Ipas ETHIOPIA Partners for Reproductive Justice

Impact of drought on SGBV incidence, service and the existing responses to address SGBV issues and service needs in drought-affected areas in Ethiopia

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EXECUTIVE SUMMARY

Background: Drought is a major threat to human security, and it can have a particularly devastating impact on women and girls. When drought strikes, families are forced to make difficult choices about how to allocate scarce resources. This can lead to increased stress and conflict within families, which can make women and girls more vulnerable to violence. Ethiopia is one of the most drought-prone countries in the world. In recent years, the country has experienced a series of severe droughts, which have had a devastating impact on the population. Drought can have an impact on women's reproductive and fertility decisions and behavior because it makes it difficult to access health care due to disrupted transportation and communication networks and causes economic hardships. Hence, drought can lead to increased rates of unwanted pregnancy, unsafe abortion, and maternal morbidity and mortality. Drought can also exacerbate gender inequalities adding workload and financial hardship to the women making it difficult for them to participate in education and employment and leaving them at increased risk of SGBV. Therefore, this study aimed to explore the impacts of drought on SGBV services utilization and care delivery and the preparedness, mitigation and responses to address its effect in drought-affected areas.

Methods: A qualitative content analysis was conducted from April to May, 2023 in three regions of Ethiopia; Oromia, Somali, and SNNPR and Addis Ababa city administration. A total of 43 participants were involved in the study; 9 survivors, 7 service providers, 13 program managers/experts, 8 representatives from implementing partners, 3 IDP site representatives, and 3 key community members. Data was gathered using a semi-structured interview guide. Before being entered into the Dedoose software for content analysis, the audio data was transcribed verbatim and translated into English. The data was coded using the research team's codebook. The codes were then organized into categories and themes, which served as the framework for the results presentation and discussion. To supplement the findings from the primary data, a desk review of relevant literature was performed.

Results: The magnitude of SGBV is reported to increase throughout the drought but there is a lack of clear data to estimate the true magnitude. This was mainly due to the lack of properly established system to identify cases that is hampered due to the ongoing conflict and the COVID-19 pandemic which has diverted stakeholders' attention from the drought area which has made most to believe that the magnitude is not as alarming as the other situations when it actually was proved to be.

Most of the survivors had been victims of sexual assault (6/9) and the rest (3/9) sustained abduction and/or physical assault. In addition, transactional sex , early marriage, female genital cutting, psychological and economic violence, human trafficking, and child labor exploitation were reported to be equally prevalent. Common perpetrators were found to be family members, close friends/peers, neighbors, powerful members of the community who have the advantage of distributing high-demand goods such as food and sanitary products, and even healthcare professionals. The following are identified as major facilitators of violence during the drought; poor housing condition, weak cultural norms, change in lifestyle, financial drives, and lack of male household leader. Unlike the typical community, disclosing and seeking care was difficult due to the fact that SGBV case was not seen as priority, not only by stakeholders but also by the survivors themselves because basic necessity, like securing food, was an issue for all. Additionally, the lack of primary reporting system at IDP site has been a barrier to timely disclosure. However, different types of community-based teams were organized to overcome this barrier to facilitate case identification and reporting. Furthermore, in most cases, following disclosure of the assault, the case is settled using traditional court system. This has prevented most survivors not only from seeking proper justice but also from getting the proper medical care they need and that results in unwanted pregnancy. Overall, due to the little attention given to the drought affected areas, there is poor coordination between stakeholders for better reporting and intervention and health care facilities are not equipped to the required level to provide the proper care.

Conclusions: SGBV has increased in the drought-affected areas although definite data can be provided. Women and girls are vulnerable because they have to travel in search of food and water, engage in transactional sex to secure their food, do not have their husband available to protect them, and get separated from their families because of displacement. All forms of SGBV were reported mainly sexual assault, transactional sex, intimate partner violence, female genital cutting and early marriage. SGBV in the drought areas happened at home, IDP centers and streets. However, there was no clear referral pathway for care receipts when they sought care. The leadership at different levels in the health system failed to acknowledge SBGV was a serious problem that needed urgent attention. Besides, while dealing with managing drought and its consequences, most humanitarian programs did not consider SGBV as a priority intervention area. Few actors supported in the training of health providers on clinical management of rape and

availing the necessary supplies for clinical service. Yet, those efforts seem to be limited when compared with the need and extent of the problem.

Recommendations: SGBV programs should support those who are vulnerable wherever they are at their communities, at the IDP sites and even on the streets by providing care, prevention services, educating those who are vulnerable on how to protect themselves, availing clinical and psychosocial support at the sites and enforce the law that protects their vulnerability. There has to be programs designed to make facilities ready for SGBV care as well. The program can aim at training of health service providers and availing inputs for provision of SGBV care. There has to be a referral system in place for continuum of care to health facilities, one stop centers and safe houses whenever there is a need for advanced clinical, mental and psychosocial support.

Community awareness is critical to address stigma in the society, improve reporting and linking to other services through involving health extension workers and community leaders. It is important to prepare the community for the possibility of emergence of SGBV whenever there are such humanitarian crises. They should be educated on how to prevent and what to do when SBV occurs. It is necessary to avail social support for victims while reintegrating them with their community.

Finally, it is necessary to show the importance of leadership in the health system and do advocacy and sensitization for humanitarian actors and government. As a result, they give equal emphasis for SGBV intervention and avail mobile SGBV care, which fulfills the minimum service package list as recommended by WHO.

1. INTRODUCTION

1.1. Background

1.1.1. Climate Change

The Intergovernmental Panel on Climate Change has defined climate change as "any change in climate over time, whether due to natural variability or as a result of human activity". The altered state of the Earth's climate exacerbates hazards with slow-onset effects, such as droughts and sea level rise, and sudden-onset disasters, such as hurricanes, flooding, and wildfires (IPCC, 2007).

Climate change has the potential to affect virtually everyone on Earth (Denchak M., 2017). But because of the Earth's varied environmental zones, different regions will be impacted differently by slow-onset and sudden-onset hazards. Since 2010, climate disasters have killed more than 410,000 people and affected more than 1.7 billion. In 2019 alone, 97.6 million people were impacted by 308 disasters triggered by natural hazards, 77% of which were the results of events exacerbated by climate change: 127 floods, 59 storms, 25 hydrological-related landslides, 10 extreme temperature events, 8 wildfires, and 8 droughts. Based on the increasing frequency of such events and the acceleration of disasters' intensity, the IFRC projects that around 150 million people annually will need humanitarian assistance related to climate events by 2030, compared to about 100 million now (IFRC, 2020). Geographically, it is forecasted that urban areas and rural regions in sub-Saharan Africa and Southeast Asia will be most severely affected (IPCC, 2018).

Africa is predicted to face severe drought, compromising access to food and exposing 75-250 million people to water stress (USGS, 2020). Without an adequate transformation in climate, violence, civil war, and mass displacements could increase, and people in poverty now, who are more likely to rely on rainfed agriculture and to live on the most marginal lands, will suffer the most (Global Commission on Adaptation, 2020).

Low-income countries are also likely to suffer greater problems of displacement due to low capacity to anticipate, adapt, and rapidly respond to emergencies. In comparison to 1980, the likelihood of being displaced by a disaster is now 60% higher, with the largest displacement disasters driven by climate events. In 2019, 33.4 million people became newly displaced, 70% of whom were displaced due to climate disasters. (Denchak M., 2017, CARE International, 2020).

As such, with the growing global population size and urbanization, climate change is recognized to be a "common concern of mankind" by the United Nations implying the importance of huge investment in its prevention and management of its consequences (UN, 2015).

1.1.2. Causes and Trend of Gender Based Violence

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.

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 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).

It is estimated that one in three women will experience sexual or physical 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). While gender-based violence affects women and children of all ages and race, it is particularly reported to be highly prevalent in Africa due to the persistence of harmful gender norms, alcohol use and overall increased poverty, conflicts. The region has a high prevalence of GBV and harmful practices among adolescents and young women. Of girls aged 20 to 24 years, 31 per cent were married before the age of 18. experienced sexual violence by their intimate partner. Furthermore, Sexual violence against early adolescents aged 15 years and below was reported to be highest in the conflict and post-conflict countries of the DRC, Mozambique, Uganda and Zimbabwe. Women and girls with disabilities were estimated to be up to 10 times more likely to experience sexual violence, with a range of 40

to 68% of girls with disabilities below 18 experiencing sexual violence (ERC and UNFPA, 2020 and UNFPA,2021).

According to EDHS 2016 report, 23% of reproductive age women have experienced physical violence and 10% have experienced sexual violence in Ethiopia. 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 (physical and emotional violence), 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).

