

IN THEIR OWN WORDS:

UNDERSTANDING BARRIERS TO SEXUAL AND REPRODUCTIVE
HEALTH ACCESS FOR INTERNALLY DISPLACED YOUNG PEOPLE

A CASE STUDY FROM OROMIA, ETHIOPIA

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ACRONYMS AND ABBREVIATIONS

FGD	Focus group discussion	SRH	Sexual and reproductive health
GAGE	Gender and Adolescence: Global Evidence	SRHR	Sexual and reproductive health and rights
IDP	Internally displaced person	UNFPA	United Nations Population Fund
KII	Key informant interview	WASH	Water, sanitation and hygiene
NGO	Nongovernmental organization	WHO	World Health Organization
SGBV	Sexual and gender-based violence		

Executive Summary

Crises expose women, children and young people to health and protection problems that are largely overlooked in humanitarian settings. Young people — ages 10 to 24 years old — have health needs that are often unmet in the best of circumstances. Ethiopia, a nation of 104 million people, has experienced a spike in internal displacement in recent years with an estimated 3.2 million people forced from their homes by 2018. As ethnic clashes, droughts and floods continue to force people from their homes, this internal displacement has differential effects on groups within the country — over 51% of the internally displaced persons (IDPs) are women and girls and nearly 60% are under age 18. Unless the underlying roots of conflict are addressed and measures are put in place to mitigate climate-induced insecurity, Ethiopia will likely continue to see growing numbers of IDPs in need of humanitarian assistance.

Because young people as well as women and girls of reproductive age make up the majority of IDPs, the Ethiopian government and its local and international nongovernmental partners must address the unique vulnerabilities of these subpopulations. Despite the government's increased commitments to and improved policies around sexual and reproductive health (SRH), young people in Ethiopia still encounter both structural and social barriers to accessing contraception and SRH information, education and services. Additionally, contraception and SRH are still not adequately prioritized in emergency responses, though the government explicitly addresses the SRH needs of young people in its current humanitarian response plan.

To elevate the voices of internally displaced young people, PAI collaborated with Ethiopia's Jimma University on a pilot project to understand the SRH challenges young people face during displacement. As cities and towns receive ever larger numbers of IDPs, research was conducted with a displaced community in an urban location of Oromia region in October and November 2019. Through five focus group discussions (FGDs) with 42 IDPs ages 14 to 24, researchers sought to uncover how young people understand, experience and manage their SRH needs during displacement. These discussions were supplemented with 12 key informant interviews (KIIs) and additional informal conversations with other stakeholders, including IDP leaders as well as representatives of the local government and hospital administration.

The young participants identified their main SRH concerns as:

- Child, early and forced marriage and adolescent pregnancy and childbirth;
- Social and religious norms that impact the use of contraception;
- Lack of SRH education and information; and
- The displacement site as a barrier to sexual and reproductive health and rights (SRHR).

Many of the issues the young IDPs described are similar to those experienced by adolescents and youth outside of crisis settings. Like other young people in Ethiopia, the young IDPs believed that reproductive health services, such as contraception, could be beneficial to them, their families and their communities, including by helping them to meet their aspirations. They highlighted the challenges related to child, early and forced marriage that lead to early pregnancy complications, underlining the fear that having children too soon and too close together affects their ability to get an education and provide for their families — also issues that are prevalent among nondisplaced young people in Ethiopia. However, displacement has reinforced their community's adherence to cultural and religious norms around SRH. In the context of the harsh living conditions of their displacement site, these norms that make contraception taboo and pressure young people to adhere to strict gender roles

create interacting barriers that limit their increased knowledge and use of SRH services. As a result of their physical isolation and lack of consistent SRH education and service availability, misconceptions about contraception and SRH were rampant among the participants. Overarching, the dire living conditions in the displacement site make it difficult for individuals to prioritize their SRH over meeting more basic daily needs and survival. Additionally, the cramped and unhygienic location itself further contributes to poor SRH outcomes, such as safe delivery and menstrual hygiene management — issues particularly impacting the rights of women and girls.

While this case study represents the experience from only one community living in a situation of protracted internal displacement, it demonstrates the impacts that multiple displacements can exact on young IDPs who already suffer from a lack of adequate access to services. The possibility of prolonged or even additional displacements puts these young people at risk of continued poor SRH outcomes. It makes them further vulnerable to related violations of their SRHR, including early and forced child marriage, and impacts their ability to make informed decisions about their health and futures. Additionally, this kind of continued displacement can have generational impacts as young people miss educational and economic opportunities and may not have the ability to adequately care for themselves and their families. As the Ethiopian government undertakes the return of IDPs, it must listen to the

health and development challenges the young people themselves have identified to meet their needs both during displacement and once they are resettled. This response should meaningfully engage young people and address the following areas:

- Improve living conditions in displacement sites, including water, sanitation and hygiene (WASH) and nutrition support.
- Deliver SRH services where the community is physically located.
- Ensure culturally appropriate interventions that collaborate with IDP leaders.
- Provide education for young people with an emphasis on girls to ensure their health, well-being and rights.

