IMPACT OF CONFLICT-RELATED SEXUAL VIOLENCE ON THE WELL-BEING OF WOMEN IN TIGRAY REGION, ETHIOPIA

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A Research Project Submitted in Partial Fulfilment of the Requirements for the Award of the Degree of Master of Science in Governance, Peace, and Security Department of Governance, Peace, and Security, School of Humanity and Social Science of Africa Nazarene University.

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DECLARATION

I declare that this document and the research that it describes are my original work and that they have not been presented in any other university for academic work.

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We have examined this document, and the research has met or exceeded the requirements for the degree sought. In addition, the candidate has sufficiently defended the material presented to merit the awarding of the degree of (the name of the degree being awarded)

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DEDICATION

This research project is dedicated to my family

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ABSTRACT

The humanitarian crisis in Tigray, Ethiopia, has precipitated widespread conflict-related sexual violence (CRSV), significantly undermining the well-being of women through physical, psychological, and socio-economic harm. Despite global recognition of GBV as a serious human rights violation, limited empirical research has examined its specific effects on women in conflict-affected settings such as Tigray. This study was guided by the need to address this gap. The general objective of the study was to examine the impact of conflict-related sexual violence on the well-being of women in the Tigray region of Ethiopia, with a focus on physical, psychological, sexual, and socioeconomic outcomes, as well as the moderating role of coping strategies. The specific objectives were to assess the physical and mental health outcomes associated with conflict-related sexual violence among women in Tigray, Ethiopia; to establish the socio-economic consequences of GBV in Tigray, Ethiopia; and to examine the moderating role of coping strategies on the relationship between conflict-related sexual violence and the well-being of women in Tigray, Ethiopia. The study was anchored on Eco-System Theory and Trauma Theory, which provided a useful basis for understanding gendered power relations and the long-term effects of violence on survivors. A descriptive cross-sectional research design was adopted. The target population comprised 2,340 women survivors of conflict-related sexual violence residing in internally displaced persons camps across Tigray. A sample of 344 respondents was selected using stratified and purposive sampling techniques. Data were collected through structured questionnaires, key informant interviews and focus group discussions, thereby allowing both quantitative and qualitative data to be generated. The findings revealed that 82% of respondents experienced severe physical injuries, including trauma, disability and chronic health complications, while 77% reported depression, post-traumatic stress disorder and anxiety. Further, 69% of respondents reported loss of livelihoods, while 64% indicated disruption of education and reduced employment opportunities. The study also established that coping strategies played a moderating role in shaping women's well-being, although such strategies were not sufficient to fully offset the adverse effects of conflict-related sexual violence. The study concluded that conflict-related sexual violence in Tigray has devastating physical, psychological and socio-economic effects on women, and that coping strategies only partly cushion survivors from these outcomes. The study recommends strengthening survivor-centred interventions, including improved access to medical care, psychosocial support and livelihood recovery programmes, while also enhancing community-based and institutional coping mechanisms to improve women's resilience and well-being in conflict settings.

DEFINITION OF TERMS

Conflict-Related Sexual Violence (CRSV): Harmful acts against women during conflict, including sexual Violence. In this study, it is the independent variable covers rape, sexual slavery, forced pregnancy, physical assault, and trauma in Tigray.

Well-being of women: The overall state of women's health, security, and stability. In this study, the dependent variable is measured through physical health, mental health, and socio-economic outcomes.

Physical health outcomes: Injuries and medical complications resulting from CRSV, such as disability, HIV/AIDS, sexually transmitted infections, unwanted pregnancies, and reproductive health problems.

Mental health outcomes: Psychological harm caused by CRSV, including depression, anxiety, post-traumatic stress disorder (PTSD), suicidal thoughts, and emotional withdrawal.

Socio-economic consequences: The social and economic disruptions caused by CRSV, including loss of livelihoods, displacement, disrupted education, unemployment, stigmatization, and weakened social networks.

Coping strategies: Methods used by survivors to deal with the effects of CRSV. In this study, they are the moderating variable, categorized into problem-focused coping (seeking help, problem solving), emotion-focused coping (spirituality, social support), and avoidant coping (denial, isolation).

Trauma-informed care (tic): A framework that recognizes the lasting effects of trauma and emphasizes safety, trust, empowerment, and collaboration in supporting survivors. It guides the interpretation of women's well-being in this study.

ABBREVIATIONS AND ACRONYMS

CRGBV – Conflict-Related Gender Based Violence

CRSV – Conflict-Related Sexual Violence

EDF – Eritrean Defence Forces

ENDF – Ethiopian National Defence Forces

GBV – Gender-Based Violence

HIV/AIDS – Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

IDP – Internally Displaced Persons

KII – Key Informant Interview

NGO – Non-Governmental Organization

PTSD – Post-Traumatic Stress Disorder

SPSS – Statistical Package for Social Sciences

STI – Sexually Transmitted Infection

TIC – Trauma-Informed Care

TPLF – Tigray People's Liberation Front

UN – United Nations

UNFPA – United Nations Population Fund

WHO – World Health Organization

CHAPTER ONE

INTRODUCTION

1.1. Introduction

The chapter presents the foundation of the study by outlining the background, statement of the problem, purpose, objectives, and research questions. It further explains the significance, scope, delimitations, limitations, and assumptions of the study. The chapter also introduces the theoretical and conceptual frameworks that guide the investigation into the impact of conflict-related gender-based violence on women's well-being.

1.2.Background of the Study

Gender-Based Violence (GBV), particularly Conflict-Related Sexual Violence (CRSV) against women and girls, is a widespread and devastating phenomenon. CRSV is a grave violation committed against civilians during armed conflict and remains one of the most inhumane tactics of modern warfare (UN News, 2024). Its consequences are severe, leading to long-term health complications and socio-economic disruption. Generally, CRSV manifests in various forms, including sexual slavery, rape, forced pregnancy, prostitution, sterilization, abortion, and child marriage, affecting women, girls, and occasionally boys in conflict zones worldwide.

Globally, CRSV continues to rise, with CRSV showing alarming trends in recent years. In 2021, the United Nations verified 3,293 cases, increasing to 3,688 in 2023 across 21 conflicts, a 50% surge (Kravchuk, 2023). Reports from the UN and NGOs like Amnesty International confirm an alarming escalation in CRSV, disproportionately impacting women and girls. Notably, women and girls consistently bear the brunt of wartime sexual violence, used systematically to terrorise, control, and destabilise communities. The link between conflict and GBV is evident across diverse areas, with regions such as Syria to Myanmar underscoring the global pervasiveness of CRSV.

In Syria and Iraq, sexual violence has become a hallmark of the civil war. Since 2011, government forces and militias in Syria have used rape during home raids in cities such as Homs, Damascus, and Dara'a. Here, survivors, some as young as nine, were often assaulted publicly (Younis & Lafta, 2021). Detention centers and checkpoints became routine sites of abuse, with men and boys also targeted (A/HRC/37/72/CRP.1; UN, 2017). In Iraq, the fall of Islamic State (ISIL) territories revealed mass sexual violence, particularly against Yazidi and Christian women. Survivors endured slavery, forced marriage, and rape. By November 2017, UN, 2017 and Younis and Lafta (2021) state that 3,202 civilians, including over 2,000 women and girls, had been rescued, though many remain missing.

In Myanmar, CRSV formed part of a broader ethnic cleansing campaign. The UN Fact-Finding Mission (2018) documented rape and mutilation as tools of terror during military campaigns against the Rohingya in Rakhine, Kachin, and Shan states (Davies & True, 2018). Colombia's protracted conflict also saw widespread CRSV. As of 2017, over 24,000 survivors were registered, though prosecution remains minimal. Only 17% of cases led to indictments, and just 5% resulted in convictions. Displaced women, according to Svallfors (2023) faced up to a 40% higher risk of intimate partner violence (IPV) compared to non-displaced populations.

In Afghanistan, 53 cases of CRSV were documented in 2017, though underreporting suggests much higher figures. Perpetrators included state forces, the Taliban, and other armed groups. The sexual exploitation of boys also remains a concern, with 78 credible reports recorded that year (UNAMA, 2017). The eastern Ukraine conflict, which began in 2014, has significantly increased women's vulnerability to GBV. Displaced women are three times more likely to be abused than their non-displaced counterparts. Along conflict zones, particularly in Russian-occupied areas, reports of rape, including in front of children, are common (Capasso, Skipalska, Chakrabarti & Guttmacher, 2022). The global examples, from Colombia to Ukraine, among

other countries, illustrate the consistent use of CRSV as a recurring weapon of war. Similar patterns are evident across Africa.

In Sudan's Darfur conflict, which began in 2003, UNAMID documented 152 cases of CRSV in 2017 alone, mostly involving rape, with perpetrators including national forces and militias. South Sudan's conflict since 2013 has produced extensive sexual violence. UNMISS reported 196 CRSV cases in 2017, including gang rapes and abductions. Multiple factions, including the SPLA and opposition militias, were implicated. In Somalia, long-standing conflict has left women and girls, especially from minority clans and displaced populations, highly vulnerable. In 2017, the UN verified 329 CRSV cases, mostly involving rape. Perpetrators included Al-Shabaab, the Somali National Army, and unidentified armed groups (Abdi, 2016).

Burundi's 2015 political unrest triggered a rise in CRSV. Between May and December that year, the UN documented 19 sexual assaults by security forces, often during raids targeting opposition supporters. The Imbonerakure youth militia was notorious for inciting and committing GBV. In Nigeria, Boko Haram has systematically weaponized sexual violence. In 2017, 997 incidents—including rape, slavery, and forced marriage—were recorded. Many survivors, including pregnant returnees, face stigmatization and rejection from their communities (Ehiane & Abuloye, 2021). Overall, the prevalence of CRSV in Africa reflects broader global patterns.

Ethiopia's Tigray region, in particular, mirrors a disturbing trend on the prevalence of CRGBV. Since conflict erupted on November 4, 2020, reports of widespread GBV have emerged. Parties involved include the Ethiopian National Defence Forces, Eritrean Defence Forces, and Amhara regional forces (Mishori, McHale, Green, Olson, & Shah, 2023). Survivors in Tigray report extreme violations, including gang rape and the insertion of foreign objects into reproductive organs. During the two-year conflict, 40–50% of women and girls in Tigray, Oromia, and Afar

were exposed to CRGBV (Fisseha *et al*., 2023), figures likely underestimated due to stigma and the destruction of over 70% of healthcare infrastructure.

The humanitarian crisis underscores the urgent need to address the physical, psychological, and socio-economic toll of CRSV in Tigray. These atrocities are not isolated but part of a broader continuum of gendered violence in conflict. Like in South Sudan, Somalia, and Nigeria, the Ethiopian case highlights the systemic use of sexual violence as a tool of war, emphasizing the need for comprehensive, survivor-centred interventions.

1.3 Statement of the problem

The Ethiopian civil war that erupted in November 2020 left deep social, political and economic scars, with the Tigray region bearing some of the most severe consequences. Beyond mass displacement and the collapse of essential services, the conflict was marked by widespread conflict-related sexual violence against women and girls (OHCHR & EHRC, 2021; WHO, 2021). Available evidence shows that rape and other forms of sexual violence were not merely incidental acts of war, but formed part of a broader pattern of abuse used to terrorise, degrade and dehumanise victims during the conflict (OHCHR & EHRC, 2021; Human Rights Watch, 2021). Although a cessation of hostilities agreement was signed in November 2022, survivors continued to experience severe physical, psychological and socio-economic harm, while the full scale of conflict-related sexual violence remained obscured by stigma, fear of retaliation, underreporting, and limited access to trusted reporting and support mechanisms in conflict settings (IGAD, 2022; Human Rights Watch, 2021; Mishori *et al*., 2023).

Reports from humanitarian and human rights agencies reveal the alarming scale of sexual violence during the conflict in Tigray. For example, more than 136 rape cases were reported in hospitals in Mekelle, Ayder, Adigrat and Wukro between December 2020 and January 2021, while 1,288 official gender-based violence cases were recorded across the region between

February and April 2021; however, both figures were considered likely underestimates of the true burden (OHCHR, 2021; OCHA, 2021). Joint investigations further documented rape, gang rape, unwanted pregnancies, and sexually transmitted infections, including HIV, highlighting the serious and lasting health consequences faced by survivors (OHCHR & EHRC, 2021). In addition, Human Rights Watch reported that the destruction of health facilities, insecurity and restrictions on humanitarian access significantly constrained survivors' access to timely medical and psychosocial support (Human Rights Watch, 2021). These patterns suggest that the magnitude of conflict-related sexual violence in Tigray was far greater than reported, particularly because many women remained silent due to fear, trauma and stigma.

The added citations above are grounded in the Pretoria cessation-of-hostilities agreement, WHO's 2021 statement on gender-based violence in Tigray, the OHCHR-EHRC joint investigation, OCHA's June 2021 humanitarian update, and Human Rights Watch's report on barriers to care for survivors

1.4 Purpose of the Study

The main purpose of this study was to investigate the impact of conflict-related sexual violence (CRSV) on the well-being of women in the Tigray region of Ethiopia. The study sought to assess the physical and mental health outcomes associated with CRGBV among women, establish its socioeconomic consequences and examine the moderating role of coping strategies in shaping the relationship between CRSV and women's well-being. By addressing these dimensions, the study aims to generate comprehensive evidence to inform policy, humanitarian responses, and post-conflict recovery strategies, thereby contributing to survivor-centred interventions and gender-sensitive peacebuilding efforts in Tigray.

1.5 Objectives of the Study

The section highlights both the general objective of the study as well as the specific objectives of the study.

1.5.1 General Objective

The general objective of the study was to examine the impact of conflict-related sexual violence on the well-being of women in the Tigray region of Ethiopia, with a focus on physical, psychological and socioeconomic outcomes as well as the moderating role of coping strategies.

1.5.2 Specific Objectives

i. To assess the physical and mental health outcomes associated with conflict-related sexual violence among women in Tigray, Ethiopia.
ii. To establish the socio-economic consequences of GBV in Tigray, Ethiopia.
iii. To examine the moderating role of coping strategies on the relationship between conflict-related sexual violence and the well-being of women in Tigray, Ethiopia.

1.6. Research questions

The study sought to answer the following research questions

i. What are the physical health and mental health outcomes associated with GBV among women in Tigray, Ethiopia?
ii. What are the socio-economic consequences of GBV in Tigray, Ethiopia?
iii. How does the coping strategy moderate the relationship conflict-related sexual violence and the well-being of women in Tigray, Ethiopia?

1.7. Significance of the Study

The study holds both theoretical and practical significance in understanding the impacts of conflict-related sexual violence on women's well-being in Tigray, Ethiopia. Theoretically, the

study contributes to the existing body of literature by extending knowledge on the multidimensional outcomes of CRSV beyond prevalence statistics. While much of the available research focuses on sexual violence as a single form, this study examines physical, psychological, and socioeconomic consequences and, importantly, incorporates scoping strategies as a moderating factor. This theoretical framing enriches gender and conflict studies by providing a holistic perspective on the complex interplay between violence, resilience, and recovery in post-conflict societies.

Practically, these findings will provide evidence to guide humanitarian actors' healthcare providers and community-based organizations in designing interventions that address survivors' immediate and long-term needs. By highlighting the physical and mental health outcomes of CRSV, the study can inform the provision of trauma-informed health care services, psychosocial support, and community reintegration programs. The insight on socioeconomic consequences will also be critical for programs aimed at restoring livelihoods and reducing stigma, thus helping survivors so as rebuild their lives.

From a policy perspective, the study offers valuable evidence for Ethiopian authorities, international agencies, and peace-building institutions to formulate survivor-centred policies. It underscores the need for stronger protection frameworks, improved healthcare infrastructure in conflict-affected regions and policies that integrate psychosocial and economic recovery within post-conflict reconstruction agendas. The study's findings can also support advocacy for justice and accountability mechanisms to address human rights violations committed during the conflicts.

For other institutions such as non-governmental organizations, women's rights groups and International Development partners, the study provides actionable insights for targeted

programming, capacity building, and funding allocation. Academic institutions can also benefit by using the findings as a reference point for further research on gender conflict and resilience.

1.8. Scope of the Study

The study examined the impact of conflict-related sexual violence on the well-being and socio-economic outcomes of women in the Tigray Region of northern Ethiopia. Geographically, the study was limited to selected internally displaced persons camps and refugee settlements within Tigray where women survivors of conflict-related sexual violence were residing. The study focused specifically on female survivors of GBV in Tigray and excluded male survivors as well as survivors from other regions of Ethiopia in order to allow an in-depth analysis of a highly vulnerable population within the conflict setting.

In terms of content scope, the study assessed the physical and mental health outcomes associated with conflict-related sexual violence, examined the socio-economic consequences such as disrupted livelihoods, interrupted education and reduced employment opportunities, and analysed the moderating role of coping strategies in influencing these outcomes.

In terms of time scope, the study focused on the period of the Tigray conflict from November 2020, when the armed conflict began, to November 2022, when the Cessation of Hostilities Agreement was signed. This period was considered appropriate because it captures the peak of the conflict and its immediate aftermath, during which women experienced significant exposure to conflict-related sexual violence and its effects.

1.9.Delimitation of the study

The study focused on examining the impacts of conflict-related sexual violence on the well-being of women in the Tigray area of Ethiopia. Emphasis was on physical health outcomes, psychological trauma, and socioeconomic challenges. The research concentrated exclusively on female survivors of GBV within the context of the Tigray conflict, thereby excluding men, children and other groups who might have also experienced GBV. Geographically, the study was limited to internally displaced persons, refugee settlements, and other conflict-affected areas within the Tigray region, which restricted the generalizability of their findings to other regions of Ethiopia or different conflict settings. Methodologically, the study employed a cross-sectional research design, and participants were recruited using snowball sampling, which limited the diversity of respondents. In addition, the study relied primarily on self-reported data, which, although valuable, was subject to recall and reporting biases. These delimitations allowed the research to maintain forecast, context-specific and aligned with its objectives while acknowledging its inherent boundaries in scope, population, and methodology.

1.10. Limitations of the study

While this study generated viable insights into the impacts of conflict-related sexual violence (SV) on the well-being of women in Tigray, several limitations were acknowledged. The first one was the reliance on self-reported data has which posed challenges of recall bias, under-reporting, and social desirability bias; GBV survivors might have withheld sensitive information due to stigma, fear, or trauma. Secondly, the use of snowball sampling, though effective in reaching hard-to-access populations, limited the representativeness of the sample and restricted the diversity of perspectives captured., The cross-sectional research design constrained the ability to establish cultural relationships between conflict-related sexual violence and long-term well-being outcomes, therefore offering only a snapshot in time. Furthermore, access to certain conflict-affected areas was restricted due to insecurity, meaning

more voices of survivors in remote or highly water-logged locations could not be included. The disruption of health care and support services in Tigray limited the availability of secondary data, which could have complemented the primary findings.

1.11. Assumptions of the study

The study was guided by several assumptions that underpinned the credibility and dependability of its findings. It was assumed that women participants would respond truthfully and openly about their experiences with conflict-related sexual violence (CRSV). Given the sensitivity of the subject matter, the quality and reliability of the data were believed to depend on participants' willingness to share the experiences without fear, stigma, or hesitation. It was also assumed that the narratives provided during data collection accurately reflected the physical, psychological, and socioeconomic consequences of GBV within the Tigray context. It was also assumed that the copying strategies reported by survivors significantly shaped variations in their well-being and socioeconomic outcomes. As this was critical in analysing, coping mechanisms have a moderating factor in the relationship between CRSV and women's overall well-being. Furthermore, it was assumed that the instruments used, including interview guides and questionnaires, were contextually appropriate and capable of capturing the complex dimensions of trauma, resilience, and recovery. The study assumed that the participants were able to understand and respond effectively to the questions posed. In conclusion, the study assumed that the insights obtained from the sampled participants were reasonable. Representation of product experiences among conflict-affected women in similar displacements and conflict settings across Tigray. These assumptions provided the foundation for interpreting findings and drawing meaningful conclusions on the multifaceted impact of CRSV on women's well-being.

1.12. Theoretical framework

Theoretical framework provides the foundation for a study by offering concepts, principles and perspectives that guide the interpretation of research findings. It explains how and why certain phenomena occur and anchors the study within established knowledge, thereby enhancing its coherence and analytical depth. In this study, the theoretical framework is important in explaining the multifaceted impact of conflict-related sexual violence (CRSV).) on the well-being of women in Tigray, Ethiopia. The study draws on Trauma-Informed Care Theory and Eco–System Theory because the two theories provide complementary explanations of women's experiences. Trauma-Informed Care Theory explains the individual and survivor-centred effects of violence, while Eco–System Theory situates these experiences within wider family, community, institutional, cultural and conflict-related systems.

1.12.1 Trauma Informed Care Theory

Trauma-Informed Care (TIC) was advanced through the work of Harris and Fallot (2001) and later strengthened by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States. The theory emphasises that trauma is not simply an isolated event, but an experience with profound and long-term effects on an individual's physical health, emotional stability, behaviour and social functioning. It challenges traditional service delivery models by encouraging service providers to move from asking, "What is wrong with you?" to asking, "What happened to you?" In this way, the approach promotes survivor dignity, healing and empowerment.

The core principles of Trauma-Informed Care include safety, trustworthiness, peer support, collaboration and empowerment. Safety involves creating physical and emotional environments in which survivors feel secure. Trustworthiness emphasises honesty, consistency and transparency in relationships and services. Peer support values shared experiences as a source of healing and validation. Collaboration stresses active survivor participation in decisions affecting their recovery, while empowerment promotes resilience, autonomy and self-worth.

The theory is relevant to this study because women in Tigray who experienced conflict-related sexual violence (CRSV) are likely to face trauma that affects their physical, psychological and socio-economic well-being. TIC helps explain how survivors experience depression, anxiety, fear, emotional distress, social withdrawal and disrupted functioning after exposure to violence. It is also relevant in understanding coping strategies, since healing and resilience are shaped by whether survivors feel safe, supported and empowered.

The major strength of Trauma-Informed Care Theory is that it provides a survivor-centred lens for understanding the lived experiences of women affected by CRSV. It is particularly useful in explaining psychological harm, emotional recovery, resilience and the importance of safe and supportive interventions. It also aligns well with this study's focus on women's well-being because it highlights the lasting and interconnected consequences of trauma.

However, the theory also has limitations. First, it places stronger emphasis on individual trauma and recovery, which may make it less effective in fully explaining the broader structural, cultural and institutional factors that shape violence in conflict settings. Second, it was largely developed within health and social service contexts, meaning that on its own it may not sufficiently capture the wider political and conflict-related systems that influence survivors'

experiences in Tigray. Therefore, although TIC is valuable for explaining trauma and healing, it requires supplementation by a broader contextual theory.

1.12.2 Eco System Theory

Eco System Theory, also known as Ecological Systems Theory, was developed by Urie Bronfenbrenner (1979). The theory explains that an individual's development, behaviour and well-being are influenced not only by personal characteristics but also by the multiple environmental systems within which the individual lives. These systems interact in ways that can either support or undermine well-being. The theory has been widely applied in psychology, sociology, public health and gender studies because it is useful in examining how family, community, institutions, culture and history shape human experiences.

Bronfenbrenner identified five interrelated systems: the microsystem, mesosystem, exosystem, macrosystem and chronosystem. The microsystem refers to the immediate environment, such as family, peers and close social networks. The mesosystem refers to the interaction between these immediate settings. The exosystem includes wider institutional and structural contexts, such as healthcare systems, legal services, humanitarian organisations and media. The macrosystem refers to broader cultural values, beliefs, gender norms and policies. The chronosystem introduces the dimension of time and focuses on the influence of life transitions and historical events such as war, displacement and prolonged instability.

The relevance of Eco–System Theory to this study lies in its ability to explain that conflict-related sexual violence (CRSV) does not occur in isolation. Rather, it is shaped by interconnected systems. In this study, the microsystem is reflected in disrupted family life and broken social support networks. The mesosystem is visible in the interactions between survivors, communities and support actors. The exosystem is reflected in the availability or breakdown of healthcare, humanitarian assistance and justice systems. The macrosystem helps

explain how gender norms, stigma and silence affect disclosure and support-seeking. The chronosystem captures the impact of the Tigray conflict, displacement and the prolonged consequences of violence over time.

The major strength of Eco–System Theory is that it provides a holistic and multi-level explanation of women's well-being. It is especially useful in this study because it shows how CRSV is shaped by personal, relational, institutional and cultural factors. It also helps explain why women exposed to similar violence may experience different outcomes depending on the support, stigma, services and opportunities available in their environment. In addition, the theory is useful for examining coping strategies because these are influenced by social networks, institutions and community contexts.

Despite these strengths, Eco–System Theory also has weaknesses. First, because it is broad, it may not provide a sufficiently detailed explanation of the internal psychological processes through which trauma affects survivors. Second, the theory can be difficult to operationalise fully in empirical research because each system contains many interacting factors that may be challenging to measure comprehensively. Third, on its own, it may explain the context of violence more effectively than the deep emotional and psychological consequences of trauma.

Justification for Using Two Theories

The use of Trauma-Informed Care Theory and Eco–System Theory together was justified because the phenomenon under study is both personal and structural in nature. Conflict-related sexual violence affects women at the level of the body, mind and emotions, but it is also shaped by family disruption, community responses, institutional breakdown, cultural stigma and conflict history. No single theory could adequately capture all these dimensions.

Trauma-Informed Care Theory was therefore used to explain the survivor-centred and psychological dimensions of CRSV, especially how violence affects women's physical and

mental well-being and how healing, resilience and coping may be understood. Eco–System Theory was used to explain the broader environmental and structural conditions within which violence occurs and recovery takes place. Together, the two theories provided a more comprehensive analytical framework for examining the impact of CRSV on women's well-being in Tigray.

The combination of the two theories strengthened the study in three ways. First, it enabled the study to examine both individual trauma and broader social context. Second, it helped explain the moderating role of coping strategies by showing that coping is not only personal but also shaped by environmental support systems. Third, it enhanced the study's ability to generate practical recommendations at multiple levels, including psychosocial support, community-based interventions, institutional strengthening and policy reform. For these reasons, the two theories were considered complementary and appropriate for guiding the study.