1.2. Trend of GBV during Drought

Although drought and any other climate change affects everyone, it has a disproportionately high impact on women and girls in developing countries. Drought can increase levels of GBV in a variety of ways. Climate change can amplify and accelerate pre-existing gender inequalities, exacerbating dispossession, marginalization, and discrimination of women and girls in affected communities. This impact in turn affects women and girls' ability to adapt or recover from a climate-induced emergency and risks their livelihoods disproportionately. Their vulnerability is ascribed to the interplay of biological, psychological, social, cultural, economic and political factors that exacerbate women and girls' risk of exposure to violence as well as men's likelihood for perpetrating violence. (Castañeda et al, 2020, Heise LL, 1999).

In most developing countries, Women and girls' heavily depend on climate-sensitive work, such as farming. During times of drought, when their work is negatively impacted, their earning drops significantly (UN Women, 2009). Since most of them primarily assume the role of caretaker in their family, they are responsible for securing food and water that requires them to walk long distances to find potable water and suitable food, and hence constantly lead a life that is GBV and harmful practices such as child marriage (Un Women, 2009, CARE International, 2020). In addition to that, due to their burden in the house, most girls are forced to withdraw from school laying the foundation for their continued deprivilege throughout their lifetime due to low educational attainment and hence their lack of capacity to adapt to changing circumstances. In situations of scarcity, women and girls may also be forced to resort to transactional sex and other

forms of sexual exploitation in order to provide basic necessities for their families (Röhr U. 2007, Gevers A. et al, 2020).

Furthermore, because of inequitable power relations between males and females, when climate change makes an environment inhospitable or unproductive, women and girls typically remain at home to meet their domestic responsibilities, while men migrate to earn a living elsewhere and send remittances home. In addition, extreme stress, property and communal loss, and scarcity of food and water may contribute to community conflict over resources and increased incidents of violent behavior by men, including GBV. In some cases, additional workloads for women and girls may mean they are not able to be as responsive to the domestic demands of male family members, increasing household tensions that result in violence. Similarly, when families are unable to meet their basic needs, evidence suggests that the risk of child marriage increases significantly for girls (Castañeda et al, 2020, Gevers A. et al, 2020).

GBV in the context of drought is not only associated with the nature of the disaster, but it is also associated with the pre-existing societial norms and practices around women's rights and GBV. As a result, the incidence and outcome of GBV in different countries varies accordingly. With this regard, the deep-rooted societal gender-based discrimination, means of livelihood and large population with low educational attainment, most women in African countries suffer a lot worse as compared to women and girls in developed nations who face similar situations. High levels of displacement and GBV due to drought and flooding are reported in Kenya and Namibia (IFRC, 2015). A study reported that transactional sex, as a means of supporting livelihood, was highly practiced during the time of drought in Mozambique (CARE International 2017). Another study from Uganda showed that intimate partner violence (IPV) was high due to the limited resources in a household to sustain everyone. In addition, in this area, harmful practices like child marriage and Fenale genital cutting (FGM) were rampant during crisis times (Castañeda et al, 2020, Le Masson et al, 2016).

Similar situations are also reported in Ethiopia where women were vulnerable to continued IPV due to resource limitation, especially by husbands with substance use history (Le Masson et al, 2016). The practice of early marriage in exchange for livestock to help their families survive was notable in the country (Castañeda et al, 2020). During the recent drought, most men were forced to leave their home town in search of work while the women stayed home and took care of the rest

of the family. This has caused not only a heavier domestic burden but also increased vulnerability to GBV in the absence of their husbands, brothers or fathers to protect them. Moreover, in severe circumstances, when displacement was inevitable, women and girls were again victims in the overcrowded shelters (Castañeda et al, 2020, CARE International, 2020). 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 (Castañeda et al, 2020, CARE International, 2020).

Emerging evidence showed that the problem of GBV is aggravated in the country with the preceding COVID-19 pandemic and conflict that laid a futile soil for the continued abuse to women and girls (GRID 2020). Drought on top of the pre-existing conflicts in Ethiopia overburden the primary health care systems, resulting in the disruption of basic primary healthcare provision to victims.

1.3. Response to mitigate and manage GBV during Drought

The United Nations Framework Convention on Climate Change (UNFCCC) is the main international body tasked with leading the global response to climate change (United Nations, 1992, UNFCCC, 2020). A crucial constituency of the UNFCCC is the Women's Major Group, led by Women's Enviroment and Development Organization (WEDO), which seeks to mainstream gender equality into the Convention's frameworks and policies (The Women's Major Group). Among the UNFCCC guiding policy frameworks, the Lima Work Programme, created at the 20th annual Conference of Parties (COP) in 2014, was the first to recognize that women and girls are disproportionately affected by climate change and are more dependent on climate-sensitive resources. The Programme sought to promote gender balance and gender-responsive policy by supporting awareness-raising and capacity-building activities on issues related to gender and climate change (Gama Stella, 2016). Subsequently, the UNFCCC Gender Action Plan, Adaptation Fund, Green Climate Fund have all tried to address the needs of girls and women during climate change through mainstreaming of gender into international climate responses. However, there is a gap in defining a clear intervention and support, including monetary, to GBV in particular

(UNFCCC, 2020). In recognition of this, in recent years, the WHO, UNHCR, UNFPA and UN women have addressed the issue of GBV during climate change through designing projects that can mitigate the risks of GBV in areas vulnerable to climate change (WHO, 2015, UNHCR, 2019, UNFPA and the Climate Crisis, 2020, UN women,2020).

In recent years, the humanitarian community has also turned its attention to the relationship between climate change and GBV. The Emergency Relief Coordinator Mark Lowcock has outlined four priorities in building out humanitarian response, the first of which is "support for women and girls, including tackling gender-based violence, reproductive health and empowerment." (IFRC, 2015, ERC and UNFPA, 2020)

In spite of this attention, much work remains to be done. A 2015 report by IFRC characterizes the current situation, stating "during past disasters, GBV has been largely unseen and unheard," as a result of a lack of knowledge on the topic due to stigma around reporting, a lack of services and embedded gender discrimination. A UN Office for Disaster Risk Reduction (UNDRR) report showed that the lack of gender-disaggregated data on disasters caused female mortality, injuries and violence invisible (UNDRR, 2015-2030).

In 2019, the Ethiopian government has established a Gender Action Plan (GAP) with the aim of advancing towards the goal of mainstreaming a gender perspective into all elements of climate action. The GAP sets out five priority areas; Capacity-building, knowledge sharing and communication, Gender balance, participation and women's leadership, Coherence, Gender-responsive implementation and means of implementation, and Monitoring and reporting. Through an integrated approach, some improvements have been achieved so far. However, continued efforts at all levels are required for better achievement. In addition, the report stated that "Understanding the real situation of women and men in relation to climate change and its impacts through research would enable us to make informed decisions" showing the scarcity of evidence in the area.

2. OBJECTIVE

2.1. General Objective

The main objective of the study was to explore the impacts of drought on SGBV services utilization and care delivery and the preparedness, mitigation and responses to address its effect in drought-affected areas.

2.2. Specific Objectives

The specific objectives of the research were to:

- Explore the magnitude of SGBV incidents and access to care in drought affected areas.
- Explore how the drought impacts women's access to care, and the decision to seek and receive care.
- To identify preparedness, enabling factors, and barriers on SRH including SGBV service delivery
- Document gaps in government and stakeholders' effort in the prevention, preparedness, mitigation and response strategies to address the effect of drought on SGBV.

3. METHODOLOGY

3.1. Study setting and design

This study was conducted from April to May 2023 in three regions of Ethiopia; Oromia, Somali, and SNNPR and Addis Ababa city administration. To achieve the study objectives, a qualitative content analysis approach was employed.

3.2. Population and recruitment

The study was conducted among SGBV survivors, service providers, program managers/experts, facility heads, key community members/leaders and implementing partners.

A total of 42 participants were involved in the study; 9 survivors (5 from Oromia and 4 from SNNPR), 7 service providers, 12 program managers/experts (woreda and region level), 8 representatives from implementing partners, 3 IDP site representatives/focals, and 3 key community members/leaders.

Purposive sampling was used to include participants based on their SGBV violence exposure, experience in SGBV prevention and mitigation efforts, particularly in the context of drought, and who could provide better information about SRHR service needs. Eligible participants were selected and interviewed until the required information was saturated.

3.3. Data collection and quality assurance

The study mainly used primary data to meet its objects. Data was collected using semi-structured interviews to perform the IDIs and KIIs. 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.

3.4. 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.