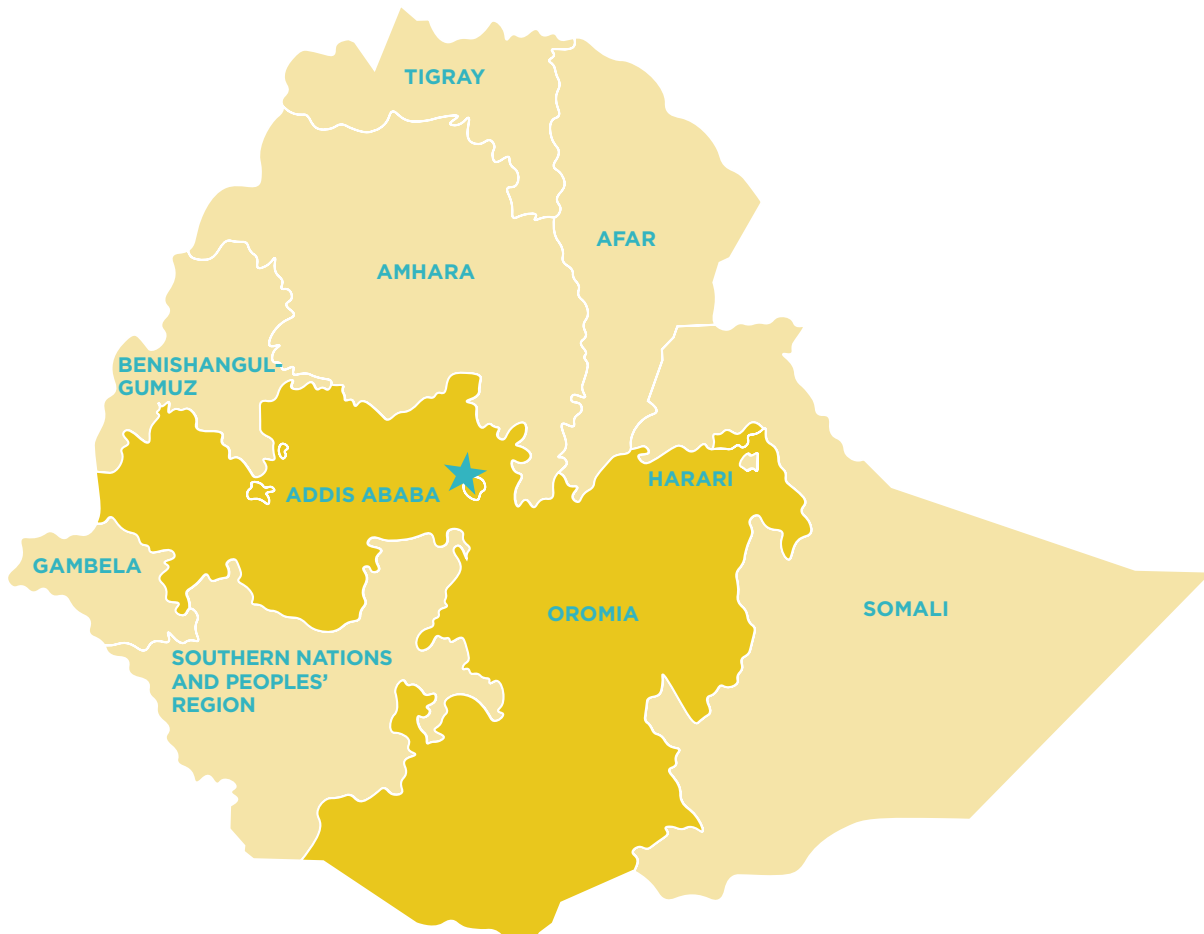
In order to help young people and their communities make informed choices about their SRH and improve their overall well-being, the government and humanitarian and development actors should consult, educate and work with displaced communities in culturally appropriate ways. Engaging communities in problem-solving around their SRH needs would ensure that displaced populations are aware of and connected to necessary services and health outreach programs. In the context of the worsening climate crisis and continued forced movement, populations that suffer these kinds of displacements will only be further left behind without concerted, participatory efforts to address their identified needs.

Background

As of 2018, an estimated 3.2 million Ethiopians were internally displaced within the country due to ongoing conflict and climate crises that forced them from their homes, vastly outpacing the 900,000 refugees the country hosts.¹ Over 51% of IDPs in Ethiopia are women and girls and nearly 60% of IDPs are under age 18.^{2,3} Displacement within the country has spiked in recent years and Ethiopia has registered one of the fastest-growing populations of IDPs in the world. However, the country also has large numbers of IDPs living in protracted displacement as a result of past wars with its neighbors, years of interethnic clashes, droughts, floods and famines.⁴ Like refugees, IDPs are affected by systemic violence and fear returning to their homes; they lose their livelihoods and access to essential services; and are subsequently at risk of human rights abuses. While the Ethiopian government began returns of displaced populations in April 2019 with 1.8 million people returned as of June 2019, populations continue to be displaced and those living in displacement sites or among host communities require protection and humanitarian assistance.⁵

FIGURE 1: Map of Ethiopia's Regional States

Research for this case study on the SRH challenges and needs of adolescent girls and young IDPs took place in Oromia regional state.



Ethiopia has a population of 104 million people with 3.2 million IDPs — 51% of whom are women and girls and 60% are under age 18.

