those who became pregnant were forced to seek abortion services from a covert practitioner inorder to avoid disclosure by going to a health facility. In some cases, when the survivors discovered they had been sexually assaulted, their spouses or partners left them. This could exacerbate the psychological trauma that the survivors had already endured. This was further complicated by the shame and guilt of defaming the family name. Most were compelled to leave their homes, which caused them to stop attending school or to stop working, both of which were necessary for their financial well-being and potential avenues to independence.

"I was assaulted by armed forces and during which I also sustained physical trauma. Even if I wanted help, I couldn't get it until a month after I arrived at the IDP camp. I had a

mental breakdown because I didn't have anyone to care for me, on top of the physical pain I was in and the shame of defaming my family's name. Most of what I did I don't even remember. I had trouble sleeping and screamed a lot. I'm starting to feel better now that I've received medication and counseling." [Survivor 11, from Afar IDP site]

5.3. SGBV reporting/disclosure and care seeking

5.3.1. Disclosing the assault and care seeking

Most found disclosing the assault difficult for different reasons grounded in culture. Few disclosed it right away, owing to the fact that others were aware of it. However, most chose to keep it a secret until they discovered that they had been injured, were ill, or were pregnant. Even one survivor kept it a secret until after giving birth, when she told a doctor about it and was connected to the police.

The decision to disclose was mainly driven by the women' type and level of post-assault concerns. After the attack, the survivors expressed varying degrees of fear. Many cited difficulties in finding the right care, raising a child on their own, finding a place to live, getting money, finding someone to take care of them, contracting infections (HIV and other STIs), and becoming pregnant as their top concerns. The stigma linked to it, the dread of embarrassing parents or family, and the fear of discrimination by coworkers, friends, or the community at large, were equally and in some even more concerning.

When they decided to disclose, almost all disclosed it to a close person; a family member, relative, neighbor, or friend. When they were rejected by the first person they told, almost all preferred to remain silent for an extended period leading to further deterioration in their health and mental conditions, with the exception of one who went to the police and a health care professional and persevered in being heard.

5.3.2. Enablers and barriers to disclosure

The survivors included in our study are all those who came forward and sought help, which was made possible by the presence of a caring person to whom the women felt comfortable enough to disclose the incident, family, neighbors, acquaintances, health care professionals or others.

The service providers stated that one of the key enablers for exposing the occurrence was having access to a female healthcare practitioner. Most women seek medical attention and then depart without mentioning what happened, unless the care provider is a woman. Additionally, the majority of women who opted to remain silent benefited from home visits by health extension workers. Because most health extension workers are female and are regarded as members of the community, telling them about it was simpler.

In addition to the service provider's gender, the level of compassion is a very vital criteria for most women to disclose the incident. Unless efforts are made to encourage women to speak out, most find it difficult to speak out in the existing environment where maintaining client privacy might be difficult. This is because of either lack of professional commitment or inconvenient health facility setup.

> *"Yes, some women made an effort to conceal what had truly happened to them, but when we spoke to them in a frienldy manner, they admitted to having been raped. Therefore, our strategy is crucial in revealing the victims' concealed secrets." [SGBV service provider and focal from Amahra]*

Almost all, however, found it difficult to get to the point where they could receive care. The main factors cited were cultural influences, lack of awareness about SGBV services and where to seek assistance, and economic dependence caused by young age or gender disparity in the distribution of resources.

Social norm influences beliefs about what behaviors are appropriate for both men and women, as well as between men and women. Gender identity and culture are inextricably linked because they affect daily life in the workplace, family, home, and community. These deeply ingrained cultural pressures have led to unequal involvement of men and women in public life, denying many women of their basic rights including the freedom of speech, social interaction, better education, and economic independence. Even in the face of what is believed to be misconduct, the stigma against women is worse than any man could possibly experience. Due to these, most women find it difficult to openly discuss their experiences, even with their immediate family.

"Yes, I was too late to join this program because I was afraid of the social criticism I might receive from my community. I tried to hide what was going on because I knew that if I told them right away what was wrong and tried to get help, they would laugh at me. That is how women are treated in our community. As a result, I joined the camp later than I should have"." [Survivor 01, from Amhara region safe house]

Similarly, service providers stated that most women do not disclose for fear of losing their marriage or being unsuitable for marriage in the future.

"Most of their husbands weren't there when the incident occurred because they had relocated due to the tension. If their husbands found out what happened, they might divorce them." [Health extension worker from Amahra]

As mentioned above, due to the cultural influences that caused low levels of education among women, most don't know what to do when they encounter such difficulties. The majority of women reported being unaware that there are health facilities equipped to provide SGBV victims with specific services. They also stated that they were unaware that the legal system could be beneficial and that there are safe houses where they could be protected and receive appropriate intervention. Others claimed that if the other victims who remained silent had known about it, they would have spoken up. Service providers also claimed that a significant proportion of victims do not seek treatment on time due to a lack of awareness about what types of problems a woman will face after being raped, the diseases she will be exposed to, and what will happen to her if she does not seek treatment right away.

