Sexual and Gender-Based Violence during crisis and war: Recommendations for interventions

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Sexual and Gender-based Violence (SGBV) is defined as violence that is directed against a person based on their gender or sex, including acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty. It can be physical, sexual, emotional, psychological, financial, or structural violence perpetrated or condoned within the family, by intimate partners, acquaintances, strangers, the general community, or by the State and institutions (1–4). Violence against women (VAW) is a universal phenomenon that persists in all countries of the world (5,6). Sexual and Gender-based Violence is a global health and human rights issue (6). Most acts of interpersonal Gender-based Violence (GBV) are committed by men against women, and the man perpetrating the violence is often known by the woman, such as a partner or family member [3]. Gender-based Violence against women, often referred to as violence against women and girls (VAW/G), is a grave human rights violation that can cause long-term and life-threatening injury and trauma to victims/survivors (1,7).

Gender-based Violence is estimated to affect the lives, health, and well-being of millions of women, girls, boys, and men worldwide. Indeed, prevalence figures released by the World Health Organization based on 2018 data, confirmed that 1 in 3 women around the world has been subjected to physical or sexual violence by an intimate partner or non-partner, indicating that levels of VAW/G remained disturbingly high and gains in women's rights fragile, even before COVID-19 (7,8). The overall prevalence of overall GBV, sexual, physical, and emotional violence was high in Sub-Saharan Africa; lowest in Nigeria (42.3%) and highest in Ethiopia (67.7%) (2,9).

Although GBV takes place in all societies and all cultures, forced displacement, including conflict, breakdown of the rule of law, and collapse of family and community structures tend to increase both the frequency and brutality of such violence (1). Violence against women and girls remains the most widespread breach of human rights, a long-standing pandemic whose many forms and manifestations are often exacerbated in times of crisis (7). Growing research has also highlighted the health burdens, intergenerational effects, and demographic consequences of such violence (10). VAW/G is a horrific act committed by husbands, partners, fathers, brothers, friends, and strangers-violent men (7).

The cause of GBV cannot be attributed to a single factor, but an interplay of individual, community, economic, cultural, and religious factors interacting at different levels of society. Moreover, gender inequalities between men and women, social constructions of the supremacy of masculinities, social perceptions of what it means to be a man, normalization of GBV, different cultural practices (2,11), a breakdown of traditional accountability mechanisms, increased exposure to GBV, lack of economic opportunities, alcohol abuse, under-prioritization of GBV, lack of GBV reporting mechanisms and inadequate healthcare workers trained in GBV management are highlighted as contributing factors (12). Furthermore, overcrowded Shelters for Internally Displaced Persons (IDPs sites), shortage of basic services, and the looming famine are likely to exacerbate the GBV risks for women and girls (13). Evidence from the literature revealed GBV was significantly associated with place of residence, witnessing parental violence, substance abuse, marital status, and educational status (9).

As COVID-19 swept the globe, a health pandemic of devastating proportions, another storm of VAW/G was unleashed. Hitherto it took the profound suffering caused by one global human tragedy to focus the world's attention on another: the ease with which women and girls are harassed, beaten, raped, and abused, on a COVID or non-COVID day. VAW/G did not emerge last year as a new or COVID-related phenomenon. It happens every day (7,14).

The decisions designed to protect us from COVID-19, locked homes, empty streets, overstretched medical services, the closures of schools and justice system institutions, and lack of access to regular social

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networks and sources of social support, exposed the depth of VAW/G. They revealed a core pattern of neglect, flawed structures, and inequities affecting the lives of women and girls. More forms of violence just increased, intensified, and expanded with no escape route, support, or help during the crisis (7).

In Ethiopia, GBV is a serious issue and VAW/G continues to be a major public health challenge, a threat to women's empowerment and continues to be a pervasive national issue. Intimate partner violence (IPV), domestic violence, female genital mutilation/cutting, sexual assault, rape, marriage by abduction, and child marriage are just some of the forms of GBV that are prevalent in Ethiopia (10,15). Women and girls face physical, emotional, and sexual abuses that undermine their health and ability to earn a living; disrupt their social systems and relationships; rob them of their childhood and education. The Ethiopia Demographic and Health Survey (2016) shows that 33% of women ages 15-49 have experienced physical or sexual violence; domestic violence is the most common form of violence towards women; around 65% of women 15-49 have been circumcised, and child marriage is still a significant problem in Ethiopia. Among women 15-49, 10% have ever experienced sexual violence (10). Laws prohibiting GBV exist, but there are substantial gaps in their enforcement due to social norms and lack of enforcement through local legal structures (15). Power dynamics between men and women are the leading cause of GBV. While a few programs are working on GBV, the impact of those programs is not well established (15).