Women, children and young people have specific health promotion, disease prevention and treatment needs that are often unmet in IDP settings. In 2018, for instance, the United Nations Population Fund (UNFPA) estimated that over 1 million internally displaced Ethiopian women and girls of reproductive age were without adequate lifesaving interventions, including safe birth; maternal and newborn care; safe spaces for women and children; and risk mitigation and response to sexual and gender-based violence (SGBV).⁶

Young people — ages 10 to 24 — have unique health needs that can go unmet in the best of circumstances. The government of Ethiopia has worked to improve the SRH status of its young population, an official priority given that 41% of the country's 104 million people are under the age of 15 and more than 28% are ages 15 to 29.^{7,8} Young people undergo rapid physical, cognitive, emotional and social developments during adolescence and into young adulthood. Broadly, however, young people in Ethiopia often lack knowledge about their health and available health services; they face mobility constraints, particularly for girls; and they are restricted by norms and biases either from their family, peers or service providers that impact their access to services.⁹ SRH needs do not lessen due to young people's displacement status where barriers to accessing health care are exacerbated and adolescents and youth are at greater risk of health and protection problems.¹⁰ According to Ethiopia's national humanitarian response plan, an estimated 8.4 million people will require humanitarian assistance

within the country in 2020.¹¹ One of the priorities identified in the plan is addressing critical problems related to living standards, including providing access to essential SRH services. In these situations of crisis, sectoral clusters led by the government and co-led by international organizations are designed to respond to the gaps displaced persons face, including food, nutrition, health and protection.¹² Given that more than one-third of the current IDPs have been displaced in the last three years, unless underlying drivers are addressed, the displacement triggered by conflict and disasters can be expected to persist and the number of people affected to rise — critically affecting women and girls of reproductive age, adolescents and youth.¹³

As the causes contributing to migration — and the displacement itself — are usually accompanied by a diminished capacity to respond to SRH needs, situations may be further aggravated by under-resourced and inappropriate responses. Government actors, nongovernmental organizations (NGOs) and other partners providing support to displaced populations must have a better understanding of the SRH vulnerabilities of young people in situations of displacement. This is particularly critical as IDPs find themselves in cities and towns searching for shelter, livelihood and health care.¹⁴ In these settings, the boundaries between crises and development programs blur over time as populations experience multiple, compounding displacements, and are potentially lost in urban centers.

Listening to Young IDPs: Findings

Across the globe, evidence has demonstrated that during displacement and conflict, women and girls are highly vulnerable to SGBV. In Ethiopia, the ongoing Gender and Adolescence: Global Evidence (GAGE) program — a mixed methods longitudinal research and evaluation study into adolescent well-being in nine countries — has uncovered multiple examples of rape and sexual violence toward IDP women and girls.¹⁵ Crisis-affected women and girls experience higher levels of unwanted pregnancies due to unmet contraception needs and a lack of access to safe abortion care, and pregnancy and childbirth in humanitarian settings can be life-threatening.¹⁶ While there is an effort to provide IDPs with quality SRH information, services and supplies, these efforts are chronically underfunded and not adequately prioritized in responses.¹⁷ In order to better understand how to meet and serve crisis-affected populations, the Inter-agency Working Group on Reproductive Health in Crises in 2018 identified gaps in studies focusing on SRH in emergencies and the specific challenges facing adolescents and youth.

To contribute to the development of this SRH knowledge, PAI sought to elevate the perspectives of displaced young people to ensure that SRH programs and policy recommendations are inclusive, rights-based and strategic. PAI collaborated with Jimma University that led research among a displaced community in a town in Oromia region, Ethiopia, focusing on how young people understand, experience and manage their SRH needs and whether services are best tailored to their experiences as IDPs and as adolescents and youth. The research was conducted in October and November 2019 through five FGDs with 42 young people — defined by the World Health Organization (WHO) as those ages 10 to 24 years.¹⁸ For this report, we did not include very young adolescents ages 10 to 13. The FGDs were separated by age range (14- to 18-year-old adolescents and 19- to 24-year-old youths) and gender. The FGDs were supplemented with 12 KIIs as well as additional informal conversations with selected young people, IDP community and women leaders, local health officials, NGO representatives and other stakeholders.

The young people interviewed for this report live within an urban IDP settlement. The location and identifying details of the displacement site and the town in which it is located are withheld for the protection of the FGD participants and other respondents. Originally from the Harari region in eastern Ethiopia, the IDP community was initially displaced due to drought in the early 2000s. They have endured multiple displacements since, with

the most recent instance in June 2018 from their previous location in southwestern Oromia region. For nearly 20 years, this group has experienced what is known as protracted displacement, having experienced forced migration repeatedly due to a series of droughts and subsequent unsuccessful government-led resettlement efforts in areas that were not conducive to an agricultural lifestyle and rural livelihood security.