SGBV experts also emphasized that a lack of community awareness about SGBV, its consequences and the available services is a significant barrier to disclosure. They claimed that this was due to the difficulty of reaching remote communities in most regions due to a lack of vehicles and funds. This made it difficult to enlist the participation of influential people, such as community leaders and religious leaders, in the awareness-raising campaign.

As a result, most rely on the sole option of finding someone to share the incident within order to get the support they need rather than searching for a solution on their own. For most, finding that savior was also difficult due to the fact that the perpetrator was a close person in their social circle

or they were not living with a first-degree family or it was not convenient due to the war and displacement. In almost half of the cases, neighbors found out about it and insisted on helping.

> *"My mother was working in the Arab country to support the family. My father began raping me after she left. When it first happened, I was ten years old, and my siblings were younger. We (the survivor and her siblings) have not disclosed the incident the first time. We were afraid of being attacked by the perpetrator. We had been crying all the time because there was no one to defend us. We have been living in the compound where my father works, and there were other workers in the compound. We told them about the incident but learned that they already knew about it through time. They handle the information secretly and recommend that we report it to the police. They accompanied us and took us to the police office." [Survivor 14, from Oromia region safe house]*

> *"No, I did not tell anyone about the sexual assault I experienced. In fact, I was thinking about contacting a health expert; however, I couldn't find one due to the conflict." [Survivor 07, from Amhara region safe house]*

The remainder disclosed it to a close family member only when they developed an injury, were unwell, or became pregnant. In extreme cases, survivors have been reported to have chosen to keep it a secret all the way through their pregnancy without any follow-up and even delivery out of fear of the repercussions, particularly those who do not live with a first-degree family.

> *"I was living with my aunt in order to further my education and have a better life. My cousin assaulted me repeatedly and I got pregnant. I knew if I told anyone, they'd throw me out, so I kept quiet, hid my pregnancy with clothing, and continued to learn until labor began. I never returned after that. I'm staying at a safe house." [Survivor 18, from Addis Ababa safe house]*

It is noted that in some cases, again due to the cultural influences, the women have learned to put the needs of others before their own, which made disclosing the assault challenging.

> *"I was abused by my brother almost every day for over a year and lived with the trauma without telling anyone about it. My mother was very sick by that time. I was afraid she would get sicker and might even die if she learned about it. After a year, when I started to*

have severe pain, I told the rest of the family members." [Survivor 15, from Oromia region, safe house]

From the service providers interview, the following additional factors were identified as barriers too. Most survivors and their families don't have faith in the legal system to provide the appropriate punishment and believe that reporting will only lead to further assault by the same perpetrator or his relatives. This is especially notable among low-income families who claimed that they can't afford to seek legal support till the end.

5.3.3. Reactions to the disclosure

Only a few women were provided with an enabling environment to disclose the event, and to receive a positive response when they did so, which included taking the survivor to a health facility, police, or other legal body, depending on the severity of the victim's injury, and raising money while doing so. Survivors mentioned that what encouraged them to disclose was having an understanding and supporting person like a relative, friend, neighbor, or health care professional. One even claimed to have received assistance from a total stranger who approached her on the street, offered to help, and connected her to the Women and Children Affairs Office.

In contrast, most women experience the opposite. Many survivors claimed to have received threats not to tell anyone else or seek further treatment, even from first-degree family members, in order to maintain family honor. In circumstances when the family demands justice, they choose cultural ways of settling the problem rather than taking it to court to obtain justice so that the incident won't go public. Furthermore, to keep the assault secret, some families tried what they thought was best for the victims at home instead of asking and fulfilling what the survivors sought/demanded or what is best for their health. Yet, the level of care the women obtained could be disputed. In the event that further help was sought by the survivors, some were labeled mentally ill by their own family, which made it almost impossible to further get help from health professionals and even the police, who persisted in not giving help by believing that it was a lie.

"I initially told my family members, but they did not want to disclose it because they are well-known families in the community, and they were concerned about their reputation. Finally, I reported the incident at the local police station. When my family was questioned

about it, they defended the perpetrator and said that I have a mental illness and that nothing happened to me. As a result, the police refused to provide any assistance, despite my persistence in getting help." [Survivor 15, from Oromia region safe house]

Furthermore, the survivors also claimed to have encountered a wide range of responses to the disclosure, including being expelled from home and left on the street in a town they didn't even know; being accused by their own family that the incident was consensual; and even getting punishment for it.