Qualitative content analysis method was employed to analyze the data using Dedoose software. The collected interview notes and recorded audios were translated in English and then transcribed using verbatim transcription technique. The transcribed document was then exported to Dedoose software for analysis. A codebook for qualitative data coding was prepared using key themes in line with the research objectives. Before coding started, two team members independently coded sample transcripts (using key themes identified based on the research objectives) to identify key themes and points of interest to produce a basic framework of themes and sub-themes. Then, the principal investigator compared the coding from each team member and produced the final codebook through a process of deleting, merging, and re-definition, to create a consolidated 'coding dictionary' of nodes. Once the final codebook is produced, the team coded all English transcripts and field notes line-by-line against the set of nodes. The coded transcript was further classified under subcategory, category, sub theme and theme. The emerging concepts and themes were finally used to synthesize and present the findings in the form of narration.

3.5. Ethics approval

The study was conducted after obtaining ethics approval from the Institutional Review Board of St. Paul's Hospital Millennium Medical College. In addition, written informed consent was received from participants who are 18 and above years old and written ascent was obtained from miniors aged less than 18 yealrs old. 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.

4. FINDINGS OF THE STUDY

4.1. Characteristics of the study participants

Nine survivors, five from Oromia and four from SNNPR, were involved in the study. All of the survivors were living in IDP camps at the time of the interview. They had been displaced from their original homelands due to drought and instability. Most of the survivors moved to the camps with their entire families, but some moved with only part of their families or alone. Almost all of the survivors (8/9) were minors at the time of the incident. All were single, except for one who was living with a partner. Four survivors had not attended any formal education, four were attending primary school, and one was in secondary school. Six of the survivors were Protestant, two were Muslim, and one was Orthodox. Four of the survivors became pregnant after being assaulted, and two of them gave birth and are currently living with their children. All of them are either students or dependent on their families, and they have no formal income.

The study also included 7 service providers working at hospitals and health centers, 3 representatives from IDP sites, 18 SRHR-SGBV experts working at national and international government and non-governmental organizations, 1 police officer, 1 lawyer, and 3 key community leaders. Most of the participants were in their mid-30s to early-40s, and 15 were female, including one key community member. Most of the experts (24/31) had over 5 years of experience in the field. (**Table 1)**

Table 1: Study particiapnts characteristics (n=42)

Study participants	Characteristics	Frequency
Survivors (n=9)	**Age**	
	14-18	8
	18-24	1
	Education	
	No formal education	4
	Attended Primary school	4
	Attended Secondary school	1
	Marital Status	
	Single	8
	Living with partner	1
	Religion	
	Orthodox	1

	Muslim	2
	Protestant	6
	Region	
	Oromia	5
	SNNP	4
Implementing Partners (n=18)	**Type**	
	INGO	5
	Professional Association	2
	Government	11
	Age	
	25-29	2
	30-34	4
	35-39	5
	40-43	7
	Gender	
	Male	12
	Female	6
	Work experience (in years)	
	< 5	4
	5-9	5
	10-14	6
	15-20	3
	Region	
	Addis Ababa	8
	SNNPR	4
	Oromia	4
	Somali	2
Health care Providers (n=7)	**Age**	
	25-29	3
	30-34	4
	Gender	
	Male	2
	Female	5
	Profession	
	Nurse	2
	Midwife	3
	HO	1
	GP	1
	Work experience (in years)	
	< 5	3
	5-9	3

	15-20	1
	Region	
	SNNPR	4
	Oromia	2
	Somali	1
Police (n=1)	**Age**	35
	Gender	Female
	Work experience (in years)	6
Lawyer (n=1)	**Age**	35
	Gender	Female
	Work experience (in years)	9
IDP site focals (n=3)	**Age**	
	30-34	1
	35-39	1
	40-43	1
	Gender	
	Male	2
	Female	1
	Profession	
	Nurse	1
	Administration	1
	Social worker	1
	Region	
	SNNPR	1
	Oromia	1
	Somali	1
Key community leaders (n=3)	**Age**	
	30-34	1
	35-39	1
	40-43	1
	Gender	
	Male	2
	Female	1

	Profession	
	Merchant	1
	Pastoralist	1
	Kebele administrator	1
	Region	
	SNNPR	1
	Oromia	1
	Somali	1

4.2. SGBV during drought

4.2.1. Trend of SGBV

Key informants reported that sexual and gender-based violence (SGBV) has increased in the region since the drought. This is evident in the rising number of SGBV cases that are being reported to health care facilities. In addition, a growing number of SGBV cases are being reported to health care facilities as part of legal investigations. In a single one-stop center, it is reported that as many as 30 SGBV cases are referred every month.

> *"Our center manges at least 30 SGBV cases in a month. Out of these 30 cases 20+ are violations committed on minors. These minor victims are mostly students." [SRH service provider, Hawassa One stop center]*

> *"Due to the recent drought hit that has resulted complete loss of asset, people migrated and started to live in camps. This has resulted rape incidence to increase." [Police, One-stop center, Yabello hospital, Oromia]*

> *"As our IDP community is more than 10,000 population, we do not have the capacity to follow what each one experienced every day. But during our meetings we get a lot of reports from those who witness such cases." [Key community leader, Borena IDP community]*

This increase does not account for the large number of unreported cases that are known or witnessed by community members and sevrive providers and SRHR experts in their home towns and in IDP sites. The unsegregated and overcrowded living conditions in IDP sites make it easier

for people to witness SGBV, as opposed to typical community structures where most incidents go unnoticed. In addition, community stigma and fear of not getting justice contribute a significant share to the underreporting like in a typical community.

> *"Community members hide SGBV cases because of community stigmatization. Sex before marriage is taboo in front of the communities. If the case is disclosed by any means, it is reported to the community leaders and legal bodies. When it gets reported, both the victims and the assailants are stigmatized by the communities.The widespread stigma is mainly because of inadequate knowledge of the community about SGBV. If they had adequate knowledge, the stigmatization won't be that much and victims and their families would definitely feel comfortable to report" [Expert of psychosocial support, Woreda health office, Oromia]*

In addition to the underpeorting of the problem, there are unique gaps in the drought situation that are distinct from other humanitarian crises situations the country has faced in the past, such as the COVID-19 pandemic and the conflict, making it far more difficult to determine the true magnitude. This is mainly due to the lack of an established system for picking the number in such crises. Health-care facilities' case-reporting formats have not been updated to include variables that indicate whether a GBV case is related to the drought. As a result, data collected at higher levels, such as woreda, region, and national, is insufficient to determine the precise number of cases.

> *"It is difficult to quantify the current drought impact on the magnitude of SGBV. This is because the case record system format doesn't include inquiries about the IDP situations, whether the victim is displaced or not, so although we know that there are many cases, we can't objectively count and repot the true magnitude." [SRH service provider, Hawassa One stop center]*

Furthermore, another contributing factor for the underreporting is that, SGBV is frequently overlooked in drought situations, not only by stakeholders and the community, but also by survivors. This is due to the fact that people in drought situations frequently struggle to meet their basic needs, such as food, water, and shelter. As a result, they may lack the time or energy to devote to GBV, or they may be afraid to report it for fear of retaliation.

"When faced with a drought, the immediate need is for food, and the immediate need is for water supply. As a result, people will be concerned about their livelihoods and the like. So, even if I am the victim of domestic violence or rape, it is unlikely that I will seek help. And the majority of the data you'll have gathered will be based on those who have sought GBV services. Furthermore, when it comes to establishing services in the drought response region, GBV services are not one of the main priorities. As a result, there are very few GBV-focused service provision sites. Because of this, evidence surrounding GBV would be limited." [WHO]

4.2.2. Types of SGBV during the drought

All types of SGBV are reported, including sexual, physical, psychological and economic violence. The majority of these incidents involve sexual violence. Human trafficking and child labor exploitation are also prevalent in many areas.

"Our center receives referrals for all types of SGBV cases. We estimate that rape accounts for more than 95% of all cases seen at the one-stop center." [Service provider and focal person, One-stop center, Yabello hospital, Oromia]

Transactional sex and marriage are also very high in order to sustain livelihood. Moreover, harmful traditional practices (HTPs), mainly child marriage, unequal age marriage, female genital cutting (FGC) and abduction, are on the rise. The rise in FGC is most likely linked to the rise in early marriage. This is because FGC is practiced as a prerequisite for marriage in some areas, resulting in the parallel increase.

"There are also early marriages and unequal age marriages. These are widely practiced by the local community at the time of the drought." [Police, One-stop center, Yabello *hospital, Oromia]*

"FGC is on the rise in the Somali Region. FGC is usually a pathway to early marriage for girls, so the drought has some impact. So, when there is a drought, one way of securing basic necessity is by getting married with someone who can provide for her, if possible for her family too. So, to go into early marriage, these girls have to get circumcised.." [WHO]

"Early marriage, human trafficking and exploitation of child labor has increased due to the drought because their parents cannot afford to keep them and feed them." [Woreda Women Affair office, Oromia]

In some cases, sexual violence is used as an excuse to enter into marriage. In a traditional community, the groom is expected to give gifts to the bride and to obtain the approval of her family. This can be expensive, which is a challenge for people living in IDP camps. As a result, some men who want to marry a girl may rape her. They know that the cultural court is likely to rule in favor of a peaceful solution that avoids community stigma. The court may order the man to marry the victim and pay a small amount of money.