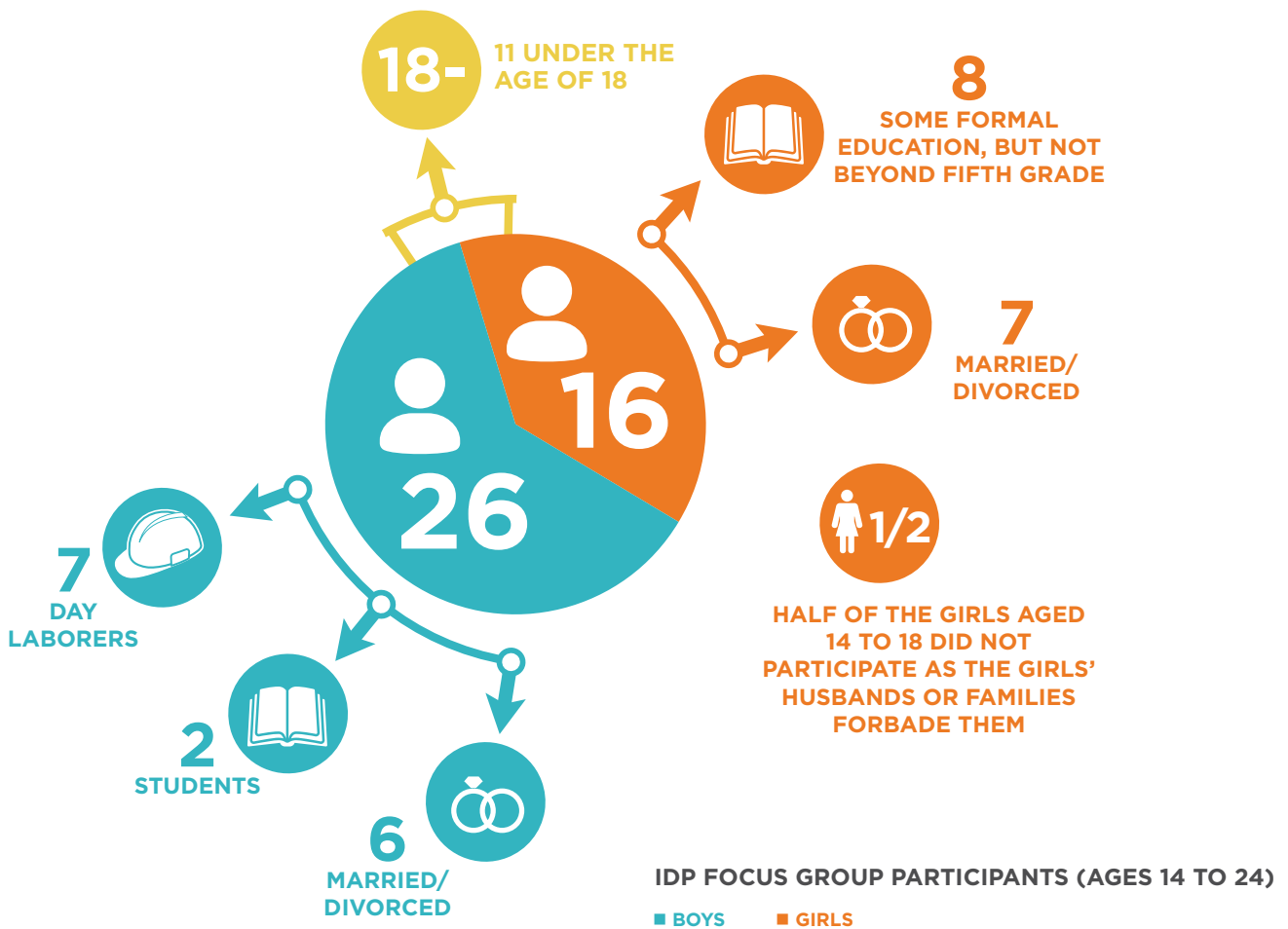
The displaced community has now been living in a converted warehouse. A single large hall with makeshift cloth partitions holds the estimated 610 households of nearly 2,500 individuals. In this environment, members of the IDP community sleep, cook and worship in an area set aside as a mosque. The families share outdoor space for additional cooking and washing, though these activities are hampered by refuse from the town's residents, including dirty water, garbage and human waste. The entire IDP community has access to one clean water source, one sanitation tank and one pit latrine, though open defecation is common, especially for children. Displaced men and boys work as day laborers and some women perform domestic labor in town. The local government provides the IDPs 15 kilograms of rations, usually maize, per person per month and the town health office has arranged for IDPs to access one of the local hospitals free of charge for diagnosis and treatment, though any necessary medications must be purchased at private pharmacies.

In this highly challenging context, among the vulnerabilities that the young people identified

FGDs with 42 Young People

Of the 42 focus group participants, 26 were male and 16 were female. Eleven were under age 18. Seven of the boys and young men were day laborers and only two were currently in school. None of the girls were currently in school. Half of the girls and young women had some formal education, but not beyond fifth grade. Six of the 26 boys and young men were married or divorced, and seven of the 16 girls and young women were married or divorced. The participants did not report if they had children. While six FGDs were planned, one of the two scheduled with girls ages 14 to 18 was canceled as the girls' husbands or families would not allow them to participate.

FIGURE 2: Research for this case study on the SRH challenges and needs of adolescent and youth IDPs took place in Oromia region.



related to SRH, their main concerns included:

- Child, early and forced marriage and adolescent pregnancy and childbirth;
- Social and religious norms that impact the use of contraception;
- Lack of SRH education and information; and
- The displacement site as a barrier to SRHR.