Few also mentioned that those people who were aware of their condition or cared to listen to had little to offer because either they had other commitments to fully engage in supporting the women or they did not know what to do. During the war, people had to flee the area for their lives so that no one had time to attend to anyone.

5.4.Care for SGBV survivors

5.4.1. Accessing care

Most attempts to seek medical attention for the physical trauma they sustained as a result of the assault were futile due to a combination of factors. However, once they had access, medical care was provided at no cost.

Survivors' paths to care varied; some went straight to the Women and Children Affairs office with friends and strangers, then were linked to safe houses, where they were both linked to health facility and the police as needed. Some sought assistance from the police, who then connected them with HF or MoWCA, and finally to the safehouse. Few people went straight to the safe house.

5.4.1.1.Enablers and Barriers to seek care

Nearly all of the survivors reported that getting to the stage where they could receive their initial care was extremely difficult and that they had to overcome numerous obstacles in an environment that was not very enabling.

For the vast majority, accessing the very first care they needed was facilitated by other people rather than by themselves. As a result, family, relatives, neighbors, and acquaintances served as

the survivors' initial sources of support and information. Few people, and only after receiving a negative response from the first close person they told, were able to go to the hospital and the police on their own. One survivor also stated that she received assistance from a stranger on the street after her stepfather and his wife abandoned her.

> *"My stepfather abused me and I got pregnant. When he and my step mother knew, they brought me to Addis Ababa and left me on the street. I was shocked and started crying when I knew that they were going to be back. Someone approached me and asked what was wrong. When I told him what happened to me and that I didn't know where to go, he took me to the women's and children's office." [Survivor 17, from Oromia region safe house]*

> *"I was assaulted by an armed individual on my way home from the market. When I missed my period after a month, I told my cousin. She was younger than me, but she was extremely helpful. She took me to a health center, where I received all of the care I needed." [Survivor 02, from Amhara region safe house]*

The most common barrier mentioned by more than two-thirds of the survivors was a lack of knowledge about where to seek treatment. They all claimed to have never heard of safe houses, and the majority claimed to be unaware that such services are provided by health facilities. Few people mentioned that, despite knowing that health facilities can help, they were either afraid to go on their own, didn't know how to get there, or didn't have the necessary resources. As a result, most required the assistance of others to obtain care, but the majority reported being rejected and even discriminated against when they disclosed the assault while seeking care.

> *"I was desperate, thinking I was the only one with this problem and that there was no special service for assaulted women. After being taken to the safe house, I'm back on my feet. None of us back home are aware of such services. If others are aware, I am confident that many girls would seek care." [Survivor 17, from Addis Ababa safe house]*

Survivors who were assaulted during active conflict claimed that, even though they were in pain, they chose to remain where they were rather than seek medical attention for fear of further assault and even death. When they decided to seek treatment, they were hampered for the following

reasons: Most couldn't get around because of the insecurity and curfew, and even if they could, the majority couldn't afford to pay for transportation because they were displaced, separated from their families, and weren't working. There were victims who were rescued by the government forces and transported to the IDP sites. The women had nothing to eat and drink for 2 to 3 days while fleeing their neighborhood before being picked up by the army. On their way to safety, the survivors had no access to health care service. There were no emergency basic health services (let alone SGBV care) on their way to either temporary mobile clinics or any sort of established facilities. That was the case to almost all of the survivors.

> *"I was assaulted by armed forces who broke into my house. I had bleeding and pain. I needed help, but the town was unstable due to the conflict, and movement was restricted due to the curfew. I even wanted to go to a town where my family lives, but I was afraid that if I got out, I would be exposed to further assault, so I decided to stay in my house and suffer." [Survivor 06, from Amhara region safe house]*

> *"Yes, money was needed. If you had money, you would not worry about anything since you could get the necessary treatments and travel everywhere you wanted. You can buy anything you want if you have money. Thus, if I had money, I could have gotten care early." [Survivor 11, from Afar region IDP site]*

Even for those who were able to reach a health facility, the challenge continues because most of the facilities, including tertiary hospitals, were damaged or looted to the extent where giving advanced care was rendered impossible. Furthermore, it was difficult to provide proper care for everyone because only a few health care professionals were giving the service as most were displaced. Survivors at IDP sites described experiencing similar difficulties, particularly inadequate health facility setup.

> *"I have waited almost 4 months without getting treatment since the roads were blocked. When the roads were open and it started to get safe, a local woman who is displaced like me and living in the IDP center, collected about 4 thousand birr from people living in the camp and took me to Dubti hospital. Nevertheless I couldn't get painkillers for a week because of a shortage of drugs. I got them a week later." [Survivor 11, from Afar region IDP site]*

In addition to the aforementioned factors, service providers stated that most women are hesitant to seek care because the care seeking and reporting system is inconvenient as it involves a lengthy process of going back and forth from the legal to the health system to file the case, get it approved and get the necessary health care and receive legal protection, which may interfere with timely care provision and also increase the risk of the community learning about it and thus the stigma.