"*To start a marriage in our culture, one person must first provide cattle, money, and clothing for the women's family. You won't get that woman unless you do that. They lack resources and money to fulfill the culture here, so they are forced to engage in unwanted rape and sex." [IDP site coordinator, Borena, Oromia]*

With regard to physical violence, inhuman experiences of physical abuse to the point of death were also reported in one IDP center. One woman was beaten to death by her husband but the IDP community decided not to interfere due to a number of factors, including cultural beliefs and societal norms that fosters gender inequality and abuse of women's rights. In the same IDP site, another murder was committed by community members on one of the women who they claimed to be "buda" (a person with strong eye sight).

"Because the community claimed she had a strong eye sight (Buda), she was marginalized and lived on the outskirts of the IDP camp. She has accessed various organizations' support for the IDP community. The community questioned why we supported her. We responded that because she is a human being, she deserves our full support. They murdered and buried her a few months ago on a Saturday evening. They take her body out again, cut it up, and burn it. The suspects were arrested by police, and the case is still being investigated." [IDP site coordinator, Konso, SNNPR]

4.2.3. Perpetrators

As in any situation, perpetrators of SGBV include family members, close friends, neighbors, and complete strangers. However, in the context of the drought, young men are the most common

perpetrators. It is emphasized that, unlike in other situations, young men engage in SGBV activities during the drought, including abduction, physical abuse, and gang rape of girls they know well as well as strange girls they meet in the community and IDP sites.

> *"Initially we agreed to get married. Even if we were young, we were in love. I agreed to marry him and planned to live with him. The marriage was totally based on our consensus. I kept it as a secret from my family because they wouldn't agree. Then, I left home with him and started a journey through the jungle to his family's home. But on the way, he raped me and made his five friends to rape me one after the other." [Survivor 9, SNNPR]*

In addition, young men from urban areas have been reported to take advantage of migrants into consensual relationships by making false promises.

> "*When a woman leaves her home and comes to an IDP site, she wants to improve or win her livelihood. In such situations, there are tendencies for a women to quickly engage in relationships with a hope of securing some beenfits. As a result, they can be easily fooled by th young men from the urban areas who promise things they won't keep just for the saking taking advantage of the women" [Woreda Women Affair office, Oromia]*

4.2.4. Facilitators

The following are identified as major facilitators of violence during the drought.

Poor housing condition

The IDP site setup is mentioned as a major factor in creating a conducive environment for rape. Almost all IDPs have a large population, up to 10,000 people, and the shelters are overcrowded. The shelters are made of materials that are not strong enough to keep attackers out. Most importantly, the majority of shelters lack doors. Furthermore, despite the overcrowding, there is no sex-based site separation. As a result, a large number of young men and women are living in an environment with very limited boundaries and safety barriers. As a result, a number of incidents can occur in a single camp in a single night. Additionally, this has provided an opportunity for many people to meet and enter into a transactional sex for the sake of securing livelihood.

> *"As our IDP community is more than 10,000 population, we do not have the capacity to follow what each one experienced every day. But during our meetings we get a lot of*

reports from those who witness such cases." [Key community leader, Borena IDP community]

"As there is no segregation in the temporary communal shelters, the risk of SGBV is high." [Women and Childrens affair office, SNNPR regional office]

In areas where there are no IDP sites or the sites are not well established, most women and children live on the street begging. This makes them vulnerable for attack given the disrupted community dynamics and legal system.

"In the zones that are heavily affected by the drought, the number of women and children living on the streets looking for food are very high. Dwelling on the streets makes the women and children prone to SGBV." [Women and Childrens affair office, SNNPR regional office]

Weak cultural norms

Since the IDPs are populated with members who come from different communities with different beliefs, this has resulted in a lack of commonly shared culture, values and beliefs. Due to this, things that were considered taboos, like transactional sex, abduction, early marriage, and sexual and physical violence, became routine.

"This area is where Borana people used to live and where culture is respected and obeyed. Since the drought struck, a lot of different communities have come here. This has caused people to drop their previous culture and adopt the new lifestyle and behaviors. Previously, sex before marriage, pregnancy without marriage, rape, and sexual attacks on women were taboo and strictly forbidden in Borena culture. But currently, the communities' culture is mixed with modernization and considered fashionable, including having sex before marriage, pregnancy without marriage, and violence against women." [Expert of psychosocial support, Woreda health office, Oromia]

On the contrary, the trend is quite different in some regions where male dominance is highly respected, even in situations where men abuse women. Let alone in the IDPs, in their former community, most men rape girls, especially following social events, and this is considered as an act of competence, and no health care service or justice is sought by the survivor or her families. This culture has continued in a magnified way in the IPDs due to the overcrowed situation and

large opportunities of social gatehrings or events that might facilite this harmful cultural practice. The community has learned to protect the perpetrators in such places.

> *"Girls are raped during their cultural dancing ceremony. On this occasion, girls will go dancing by beautifying themselves, making themselves ready for attraction. Young males will dance with these girls. It is common to be raped on this occasion. Rape is so common and legal in the community's culture. Raping is considered a way of showing young men that they are patriots, so they examine themselves through raping. As girls also have a similar perception, they usually do not go to report the assault. [Youth and reproductive health officer, Woreda, Dassench]*

Change in lifestyle

Due to the displacement and lack of adequate infrastructure in the IPDs, those young members of the community are out of school with nothing else to do. These have caused the women to engage in transactional sex or enter into family-arranged early marriages. Men, on the other hand, are engaged in drinking, doing drugs, and forming gangs that abuse women and their families. In addition, most members of society struggled to adjust to the new lifestyle and were stressed, which led to most males, including elders, beginning to drink heavily and eventually committing violence.

> *"I think one of the factors contributing to the increased magnitude of SGBV is drug addiction. Recently, we have noticed unusual drug abuses in the region that were not previously common in our community, such as hashish, khat, and other types of addiction." [Service provider, Karamara General Hospital One-stop center, Somali]*

Financial drives

Due to the loss of properties and inadequate support at the IDPs, most families don't have enough to sustain their families. In such cases, they make their sons go to some other place in search of a job, and they arrange their daughters' marriage even if they are minors. That way, they'll at least feed themselves or even bring some food, clothing, or money to the parents.

> *"Schoolchildren are supported by their parents prior to the onset of the drought. Drought-induced poverty has made it difficult for schoolchildren, particularly girls, to attend classes. There is a tendency to seek help from others as a way out of this. Taking advantage*

of this situation, girls are being raped because they have unequal bargaining power over their own bodies. Because of their delay in seeking medical care, this has put girls at risk of unintended pregnancy." [Police, One-stop center, Yabello hospital, Oromia]

Lack of male household leader

During the drought, most men in both the community and IDPs were forced to migrate in search of work, leaving women and children behind. In such cases, when the girls travel too far to collect fuel wood and water, they are abused.

"During crises, whether it is conflict where the men are taken to the battle field or drought where they go off to find new pasture or water for their cattle, the women are the ones who are left to look after their family and become breadwinners. They are expected to provide food and basic needs for their family and hence will be forced to travel long distances in search of food or engage in circumstances where they don't normally do so in order to gain access to basic needs. Hence, the consequences of drought, and climate change contribute highly to the exacerbation of violence against women." [UNFPA]

4.3. SGBV disclosure, reporting and referral system

4.3.1. Disclosure behavior and decision

In terms of disclosure, the majority of survivors interviewed stated that they had done so immediately, primarily to their family and friends. Disclosure was not an issue in some cases because the assault was witnessed by community members as they were living in a croweded situation and people can hear when the victim shouts for help in an attempt tp escape. However, some of the survivors stated that they disclosed when they discovered they were pregnant.

Following the disclosure, the path to seeking care and justice was different for different survivors. In most cases, seeking immediate health care is overlooked unless the survivor has a visible physical injury. This is mainly because of inadequate knowledge of the health consequences of such violence and the unavailability of tailored care. The other reason was, most do not report due to fear of stigma and the desire to be accepted by the community member and continue life as usual. Additoanlly, disclosure and seeking legal justice might result in further threats from the same perpetrator, so most women prefer not to disclose or settle for a traditoanl justice decision.