CHILD, EARLY AND FORCED MARRIAGE AND ADOLESCENT PREGNANCY AND CHILDBIRTH

The displaced young people are expected by their peers, families and religious leaders to observe specific norms, including refraining from premarital sex. As displacement forced their households into close quarters where there is limited privacy, the young people reported a heightened adherence to religious and other group social norms. Both the young participants and key informants claimed that the congested living conditions reduced the vulnerability of young women and children to certain kinds of SGBV because of community vigilance. However, preexisting gender roles and inequalities as well as cultural and religious norms reinforced pressures to marry early and bear children.¹⁹

Early and forced child marriage and early pregnancy and childbirth were widely acknowledged to be practiced. While these were accepted among the young participants, they acknowledged that such practices challenge young people's health, educational and economic well-being. Rates of child marriage and adolescent pregnancy remain high throughout Ethiopia in general. Over 14% of girls are married by age 15 and over 40% by age 18, and 13% of adolescents between the ages of 15 and 19 have already given birth.²⁰ According to the FGD participants, boys reportedly marry by ages 16 or 17, while it is acceptable for girls in the community to marry as early as 12- to 14-years-old. Some indicated that displacement had caused girls to marry and become pregnant earlier than they would have previously. A youth participant attributed this change due to lack of access to formal education — being out of school, adolescents were getting married earlier to have sex and start families. Out of the 42 participants, only two of the boys and none of the girls were currently

attending school in town.

The young people were particularly aware of the dangers of early pregnancy and childbirth and the risks to adolescent mothers and children. Many of the young people knew of the health problems associated with early pregnancy, including fistula and morbidity, as well as its impact on a girl's ability to gain an education and the additional ramification on her family's economic outlook. One participant described the situation:

“Early, inappropriate age of marriage is difficult because it can affect the livelihood of families. It can reduce the living standards. The marriage below the age of 18 years is problematic ... A woman can face difficulties during pregnancy and childbirth. It can also generally affect her and her family's livelihood.”

Child marriage and teenage pregnancy have strong effects on the possibilities of girls to escape poverty. If a girl can avoid pregnancy, her access to education and economic opportunities drastically increases.²¹ Displacement only worsens these prospects. However, within the IDP community, sociocultural and religious expectations to have families early is emphasized, making it difficult to delay pregnancy and prioritize education, despite the compounding hardships of the IDPs' current living conditions.

SOCIAL AND RELIGIOUS NORMS THAT IMPACT THE USE OF CONTRACEPTION

As existing sociocultural norms govern gender dynamics, they also forbid the use of modern contraception within the IDP community. In addition to the strict adherence to avoiding premarital sex, this IDP community's interpretation of Islam considers the use of condoms to be taboo. Within the community, there is an expectation for young people to marry early and bear numerous children — an obligation that has escalated during displacement with a sense of needing to bolster their numbers. These social pressures are reinforced within and among families and appear

to be echoed among the young participants and their peers. As one young man described, “In our area, even if a young couple, after getting married, wants to go to a health facility for birth control, their families won’t allow them.”

In the last two years living in their current location, the focus group participants could recall only one instance of a health extension worker visit. While the health worker had attempted to educate the IDPs about family planning and contraception, the IDP religious and cultural leaders forbade the members from taking contraception. However, some women subsequently were believed to be using or having tried to use modern methods. The young participants underscored though that married women and girls are not allowed to seek contraceptive methods without their husbands’ consent and presence. Norms limit the bodily autonomy of women and girls, and gender and power dynamics impact childbearing expectations and family planning practices. One participant said:

“There is no such thing [as] taking birth control in our area. And since there is no condom utilization practice, young people will have sex only after marriage, without using a condom. A woman will get into conflict with her husband if she is found using an [birth control] injection. Likewise, he also doesn’t use [a] condom once he gets married.”

The young people claimed to strictly adhere to their community’s beliefs regarding contraception. However, they were concerned by the problems faced by the lack of birth spacing. As one participant reported, “Look, here, a couple can have up to nine or 10 children. That’s why we are facing so many problems. Women are giving birth without gaps, every year.” The young people understood there could be benefits of contraception to delay and space children, which they believed could help alleviate the hardships brought about by their current living conditions, lack of adequate nutrition and means of livelihood. However, because of the religious and cultural norms of their community, all the young participants recognized that without

the involvement of IDP and religious leaders, there would be little chance for young people to access SRH information, education and services, including contraception. One participant went on to explain that:

“You know, most of our leaders have no schooling at all. If health professionals come to us, gather all of us together and give us an advice that would be good. They [community leaders] would get a good lesson. Since they have no education, even though young people want to use the birth control services, they fear of using it as they think it might affect their health. Therefore, it would be good if a health professional comes here and teaches them all about its benefits and how to use it.”

LACK OF SRH EDUCATION AND INFORMATION

Focus group participants expressed a limited awareness of modern contraceptive choices and SRH broadly. Some of the young people had received information about modern contraceptive methods — mainly regarding implants and injections — prior to their current displacement. They reported that most couples used the rhythm method, which is more accepted within the community, though with misconceptions about its effectiveness. There was some understanding of the dangers of sexually transmitted infections and HIV. Many of the young people were open to or had been previously tested for HIV because of prior awareness-raising efforts. They saw HIV testing as a prerequisite for marriage, though again they expressed inaccurate understanding and information regarding transmission.