1.12.3 Radical Feminist Theory

Radical Feminist Theory is one of the major schools of feminist thought and is associated with scholars such as Kate Millett (1970), Shulamith Firestone (1970) and Andrea Dworkin (1981). The theory argues that women's oppression is rooted in patriarchy, which is a social system in which men hold power and control over political, economic, cultural and personal spheres of life. Radical feminists contend that violence against women is not accidental or isolated, but rather a manifestation of unequal gender power relations that are embedded in society (Guy-Evans, 2024).

The relevance of Radical Feminist Theory to this study lies in its ability to explain conflict-related sexual violence as an expression of power, domination and control over women during conflict. In war settings, women's bodies are often targeted as sites through which armed actors

exert humiliation, terror and social destruction. Sexual violence in this sense becomes more than a personal attack; it becomes a weapon used to reinforce gender inequality and collective suffering. The theory therefore helps to explain why women in Tigray were disproportionately affected by violence and why the consequences of that violence are deeply gendered (Vollum-Dix, 2025).

In the context of this study, Radical Feminist Theory is important because it highlights the structural roots of women's suffering. It explains that the physical injuries, psychological trauma, stigma and socio-economic exclusion experienced by women survivors are connected to wider patriarchal norms and gendered inequalities that make women more vulnerable in conflict situations. It also helps to explain why women may face silence, blame and marginalisation even after the violence has occurred (Fahs, 2024).

The main strength of Radical Feminist Theory is that it directly centres women's oppression and clearly explains gender-based violence as a product of unequal power relations. This makes it highly relevant for analysing the plight of women affected by conflict-related sexual violence (CRSV) . However, the theory also has limitations. It may overemphasise patriarchy alone and give less attention to other interacting factors such as ethnicity, poverty, displacement, conflict institutions and humanitarian breakdown. For this reason, Radical Feminist Theory is useful in explaining the gendered nature of the violence, while Trauma-Informed Care Theory and Eco–System Theory help explain trauma, coping and the wider contextual environment (Irmayani, Rahman, Amir, & Abbas, 2024).

Thus, Radical Feminist Theory complements the other theories in the study by explaining the gendered power structures underlying conflict-related sexual violence (CRSV) , while the other theories explain its psychological and environmental consequences on women's well-being.

1.13. Conceptual Framework

The conceptual framework provides the structural basis for linking the study's variables and grading its analysis. It's stressed how conflict-related sexual violence (CRSV), conceptualized as the independent variable, influences the well-being of women in Tigray, the dependent variable. The framework integrates insights from trauma-informed care and consists of a theory to capture both individual trauma experiences and the broader social structural contexts in which survivors live. It also incorporates coping strategies, which are the moderating variable, thus recognizing their potential to mitigate or intensify the impacts of CRSV. This framework explains the multidimensional pathways through which CRSV affects women's physical, psychological and socioeconomic well-being.

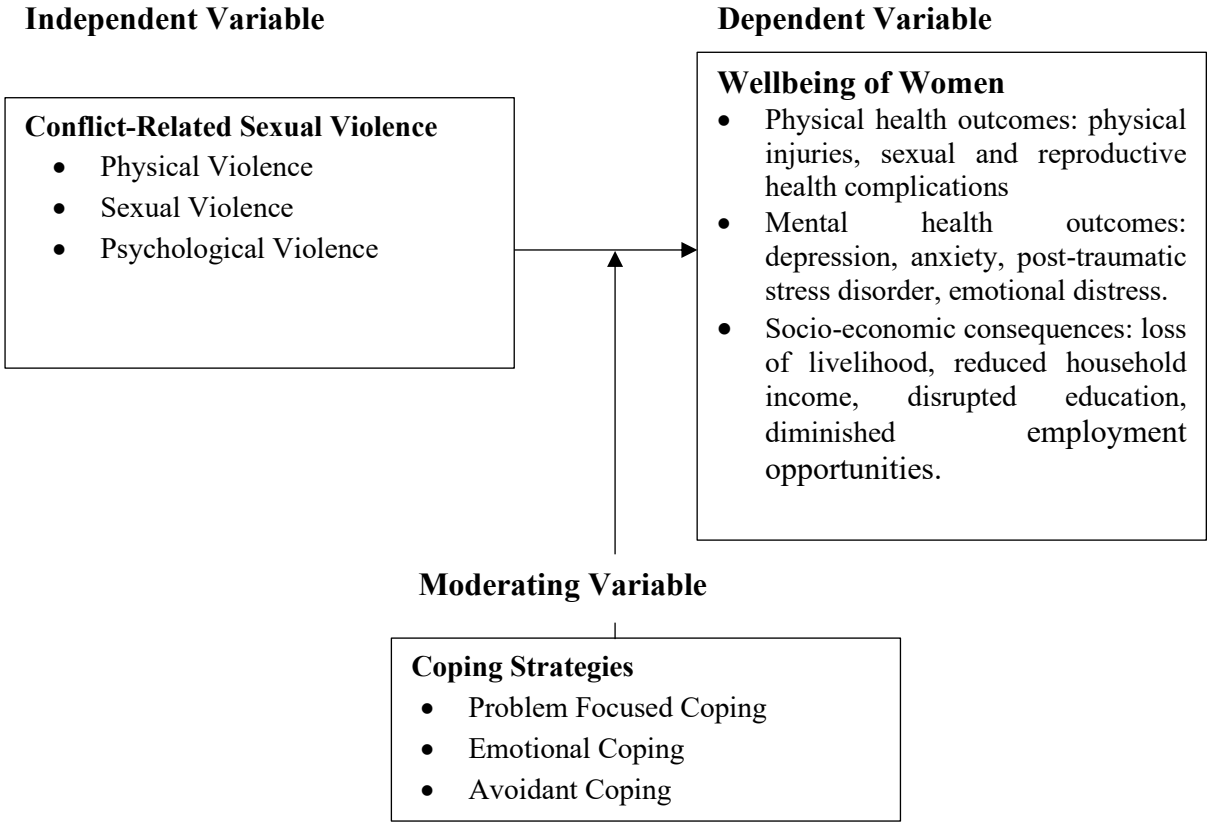

Figure 1.1: Conceptual Framework

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter provides a review of existing literature relevant to the study. It discusses global, regional, and local perspectives on women's well-being and conflict-related sexual violence (CRSV), highlighting physical, psychological, and socio-economic impacts. The chapter also examines coping strategies, identifies research gaps, and establishes the theoretical foundation that guides the study within the context of Tigray, Ethiopia.

2.2 Well-being of women

Women's well-being is a multidimensional construct that extends beyond the absence of disease to include physical health, mental and emotional stability, social belonging, safety, dignity, and economic security. Contemporary gender and public health scholarship increasingly treats well-being as both an outcome and a process, shaped not only by individual characteristics but also by the wider social, institutional, political, and economic environments in which women live. In this sense, women's well-being is closely tied to bodily autonomy, freedom from violence, access to health and psychosocial services, voice within households and communities, and the ability to secure livelihoods and participate in social life with dignity (UN Women & UN DESA, 2023; WHO, 2024).

From a capability perspective, women cannot be considered well if they are unable to live safely, access care when harmed, or recover from trauma in ways that restore agency and social functioning. The sustainable development agenda reflects this understanding by linking women's health, equality, and protection from violence to broader development outcomes. SDG 3 emphasises health and well-being, while SDG 5 stresses the elimination of all forms of violence against women and girls, equal participation, and equitable access to resources and

opportunities. These goals imply that women's well-being is relational and structural as much as it is personal. When women are exposed to violence, stigma, economic exclusion, and service breakdown, their well-being is compromised across several domains at once (UN Women & UN DESA, 2023).

Global evidence shows that violence remains one of the most important threats to women's well-being. WHO estimates indicate that violence against women remains widespread, and non-partner sexual violence alone affects millions of women globally, although the true burden is widely understood to be undercounted because of silence, fear, stigma, weak measurement tools, and limited reporting pathways (Sardinha *et al*., 2024; WHO, 2024). The well-being effects are not limited to direct physical injury. Sexual and gender-based violence can alter sleep, mood, social relationships, self-worth, reproductive health, work capacity, and long-term confidence in institutions. It can also weaken women's perceived control over their own lives, which is central to any meaningful conception of well-being.

In conflict and humanitarian settings, these risks intensify substantially. Armed conflict destroys health facilities, separates families, displaces communities, interrupts education, reduces incomes, and creates environments in which violence is both easier to commit and harder to report. Conflict therefore affects women's well-being through both direct and indirect pathways. Directly, women may experience rape, assault, sexual exploitation, or coercion. Indirectly, they may suffer the consequences of displacement, hunger, grief, social fragmentation, and the collapse of legal and medical protection systems. These layered stressors mean that women in conflict settings often experience simultaneous physical, psychological, social, and economic injuries rather than a single isolated harm (Rubini *et al*., 2023; UNFPA, 2023).

Recent scholarship on women's well-being in fragile and conflict-affected settings has moved away from narrow biomedical definitions and towards more integrated approaches. Such approaches recognise that women's well-being after violence depends on physical recovery, psychological healing, social acceptance, and economic reintegration. A woman may survive a violent assault medically, yet still experience poor well-being if she remains traumatised, abandoned, stigmatised, unemployed, or unable to return to school or productive work. This is especially important in contexts where violence becomes normalised and institutions are weakened. Under such conditions, women's well-being is deeply affected by whether communities believe survivors, whether services are accessible and confidential, whether there are opportunities for livelihood recovery, and whether survivors can rebuild relationships without blame or exclusion (Essue *et al*., 2025; Olson *et al*., 2020).

The Ethiopian context, and particularly Tigray, illustrates these interlocking dimensions of well-being. The war that began in November 2020 not only exposed women to direct violence but also damaged the infrastructures that normally support well-being, including health systems, social support networks, education systems, and livelihood opportunities. Community and clinic-linked evidence from northern Ethiopia shows that women exposed to violence commonly report anxiety, depression, physical injuries, reproductive health complications, school interruption, and other social and economic losses (Asefa *et al*., 2024; Dellie *et al*., 2024; Fisseha *et al*., 2023). These outcomes suggest that well-being in Tigray cannot be understood by looking at physical survival alone. Rather, it must be conceptualised as the condition of women's bodies, minds, relationships, and material lives after exposure to conflict-related gender-based violence.

In Tigray, the destruction of health services further complicated women's well-being. Women who needed emergency contraception, treatment for sexually transmitted infections, post-rape care, counselling, or safe referral often faced severe access barriers because facilities had been

damaged, looted, or cut off. In such settings, untreated injuries and delayed care become part of the well-being burden. Similarly, socio-economic deterioration, such as the loss of farmland, market access, income, and mobility, undermines women's recovery even when some humanitarian services are present. This means that women's well-being in post-conflict Tigray must be understood as an integrated outcome shaped by violence exposure, service access, social response, and the broader conditions of recovery (UNFPA, 2023; World Bank, 2024).

Another important point in the literature is that women's well-being is mediated by social norms. In many contexts, survivors of sexual violence face blame, shame, or silence rather than support. Such stigma worsens emotional distress, discourages help-seeking, and undermines social recovery. In other words, the same violent act may produce different well-being outcomes depending on the survivor's surrounding environment. Women who receive care, confidentiality, family support, and economic assistance are more likely to rebuild functioning than those who face rejection, fear, and prolonged insecurity. This makes well-being both a gendered and contextual phenomenon (Bekele *et al*., 2025; Mitiku *et al*., 2025).

Overall, the literature shows that women's well-being is a broad, dynamic, and context-sensitive construct. It includes physical health outcomes, mental health outcomes, and socio-economic functioning, all of which may be simultaneously damaged conflict-related sexual violence (CRSV) . For the present study, conceptualising well-being in this multidimensional way is important because it allows the effects of conflict-related sexual violence (CRSV) in Tigray to be examined holistically rather than narrowly. It also provides the basis for assessing whether coping strategies may reduce, intensify, or reshape the relationship between violence and women's well-being.

2.3 Conflict-related sexual violence

Conflict-related sexual violence (CRSV) refers to harmful acts committed against individuals based on gender that are directly or indirectly linked to armed conflict. It includes rape, gang rape, sexual slavery, forced pregnancy, forced marriage, sexual torture, sexual exploitation, physical assault, psychological abuse, and other coercive acts that are enabled or intensified by conflict conditions. Although women and girls are not the only victims, they remain disproportionately affected in most conflict settings because armed violence intersects with pre-existing gender inequalities, patriarchal norms, and institutional failures that reduce women's safety and bargaining power (OHCHR & EHRC, 2021; WHO, 2021).

Contemporary literature no longer treats conflict-related sexual violence (CRSV) as incidental to war. Instead, it is increasingly recognised as a patterned and purposeful form of violence linked to control, terror, punishment, ethnic humiliation, displacement, and the destruction of social cohesion. In some conflicts, sexual violence is used strategically to intimidate civilian populations, force movement, punish perceived enemies, or attack the collective identity of targeted communities. In other cases, it emerges from the militarisation of everyday life, the breakdown of law enforcement, and the normalisation of impunity. Both patterns are important. They suggest that CRSV is not just an individual criminal act but a manifestation of how gendered power operates in conflict settings (Rubini *et al*., 2023; Torre *et al*., 2024).

A further point in the literature is that conflict does not only increase the risk of public sexual violence by armed actors. It also reshapes household relations, livelihoods, mobility, and community norms in ways that can increase intimate partner violence, sexual exploitation, coerced survival sex, and abuse in displaced settings. Studies from displaced and conflict-affected populations in sub-Saharan Africa show that conflict, displacement, and poverty often overlap to intensify multiple forms of violence against women, not only those directly

perpetrated by combatants (Kelly *et al*., 2024; Mitiku *et al*., 2025). This broader framing is important because it widens the study of CRSV beyond a narrow focus on rape alone.

In global and regional literature, conflict-related violence against women is described as both a human rights violation and a public health emergency. This is because the consequences rarely end when the assault ends. Survivors may suffer fractures, genital injury, unwanted pregnancy, HIV and other sexually transmitted infections, depression, social isolation, loss of livelihood, family breakdown, and prolonged insecurity. In addition, the underreporting of sexual violence in war settings means that documented cases often capture only the visible portion of a much larger problem. Weak data systems, fear of retaliation, shame, and the destruction of reporting institutions all suppress disclosure (Sardinha et al., 2024; WHO, 2024; Woldie *et al*., 2025).

The Tigray conflict brought these patterns into sharp focus. Since the outbreak of war in November 2020, multiple investigations and empirical studies have documented widespread conflict-related sexual and gender-based violence against women and girls in the region. The joint OHCHR and EHRC investigation recorded rape and other forms of sexual violence, including against young girls and older women, and noted that stigma and trauma likely meant that the true prevalence was far higher than documented cases suggested (OHCHR & EHRC, 2021). WHO similarly raised alarm in 2021 about reports of targeted attacks on civilians, including rape and other horrific forms of sexual violence in Tigray (WHO, 2021).

Subsequent empirical work strengthened this picture. Fisseha et al. (2023), in a large community-based survey across 52 districts of Tigray, found that 43.3% of surveyed women had experienced at least one form of gender-based violence during the conflict, with 9.7% reporting sexual violence and 7.9% reporting rape. Among sexual violence survivors, rape accounted for 82.2% of cases, and gang rape was common. The study also documented severe

physical, psychological, and reproductive health consequences, alongside very low uptake of post-violence support services. This is important because it demonstrates that the burden of CRSV in Tigray was both extensive and severe, and that many survivors were left without adequate care.

Qualitative evidence from Tigray adds depth to this statistical picture. Gebremichael et al. (2023) found that survivors described the experience of rape in Tigray as producing not only bodily harm but also enduring psychological pain, fear, and social disruption. The study highlighted the compounding effect of destroyed critical facilities, lack of safe houses, and limited health services. More recent evidence from Abreha *et al*. (2025) similarly shows that survivors in Tigray experienced layered sexual, physical, and psychological violence, often by multiple perpetrators, with consequent severe injuries, mental distress, and reproductive health complications.

The literature also suggests that CRSV in Tigray had ethnic and collective dimensions. The OHCHR/EHRC report, later EHRC submissions, and Physicians for Human Rights have documented patterns of sexual violence that survivors and health workers linked to humiliation, terror, and the destruction of Tigrayan identity, including reports of ethnic insults, forced pregnancy, and reproductive violence (OHCHR & EHRC, 2021; PHR, 2025). Whether approached from a legal, humanitarian, or public health perspective, these patterns show that CRSV in Tigray cannot be reduced to isolated assaults. It was embedded in the wider violence of the war and compounded by institutional collapse.

Another critical issue in the literature is access to care. CRSV becomes even more devastating when survivors cannot reach medical, psychosocial, or legal services quickly and safely. In Tigray, siege conditions, transport restrictions, insecurity, looting of facilities, and communication shutdowns severely restricted access to post-rape care during the height of the

conflict. This meant that survivors were often unable to obtain emergency contraception, HIV prophylaxis, STI treatment, forensic documentation, or counselling within recommended timelines. The literature therefore frames Tigray not only as a case of high CRSV burden but also as a case where the consequences were worsened by damaged service systems (Fisseha *et al*., 2023; UNFPA, 2023).

For the present study, this literature is important in two ways. First, it clarifies that CRSV in Tigray should be conceptualised broadly, to include physical, psychological, sexual, and socio-economic forms of harm linked to the conflict. Second, it shows that the effects of violence are mediated by context, especially access to support, social response, and displacement conditions. These issues connect directly to the study objectives, which focus on health outcomes, socio-economic consequences, and the moderating role of coping strategies in shaping women's well-being after violence.

2.4 Empirical Literature Review Aligned to the Study Objectives

2.4.1 Physical Health Outcomes of Conflict-related Gender-based Violence

Physical health outcomes are among the most immediate and visible consequences of Conflict-Related Sexual Violence (CRSV). Recent literature consistently shows that sexual and physical violence in conflict settings produces a spectrum of injuries, ranging from abrasions and bruising to fractures, genital trauma, sexually transmitted infections, unwanted pregnancy, miscarriage, infertility, chronic pain, and long-term reproductive complications. These outcomes are intensified when assaults are repeated, committed by multiple perpetrators, combined with other forms of physical torture, or followed by delays in seeking care. Because such conditions are common in conflict settings, the physical health burden of CRSV is often more severe than that associated with non-conflict sexual violence (Rubini *et al*., 2023; Sardinha *et al*., 2024).

A major insight from recent literature is that the physical consequences of CRSV often extend beyond the initial assault. Survivors may develop chronic pelvic pain, reproductive tract injury, recurrent infections, untreated wounds, and disability that interfere with work, mobility, and daily functioning. Rubini *et al*. (2023), in a systematic review of qualitative evidence on conflict-related sexual violence, found repeated documentation of head injuries, fractures, stabbing injuries, bodily trauma, and long-lasting physical impairment. The review also noted that such injuries often reduce survivors' work performance and capacity for social functioning, indicating that physical harm is closely linked to wider well-being outcomes.

The public health significance of these injuries is heightened by the fact that sexual violence remains globally under-measured and underreported. Sardinha *et al*. (2024) note that non-partner sexual violence is both common and underestimated, partly because many surveys rely on single, general questions that fail to capture the full range of abusive acts. This matters for conflict settings, where disclosure barriers are even stronger. Underreporting does not reduce harm; instead, it obscures the true scale of physical injury and leads to underinvestment in care, especially post-rape clinical services.

In humanitarian settings, the physical consequences of CRSV are also shaped by service disruption. Even injuries that might have been manageable in stable contexts can become life-threatening where hospitals are looted, transport is unsafe, and emergency reproductive health services are unavailable. The WHO and humanitarian literature repeatedly emphasise that delayed care after rape can increase the risk of untreated injury, HIV transmission, pregnancy-related complications, and long-term reproductive damage. Thus, physical outcomes cannot be understood only as biomedical sequelae of assault; they must also be understood as consequences of conflict-mediated health system collapse (WHO, 2021; UNFPA, 2023).

African conflict settings provide strong evidence of this pattern. In northern Uganda, Woldetsadik *et al*. (2022) found that women survivors of conflict-related sexual violence continued to live with persistent health problems long after the end of open hostilities, including chronic reproductive health challenges. Their study is particularly useful because it demonstrates that physical consequences do not disappear with the signing of peace agreements. Rather, they often remain untreated or poorly managed in post-conflict settings where targeted services have ended. This long-tail nature of physical harm is highly relevant to Tigray, where many women remain in conditions of incomplete recovery.

Evidence from Ethiopia's northern conflict regions is especially revealing. In post-war North Shewa, Asefa *et al*. (2024) reported that women exposed to gender-based violence faced multiple health consequences, including physical injuries and abortion-related outcomes. In conflict-affected Northeast Amhara, Dellie *et al*. (2024) similarly found substantial levels of emotional, physical, and sexual violence, highlighting the broader burden of gender-based violence in northern Ethiopia and the role of low social support in worsening vulnerability. These studies are not identical to the Tigray context, but they confirm that violence in Ethiopia's conflict settings has produced layered physical harm to women.

The strongest Tigray-specific evidence comes from Fisseha *et al*. (2023). In their community-based study of 5,171 women of reproductive age, 28.6% reported physical violence and 9.7% sexual violence. Among those affected, commonly reported physical and sexual health consequences included physical trauma, sexually transmitted infections, HIV infection, and unwanted pregnancy. The scale of the study is important because it moves beyond facility-based samples and provides broader population-level evidence on violence and health outcomes during the war. It also highlights the extent to which women's physical well-being was undermined by both violence and inadequate access to support, since most survivors reported not receiving post-violence medical or psychological care.

Abreha *et al*. (2025) provide even more detailed evidence on the nature of physical injury in Tigray. Their study found that 76.5% of the sexual violence victims had experienced combined sexual, physical, and psychological violence. Among the 528 victims examined, over 90% experienced physical violence in addition to sexual violence, and two in five suffered severe injuries including internal injuries, burns, sprains, fractures, and physical disfigurement. The study also documented genital harm, reproductive problems, HIV infection, other STIs, unwanted pregnancy, and abortion. This evidence is significant because it shows that the physical impact of violence in Tigray was not limited to rape narrowly conceived. Rather, it included a wider spectrum of bodily assault intended to degrade, injure, and disable survivors.

Further confirmation is provided by Physicians for Human Rights (2025), whose medical-record and health-worker evidence documents multiple perpetrator rape, insertion of foreign objects, forced pregnancy, transmission of STIs including HIV, and other forms of reproductive violence in Tigray. Their findings indicate that survivors often require complex and long-term care rather than one-off treatment. This is a crucial point for the present study because well-being must include not only immediate injury but also the persistence of physical suffering over time.

The literature also suggests that reproductive-age women are particularly affected. Abreha *et al*. (2025) found that the majority of rape victims in their Tigray sample were of reproductive age, which heightened the implications of unwanted pregnancy, infertility, and chronic reproductive damage. This aligns with broader scholarship showing that CRSV threatens women's physical health in ways that directly affect reproductive autonomy, maternal health, and long-term bodily functioning. In patriarchal and conflict-affected settings, such reproductive harms may also intensify social stigma and economic exclusion, thereby linking physical outcomes to the study's other dimensions of well-being.

Despite the growing literature, important gaps remain. Much of the existing evidence still focuses on sexual violence as a category without sufficiently differentiating the full range of physical health outcomes or tracking them over time. Few studies follow survivors longitudinally to assess chronic pain, disability, recurring infection, or the quality of post-conflict reproductive care. In Tigray specifically, while recent studies have established the prevalence and severity of physical harm, there is still limited integrated analysis linking physical injury to women's broader well-being and to the coping strategies they employ after violence. The present study therefore contributes by examining physical health outcomes as one dimension of women's well-being within a broader analytical framework.

2.4.2 Mental Health Outcomes of Conflict-Related Sexual Violence

Mental health outcomes are among the most profound and enduring effects of conflict-related sexual violence. Recent literature consistently documents that survivors of sexual and gender-based violence in conflict settings experience elevated levels of depression, anxiety, post-traumatic stress disorder, fear, shame, nightmares, intrusive memories, sleep disturbance, social withdrawal, hopelessness, and, in some cases, suicidal ideation. These outcomes may be intensified by displacement, family separation, lack of justice, continued insecurity, and the stigma attached to sexual violence. As a result, mental health harm is often chronic rather than temporary (Woldie *et al*., 2025; Rubini *et al*., 2023).

A recent systematic review and meta-analysis by Woldie *et al*. (2025) confirms the strong association between sexual violence and mental disorders among women survivors in sub-Saharan Africa. This is especially important for the present study because it demonstrates that the link between sexual violence and poor mental health is not anecdotal but empirically robust across multiple African settings. The review also raises an important methodological issue: underreporting and variation in how sexual violence is measured may mean that the true association is even stronger than documented in available studies. In conflict contexts, where

sexual violence is often accompanied by other war-related trauma, the psychological burden may be cumulative.

The literature further suggests that psychological injury after CRSV is shaped not only by what happened during the assault but also by what happens afterwards. Survivors who encounter disbelief, blame, social rejection, or inadequate services are more likely to experience prolonged trauma. Conversely, timely psychosocial support, social acceptance, and survivor-centred care may reduce symptom severity and improve functioning. This means that mental health outcomes are embedded in social context rather than being purely internal responses to violence (Torre *et al*., 2024; Berring *et al*., 2024).

In post-conflict northern Uganda, Woldetsadik *et al*. (2022) found that women survivors continued to face significant health and social problems long after the conflict, including persistent emotional suffering. Their study underscores a critical issue often neglected in post-war response: psychological harm may endure for years, especially when specialised services established during the immediate post-conflict period later disappear. The authors argue for increased access to tailored mental health services, a recommendation that resonates strongly with the needs identified in Tigray.

The Tigray-specific evidence on mental health is increasingly compelling. Fisseha *et al*. (2023) found that depression was one of the commonly reported consequences of war-related gender-based violence in their community survey, and that nearly 90% of survivors had not received post-violence medical or psychological support. This lack of support is analytically important because it means that psychological harm cannot be separated from the collapse of response systems. Women were not only traumatised by violence; they were also left to cope in settings where formal care pathways were weak or inaccessible.