"After the assault, I didn't have any physical injury so I did not insist to go to a health facility nor did my family wanted to do that. So, I just continued living my life." [Survivor 9, SNNPR]

"I wasn't worried about my health; I was worried about other things. If my boyfriend, the perpetrator,refused to accept, what could I do? But how I could live in the community was my worry. You know what? Here, our community strictly stigmatize and discriminate such individuals *." [Survivor 1, Borena, Oromia]*

"No, I am not worried about disease or pregnancy. I only worried about family and community stigma." [Survivor 5, Borena, Oromia]

Health care providers also reported the same thing. They claimed that they see few SGBV cases because most get resolved by traditional methods and don't even come to the health facilities for HIV and pregnancy testing.

"We know there are many SGBV cases, but none of these cases have ever reached our health center as they are being resolved through traditional mitigation practices. Personally, I have never treated a SGBV victim. So there is nothing much for me to say about it.." [SRH service provider, health center, Dasenech, South Omo, SNNPR]

With regard to seeking justice, in most cases, the path to justice was sought through the traditional court rather than the legal process, which has been an acknowledged institution for a long time not only by the community but also by legal entities.

"I immediately informed my mother about the situation. My mother also has no husband. She took the case to clan elders according to the local Borana culture. Elders took the case and resolved it by deciding on the perpetrator to pay 3000 Birr for me. He paid, and the case was finalized." [Survivor 3, Borena, Oromia]

"I told my father what happened to me, and my father asked the man by the culture of Borena. At that time, the attacker denied the case in front of the elders; in Borena culture, if the man denies the issue, you don't get justice. If it had been women's affairs, I would have gotten justice. But we were not going into women's affairs; we accepted the borena

elder's judgments. For that reason, I didn't get justice from the elders." [Survivor 1, Borena, Oromia]

"If one woman is raped by somebody, the one who raped her must marry her. But if the attacker escapes or leaves the community, we bring the case to the Women and Child Affairs office. Following that, she will get a health care service, which is pregnancy testing in the health center. If she is pregnant, the office supports her by linking her to legal counseling and giving financial support. At the community level and woreda level, the women and child affairs office works in coordination with other stakeholders like health facilities and police." [IDP site coordinator, Borena, Oromia]

In some cases, families of victims choose not to disclose the case, even if it meant relocating to a different town to avoid the stigma Some even were afaird of disclosing some members of the family, like father of the victim. Hence these cases miss out the opportunity to seek proper medical and legal services out of fear of some family members and/or to avoid community stigma.

"Community has no awareness. Victims are not accepted by their communities. As a result, the survivors conceal their violence and pregnancy until it is visible. It is difficult to handle the case from a health and legal standpoint as the pregnancy weeks and day of attack increased." [Expert of child and women protection, Woreda health office, Oromia]

"My mother and aunt forced me to relocate so that my father would not learn about the incident or the pregnancy. Nobody in the community is aware, and justice was never sought." [Survivor 5, Borena, Oromia]

Furthermore, in some cases, appropriate punishment of perpetrators is not made, so survivors are discouraged from reporting for fear of further assault on themselves and their families.

"Most men who commit such violence do not receive the appropriate punishment. This discourages other victims from coming forward to seek justice because they know justice will not be served, so they choose to remain silent. As a result, legal institutions should work to provide justice, which will hopefully discourage men from committing such violence and encourage women to seek legal assistance when they are victims." [SRHR Program expert, Professional Association 1]

"When I go to the police station, there is no good service; instead, they are attempting to conceal the case. They did not provide me with a solution. My brothers took me to the health center, and the social worker assisted me by writing a support letter and following up to go to the police station." [Survivor 7, SNNPR]

On the other hand, in very few cases , survivors' families chose to seek modern medical care and report legally. Depending on the circumstances, they either seek medical care or report to the police or the office of women and children affairs first. The process will then be taken to higher offices one by one, up to the highest level, in order to keep the survivor safe, get her proper medical care, and follow the legal process until justice is served. (Details on the reporting and referral process are provided in the following section).

4.3.2. Formal reporting and referral pathway

Depending on the type of assault, the severity of the survivor's injury, and the community structure, the formal reporting and referral linkage can begin with one of the offices involved in the prevention and response to SGBV.

One of the following paths can be taken in an ideal situation in which all organizations on the path are available and functional.

Typical community structure

In such cases, the reporting path is set to begin with the kebele structure (formal office or, more commonly, other existing groups such as 1-5 development groups). Although not available in every kebele, this structure is strong and has been found to be useful by providing a more convenient setup for survivors to report without having to travel long distances to woreda structures, which they may not be familiar with in most cases.

"At the kebele structure, we have a structure called Hadha Sike that works on women and children issues. Survivor will go to Hadha Sike first, and Hadha Sike will report for us, after which we will inform police and go together to arrest and investigate the case. We will transport her to a medical facility for treatment, while the police will conduct an investigation and bring him to woreda court. We might refer the survivor to the zone as necessary for further court hearing." [Woreda Women Affair office, Oromia]

From the kebele, a report will be made to the woreda women and children affair office. From there, the survivor will be immediately linked to a one-stop center, and police will be notified of the situation. Then, with the help of the women and children's affairs office and the police, a link will be established to a health institution for proper medical care as well as the gathering of evidence to present the case in court. Depending on the level of care required, the survivor may be referred to a higher institution, such as a tertiary hospital. The case will then be presented to woreda court; if a decision cannot be reached at this level, the case will be referred to zonal court.

IDP sites

Because there are no Kebele structures in IDPs, the reporting and reporting path does not begin with kebele structures in these communities. Due to the living conditions in the camp and a lack of resources to travel to the woreda, it has been difficult to report cases directly to the woreda offices without the assistance of someone or some organization. The respective stakeholders and the IDP community recognized this gap and established a system to replace the kebele structure in which survivors can easily and quickly report.

The first is that some IDPS have a designated member of the community (or a social worker) to whom survivors can report at any time to receive the necessary assistance.

> *"We are a pastoral community with a distinct culture. We have a responsible body to whom you can report anything that has happened to you. If survivors approach us, we can refer them to the woreda women's affairs office. They can also report themselves to woreda. They can find a solution in either case but the first one is easier and convenient." [Pastoralist, A women representative of Borena IDP community]*

The second is that in some IDPs, a community police team is formed, which is chosen by the community members themselves. These are teams that not only accept survivors' reports, but also conduct active community searches door to door to identify cases that did not report for a variety of reasons.

> *"Community police are used to monitor GBV. People from the community are chosen for community policing. This is possible if the community discloses the case. Nothing could be done unless they disclose the problem. Once they report, the case may be brought up to the*

woreda, and there is no problem in providing the necessary services. If a girl is raped, there is no culture of reporting it and it will never be discovered unless those neighborhood cops had looked into the case.." [Youth and reproductive health officer, Woreda, Dassench]

In other areas, the aforementioned groups take the form of a child protection committee, which is consulted in cases of assault and also oversees the community in preventing any form of SGBV. These teams are said to go above and beyond to get victims the care and justice they deserve.

"Yes, there is a formal reporting and referral system in place to deal with GBV cases. The child protection committee (CPC) is an organized committee composed of influential members of the community whose sole responsibility is to prevent GBV and sexual exploitation incidents. When a GBV incident occurs, CPC members assess the situation and report it to our bureau (IDP), where we document the incident and forward it to the police. Sometimes these GBV cases reach the police before they reach the bureau, and based on medical confirmation, the police begin the legal process." [Women and Childrens affair office, South Omo]

"When a GBV victim reports their case and we suspect that they may be subjected to family manipulation and pressure, we immediately transport them to a hostel like the ones we have in Omorate and Noborums, where they will stay until the due process of their case is completed and a verdict is issued." [Women and Childrens affair office, South Omo]

In others, they formed a team of influential community members who met on a regular basis to monitor community activity and ensure the safety of women and girls. A separate team called the "Women Association" is also formed to protect the rights and benefits of women and girls.

"*Another mechanism we devised is the formation of various committees at various administrative levels. Administrative officials, elders, religious leaders, media personalities, and other influencial memebrs serve on these committees. The sole purpose of these committees is to prevent harmful traditional practices, including SGBV, by holding public discussions at 15-day intervals and diligently following up on violation cases to ensure justice is served." [Women and Childrens affair office, SNNPR regional office]*

In both cases, normal community and IDP, the first entry into the system will be through health institutions in assaults where the survivors sustained physical injury, genital bleeding, bruises, or fractures as a result of the violence. Depending on the level of injury sustained by the survivor, immediate reporting will be made to the kebele structure or woreda women and children affair office. The above-mentioned care process continues from them. In other cases, where there is a persistent threat, the police may be notified directly by the health institution, and the police will proceed to secure care in collaboration with the woreda women and children affair office.

Poor coordination in reporting

As mentioned above, the starting point for reporting is at the kebele level, but in some areas this structure may not be available or functional. In such areas, the reporting system is deficient, which is most likely due to the community's limited knowledge and inadequately trained health care providers. Some health institutions have also been observed to have no knowledge of the referral path due to a lack of training among their staff.