Even for those who would want to use contraceptive methods, despite the IDP community pressures, participants had limited knowledge of the SRH information and services available. The local hospital the IDPs can access does provide contraception, including injections and condoms, and other SRH diagnosis and treatment free of charge. Some of the participants were

aware of this, though there is confusion as other prescription medication must be purchased from private providers. Additionally, some participants believed that only married couples could go to the hospital to seek information and family planning advice and that a woman or girl going on her own would be turned away.

Other than the one reported health outreach attempt, there have been no known efforts by the public or private sectors to inform the young people and the IDP community about SRH information and services. Two local SRH NGOs operate in the town and are aware of the IDP community. However, neither organization has engaged with the community to provide services, which is particularly unfortunate as NGOs often fill a unique service delivery gap for young people who might otherwise avoid public health facilities for their SRH needs. As a result, since their current displacement, young IDPs had not received any tailored, youth-appropriate SRH services or accessed youth-friendly spaces. The young participants emphasized a desire for reproductive health education and a better understanding of the services they could access at the local hospital. They described a clear link between the need for SRH information and education and contraceptive use that could be beneficial to their situations:

“If you are well-educated you will be able to plan to space your children in such a way that it won’t negatively affect your life. But due to lack of education in our area, there is nothing we do to space children in families. I mean, there are no birth control efforts. Due to the existing problems, there are young people who would get up to three or four children, despite being too young for marriage, let alone having a child. And, subsequently, they are facing several challenges. But the reason is simple. They weren’t educated about family planning.”

THE DISPLACEMENT SITE AS A BARRIER TO SRHR

Living in an IDP site has caused multiple, interacting SRH problems beyond access to contraception. The displacement location isolates the community from the rest of the town and the site itself poses additional SRH challenges, particularly for young women, girls and children. The living conditions have contributed to unsanitary practices that impact SRHR, in particular due to lack of clean WASH on-site, which disproportionately impacts women and girls.

The young people described difficulties in physically accessing the hospital, particularly during emergencies like childbirth. Women, it was reported, often give birth in the camp because ambulances do not always come when called. Additionally, the young people were wary about the health services in town. Some of the young people had experienced bias in treatment at the hospital because of their age or status as IDPs or believed that they would if they tried to seek services. According to the hospital administration, few IDPs seek medical services, as reportedly only 10% of the IDP population had been in for treatment or testing in the last two years. There was confusion among the youth participants as to whether services were available free of charge, and they avoided seeking services as they would not be able to afford any resulting prescriptions.

The congested and unsanitary site and inability to regularly access clean water is an enormous burden for women and girls in the community. As one male respondent described, “In our displaced site, some men can go and take showers by paying money. But since our families have many children, we cannot all go pay to use them. So, we use an open field to bathe. A mother can’t keep up her hygiene along with her babies.” Participants explained that public showers in town cost 6 Ethiopian birr (19 cents) to use, which the IDPs cannot afford. As a young woman described, a piece of soap already costs her 2 birr (6 cents). When she menstruates, she cannot always afford to wash her clothes daily. Some of the girls and young women described bathing in groups to shield each other while washing in the field. However, the area available outside the hall where they communally live is filled with waste and

refuse from the town, exposing the community to additional health dangers. Both female and male participants described the risks this poses for women and girls, including the problem of menstrual hygiene management:

“Women have strong fears in these conditions. There is no space for girls to keep their hygiene. None at all. And when girls menstruate, they have no space to clean themselves ... There is no separate space prepared for this purpose. They have no freedom at all. Their rights are not being protected.”

Recommendations from Young Displaced People

The IDP adolescents and youth that participated in this case study experience compounding vulnerabilities, including problems due to insufficient income generation and inadequate WASH, nutrition and educational opportunities. These health and protection problems impact their ability to attain their SRHR and ensure their well-being. Overall, the IDPs and other stakeholders acknowledged that this population's priority is to be resettled permanently, though at the time of writing the local administration's resettlement plan and timeline was unknown. In the interim and through resettlement, this community must be supported with an adequate government-led and NGO-complementing response that includes SRH information, education and services.

While the local administration has provided rations and, on paper, linked the IDPs to one hospital for free services, these efforts are not enough. Additional support should address the following areas identified by participants and key informants:

1 Improve living conditions in the displacement site

The young people and their community require supplemental nutritional support, livelihood opportunities and WASH services to improve their overall health and well-being in their current state of displacement.

WASH: Researchers observed the unsanitary conditions in the displacement site. A recommendation from one of the male participant groups was that they, with support, could construct a safe washing space for women and girls. "It would be easy to go and shower somewhere else for men, but it's difficult for women and girls. They have their menstrual cycle every month. So, the youths should cooperate to construct some temporary showering space for them so that they can fetch water and take bath there." Additionally, as the one pit latrine the IDPs have access to has overflowed, the local government and stakeholders should address sanitation concerns, particularly to avoid additional health problems and disease burden.

Nutrition: Multiple respondents indicated that the 15 kilograms of maize per month per person from the government was not enough to ensure a balanced diet, particularly for children and pregnant women. Given potential fiscal limitations of the local administration, NGOs should supplement nutritional efforts as they relate to maternal, newborn and child health.

