GENDER-BASED VIOLENCE LANDSCAPE ANALYSIS – AMHARA CASE STUDY

USAID/ETHIOPIA TRANSFORM: PRIMARY HEALTH CARE PROJECT

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CONTENTS

ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral therapy
GBV	Gender-based violence
IPV	Intimate partner violence
MCH	Maternal and child health
OPD	Outpatient department
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother-to-child transmission
SOP	Standard operating procedure
STI	Sexually transmitted infection
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDRL	Venereal disease research laboratory (testing)
YFS	Youth-friendly services

INTRODUCTION

Research shows that gender-based violence (GBV) is widespread in Ethiopia. Wife-beating is commonly accepted and adolescent girls are subject to harmful practices, such as female genital cutting, marriage by abduction, and early and forced marriage.[1] Little information is available on married adolescents, but with child marriage rates estimated at up to 41 percent,[2] this large population faces especially difficult challenges in accessing health services—lack of information about sexual and reproductive health, poor perceptions about sexual and reproductive health, feeling of shame, fear of being seen by others, restrictive cultural norms, lack of privacy and confidentiality, and unavailability of services.[3] Girls and women face different forms of GBV across their lifecycle, and the health system is often best placed to respond to GBV given the frequency of girls' and women's interaction with it.

The government of Ethiopia has made great strides with supportive policies and tools to address gender inequality and prevent GBV and harmful norms, such as establishing a Women and Youth Affairs Directorate within the Federal Ministry of Health; assigning gender experts at regional, zonal, and *woreda* offices; and increasing the capacity of the Ministry of Women and Children to prevent and respond to GBV. These efforts have resulted in declines in early and forced marriage, and increases in school enrollment.[4] However, challenges remain, such as healthcare providers' disrespect of mothers during delivery, limited autonomy for women and girls to make health decisions, and lack of male involvement in supporting women's health.[5] Policy operationalization requires further support to bolster government investments in preventing child and maternal deaths, and improve service uptake.

In 2017–2018, the Transform: Primary Health Care project conducted a gender analysis to identify gender gaps and opportunities the project needed to address to achieve its intended results. The gender analysis findings showed a gap in the health sector's understanding and implementation of GBV prevention and response. To fill this gap, the project conducted a GBV landscape analysis to map existing Ethiopian health system GBV prevention and response interventions, and identify opportunities for the project to support the Ministry of Health to improve the health system's response to GBV. The analysis covers the regions of Amhara, Oromia, Southern Nations, Nationalities, and Peoples' Region, and Tigray. This report presents findings, conclusions, and recommendations of the Transform: Primary Health Care project's GBV Landscape Analysis in the Amhara region.

