



ELiDA ETHIOPIA

RAPID PROTECTION RISK ANALYSIS REPORT

North Wollo Zone, Amhara Region

Project: STAR Supporting Transformative Action and Resilience

Implementing Organization: ELiDA Ethiopia

Sub-implementing Partner: UEWCA

Funded by: OCHA-EHF

Target Woredas: Raya Kobo, Habru, Lasta, and Bugna

Report Date: 24 September 2025

1. Executive Summary

A Critical Protection Crisis in North Wollo Zone

The Rapid Protection Risk Analysis (RPRA) reveals a community where pervasive insecurity, deeply rooted harmful practices, and near-total absence of specialized services converge to place women, girls, and persons with disabilities at severe risk.

59.02%

Rate safety as "Unsafe"

45.08%

Respondents affected by GBV in past year

70.49%

Unaware of available GBV services

In response to urgent protection challenges in North Wollo Zone, ELiDA Ethiopia together with sub-implementing partner UEWCA is implementing the STAR Project (Supporting Transformative Action and Resilience). This Rapid Protection Risk Analysis (RPRA) was commissioned as a foundational first step, establishing a rigorous, data-driven evidence base across the target woredas of Raya Kobo, Habru, Lasta, and Bugna.

Based on a survey of 122 respondents and Key Informant Interviews (KIIs), the analysis reveals a protection crisis driven by political insecurity (53.28%), the presence of arms (38.52%), widespread GBV, harmful traditional practices, and a total absence of accessible, specialized support services. Women (44.26%), persons with disabilities (26.23%), and girls (22.13%) are the most disproportionately affected groups.

A 100% reporting vacuum exists: all participants are unaware of formal government or institutional GBV reporting mechanisms. Informal community structures while active lack training, resources, and coordination. The analysis underscores the urgent need for targeted interventions addressing root causes of insecurity, accessible protection services, and strengthened community structures.

2. Background and Objectives

The North Wollo Zone of the Amhara Region is experiencing a complex protection emergency compounded by ongoing armed conflict, economic fragility, displacement, and the erosion of social support systems. Large-scale humanitarian reports by OCHA and the Protection Cluster consistently identify critical gaps in GBV services, which are predominantly limited to major urban centres such as Woldiya. Protection risks including GBV, early marriage, and child abuse are among the highest-priority humanitarian concerns across conflict-affected Amhara.

2.1 General Objective

To generate a comprehensive, evidence-based analysis that guides the STAR Project's implementation strategy and contributes to a more informed humanitarian and protection response in North Wollo Zone.

2.2 Specific Objectives

- Conduct a detailed analysis of key protection risks, with emphasis on GBV including early marriage, sexual violence, FGM, abduction, and exploitation.
- Map the specific vulnerabilities of key groups including women, girls, persons with disabilities (PWDs), Internally Displaced Persons (IDPs), and host communities.
- Assess existing community-based coping mechanisms and local capacities, while identifying critical service gaps in GBV case management, MHPSS, legal aid, and safe spaces.
- Provide actionable, contextually appropriate recommendations for risk mitigation, targeted interventions, and advocacy.

2.3 Geographic Scope and Timeline

The RPRA covers the North Wollo Zone STAR project locations, with a primary focus on Raya Kobo and Habru woredas. The assessment was conducted from 1 September to 20 September 2025, and encompassed desk review, primary data collection through KIs and surveys, community mapping, and analysis of protection risks, service gaps, and referral pathways.

3. Methodology

The RPRA employed a mixed-methods, cross-sectional study design, integrating quantitative surveys with qualitative data collection to ensure a comprehensive understanding of protection risks and community dynamics.

3.1 Study Design

A descriptive cross-sectional design was used to capture a snapshot of the protection landscape at project onset. Quantitative methods provided statistical breadth, while qualitative methods through KIIs and community mapping captured contextual depth and survivor narratives.

3.2 Sample Size Determination

Sampling Formula: Kish Leslie (1965) Single Population Proportion
 Confidence Level: 95% | Estimated Prevalence (P): 0.5 | Margin of Error (d): 5%
 Final Sample Size: 122 survey respondents across Raya Kobo and Habru Woredas

The sampling strategy was proportionally allocated across sites based on total stakeholder population size, with intentional weighting toward female respondents (64.75%) to capture experiences of the most vulnerable group. Active participation of persons with disabilities was explicitly ensured throughout.