2 Deliver SRH services where the community is physically located

To ensure that SRH information, education and services are available, accessible and appropriate to the IDP community, the local administration should ensure that these activities meet the population where they are on-site. As women, young people and girls have mobility constraints, services that are coordinated with public sector efforts could be provided by a temporary clinic as well as health extension workers, mobile outreach by NGOs and local health institutions in the area. This must involve building trust with the community and ensuring referrals for other health concerns. Services should additionally be age-appropriate and tailored to young people's needs.

3 Ensure culturally appropriate interventions in collaboration with IDP leaders

The youth participants made it clear that, in order to accept modern contraceptive methods and begin to change some of the norms and behaviors leading to early marriage and

pregnancy, the entire community should be involved. Local NGOs serving the town with experience conducting mobile contraceptive and SRH outreach have the opportunity to create interventions for this IDP community and others, ensuring they are culturally appropriate and engage religious and other leaders in participatory decision-making. “We cannot do anything alone,” as one participant said. “If it is done with the community, we can give up traditional [contraceptive] methods and start using modern methods.”

4

Provide education for displaced young people, with an emphasis on girls, to ensure their health, well-being and rights

All FGDs highlighted the importance of education and that attending school would improve young people’s health, well-being and future. Local administration and relevant NGOs should ensure young people are linked to

educational and economic opportunities. One youth participant summarized the interacting barriers caused by displacement and lack of education to better understand SRH and to tackle child, early and forced marriage:

“According to our culture, girls get married at the ages of 13, 14 and 15. According to our culture, the young men also get married early. But what we want you to know is that as a youth, we have a plan to go back to school, though the situation we are currently in does not allow us. We want to become strong and study, get education and improve our awareness. Therefore, we have a plan to be educated to combat these things.”

Conclusion

Despite progress in recent decades to globally address SRH in crisis settings, services on the ground can lag behind need and populations are at risk of being left behind. In Ethiopia, comprehensive and appropriate SRH care must be made available to adolescent and youth IDPs as ongoing conflicts continue to fuel forced migration; climate shocks will only increase, compounding existing displacement.²² The Ethiopian government has demonstrated commitment to improving the health status of its population, enacting crosscutting initiatives for SRH, education and services, including for young people.²³ As the government continues IDP returns and seeks to meet the commitments set forth in national policies and its humanitarian response plan, it must consider sustainability in the context of the climate crisis and the ability to link mobile populations to lifesaving services, including SRH care, information and education to bridge the humanitarian-development nexus.

Adolescents and youth, even in situations of crisis and displacement, are able to identify the challenges they face and devise realistic solutions. In order to adequately respond to the needs of displaced young people, government and other service providers must involve them and their displaced communities in developing and implementing programs and solutions. Of course, meeting the SRH needs of these populations in crisis cannot be done without adequate funding, including international development assistance. The international community must continue to advocate for and monitor the extent to which IDPs are provided with adequate support, including complementing the work of governments with assistance to support food, shelter, access to health care and education for IDPs.²⁴ As displaced young people find themselves in high-risk settings, with vital SRH information and services disrupted, particular emphasis should be placed on ensuring that services are inclusive and tailored to their specific needs.²⁵

While this case study represents the experience of only one IDP community living in a situation of protracted displacement, it demonstrates the impacts that multiple displacements can exact on populations. IDPs already suffer from inadequate access to services and continued displacement can have generational impacts. Displaced young people miss educational and economic opportunities and may not have the ability to adequately care for their families. They are thus further restricted from enjoying the development gains a country like Ethiopia has made in the last 20 years, including in terms of SRH outcomes. As well as enshrining practices that place young women and girls at risk of early and forced marriage and adolescent pregnancy and childbearing, these patterns will continue to threaten the health and well-being of young people and their communities. Governments and their NGO and donor partners must renew their commitments to and reaffirm the equal rights of displaced and crisis-affected populations to health, including collaboratively responding to the needs the IDPs themselves identify and call for.

Methodology

PAI and Jimma University designed this research to explore the SRH barriers, needs and understanding of young IDPs in a community within a town of Oromia region, Ethiopia. Research for the report was conducted under the leadership of professor Sudhakar Morankar, director of the Ethiopian Malaria Alert Center at Jimma University, and associate professor Zewdie Birhanu, head of the Department of Health, Behavior and Society in the Institute of Health at Jimma University. Jamie Vernaelde, senior research and policy analyst at PAI, reviewed the research plan and methodology. Jimma University's Institutional Review Board approved the research and additional approvals were provided by local administrative authorities to engage with the IDPs. Jimma University data collectors who facilitated the FGDs and KIIs included Yohannes Kebede, Fira Abamecha, Alemi Kebede and Gelila Abraham. The report was written by Jamie Vernaelde and reviewed by Sudhakar Morankar and Zewdie Birhanu.

The research was conducted on site with young people using a participatory qualitative research approach. The IDP site was selected per project implementer capacity with a focus on an urban location. Data was collected through five FGDs with 42 adolescents and youth from one IDP community, divided into groups by gender and age range (14- to 18-years old and 19- to 24-years-old) and supplemented by 12 KIIs that were purposively selected to provide additional context and information. These included adult IDP community and women leaders, community health workers and administrative government and hospital representatives, among others. Additional informal conversations were held with other stakeholders. A sixth FGD was planned but participants, girls age 14 to 18, were barred from attending by their husbands and families.