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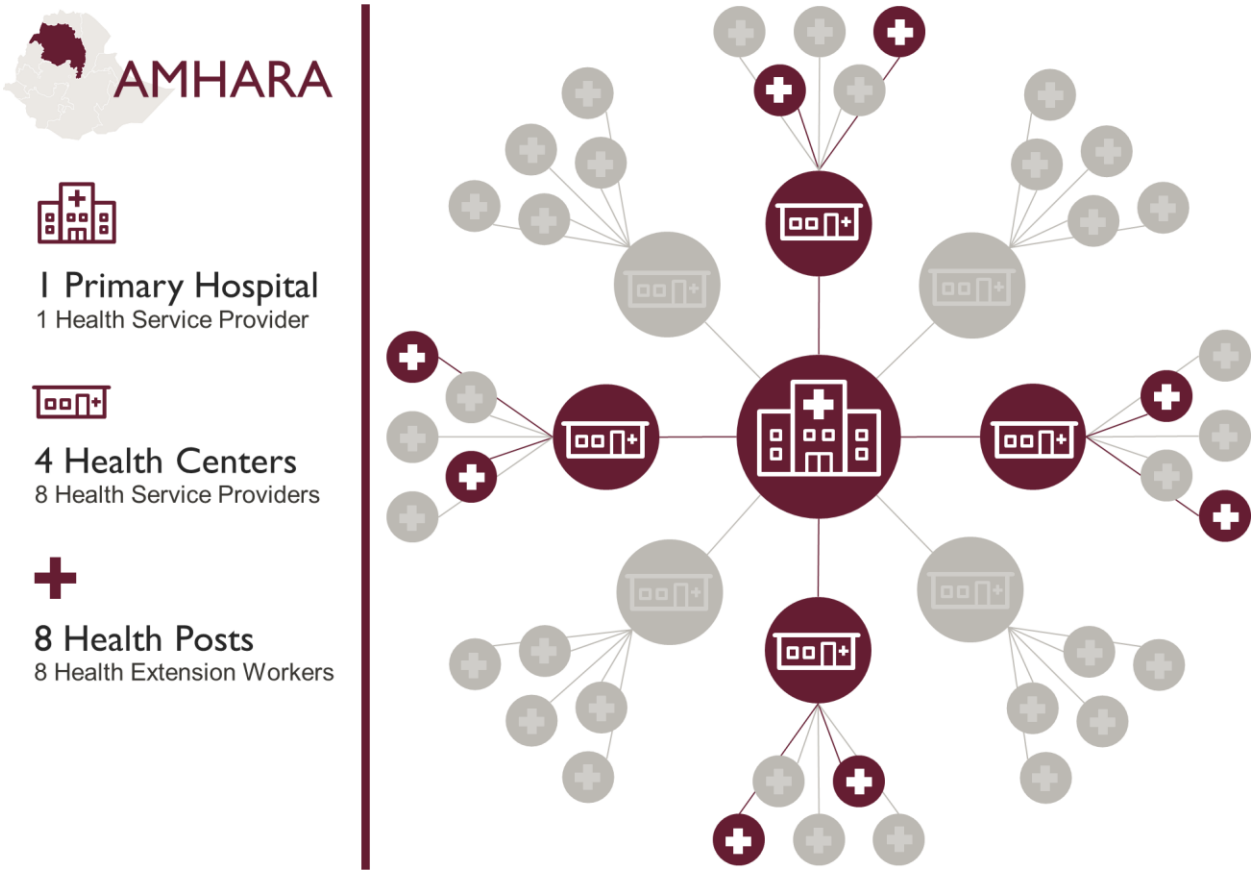
[1] Federal Democratic Republic of Ethiopia Ministry of Women, Children and Youth Affairs. 2013. *National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia*. Accessed October 3, 2018: http://www.africanchildinfo.net/clr/policy%20per%20country/2015%20Update/Ethiopia/ethiopia_htp_2013_en.pdf.
[2] The United Nations Children's Fund (UNICEF) 2016
[3] Central Statistical Agency and Inner City Fund (ICF) 2016; Brhane and Kidane-Mariam 2016; USAID 2016
[4] Erulkar et al. 2017
[5] UNICEF. 2016. *State of the World's Children*. UNICEF: New York.

CONTEXT

The health network in the selected learning/demonstration *woreda* of the Amhara region consisted of eight health centers. The sample was comprised of one primary hospital, four health centers, and eight health posts (two under each health center). The interview sample included one health service provider at the primary hospital, two health service providers at each sampled health center, and one health extension worker at each sampled health post. *Exhibit 1* depicts the full health network and the sample selected for the Amhara case study.

Exhibit 1: Amhara research sites



FINDINGS

Evaluation Question 1: What GBV prevention and response services currently exist within the Ethiopian primary healthcare system that the Transform: Primary Health Care project can build upon?

FINDING 1: Healthcare workers had narrow definitions of GBV, indicating the most commonly reported types of GBV were physical violence, rape, and other sexual violence.

When respondents were asked to share their understanding and definition of GBV, most understood GBV to be physical and sexual violence/harassment. Some respondents perceived inequality in other areas as forms of GBV, and a few raised the issue of forced marriage. Those who mentioned inequality in other areas gave specific examples of the unequal division of domestic labor and decision making. Only two respondents mentioned social harassment, and only three noted emotional or psychological violence as forms of GBV. A few respondents said they understood GBV to *only be against women.*

> *Gender based violence also includes violence against women by intimate partner such as preventing women from making decision in the family property, money, and household maters and forcing to carry out instructions given by husband. —Female health extension worker, health post*[6]

The most commonly reported types of GBV across the different levels of facilities were physical violence, rape, and other sexual violence (not including rape). Health extension workers stated that the most commonly disclosed incidents of GBV at health posts were intimate partner violence (IPV) related to early marriage, and disagreements on family planning decisions; however, these instances were not consistently perceived as GBV. Only health extension workers cited observing cases of early marriage. Half of the respondents noted that no GBV cases had been reported in their facility; the data did not reveal whether this was because cases were not reported or because the respondents had not actually encountered GBV cases.