Abreha *et al*. (2025) deepen this evidence by documenting extensive psychological trauma among survivors of sexual violence in Tigray. Their study found that more than four in five victims reported psychological violence alongside sexual assault, and that survivors described anxiety, sleep disturbance, nightmares, flashbacks, disappointment, crying, isolation, avoidance of people, and even suicide attempts. The study also reports that about 12% of victims suffered PTSD and that roughly three quarters experienced at least one form of mental or behavioural health consequence. These findings are important because they show that mental health harm was widespread, severe, and intertwined with both physical violence and humiliating treatment during the assaults.

Qualitative evidence from Tigray reveals the lived meaning of these outcomes. Gebremichael *et al*. (2023) found that rape survivors described immense psychological damage alongside physical suffering, with women narrating fear, trauma, and the added burden of destroyed services. Such qualitative accounts matter because they show that mental health symptoms are not abstract categories but lived disruptions to sleep, memory, relationships, self-esteem, and everyday functioning. They also highlight the particular vulnerability of younger survivors, who may be simultaneously managing trauma, dependency, interrupted education, and family instability.

Comparable studies from nearby Ethiopian conflict settings support these findings. Asefa *et al*. (2024) reported anxiety, depression, self-blame, and school dropout among women exposed to gender-based violence in post-war North Shewa. Dellie *et al*. (2024) found that low social support was associated with greater vulnerability in conflict-affected Northeast Amhara. These studies suggest that psychological harm in northern Ethiopia is strongly linked to the broader environment of conflict and support, rather than being reducible to isolated incidents. This point is central to the present study because it helps explain why coping strategies may matter as moderators of well-being outcomes.

The role of trauma-informed interventions is also increasingly emphasised in recent literature. Berring *et al*. (2024) note that trauma-informed care is important for personal well-being and adjustment across settings because it promotes safety, trust, and recovery. Although much of this literature is not conflict-specific, its relevance is clear in humanitarian contexts where survivors often fear disclosure, anticipate blame, or mistrust service providers. Trauma-informed and violence-informed models are therefore particularly appropriate for understanding mental health in Tigray, where violence, displacement, and institutional breakdown intersected.

Another emerging insight comes from mental health and psychosocial support programmes for survivors of CRSV. Torre *et al.* (2024) examined symptom severity and improvement among survivors receiving mental health support in a conflict setting and highlighted the importance of early intervention. This finding is directly relevant to Tigray because many survivors were unable to access early psychosocial care due to insecurity and damaged health systems. Delayed support likely contributed to the persistence and deepening of mental distress among women survivors.

Mental health outcomes also have social dimensions. Shame, social withdrawal, avoidance of public life, and fear of community judgement can deepen trauma even when some formal services exist. In Tigray and comparable settings, survivors may not only relive the violence internally but also continue to negotiate a social environment in which disclosure carries risk. This helps explain why mental health outcomes are often accompanied by silence, withdrawal from education or work, and weakened trust in others. The literature therefore supports treating mental health as a central dimension of women's well-being rather than a secondary consequence.

Despite important advances, the literature still has notable limitations. Much of the empirical work remains cross-sectional, making it difficult to understand trajectories of recovery over time. There is also limited evidence that directly examines how coping strategies, social support, and access to services alter the relationship between CRSV and mental health outcomes in Tigray specifically. Most studies document the prevalence or severity of trauma but do not test moderating mechanisms. This leaves a clear gap for the present study, which examines mental health as part of overall well-being and considers whether coping strategies shape the extent of harm women experience after conflict-related violence.

2.4.3 Socio-economic Consequences of conflict-related sexual violence

Beyond physical and mental health outcomes, conflict-related sexual violence (CRSV) has profound socio-economic consequences for survivors, their households, and their communities. Recent literature shows that CRSV often disrupts livelihoods, schooling, asset ownership, mobility, family relations, marriage prospects, and access to productive opportunities. These consequences arise both from the violence itself and from the wider conflict environment that destroys markets, services, infrastructure, and social networks. For women in already vulnerable settings, violence can therefore trigger long-term downward economic mobility and social exclusion (Kelly *et al*., 2024; UN Women & UN DESA, 2023).

The literature increasingly recognises that socio-economic harm is not a peripheral effect of CRSV. Instead, it is one of the main reasons survivors struggle to recover even after the immediate assault has ended. Women may be unable to return to work because of injury, trauma, stigma, or insecurity. They may lose access to land, trading routes, markets, education, or social capital. Households may deplete assets to cover medical costs, and survivors who become displaced may enter settings in which dependency, exploitation, and poverty are intensified. In this way, CRSV reshapes women's economic and social lives long after violence occurs.

Recent work from eastern Democratic Republic of Congo is useful here. Kelly *et al*. (2024) show that conflict, displacement, and overlapping vulnerabilities are strongly associated with higher risks of both sexual violence and intimate partner violence among displaced women. Their findings are important because they reveal how violence and displacement reinforce one another. Women who are currently or formerly displaced face higher odds of violence, which in turn undermines their capacity to achieve socio-economic stability. This perspective is highly relevant to Tigray, where many affected women were also internally displaced and living in conditions of material precarity.

The broader global gender equality literature supports the same point. The Gender Snapshot 2023 argues that the world remains off track on gender equality, with conflict, poverty, and inadequate investment in women's rights continuing to undermine women's social and economic status (UN Women & UN DESA, 2023). While this literature is not specific to CRSV, it provides an important macro frame: women's socio-economic recovery after violence depends not only on personal resilience but also on structural opportunities, legal protections, access to resources, and supportive institutions.

Ethiopia's legal and policy environment also matters for socio-economic recovery. The World Bank's Women, Business and the Law 2024 snapshot for Ethiopia shows that although the country performs well in some domains, women still face legal and policy constraints related to pay, marriage, parenthood, and pension. These issues are relevant because women recovering from conflict-related violence require not just emergency support but also a policy environment that protects their economic rights and supports re-entry into work, enterprise, and asset security. If such structural conditions are weak, socio-economic recovery becomes even harder (World Bank, 2024).

The Tigray conflict intensified these structural challenges. In addition to direct violence, women experienced the collapse of health systems, interruptions in humanitarian access, destruction of infrastructure, and major livelihood disruption. UNFPA's 2023 humanitarian response plan for Ethiopia explicitly highlighted the enormous sexual and reproductive health and GBV needs generated by multiple shocks, including conflict, and the difficulties of meeting them under humanitarian strain. This implies that survivors in Tigray were trying to recover not in a stable economy but in a setting of broader institutional and material collapse (UNFPA, 2023).

Empirical studies from Tigray substantiate these broader concerns. Fisseha *et al*. (2023) found that conflict-related sexual violence (CRSV) was associated not only with physical and psychological consequences but also with poor utilisation of support services, which has direct socio-economic implications because untreated injury and trauma reduce women's ability to work and participate in social life. Their study also documented unwanted pregnancy and depression, both of which can disrupt education, household relations, and livelihoods.

Kidie *et al*. (2025), in a mixed-methods study on sexual violence among women in northern Ethiopia's 2022 conflict, reported that the main impacts included psychosocial effects, external blame, stigma, fear of humiliation, divorce, and displacement. These outcomes are both socio-economic and psychological. Stigma and divorce may reduce women's access to household resources or social protection, while displacement frequently interrupts income generation, schooling, and access to markets. The study therefore reinforces the idea that violence alters women's position within families and communities, not just their internal state of mind.

Qualitative work from Tigray also points to social fragmentation and economic harm. Gebremichael *et al*. (2023) showed that survivors' experiences extended "beyond rape" to encompass broader disruptions to life and support systems. The destruction of critical facilities

and lack of safe houses meant that survivors faced recovery in environments with limited assistance. In conflict settings, such absence of support is itself socio-economic harm because it transfers the burden of recovery onto already vulnerable women and households.

Recent documentation by Physicians for Human Rights (2025) further highlights the socio-economic consequences of violence in Tigray. Their report notes that survivors and health workers described economic, mental, and physical damage resulting from conflict-related sexual and reproductive violence. Importantly, the report also links ongoing violence and lack of accountability to continued instability, meaning that women's socio-economic recovery is undermined by persistent insecurity and incomplete justice. This matters because economic rebuilding is difficult where violence remains unresolved, and impunity persists.

Service-access studies from displaced Ethiopian women also provide insight into the socio-economic dimensions of recovery. Mitiku *et al*. (2025) found that even where healthcare, legal, and counselling services were nominally free, survivors faced secondary costs such as transport fees, waiting times, and fear of exposure. These barriers are socio-economic because they determine who can actually use services and who cannot. Financial support for transport and discreet referral improved access, showing that material assistance is part of survivor recovery, not separate from it. The same study documented gossip, poor community support, overcrowding, and weak accountability, all of which can further isolate survivors and reduce their ability to rebuild livelihoods and social roles.

The literature also suggests that socio-economic outcomes are heavily gendered. Women are often primary carers, informal traders, agricultural workers, or dependants within households whose bargaining position may weaken after violence. Where stigma leads to rejection by spouses or relatives, survivors may face sudden income insecurity and housing instability. Where girls are forced out of school because of pregnancy, trauma, or shame, the consequences

extend into the future through lost educational and employment opportunities. In this sense, the socio-economic consequences of CRSV are both intergenerational and immediate.

Nonetheless, socio-economic outcomes remain underdeveloped in much of the literature compared with the extensive focus on rape prevalence and health trauma. Many studies mention livelihood loss, stigma, displacement, or educational interruption, but fewer examine these systematically as central dimensions of women's well-being. In Tigray in particular, the literature is still fragmented, with some studies focusing on health facilities, others on narratives of rape, and others on general humanitarian need. There remains limited integrated analysis of how violence affects women's economic security, social participation, and future opportunities, especially when combined with displacement and weak coping resources. The present study therefore addresses an important gap by examining socio-economic consequences explicitly as part of women's well-being rather than treating them as secondary background factors.

2.4.4 Coping Strategies and the Moderating Role of Coping on Women's Well-being

Coping strategies refer to the cognitive, emotional, behavioural, spiritual, relational, and practical responses that individuals use to manage stress, trauma, and adversity. In the context of conflict-related sexual violence, coping strategies may include silence, avoidance, prayer, seeking social support, disclosure to trusted persons, help-seeking from health providers, participation in survivor groups, economic improvisation, relocation, meaning-making, and engagement with formal or informal support structures. The literature generally distinguishes between coping strategies that are more adaptive or supportive of recovery, and those that are avoidant or maladaptive, although the boundary between these categories can be context-dependent (Berring *et al*., 2024; Bekele *et al*., 2025).

The relevance of coping to this study lies in the fact that not all women exposed to CRSV experience identical well-being outcomes. Even when levels of violence are similar, differences in coping resources, support networks, and access to services may shape the severity and persistence of physical, mental, and socio-economic consequences. This is why coping is best treated not merely as an outcome but as a potential moderating factor. It may buffer some harms, delay others, or, in the case of negative coping, intensify distress and isolation.

Recent literature on trauma and recovery supports this view. Trauma-informed scholarship emphasises safety, trust, collaboration, empowerment, and peer support as central conditions for healing after violence. Berring *et al*. (2024), in a scoping review of trauma-informed care implementation, argue that trauma-informed approaches are important for well-being and adjustment because they reduce coercion, improve safety, and support recovery. Although this literature is often broader than conflict-related sexual violence specifically, it provides a useful lens for understanding why coping strategies involving help-seeking, support, and empowerment may moderate the relationship between violence and well-being.

At the same time, the literature also shows that coping is shaped by the surrounding environment. A survivor cannot easily seek help where health services are absent, where confidentiality is weak, or where stigma is pervasive. Thus, coping is not only an individual psychological process; it is socially and institutionally conditioned. This point is particularly important in conflict and displacement settings, where the feasibility of adaptive coping may be limited by insecurity, cost, service collapse, and community silence (Mitiku *et al*., 2025; Olson *et al*., 2020).

Evidence from post-conflict Uganda illustrates this clearly. Woldetsadik *et al*. (2022) found that women survivors continued to face enduring health and social problems, while many

targeted programmes that had existed at the end of the war were no longer available. This means that even where survivors wished to seek care or support, the relevant services had diminished. The implication is that coping capacity is partly institutional. Survivors' outcomes depend not only on internal resilience but also on whether long-term reproductive health and mental health services remain accessible.

Recent qualitative evidence from Ethiopia provides more direct insight into coping strategies. Bekele *et al*. (2025), studying socially isolated survivors of wartime sexual assault in North Wollo Zone, identified several coping strategies: trust in God, seeking guidance from religious leaders, sharing experiences with friends, elders, and experts, and participating in coffee ceremonies as forms of communal support. These findings are valuable because they show that in low-resource and conflict-affected settings, coping often takes place through faith, everyday social rituals, and selective disclosure rather than formal mental health channels alone. Such strategies may reduce loneliness, restore dignity, and create spaces for emotional expression, even where professional services are limited.

However, the same study also suggests that coping is constrained by isolation, service disruption, and ongoing vulnerability. Survivors reported helplessness, diminished self-confidence, and abuse-related segregation. Thus, while faith and social interaction may provide some emotional containment, they are unlikely to fully compensate for the absence of comprehensive rehabilitation. This suggests that coping can mitigate harm, but not necessarily eliminate it.

Evidence from displaced Ethiopian women further highlights the importance of social and institutional coping resources. Mitiku *et al*. (2025) found that community-based GBV workers, NGOs, referral pathways, one-stop facilities, safe spaces, and discreet financial support could all facilitate help-seeking and improve survivor protection. Yet the same study reported major

barriers including stigma, poor confidentiality, transport costs, insecurity, overcrowded camps, and mistrust of justice systems. These findings are analytically important because they show the mechanism through which coping may moderate well-being: women with access to trusted social support and effective referral systems are more likely to seek care and recover; women facing secrecy breaches, gossip, and insecurity are more likely to delay care, withdraw socially, or rely on silence.

The one-stop centre literature supports this interpretation. Olson *et al*. (2020), in a systematic review of one-stop centres for survivors of intimate partner and sexual violence in low- and middle-income countries, found that integrated models can reduce fragmentation in care, but their effectiveness depends on adequate staffing, privacy, multisectoral coordination, and clear responsibilities. Where these conditions are absent, survivors face long waits, cost barriers, and retraumatisation risks. This is relevant to the present study because coping through formal help-seeking can only be effective where service systems are functioning in survivor-centred ways.

The Tigray literature suggests that many survivors faced severe constraints on coping. Fisseha *et al*. (2023) reported that nearly 90% of survivors did not receive post-violence medical or psychological support. Abreha *et al*. (2025) similarly found that only a small minority of sexual violence victims in their sample actually received medical care and treatment. These findings imply that even when women attempted to cope through formal care-seeking, service access was extremely limited. In such contexts, women may resort to silence, withdrawal, religious coping, or dependence on informal networks, not necessarily because these are ideal responses but because they are the most accessible.

Qualitative evidence from Tigray and nearby settings points to both adaptive and harmful coping patterns. Survivors may seek safety through relocation, conceal their assault to avoid stigma, or disengage socially to protect themselves from blame. Yet such avoidant coping may

also prolong trauma, delay treatment, and deepen isolation. By contrast, selective disclosure to trusted relatives, survivor groups, or community workers may facilitate earlier access to care and a stronger sense of solidarity. The literature, therefore, supports the view that coping is heterogeneous and that different strategies are likely to have different implications for well-being.

Recent reports on service delivery in Tigray show some positive developments after the most acute phase of the war. The World Bank (2024) notes that since 2023, conflict-affected women and girls in Tigray have accessed women- and girl-friendly safe spaces, mental health and psychosocial support, and referrals to medical, legal, and basic services through supported facilities. These developments suggest that institutional and community-level coping supports are possible and may improve recovery when properly resourced. However, such progress does not erase the earlier service vacuum or the scale of unmet need documented in earlier studies.

The literature also shows that coping is relational. Survivor recovery is strongly shaped by whether family and community responses are supportive or stigmatising. Mitiku *et al*. (2025) found that some women in camps lacked anyone to turn to, while others benefited from community workers who increased awareness and linked them to care. Bekele *et al*. (2025) similarly highlight the importance of socialising and talking with others as part of coping. These findings are consistent with the wider violence literature, which emphasises that social support can buffer trauma whereas blame and gossip exacerbate it.

Despite its importance, coping remains under-examined in the Tigray literature. Most studies document health consequences or violence prevalence, while few directly test how coping strategies shape outcomes across physical, mental, and socio-economic domains. Even fewer analyse coping as a moderating variable. This is a significant gap because the same level of violence may produce different outcomes depending on whether survivors have access to social

support, faith-based resources, safe spaces, counselling, discreet referrals, livelihood assistance, or community acceptance. The present study responds to this gap by explicitly examining the moderating role of coping strategies in the relationship conflict-related sexual violence (CRSV) and the well-being of women in Tigray.

2.4.5 Summary Review of Literature and Research Gaps

The reviewed literature demonstrates three broad points. First, conflict-related sexual violence has extensive and severe consequences for women's well-being. Recent evidence from global, African, and Ethiopian studies consistently shows that survivors face intertwined physical, psychological, and socio-economic harms. Injuries, reproductive health complications, depression, anxiety, stigma, livelihood loss, displacement, and social fragmentation are recurrent themes across the literature. This supports the study's conceptualisation of women's well-being as multidimensional rather than narrowly biomedical.

Second, the literature on Tigray has grown rapidly since 2023 and now offers strong evidence that CRSV during the conflict was widespread, serious, and compounded by institutional breakdown. Community-based and qualitative studies have documented rape, gang rape, physical trauma, reproductive harm, mental distress, and service inaccessibility. Recent documentation also suggests that the consequences of violence extended beyond the formal cessation of hostilities and that many survivors continue to require complex care. This means the Tigray case is now better evidenced than in the immediate aftermath of the war, but important analytical gaps remain.

Third, and most importantly for the present study, the literature remains uneven in how it organises and explains outcomes. Much of the existing research has focused on prevalence, legal characterisation, or immediate health consequences of sexual violence. Fewer studies have integrated physical, mental, and socio-economic outcomes within one coherent well-

being framework. Even fewer have examined how coping strategies influence the relationship between CRSV and women's well-being. Where coping is discussed, it is often descriptive, focusing on survivors' narratives of faith, silence, support-seeking, or resilience, rather than being analysed as a moderating factor in an empirical model.

There are also methodological gaps. Much of the available evidence is cross-sectional, facility-based, or qualitative. These designs are valuable, but they limit understanding of how different dimensions of harm interact and how contextual resources shape outcomes. In Tigray specifically, there is still limited integrated evidence that combines violence exposure with physical health outcomes, mental health outcomes, socio-economic consequences, and coping strategies in one analytical framework. Likewise, while several studies mention stigma, social support, or help-seeking barriers, few directly examine whether coping reduces or worsens the impact of violence on women's overall well-being.

Another gap concerns population focus. Existing studies often address sexual violence survivors generally or women in conflict settings broadly, but there is less focused work on displaced women in Tigray as a distinct population coping with layered forms of vulnerability. Displacement matters because it changes access to services, social networks, privacy, safety, and economic opportunity. Since many women affected by CRSV in Tigray experienced displacement, a study that centres their well-being is especially relevant.

The present study, therefore, contributes to the literature in several ways. It aligns with current evidence showing that women's well-being after CRSV is multidimensional. It responds to the relative underdevelopment of the socio-economic consequences literature by examining those outcomes explicitly. Most importantly, it addresses a clear empirical gap by investigating the moderating role of coping strategies on the relationship between conflict-related sexual violence and women's well-being in Tigray. In doing so, the study moves beyond documenting

harm to explaining variation in outcomes among survivors. This makes it useful not only for scholarship but also for policy and programming, since interventions that strengthen adaptive coping and supportive environments may reduce the severity of violence-related harm.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

The chapter outlines the research methodology adopted for the study. It describes the research design, study site, target population, sampling techniques, and sample size. The chapter also details the data collection tools, procedures, and analysis methods, alongside ethical considerations.

3.2. Research Design

A research design is the overall plan that guides the collection, measurement and analysis of data in a study so as to address the research problem systematically and accurately (Kothari, 2014). This study adopted a descriptive cross-sectional research design. A descriptive cross-sectional design involves collecting data from a defined population at a single point in time in order to describe existing conditions, characteristics, patterns and relationships among variables. The design does not involve follow-up of respondents over time but instead provides a snapshot of the phenomenon under investigation as it exists during the period of study.

The design was appropriate for this study because it enabled the researcher to examine the impact of conflict-related sexual violence on the well-being of women in Tigray Region, Ethiopia, within a specific time frame. In particular, the design made it possible to assess the physical and mental health outcomes associated with conflict-related sexual violence, establish its socio-economic consequences, and examine the moderating role of coping strategies on women's well-being. Since the study sought to collect information on women's experiences, health outcomes, socio-economic conditions and coping strategies at one point in time, the cross-sectional approach was suitable.

The design was also practical for the study context because the target population consisted of women survivors residing in internally displaced persons camps and refugee settlements, where mobility, vulnerability and resource limitations made longitudinal follow-up difficult. By collecting data once through structured questionnaires, key informant interviews and focus group discussions, the study was able to generate timely evidence while minimising respondent burden and reducing the risk of repeated retraumatisation. In addition, the design allowed the researcher to describe the prevalence and patterns of conflict-related sexual violence and analyse associations among the study variables, thereby providing useful evidence for humanitarian programming and policy interventions in conflict-affected settings.

3.3. Research Site

The study was conducted in three selected internally displaced persons (IDP) sites in the Tigray Region of northern Ethiopia. Tigray is not a village or a district; it is one of Ethiopia's regional states, with Mekelle serving as its regional capital. Geographically, Tigray lies in the northernmost part of Ethiopia and borders Eritrea to the north, Sudan to the west, Amhara Region to the south, and Afar Region to the east. Much of the region consists of highland plateau and escarpment landscapes, while the eastern section descends towards the Rift Valley. The 2007 population census recorded 4,314,456 people in Tigray, of whom 19.5% were urban residents and 80.5% were rural residents; pre-war estimates placed the population at nearly 5.7 million. The region occupies just over 50,000 square kilometres, making it a large and administratively significant regional unit within Ethiopia.

Administratively, Tigray is organised into zones and woredas (districts), which makes it an appropriate regional setting for examining conflict-related sexual violence across different displaced populations rather than within a single local community. The use of three IDP sites

within the region enabled the study to capture variation in population composition, conflict exposure and access to humanitarian services, while keeping the investigation within one coherent administrative and socio-political context.

Climatologically, Tigray is largely arid to semi-arid, with considerable variation across the region. In many areas, annual rainfall ranges from about 400 to 600 mm, while some western and southern highland areas receive about 800 to 1,000 mm. Recent studies also show warming trends and declining rainfall in parts of western Tigray. These conditions are relevant to the study because climate and ecology shape livelihoods, water access, mobility and vulnerability, especially among displaced women who depend on fragile local resources and humanitarian support.

The choice of Tigray was both scholarly and practical. Scholarly justification lies in the fact that Tigray was the epicentre of the 2020 to 2022 northern Ethiopia conflict and remains one of the country's most displacement-affected regions. In 2024, the region was estimated to host about 950,000 IDPs, 53% of whom were female. In addition, empirical studies conducted in Tigray have documented substantial war-related sexual and gender-based violence and severe physical, sexual and mental health consequences among women survivors. Tigray was therefore an appropriate site for examining the impact of conflict-related sexual violence on women's well-being and the moderating role of coping strategies.

The three selected IDP sites were chosen because they provided access to women who had directly experienced conflict-related displacement and gender-based violence, had sufficient survivor populations for the study, and were feasible for ethical data collection with the support of local authorities and humanitarian partners. Their selection therefore strengthened the relevance, diversity and feasibility of the study.

The study was carried out in three separate internally displaced persons (IDP) sites within the Tigray region. Between 2007 and 2024, the population of Tigray increased from 4.3 million to 5.9 million. Tigrayans, who primarily inhabit the region, now represent approximately 6% of Ethiopia's total population. In November 2020, conflict erupted between the Ethiopian federal government and the Tigray People's Liberation Front (TPLF). By 2025, more than 5,300 deaths had been reported in Tigray due to direct combat and violence targeting civilians, including 3,151 civilian fatalities. The war has led to large-scale internal displacement and widespread destruction of infrastructure, with around 70 percent of health facilities damaged or destroyed. The conflict has also been marked by widespread sexual violence against women, with over 10,000 survivors documented to date.