The other is that most families prefer to resolve the issue through cultural means rather than going to court, such as obtaining compensation from the perpetrator or arranging a marriage between the victim and the perpetrator. As a result, they refuse to take the victim to a health care facility because the facilities are required to notify the police if they become aware of the incident.

5.4.2. Care at health facility, IDP center and safe house: Level of care, satisfaction/compassion and areas for improvement

5.4.2.1.Care at health facility

Services provided by most facilities include HIV and other STI screening, pregnancy test and emergency contraception. Only a few health facilities provide comprehensive SRHR-GBV care because they have a one-stop center that is equipped to provide every care needed. Nearly half of the facilities do not provide safe abortion services, which are commonly requested by victims. Furthermore, only half of the facilities have a psychological support system, which is critical for survivors. However, for those who require additional assistance, a referral system to higher health facilities, legal systems, donor institutions, and safe houses is available.

> *"We have many assault cases where the women request abortion services, but our clinic is not equipped to provide the service. As a result, we must refer them to a nearby hospital. Most of them find it difficult to do so because they have to keep it a secret, which becomes difficult when we refer them because they either need money for transportation or someone to accompany them, both of which forces them to disclose it to someone or else return home and remain silent." [SRH service provider from Amhara region]*

The majority of the institutions are not fully staffed to provide the necessary care. Even institutions with one stop center, the professional composition is not as per the protocol, especially missing are the non-health professionals to provide the comprehensive care required by one stop centers.

Aside from the number of available employees, competency is raised as a concern. Those who received training in the care of SGBV survivors reported that it was extremely beneficial and changed their approach to providing care. However, they claimed that training is not provided uniformly to all employees and is not ongoing in order to keep them up to date and assist them in providing the expected level of service. Because training is typically provided by external offices such as universities, health bureaus, or women's affairs, new employees and those in need of additional training were unable to receive it on time.

> *"Before the training, we usually judged victims as if they had not been raped, and we assumed that they falsely reported as victims. But now, we don't ask them for unnecessary information." [SGBV service provider and focal for SRH services from Amhara region]*

Although the majority of participants recommended having a one-stop center for better service because one-stop centers are designed to help survivors obtain immediate care without having to get caught up in the lengthy system to get medical care so that they can receive all clinical, psychological, legal, and social support at the same place. However, one interviewee viewed it as an outdated approach that is difficult to sustain. The respondent suggested the services should be available at multiple sites ensuring the health care providers have the skills in providing care.

> *"To improve access for SGBV care and ensure sustainability, SGBV should be treated just like any other health care service still with the notion that it is a sensitive care. All providers should have the skills to manage and all facilities should make the necessary medical supplies and equipment available*." *[Representative of a professional association]*

Another barrier to the provision of holistic care was a shortage of room. Most institutions don't have a dedicated room for SGBV service provision. As a result, establishing a one-stop center is not feasible, and different stakeholders who want to provide ongoing support are unable to do so because they lack access to dedicated room(s). Some regions don't have safe houses, making it difficult for most survivors, particularly those from remote areas, to follow their care because they cannot afford to stay in a hotel. Health institutions are unable to provide victims with a room to stay in, even temporarily, due to a lack of space. This interferes with the provision of necessary care.

"This GBV clinic was not originally built for this purpose; rather, it was built to be a kitchen. Since we didn't have a GBV clinic, we remodeled the kitchen and are using it. All necessary stakeholders require space to carry out their duties." [SGBV service provider and focal from Amhara region]

Furthermore, most of the institutions lack laboratory and pharmacy services. Even in some, gloves are not available making it difficult to perform a physical examination for the victim. So, the victim is expected to buy a glove from nearby private pharmacies.

Due to the aforementioned barriers, most survivors are subjected to receiving services in an inconvenient setting where privacy cannot be maintained, or they will be referred to another institution, which may not be feasible for most due to a lack of money, transportation, and instability, as well as a fear of stigma as a result of further disclosing the incident.