> *… When most of the women appeared to us taking birth control, husbands in turn beat them… Even recently giving a woman a birth control… when getting back home, her husband attempted to assault her and she ran to me while he followed her to the health post… We face many of such cases; we even go door-to-door counseling the husband and reconciling the husband and the wife. Most of the cases referred to us are the cases of assault of the wife by her husband. —Female health extension worker, health post*

> *The thing I would like to add is our community has not much known about GBV, they have no experience of referring to the law bodies as well health facilities even when victimized. They see the beating of husbands as a normal thing. —Female health extension worker, health post*

[6] The GBV Landscape Analysis team translated the respondents' quotes from local languages to English, then edited them for clarity as appropriate.

FINDING 2: Healthcare workers provided a wide range of GBV prevention and response services.

In general, when health extension workers encountered GBV survivors, they provided counseling/psychological support, emergency contraception such as post pills, and referrals to other health facilities. Health extension workers indicated that they commonly responded to cases of IPV by reconciling or counselling the couple together, and addressing physical injuries. Some respondents acknowledged there were few services they could provide to GBV survivors.

> *If a woman who experienced forced sex or rape comes to us, we will provide her emergency contraceptive and refer her to health center so that the health center will provide HIV testing and tests for other sexually transmitted diseases. —Female health extension worker, health post*

> *As I told you GBV cases reported to us are the dispute between the husband and wife and physical assault. When facing such things, we counsel, reconcile and send them home by resolving the issue but do nothing else. —Female health extension worker, health post*

> *For physical or sexual violence, I will refer to a health center since there is no good medical care to be given at health post level here except doing prevention activity. —Female health extension worker, health post*

When health service providers at health centers and primary hospitals encountered GBV survivors, they provided first aid to treat physical wounds, counseling/psychological support, post-exposure prophylaxis (PEP), emergency contraception such as post pills, and referrals to other health facilities. They also worked with or provided referrals to the police. Only one health service provider indicated supplying testing for HIV and other sexually transmitted infections (STIs) for IPV survivors.

> *We can give clinical response to physical violence, though not complete we can give response for sexual violence, such as providing ARV [antiretroviral therapy] prophylaxis and post pills, but we can't take swab for we have no material. Other than this, we can give psychosocial support partially. So, we can give all services. —Male health service provider, health center*

All of the health centers and the primary hospital had an HIV testing services counselor, and all provided HIV testing services and counseling. Only two of the health centers and the primary hospital provided comprehensive HIV care (including antiretroviral therapy [ART], prevention of mother-to-child transmission [PMTCT], care, and support), although the two health centers that lacked comprehensive services did provide PMTCT. The observed health centers and primary hospital all provided safe abortion services.[7]

Exhibit 2: Health centers' and hospital's performance on HIV services indicators per standard operating procedures (SOPs)

SERVICES AVAILABLE	HEALTH CENTERS (N=4)	HOSPITALS (N=1)
HIV testing services counselor	4	1
The following services:		
• HIV testing services	4	4
• HIV counseling	4	4

[7] The Transform: Primary Health Care project does not support the provision of abortion.

SERVICES AVAILABLE	HEALTH CENTERS (N=4)	HOSPITALS (N=1)
• *HIV comprehensive care (including ART, PMTCT, care, and support)*	2	1
Safe abortion services	4	1

FINDING 3: Health service providers reported that GBV survivors accessed services through a number of departments at the health centers and primary hospital.

GBV prevention and response services were provided at the hospital and health centers. Examination, first aid, contraception, testing, counseling, post pills, and referrals were available to GBV survivors most notably in outpatient department (OPD), but also the ART, maternal and child health (MCH) department, youth-friendly services (YFS), and the emergency departments. It was generally agreed that GBV prevention and response services were available in OPD; therefore, clients were either referred to OPD or personally, directly accessed services through OPD. Severe cases sought care in the emergency department or the hospital. HIV-positive survivors often accessed GBV prevention and response services in the ART clinic. Survivors with pregnancy-related issues or seeking abortion services pursued care at MCH, the maternity ward, or the laboratory for HIV, STI, and pregnancy testing.

> *Clinical response service is provided in OPD, MCH department for pregnancy, post pill, HIV services. In general, service is provided in all departments as per the indication of the case. For instance, if a raped woman or girl comes to me in OPD, I will screen her in the OPD, refer her for pregnancy test in laboratory, test HIV onsite, and if she comes from laboratory being positive for pregnancy, I will counsel her for additional services and link her to other services. So, all departments give clinical response services. —Male health service provider, health center*

FINDING 4: Healthcare workers faced challenges in identifying GBV survivors, using ad hoc approaches or relying on survivor disclosure; when they were identified, GBV survivors received priority care.