> *"We do not have a formal reporting system for GBV survivors; instead, they are referred to the hospital, as in any other case of a referring system." [SRHR-SGBV service provider, Dubuluk health center, Dubuluk, Oromia]*

> *"There is no referral system in place for GBV survivors. We only see her when her family brings her to the facility center. There is no formal pathway because no formal platform has yet been created to entertain this. This system doesn't exist in our catchment area." [SRH Service provider, Karat Primary Hospital, Konso]*

> *"The current reporting and referral linkage is better than the previous one, but it is insufficient for timely managing GBV cases. There is delay between reporting to kebele and reporting from kebele to the woreda. You must return several times. For example, health professionals claim that if a girl/woman is raped, it is impossible to determine whether she was raped or not if she presents after three days. So, case management is a little difficult under the current structure. It would be preferable if a social worker were added to the current reporting structure to strengthen it." [Woreda Women affair Oromia]*

Current efforts to improve reporting and referral linkage

In cases where a clear pathway for reporting exist, some of the structures along the path might be unavailable or not functional. One of the most frequently mentioned gaps is a lack of adequate number of one-stop centers or limited capacity to accommodate the growing number of survivors. This is true across all regions studied. In such cases, survivors have to follow their medical care and legal proceedings from their homes. In the pre-drought era, this was a viable option for families who could afford the costs of traveling to these locations on their own and, more importantly, who want to protect the survivor from further assault. However, this is not the case for IDP families. As a result, an alternative method of securing a temporary shelter for survivors until their process is completed is being developed in collaboration with non-governmental organizations.

> *"There is a coordinated effort between teams, but there is no one-stop center here to house survivors until their cases are resolved. We have been coordinating with justice and court offices to link survivors to concerned organizations that can provide temporary shelter, but this is not always effective." [Woreda Women Affair office, Oromia]*

4.4. Preparedness for SGBV care during drought: Prevention, Mitigation and Response

4.4.1. Organizations involved and their role

During the drought, a number of stakeholders, both existing and newly formed, government and non-governmental orgranizations were involved in the response to SGBV. Government organizations involved in the response includes women and child affair, MSI and EPHI. The non-governmental organizations which had high involvement includes UNFPA, WHO, Project Hope. The national SRH technical working group (SRH-TWG) led by MOH and EHPI play a coordinating role bring all stakeholders working in the areas of GBV. The working group is composed of MOH, EPHI, ENGENDER Health, UNFPA, Mary Stops, Project Hope, Maternity foundation, WHO, ESOG, Midwife association, USAID, UNHCR, IOM, MOH, Plan International, Pathfinder, and UNICEF.

The following is highlights of key actors' engagement in GBV reponse. The women and child affair engaging the woreda and regional health offices, non-governmental organizations (NGOs) such as IOM and WFP, and other local voluntary organizationsdevised a communication system

with newly established reporting portals at the IPD sites to ensure that the referral path remained operational. They provide survivors with safe and free transportation to regions where they can receive medical care and be connected with safe houses.

They provide survivors support and skill training so that they can continue their formal education and/or learn new skills and find a job. They also teach women and girls in IPDs how to defend themselves against assault and how to escape and report. Training is also provided to community members to educate them about GBV and to protect women and girls from those who commit violence. Psychological support was also provided to all members of the IDP community, as it is expected that people will struggle to adjust to their new lifestyle.

In collaboration with UNFPA, MSI delivered a minimum initial service package (MISP), helped to strengthen one-stop centers and mobile clinics and assigned mental health and psychosocial advisors (MHPSS) in the mobile clinics.

After the situation was declared as an emergency by the humanitarian country team (HCT), UNFPA has started interventions in the drought affected areas. A drought response plan was developed, consisting of 11 clusters and four areas of responsibility, including GBV, housing lands and property. child protection and general protection, identification of those in need, and response based on capacity.

UNFPA was involved in the provision of psychosocial support, case management services to address the survival needs of sexually and physically violated victims, and addressing the demand of survivors with an inter-agency reproductive kit that includes a dedicated kit called kit number 3, 5, and 8. One kit includes post-exposure prophylaxis, emergency contraception, STI and pregnancy testing, STI management, and abortion-related supplies. They also have a kit for girls and women of reproductive age to ensure menstrual hygiene.

They are also attempting to strengthen the referral pathway by supporting safe houses and collaborating with food-supply and psychosocial support organizations. They ensured that victims were linked to closer and more convenient organizations within the chain by identifying convenient pathways. The team also developed mobile clinic health and nutrition teams composed

of health professionals such as midwives to deal with the GBV component, which is a better fit for their specific need.

The office formed a technical working group to address both the mental health and GBV components. The team focuses on identifying the capacity requirements of the response partners. They have recognized the gap in competence in delivering the expected service with regard to SGBV, particularly in the drought context. As a result, in collaboration with the regional health bureaus, they have designed two types of trainings to be delivered to health care professionals working in the three regions.

The first one is a training on clinical management of rape, and intimate partner violence. They hope to solve the problem of having only a few One Stop Centers in the country, which are not easily accessible to every survivor, forcing them to travel long distances to access medical services. As a result, the team is considering broadening the scope beyond one-stop centers, ensuring that mobile health and nutrition teams, as well as other primary health facilities, can provide GBV services on the spot without the need to go to One Stop Centers.

The second training is on mental health and psychosocial support. This is emphasized because it is an essential component of GBV management. In addition to its primary goal of supporting the psychosocial needs of survivors, it has been demonstrated that it can be used as an entry point for the majority of SGBV survivors. As a result of the training, these teams are now able to identify SGBV cases that present to them and refer them to the clinical case management team for medical care and additional support.

4.4.2. Health care facility: Services provided and barriers

IDP site health centers/ mobile clinics

In these sites, basic emergency care is provided including family planning counseling, HIV testing, and emergency contraception. Aside from that, survivors are referred to a nearby health center. However, due to poor clinic setup at the sites, a significant number of cases received no care at all.

Health centers

The health centers provide basic care for survivors including family planning counseling, HIV testing, basic emergency obstetric care, ante-natal care, postnatal care, and emergency

contraception. For additional services and for further medical care, they refer the survivors to nearby hospitals. At times, they even ran out of these supplies and had to refer cases for every care.

> *"The health center has a shortage of post pills, regents to do STI testing and other related materials." [SRHR-SGBV service provider, Dubuluk health center, Dubuluk, Oromia]*

Hospitals (one stop centers): Most essential SRH services, such as family planning counseling, HIV counseling, HIV testing, STI prophylaxis/treatment, basic emergency obstetric care, ante-natal care, post-natal care, emergency contraception, safe abortion care, psychosocial support, psychiatric care, and legal counseling, are available in some hospitals but not in all.

Some one-stop centers do not provide safe abortion care services and must refer survivors to other hospitals for that care. In some others, the required team composition is not as recommended, making comprehensive care provision difficult.

> *"The one-stop center also has all of the necessary medical professionals, from nurses to medical specialists, but no psychologist. We also have a lawyer and police officers who work at the center on a regular basis. They conduct an investigation, present the case in court, and follow up on the case until it is resolved." [Service provider and focal person, One-stop center, Yabello hospital, Oromia]*

Barriers to access health services

At the level of health centers, referring cases is difficult due to the drought and ongoing conflict, which has made travel difficult and resulted in communication barrier. As a result, the majority of cases, including non-medical ones, are handled by health care professionals who are not trained to that level.

> *"Most of the time the responsibility of treating SGBV victims falls in the hands of health extension workers. Both medical and legal needs of SGBV cases are handled by the same health extension workers." [SRH service provider, health center, Dasenech, South Omo, SNNPR]*

"After 5 days, I went to Dillo Health Center, where they tested my blood and found that I was HIV/AIDS negative, but they said nothing about the pregnancy. So I was pregnant and gave birth to that child." [Survivor 3, Borena, Oromia]

"After two months, I went to Dubluk Health Center to check for pregnancy. They only tested for pregnancy and not for STIs or HIV AIDS. They informed me that I am pregnant. I only received medical care in order to have an abortion. Apart from the abortion service, I received no psychological support." [Survivor 4, Borena, Oromia]

This is especially true in areas where the number of medical professionals is limited and/or they are preoccupied with other cases. We've learned that, in some cases, health centers aren't even prepared to deal with SGBV during the drought. Instead, they are prepared to respond to other outbreaks such as cholera and malaria.