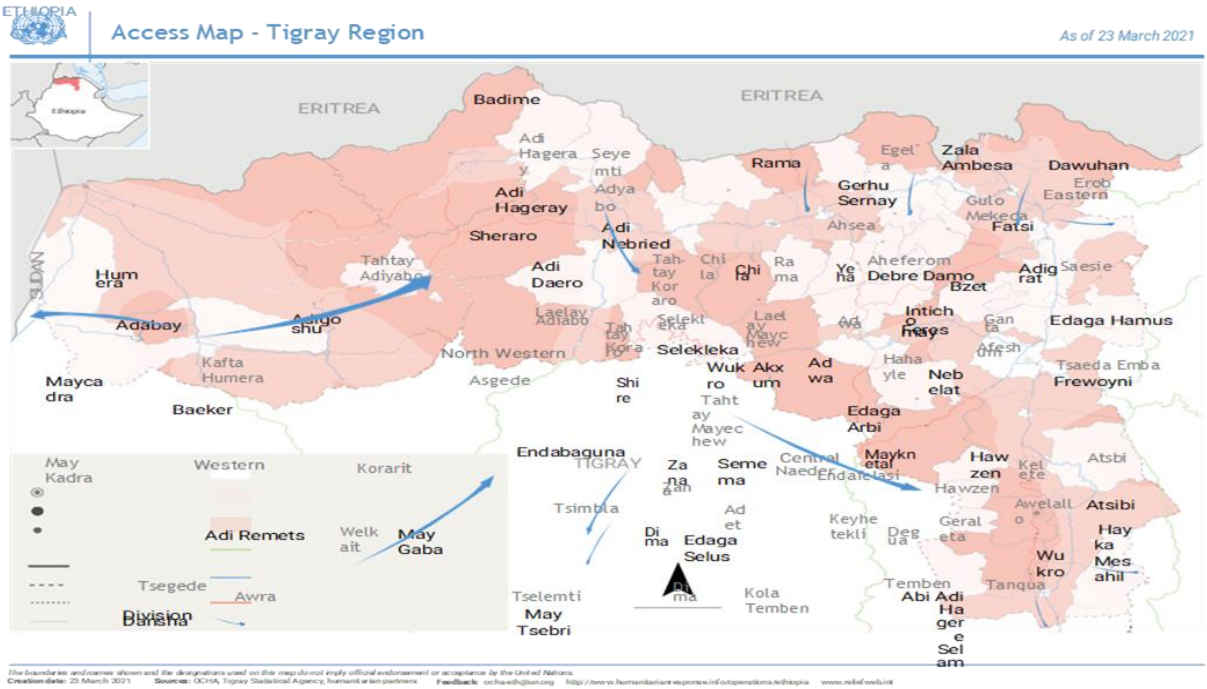

Figure 3.1: Map for Tigray Region in Ethiopia

These sites have been specifically selected based on several critical factors. First, they represented a diverse cross-section of the population affected by the conflict, varying in

demographic composition, population size and the type of services available to displaced individuals. This diversity is essential to ensure that the study captures a broad spectrum of experiences and the varied psychological impacts of conflict-related sexual violence. Secondly, the chosen sites are known for having a high incidence of reported gender-based violence cases. This prevalence makes them particularly relevant for examining the psychological outcomes, such as post-traumatic stress, among survivors. The concentration of SGBV cases in these areas provides a more robust sample for analysis and helps in drawing more generalizable conclusions about the broader conflict-affected population in Tigray. Furthermore, the selection of these three sites is also based on their accessibility and the willingness of local authorities and partner organisations to facilitate the research. Their cooperation was crucial for the ethical and efficient collection of data.

3.4. Target Population

A target population refers to the broader group of individuals or entities to which researchers intend to generalise their findings. In this study, the target population comprised adult women aged 18 years and above residing in selected internally displaced persons (IDP) and refugee sites within the Tigray region. It also included managers and practitioners involved in gender-based violence (GBV) prevention and response within these settings. The study specifically focused on women because they were the primary survivors and the main population disproportionately affected by conflict-related sexual violence in the Tigray conflict. Since the study sought to examine the impact of conflict-related sexual violence on the well-being of women, women were the most appropriate population for generating direct evidence on the physical, psychological and socio-economic consequences of such violence, as well as the coping strategies used in response. Men and children were not included as the primary target population because they fall outside the central focus of the study and would require separate conceptual, ethical and methodological considerations. Overall, World Bank (2024) points out

that over 600,000 women in the Tigray region have experienced some form of conflict-related sexual violence.

3.5. Study Sample

A study sample refers to a subset of individuals, data points or items selected from a larger population to conduct research. It represents the broader population during research when it is not feasible to collect data from every member of that population.

3.5.1. Study Sample Size

Sample size refers to the number of respondents selected from the target population to participate in a study. It should be large enough to allow valid generalisation of findings to the wider population. In this study, the quantitative sample size for women respondents was determined using Cochran's formula for large populations at a 95% confidence level and 5% margin of error (Cochran, 1977). Since the target population of adult women in the three selected IDP camps was assumed to be large, the formula was applied as follows:

$$\boldsymbol{n_0 = \frac{Z^2 p(1-p)}{e^2}}$$

Where:

n_0= required sample size

Z= standard normal deviation at 95% confidence level = 1.96

p= estimated proportion of the population with the characteristic of interest = 0.5

e= margin of error = 0.05

Below is a revised hypothetical distribution for four camps using women populations between 30,000 and 120,000, while still yielding a total survey sample of 384.

Hypothetical population by camp

- Camp A = 120,000 women
- Camp B = 80,000 women
- Camp C = 60,000 women
- Camp D = 40,000 women
- Total = 300,000 women

Proportionate sample allocation

The sample for each camp is calculated using:

$$n_i = \frac{N_i}{N} \times n$$

Where:

n_i= sample for each camp

N_i= population of women in each camp

N= total population of women in all camps

n= total sample size (384)

amp A

$$n_1 = \frac{120{,}000}{300{,}000} \times 384 = 153.6 \approx 154$$

Camp B

$$n_2 = \frac{80{,}000}{300{,}000} \times 384 = 102.4 \approx 102$$

Camp C

$$n_3 = \frac{60{,}000}{300{,}000} \times 384 = 76.8 \approx 77$$

Camp D

$$n_4 = \frac{40{,}000}{300{,}000} \times 384 = 51.2 \approx 51$$

Table 3.1: Distribution of Target Population and Proportionate Sample Size Across Selected IDP Camps

Camp	**Women Population**	**Proportion**	**Sample Size**	**Sampling Technique**
Camp A	120,000	40.00%	154	Proportionate stratified, then simple random sampling
Camp B	80,000	26.70%	102	Proportionate stratified, then simple random sampling
Camp C	60,000	20.00%	77	Proportionate stratified, then simple random sampling
Camp D	40,000	13.30%	51	Proportionate stratified, then simple random sampling
Total	**300,000**	**100%**	**384**	

3.6.Sampling Procedure

The sampling procedure was designed to ensure the inclusion of all eligible survivors of conflict-related sexual violence), as well as all managers and practitioners responsible for GBV response in Tigray's internally displaced persons (IDP) and refugee sites. Two complementary strategies were employed: chain referral sampling for women survivors and purposive mapping for key informants. These approaches aimed to capture the full range of lived experiences and operational perspectives across all camps. For the survivor cohort, the study began by engaging trusted community focal points, such as women's support groups, camp health committees, and local non-governmental organizations, to identify an initial group of participants who met the inclusion criteria (adult women who experienced GBV following displacement). Each of these initial participants completed the survivor questionnaire and was subsequently asked to refer other women in their network who also met the eligibility criteria. This referral process continued in successive waves until no additional eligible participants were identified. By leveraging existing social networks and ensuring that each referral was made by someone who had already participated, the study aimed to reach survivors who might otherwise remain inaccessible, while safeguarding confidentiality and promoting the emotional safety that is critical in GBV research. Simultaneously, the study compiled a comprehensive list of all individuals involved in GBV-related work within each camp. This roster was developed using organisational charts, camp administration records, and databases provided by coordinating bodies. From this list, key informants were purposively selected to ensure representation across various functional roles, including camp protection officers, psychosocial counsellors, and legal aid coordinators, as well as geographic zones. Every individual on the roster with responsibilities for GBV programming or oversight was invited to participate in a key informant interview (KII), thereby minimizing selection bias and ensuring that the full spectrum of managerial perspectives was represented.

3.7. Data collection

Data collection refers to the systematic process of gathering and recording information relevant to the study in order to answer the research questions and achieve the study objectives. In this study, both primary data and secondary data were used. The primary data collection tools were the questionnaire and the key informant interview guide. These tools were selected because they enabled the researcher to obtain both quantitative and qualitative data on conflict-related sexual violence and its impact on the well-being of women in Tigray.

3.7.1 Questionnaire

The questionnaire (Appendix I) was administered to adult women aged 18 years and above residing in the selected IDP and refugee sites in Tigray. These respondents included women who were direct survivors of conflict-related sexual violence as well as women from communities significantly affected by such violence. The questionnaire was structured into thematic sections covering socio-demographic characteristics, exposure to gender-based violence, physical and mental health outcomes, socio-economic consequences, access to support services, and coping strategies. It mainly consisted of closed-ended questions to generate quantitative data, although a few open-ended items were included to allow respondents to provide further clarification where necessary. Responses to attitudinal and perception items were measured using a five-point Likert scale, namely: Strongly Agree, Agree, Neutral, Disagree, and Strongly Disagree. A few open-ended items were also included to allow respondents to provide further clarification where necessary.

3.7.2 Key Informant Interview Guide

The key informant interview guide (Appendix II) was used to collect qualitative data from managers, healthcare professionals, GBV practitioners, and other service providers involved in gender-based violence prevention and response within the selected sites. The interviews were semi-structured to allow flexibility in probing issues such as the prevalence and forms of GBV,

the impact of violence on women, available intervention measures, service delivery gaps, and challenges in supporting survivors. The key informant interviews complemented the questionnaire data by providing expert and operational perspectives on the issue under study.

3.7.3 Secondary Data

In addition to primary data, the study also utilised secondary data from published and unpublished sources relevant to conflict-related sexual violence in Tigray. These included journal articles, books, reports from humanitarian agencies, government publications, policy documents, and institutional records on GBV and women's well-being. Secondary data were useful in providing background information, contextualising the study problem, supporting the literature review, and triangulating findings obtained from primary data sources.

3.8. Pilot Testing of Research Instruments

Before the primary data collection, the questionnaires and key informant interview guides underwent a pilot study. The instruments were administered to a sample of 40 women from a comparable context outside the main study population. The purpose of the pilot was to evaluate the clarity, relevance, and sensitivity of the questions in relation to the research objectives. Key informant interviews with managers working in internally displaced persons and refugee sites addressing gender-based violence were also piloted to ensure the questions elicited meaningful qualitative data. Feedback from the pilot informed revisions to improve question clarity and alignment with the intended data. The pilot further facilitated estimation of the time needed for administration and helped identify potential logistical challenges in the data collection process.

3.8.1. Instrument Reliability

Reliability refers to the extent to which an instrument consistently measures what it is intended to measure over time. In this study, the reliability of the questionnaire and the key informant interview guide was evaluated during the pilot phase using the test–retest method.

Participants completed the questionnaire on two separate occasions, and their responses were compared to assess consistency. Internal consistency was measured using Cronbach's alpha, with a coefficient of 0.7 or above deemed acceptable. For the key informant interviews, interrater reliability was employed by comparing the consistency of responses obtained by different interviewers. These procedures ensured that the instruments produced dependable and consistent data.

3.8.2. Instrument Validity

Validity is essential to ensure that research instruments accurately measure the intended constructs. In this study, content validity, construct validity, and face validity were systematically evaluated. Content validity was established through expert review by specialists in gender-based violence programming and research methodology, who assessed whether the items adequately captured the multidimensional impact of sexual and gender-based violence on women in conflict-affected settings. Construct validity was confirmed by aligning the questionnaire items with the study's theoretical framework and specific research objectives. Face validity was examined during the pilot phase, during which participants provided feedback on the clarity, relevance, and comprehensibility of the questions.

3.9. Data Collection Procedure

Data collection for this study was conducted under the supervision of the Graduate School at African Nazarene University (ANU). Prior to fieldwork, ethical approval was obtained from the ANU Institutional Research Ethics Committee. The complete research protocol, which included the questionnaire and the key informant interview (KII) guide, was submitted alongside informed consent forms and participant information sheets for review. Following approval, the research team secured letters of introduction from the Registrar's Office and the Department of Social Sciences. These documents facilitated access to internally displaced persons (IDPs) and refugee sites in Tigray. A trained team of female research assistants, each

holding at least a bachelor's degree in social work or a related field, conducted the data collection. Prior to fieldwork, the team completed a two-day training workshop focused on ethical approaches to sensitive gender-based violence issues, confidentiality protocols, referral procedures for distressed participants, and standardized methods for administering the survivor questionnaire and conducting semi-structured KIIs with camp officials and service providers. Fieldwork commenced with formal introductions to camp authorities and community focal persons, during which the team presented all institutional documentation. Survivor participants were privately approached and invited to provide written informed consent before completing the questionnaire in a secure and confidential environment. Key informant interviews with managers and practitioners followed the same consent process. To safeguard participants' rights and privacy, all data were anonymized at the point of collection and stored on encrypted devices approved by ANU's Ethics Committee.

3.10. Data Processing and Analysis

Data analysis for this study employed both quantitative and qualitative approaches. Quantitative data collected through questionnaires were coded and entered into statistical software, such as SPSS, for analysis. Descriptive statistics, including frequencies, percentages, and means, were used to summarize the prevalence and types of GBV reported by participants. Cross-tabulations were conducted to examine associations between demographic variables, such as age, marital status, and educational attainment, and the incidence of GBV. Inferential statistical techniques, including chi-square tests and logistic regression, were utilized to assess the significance of relationships between independent variables (conflict-related sexual violence) and the dependent variable (women's well-being). These analyses helped identify key predictors of GBV among women in refugee settings. Qualitative data from key informant interviews were analysed using thematic analysis. Transcripts were reviewed thoroughly to identify recurring themes and patterns related to the management of GBV in IDP contexts.

These themes were coded systematically, and a comprehensive narrative was constructed to enrich the quantitative findings. Triangulation of data sources, including questionnaires and interviews, enhanced the credibility and validity of the results.

3.11. Legal and ethical Considerations

The study complied with rigorous ethical standards by adhering to international guidelines, national regulations, and gender-based violence (GBV) guiding principles to safeguard participants' rights and well-being. Informed consent was obtained through clear communication and appropriate language assistance, with participants assured of their right to withdraw at any point without adverse consequences. To ensure confidentiality, data were anonymized and securely stored, with personal identifiers accessible only to authorized research personnel. Given the sensitivity of the subject matter, psychological support was made available to distressed participants through established referral systems within local GBV service providers. Ethical clearance was obtained from African Nazarene University (ANU) and the host agency in Ethiopia.

CHAPTER FOUR

DATA ANALYSIS AND FINDINGS

4.1. Introduction

The chapter presents the data analysis and research findings. It begins with the response rate and socio-demographic characteristics of respondents, followed by an examination of physical, psychological, and socio-economic impacts of conflict-related sexual violence. The chapter also incorporates qualitative insights and highlights coping strategies employed by survivors, thereby linking empirical evidence to the study objectives and conceptual framework.

4.2. Response Rate

Table 4.1 presents the distribution of questionnaire responses from the targeted sample of women affected by conflict-related sexual violence in Tigray. It indicates the proportion of participants who completed and returned the questionnaires compared to those who did not, providing insight into the level of participation and the completeness of the data collected.

Table 4. 1: Response Rate

Response Status	**Frequency**	**Percentage**
Responded	345	89.84
Not Responded	39	10.16
Total	**384**	**100**

Table 4.1 shows that out of a target sample of 384 women, 345 returned completed questionnaires, giving a response rate of 89.84%, while 39 did not respond, representing a non-response rate of 10.16%. This response rate was considered adequate for the study. Ericson et al. (2023) note that survey response rates of 70% or higher are important for ensuring that findings are reasonably representative and generalisable to the study population. In addition,

Wu et al. (2022) found that the average response rate in published online surveys was 44.1%, which suggests that the response rate achieved in this study was considerably high. The high participation level therefore strengthens confidence in the findings and reduces the likelihood of serious non-response error, although it should be noted that response rate alone does not completely eliminate the possibility of non-response bias (Hendra & Hill, 2019).

4.3. Socio-Demographic Characteristics of the Respondents

Table 4.2 presents the socio-demographic characteristics of the participants, highlighting age, marital status, education level, and displacement period, which are critical in understanding the background and diversity of respondents.

Table 4. 2: Socio-Demographic Profile of the Participants

Category	Frequency	Percentage
Age		
18-25 years	101	29.20
26-30 years	119	34.40
31-35 years	49	14.30
36-40 years	50	14.60
41-50 years	15	4.30
Above 50 years	11	3.20
Marital Status		
Single	108	31.30
Married	194	56.20
Widowed	23	6.70
Divorced	20	5.80
Education		

No formal education	97	28.20
Primary school	92	26.70
Secondary school	125	36.20
Tertiary education (college/university)	31	8.90
Displacement Period		
Less than 6 months	44	12.80
6 months – 1 year	134	38.90
More than 2 years	64	18.50
1 – 2 years	103	29.80

4.3 Socio-Demographic Characteristics of the Respondents

Table 4.2 presents the socio-demographic profile of the respondents and provides the social context within which the effects of conflict-related sexual violence should be interpreted. Although demographic variables are often introduced as descriptive background information, in this study, they are analytically important because age, marital status, education level, and duration of displacement shape women's exposure to violence, access to support, coping capacity, and recovery outcomes. In conflict and displacement settings, these variables do not operate independently. Rather, they intersect to produce different levels of vulnerability and resilience among women.

The age distribution shows that the largest category of respondents was women aged 26 to 30 years, who accounted for 119 (34.40%), followed by those aged 18 to 25 years, who were 101 (29.20%). This means that nearly two-thirds of the respondents were young adult women. The other age groups were represented at much lower proportions, with 31 to 35 years accounting for 49 (14.30%), 36 to 40 years accounting for 50 (14.60%), 41 to 50 years accounting for 15

(4.30%), and those above 50 years accounting for 11 (3.20%). This pattern suggests that the study primarily captured the experiences of women in their most socially and economically active years. In the context of conflict, this matters because women in these age groups are more likely to combine multiple burdens, including reproductive health concerns, childcare demands, livelihood responsibilities, and pressure to maintain household survival under unstable conditions.

The predominance of younger women also suggests that the sample reflects a group that is especially exposed to gendered insecurity in displacement settings. Women in early and middle adulthood are more likely to move frequently in search of food, healthcare, and water, and this mobility can increase exposure to harassment, assault, and intimidation. At the same time, younger women may be more visible targets of sexualised and gendered violence during conflict. The age structure of the sample, therefore, provides an important lens through which the later findings on physical, sexual, and psychological violence should be understood. It implies that the study is speaking largely to the experiences of women whose health, bodily autonomy, labour participation, and future life opportunities were all at risk.

The marital status distribution provides additional social context. The largest category was married women, who accounted for 194 (56.20%), followed by single women at 108 (31.30%), while widowed women accounted for 23 (6.70%) and divorced women accounted for 20 (5.80%). This pattern suggests that most respondents were situated within household and family structures, rather than living as socially independent individuals. In displacement and conflict contexts, marital status often shapes not only household obligations but also the type of support or exclusion a woman may experience. Married women may have spouses or children who depend on them, which means the consequences of violence are likely to extend beyond the individual survivor to the household unit. By contrast, widowed and divorced

women may face reduced social protection, weaker financial support, and greater economic precarity.

The education profile further deepens the interpretation of respondents' vulnerability. The largest category was secondary education, at 125 (36.20%), followed by no formal education, at 97 (28.20%), and primary education, at 92 (26.70%). Only 31 (8.90%) reported tertiary education. This indicates that the majority of respondents had low to moderate educational attainment, with very few having progressed to higher education. In practical terms, education shapes access to information, awareness of rights, confidence in approaching formal institutions, and capacity to rebuild livelihoods. Women with limited education may struggle to understand referral pathways, legal processes, or service entitlements. They may also have narrower employment opportunities, which makes post-conflict recovery more difficult. The education profile, therefore, suggests that the sample included many women whose recovery options were likely constrained by limited formal human capital.

The final demographic variable, duration of displacement, adds a temporal dimension to the findings. The largest category was women displaced for 6 months to 1 year, at 134 (38.90%), followed by those displaced for 1 to 2 years, at 103 (29.80%). Another 64 (18.50%) had been displaced for more than 2 years, while 44 (12.80%) had been displaced for less than 6 months. This distribution suggests that the majority of respondents were not in the earliest emergency stage of displacement. Rather, many had already entered medium-term or prolonged displacement, where hardship becomes cumulative rather than temporary. Long stays in IDP settings often weaken social networks, deepen financial exhaustion, and increase dependency on fragile humanitarian systems. The duration profile, therefore, suggests that the respondents' experiences of GBV and well-being were shaped not only by single violent events but also by the prolonged stress of insecure living conditions.

The qualitative data, presented here for demonstration purposes, reinforce the importance of age as a vulnerability factor. One informant explained that *"Most of the women who came to us were young mothers. They were trying to care for children, look for food, and stay safe at the same time, and that exposed them to many risks"* (KI-01). Another stated, *"Younger women were often the ones moving around the camp and outside it, so they were more exposed to harassment and fear than elderly women who stayed hidden"* (KI-02). These excerpts support the quantitative finding that younger women formed the largest share of the sample and help explain why that matters. The issue is not simply that they were numerically dominant, but that their age position placed them at the intersection of mobility, caregiving, reproductive vulnerability, and economic responsibility.

Marital status was also echoed strongly in the qualitative material. One respondent explained that, *"For married women, the violence did not stop with the attack itself. They still had to feed children, answer to husbands, and hold the family together while they themselves were breaking"* (KI-03). Another informant added, *"Widowed and divorced women were often the most alone. Some had no one to speak for them, no money, and no family network to fall back on"* (KI-04). These insights show that marital status influenced not only social identity but also the structure of burden and support. Married women may have had stronger family ties, but they also had heavier domestic obligations. Widowed and divorced women may have had fewer obligations to spouses, yet they often experienced deeper forms of isolation and economic insecurity.

Education emerged as another key differentiating factor in the qualitative accounts. One key informant observed that, *"Women with little or no schooling often did not know where to report, what help existed, or how to follow referrals. Many simply stayed silent because the system felt too complicated"* (KI-05). Another noted, *"Even when services were there, not all women could navigate them. Some could not read forms, some feared officials, and some*

thought they had no right to ask for help" (KI-06). These excerpts help explain why low educational attainment matters in the analysis. Education affects more than literacy. It shapes confidence, procedural knowledge, and perceived entitlement to support, all of which influence recovery pathways after violence.

The qualitative evidence on displacement duration also strengthens the demographic interpretation. One informant stated that, *"Women displaced for many months became tired in a different way. At first they feared the violence, but later they also feared hunger, debt, and being forgotten"* (KI-07). Another noted, *"The longer women stayed in the camps, the more their problems became layered. It was no longer only about the original harm, but about stress, illness, lack of income, and constant uncertainty"* (KI-08). These accounts indicate that the duration of displacement magnified rather than diluted vulnerability. Over time, women's challenges shifted from emergency survival to chronic insecurity, making it harder to separate the direct effects of Sexual Violence from the ongoing effects of camp life and social dislocation.

The demographic pattern observed in this study is broadly supported by empirical literature. Workie et al. (2023) found that internally displaced women in Northwest Ethiopia experienced high levels of sexual violence, and younger age groups were significantly represented among those affected. Similarly, Fisseha et al. (2023) reported that war-related sexual and gender-based violence in Tigray heavily affected women in younger reproductive-age groups, while Kibret et al. (2024) found that low educational status was associated with greater vulnerability to gender-based violence in northern Ethiopia. Namer et al. (2024) also showed that violence among married young women in southern Ethiopia remained substantial, suggesting that marital union should not be assumed to protect women from violence. In addition, Mitiku et al. (2025) found that displaced women in Ethiopia faced persistent barriers related to stigma, low awareness, insecurity, and weak service access, particularly in settings marked by

prolonged displacement. These studies reinforce the present interpretation that demographic variables are part of the explanation for women's vulnerability and not merely descriptive characteristics.

4.4. Physical and Mental Health Outcomes Associated with Conflict-Related Gender-Based Violence Among Women

Table 4.3 presents the distribution of responses on conflict-related physical violence among women, showing how participants experienced or perceived various forms of violence during the conflict. The respondents rated each item on a five-point Likert scale, and the resulting mean scores and standard deviations offer insights into consensus and variability.

Table 4. 1: Conflict-Related Physical Violence among Women

Item	SD	D	N	A	SA	Mean	Std. Dev
Experienced physical harm or assault during the conflict	8.86	5.47	33.44	24.26	27.97	3.57	0.95
Witnessed acts of physical violence against women during the conflict	21.72	8.3	5.07	32.2	32.71	3.46	1.14
Been physically intimidated because of gender during the conflict	4.53	25.41	14.3	21	34.76	3.56	1.31
Experienced direct physical attacks by armed groups or individuals	11.73	7.86	30.99	27.33	22.09	3.40	1.24
Believe physical violence is used as a tactic against women in the conflict	20.37	12.68	8.66	17.23	41.06	3.46	0.86

The findings from Table 4.3 reveal that 24.26% agreed and 27.97% strongly agreed that they experienced physical harm or assault, while 33.44% were neutral, 5.47% disagreed, and 8.86% strongly disagreed, yielding a mean of 3.57 (SD = 0.95), which indicates a moderate to high level of agreement that women suffered physical harm. Similarly, 32.20% agreed and 32.71% strongly agreed that they witnessed acts of physical violence against women, compared to 5.07% neutral, 8.30% disagree, and 21.72% strongly disagree, with a mean of 3.46 (SD = 1.14), suggesting that witnessing violence was relatively common. On whether participants had been physically intimidated because of gender, 21% agreed and 34.76% strongly agreed, while 14.30% were neutral, 25.41% disagreed, and 4.53% strongly disagreed, resulting in a mean of 3.56 (SD = 1.31), reflecting significant exposure to gender-based intimidation. Regarding direct physical attacks by armed groups or individuals, 27.33% agreed and 22.09% strongly agreed, compared to 30.99% neutral, 7.86% disagree, and 11.73% strongly disagree, giving a mean of 3.40 (SD = 1.24), which demonstrates that direct assaults were experienced by a considerable portion, though with slightly lower intensity compared to intimidation. Finally, when asked whether physical violence is believed to be a deliberate tactic used against women in the conflict, 17.23% agreed and 41.06% strongly agreed, against 8.66% neutral, 12.68% disagree, and 20.37% strongly disagree, with a mean of 3.46 (SD = 0.86), confirming that many respondents perceived violence as a systemic weapon of war.

The quantitative pattern is analytically important because it suggests that conflict-related physical violence operated at several levels simultaneously. First, women reported personal experiences of harm. Second, they observed violence happening to other women. Third, they identified physical intimidation as gendered, rather than random. Fourth, many were close to agreeing that violence was used tactically against women. Taken together, these results suggest that physical violence in the conflict was not reducible to isolated incidents. Instead, it formed part of a climate in which women's bodies were exposed to assault, fear, and coercive control.