Most healthcare workers observed patients as a means of identifying GBV survivors; however, if they could not identify a survivor physically, they used additional resources, including asking questions, physical examination, and testing for STI, HIV, and pregnancy. Many healthcare workers identified GBV survivors by collecting their medical history and information. In addition to asking the survivor questions, one respondent also asked relatives questions about the survivor's medical history, if the survivor was accompanied by a relative. Nonetheless, healthcare workers, especially health extension workers, primarily relied on GBV survivors to disclose their stories to be identified; some providers had not come across any GBV survivors.

> *Self-reported history, physical examination and observation of physical violence, for example injury can be used to determine whether she or he is a survivor of violence. Information collected during history taking and physical examination can be used to determine survivors of sexual violence. —Female health service provider, health center*

> *If a victim of violence comes to us, we will bring [the victim] in the health post and ask what happened to her or what problem she faced. I think that asking the victim is the only way to have the information in order to determine whether she is a survivor of GBV. —Female health extension worker, health post*

Most respondents agreed that patients identified as GBV survivors received priority treatment. Providers said that if a survivor did not self-identify or was identified through physical wounds, they were treated as any other patient and not given priority.

> *Yes, we give priority. Physical appearance and observation is [sic] decisive to give priority. Accordingly, injury, chronic and acute cases are given priority though we do not have triage. However, cases related to rape and reproductive health, which cannot be physically observed, are difficult to give priority. It is after the client is recorded and seen in OPD the case is known and we will try to provide fast services. —Male health service provider, health center*

When interacting with GBV survivors, most healthcare workers approached GBV survivors of sexual and physical violence similarly, although some provided different services depending on the form of violence the GBV survivor had experienced. Certain healthcare workers reported treating survivors like any other patient.

> *I will provide emergency contraceptive to survivor of sexual violence and refer to health center for HIV testing. Similarly, I will provide first aid service to victim of physical violence and refer to health center. The only thing we can do is referring to the health center as health center is responsible to provide medical certificate to the GBV survivor to present to the police. —Female health extension worker, health post*

> *I treated the previous GBV survivors like any other patients. I did nothing special to them. —Male health service provider, primary hospital*

As indicated above, healthcare workers might seek information from relatives if they accompanied the GBV survivor when accessing services. Most commonly, healthcare workers indicated that family members accompanied survivors, but they also described survivors seeking care with friends, neighbors, husbands, and women more generally. Respondents indicated that survivors might access services alone. It was also shared that who accompanied the GBV survivor could depend on the type of violence, severity of the situation, or other situational factors.

> *The first is that when she comes to our facility, she may come alone, with her mother or friend. If the case is severe, she may come with her father. —Male health service provider, health center*

> *If women are affected by person other than their husbands, they come with their husbands to access services. If the perpetrators are their husbands, they come with their neighbors. —Female health extension worker, health post*

FINDING 5: Healthcare workers viewed survivors as primarily accessing GBV prevention and response services through the police and healthcare facilities.

Healthcare workers reported that GBV survivors largely accessed GBV prevention and response services through the police and healthcare facilities, although many healthcare workers acknowledged that some survivors did not seek any services. Healthcare workers discussed survivors going to the police—either instead of or in addition to going to the health center—to receive GBV prevention and response services. Respondents noted that GBV survivors' point of entry into the system depended on the service the survivor wanted; for example, for healthcare services they would go to the health center, and for legal services they would go to the police. Some respondents, especially health extension workers, indicated that survivors were not accessing GBV prevention and response services at all due to

lack of information, fears about confidentiality, or GBV being hidden within the community. One health extension worker respondent also mentioned that customary/traditional systems could be used instead.

> *I think if they wanted GBV-related healthcare service, they would go to health centers, and if they want protection or legal support, they would go to the police, accompanied by relatives and neighbors. —Female health extension worker, health post*

> *When there is conflict and violence, the community solves problems based on their custom. Even when people go to a legal body, the court sends them to traditional leaders for solution. —Female health extension worker, health post*

> *I don't think that there is motivation for the community members to access GBV services from this health post due to limited services we provide and concern related to confidentiality. I think confidentiality, availability of service within short distance, and rapid service delivery might motivate people to seek GBV service from health facility. —Female health extension worker, health post*

Healthcare workers referenced a variety of health services survivors sought out first, with the responses spread fairly evenly among the service types: emergency contraception, treatment for physical violence, counseling, and medical services more generally, such as "clinical services" and "treatment."