Recently, while the exact prevalence of gender-based violence is unknown, the estimates are shocking. Not only COVID-19 but also the crisis in different regions of the country has resulted in protection risks and concerns that have heightened the vulnerability of women, girls, boys, and men in the region (13,16). Continued fighting, insecurity, break-down of security systems and social services, involvement of multiple armed actors, critical humanitarian needs, and dire living conditions have created a high-risk environment and forced displacement in which GBV is a widespread daily reality for women and girls (17–19). Women and girls in Amhara, Tigray and the Afar regions of Ethiopia have reported being sexually assaulted and raped during the conflict while fleeing from the conflict (20). Besides, access to health, social welfare, and justice services is challenging for women and children (19). Findings by the International Rescue Committee (IRC) show that there is an increase in sexual harassment, assault, rape, and Intimate Partner Violence (IPV) (12,13). However, GBV is not an inevitable consequence of conflict; it can and should be prevented (18).

Miscarriage, unwanted pregnancy, unsafe abortion, sexually transmitted diseases including HIV/AIDS, menstrual disorders, pregnancy complications, gynecological disorders, and sexual disorders are among the Sexual and Reproductive Health (SRH) consequences of GBV. In the other hand, while injury including fistulas, shock, disease, and infection are the acute physical consequences of GBV, chronic physical consequences include disability, chronic pain or infection, gastrointestinal problems, eating or sleeping disorders, and alcohol/drug abuse. In addition, homicide, suicide, maternal mortality and infant mortality are consequences frequently associated with GBV. Furthermore, emotional and psychological consequences of GBV include post-traumatic stress disorder (PTSD), depression, anger, anxiety and fear, shame, self-hate and self-blame, and mental illness. Still GBV has also social and economic consequences including blaming the victim/survivor, loss of role or functions in society, social stigma, rejection and isolation, feminization of poverty, increased gender inequalities, loss of livelihood and economic, dependency and arrest, detention and/or punishment (1,21).

The growing recognition of the high prevalence and significant health and other impacts of GBV have contributed to the inclusion of 'the elimination of all forms of VAW in the 2030 Agenda for Sustainable Development. Target 5.2 of the Sustainable Development Goals (SDGs) is about the elimination of all forms of violence against all women and girls in the public and private spheres is monitored using the following indicators (3).

Addressing GBV is essential to improve SRH for girls and women in LMICs (21). Gender-based violence prevention and response need multi-sectoral approaches. GBV partners including international non-governmental organizations (INGOs), national NGOs/local civil society organizations (CSOs), Government organizations and UN agencies, and all human rights and humanitarian actors must ensure that efforts are made from the onset of an emergency to prevent and respond to acts of GBV and provide adequate care, treatment, and support to its victims/survivors (20).

One Stop Center (OSC) model of support for survivors of GBV is used throughout Ethiopia to deliver comprehensive multi-sectorial services. This hospital-based OSC model is used to provide health services, psychosocial support, and legal service in the same location to survivors of GBV in Ethiopia. Ethiopia's response services aim to support and help survivors of violence in a variety of ways (for instance medical help, psychosocial support, and shelter). The diversity of interventions can allow decision makers to tailor interventions to the context, age range, and gender of the target population. While prevention initiatives look at how GBV can be prevented from happening, response services can in turn contribute to preventing violence from occurring or reoccurring (22). Efforts to improve SRH for women and girls in LMICs may benefit from a focus on their early risks of exposure to multiple and diverse forms of GBV. Advocates and practitioners must consider and address the structural, community, and relationship contexts that influence SRH (4).

Community-level interventions aimed at eliminating GBV by changing social norms are vital and must be coupled with enhanced individual-level resource investments, community engagement, and community infrastructure improvements (23). Evidence-based sexual education also is crucial, especially programs that explicitly attend to gender and power in relationships (22,24). Moreover, increased access to STI screenings, contraception, age/developmentally/culturally appropriate clinical services, and youth development and economic opportunities are needed in LMICs (25). Policy and structural changes must be prioritized to combat GBV and move closer to the goal of ensuring universal access to SRH and rights for all (21). The ongoing GBV interventions in Ethiopia, in collaboration with GBV partners, include establishing new and strengthening existing One-Stop Centers (OSCs), the establishment of Women and Girls Friendly Spaces (WGFSs), awareness-raising and capacity-building training for frontline service providers, provision of case management (especially for cases of rape survivors), psychosocial support, distribution of Dignity Kits, integration with RH services, referrals to life-saving care, protection from sexual exploitation and abuse (PSEA), and community outreach, engagement and mobilization, and support services for survivors of GBV (13) are very essential. Besides, those services are limited in many areas.

Violence prevention policies and programs should be informed by the best evidence we have available. Although GBV may impact SRH, a reciprocal causal relationship also may exist. Thus, longitudinal research may be needed to fill this gap. Understanding the temporal relationship between GBV and SRH could facilitate the development of policies and interventions that reflect girls' and women's lived experiences (21,23). Furthermore, advocacy with relevant actors, including national and local authorities, traditional, cultural, or religious bodies, armed forces and security forces, law enforcement officials, civil society groups, and others including non-state actors are very important to improve GBV prevention and response.

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