3.3 Data Collection Methods

- Structured surveys administered via KoboToolbox enabling real-time data capture, GPS tagging, and audit trails
- Key Informant Interviews (KIIs) with officials from North Wollo Zone, Raya Kobo, and Habru Women's Offices
- Focus Group Discussions (FGDs) with community members, survivors, and service providers
- Desk review of existing humanitarian assessments, OCHA reports, and Protection Cluster analyses
- Community observation and protection mapping

3.4 Ethical Considerations

All participants provided informed verbal or written consent following a full briefing on the study's objectives and sensitive nature. Strict confidentiality protocols were observed in line with "Do No Harm" principles. Data collection was conducted by trained field staff including local enumerators familiar with community context who applied trauma-informed, gender- and disability-sensitive approaches. Sex, Age, and Disability Disaggregated Data (SADD) was systematically collected throughout.

4. Respondent Profile



Lead . Inspire . Empower

Total respondents	Female (intentional weighting)	Married	Persons with disabilities
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The survey engaged 122 respondents from the targeted woredas. The gender distribution is intentionally skewed toward women (64.75%) to capture disproportionate GBV vulnerability and improve representativeness in IDP-affected areas where women constitute a larger proportion. The average participant age was 39.20 years (median: 35.50), reflecting a middle-aged adult population. The majority were married (59.02%), and 11.48% reported a disability.

Woreda	Sample Size	Male Respondents	Female Respondents
Raya Kobo	64	23	41
Habru	58	20	38
Total	122	43	79

This demographic profile predominantly married, middle-aged women provides essential context for interpreting protection risks. The 100% consent rate among participants signals a strong community desire to engage with this topic, underscoring that silence around GBV is a product of systemic barriers, not lack of willingness to disclose.

5. Key Findings

5.1 Community Safety and Vulnerability

A significant majority of the community feels unsafe, with 59.02% of survey respondents rating their personal safety as "unsafe." This pervasive insecurity is primarily driven by political differences (53.28%) and the presence of arms (38.52%), indicating that violence is deeply rooted in broader socio-political and intercommunal dynamics including conflicts between organized non-state groups such as Fano and TDF with disputes over land and local leadership.

The most vulnerable groups identified are:

- Women (44.26%) heightened risk of sexual violence, early marriage, and economic exploitation
- Persons with disabilities (26.23%) face mobility barriers, are excluded from services due to lack of interpreters and disability-sensitive care
- Girls (22.13%) at risk of early forced marriage, often as a poverty-driven coping mechanism
- Children (boys and girls) vulnerable to child labour, child rape, and illegal migration
- Elderly often dependent on others for safety and support

5.2 GBV Prevalence and Types

45.08% of respondents or a family member experienced GBV within the past year.
29.51% rate the likelihood of a GBV incident as "Very high" in their community.

The incidence of GBV is alarmingly high across both woredas. Physical violence is the most reported form (54.11%), followed by economic violence (17.93%), emotional abuse (16.39%), and sexual violence (11.57%). According to KIIs respondents, these forms of violence are deeply rooted in poverty, illiteracy, and harmful gender norms that normalize and perpetuate abuse.

Key qualitative findings from KIIs highlight domestic violence as a major issue that often originates in the home, with specific risks including child rape (with weak legal responses) and workplace discrimination indicating that interventions must address the full spectrum of GBV, not only sexual violence.

5.3 Harmful Traditional Practices

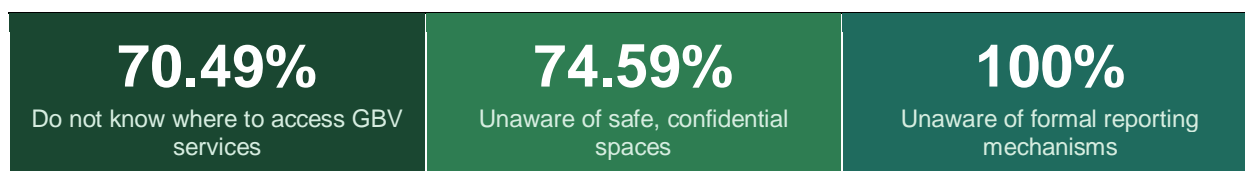
Early Child Marriage (ECM)

25.41% of respondents or their family members have experienced Early Child Marriage, with the highest prevalence in the 15–18 age range (14.75%) and under-15 (15.57%). KIIs confirm that ECM is used as a coping mechanism for economic vulnerability, particularly among displaced families. This exposes minors to severe physical and psychological harm and perpetuates cycles of poverty and dependency.