> *First, if they have physical trauma, they seek out medical service for this and then other services if they have other problems. —Male health service provider, health center*

FINDING 6: Healthcare workers disaggregated patient data, but none reported having a separate registry for GBV prevention and response services.

All of the observed health posts, health centers, and the primary hospital were found to disaggregate patient files by name, address, age, date of birth, and sex. Most (five of eight) health posts also had written policies in place to govern who could access the family folder and any register at the health post level. None of the health centers or the primary hospital had such written policies. None of the facilities had consent forms available for the GBV survivor and/or parent/guardian of the survivor.

None of the health centers or the primary hospital possessed a register for GBV cases. The primary hospital specifically noted that they did not have a separate register for GBV cases, and that GBV patients' information was registered the same way as that of other patients. They also stated they had only identified one client as a GBV case. The absence of a separate registry for GBV cases was corroborated in the interviews where neither health service providers nor health extension workers reported having a separate registry for GBV cases; when they encountered survivors, health service providers and health extension workers recorded their cases on regular patient cards.

> *We don't have separate recording and tracking system to this day. No significant effort has been made to this day to improve recording and tracking system. This might be due to the fact that the GBV cases are small in number. We simply record them like any other patients. —Male health service provider, primary hospital*

FINDING 7: There was an informal and unsystematic approach to following up with GBV survivors.

It is unclear from the data how follow-up was conducted to make sure patients received appropriate services, or whether healthcare workers were describing referrals within the health system, outside of the health system, or both. One healthcare worker stated he would ask the patient for a follow-up visit, and another noted that he would check in with the survivor or review the patient/client card to ensure treatment was provided. One health service provider also said that because the health center was close to the health post, she would "make the necessary follow-up" or "would use the health development army [at the] community level to follow up." There is a need for further research or clarification on how follow-ups are conducted.

> *If she experienced rape or forced sex, I would provide emergency contraceptive and refer to health center for HIV testing. If she experienced physical violence, I would provide first aid. As the health center is close to the health post, I would also make the necessary follow-up whether she was provided health service. In addition, I would use health development army community-level follow-up. —Female health extension worker, health post*

> *The first way to ensure is checking from the survivor who got service and second is by reviewing the patient's or client's card. Though we do not assess patient satisfaction, if the survivor witnessed about the service with no complaint, we say that the client has got an appropriate service. This works for all clients; we do not have unique means to ensure provision of appropriate service to GBV survivors. —Male health service provider, health center*

> *For GBV survivors, we provide treatment we think appropriate to the survivor, then we refer to appropriate authorities including to police as necessary and advise the patient to make necessary follow-up visit. —Male health service provider, primary hospital*

Evaluation Question 2: What supports and hinders primary healthcare workers to deliver quality GBV prevention and response services at the primary healthcare level?

FINDING 8: Most healthcare workers were not aware of hotlines and shelters in the region.

Very few healthcare workers were aware of any hotline for health-related information, particularly support for GBV survivors. Some health service providers were aware of the 952 hotlines; however, they were not sure whether it included information on GBV. Health extension workers did not have any information on hotlines.

> *I am aware of hotline phone 952 for health-related information. But I don't know other number or hotline service for GBV. —Male health service provider, primary hospital*

> *I do not know anything about hotline. I don't know about the availability in our community. —Female health extension worker, health post*

Most health service providers and health extension workers did not know about shelters in Amhara. The few health service providers who were aware of such shelters stated they were located in other areas within Ethiopia, but not within their own regions.

I heard that there is at Bahir Dar at the hospital level. —Female health service provider, health center

I was told while I was taking the training as there are shelters around Addis Ababa and few hospitals. — Male health service provider, primary hospital

FINDING 9: Access to essential medical supplies to provide GBV prevention and response services was uneven across health facilities.

None of the health posts were observed to have first aid kids.

To varying degrees, most health centers and the hospital possessed the majority of the essential supplies to stabilize bleeding, splint fractures, manage pain, as well as treat cuts, bruises, and superficial wounds.