The qualitative findings deepen this quantitative interpretation. One key informant stated that, *"Many women came with injuries that clearly affected their movement for months. Some could not fetch water, carry children, or even sit comfortably after the attacks"* (KI-09). Another noted, *"Even after wounds healed on the surface, many women said their bodies had not returned to normal, and simple household work had become painful"* (KI-10). These excerpts make the numerical findings more concrete. The item on physical harm or assault is not only about the event of violence itself. It is also about what happens afterwards, including persistent pain, loss of mobility, and reduced ability to perform ordinary physical tasks. The qualitative material therefore supports the interpretation that physical violence affected women's day-to-day functioning in tangible and lasting ways.

A second qualitative theme concerns the use of intimidation as a specifically gendered form of physical control. One respondent explained that, *"Women were often threatened in ways that made it clear their bodies were being targeted because they were women, not simply because they were civilians"* (KI-11). Another informant stated, *"Sometimes the goal seemed to be to make women afraid to move, to collect food, or to speak. Fear itself became part of the violence"* (KI-12). These statements are important because they help interpret the high mean for physical intimidation. Intimidation was not only a precursor to direct assault. It was itself part of the violence, shaping women's movement, decisions, and sense of bodily security.

A third qualitative theme concerns direct attacks by armed actors and the social meaning of witnessing physical violence. One informant reported that, *"There were many accounts of women being beaten in public or on the way to collect essentials. Even those who were not attacked themselves still carried the fear because they had seen it happen to others"* (KI-13). Another noted, *"Witnessing violence against another woman changed how people moved and behaved. It sent a message to the whole community, especially to women"* (KI-4). These excerpts reinforce two quantitative items at once: witnessing violence and direct physical

attacks. They suggest that physical violence had a communicative function. It was not only destructive for individual victims, but also disciplinary at community level, shaping behaviour through fear.

The fourth qualitative theme concerns what happened after injury. One key informant explained that, *"Many women reached services late because they had no transport, no money, or no safe route. By then, small injuries had become serious problems"* (KI-5). Another added, *"Clinics were overwhelmed and some had almost nothing. Women might arrive for help and leave without proper treatment, pain relief, or follow-up care"* (KI-16). These statements add an important layer to the quantitative results. The impact of physical violence cannot be understood only in relation to the moment of assault. It must also be understood through the collapse or weakness of post-violence care systems. In this way, the severity of physical harm is intensified by the inability to obtain timely treatment.

Secondary evidence supports this interpretation of physical violence as widespread and severe in the Tigray conflict. The joint OHCHR and EHRC investigation found reasonable grounds to believe that all parties to the conflict committed sexual and gender-based violence and noted that many forms of violence were used to degrade and dehumanise victims, with survivors requiring free and timely medical, psychosocial, and legal services (OHCHR & EHRC, 2021). WHO (2021) similarly warned of reports of rape and other serious abuses in Tigray and highlighted the destruction of health systems. This broader documentary evidence aligns with the present findings by showing that physical violence occurred within a context of institutional breakdown and weakened protection.

The present findings are also broadly consistent with empirical studies. Fisseha et al. (2023) found that war-related sexual and gender-based violence in Tigray was prevalent and often severe, with physical violence affecting a substantial proportion of women. Abreha et al. (2025)

further documented major physical, sexual, and mental health consequences among women and girls in conflict-affected areas of Tigray, including severe bodily injuries and longer-term health complications. Workie et al. (2023) also reported high prevalence of GBV among internally displaced women in Northwest Ethiopia, indicating that conflict and displacement environments significantly increase women's exposure to physical and related harms. These convergences strengthen the credibility of the current results.

At the same time, there are important nuances. The present table mean remained at the upper edge of neutral rather than well into the agree range. This may partly reflect underreporting, variation in how respondents define physical violence, or fear associated with disclosure. It may also reflect that some women experienced intimidation and witnessing more often than direct physical attack. In this sense, the study does not suggest a uniform experience of violence. Rather, it shows layered exposure in which not every respondent was directly assaulted, but many lived within a social environment shaped by the threat and visibility of physical violence.

Critically, the findings suggest that physical violence in this setting should be interpreted as both personal and structural. Personal, because women reported direct bodily harm and lasting impairment. Structural, because the violence was embedded in a larger conflict context where health services were damaged, mobility was constrained, and community fear was normalised. The qualitative material shows that women's bodies became sites of both immediate injury and prolonged suffering. The literature comparison further suggests that this pattern is not unique to the current sample, but consistent with wider evidence from Tigray and other conflict-affected Ethiopian settings.

Conflict-Related Sexual Violence Among Women

Table 4.4 presents findings on conflict-related sexual violence among women, capturing experiences, perceptions, and observations during the conflict.

Table 4. 2: Conflict-Related Sexual Violence Among Women

Item	SD	D	N	A	SA	Mean	Std. Dev
I have experienced unwanted sexual advances or harassment during the conflict	7.07	15.7	7.65	24.44	45.14	3.84	1.33
I have been forced or coerced into sexual activities during the conflict	5.64	16.94	17.42	29.11	30.89	3.61	1.24
I have witnessed instances of sexual violence against other women during the conflict	2	3	5	39	51	4.34	0.86
I believe that sexual violence is used deliberately as a weapon against women in the conflict	31.79	18.57	8.45	27.97	13.22	2.74	1.48
I have experienced other forms of sexual abuse (e.g., forced nudity, humiliation) during the conflict	19.11	6.8	31.02	16.36	26.71	3.25	1.12

The results from Table 4.4 indicate that 24.44% agreed and 45.14% strongly agreed that they had experienced unwanted sexual advances or harassment, while 7.65% were neutral, 15.70% disagreed, and 7.07% strongly disagreed, yielding a high mean score of 3.84 (SD = 1.33), suggesting that harassment and unwanted advances were widespread. Similarly, 29.11%

agreed and 30.89% strongly agreed that they had been forced or coerced into sexual activities, compared to 17.42% neutral, 16.94% disagree, and 5.64% strongly disagree, with a mean of 3.61 (SD = 1.24), showing that coercive sexual acts were significantly reported. Witnessing sexual violence against other women was even more prevalent, as 39% agreed and 51% strongly agreed, while only 5% were neutral, 3% disagreed, and 2% strongly disagreed, giving the highest mean of 4.34 (SD = 0.86), which highlights that sexual violence was not only individually experienced but also commonly observed within the community. On whether sexual violence was perceived as a deliberate weapon of war, 27.97% agreed and 13.22% strongly agreed, while 8.45% were neutral, 18.57% disagreed, and 31.79% strongly disagreed, producing the lowest mean score of 2.74 (SD = 1.48), indicating divided perceptions and possibly reflecting variations in awareness or framing of sexual violence as a systematic strategy. Lastly, regarding other forms of sexual abuse such as forced nudity or humiliation, 16.36% agreed and 26.71% strongly agreed, with 31.02% neutral, 6.80% disagree, and 19.11% strongly disagree, resulting in a mean of 3.25 (SD = 1.12), showing moderate prevalence with a tendency toward underreporting due to sensitivity. The results demonstrate that women were disproportionately subjected to various forms of sexual violence, with particularly high levels of unwanted harassment, coercion, and witnessing violence against others, underscoring the severe impact of conflict on women's bodily integrity and psychological well-being.

The results pattern is analytically revealing. The very high mean for witnessing sexual violence suggests that many women lived in an environment where sexual abuse was socially visible and widely known, even if not every respondent named the violence in explicitly strategic or political terms. The lower mean on "weapon against women" does not necessarily imply disagreement with the existence of systematic violence. Rather, it may indicate variation in the language respondents use to interpret violence, differences in awareness of broader conflict strategy, or reluctance to frame their experience in overtly political terms. In other words,

women may have clearly observed and experienced sexual violence without necessarily describing it using the formal language of "weaponisation".

The qualitative findings strengthen this interpretation. One key informant stated that, *"Women described unwanted sexual attention as a daily threat in some locations. It shaped where they walked, when they moved, and who they trusted"* (KI-7). Another noted, *"Harassment was often normalised as if it were a minor issue, but for the women it was a constant warning that more serious abuse could follow"* (KI-8). These quotations support the high mean for unwanted sexual advances and harassment. They show that harassment was not trivial or isolated. Instead, it functioned as a daily mechanism of fear, surveillance, and restricted movement.

A second qualitative theme concerns coercive sexual acts and the erosion of bodily autonomy. One informant explained that, *"Some women spoke of coercion in ways that made clear they had no real choice. They were threatened, overpowered, or placed in situations where refusal did not feel possible"* (KI-9). Another stated, *"The violence left many women feeling that their bodies were no longer their own, and that sense of violation stayed long after the event"* (KI-2). These insights help interpret the item on forced or coerced sexual activity. The quantitative mean of 3.61 already indicates agreement, but the qualitative material shows why coercion is especially damaging. It is not only a physical invasion. It is also a destruction of autonomy, safety, and personal control.

A third theme concerns the widespread witnessing of sexual violence against other women. One respondent explained that, *"Even women who were not directly assaulted still carried the trauma of hearing the stories, seeing the aftermath, or knowing neighbours who had been attacked"* (KI-2). Another key informant noted, *"Sexual violence became part of the camp's shared memory. People might not say everything openly, but everyone knew it was happening"* (KI-22). These statements give depth to the highest table mean of 4.34 for witnessing sexual

violence. They suggest that the burden of sexual violence in this context was not confined to direct survivors alone. It also affected the wider social and emotional environment, producing communal fear, silence, and secondary trauma.

The fourth qualitative theme concerns humiliation, shame, and underreporting. One informant stated that, *"Some women could speak about beatings more easily than sexual abuse. Humiliation was often the part they hid most"* (KI-3). Another added, *"Forced humiliation and sexualised degradation were deeply silencing. Many women feared blame more than anything else"* (KI-4). These excerpts help explain why the item on other forms of sexual abuse and the item on deliberate use as a weapon recorded lower means than direct experience or witnessing. Sensitive and shame-laden forms of abuse are often underreported, minimised, or described indirectly. The qualitative evidence therefore suggests that the lower means may reflect under-disclosure or conceptual uncertainty rather than low prevalence.

Secondary data strongly support the broader interpretation that sexual violence in Tigray was severe and widespread. The OHCHR and EHRC report documented rape and other forms of sexual violence by multiple parties to the conflict and found reasonable grounds to believe that such abuses were used to degrade and dehumanise victims (OHCHR & EHRC, 2021). The report also highlighted the need for timely medical, psychosocial, and legal support for survivors. These findings align with the current section by showing that sexual violence was not an isolated occurrence but a major feature of the conflict environment.

The present findings also converge with empirical studies from Tigray and related settings. Fisseha et al. (2023) found that sexual violence was a major component of conflict -related sexual violence in Tigray, with rape accounting for a large share of reported sexual violence cases and gang rape being common. Abreha et al. (2025) similarly documented widespread physical, sexual, and mental health consequences among women and girls exposed to GBV

during the conflict. These studies support the current results, especially the strong means for coercion, harassment, and witnessing sexual violence. At the same time, the lower mean on the perception of sexual violence as a deliberate weapon appears somewhat more cautious than the framing in human rights documentation, which more explicitly describes systematic and targeted patterns. This divergence may reflect differences between survivor-centred survey language and legal or policy interpretation. It may also suggest that women's everyday framing of abuse does not always mirror the formal conflict analysis used by external institutions.

A critical reading of these results suggests that sexual violence in the study setting had at least three dimensions. First, it was individually experienced through harassment, coercion, and humiliation. Second, it was socially witnessed, which means the violence shaped not only direct survivors but also the wider community of women. Third, it was partially but not uniformly recognised as strategic or deliberate. The combination of these dimensions matters because it shows that women were living in a landscape of sexual threat even where not all respondents named the violence in political or military terms.

The implications for women's well-being are substantial. Sexual violence undermines bodily integrity, reproductive health, emotional safety, and trust in others. Even witnessing sexual violence against other women can generate fear, stress, and altered behaviour. The qualitative material also shows that humiliation and silence are central to the experience, which means the effects of sexual violence are intensified by stigma and difficulty in disclosure. In this sense, the harm of sexual violence extends far beyond the immediate act, reaching into memory, movement, social trust, and help-seeking.

Psychological Violence Among Women

Table 4.5 highlights the extent of psychological violence experienced by women during the conflict, focusing on verbal abuse, intimidation, isolation, witnessing abuse, and perceptions of systematic use of psychological violence.

Table 4.3: Psychological Violence Among Women

Item	SD	D	N	A	SA	Mean	Std. Dev
I have experienced verbal abuse or humiliation specifically related to my gender during the conflict	6.7	11.52	23.92	23.65	34.21	3.67	1.24
I have been subjected to threats or intimidation that have caused significant distress during the conflict	6.71	5.85	20.75	31.29	35.4	3.83	1.17
I have been isolated or deliberately alienated from my social network as a tactic of psychological violence during the conflict	21.41	25.05	12.57	15.42	25.55	2.99	1.51
I have witnessed psychological abuse (e.g., public shaming or degradation) against other women during the conflict	6.45	6.05	8.52	22.33	56.65	4.17	1.2
I believe that psychological violence is a systematic method used against women in the conflict	7.16	8.49	17.17	57.52	9.66	3.54	1.02

The findings from Table 4.5. show that 23.65% agreed and 34.21% strongly agreed that they had experienced verbal abuse or humiliation specifically related to their gender, while 23.92% were neutral, 11.52% disagreed, and 6.70% strongly disagreed, giving a mean of 3.67 (SD = 1.24), indicating that gender-based verbal humiliation was a common form of psychological harm. Similarly, 31.29% agreed and 35.40% strongly agreed that they had been subjected to threats or intimidation causing significant distress, compared to 20.75% neutral, 5.85% disagree, and 6.71% strongly disagree, yielding a high mean of 3.83 (SD = 1.17), which suggests that intimidation was one of the most prevalent psychological tactics. In contrast, isolation or deliberate alienation from social networks recorded lower agreement, with 15.42% agreeing and 25.55% strongly agreeing, while 12.57% were neutral, 25.05% disagreed, and 21.41% strongly disagreed, producing the lowest mean of 2.99 (SD = 1.51), showing that while social alienation was present, it was less widely experienced than other psychological forms. Witnessing psychological abuse against other women, such as public shaming or degradation, was highly prevalent, with 22.33% agreeing and 56.65% strongly agreeing, compared to 8.52% neutral, 6.05% disagree, and 6.45% strongly disagree, giving one of the highest means of 4.17 (SD = 1.20), indicating that public acts of psychological abuse were widely observed in conflict settings. Finally, 57.52% agreed and 9.66% strongly agreed that psychological violence is a systematic method used against women in conflict, while 17.17% were neutral, 8.49% disagreed, and 7.16% strongly disagreed, yielding a mean of 3.54 (SD = 1.02), which reflects strong acknowledgment that psychological tactics are deliberately employed as part of gender-targeted violence. The findings demonstrate that verbal abuse, intimidation, and witnessing public humiliation were highly prevalent, while isolation was less common but still significant, underscoring that psychological violence was systematically used to disempower women, erode resilience, and perpetuate gendered oppression during conflict.

The data pattern in the results above suggests that respondents more readily identified overt and visible forms of psychological violence, such as threats, humiliation, and public abuse, than more socially diffuse experiences such as isolation. This does not mean that social alienation was absent. Rather, it may suggest that isolation was experienced in more varied and complex ways, or that respondents associated psychological violence more strongly with direct verbal and emotional aggression than with the slower erosion of social support. The table therefore shows both the breadth and the uneven recognition of psychological harm.

The qualitative data deepen this interpretation considerably. One informant explained that, *"Many women said that the words used against them stayed longer in the mind than the incident itself. Humiliation followed them even when no one was touching them anymore"* (KI-5). Another noted, *"Gendered insults made women feel that they were being reduced to something less than human. It was not just anger. It was deliberate degradation"* (KI-6). These quotations support the high mean for verbal abuse and humiliation. They show that language itself functioned as violence, especially when it was tied to gender and aimed at eroding women's dignity.

A second qualitative theme concerns threats and intimidation as instruments of psychological control. One key informant stated that, *"Fear became part of daily life. Women often said they were not only afraid of what had happened, but of what could happen again at any moment"* (KI-7). Another added, *"Threats did not end with the event. Some women remained in a state of alertness for weeks and months, as if danger was always nearby"* (KI-28). These insights help explain the strong mean of 3.83 for threats and intimidation. They show that intimidation worked by stretching violence across time. Even where direct assault had ended, the expectation of further harm continued to shape women's emotional state and behaviour.

The third qualitative theme concerns public shaming and witnessing abuse against other women. One respondent explained that, *"When women saw others being insulted, mocked, or degraded in front of people, it sent fear through the whole community"* (KI-9). Another stated, *"Public humiliation affected everyone who witnessed it. It taught women to stay silent, stay hidden, and distrust what would happen if they spoke"* (KI-3). These verbatims align closely with the highest item mean in the table. They suggest that public psychological abuse had a social reach beyond the immediate target. By humiliating one woman publicly, the violence communicated a broader warning to other women, thereby turning psychological abuse into a collective mechanism of control.

The fourth qualitative theme concerns social withdrawal, alienation, and mistrust. One informant observed that, *"Some women started to avoid neighbours, meetings, and even relatives because they feared gossip, judgement, or being asked painful questions"* (KI-3). Another explained that, *"Isolation was sometimes less visible than threats, but it became one of the most painful consequences. Women who once belonged to a community began to feel alone in it"* (KI-2). These excerpts help interpret the lower mean for isolation. Although the item remained in the neutral range, the qualitative material suggests that alienation may have been experienced as an outcome of humiliation and fear, rather than always as a direct tactic recognised by respondents at the time. In this way, the table may underestimate the depth of social isolation because respondents may have interpreted it as a consequence rather than a form of violence in itself.

Secondary evidence strongly supports the conclusion that psychological violence was systematic and harmful in conflict settings such as Tigray. The OHCHR and EHRC report documented not only sexual and physical abuses but also degrading and dehumanising treatment of women, highlighting the need for survivor-centred support that addresses emotional and psychosocial damage as well as bodily harm (OHCHR & EHRC, 2021). This

aligns with the present findings by showing that psychological violence was not secondary or incidental, but part of the wider architecture of conflict-related sexual violence .

The empirical literature also provides strong support. Abreha et al. (2025) documented major mental and emotional consequences of GBV among women and girls in Tigray, including anxiety, distress, and lasting psychological suffering. Gebreyesus et al. (2024) reported high levels of post-traumatic stress symptoms among internally displaced populations affected by the war, indicating the wider mental health burden of violence and conflict exposure. Woldetsadik et al. (2022), working in northern Uganda, also found that survivors of conflict-related sexual violence experienced enduring health and social well-being consequences long after the violence itself, showing that psychological damage often remains chronic and socially embedded. These studies support the current findings, especially the strong agreement around threats, humiliation, and emotional harm.

A point of critical interpretation, however, is that psychological violence is often harder to measure than physical or sexual violence. Respondents may recognise threats and humiliation immediately, but may not always identify mistrust, withdrawal, or emotional numbness as forms of violence, particularly when such responses have become normalised in prolonged displacement. This may explain why the item on isolation scored lower than the others. It does not necessarily mean isolation was unimportant. Rather, it may indicate that social alienation was experienced in a more diffuse and less directly named way.

Another important insight is that psychological violence in this study appears to have operated both individually and publicly. It harmed women internally through fear, anxiety, and humiliation, but it also worked socially by sending messages, producing silence, and weakening trust. This makes it especially significant in conflict settings, where social bonds are already fragile. The strong means for witnessing public psychological abuse suggest that

women's emotional environments were shaped not only by private suffering but also by the visible degradation of other women.

4.5.4. Wellbeing Outcomes of Conflict Related Gender Based Violence Victims

This section presents the results on well-being outcomes among women who experienced conflict-related sexual violence in Tigray. Drawing on a structured questionnaire, this section examines three interrelated dimensions of well-being: physical health, psychological health, and socio-economic stability, each measured through a series of Likert-style items. Table 4.6 presents the well-being outcomes of survivors of conflict-related sexual violence (CRSV), focusing on physical health, psychological health, and socio-economic consequences.

Table 4. 4: Wellbeing Outcomes of Conflict Related Gender Based Violence Victims

Item	SD	D	N	A	SA	Mean	Std. Dev
Physical Health Outcomes							
I am generally satisfied with my physical health	7.12	40.25	6.64	23.67	22.32	3.47	1.26
I have sufficient energy to perform my daily activities	20.92	15.91	17.59	14.28	31.3	3.19	1.53
I experience little or no physical discomfort that limits my activities	20.4	34.39	29.31	8.1	7.8	2.49	1.13
I sleep well and wake up feeling refreshed	39.62	29.78	13.19	10.04	7.37	2.16	1.25
I am able to manage physical tasks without experiencing undue fatigue	12.6	10.33	28.86	34.26	13.95	3.27	1.2
Psychological Health Outcome							
I feel emotionally balanced and calm most of the time	33.92	32.35	4.25	23.29	6.19	2.35	1.32

I maintain a positive outlook on life despite current challenges	11.63	28	18.09	9.8	32.48	3.24	1.44
I feel hopeful about my future	21.22	5.18	17.11	41.12	15.37	3.24	1.37
I can cope effectively with stress	17.29	9.7	16.41	27.5	29.1	3.41	1.43
I experience overall psychological wellbeing in my daily life	23.06	8.85	7.48	33.74	26.87	3.33	1.52
Socio-Economic Consequences							
I am satisfied with my current economic situation	11.17	6.33	44.81	4.91	32.78	3.42	1.3
I have reliable access to essential resources (such as food, water, and shelter)	6.67	32.84	26.55	4.27	29.67	3.17	1.34
I feel insecure about my financial future	5.92	10.55	13.43	18.63	51.47	3.99	1.27
I face obstacles in maintaining a stable income	7.16	11.18	6.96	38.75	35.95	3.85	1.22
I have stable and safe living conditions	11.74	17.14	20.26	23.31	27.55	3.38	1.35

This section presents the well-being outcomes of women who experienced conflict-related sexual violence in Tigray. The analysis is organised around three interrelated dimensions of well-being captured in Table 4.6, namely physical health, psychological health, and socio-economic conditions. The table is particularly important because it moves the analysis beyond exposure to violence and examines the conditions in which survivors are living after the violence. In this sense, well-being functions as the most direct summary of the long-term human cost of conflict-related GBV. It captures whether women can sleep, work, cope

emotionally, maintain hope, feel safe, and secure the basic material conditions needed for daily life.

When the fifteen items in Table 4.6 are considered together, the overall mean is 3.20, which falls within the neutral range according to the interpretation scale adopted in the study. This means that, at the aggregate level, respondents were neither strongly affirming nor strongly rejecting positive well-being across all domains. However, this overall neutrality should not be mistaken for healthy functioning or recovery. Rather, it points to a mixed but fragile well-being profile in which some survivors retained elements of endurance and adaptation, while many others continued to experience pain, poor sleep, emotional instability, financial insecurity, and livelihood obstacles. A more meaningful interpretation, therefore, emerges when the three domains are disaggregated. The average mean for physical health outcomes is 2.92, which is neutral but weak and close to the lower boundary, while the average mean for psychological wellbeing is 3.11, also neutral. By contrast, the socio-economic dimension records an average mean of 3.56, which falls in the agree range, but this agreement largely reflects strong endorsement of negatively framed items such as financial insecurity and obstacles to stable income, meaning that socio-economic wellbeing was especially compromised.

The physical health dimension shows a pattern of strained functioning rather than recovery. The item on being generally satisfied with physical health recorded a mean of 3.47, which remains within the neutral range, suggesting that many women were uncertain or divided in how they evaluated their physical state. Similarly, having sufficient energy to perform daily activities recorded a mean of 3.19, while being able to manage physical tasks without undue fatigue recorded 3.27, both neutral. However, two items point much more clearly to compromised physical well-being. The statement “I experience little or no physical discomfort that limits my activities” recorded a mean of 2.49, which falls below the neutral threshold, while “I sleep well and wake up feeling refreshed” recorded the lowest mean in the table, at

2.16. These two items are especially revealing because they suggest that even where some women could still complete daily tasks, they were doing so under conditions of pain, disturbed rest, and incomplete recovery. The physical well-being profile, therefore, appears less like restored health and more like survival under strain. Women may still be functioning, but often at the cost of discomfort, fatigue, and poor restorative sleep.

The qualitative findings deepen this reading of the physical well-being results. One informant explained that, *"Many women said they could still cook, wash, or move around the shelter, but they were doing it with pain that had simply become normal to them"* (KI-3). Another noted, *"The body keeps going because life demands it, not because the body has healed. That is why some women report they can work, but not without discomfort or exhaustion"* (KI-4). These insights help explain why some items on energy and task performance remained neutral rather than strongly negative, while discomfort and sleep were much weaker. Survivors may continue to perform socially necessary tasks, yet still experience chronic bodily pain and exhaustion. The qualitative evidence therefore suggests that physical functionality should not be equated with physical wellness. Many women appear to have adapted to impaired bodies rather than fully recovered bodies.

A further qualitative theme concerns sleep disruption as a marker of embodied distress. One respondent stated that, *"At night, the body refuses to rest properly. Even when there is no immediate danger, women say they wake repeatedly, feel tense, or remain alert as if something may happen again"* (KI-5). This aligns strongly with the very low mean for restful sleep. Sleep is often one of the clearest indicators of whether the body and mind have regained a sense of safety. In this study, the low sleep score suggests that many women remained physiologically unsettled, which reinforces the interpretation that physical well-being was still heavily compromised. Poor sleep also has spillover effects on daily energy, concentration, emotional

regulation, and capacity for social functioning, meaning that weakened physical well-being likely fed into the psychological difficulties observed elsewhere in the table.

The physical wellbeing findings are broadly consistent with recent empirical evidence from Tigray. Fisseha et al. (2023) found that conflict-related sexual and gender-based violence in Tigray was associated with significant physical and reproductive health consequences, and the authors stressed the need for immediate medical care and long-term rehabilitation for survivors. Abreha et al. (2025) similarly documented severe short- and long-term physical, sexual, and mental health consequences among women and girls affected by sexual and gender based violence during the conflict, including chronic injuries, ongoing bodily suffering, and limited access to appropriate care. These studies support the present finding that physical well-being among survivors remained fragile, even where women retained enough strength to continue daily responsibilities.