Female Genital Mutilation (FGM)

18.03% of respondents report that FGM is practiced in the area. Critically, 81.15% of the community recognizes its health complications indicating genuine potential for change through targeted awareness campaigns. KIIs note that while harmful traditional committees and cultural dominance remain barriers, some religious leaders and community-based organizations are actively supporting FGM reduction efforts and represent a key leverage point.

5.4 Access to GBV Services



A profound service gap exists across all target woredas. In Raya Kobo, MHPSS and safe houses are entirely absent; legal and livelihood aid is only occasional or requires referral to Woldiya. In Habru, KIIs explicitly confirmed that no specialized services (health, MHPSS, safe house, or legal) are available. While a referral pathway exists on paper, community awareness of it is negligible.

Services are fragmented not organized in one-stop centres forcing survivors to navigate multiple sectors, a process that is often re-traumatizing and exhausting. The single One-Stop Centre in Woldiya (North Wollo) is underequipped and suffers from weak confidentiality arrangements due to lack of lockable information areas.

5.5 Knowledge of GBV

A widespread information deficit on GBV exists: 69.8% of participants lack comprehensive knowledge of available services, local laws, diverse impacts, and prevention methods. Critically, this deficit is consistent across genders knowledge did not have a statistically significant association with sex confirming that both men and women equally lack critical information. Future interventions must therefore adopt a gender-inclusive approach to all awareness and education programming.

5.6 Child Protection

54.10% of respondents do not believe children are adequately protected from neglect, exploitation, and abuse. KIIs in North Wollo highlighted that child rape cases are insufficiently prosecuted. Girls are at particular risk of early forced marriage as a family coping mechanism, while boys face heightened risk of illegal migration to countries such as Saudi Arabia and Yemen via the Red Sea and Yemen routes. This multifaceted vulnerability requires a comprehensive response encompassing positive parenting education, community protection mechanisms, and justice reform.

5.7 Women's Economic Disempowerment

Economic disempowerment is a critical structural driver of GBV vulnerability. Only 19.9% of women engage in business activities beyond traditional roles, and access to formal financial services is near-zero (8.7%). 44.7% of women have no control over household finances, and vast majorities are restricted from participating in public meetings (84.5% excluded from meetings with men; 78.9% excluded from community meetings). These systemic restrictions directly undermine women's agency, ability to seek help, and participation in development initiatives.

5.8 Survivor-Centred Care Gaps

The assessment reveals a profound inadequacy in survivor-centred care at both zonal and woreda levels. Less than 10% of service providers assessed safety plans for survivors, and 91% of providers were found to pressure clients to disclose their experiences a direct violation of survivor-centred principles. Referral systems are dysfunctional, with only 45.5% of providers reporting they

consistently operate. Services lack trained staff, essential medicines, and established protocols for digital or psychological trauma.

5.9 Community Resilience and Coping Mechanisms

Community leaders are the primary structures for managing tensions and conflicts, identified by 69.67% of respondents. Informal mechanisms including elder mediation and women's associations are active but lack formal training, reporting tools, and coordination with official systems. Common coping strategies include traveling in groups, avoiding unsafe areas at night, and seeking mediation from religious leaders

6. Woreda-Level Protection Profiles

6.1 Raya Kobo Woreda

Raya Kobo faces a critical vulnerability gap in specialized support services. Key informants confirmed that MHPSS and safe houses are absent, and legal or livelihood assistance is only occasional or requires referral to Woldiya. While a GBV referral pathway exists on paper, community awareness remains negligible and no one-stop centre is operational.

Primary protection risks include sexual and gender-based violence, early and forced marriage, and exploitation driven by poverty. Insecurity is geographically concentrated around shelters, latrines, and water points at night severely limiting women's freedom of movement and economic participation. Violence is frequently intercommunal, rooted in political and land-related disputes between non-state groups. Community resilience relies heavily on informal elder mediation, which while active lacks formal training and coordination.

6.2 Habru Woreda

Habru Woreda's protection profile is shaped by ongoing conflict and chronic safety failures that directly impede daily life and livelihoods. KIIs explicitly confirmed the absence of all specialized services including health, MHPSS, safe house, and legal support though a basic referral pathway and a limited rehabilitation centre exist.

The main protection risks are concentrated around early marriage, illegal migration (particularly boys to Arabian countries), and child abuse. The entire community faces heightened exposure during active conflict periods. Priority interventions for Habru must focus on basic security stabilization and establishing functional, minimum-standard service delivery to address immediate protection threats and restore community normalcy.