"Our clinic does not even have gloves and the pharmacy is mostly out of stock. Therefore, we request that the women bring one from a private pharmacy so that we can conduct an examination. Most of them may not have the money to buy or may be afraid of going out to buy for fear of being exposed." [Service provider from Amhara region]

"The SGBV-SRH service is poorly integrated into the routine hospital system. The system is so disorganized that the victims have to go from office to office in the hospital to get a medical registration card, get examined, treated or referred and so on. This has made many women uncomfortable because they usually run into someone they know who is in the hospital for another reason. Due to this, many return home before getting help. It would be much more convenient if we had a one-stop center." [Service provider from Somali region]

In addition to addressing the previously mentioned barriers, health care professionals advised that the service could be improved if it was available throughout the week. They claimed that most victims prefer to visit the clinic on weekends as it is more convenient for most to come but it is closed on those days. Weekends also disrupt appointments for pregnancy tests, abortion services, and other services.

5.4.2.2. Care at IDP center

IDP center/sites are sites that provide basic needs including basic health care services for internally displaced people in the country.

Care provided: IDP centers offered women with food, clothing, and sanitary products in addition to shelter. The survivors received psychological support and got referred for medical care when necessary. Victims were also educated on self-empowerment and self-protection. This holistic support has a lot of contribution for victims to recover from their psychological trauma. For some, it was so quick that they wanted to leave the center to reunite with their families.

Some survivors were lucky enough to be taken to hospital right away following the assault where they obtained comprehensive care for SGBV at one stop center of the hospital including the legal support. There were encounters whereby the police were already pursuing the legal process while the survivors were brought to the IDP center. On the other hand, there were victims who let alone get care for SGBV, they had trouble getting into the center. When they did, it was too late to receive the necessary support. It took several days for women to get attention. Not all who managed to get to the IDP center obtained the necessary immediate medical attention.

The centers work in collaboration with the police, health bureaus, women and children affairs of the region and non-governmental organizations. To provide comprehensive and high quality SRH for survivors of SGBV in a humanitarian setting, it requires engagement of various stakeholders who should operate in an integrated manner.

Challenges: Some IDP sites failed to either assign a person and designated body to take care of the victims once arrived. In certain circumstances, it was men volunteers who assisted women – accompanying them to the washroom, feeding them and attending to their overall needs. It was reported that some centers were suffering from shortage of medication and medical supplies. This had compromised the level of medical care provided at the sites. Apart from the medical logistic problems, there was lack of coordination particularly to attend to the needs of the victims. Although it was reported that the IDP centers had a women's committee who identified survivors and linked them with the authorities there so that they obtain care, for some women who enter the center directly, it took the centers months to refer them to health facilities.

In a nutshell, the centers may not have been prepared to handle these problems as they should. They don't have the structure and capacity to deal with survivors.

5.4.2.3. Care at safe house

Safe houses, temporary shelters for survivors of SGBV, are available in all regions included in the study except one, the Somali region. They provide the service for women of all ages who are survivors of SGBV. Safe houses provide vocational training to survivors, reintegrate them with their families, and avail startup capital and entrepreneurship skills to establish their own business. Student survivors were given the opportunity to get back to school. They keep pregnant women temporarily to give birth.

Most survivors were brought to the house by the bureau of women and children affairs or local gender office. Policemen were victims' first encounter for some survivors who advised them to go and get help at safe houses. All did not come to the house directly, some victims had to go to seek healing from holy water. Some were taken to hospitals for medical care before being brought to the center.

In terms of the services, almost all survivors expressed their satisfaction and appreciation for the health workers who showed them love and compassion at the safe houses. They gave testimonies how that had helped them recover from their trauma. This indicated how powerful compassion is to such service.

All said the same thing about the impact of professional psychological support for hastening their recovery from their pain and gain their purpose and seeing the possibilities in their lives. The effect of emotional support provided by trained professionals was highly emphasized.

5.5. Stakeholders and community engagement

The SGBV care requires holistic care, which necessitates the involvement of various stakeholders and the community including women and children affair bureau, woreda health office, police, both local and international development partners and the community.

The service providers stated that they receive assistance from government offices such as the police and women's affairs, as well as non-governmental organizations. They reported that the NGOs train the staff, donate medications and some equipment to the facilities, and provide survivors with kits. A few of them assist in the construction of an SGBV clinic in some remote areas. However, service providers claimed that the services are not always continuous and need driven.

Women affairs bureau at all regions is in charge of addressing women's right, women empowerment and prevention of all forms of GBV including female genital cutting, early marriage, abduction, sexual assault and intimate partner violence. They facilitate victims obtaining care at health facilities, counseling service, justice, settle disputes between partners and support survivors to stay with their children at temporary shelters called safe houses. They work towards creating community awareness about GBV as well.

The office has mainly a coordination role so that SGBV survivors obtain health care, counseling, and legal services. It works in partnership with the smallest admin unit, woreda health office, police, legal office, safe house, and other relevant stakeholders. It ensures women economic empowerment through facilitating loans and providing them with the skills on how to run their business. The gender focal persons are in charge of ensuring women's rights so that they get fair share of resources and representation.