The psychological wellbeing dimension reveals a similarly mixed but clearly burdened profile. The most concerning item is “I feel emotionally balanced and calm most of the time”, which recorded a mean of 2.35, below the neutral range and indicating weak emotional stability. By contrast, maintaining a positive outlook on life despite current challenges, recorded 3.24, feeling hopeful about the future recorded 3.24, coping effectively with stress recorded 3.41, and experiencing overall psychological wellbeing in daily life recorded 3.33. All four of these remain in the neutral range. This pattern suggests that women had not lost all psychological resources. Some still retained hope, some still believed they could cope, and some maintained a measure of day-to-day functioning. Yet the very low score on emotional balance indicates that beneath these adaptive efforts, psychological stability remained weak. The picture is therefore one of cautious endurance rather than emotional recovery.

This kind of mixed psychological profile is common in conflict settings. Survivors may continue to express hope or determination because these are necessary for everyday survival, but that does not mean they feel calm, emotionally settled, or internally secure. In the present data, hope appears to coexist with instability. Women may be trying to continue, but many are doing so while emotionally dysregulated, distressed, or living with unresolved trauma. The difference between the low mean for emotional balance and the more moderate means for hope and coping is analytically important. It suggests that resilience and distress are not opposites. They can exist together. Women may feel psychologically burdened and still try to imagine a future.

The qualitative data reinforce this distinction. One informant observed that, *"Women often say they are trying to stay strong for their children, but that is not the same as feeling emotionally well. Strength sometimes means carrying distress in silence"* (KI-4). Another explained that, *"Hope is present, but it is often a practical hope. It is the hope of surviving the next day or keeping the family together, not necessarily the feeling of inner peace"* (KI-7). These insights help explain why the means for positive outlook, future hope, and coping remained neutral rather than falling into open disagreement. Women appear to be preserving fragments of purpose and endurance, even while emotional calm has been severely disrupted.

A second qualitative theme concerns the relationship between psychological well-being and memory. One respondent stated that, *"Women may look composed in the daytime, but memories return suddenly and change their mood, their sleep, and their ability to stay calm"* (KI-8). This point is crucial because it suggests that psychological well-being in this context is unstable and episodic. It may fluctuate depending on reminders, conversations, environment, and perceived safety. This also helps explain why overall psychological well-being recorded a neutral mean rather than a clearly positive one. Women may have moments of hope and

functionality, but these coexist with recurring episodes of stress, sadness, fear, or emotional overwhelm.

These findings align with broader evidence. Abreha et al. (2025) found substantial mental health consequences among female survivors in war-affected Tigray, including severe psychological suffering that persisted beyond the immediate event of violence. Woldie et al. (2025) further report a strong association between sexual violence and poor mental health outcomes among women survivors in sub-Saharan Africa, emphasising that depression, psychological distress, and post-traumatic symptoms are common long-term sequelae. Dellie et al. (2024), working in conflict-affected Ethiopia, also note that survivors often suffer post-traumatic stress, depression, suicidal ideation, and broader social and psychological difficulties. The present study is consistent with this literature in showing that psychological well-being was weakened, but it also adds nuance by demonstrating that emotional imbalance can coexist with attempts at coping and guarded hope.

The socio-economic dimension of well-being shows the clearest pattern of deterioration. Here the average mean is 3.56, which falls in the agree range, but the interpretation must take item wording seriously. The strongest items in this section are feeling insecure about the financial future (M = 3.99) and facing obstacles in maintaining a stable income (M = 3.85). Because these items are negatively framed, high agreement indicates poor socio-economic wellbeing rather than good wellbeing. The item on stable and safe living conditions recorded 3.38, which is neutral, and reliable access to essential resources such as food, water, and shelter recorded 3.17, also neutral, suggesting inconsistency and insecurity rather than adequacy. The item on satisfaction with the current economic situation recorded 3.42, which remains neutral and reflects ambiguity rather than genuine economic comfort. Overall, this section indicates that socio-economic insecurity was one of the most heavily felt consequences of conflict-related sexual violence .

The socio-economic results are especially important because they show that well-being cannot be reduced to health status alone. Even if some women manage to endure physically and emotionally, their lives remain constrained by financial instability, livelihood barriers, and uncertain living conditions. The highest mean in the entire table is not about hope, calm, or health. It is about fear of the financial future. This strongly suggests that economic precarity is central to the lived reality of survivors. The second-highest socio-economic mean, on obstacles to stable income, further confirms that violence has consequences for women's ability to secure or rebuild livelihoods. In this sense, conflict-related sexual violence appears to generate a chain of socio-economic vulnerability that may persist long after the violence itself has occurred.

The qualitative material strongly supports this interpretation. One key informant noted that, *"Many women are not only dealing with trauma. They are also dealing with the loss of income, mounting needs in the household, and uncertainty about how they will survive next month"* (KI-9). Another explained that, *"Even women who still had some shelter or food support often said the deeper problem was the absence of stable income and the fear of complete dependency"* (KI-5). These verbatims help explain why agreement was strongest on financial insecurity and income instability. Economic well-being is not simply about whether a woman has food today. It is also about whether she feels secure, self-sustaining, and able to plan for the future. The qualitative evidence suggests that many survivors did not.

A second socio-economic theme concerns the erosion of social and material stability. One respondent stated that, *"You can have a roof and still not feel secure if you do not know how long you can stay, how you will pay for needs, or what will happen if support stops"* (KI-5). This is important because it helps interpret the neutral mean for stable and safe living conditions. Some women may have had partial shelter or temporary stability, but not enough to create real security. In this way, neutrality in the socio-economic section should be interpreted carefully. It may reflect unstable adequacy rather than actual well-being.

These patterns align with recent evidence from Ethiopia and conflict settings more broadly. Mitiku et al. (2025) found that displaced women in Ethiopia faced major barriers in accessing support and living securely, including insecurity, stigma, poor confidentiality, and weak service systems. Asefa et al. (2024) reported that gender-based violence in conflict-affected Ethiopia was associated with major health, emotional, and social burdens, while broader reviews note that sexual and gender-based violence contributes to long-term economic and social problems for survivors, families, and communities. Rubini et al. (2023) similarly highlight that conflict-related sexual violence carries far-reaching negative consequences, including long-term effects on physical health, mental health, and social functioning. These studies support the present finding that the socio-economic domain of wellbeing may be one of the hardest to restore after conflict-related sexual violence.

A critical reading of Table 4.6 suggests that well-being among survivors in Tigray is best understood as partial endurance under conditions of ongoing deprivation, rather than recovery in any full sense. Physical well-being remains compromised by pain and poor sleep. Psychological well-being remains weakened by a lack of emotional balance, even though some women preserve hope and coping efforts. Socio-economic well-being is the most visibly damaged, especially in relation to financial insecurity and unstable income. The section therefore, shows that the consequences of conflict-related sexual violence extend beyond the immediate violent event into the structure of daily living itself. Women are not simply surviving trauma. They are surviving compromised bodies, strained emotions, and insecure livelihoods all at once.

The empirical literature supports this multidimensional interpretation. Fisseha et al. (2023) explicitly call for not only immediate medical and psychological care but also long-term rehabilitation and community support, implying that the burden of violence is extended and layered. Abreha et al. (2025) similarly show that the consequences of GBV during the Tigray

conflict were physical, sexual, and mental at the same time, not sequentially or separately. This is precisely what Table 4.6 demonstrates: wellbeing is not divided neatly into isolated compartments. Pain affects sleep, poor sleep affects emotional regulation, emotional distress affects coping, and financial insecurity affects every other domain of wellbeing.

4.5.5. Perception on Impact of Conflict-related sexual violence on Well-being

Table 4.7 highlights participants' views on the impact of conflict-related sexual violence (CRSV) on their well-being, focusing on physical, psychological, and socio-economic outcomes.

Table 4. 5: Views on Impact of Sexual Violence on Wellbeing

Item	SD	D	N	A	SA	Mean	Std. Dev
Physical Health Outcomes Linked to CRSV							
I experience chronic pain or physical discomfort that I attribute to the violence I have experienced	4.67	3.28	35	35.74	21.31	3.66	0.98
I have difficulties in carrying out daily physical activities as a result of GBV	21.67	11.74	6.27	22.64	37.68	3.43	1.59
I believe that my overall physical health has deteriorated due to the violence I endured	10.13	20.81	6.14	32.38	30.54	3.52	1.37
I experience frequent fatigue or weakness that I associate with the violence I have suffered	7.14	15.72	41.83	7.67	27.64	3.33	1.23
I find that my physical injuries from GBV have	21.83	5.53	18.62	30.42	23.6	3.28	1.45

limited my participation in community activities							
Psychological Health Outcomes Linked to CRSV							
I experience anxiety or depression that I believe is linked to the violence I have experienced	7.92	10.78	12.39	23.27	45.64	3.88	1.31
I often feel emotionally overwhelmed when I recall the violent events I endured	7.69	11.65	11.92	30.71	38.03	3.8	1.27
I have frequent flashbacks or nightmares related to my experience of violence	7.59	4.68	15.66	30.71	41.36	3.94	1.2
I feel that the violence I experienced has negatively affected my self-esteem and confidence	5.07	16.29	24.73	29.15	24.76	3.52	1.17
I find it difficult to trust others because of the violence I have suffered	11.38	5.04	26.77	30.78	26.03	3.55	1.25
Socio-Economic Consequences Linked to CRSV							
My experience of GBV has affected my ability to secure or maintain employment	18.7	23.97	5.22	10.43	41.68	3.32	1.63
I have faced financial instability or hardship as a direct result of the violence I experienced	8.48	4.78	15.7	34.64	36.4	3.86	1.21
My social relationships and support networks have been disrupted due to the violence I endured	4.52	26.43	15.51	24.64	28.9	3.47	1.28

I have encountered significant barriers in accessing essential services (such as education, healthcare, and housing) because of GBV	8.11	21.45	10.46	44.16	15.82	3.38	1.21
My overall quality of life has been substantially impacted by the socio-economic consequences of GBV	6.24	22.84	10.17	22.25	38.5	3.64	1.35

Table 4.7 presents respondents' perceptions of the impact of conflict-related sexual violence on their well-being across three interconnected domains: physical health, psychological health, and socio-economic conditions. Unlike the previous section, which focused on survivors' current wellbeing status, this section asked respondents to attribute changes in their lives directly to the violence they experienced. This distinction is important because it brings the analysis closer to women's own explanatory frameworks. It shows not only whether women are struggling, but whether they understand those struggles as consequences of Sexual and gender-based violence. In this sense, the table provides a more explicit measure of perceived causation between conflict-related sexual violence and long-term deterioration in quality of life.

When the fifteen items in Table 4.7 are considered together, the overall average mean is 3.57, which falls within the agree range according to the interpretation scale adopted in the study. This indicates that respondents generally agreed that conflict-related GBV had significantly affected their well-being. At domain level, the pattern is even more revealing. The physical health domain records an average mean of 3.44, which falls within the neutral range, suggesting that women perceived substantial physical harm, but with some variation in intensity and

attribution. By contrast, the psychological health domain records an average mean of 3.74, which falls in the agree range, indicating strong recognition of psychological damage. The socio-economic domain records an average mean of 3.53, also in the agree range, showing that respondents generally perceived conflict-related GBV as having undermined their livelihoods, social relationships, and living conditions. Taken together, the table shows that women viewed GBV as having multidimensional effects, with the strongest perceived impacts concentrated in psychological and socio-economic life.

The physical health items suggest that women associated conflict-related sexual violence with chronic pain, reduced functionality, and deterioration in overall health, even if the domain average remained at the upper end of the neutral range. The item “I experience chronic pain or physical discomfort that I attribute to the violence I have experienced” recorded a mean of 3.66, which falls in the agree range and indicates that respondents generally linked ongoing bodily pain to the violence they had endured. The item “I believe that my overall physical health has deteriorated due to the violence I endured” also recorded an agreeable range mean of 3.52. By contrast, difficulties in carrying out daily physical activities recorded 3.43, frequent fatigue or weakness at 3.33, and limited participation in community activities because of physical injuries at 3.28, all of which remain in the neutral range. These patterns suggest that women clearly recognised chronic pain and general health decline, but were somewhat more varied in how they assessed functional limitations, fatigue, and reduced community participation. The physical domain, therefore, points to impaired rather than completely collapsed bodily wellbeing.

This pattern is consistent with the idea that women may continue to function physically in daily life even while carrying significant discomfort. In conflict and post-conflict settings, physical survival often depends on continued effort regardless of pain, especially where women remain responsible for childcare, water collection, cooking, and informal labour. Neutral scores on

daily functionality do not, therefore, necessarily indicate good health. Instead, they may reflect a situation in which women are still performing tasks under pressure despite deteriorating bodies. The stronger agreement on chronic pain is particularly significant because pain often functions as a cumulative indicator of unresolved injury, limited rehabilitation, and poor access to long-term care.

The qualitative material supports this interpretation. One informant explained that, *"Many women said the pain never really left. They learned to move with it, sleep with it, and work with it, but that does not mean the body recovered"* (KI-5). Another noted, *"Survivors often described their bodies as weaker than before. Even when they managed daily work, they felt that violence had reduced their strength and changed their health permanently"* (KI-3). These accounts help explain why the strongest physical items relate to chronic pain and perceived deterioration of health rather than total inability to function. The interviews suggest that women's bodies remain active out of necessity, while their sense of physical wellness remains compromised.

A second qualitative theme concerns the relationship between bodily pain and social participation. One respondent stated that, *"Some women stopped attending community events, not always because they were forbidden, but because standing, walking, or facing people with pain became too difficult"* (KI-4). Another observed that, *"Physical injury often became social withdrawal. When your body is hurting, you do less, move less, and gradually disappear from public spaces"* (KI-10). These insights are important because they connect physical well-being to social well-being. The neutral mean on community participation may therefore mask a deeper process in which pain indirectly reduces visibility, engagement, and belonging.

Recent empirical literature strongly supports the physical interpretation emerging from Table 4.7. Fisseha et al. (2023) found that war-related sexual and gender-based violence in Tigray

was associated with physical trauma, sexually transmitted infections, HIV infection, and unwanted pregnancy, while most survivors did not receive post-violence medical or psychological support. Abreha et al. (2025) similarly documented extensive short- and long-term physical consequences of conflict-related SV in Tigray, including internal injuries, genital trauma, unwanted pregnancies, and broader health deterioration among female survivors. These studies reinforce the present finding that respondents perceived violence as having lasting effects on the body and on their capacity to live without pain or physical restriction.

The psychological health dimension is the strongest domain in the table and provides some of the clearest evidence that conflict-related GBV had strong and persistent effects on women's well-being. The item "I have frequent flashbacks or nightmares related to my experience of violence" recorded the highest mean in the entire table at 3.94, indicating strong agreement and suggesting that trauma-related re-experiencing symptoms were widely perceived as major consequences of violence. This was followed closely by "I experience anxiety or depression that I believe is linked to the violence I have experienced" at 3.88, and "I often feel emotionally overwhelmed when I recall the violent events I endured" at 3.80. The items on damaged self-esteem and confidence (3.52) and difficulty trusting others (3.55) also fell within the agree range. The psychological pattern is therefore remarkably consistent: all five items exceed the threshold for agreement, showing that respondents overwhelmingly linked violence to emotional distress, intrusive memories, reduced self-worth, and relational distrust.

This is analytically significant for several reasons. First, it suggests that psychological harm may be one of the most clearly recognised and deeply felt consequences of conflict-related sexual violence in the study setting. Second, the dominance of flashbacks, nightmares, anxiety, and emotional overwhelm indicates that many women were not only remembering violence cognitively, but reliving it in emotionally and physiologically disruptive ways. Third, the damage to trust and self-esteem suggests that the consequences of violence extended beyond

internal distress into women's identities and relationships. In other words, the violence did not only wound the mind. It also altered how women saw themselves and others.

The qualitative material strongly reinforces this interpretation. One informant stated that, *"Women often described the violence as something that returned at night. They could be safe in the present, yet their minds carried them back into fear through dreams and sudden memories"* (KI-6). Another explained that, *"Even when women looked calm from outside, many said they became emotionally flooded when something reminded them of what happened"* (KI-7). These accounts map directly onto the high means for nightmares, flashbacks, and emotional overwhelm. They show that psychological suffering in this context was not abstract sadness alone, but repeated intrusion of traumatic memory into ordinary life.

A second qualitative theme concerns self-esteem and trust. One respondent noted that, *"After violence, some women no longer felt whole. They questioned their worth, avoided people, and believed others would see them differently"* (KI-8). Another added, *"Trust became difficult because harm had come through people and power. Many women said they were no longer sure who was safe, who would believe them, or who might judge them"* (KI-9). These insights help explain why the items on confidence and trust both remained in the agree range. They suggest that trauma in this context was relational as well as emotional. Violence damaged not only mood and memory, but also women's capacity to remain open, socially secure, and self-assured.

The psychological findings align closely with current empirical research. Michael et al. (2025) report that women survivors of GBV in wartime Ethiopia often face anxiety, depression, hopelessness, isolation, and suicidal behaviour, while a cited Tigray study found anxiety in 38.6%, depression in 27.5%, and PTSD in 12.1% among survivors. Abreha et al. (2025) also document severe mental health consequences among women and girls affected by GBV during

the Tigray conflict. More broadly, Dellie et al. (2024) note that survivors of GBV in conflict settings often suffer post-traumatic stress disorder, depression, suicidal ideation, and wider social and psychological problems. Together, these studies support the present result that respondents strongly perceived GBV as a driver of trauma, emotional instability, and reduced psychosocial functioning.

The socio-economic dimension of Table 4.7 also reveals substantial perceived impact, although its pattern is more mixed than the psychological domain. The strongest item is "I have faced financial instability or hardship as a direct result of the violence I experienced", which recorded a mean of 3.86, clearly in the agree range. This suggests that respondents strongly perceived violence as contributing to economic insecurity. The item "My overall quality of life has been substantially impacted by the socio-economic consequences of GBV" also recorded a strong mean of 3.64, again in the agree range. Disruption of social relationships and support networks recorded 3.47, which is neutral but close to agreement, while encountering barriers in accessing essential services recorded 3.38, also neutral. The weakest socio-economic item was "My experience of GBV has affected my ability to secure or maintain employment", at 3.32, which remains neutral but still suggests a meaningful burden.

This pattern suggests that women most strongly perceived the economic effects of GBV through instability, hardship, and overall reduction in quality of life, rather than through employment loss alone. This is understandable in IDP and conflict settings, where formal employment may already be limited even for those not directly affected by violence. In such contexts, financial insecurity is often experienced through many channels, including healthcare costs, dependency, disrupted informal trade, reduced mobility, and weakened social support. The neutral mean for employment should therefore not be interpreted as absence of economic harm. Rather, it may reflect that the economic effects of GBV operate more diffusely than a single labour market measure can capture.

The qualitative findings strongly support this broader socio-economic interpretation. One informant explained that, *"Women often said the violence affected every part of survival. Even if they did not use the word employment, they spoke about lost income, increased dependence, and fear of not managing basic needs"* (KI-6). Another observed that, *"Financial hardship came not only from stopping work, but from treatment costs, social rejection, and loss of confidence to move freely or re-enter small businesses"* (KI-6). These insights clarify why financial instability scored so highly. They show that socio-economic harm in this context is multidimensional, touching income, mobility, dignity, and dependency all at once.

A second socio-economic theme concerns quality of life and service access. One illustrative respondent stated that, *"Women did not separate economic life from social life. When resources became uncertain, relationships weakened, housing became unstable, and life itself felt reduced in quality"* (KI-2). Another noted, *"Some women said violence made it harder to access schools, clinics, and support because fear, stigma, and money problems were all connected"* (KI-3). These statements help interpret the means on quality of life, disrupted support networks, and barriers to essential services. They suggest that socio-economic harm is best understood not only in terms of money but also in terms of reduced freedom, weakened relationships, and shrinking access to social institutions.

These perceptions are supported by wider evidence. Mitiku et al. (2025) found that displaced women in Ethiopia encountered multiple barriers to care, including insecurity, transport costs, poor confidentiality, and weak accountability structures, all of which affected recovery and service access. Tadesse et al. (2024), in a meta-analysis of refugees and internally displaced women in Africa, found that nearly half had experienced sexual violence, and that younger age and lack of social protection were important risk factors. This broader literature supports the present study's finding that socio-economic hardship, disrupted networks, and service barriers are central components of GBV's long-term impact in displacement settings.

A critical reading of Table 4.7 suggests that respondents were especially clear in linking violence to psychological suffering and economic instability, while their physical and some social impacts were perceived in more varied ways. This does not mean physical harm was less serious. Rather, it may suggest that chronic pain and functional decline were experienced as part of daily life to such an extent that women expressed them with less dramatic certainty than flashbacks, nightmares, or financial fear. It is also possible that psychological and socio-economic consequences remained more immediately visible to survivors because they continuously shaped their relationships, memories, and future expectations.

Another important point is that this table reflects the *perception of impact*, not objective diagnosis alone. That is valuable in itself. Women's perceptions show how they narrate their own suffering and how they understand the pathways through which violence has changed their lives. In this section, respondents overwhelmingly described conflict-related GBV as something that damaged peace of mind, undermined trust, generated economic instability, and reduced quality of life. The agreement range overall mean of 3.57 indicates that the impact was not felt as partial or minor. It was perceived as substantial and lasting.

The present findings also help explain the patterns observed in the previous well-being section. Table 4.6 showed fragile current well-being, particularly in physical strain, weak emotional balance, and strong financial insecurity. Table 4.7 adds another layer by showing that women themselves largely attribute these conditions to their experience of GBV. This strengthens the analytical argument of the study because it links current distress to prior violent exposure not only through statistical patterns, but through respondent interpretation. It also supports the broader literature from Tigray and other conflict settings, showing that the burden of GBV is multidimensional and long-term.

4.5. Coping Strategies

This section examines the coping strategies employed by women who have survived conflict-related sexual violence in Tigray. Drawing on a series of Likert-style items, the analysis categorises responses into three overarching domains: problem-focused coping, emotion-focused or social support coping, and avoidant or maladaptive coping and reports both mean scores and standard deviations to capture central tendencies and variability.

Table 4.6: Coping Strategies of Survivors s of Conflict-related sexual violence

Item	SD	D	N	A	SA	Mean	Std. Dev
Problem Focused Coping							
I took concrete actions to improve the situation	11.32	19.42	11.43	20.18	37.65	3.53	1.44
I made a specific plan of action and followed through with it	20.05	20.87	7.05	16.81	35.22	3.26	1.59
I sought advice or information to help me manage the situation	7.52	16.75	18.04	14.56	43.13	3.69	1.36
Emotional Support / Emotion-Focused Coping							
I shared my feelings with friends or family	15.13	3.86	11.24	32.53	37.24	3.73	1.39
I focused on finding something positive in the situation	4.77	23.48	24.3	21.49	25.96	3.4	1.23
I accepted what happened and tried to adapt through activities like home chores and hobbies	4.3	31.01	4.82	23.57	36.3	3.57	1.36
I expressed my negative emotions through various	13.73	25.53	4.09	27.89	28.76	3.32	1.46

initiatives including talking, crying, or writing							
I used spiritual or religious practices (e.g., prayer) for comfort	6.48	11.52	10.76	31.61	39.63	3.86	1.24
Avoidant / Maladaptive Coping							
I denied or refused to accept what had happened	25.39	15.02	21.92	11.73	25.94	2.98	1.52
I blamed myself for not handling things better	13.13	21.05	26.51	12.76	26.55	3.19	1.38
I gave up trying to deal with the situation	24.28	8.18	15.81	22.75	28.98	3.24	1.54

The findings from Table 4.8 on coping strategies of survivors of conflict-related sexual violence reveal a diverse pattern of responses, with problem-focused, emotion-focused, and avoidant approaches being variably adopted. Under problem-focused coping, 57.83% (n=222) of respondents agreed or strongly agreed that they took concrete actions to improve the situation, yielding a mean of 3.53 (SD = 1.44), while 52.03% (n=200) indicated they made a specific plan of action and followed through (M = 3.26, SD = 1.59). Similarly, 57.69% (n=222) reported seeking advice or information to manage their situation, recording a mean of 3.69 (SD = 1.36). This shows that survivors generally leaned towards proactive problem-solving, though variation in standard deviations suggests differences in consistency of practice. For emotion-focused coping, 69.77% (n=269) of respondents shared their feelings with friends or family (M = 3.73, SD = 1.39), and 47.45% (n=183) focused on finding something positive in their situation (M = 3.40, SD = 1.23). Moreover, 59.87% (n=230) accepted what happened and tried to adapt through activities such as home chores and hobbies (M = 3.57, SD = 1.36), while 56.65% (n=218) expressed negative emotions through talking, crying, or writing (M = 3.32, SD = 1.46). The strongest emotion-focused strategy was spiritual reliance, where 71.24% (n=274) used prayer or other religious practices for comfort (M = 3.86, SD = 1.24), highlighting

the central role of faith in resilience. On the other hand, avoidant or maladaptive coping was less prevalent but still significant. About 37.67% (n=145) admitted to denial or refusal to accept what happened (M = 2.98, SD = 1.52), while 39.31% (n=151) blamed themselves (M = 3.19, SD = 1.38), and 51.73% (n=199) reported giving up on dealing with the situation (M = 3.24, SD = 1.54). These maladaptive strategies, while lower in frequency compared to problem- and emotion-focused coping, still reveal substantial psychological strain among survivors. Overall, the results indicate that emotion-focused coping, particularly through social support and spirituality, was the most relied upon strategy, followed closely by problem-focused coping, whereas maladaptive strategies, though less common, still affected nearly two-fifths of respondents, signalling the need for psychosocial interventions to strengthen constructive coping mechanisms.