All of the facilities had the laboratory supplies needed to collect samples during physical examination: containers for collecting urine, stool, and other bodily fluids; pregnancy tests; and syringes and vials for collecting blood for STIs, HIV, and Hepatitis BsAg testing. However, only one health center and the primary hospital had oral swabs, and none of the facilities had vaginal swabs. Most health centers (three of four) and the primary hospital had functional refrigerators or freezers to store specimens, and the temperatures of these appliances were regularly monitored. The one health center that lacked a refrigerator shared a solar refrigerator with another, nearby health post. Most health centers (three of four) and the primary hospital had on-site laboratories capable of evaluating forensic evidence.[8]

Availability of equipment for testing was uneven. The primary hospital was found to have both an x-ray machine and an ultrasound machine, while only one health center had an ultrasound machine. Regarding laboratory, equipment, and supplies to test for STIs, none of the facilities were found to have direct wet mounts or the equipment needed to conduct cultures. Most of the health centers (three of four) and the primary hospital had equipment for conducting venereal disease research laboratory (VDRL) tests. One health center mentioned they used a syndromic approach to examine STIs instead of the types of equipment assessed during the observation. Only one health center and the primary hospital had the necessary supplies to test for Hepatitis B.

Exhibit 3: Medical supplies and equipment

MEDICAL SUPPLIES AND EQUIPMENT	HEALTH CENTERS (N=4)	HOSPITALS (N=1)
Patient room has the following supplies to stabilize bleeding, splint fractures, manage pain, treat cuts, bruises, and superficial wounds:		
Adult BP cuff	4	1
Bandages	4	1
Gauze	4	1
HIV post-exposure prophylaxis	3	1
Pediatric BP cuff	0	0
Rape kits	0	0
Rubber gloves	4	1
Scale	4	1

[8] Many providers understood forensic evidence collection as an umbrella term for all types of laboratory tests, so providers might have conflated the presence of a laboratory with having the capability to evaluate forensic evidence. Forensic evidence collection and evaluation requires substantial additional training and equipment, so the actual capacity for forensic evidence evaluation could be much lower than stated.

MEDICAL SUPPLIES AND EQUIPMENT	HEALTH CENTERS (N=4)	HOSPITALS (N=1)
Specula	4	1
Sphygmomanometer	4	1
Splints	0	1
Thermometer	4	1
Antibiotics	4	1
Booster tetanus vaccination	2	1
Sutures	4	1
Tetanus anti-toxoid	3	1
Pain medicine	4	1
Acetylsalicylic acid	4	1
Diclofenac sodium	4	1
Ibuprofen	3	1
Pethidine 50mg 100mg	1	1
Tramadol hydrochloride	3	1
Paracetamol	4	1
Patient room has large envelopes and tape to put evidence into	0	0
Clean clothes for the in-patient to wear (i.e., a gown)	0	0
A camera on site (for the purpose of taking photos of fresh wounds, bruises, etc. as forensic evidence)	0	0
Laboratory supplies needed to collect samples during the physical examination:		
Containers for collecting urine, stool, other bodily fluids	4	1
Oral swabs	1	1
Pregnancy tests	4	1
Syringes and vials for collecting blood for STIs, HIV, Hepatitis BsAg	4	1
Vaginal swabs	0	0
A functional refrigerator or freezer to store specimens	3	1
The temperature of the refrigerator is regularly monitored	3	1
A laboratory on site that is capable of evaluating forensic evidence	3	1
The tools needed to conduct a radiologic investigation:		
X-ray machine	0	1
Ultrasound machine	1	1
Stock of supplies to treat emergency, severe, and/or life-threatening conditions:		
Operating room	1	1
Scalpels and operating tools	1	1
Respirators	1	1
Oxygen	0	1
Supplies and expertise to treat dental issues	0	1
Ear perforation	0	1
Stock of contraception options:	4	1
Emergency contraceptives	3	1
Implants	4	1
Injectables	4	1
Combined or oral contraceptives	4	1
Copper T intrauterine device (IUD)	4	1
The following medications are in stock at the time of data collection:		
Acetaminophen	4	1