"Our primary goal and commitment is to prevent a malaria epidemic. We are more concerned with malaria prevention than with SGBV. During the summer, our health center goes on an outreach missions, even by crossing the river, to prevent a malaria epidemic outbreak in IDP camps. Because the death rate caused by such an epidemic is incomparable to the harms caused by SGBV, we are more concerned and committed to preventing malaria cases than to working on SGBV." [SRH service provider, health center, Dasenech, South Omo, SNNPR]

Due to delayed case reporting, providing the bare necessities to survivors has been difficult. This has made it difficult to provide emergency contraception, STI prevention services, and safe abortion, resulting in unwanted pregnancy. This is primarily due to the decision to handle cases through the traditional system, which can take a long time, and by the time the survivor arrives at a health facility, if at all, it is too late to provide any of the aforementioned prevention services.

"Failure to report rape cases on time has also placed a strain on the referral system. They are more likely to go to the traditional crime management system rather than directly to the appropriate area. In the traditional community crime case management system, they must go through a lengthy process, such as dealing with the case by sending elders to the survivor's parents. If the survivor's parents or relatives do not agree with the elders, they

will report the case. This has imposed additional burdens on survivors, such as the inability to obtain justice in a timely manner." [Police, One-stop center, Yabello hospital, Oromia]

Although efforts have been made to establish one-stop centers, providing a comprehensive service has proven difficult. The first shortcoming is a lack of adequate infrastructure, which includes medications and laboratory supplies. In some cases, there is insufficient space to house survivors until they are linked to safe houses or other temporary shelters. Furthermore, most professionals claim that they are not qualified to provide the service due to a lack of training, at least once.

"We face some challenges in providing services to SGBV victims; for example, we require a mini pharmacy and a mini laboratory that only serve one-stop center clients, but we lack those services. The main challenge stems from society's attitude that prevents victims from seeking services from professionals. Even those who overcome all obstacles and make it to our centers usually leave after their first visit because they don't have a place to stay and receive the services they require. As a facility, we don't have the capacity or space to let them stay longer than 72 hours. For these reasons, we lost most survivors before they received the basic services." [Service provider, Karamara General Hospital One-stop center, Somali]

"I've been trained in GBV management techniques. I recently received such training. I had no idea about GBV and its management prior to that training. One other professional has received such training as well. However, there is no separately prepared room and necessary materials to setup the clinic on the one hand and a lack of necessary drugs on the other to deliver the service." [SRH Service provider, Karat Primary Hospital, Konso]

The other issue is that, while efforts have been made to strengthen one-stop centers to provide comprehensive care, making it accessible has been a challenge during the drought. Most cases that require referral for higher level care are unable to leave on time due to a lack of and/or inability to afford transportation. The health centers do not have enough ambulances, and may not even have one to transport the survivors themselves. In such cases, health centers must bear the burden of keeping the survivor and her attendees at the center until they can access referral services. In such cases, health centers lack sufficient resources to feed and house everyone, including the survivor.

This causes not only further delays in receiving necessary care on the survivor's side, but also competition for hospital resources with other cases who can actually benefit from the health centers.

Financial constraints are also seen at one-stop centers. Because the services are not integrated with other critical hospital services, they are not provided for free. As a result, most survivors are unable to afford the service.

> *"In most SGBV cases the victims are economically poor. When the victims arrive in our center they have to spend more than 500 birr to cover the expenses of the services that they need. They have to pay 60 birr for a triage examination, 200 up to 300 birr for laboratory tests, some amount to get prescribed pharmaceuticals, for transport fees and for other expenses. Because of this, most victims are forced to leave the center as they are economically poor and can't afford the treatments." [SRH service provider, Hawassa One stop center]*

Furthermore, the one stop centers provide service during working hours only. Hospitals did not allocate a budget to run the center 24 hours a day. This has caused a gap in delivering the required service to survivors at the time they need it.

> *"The service time for the one-stop center should be 24 hours because this is an emergency and you never know when a case will come to the center. Our team has been providing the extra hour services for free. It is common for extra time work to be compensated with duty hour payment. While we worked for years in the one-stop center, we were never paid because the center has no budget." [Service provider and focal person, One-stop center, Yabello hospital, Oromia]*

Finally, a lack of adequate safe houses has resulted in a continuous interruption in service provision due to a lack of a place to stay in between services, medical care, and legal processes, which requires better financial status to follow on their own and may also lead to further assault by the perpetrators.

> *"There are two one-stop centers that serve the community: Jijiga Karamara Hospital and Gode Referral Hospital. So far, we don't have a place (safe house) to keep the survivors*

until the process is completed, and it would have been ideal if one could be built." [Gender Director, regional bureau, Somali]

4.4.3. Community

Diversity in understanding and response to SGBV among communities is observed. In most communities, there is a lack of knowledge about the issue, and in others, an unfavorable attitude is cited as a major barrier.

As previously stated, some interventions to raise community awareness have been implemented at IDP sites. Furthermore, the community has been tasked with forming teams to combat violence against women and girls. As many members as there are who took this seriously and worked on prevention and response as needed, and even more, the majority have not understood the concern and have been involved in the violence themselves, refrained from intervening when they witness one, or refused to participate in the response. One of the biggest barriers to addressing SGBV is poor community awareness. Many communities lack understanding of what SGBV is, the different forms it can take, and the negative consequences it can have on victims. In addition, in many cultures, there are deeply ingrained beliefs that support SGBV. These beliefs can include the idea that women are inferior to men, that violence against women is justified, and that victims of SGBV should be silent. These lack of awareness and cultural barriers can lead to a number of problems, including: victims of SGBV may be afraid to come forward because they fear being stigmatized or blamed, communities may not be supportive of victims or may even blame them for the violence they have experienced, and there may be a lack of resources available to help victims, such as medical care, counseling, and legal assistance.

"The community lacks adequate GBV awareness and knowledge. It necessitates greater awareness. In my opinion and experience, more than 75% of our community is illiterate. Greater awareness is required by going door to door in the community to educate people about the impact of GBV and how to protect themselves." [Woreda Women affairs, Oromia]

"The communities have knowledge as a result of different levels of awareness creation and training. The legal sector provides training and awareness creation on SGBV from a legal standpoint; our sector also provides awareness creation on SGBV for communities and

other sectors; other community cooperation such as women's development and legal development learning discuss each other's issues. Because they are refreshed on a regular basis, these community groups have more knowledge than us. The main problem of the communities is not lack of knowledge, but rather it is because of gender inequality and social norm deep rooted in the society*; this is not only a problem of the communities, but also of government workers." [Team leader of women mobilization, Regional Women and Child office, Oromia]*

4.5. Opportunities and Challenges

4.5.1. Opportunities

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- A rapid response to the drought was made in terms of food security. As a result, the mobile nutrition team that was deployed to provide this first line of defense was trained and double-tasked with identifying SGBV cases and connecting them to the proper care system. Furthermore, the team that works on mental health and psychosocial support (MHPSS) is trained to identify survivors. Because a formal team to work on SGBV was not established on time, this system assisted in identifying cases earlier. Additionally, due to the large size of the IDPs and the increasing number of cases, it is not possible to address it with a smaller than required number of proper professionals alone, and this team fills that gap.

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- We found a huge number of individuals of all age groups and mixed gender at the IDP camps. This has facilitate running awareness creation on SGBV much easier.

> *"As you can see, the community has gathered at one location. This has made awareness creation easier. It is not necessary to go from house to house to educate the community on SGBV." [Woreda Women affair, Oromia]*

4.5.2. Challenges

- **Lack of attention hence, limited resource:** The country's conflict in the north has made it difficult to devote adequate attention to drought-affected areas. Government and donor

attention is still focused on conflict-affected areas SGBV interventions in drought affected areas less priority.

"We have been working in emergency situations in the northern part of Ethiopia since the war began. Those working on SRH in the Northern region are receiving adequate funding unlike those in drought affected south. We support internally displaced people deploying 11 mobile health teams in Afara, Amhara, and Tigray. however ,we do not have one in drought affected areas." [MSI]

"One of the most significant challenges we face when responding to such a crisis is a lack of resources. Despite the willingness of humanitarian organizations to act immediately, resource providers and donors are not convinced enough to release funds in the absence of adequate information. While we work to provide these donors with data on a specific crisis, another crisis may arise, and these donors may refuse to shift the fund to the other type of emergency, leaving us ill-equipped to deal with the constantly changing emergency situations that are interdependent on one another. The main issue here is that stakeholders prefer to work on cases that have already caused destruction rather than those that can be avoided." [UNFPA]

The MISP system is dependent on donors, and there is no alternative local solution in place in the event of their absence or service interruption. Furthermore, the majority of organizations in the national technical working group stated that they do not have a plan to intervene in the drought area and will continue to work in the conflict-affected area because that is where all of the support is.

- **Other medical conditions were priority than SGBV:** In drought-affected areas, there were acute medical conditions (communicable diseases) such as cholera and measles outbreaks, and nutrition insecurity. Hence, the programs seems to put their resources into these issues than SGBV.