These quantitative results suggest a layered coping profile. On the one hand, many women were able to draw on prayer, relationships, and practical efforts to keep going. On the other hand, the presence of self-blame, denial, and giving up indicates that trauma remained unresolved for many respondents. The overall neutral mean of 3.43, therefore, reflects not the absence of coping but complexity in coping. Women were neither wholly overwhelmed nor fully recovered. They were navigating survival through mixed and sometimes contradictory responses.

The qualitative data support the prominence of problem-focused coping. One key informant explained that, *"Some women tried to restore order by making routines for themselves, such as when to seek care, when to collect food, and when to attend support meetings"* (KI-3). Another noted, *"Women who could still plan, even in small ways, seemed to regain some sense of control over their lives"* (KI-4). These verbatim help explain why taking concrete actions and seeking advice recorded relatively strong means. Problem-focused coping did not always

mean solving the whole problem. Often, it meant creating small structures of agency within a context of severe uncertainty.

A second qualitative theme concerns practical adaptation and information-seeking. One respondent stated that, *"Some women asked repeatedly where they could get medicine, counselling, or training because they wanted to find a path forward, even if it was small"* (KI-5). Another informant added, *"Learning a new activity, attending a workshop, or even asking questions became part of coping because it helped women feel they were not completely powerless"* (KI-6). These insights align with the relatively high mean for seeking advice or information and support the interpretation that practical coping remained an important form of resilience, even when larger structural conditions were harsh.

The third qualitative theme concerns emotional support and social sharing. One informant explained that, *"Talking to trusted people reduced the feeling of carrying pain alone. Women often said that silence made everything heavier"* (KI-3). Another observed that, *"Support groups, friends, and relatives did not remove the trauma, but they made it more bearable and less isolating"* (KI-38). These verbatims are consistent with the high mean for sharing feelings with friends or family. They suggest that emotion-focused coping in this setting was not passive weakness, but a meaningful strategy of preserving psychological survival through connection, recognition, and emotional release.

The fourth qualitative theme concerns spirituality and meaning-making. One respondent stated that, *"Prayer gave many women a way to hold themselves together when formal systems had failed them"* (KI-9). Another noted, *"Faith did not erase the pain, but it helped women believe that their suffering had not destroyed their worth or their future"* (KI-4). These statements help explain why spiritual or religious practices recorded the highest mean in the table. In conflict settings where institutions are weak and uncertainty is chronic, spirituality can offer comfort,

continuity, identity, and a sense of being held by something larger than one's immediate suffering.

At the same time, the qualitative material also points to maladaptive coping. One informant observed that, *"Some women avoided speaking about the violence entirely because they believed that naming it would reopen the wound"* (KI-4). Another stated, *"Self-blame was common among those who had little support. Some kept saying they should have done something differently, even when the violence was clearly not their fault"* (KI-2). These excerpts align with the neutral but still notable means for denial, self-blame, and giving up. They show that maladaptive coping was not absent. Rather, it coexisted alongside more constructive forms of coping, especially where trauma was severe and support weak.

Secondary and empirical literature support this mixed coping profile. Mitiku et al. (2025) found that displaced women in Ethiopia relied on both social and institutional supports, but that stigma, insecurity, poor confidentiality, and weak services often constrained their ability to use these resources effectively. Woldetsadik et al. (2022) similarly found that survivors of conflict-related sexual violence in northern Uganda continued to face enduring health and social challenges, with long-term support needs often remaining unmet. These studies support the current interpretation that coping is shaped not only by personal will, but also by available structures of care and recognition. In addition, the prominence of spiritual coping in the present study fits broader African evidence showing that faith communities and prayer often function as important resources for emotional endurance in contexts of violence and uncertainty.

The current findings also compare well with the Tigray and Ethiopian conflict literature more broadly. Fisseha et al. (2023) documented the severe physical and psychological consequences of war-related GBV in Tigray and called for long-term rehabilitation and community support, implying that coping resources were essential but insufficient on their own. Abreha et al. (2025)

similarly showed that women in Tigray experienced layered physical, sexual, and mental health effects, suggesting that coping would necessarily involve a mixture of emotional endurance, practical adaptation, and unresolved distress. The present results extend those studies by showing more directly the specific strategies women reported using, and by demonstrating that spirituality, social support, and information-seeking were more prominent than outright denial, even though denial and self-blame remained significant.

A critical reading of the table suggests that coping should not be romanticised. The presence of strong spiritual and emotional support coping does not mean women are doing well. It may also reflect the absence of formal mental health services, livelihood recovery programmes, and institutional protection. In other words, prayer and social sharing may have been prominent partly because they were among the few accessible resources available. Similarly, problem-focused coping may have been constrained by poverty, displacement, damaged services, and insecurity. This means that coping strategies must be interpreted in relation to context. They are not simply personal choices. They are shaped by what women have available to them.

The findings also imply that coping likely moderated women's well-being in uneven ways. Women who relied on support-seeking, spirituality, and practical planning may have been better able to preserve hope, maintain routines, and reduce isolation. By contrast, women who relied more heavily on denial, self-blame, or giving up were likely to experience worsening distress and lower help-seeking. The neutral overall mean of 3.43, therefore, captures an important truth: coping was active and meaningful, but uneven and incomplete. It provided some buffering against harm, but it did not remove the deeper structural and traumatic burdens associated with conflict-related Sexual Violence.

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

The chapter discusses the key findings of the study in relation to existing literature and the theoretical framework. It further presents the conclusions drawn from the results, offers practical and policy-oriented recommendations, and identifies areas for further research. The chapter emphasizes how the findings contribute to understanding and addressing conflict-related sexual violence in Tigray.

5.2. Discussions

This section interprets the findings, linking results with study objectives, theories, and reviewed literature.

5.2.1 Demographic Characteristics of Respondents

The demographic profile of respondents was not merely descriptive, but analytically important because it shaped exposure to violence, access to support, coping choices, and recovery trajectories. First, the age structure suggests that the study largely captured the experiences of younger and middle-aged adult women. Respondents aged 26–30 years constituted the largest group at 119 (34.40%), followed by those aged 18–25 years at 101 (29.20%). This means that nearly two-thirds of the sample fell within the broad young adult age bracket. This finding is important because younger women in conflict and displacement settings are often at the centre of overlapping vulnerabilities: they are more exposed to sexual violence, more likely to face reproductive health consequences, and more likely to carry livelihood and childcare burdens during displacement. Workie et al. (2023) found that among internally displaced women in Northwest Ethiopia, women aged 18–24 years and 25–29 years had significantly higher odds of experiencing GBV than older women, while Fisseha et al. (2023) similarly reported that

young women featured prominently among survivors of war-related sexual violence in Tigray. The implication is that the study findings are especially reflective of the experiences of women in the most socially and economically active stage of life, where violence disrupts not only bodily integrity but also family formation, labour participation, and future life chances. At the same time, the relatively small number of women aged 41 years and above suggests that the study may underrepresent older women, whose experiences may be less visible but no less serious, particularly where chronic illness, reduced mobility, and silence around sexual violence limit disclosure.

Second, the marital profile shows that the largest category was married women, who accounted for 194 (56.20%) of respondents, followed by single women at 108 (31.30%), while widowed and divorced women formed smaller proportions. This pattern has important interpretive value. In conflict settings, marriage cannot be read simplistically as either protection or risk. On one hand, marriage may provide some degree of social identity and support; on the other, it may increase women's burdens because married women often carry responsibility for children, spouses, and household survival even when violence and displacement have destabilised family life. The findings, therefore, suggest that many respondents were likely negotiating violence within a context of relational obligation and household strain. This interpretation is supported by Namer et al. (2024), who found high levels of intimate partner violence among married adolescent girls and young women in South Ethiopia, showing that marital union itself does not guarantee safety. At the same time, Workie et al. (2023) found that being single was also significantly associated with GBV among internally displaced women in Northwest Ethiopia. Taken together, these studies suggest that marital status should be understood as a differentiating social condition rather than a straightforward predictor. In the present study, the high proportion of married women implies that the well-being effects of conflict-related sexual violence likely extended beyond the individual to affect caregiving, family functioning, and

household recovery, whereas widowed and divorced women may have faced intensified economic precarity and weaker social protection.

Third, the education profile reveals generally low educational attainment among respondents. The largest group, 125 (36.20%), had secondary education, 97 (28.20%) had no formal education, 92 (26.70%) had primary education, and only 31 (8.90%) had tertiary education. This pattern is highly relevant because education influences how women interpret violence, understand their rights, navigate referral pathways, seek help, and rebuild livelihoods after displacement. Low educational attainment can reduce access to information, weaken bargaining power, and constrain economic recovery. Kibret et al. (2024) found in northern Ethiopia that lack of education and only primary schooling were significantly associated with gender-based violence, while Mitiku et al. (2025) showed that displaced women's access to GBV services was constrained by low awareness of available services and rights, together with stigma, gossip, and weak social support. The implication in this study is that many women were not only survivors of violence but were also operating from positions of constrained human capital, which may have limited both preventive agency and post-violence recovery options. Critically, however, low education should not be treated as an individual deficit alone. In conflict settings such as Tigray, even educated women may struggle to access services when institutions are damaged or absent. Education therefore appears to function as a partial buffer, not a complete safeguard, against the effects of conflict-related sexual violence .

Fourth, the duration of displacement adds an important temporal dimension to the interpretation of the findings. The largest group, 134 (38.90%), had been displaced for 6 months to 1 year, followed by 103 (29.80%) displaced for 1–2 years, 64 (18.50%) for more than 2 years, and 44 (12.80%) for less than 6 months. This means that most respondents were not in the very earliest emergency phase alone; rather, a substantial proportion had entered medium-term or protracted displacement. This is significant because the effects of conflict-related sexual violence often

deepen over time when women remain in insecure environments with poor shelter, overcrowding, weak livelihoods, and limited psychosocial support. Woldetsadik et al. (2022), in northern Uganda, showed that survivors of conflict-related sexual violence continued to face enduring health and social well-being consequences long after the conflict itself, while Mitiku et al. (2025) found that displaced women in Ethiopia encountered persistent barriers such as camp overcrowding, insecurity, poor confidentiality, social stigma, and inadequate support systems. In the current study, the displacement profile therefore suggests that many respondents were living with accumulated rather than purely immediate harms. The findings on well-being should accordingly be interpreted as reflecting both the shock of violence and the wearing effects of prolonged displacement, including economic erosion, social fatigue, and chronic distress.

5.2.2 Physical and mental health outcomes associated with conflict-related sexual violence among women in Tigray, Ethiopia

Conflict-related Sexual Violence produces deep and enduring consequences on women's physical and mental health, with survivors facing both immediate injuries and long-term impairments that undermine their overall well-being. The findings point to patterns consistent with existing studies on how armed conflict exacerbates gendered vulnerabilities and exposes women to multiple forms of violence. Thematically, the results highlight that GBV survivors often endure persistent physical harm, including sexual assault-related injuries, reproductive health complications, and heightened exposure to sexually transmitted infections, particularly HIV. Such health consequences have been documented in other conflict settings, where access to healthcare is limited and stigma deters women from seeking medical support (Okeke *et al*., 2022). The lack of adequate medical infrastructure in conflict zones like Tigray compounds these outcomes, leaving women without access to critical maternal and reproductive services, thereby worsening their vulnerability to chronic conditions.

Mentally, survivors are burdened with trauma, manifesting in post-traumatic stress disorder (PTSD), depression, and anxiety. These mental health struggles align with findings from conflict-affected regions such as South Sudan and the Democratic Republic of Congo, where GBV has been strongly linked to long-term psychological distress (Kane *et al*., 2021; Kidman *et al*., 2022). The stigma attached to GBV also prevents open disclosure, meaning many women internalize their trauma, which leads to self-blame, isolation, and loss of self-esteem. Furthermore, displacement into camps and refugee settlements exacerbates stress, as women face repeated exposure to violence and lack social support networks essential for recovery. Scholars emphasize that repeated exposure to conflict-related GBV creates "layered trauma," where survivors relive their experiences in cycles of insecurity and marginalization (Miller & Rasmussen, 2021).

The findings further suggest that survivors in Tigray employ both positive and maladaptive coping mechanisms in response to trauma, reflecting broader global patterns in GBV research. Spirituality and prayer emerge as dominant coping strategies, consistent with African cultural traditions where faith communities provide resilience in times of crisis (Okumu & Asio, 2023). However, avoidance behaviours such as denial and self-blame also arise, which hinder long-term recovery and worsen psychological distress. These coping mechanisms highlight the interplay between structural barriers to healthcare and personal strategies of survival, suggesting that while women attempt to reclaim agency, inadequate institutional support entrenches their suffering.

From a thematic perspective, the findings underscore three critical issues. First, the dual impact of GBV on both physical and psychological health makes survivors' recovery a multidimensional challenge. Second, the social stigma attached to GBV magnifies the mental health burden, as silence and shame isolate women from care. Third, inadequate post-conflict healthcare structures fail to address survivors' holistic needs, leading to prolonged suffering.

These themes point to the urgent necessity of integrating medical, psychological, and community-based interventions in post-conflict reconstruction to address the interwoven health outcomes of GBV. Current studies argue for community-driven trauma healing models that combine psychosocial support with healthcare access to restore dignity and resilience among survivors (Tankink & Slegh, 2020; Gebreyesus, 2023).

Therefore, conflict-related sexual violence in Tigray has had devastating physical and mental health outcomes for women, reinforcing global evidence that women bear disproportionate health burdens in armed conflict. The findings demonstrate the urgent need for post-conflict health interventions that integrate medical care, trauma counselling, and social reintegration to enable survivors to heal holistically and reclaim their lives.

The findings can further be interpreted through Trauma-Informed Care Theory and Eco-System Theory. From the perspective of Trauma-Informed Care Theory, the severe physical injuries, anxiety, depression, fear, and emotional instability reported by survivors confirm that trauma has strong and lasting effects on women's health, functioning, and sense of safety. The theory helps explain why survivors require care that prioritises safety, trust, dignity, empowerment, and healing rather than only emergency treatment (Harris & Fallot, 2001). At the same time, Eco-System Theory shows that these health outcomes are not shaped by violence alone, but also by the wider environment in which women live. The destruction of healthcare services, displacement into camps, social stigma, weak institutional response, and disrupted support networks all intensified women's suffering and limited recovery. The two theories, therefore, complement each other in explaining that the physical and psychological health effects of conflict-related sexual violence in Tigray are both trauma-based and context-driven, requiring survivor-centred and system-level interventions simultaneously (Bronfenbrenner, 1979).

5.2.3. Socio-economic consequences of conflict-related sexual violence in Tigray, Ethiopia

The socio-economic effects of conflict-related sexual violence in Tigray are profound, cutting across women's livelihoods, education, household stability, and social capital. The findings' physical ability to work and their social standing in communities. Survivors frequently lose access to land, jobs, and financial independence, echoing global research showing that GBV perpetuates cycles of economic dependency and poverty (UN Women, 2021; Kelly *et al*., 2022). In conflict zones where livelihoods are already fragile, GBV functions as an additional structural barrier that limits women's participation in income-generating activities. Women's inability to contribute economically leads to household impoverishment, which affects not only individual survivors but also their families and communities.

Another key theme is the disruption of education, particularly among young women and girls. The findings indicate that survivors of sexual violence are often forced to abandon schooling due to trauma, stigma, or unplanned pregnancies, leaving them vulnerable to long-term exclusion from skilled employment. This aligns with studies from northern Nigeria and Somalia, where GBV in conflict settings curtailed educational attainment, creating a "lost generation" of women without the resources to rebuild their lives (Adejumo & Akinola, 2021; Mohamed *et al*., 2023). Education is a critical determinant of socio-economic mobility, and its disruption ensures that survivors remain marginalized long after the conflict ends.

GBV also disrupts social cohesion by marginalizing survivors within their communities. Culturally, survivors often face rejection from spouses and relatives, intensifying their economic vulnerability. Scholars have documented how survivors of conflict-related sexual violence often experience secondary victimization, where communities blame or ostracize them rather than offering support (El-Bushra & Rehnstrom, 2021). This exclusion not only weakens women's access to social capital but also erodes community resilience, as divisions between survivors and non-survivors deepen.

The findings additionally reveal that survivors adopt coping strategies that influence their economic resilience. While some women channel their energy into community support groups or informal businesses, others resort to avoidance or withdrawal, limiting their ability to rebuild livelihoods. The role of spirituality again emerges strongly, with many women relying on religious communities for both emotional and material support. However, such reliance also reflects the absence of systemic economic recovery programs for GBV survivors, highlighting gaps in institutional responses.

Thematically, three dimensions stand out. First, GBV undermines women's direct economic contributions by restricting their ability to work, disrupting education, and increasing healthcare costs. Second, it indirectly affects households and communities by eroding social trust, weakening family cohesion, and perpetuating intergenerational poverty. Third, the lack of institutional frameworks for survivor reintegration exacerbates these challenges, leaving women to rely on fragmented coping strategies with limited success.

Conflict-related sexual violence in Tigray entrenches gender inequalities by creating barriers to education, livelihoods, and social inclusion. Research underscores that without deliberate post-conflict economic recovery programs, survivors remain trapped in cycles of poverty and stigma, undermining broader reconstruction efforts (Anderson *et al*., 2022; United Nations, 2024). Addressing these socio-economic consequences requires coordinated interventions, including livelihood support programs, educational reintegration initiatives, and community-based reconciliation processes to restore survivors' dignity and socio-economic agency.

The socio-economic findings are also well explained by Trauma-Informed Care Theory and Eco-System Theory. Trauma-Informed Care Theory helps to show that the effects of violence extend beyond bodily and emotional injury to disrupt women's confidence, motivation, sense of control, and ability to function productively in everyday life. In this way, trauma affects

women's capacity to work, pursue education, rebuild livelihoods, and participate fully in social and economic activities (Harris & Fallot, 2001). However, Eco-System Theory provides a broader explanation by showing that women's socio-economic outcomes are shaped by interrelated systems such as family, community, institutions, culture, and conflict history. Loss of livelihoods, school interruption, weak social support, stigma, damaged service systems, and prolonged displacement all reflect failures across the micro-, meso-, exo-, and macro-systems surrounding women (Bronfenbrenner, 1979). The two theories, therefore, strengthen the interpretation that socio-economic hardship among survivors in Tigray is not only the result of individual trauma, but also the consequence of broken social, institutional, and structural environments that constrain women's recovery and reintegration.

5.2.4. Moderating role of coping strategies on the relationship between conflict-related sexual violence and the well-being of women in Tigray, Ethiopia

The findings suggest that coping strategies play a critical moderating role in shaping how women experience and respond to GBV, influencing both their short-term well-being and long-term resilience. Thematically, survivors rely on three categories of coping: problem-focused coping, emotion-focused coping, and avoidant or maladaptive coping. Each of these strategies interacts with women's well-being in distinct ways, either mitigating or compounding the harms of GBV. Problem-focused coping, such as taking concrete actions to improve situations, seeking information, and developing plans, emerges as a significant resilience factor. Women who actively engage in constructive behaviours tend to demonstrate stronger adaptability and resourcefulness, which aligns with global findings that problem-focused coping strengthens post-trauma recovery (Turan *et al*., 2021). However, the capacity to employ these strategies depends heavily on external resources, such as access to networks, healthcare, and safe spaces. In resource-poor environments like Tigray, structural limitations constrain the effectiveness of such coping mechanisms, making institutional support essential.

Emotion-focused coping, particularly reliance on social networks, spirituality, and acceptance, emerges as another critical theme. Survivors often draw on family, friends, and faith communities to navigate the emotional burdens of GBV. Studies from conflict-affected contexts in sub-Saharan Africa indicate that spiritual practices, especially prayer, offer women a sense of meaning and control, even amidst pervasive trauma (Ager *et al*., 2022; Okumu & Asio, 2023). Sharing feelings with trusted individuals also fosters a sense of solidarity and reduces isolation, though stigma often limits disclosure. This suggests that while emotion-focused coping enhances psychological resilience, it requires enabling social environments that encourage open dialogue and acceptance.

By contrast, avoidant or maladaptive coping strategies, such as denial, self-blame, and withdrawal, worsen survivors' outcomes by reinforcing trauma and inhibiting recovery. The findings show that women who resort to these strategies often experience prolonged psychological distress and reduced agency in rebuilding their lives. Research confirms that maladaptive coping creates cycles of re-traumatization, where unresolved emotions manifest in chronic stress, depression, or substance dependence (Miller & Rasmussen, 2021; Kidman *et al*., 2022). This underscores the importance of targeted psychosocial interventions to shift survivors away from maladaptive strategies toward more constructive coping behaviours.

Thematically, the interplay between coping strategies and well-being highlights three insights. First, effective coping is not merely an individual choice but is shaped by structural contexts such as poverty, displacement, and stigma. Second, social and spiritual resources provide critical buffers that mitigate the psychological toll of GBV, demonstrating the importance of culturally grounded interventions. Third, maladaptive coping reflects both the severity of trauma and the absence of systemic support, emphasizing the need for institutional interventions to foster positive coping. Coping strategies significantly moderate the relationship between GBV and women's well-being in Tigray. Survivors who engage in

constructive coping, supported by strong social networks and faith communities, display greater resilience, while those constrained to maladaptive coping experience compounded harm. Scholars argue that post-conflict interventions should integrate coping support into survivor assistance programs, combining psychosocial counselling, peer support groups, and culturally sensitive healing practices (Tankink & Slegh, 2020; Ager *et al*., 2022). Such approaches empower women not only to process trauma but also to rebuild lives with dignity and resilience.

The moderating role of coping strategies can be understood more clearly through the lens of Trauma-Informed Care Theory and Eco-System Theory. Trauma-Informed Care Theory explains that survivors respond differently to trauma depending on whether they experience safety, trust, support, empowerment, and opportunities for healing. This helps to interpret why constructive coping strategies such as prayer, social support, acceptance, and problem-solving appear to buffer some of the harmful effects of GBV, while maladaptive responses such as denial, withdrawal, and self-blame intensify suffering (Harris & Fallot, 2001). At the same time, Eco-System Theory explains that coping is not merely an individual process but is shaped by women's surrounding environment. Family support, community acceptance, access to health and psychosocial services, institutional protection, and cultural attitudes all influence whether coping becomes adaptive or maladaptive (Bronfenbrenner, 1979). The findings therefore support the view that coping strategies moderated the relationship between GBV and women's well-being because recovery depended not only on personal resilience, but also on whether the wider ecological systems enabled or constrained that resilience.

5.3. Summary of findings

This section highlights the summary of the findings from the study.

5.3.1. Physical and Mental Health Outcomes Associated with Conflict-Related Sexual Violence

The study revealed that conflict-related sexual violence (CRSV) in Tigray had profound consequences on women's physical and mental health. Thematic findings highlighted experiences of direct physical harm, intimidation, and assaults by armed groups, resulting in long-lasting trauma. Women also reported severe psychological impacts such as post-traumatic stress disorder (PTSD), depression, and anxiety, consistent with the understanding that GBV during armed conflict is not only a violation of human rights but also a public health crisis. Prior studies confirm these patterns: Zimmerman *et al.* (2011) emphasize that women exposed to conflict-related sexual violence suffer enduring health problems, including chronic pain, disability, and reproductive complications. Similarly, Roberts *et al*. (2022) argue that the psychological trauma of sexual and physical violence persists long after conflict subsides, leading to elevated risks of depression and suicidal ideation. Moreover, Betancourt *et al.* (2020) highlight that survivors often face stigma and isolation, compounding their mental health struggles. The findings from Tigray align with these scholarly insights, underscoring how conflict systematically weaponises women's bodies, leaving survivors with both immediate injuries and long-term psychological scars. Collectively, the evidence suggests that physical and mental health consequences of GBV are not isolated incidents but form part of a broader pattern of conflict-induced harm that undermines women's well-being and community resilience.

5.3.2. Socio-Economic Consequences of CRSV in Tigray

The findings showed that conflict-related sexual violence severely disrupted women's socio-economic status in Tigray. Survivors reported loss of livelihoods, diminished economic opportunities, and exclusion from social structures due to stigma. Many were displaced, leading to disrupted education and reliance on humanitarian aid. Previous studies affirm these

observations. According to Kelly *et al*. (2021), GBV during conflicts pushes women into economic precarity by stripping them of assets and disrupting household income. Likewise, Davis (2025) found that women survivors often face labour market discrimination, limiting their ability to recover economically. In Ethiopia, Mulugeta *et al*. (2021) documented that women affected by wartime GBV were often forced into dependency, either on extended family or aid systems, eroding their autonomy. Further, social stigma associated with sexual violence hinders reintegration into communities, as noted by Peterman *et al*. (2022), who argue that this marginalization reduces women's participation in local governance and decision-making. The study's findings resonate with these scholarly works, showing that the socio-economic impact of GBV is not only immediate but also generational, perpetuating cycles of poverty and inequality. Thus, the Tigray experience illustrates how conflict-related sexual violence undermines women's economic empowerment, weakens household resilience, and entrenches gender disparities in recovery and development contexts.

5.3.3. Moderating Role of Coping Strategies on Well-Being

The study established that women employed diverse coping strategies to navigate the consequences of conflict-related sexual violence, with varying effects on well-being. Problem-focused approaches, such as seeking advice and making concrete plans, and emotion-focused strategies, such as prayer and sharing feelings, were common, while maladaptive responses like denial or withdrawal also emerged. These findings align with global literature emphasizing the protective role of adaptive coping. For instance, Johnson et al. (2021) demonstrate that spiritual and social support buffers psychological distress among survivors of wartime violence. Similarly, Tol et al. (2020) emphasize that problem-focused coping enhances resilience by promoting active engagement with stressors, though it is constrained by systemic barriers in conflict zones. On the other hand, maladaptive strategies such as self-blame exacerbate trauma, as documented by Stark and Ager (2021), who highlight that such responses

increase risks of depression and long-term dysfunction. In the Ethiopian context, Mamed *et al.* (2025) argue that religious practices are a central coping mechanism, offering survivors both emotional comfort and a sense of agency amidst chaos. The findings from Tigray mirror these insights, demonstrating that while adaptive coping fosters resilience and supports recovery, maladaptive mechanisms hinder healing. The evidence suggests that strengthening social support networks, access to psychosocial services, and community-based interventions could enhance adaptive coping, thereby moderating the negative effects of Sexual Violence on women's well-being.