MEDICAL SUPPLIES AND EQUIPMENT	HEALTH CENTERS (N=4)	HOSPITALS (N=1)
Acetyl Salic Acid	4	1
Codeine phosphate	0	0
Diclofenac potassium	4	1
Ibuprofen	2	1
Fentanyl	0	0
Morphine hydrochloric	0	0
Morphine phase	0	0
Pethidine	0	1
Tramadol hydrochloride	2	1
Amoxicillin	4	1
Amoxicillin + Clavulanic acid	3	1
Ampicillin	4	1
Cloxacillin	4	1
Penicillin	3	1
Benzathine	1	1
Procaine penicillin fortified	4	1
Azithromycin	3	1
Cefazolin	2	1
Cefixime	0	0
Metronidazole	4	1
Doxycycline	4	1
Cotrimoxazole	4	1
Clindamycin	0	0
Abacavir Sulphate	1	1
Abacavir Sulphate/Lamivudine	2	1
Atazanavir (Ritonavir)	0	1
Darunavir	0	0
Efavirenz + Emtricitabine + Tenofovir	0	1
Emtricitabine + Tenofovir	0	1
Lamivudine	1	1
Lamivudine + Zidovudine	2	1
Lamivudine + Zidovudine + Nevirapine	2	1
Lopinavir + Ritonavir	0	1
Nevirapine	2	1
Saquinavir	0	0
Tenofovir	1	0
Zidovudine/Azido thymine	1	0
The laboratory equipment and supplies to test for STIs:		
Direct wet mount	0	0
Culture	0	0
VDRL	3	1
The minimum package for HIV post-exposure prophylaxis is met:		
At least one physician/health officer/nurse trained in PEP assigned as focal person for the facility	1	1
The contact address of the facility PEP focal person and the facility ART nurse or any other person assigned to coordinate PEP activity in the facility posted in all outpatient and inpatient departments within the health facility	0	0
PEP starter packs, including ARV drugs, available inside the health facility and accessible to all staff, 24 hours and 7 days a week	0	0

MEDICAL SUPPLIES AND EQUIPMENT	HEALTH CENTERS (N=4)	HOSPITALS (N=1)
Provider support tool algorithm for determining the severity of exposure (exposure code) and PEP register are available	0	1
Supplies to test for Hepatitis B	1	1
Supplies to administer the Hepatitis B immune globulin vaccine	1	0

FINDING 10: Most healthcare workers were not aware of SOPs, guidelines, and protocols, and did not have GBV-specific training to provide quality, comprehensive GBV prevention and response services.

Almost all health service providers and health extension workers reported they were not aware of any GBV-related policies/guidelines/protocols in their facility, although they thought that such tools would be helpful. Health service providers specifically noted that they provided the same services and referrals to survivors as any other patient because they were not aware of any guidelines, policies, or protocols. A few health extension workers and health service providers stated they had manuals and guidelines from previous training courses, which were stored at their facility. Another health extension worker was aware policies existed, but was unsure of the details.

> *We don't have specific policies, guidelines, or protocols for working with those who experienced physical or sexual violence. We provide treatment and referral service to GBV survivors like any other patient. — Female health service provider, health center*

> *I think it is important to have a clear policy guideline and protocol for working with GBV survivors that covers all services we need to provide to GBV survivors and how to provide them, as well as issues related to referral and reporting procedures. In addition, it is important to ensure that all health professionals are aware of policies, guidelines, and protocols, and have the knowledge and skill to implement them. —Female health service provider, health center*

> *We have protocol and guidelines related to the training which I took. There are five manuals and I have put them on the shelf. I told to staff to refer them when they need and I will refer them if a GBV case comes to me. —Male health service provider, health center*

Across health facility types, there were observed gaps in checklist, SOPs, or set of guidelines for conducting referrals and recording GBV cases. There was variability in the availability of national protocols and guidelines for STI referral and HIV counseling, and a code of medical ethics.

Exhibit 4: SOPs and guidelines available at the facility

SOPS, GUIDELINES, AND OTHER JOB AIDS	NO. OF HEALTH POSTS (N=8)	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
A copy of the *Pathway for Initial Care after Assault* poster	0	0	0
Code of medical ethics or ethical code of conduct visibly displayed	3	0	1
National protocols of referral for STIs available and visible	0	3	1
National guidelines for HIV counseling available and visible	4	3	1

SOPS, GUIDELINES, AND OTHER JOB AIDS	NO. OF HEALTH POSTS (N=8)	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
A checklist or document on the general signs and symptoms of GBV or sexual violence that is easily seen and accessible to healthcare workers	0	1	0
A checklist, post, or set of guidelines in the health post that lays out the process for evaluating or documenting a survivor of GBV, including the *Standard Operating Procedures for the Response and Prevention of Sexual Violence in Ethiopia, 2016*	0	0	0

In addition, the health centers and the primary hospital lacked job aids or other reference materials on how to conduct examinations and evaluate or document findings. One health center noted that while there was a resource on how to conduct a vaginal examination for different age groups, it could not be located at the time of observation. Facilities also did not have a copy of the *Pathway for Initial Care after Assault* poster, national guidelines for Hepatitis B vaccines, or a written policy in place to govern who can access patient files, medico-legal forms, and forensic evidence. All of the health centers and the primary hospital were found to lack stocks of body maps and sexual violence medical certificates.