"For the time being, the priority in drought-affected areas is malnutrition and outbreaks, so they focused on nutrition rather than SGBV. Also, the prevalence of

SGBV in these areas is lower than in conflict zones. Of course, we cannot say that there is no SGBV in drought-affected areas, but it is not as prevalent as in conflict-affected areas. That's why they didn't pay attention to it." [SRHR expert, National Technical Working Group]

"During the drought, the focus is on providing food, shelter, and other materials to all disaster-affected people. Aside from that, no special assistance is provided to children, girls, or women." [Youth and reproductive health officer, Woreda, Dassench]

- **Limited capacity of the health facilities:** The health care institutions are not operating at their capacity due to; shortage of medications, equipment and laboratory setups, inadequately trained professionals, under staffed setups, and shortage of ambulances for emergency referrals. Even if an attempt is made to buy medical supplies, the process takes months as the purchase is made in foreign currency and the importing takes time.

"Concerning SRH services included in one-stop services, there are no such services available at the kebele level; they are only available in administrative cities with hospitals." [Women and Childrens affair office, SNNPR regional office]

- **Lack of data to tell the actual magnitude of SGBV:** The actual magnitude of SGBV in any of the sites, IDPs, or typical communities cannot be quantified due to underreporting, a lack of coordination and a poor documentation and reporting system.
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- **Poor community awareness:** Even though the community is the primary source of protection for women and girls, the majority have a poor understanding of SGBV issues and react negatively to any attempt to involve them in the prevention and response act.
- **Cultural barriers:** Due to deeply ingrained cultural beliefs, gender inequality, and a lack of awareness about the issue, the community is engaged in a variety of activities that prevent victims from receiving the basic medical care they require and/or the justice they deserve.

5. Strength and Limitation of the Study

The findings of this study have to be interpreted with its strengths and limitations in mind. Its strength is that, to the best of our knowledge it is the first study to assess SGBV issues in drought affected areas. We have learned that stakeholders at every level, national and international, including the national technical working group have not conducted a study to have a full image of the burden in order to design target intervention. Hence, this study serves as a baseline to design a program for Ipas and also for conducting further research for other interested stakeholders.

However, the study has the following limitations. The study is designed to address major drought affected areas in the country. Hence, Four regions were selected for this purpose, Oromia, Somali, SNNPR, and South West regions. The study went as planned at Oromia and SNNPR regions. We were even able to involve additional key informants than originally planned when we found them to be relevant during the conduct of the study. On the contrary, the South West region was not involved at all due to the lack of IDP sites in the region that resulted in difficulty of accessing survivors, IDP site coordinators and service providers. It is more of a typical community structure. We have tried to gather data from program experts at woreda level but again due to the poor coordination starting from the higher level, accessing the proper informants was not feasible. In the Somali region, the team has dedicated double effort to engage all participants as originally planned but due to the unavailability of most program experts at offices due to different reasons, we were unable to engage all. In addition, after identifying 2 survivors from the IPD sites, they both did not consent to participate in the study. We have learned that most did not disclose and the cases are not acknowledged by the IPD members and hence finding survivors was also difficult. We have allocated additional 02 weeks time to obtain more data in the region but it continued to be inconvenient. The gap in getting adequate data from this region is also witnessed by the emergency team that was deployed by EPHI and the national technical working group.

6. CONCLUSION

This study has identified key findings on the magnitude and type of SGBV, the services they obtained, and implementation of programs to prevent, mitigate and respond to SGBV in the drought-affected areas.

SGBV has increased in the drought-affected areas. This is supported by literature as drought contributes to the rise of SGBV, disruption of economic, social, psychological, physical and political infrastructure of the community. Women and girls are vulnerable because they have to travel in search of food and water, engage in transactional sex to secure their food, do not have their husband available to protect them, and get separated from their families because of displacement.

We witnessed all forms of SGBV mainly intimate partner violence, sexual assault, transactional sex, female genital cutting and early marriage. SGBV in the drought areas happened at home, IDP centers and streets. However, there was no clear referral pathway for care receipts when they sought care.

The perpetrators of SGBV include family members, close friends, neighbors, and complete strangers. Young men were the most commonly reported perpetrators of abduction and physical abuse both in the community and IDP sites.SGBV is frequently overlooked in drought situations, not only by stakeholders and the community, but also by survivors. This is due to the fact that people in drought situations frequently struggle to meet their basic needs, such as food, water, and shelter.

Despite the efforts made to strengthen one-stop centers to provide comprehensive care, making it accessible has been a challenge during the drought. Most cases that require referral for higher level care are unable to leave on time due to a lack of and/or inability to afford transportation. The health centers do not have enough ambulances, and may not even have one to transport the survivors themselves. In such cases, health centers must bear the burden of keeping the survivor and the attendees at the center until they can access referral services. Once referred, because of the financial constraints the one-stop centers could not provide service for free for thesurvivors who were unable to afford the service.

Lack of adequate safe houses has resulted in a continuous interruption in service provision due to a lack of a place to stay in between services, medical care, and legal processes, which requires better financial status to follow on their own and may also lead to further assault by the perpetrators.

There is a lack of knowledge about GBV in the community. In response some interventions to raise community awareness have been implemented at IDP sites. Furthermore, the community has been tasked with forming teams to combat violence against women and girls.

The drought response team did not have a team working on GBV. Hence, the other teams had to take the roles. The mobile nutrition team that was deployed to provide this first line of defense was trained and double-tasked with identifying SGBV cases and connecting them to the proper care system. The team that worked on mental health and psychosocial support (MHPSS) was trained to identify survivors.

The leadership at different levels in the health system failed to acknowledge SBGV was a serious problem that needed urgent attention. Besides, while dealing with managing drought and its consequences, most humanitarian programs did not consider SGBV as a priority intervention area. Few actors supported in the training of health providers on clinical management of rape and availing the necessary supplies for clinical service. Yet, those efforts seem to be limited when compared with the need and extent of the problem.

7. RECOMMENDATION

Addressing SGBV in drought striken areas demands advanced preparation and swift response. Not only should we prepare the community to have awareness about SGBV during crisis, we should raise their awareness about gender and SGBV and the underlying causes and prevention before any crisis so that it could be much easier to intervene during humanitarian situation. Community engagement: Working on the community is critical to address stigma in the society, improve reporting and linking to other services through involving health extension workers and community leaders. It is important to prepare the community for the possibility of emergence of SGBV whenever there are such humanitarian crises. We need to educate them on how to prevent and what to do when SBV occurs. We should avail social support for victims while reintegrating them with their community.

SGBV programs should support those who are vulnerable wherever they are at their communities, at the IDP sites and even on the streets. This requires engaging multiple stakeholders which are engaged in GBV.

Have GBV care as part of emergency response: As part of response, the mobile humanitarian response team need to involve those professionals who have the skills to care for survivors. Hence, victims receive appropriate care.

Make health facilities ready for GBV care: Primary health facilities need to be equipped with the necessary materials and supplies and staffed with skilled providers so that there won't be delay in the provision of care for survivors. There has to be programs designed to make facilities ready for SGBV care as well. The program can aim at training of health service providers and availing inputs for provision of SGBV care.

There should be strong referral system to one stop centers. There has to be a referral system in place for continuum of care to health facilities, one stop centers and safe houses whenever there is a need for advanced clinical, mental and psychosocial support.

The one stop centers should also have the necessary equipment, supplies and trained provider. Avail GBV prevention and care at IDP centers: Essential services should also be available at IDP centers. SGBV programs should also have interventions on SGBV prevention and care at IDP sites. The programs should aim at educating those who are vulnerable on how to protect themselves, avail clinical and psychosocial support at the sites and enforce the law that protects their vulnerability. Making women and young girls aware of the possibility of SGBV at IDP centers improves their protection. Women need to receive information on who the perpetrators can be, what to do to prevent it and the need to seek help while encountering such unfortunate incidents

Setting up safe houses: Temporary safe houses should be set up to accommodate those in need of psychosocial support.

Those adolescents and women who were out on the street had to engage in transactional sex to sustain their lives. Thus, SGBV prevention programs should target these specific groups so that we keep them away from transactional sex and its consequences. To prevent further escalation of sexual violence, it is important we address the social consequences of humanitarian crisis. Safe houses could play a pivotal role in this regard.

Strengthening coordination among all stakeholders: To establish health facilities (have the materials and resources), we need to pool resources. This needs effective coordination. A team has to be organized with task of mapping resources so that we avoid wastage and assure efficient utilization. We align the engagemebt of the various local and international partners.

Engage leadership and do advocacy: Finally, it is necessary to show the importance to the leadership in the health system and do advocacy and sensitization for humanitarian actors and government so that they see SGBV as equally important issue to address during humanitarian crisis. As a result, they give equal emphasis for SGBV intervention and avail mobile SGBV care, which fulfills the minimum service package list as recommended by WHO.

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