During and following this crisis, the women affairs office collaborated with partners like Maria Stopes for victims to have medical care, made arrangements for temporary shelter (safe house) till they get care and facilitated psychosocial support including basic hygiene materials. The offices have trained individuals from the local area to do an active search for victims to help them access care.

The offices in those places where there were humanitarian crises were overwhelmed with many cases of SGBV which they were not prepared for (too many to handle). They did not have the resource both finance and human power, to do what they used to. The facilities were destroyed, and health providers had fled the areas.

The woreda health office assisted in transporting victims to the women affair bureau who took victims to hospitals with one stop center.

The police are responsible to bring perpetrators to justice, negotiate conflict between partners to save families, taking survivors to safe houses where survivors are supported to obtain clinical care, psychosocial support, counseling and legal services. They also assist taking victims directly to health facilities when they think the cases require urgent medical attention. Police also raise community awareness in prevention of GBV and support community policing. They closely work with the justice department and women affairs bureau.

Local NGOs like Oromo development agency (ODA) had interventions. The first intervention is educating the community using community volunteers called health development army and the young at schools, the second intervention is creating survivors clinical service access at health facilities and the third is facilitating victims to have legal services. The agency, with financial assistance from UNFPA is also playing a key role in creating a platform that brings relevant stakeholders together.

New Millennium in partnership with Ipas built the capacity of health extension workers in creating awareness about GBV in the community, de-stigmatizing it so that more victims would come forward to receiving care and facilitating survivors get access to care through transporting them to service outlets.

Family guidance association of Ethiopia (FGAE) was also involved in SGBV management. It provides STI screening, HIV testing, emergency contraception etc. along with psychological support and referral for major trauma. It also has community programs that aim at creating awareness through engaging community leaders and health extension workers and schools to disseminate messages via various media outlets.

During the conflict, UNFPA was involved in supporting victims in humanitarian settings. It availed essential materials like dignity kits and sanitary material. It facilitated survivors getting access to medical care as well. IOM and IMC were operating in the IDP centers. Save the Children provided financial assistance to the victims. The Ethiopian society of obstetrics and gynecology (ESOG) supported the development of clinical care guideline for sexual assault survivors, establishment of one stop center, in provision of clinical care for survivors. It was also a key player in responding to SGBV during the conflict.

In terms of community involvement in the fight against SGBV, little to no involvement has been reported. Few people reported that the community helped victims get the necessary care and move on with their lives. Especially notable is the role the community played in protecting women from sexual assault during the crisis. It was claimed that the religious leaders and community elders had contributed to reducing the incidence significantly. The vast majority of the time, the community stigmatizes victims, adding to their psychological trauma. Because of this lack of support, most victims' families prefer to conceal the case and, in some cases, attempt to resolve the case by marrying the victim with the perpetrator. According to service providers, there are awareness-raising activities at community meetings and public holidays where people gather. This may make it easier to report GBV cases. However, they suggested that more awareness-raising programs at places where everyone goes, such as Kebele's, be made available to everyone.

6. CONCLUSION

Sexual and gender-based violence takes different forms and the ones that were common during northern conflict were rape and abuse. These had left women and girls with chronic reproductive health, mental and psychological problems in the post-conflict. The conflict related sexual violence (CRSV) affected their physical (chronic reproductive health issues), social (social marginalization) and mental health. SGBV survivors hardly accessed the immediate care including clinical care during the conflict because they live too far from service delivery points. They had to travel long distances before reaching to safety and care at which time they miss the critical time to receive medical care including emergency contraception, HIV PEP, STI treatment and even safe abortion care service and counseling services.

In the post-conflict, they also barely access critical services for chronic reproductive and mental health services like treatment for anxiety, depression, and post-traumatic stress disorder. This is because the health facilities are either destroyed or looted or those which were functional did not have the supplies and trained health care providers to render service.

Significant number of women and girls did not access care even when the service was available. Survivors of SGBV especially rape did not seek care for multiple reasons mainly stigma and shame in the community during the conflict area. Fear of reprisal was also another reason in addition to stigma and shame in non-conflict areas. Lack of information where and how to seek care is identified as an important reason. Community arbitration allowing perpetrators to walk away without punishment has also contributed to limited disclosure and underreporting. Trust upon the police and legal system stood out as a critical factor for not reporting. Victims need assurances that they get timely and fair trials to "risk" disclosure.

Underreporting being recognized as a challenge to understand the magnitude of the problem and plan for effective service provision, even tracking of the existing data have become a challenge. We don't know which GBVs exist to what extent, how many have ever accessed care.