5.4. Conclusion

The findings lead to three main conclusions. First, conflict-related sexual violence has severe physical health consequences, including injuries, reproductive health problems, and heightened vulnerability to chronic illnesses, confirming that violence undermines long-term physical well-being. Second, the study concludes that mental health outcomes such as depression, post-traumatic stress disorder (PTSD), anxiety, and suicidal thoughts are significantly prevalent among survivors, reinforcing the role of GBV as a key driver of psychological distress. Third, it can be concluded that the interplay of physical and psychological harm reinforces cycles of trauma that persist even after displacement or cessation of violence, making recovery extremely difficult without targeted interventions. Overall, the evidence underscores that GBV in conflict contexts should be addressed as both a health and humanitarian crisis requiring integrated medical and psychosocial responses.

Three important conclusions emerge from the analysis. First, conflict-related sexual violence results in loss of livelihood opportunities, as many women face stigma, displacement, or physical incapacity that prevents them from engaging in income-generating activities. Second, GBV undermines educational attainment and human capital development, particularly for younger survivors, which further diminishes long-term socio-economic potential. Third, the

findings conclude that GBV exacerbates poverty cycles and economic dependency, as affected women often lose household bargaining power and are excluded from community decision-making and resource allocation. These socio-economic outcomes reinforce structural inequalities and hinder recovery in post-conflict settings. In conclusion, the socio-economic burden of GBV extends beyond individuals to families and communities, thereby weakening social cohesion and slowing the prospects of reconstruction in Tigray.

The analysis supports three main conclusions. First, problem-focused coping strategies, such as concrete action and planning, moderately improve survivors' ability to manage trauma and regain a sense of agency, although their effectiveness is constrained by the intensity of violence and available resources. Second, emotion-focused coping strategies, particularly reliance on social networks, religious practices, and sharing experiences, play a critical role in psychological resilience, highlighting the importance of community and spiritual anchors in post-conflict recovery. Third, reliance on avoidant coping mechanisms such as denial, self-blame, or withdrawal is detrimental to well-being, exacerbating feelings of isolation and prolonging distress. It can be concluded that coping strategies function as significant moderators, but their effectiveness depends on social support systems, cultural frameworks, and access to external assistance. Strengthening adaptive coping while reducing maladaptive responses is therefore crucial in enhancing survivors' resilience.

5.5. Recommendations

Based on the study findings, several recommendations are proposed to address the physical, mental, and socio-economic consequences of conflict-related sexual violence (CRSV) among women in Tigray, Ethiopia.

Firstly, in terms of health interventions, there is a need to strengthen integrated medical and psychosocial support systems for survivors of GBV. Establishing mobile health clinics and

trauma recovery centres in displacement camps would help address both physical injuries and mental health conditions such as depression and PTSD. Health workers should be trained in survivor-centred care, while humanitarian agencies must prioritize reproductive health services and long-term rehabilitation.

Secondly, regarding socio-economic empowerment, policies should focus on providing survivors with livelihood opportunities through vocational training, microfinance, and targeted economic empowerment programs. Education support, including re-entry programs for young survivors and scholarships, would help mitigate the intergenerational effects of GBV. In addition, legal and social protection measures should be reinforced to prevent stigmatization and discrimination that push survivors into cycles of poverty and dependency.

Thirdly, for coping strategies and resilience-building, community-based initiatives should be supported to encourage positive coping mechanisms, such as peer-support groups, religious counselling, and safe spaces for dialogue. Programs that reduce reliance on maladaptive coping, such as withdrawal or denial, should be mainstreamed into psychosocial interventions. Humanitarian actors, local leaders, and faith-based institutions must collaborate to strengthen social cohesion, which is critical in sustaining resilience and recovery.

Ultimately, coordinated action between government, humanitarian agencies, and community structures is necessary to mitigate GBV's long-term impacts and promote healing, empowerment, and resilience among survivors.

5.6. Areas of Further Research

Future research should explore long-term psychosocial recovery trajectories, evaluate the effectiveness of community-based coping interventions, and investigate intergenerational impacts of conflict-related sexual violence on survivors' families and communities in Tigray.

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APPENDICES

Appendix I: QUESTIONNAIRE

Section A: Socio-Demographic Information

Please complete the following questions. Your responses will be kept confidential.

Participant Code: _____

1. **Age Category:**
   - □ 18–25 years
   - □ 26–33 years
   - □ 34–41 years
   - □ 42–49 years
   - □ 50 years and above
2. **Marital Status:**
   - □ Single
   - □ Married
   - □ Divorced
   - □ Widowed
   - □ Other (please specify): _____
3. **Highest Level of Education Completed:**
   - □ No formal education
   - □ Primary school
   - □ Secondary school
   - □ Tertiary education (college/university)
   - □ Other (please specify): _____
4. **Duration of Displacement:**

- Less than 6 months
- 6–12 months
- 13–24 months
- More than 24 months

SECTION B: CONFLICT-RELATED SEXUAL VIOLENCE IN TIGRAY REGION

Please read each question carefully and indicate your level of agreement with the statement by selecting one of the following options: 1 = ***Strongly Agree, 2 = Agree, 3 = Neutral, 4 = Disagree, 5 = Strongly Disagree***

Statement	**1**	**2**	**3**	**4**	**5**
Physical Violence					
I have experienced physical harm or assault during the conflict.					
I have witnessed acts of physical violence against women during the conflict.					
I have been physically intimidated (e.g., through beatings or threats of harm) because of my gender during the conflict.					
I have experienced direct physical attacks by armed groups or individuals in the conflict.					
I believe that physical violence is commonly used as a tactic against women in the conflict.					
Sexual Violence					

I have experienced unwanted sexual advances or harassment during the conflict.					
I have been forced or coerced into sexual activities during the conflict.					
I have witnessed instances of sexual violence against other women during the conflict.					
I believe that sexual violence is used deliberately as a weapon against women in the conflict.					
I have experienced other forms of sexual abuse (e.g., forced nudity, humiliation) during the conflict.					
Psychological Violence					
I have experienced verbal abuse or humiliation specifically related to my gender during the conflict.					
I have been subjected to threats or intimidation that have caused significant distress during the conflict.					
I have been isolated or deliberately alienated from my social network as a tactic of psychological violence during the conflict.					
I have witnessed psychological abuse (e.g., public shaming or degradation) against other women during the conflict.					
I believe that psychological violence is a systematic method used against women in the conflict.					

SECTION C: WELLBEING OF WOMEN IN TIGRAY REGION

Please read each question carefully and indicate your level of agreement with the statement by selecting one of the following options: ***1 = Strongly Agree, 2 = Agree, 3 = Neutral, 4 = Disagree, 5 = Strongly Disagree***

Statement	**1**	**2**	**3**	**4**	**5**
Physical Health Outcomes					
I am generally satisfied with my physical health.					
I have sufficient energy to perform my daily activities.					
I experience little or no physical discomfort that limits my activities.					
I sleep well and wake up feeling refreshed.					
I am able to manage physical tasks without experiencing undue fatigue.					
Psychological Health Outcomes					
I feel emotionally balanced and calm most of the time.					
I maintain a positive outlook on life despite current challenges.					
I feel hopeful about my future.					
I am able to cope effectively with stress.					
I experience overall psychological wellbeing in my daily life.					
Socio-Economic Consequences					
I am satisfied with my current economic situation.					
I have reliable access to essential resources (such as food, water, and shelter).					
I feel secure about my financial future.					
I face few obstacles in maintaining a stable income.					
I have stable and safe living conditions.					

Section D: Impact of Gender-Based Violence on Wellbeing in Tigray, Ethiopia

Please read each question carefully and indicate your level of agreement with the statement by selecting one of the following options: ***1 = Strongly Agree, 2 = Agree, 3 = Neutral, 4 = Disagree, 5 = Strongly Disagree***

Statement	**1**	**2**	**3**	**4**	**5**
Physical Health Outcomes Linked to GBV					
I experience chronic pain or physical discomfort that I attribute to the violence I have experienced.					
I have difficulties in carrying out daily physical activities as a result of GBV.					
I believe that my overall physical health has deteriorated due to the violence I endured.					
I experience frequent fatigue or weakness that I associate with the violence I have suffered.					
I find that my physical injuries from GBV have limited my participation in community activities.					
Psychological Health Outcomes					
I experience anxiety or depression that I believe is linked to the violence I have experienced.					
I often feel emotionally overwhelmed when I recall the violent events I endured.					
I have frequent flashbacks or nightmares related to my experience of violence.					

I feel that the violence I experienced has negatively affected my self-esteem and confidence.					
I find it difficult to trust others as a result of the violence I have suffered.					
Socio-Economic Consequences					
My experience of GBV has affected my ability to secure or maintain employment.					
I have faced financial instability or hardship as a direct result of the violence I experienced.					
My social relationships and support networks have been disrupted due to the violence I endured.					
I have encountered significant barriers in accessing essential services (such as education, healthcare, and housing) because of GBV.					
My overall quality of life has been substantially impacted by the socio-economic consequences of GBV.					

Section E: Coping Strategies

When thinking about the difficulties you have faced as a result of conflict-related violence, please indicate how often you have used each of the following ways of coping in your situation.

Use this scale: ***1 – Strongly Agree 2 – Agree 3 – Neutral 4 – Disagree 5 – Strongly Disagree***

Statement	**1**	**2**	**3**	**4**	**5**
Problem Focused Coping					

I took concrete actions to improve the situation					
I made a specific plan of action and followed through with it					
I sought advice or information to help me manage the situation					
Emotional Support / Emotion-Focused Coping					
I shared my feelings with friends or family					
I focused on finding something positive in the situation					
I focused on finding something positive in the situation					
I accepted what happened and tried to adapt through activities like home chores and hobbies.					
I expressed my negative emotions through various initiatives including talking, crying, or writing					
I used spiritual or religious practices (e.g., prayer) for comfort.					
Avoidant / Maladaptive Coping					
I denied or refused to accept what had happened					
I blamed myself for not handling things better					
I gave up trying to deal with the situation					

Appendix II: KEY INFORMANT INTERVIEW GUIDE

Introduction

My name is **Fardosa Muse**, a master's student at Africa Nazarene University. I am conducting a study titled "Impact of Conflict-Related Sexual Violence on the Wellbeing of Women in Tigray, Ethiopia." The study is motivated by the humanitarian crisis in Tigray, where widespread gender-based violence (GBV), including physical, sexual, and psychological abuse, has had severe consequences on the lives and well-being of women.

This interview seeks to explore the impact of conflict-related GBV on women's physical health, psychological well-being, and socio-economic status. Your insights will contribute to a deeper understanding of these issues and inform programmatic and policy responses. Participation is voluntary, and all responses will remain confidential.

Thank you for agreeing to take part in this discussion.

Assessing the Physical Health Outcomes of GBV

1. Based on your experience, what are the most common physical health issues observed among women survivors of GBV in Tigray?
2. Can you give examples of injuries or chronic conditions? How do these affect survivors' ability to carry out daily activities?
3. How would you evaluate the availability and effectiveness of healthcare services in addressing survivors' physical health needs?
4. What challenges do survivors face in seeking care? What improvements or innovations could make healthcare more responsive?
5. Have you observed any changes or trends in the physical health complaints of GBV survivors over time?

6. What factors might explain these changes? How does the conflict context influence these outcomes?

Examining the Psychological Impact of GBV

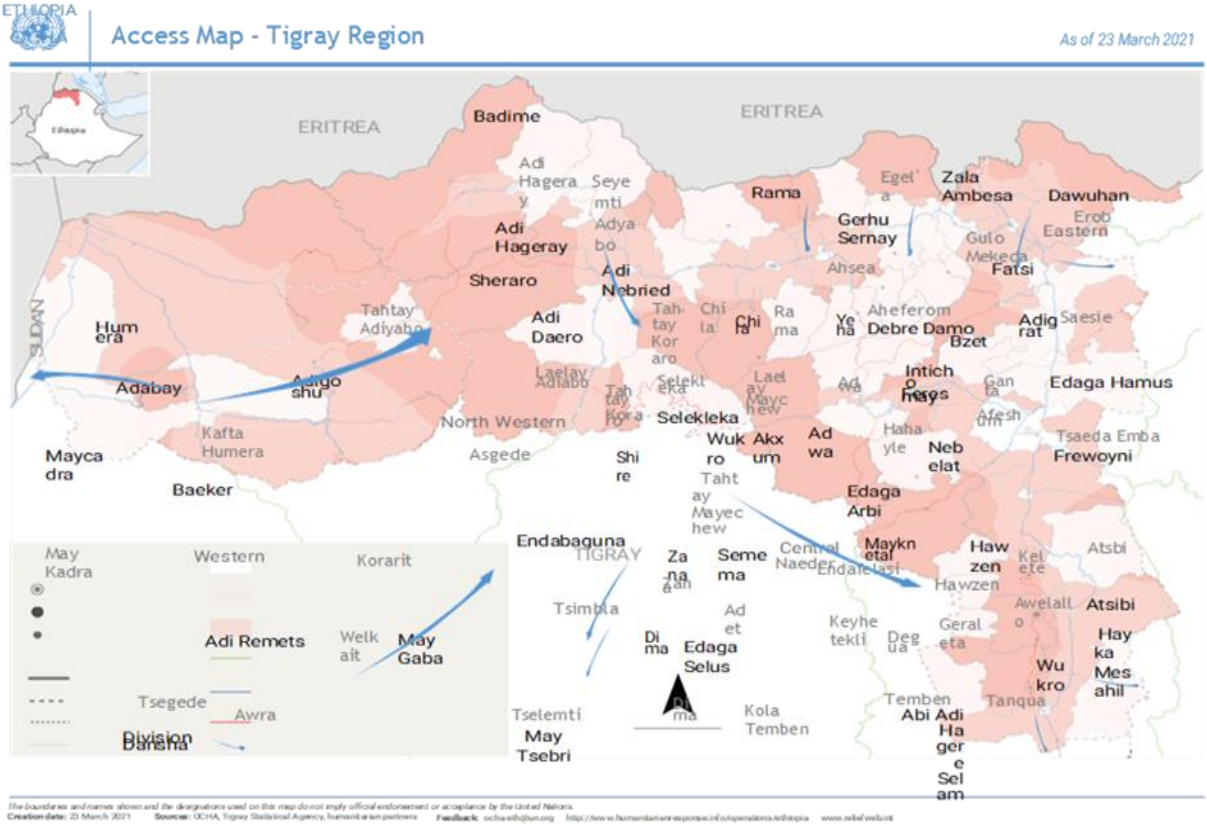
1. What psychological issues (e.g., anxiety, depression, PTSD) do you commonly observe among GBV survivors in your work?
2. Are there specific symptoms or behaviours that stand out? How prevalent are these issues among the survivors you engage with?
3. How effective are the mental health and psychosocial support (MHPSS) services available to survivors?
4. What barriers hinder access to these services? How could these services be strengthened to better meet survivors' needs?
5. In your view, how has the conflict intensified the psychological impact of GBV on survivors?
6. What conflict-related stressors worsen mental health outcomes? How do these factors interact with existing mental health support systems?

Evaluating the Socio-Economic Consequences of GBV

1. How has GBV affected the socio-economic status of women survivors, particularly in terms of employment and income generation?
2. Can you share examples of lost opportunities? How has this influenced survivors' long-term economic security?
3. What are the main socio-economic challenges survivors face when accessing essential services such as healthcare, education, or housing?
4. Do these challenges differ among different groups within the camps or communities? Which services are most limited?

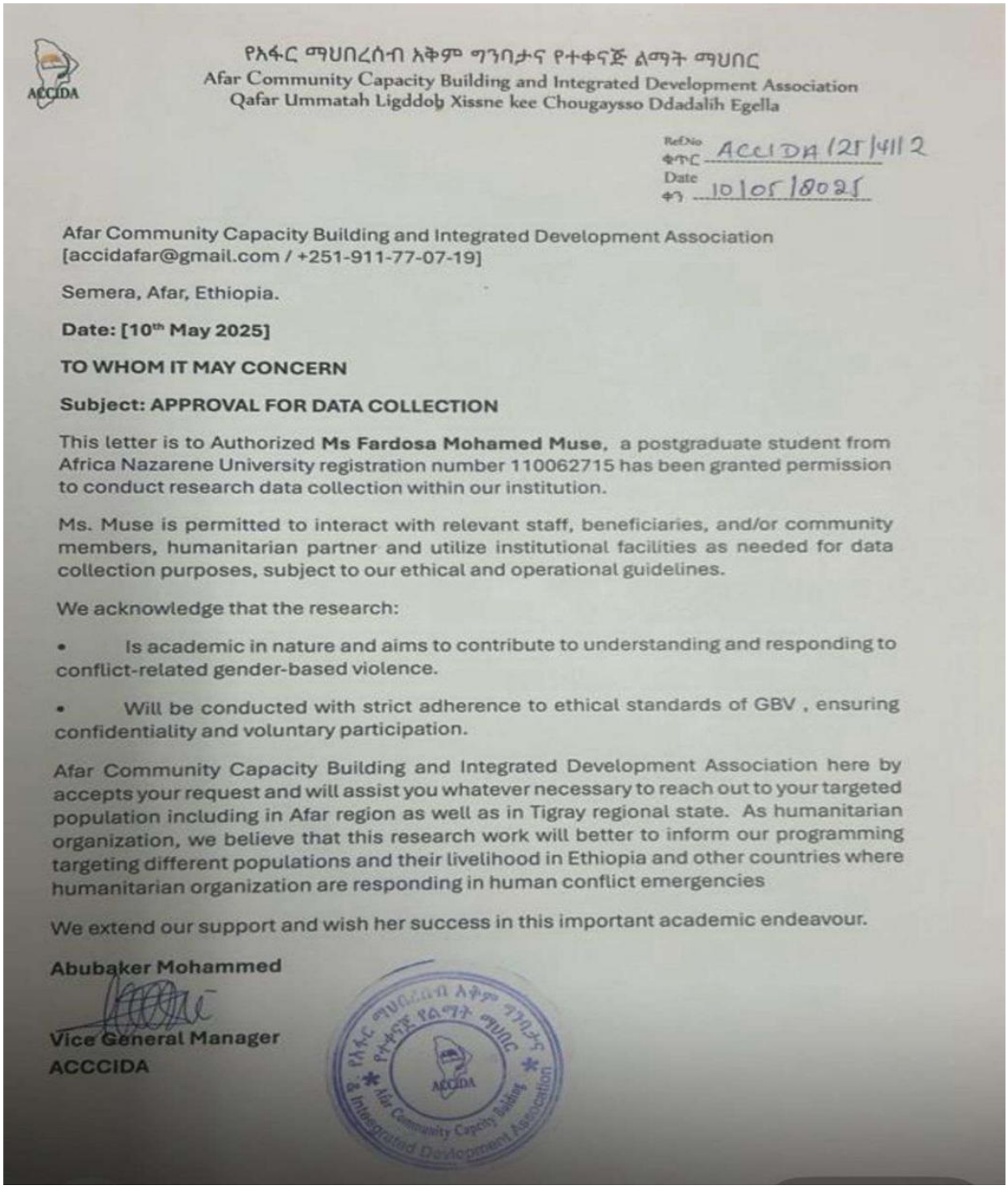
5. In your experience, how has GBV influenced survivors' social networks and community integration?
6. How has this shaped their support systems? What broader socio-economic repercussions have you observed for survivors and their communities?

Appendix III: MAP OF STUDY AREA



Appendix IV: Authorizations

Letter From Ethiopia IRB



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Afar Community Capacity Building and Integrated Development Association
Qafar Ummatah Ligddoḅ Xissne kee Chougaysso Ddadalih Egella

Ref.No ቁጥር ACCIDA/25/4112
Date ቀን 10/05/2025

Afar Community Capacity Building and Integrated Development Association
[accidafar@gmail.com / +251-911-77-07-19]

Semera, Afar, Ethiopia.

Date: [10th May 2025]

TO WHOM IT MAY CONCERN

Subject: APPROVAL FOR DATA COLLECTION

This letter is to Authorized **Ms Fardosa Mohamed Muse**, a postgraduate student from Africa Nazarene University registration number 110062715 has been granted permission to conduct research data collection within our institution.

Ms. Muse is permitted to interact with relevant staff, beneficiaries, and/or community members, humanitarian partner and utilize institutional facilities as needed for data collection purposes, subject to our ethical and operational guidelines.

We acknowledge that the research:

- Is academic in nature and aims to contribute to understanding and responding to conflict-related gender-based violence.
- Will be conducted with strict adherence to ethical standards of GBV , ensuring confidentiality and voluntary participation.

Afar Community Capacity Building and Integrated Development Association here by accepts your request and will assist you whatever necessary to reach out to your targeted population including in Afar region as well as in Tigray regional state. As humanitarian organization, we believe that this research work will better to inform our programming targeting different populations and their livelihood in Ethiopia and other countries where humanitarian organization are responding in human conflict emergencies

We extend our support and wish her success in this important academic endeavour.

Abubaker Mohammed
Vice General Manager
ACCCIDA

Letter From Africa Nazarene University

AFRICA NAZARENE
UNIVERSITY

P.O.Box: 53067 – 00200
Nairobi, Kenya.
Tel: 020 252 7170/1 – 5
Email: vc@anu.ac.ke
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30th April 2025

TO WHOM IT MAY CONCERN

RE: RESEARCH PERMIT: FARDOSA MUSE

Fardosa Muse Reg. No. (110062715) is a Bonafide postgraduate student at Africa Nazarene University in the School of Humanities and Social Sciences - Governance, Peace and Security Studies department. She is pursuing a Master's degree in Governance, Peace and Security Studies. This program entails Coursework and Thesis. She has successfully completed coursework and defended her thesis proposal entitled:

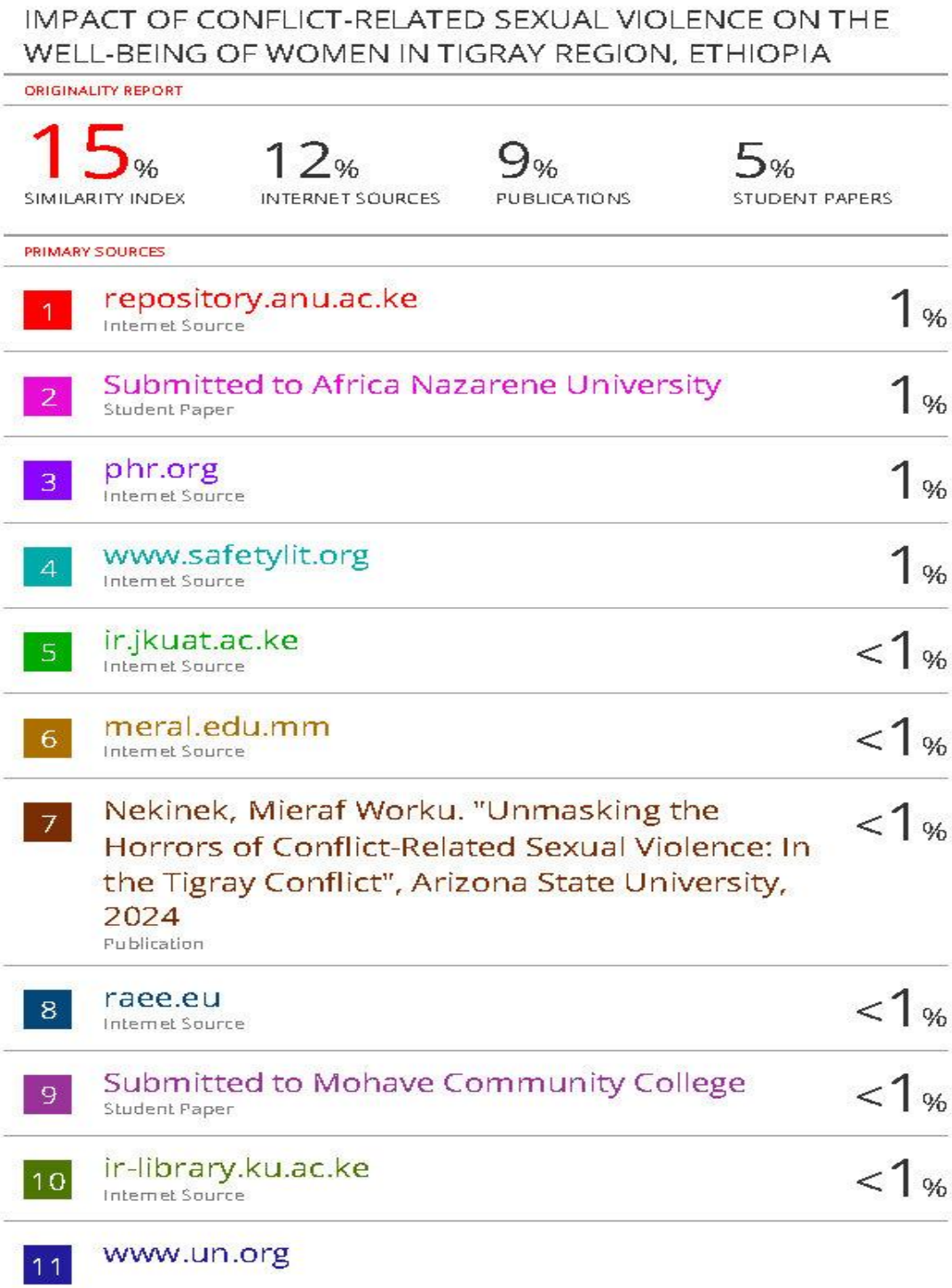
"Impact of Conflict-Related Gender-Based Violence on the Well Being of Women in Tigray, Ethiopia".

Any assistance accorded to her to facilitate data collection and complete her thesis will be highly appreciated.

Sincerely.

Dr. Simon Obwatho
Deputy Vice Chancellor, Academic & Student Affairs.

Plagiarism Report



IMPACT OF CONFLICT-RELATED SEXUAL VIOLENCE ON THE WELL-BEING OF WOMEN IN TIGRAY REGION, ETHIOPIA

ORIGINALITY REPORT

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