7. Recommendations

Based on the critical findings of this assessment, a comprehensive and impactful GBV programming strategy in North Wollo Zone covering Habru and Raya Kobo Woredas must address the following eight strategic priority areas:

1

Establish and Strengthen Survivor-Centred Services

Establish integrated, survivor-centred service centres in at least all woreda towns, serving as central referral points for all health facilities within each woreda. These centres must provide a streamlined pathway for survivors to receive immediate medical, psychosocial, legal, and safety planning assistance. The provision of cash-for-protection and dignity kits must be a foundational component directly addressing the financial barriers that prevent survivors from seeking help and enabling them to access transport, food, or temporary shelter. This holistic approach breaks the cycle where poverty and psychological distress reinforce each other.

2

Capacitate GBV Service Providers

Significantly enhance service provider capacity through comprehensive, standardized training in GBV case management, survivor-centred principles, trauma-informed care, MHPSS, Psychological First Aid (PFA), and ethical disclosure protocols. Training must include practical skills in safety planning and referral mechanisms, guided by officially approved guidelines. Critically, family support must be integrated into survivor-centred care recognizing that GBV creates multi-directional stressors leading to family breakdown. Equipping providers to address family-level dynamics reduces secondary victimization and supports durable survivor reintegration.

3

Establish Community-Based Protection Mechanisms

Implement sustained community-level interventions to challenge and transform the harmful social norms that perpetuate GBV. These must actively dismantle restrictions on women's freedom of movement, promote women's leadership at household and community levels, and normalize men's and boys' active participation in childcare and household responsibilities. Engage religious and community leaders through structured dialogues and awareness campaigns. Given that harmful attitudes cut across all age groups and both sexes, interventions must be intergenerational and gender-inclusive to foster lasting cultural change.

4

Strengthen and Map the GBV Referral Pathway

Conduct a thorough mapping of all available GBV services in each woreda, documenting service types, contact details, and confidential referral linkages. Compile findings into an accessible, widely disseminated directory. Establish clear protocols that guide survivors seamlessly from medical to legal to psychosocial and economic support without requiring them to navigate disconnected systems independently. A functional, well-documented referral system is the single most effective intervention to reduce re-traumatization and close the existing service access gap.

5

Adopt a Multi-Pronged Approach to Reduce Stigma

Combat the pervasive stigma of GBV through sustained public awareness campaigns, community dialogues, and engagement with religious and traditional leaders. Support

survivors in developing effective psychological coping strategies addressing the documented PTSD-like symptoms and social isolation. Simultaneously, shift community narratives from victim-blaming to perpetrator accountability. By reframing digital and physical violence as community responsibility rather than personal shame, interventions will create a safer environment for disclosure and encourage survivors to seek help without fear of discrimination or social ostracization.

6

Strengthen Women's Rights Organizations (WROs)

Provide targeted capacity-building and reliable funding to Women's Rights Organizations, which are currently severely constrained by budget gaps, inadequate staffing, and insufficient training. Capacity development must cover organizational management and financial sustainability, specialized GBV prevention skills (including community norm-change approaches), project planning and M&E for GBV programming, and advocacy and policy lobbying skills. Strengthening WROs ensures that local expertise, motivation, and community trust are leveraged for sustainable, context-appropriate GBV prevention and response moving beyond purely humanitarian response toward long-term empowerment.

7

Improve Multi-Stakeholder Coordination and Collaboration

Address the current fragmentation of GBV services through standardized coordination mechanisms. Develop and share implementation manuals for all GBV interventions, clarifying roles across Clusters, NGOs, and local government. Produce community engagement manuals in simple, Amharic- and Tigrinya-accessible language to foster community ownership. Integrate adaptive budget flexibility to enable emergency responses to unplanned survivor needs critical in a conflict-affected context where needs are inherently unpredictable. Leverage the strong motivation of local actors as a foundation for these collaborative systems.

8

Scale Up Comprehensive Economic Support for Survivors

Address the documented vicious cycle in which psychological distress drives economic hardship, which in turn deepens psychological distress. Interventions must move beyond immediate relief to provide start-up capital for small businesses, financial literacy training, vocational skills development, and facilitated access to Village Economic and Social Associations (VESAs). Integrating psychosocial support with economic empowerment equips survivors with the resources and tools to break cycles of poverty and vulnerability, restore financial independence, and rebuild their lives with dignity. This holistic approach is essential for sustainable recovery.

8. Annexes

- Annex A: Inception Report
- Annex B: Data Collection Tools (KoboToolbox Survey Instrument)
- Annex C: Key Informant Interview Guides
- Annex D: List of Key Informants