There is a lack of clarity in the pathway in accessing care. Victims and the community even service providers seem to have no protocol or guideline to follow in guiding survivors where to go when they seek health and legal service. The one stop centers at selected hospitals have clear designation

in the service they render. However, the role of each of the other service delivery or access points where survivors visit including IDP site, safe house, health post (health extension workers sit), health center is not clearly defined. This holds true for the professionals including health extension workers, nurses, midwives, health officers, general practitioner and gynecologist working at service points as well. The scope of service in overall care is not well defined. The type of services that can be delivered by HEW at her encounter at household and health center is not clear.

The health centers did not have the material and trained provider to render care. Overall care for SGBV was inaccessible as the service is available at few hospitals with one stop center located distant to survivors. Most of the functioning one stop centers had shortage of supplies and trained providers with the right attitude to render care. There was also attrition of SGBV trained health care providers.

SGBV victims could be identified while they come for other health care services if health care providers are skillful enough to detect it. If SGBV care were part of the training in pre-service health profession education just like any other medical care, victims would not be missed without getting the necessary care. Hence, health providers should be trained on provision of care for SGBV in pre-service education so that they have the knowledge, skills, and attitude they need while entering practice. Attrition of health providers would not also be the barrier to accessing service.

In sum, there are three delays for SGBV survivors, delay in deciding to seek care as victims are not sure whether they have got care or because of fear of stigma/shame or not having the information where and how to obtain help. The second delay was delay in reaching care, this is because victims had to travel far to seek care (don't have the services nearby). The third delay is delay in receiving care which is attributed to unavailability of trained health providers, negative attitude of provider or shortage of supplies to render care.

It appears plenty of actors both governmental and non-governmental involved in the provision of various care for survivors. Significant number of the services are delivered by non-governmental agencies. But there is lack of coordination among the stakeholders and limited engagement of government in leadership and availing finance. It became evident during the humanitarian crisis that the country was not ready to deal with SGBV survivors as we did not have an agile and robust

health system that looked after victims during the normal times nor a strong referral system in place.

There is limited data on which interventions work best and why. Multiple actors with more or less different approaches implemented their programs. This may be the right time to come together and evaluate their programs to culminate the best approaches in terms of effectiveness, cost and cultural appropriateness.

7. RECOMMENDATION

Disclosure and reporting system and case identification

There has to be a clear pathway guiding survivors accessing care which all the survivors, health providers, bureaus of women affairs, police and other key actors should be aware of to facilitate convenience and immediate care. Availing survivors call centers would facilitate accessing care as the center. It could serve as an information center to guide survivors what they can do immediately and where to go to seek care.

More cases of SGBV are discovered post-conflict when the area gets stabilized, hence, active search for survivors should continue by community health workers to bring them to health facilities for chronic SGBV care mainly to address mental health issues. De-stigmatization of SGBV should be part of the community awareness program to have more survivors access care once services are made available closer to the victims. Because availing care is not enough unless survivors are able to access it, the system should build trust for the community and survivors to come out and get the services.

Availability and accessibility of care

Comprehensive SGBV services which include medical care with forensic exam, psychosocial and legal services should be readily available to survivors. The health facilities should be equipped with the necessary trained health professionals and medical supplies to deliver essential SGBV care putting a good logistic system in place. Some of the services delivered at one stop center at hospitals should come down to health centers so that the essential services are available closer to the victims. Services should consider male survivors as well. Comprehensive SGBV care should not be entirely left to one stop centers at hospitals. Other health facilities should also have the facilities, equipment and supplies and trained providers on SGBV management with the competency and confidence to deliver care. The primary health care units should not only make the medical care available but also the psychosocial services. The legal system should be fast enough to get victims justice on time.

Victims escape to safety to IDP centers and safe houses, these could be places they initially stay for days fleeing conflict. Having the service closer and immediate would help survivors' benefit

from the immediate medical care. During conflict, it may be difficult to refer victims to hospitals (one stop center) for comprehensive care as most health facilities may not be functional. It might take days for survivors to reach care at which time they are late for certain clinical management like emergency contraception, HIV PEP, STI treatment and safe abortion care. Hence, the IDP centers and safe houses, apart from providing psycho-social support should have the capacity to provide essential SGBV care to increase access to care. Because health facilities may not be functional during conflicts. The people in charge of the IDP center and safe houses should consider clinical care including forensic exams as part of their service package.

There should be more safe houses (temporary shelter) for women to recover from their trauma and obtain necessary care. The type of care that can be delivered at each of the service delivery or access point – community, IDP site, safe house, health post, and health center should be defined depending on the situation whether there is a humanitarian crisis or not. The role of the professionals – health extension worker, nurse, midwife, health officer, general practitioner and gynecologist should be outlined clearly.