Throughout the report, names and identifying information, including the specific location of the IDP site and town, were withheld to protect the

identities of the participants and respondents. With all interviewees, voluntary informed consent was secured with both the young people and their parents if participants were under age 18, and research staff discussed the purpose of the interview, its voluntary and confidential nature, how the information would be used and the rights of the interviewees. The FGDs typically lasted 90 minutes, and KIIs ranged between 45 and 60 minutes. No compensation was provided for participation. Interviews were conducted in Afaan Oromo, and all FGDs and KIIs were transcribed verbatim and translated into English for analysis.

PAI and Jimma University would like to thank all those who shared their insight and analyses, including members of the local administration and the Jimma University data collectors who facilitated the FGDs and KIIs. Above all, we deeply appreciate the participation of the adolescents and youth who shared their time, knowledge and experiences.

ENDNOTES

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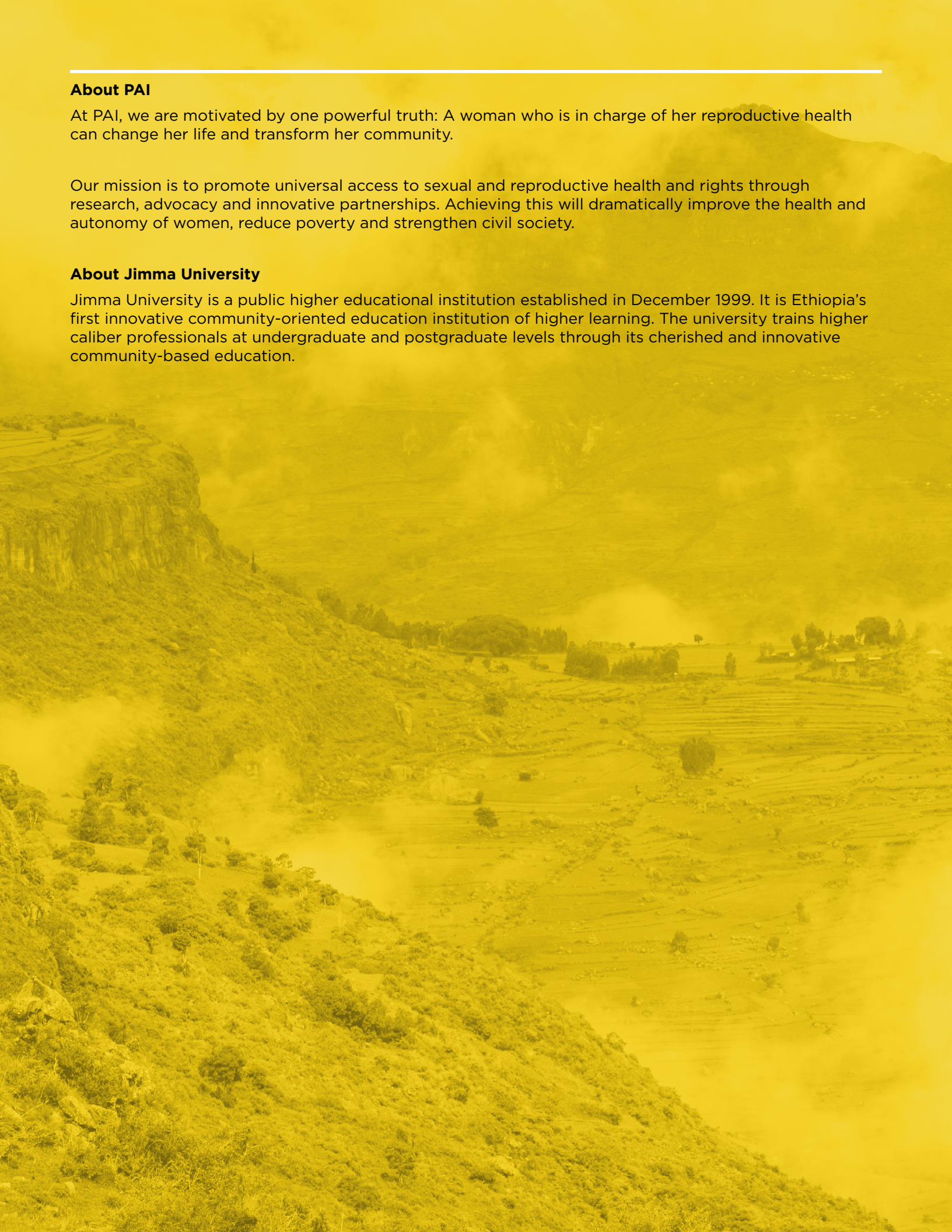
About PAI

At PAI, we are motivated by one powerful truth: A woman who is in charge of her reproductive health can change her life and transform her community.

Our mission is to promote universal access to sexual and reproductive health and rights through research, advocacy and innovative partnerships. Achieving this will dramatically improve the health and autonomy of women, reduce poverty and strengthen civil society.

About Jimma University

Jimma University is a public higher educational institution established in December 1999. It is Ethiopia's first innovative community-oriented education institution of higher learning. The university trains higher caliber professionals at undergraduate and postgraduate levels through its cherished and innovative community-based education.





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