SGBV care should be part of the training in pre-service health profession education including to those who are non-physician clinician just like any other medical care so that we don't have to do in-service training which is not sustainable when the fund dries out and attrition would not be a barrier for access and services can be available at primary health care units.

Awareness creation

We should create SGBV awareness in the community and educate women and girls in particular on the prevention, the benefit of early reporting and information about the care and where to access it. There should be regular community dialogue to address gender inequality, gender and social norms which are the root causes of GBV. We should also educate the repercussions of some of the community arbitration practices when it comes to ensuring justice for the victim. Media and schools could also be used as platforms to do advocacy work and education.

Coordination and leadership

SGBV care which demands multi-sectoral engagement has to be led by the ministry of health. It should be integrated as one of the SRH programs with required resources. The ministry and

regional health bureaus should bring stakeholders together to have an aligned plan for effectiveness and efficiency (avoid duplication of effort) and create an agile and robust system which can respond to emergency situations with a clear mitigation, response, and preparedness plan. It should be able to have a good data tracking system for SGBV survivors. The ministry should also document lessons from previous interventions and identify the most effective ones for future implementation.

Finally, the root causes of all SGBV which is gender inequality should be tackled by strengthening the proven existing gender transformation programs including having more women in leadership.

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ANNEXES

Annex 1: Characteristics of survivors of Sexual and Gender Based Violence (SGBV), Ethiopia (May - July 2022)

Survivor	Region	Location	Age (in years)	Perpetrator	Type of assault	Marital status	Education	Religion	No. of past pregnancies	No. of living children	Monthly income (ETB)
01	Amhara	Safe house	19	Armed force	Sexual	Single	Incomplete primary education	Orthodox	1	0	2000
02	Amhara	Safe house	29	Armed forces	Sexual	Divorced	Incomplete primary education	Orthodox	3	2	None
03	Amhara	Safe house	-	Armed force	Sexual	Married	Not attended school	Orthodox	3	3	None
04	Amhara	Safe house	24	Armed forces	Sexual	Married	Incomplete primary education	Orthodox	1	1	None
05	Amhara	Safe house	-	Armed forces	Sexual	Divorced	Incomplete primary education	Orthodox	1	0	None
06	Amhara	Safe house	23	Armed force	Sexual	Married	Incomplete secondary education	Orthodox	1	0	None
07	Amhara	Community	30	Armed force	Sexual	Divorced	No formal education	Orthodox	3	3	None
08	Amhara	Community	38	Armed force	Sexual	Married	Complete post-secondary education	Orthodox	5	5	None

09	Amhara	Community	44	Armed force	Sexual	Divorced	No formal education	Orthodox	7	4	None
10	Amhara	Community	45	Armed force	Sexual	Married	No formal education	Orthodox	8	6	None
11	Afar	IDP Center	24	Armed force	Sexual	Single	Incomplete primary education	Orthodox	0	0	None
12	Afar	Safe house	22	Husband	Physical	Married	Incomplete primary education	Muslim	2	1	None
13	Afar	Safe house	10	Neighbor	Sexual	Single	Incomplete primary education	Muslim	0	0	None
14	Oromia	Safe house	15	Father	Sexual	Single	Incomplete primary education	Muslim	0	0	None
15	Oromia	Safe house	18	Brother	Sexual	Single	Incomplete secondary education	Orthodox	0	0	None
16	Oromia	Safe house	15	Kidnapper	Sexual	Single	Complete primary education	Orthodox	0	0	None
17	Addis Ababa	Safe house	28	Step father	Sexual	Single	Complete primary education	Orthodox	1	1	None
18	Addis Ababa	Safe house	18	Cousin	Sexual	Single	Incomplete primary education	Orthodox	1	1	None
19	Addis Ababa	Safe house	22	Friend	Sexual	Single	Incomplete secondary education	Orthodox	1	1	None

N.B. - Two survivors didn't want to tell their age.

- Those labeled armed forces were gang rapes

Annex II: Characteristics of Sexual and Gender Based Violence (SGBV) service providers and Key experts, Ethiopia (May - July 2022)

Variable	Frequency
Age group (in years)	
24-29	6
30-39	7
40-48	6
Sex	
Male	11
Female	10
Region	
Addis Ababa	4
Amhara	8
Afar	6
Oromia	7
Somali	2
Work experience (in years)	
1-5	6
6-10	5
11-15	4
16-22	3
Role in SGBV service	

Ministry of Health	1
SRH-GBV service provider	3
Health extension worker	4
SRH program expert	4
Women's affair	4
Police officer	3
AWSAD	1
UNICEF	1
Ethiopian Society of Obstetrics and Gynecology	1
Family Guidance Association Of Ethiopia	1
AWSA Women mobilization and enhancement office	1
New millennium women Empowerment Organization	1
Oromo Development Association	1