Health centers and the primary hospital also lacked patient-facing materials on GBV and PEP, but generally had information materials on contraceptive options.

Exhibit 5: Information materials at the facility

INFORMATION MATERIALS	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
Visible information, education, and communication materials available for patients in high-traffic areas (i.e., lobby, waiting areas, consultation rooms, and/or restrooms, etc.), such as posters and/or pamphlets on:		
What to do in case an individual has experienced GBV	0	0
GBV laws and rights	0	0
Available GBV prevention and response services in the facility	0	0
The healthcare facility has pamphlets or brochures on different contraception options	3	1
Brochures or pamphlets on HIV post-exposure prophylaxis and its risks available at the healthcare facility	0	0

Health posts also lacked key written materials. None of the health posts had a checklist or document on general signs and symptoms of GBV or sexual violence that are easily seen and accessible to healthcare workers. Similarly, no facility had a checklist, post, or set of guidelines that lay out the process for evaluating or documenting survivors of GBV, including the *Standard Operating Procedures for the Response and Prevention of Sexual Violence in Ethiopia, 2016*. Only one health post had a checklist, SOP, or set of guidelines on how to conduct prevention activities (such as the one in the Ministry of Health's GBV training module) available for healthcare workers to reference or use.

In addition to lacking SOP, guidelines, and protocols to support the provision of GBV prevention and response services, most health extension workers and health service providers reported they had never received GBV-specific training. However, some health service providers and a few health extension workers mentioned having some exposure to GBV through other training, generally in college/university or through the Bureau of Health, World Vision, or the United States Agency for International Development (USAID).

I did not attend a training on gender-based violence, but I attended training on harmful traditional practices which includes early marriage and female genital mutilation. —Female health extension worker, health post

Yes, I took training on GBV for five days. The training was provided by the Ministry of Health and Transform: Primary Health Care. —Male health service provider, health center

I have attended three days training organized by World Vision on male engagement that included a session on gender-based violence. —Female health extension worker, health post

Those who have taken GBV training mentioned they were the only person in their facility with this knowledge, and acknowledged the need for written materials for providers to reference when encountering survivors. Most of the health centers and the primary hospital were found to have a provider specifically trained in GBV prevention and clinical response. The health center that did not have such a provider noted that one of their staff received a 1-day orientation or overview on GBV prevention and response, which they would not consider a training.

I am the only one who attended training in GBV in this health facility. I think it is important to provide training to midwives and emergency surgeons. —Male health service provider, primary hospital

Both health workers trained in GBV are not currently working in the health center; thus, it is necessary to train health workers on GBV from these health centers. If a GBV survivor reports to us, we might provide the services we are providing to any other patient, but we don't have adequate knowledge and skill to address their special need or service they need. Therefore, it is necessary to ensure that availability of a trained health worker. —Male health service provider, health center

Most health extension workers and some health service providers wanted more informational materials and guidelines to support their work, and cited the need for GBV-related training to strengthen GBV prevention and response services. Both health extension workers and health service providers recommended that GBV training be more widely available. Almost all health service providers and health extension workers agreed that training was needed to adequately identify GBV survivors and provide response services and referrals.

I think the provision of training and necessary guidelines and tools will help us to implement GBV prevention activities. —Female health extension worker, health post

FINDING 11: Healthcare workers collaborated with community and government structures to provide GBV prevention and response services.

Healthcare workers who had experience with GBV cases collaborated with other departments within the healthcare system, and other actors in the community and government to conduct GBV prevention and response activities. The relationship between healthcare workers and these actors was not always one of referral (see below for a presentation of findings related to referrals), but seemed to function more like a team—working together to provide services to GBV survivors. There was the perception that working together would yield the best service delivery.

There was a lady, as I told you before, who came after a dispute with her husband and beaten by him. She was not as such seriously hurt physically. After providing counseling to her, I took her to her home and reconciled with her husband. One health development army helped me in doing this. I went and reconciled the survivor together with the health development army. —Female health extension worker, health post

I provided service to a 9-years old female child raped by 23-years old person who came with her father. I carried out history taking and physical examination. She had bleeding and wound in her sexual organ, as well as physical weakness. I provided first aid service and referred her to the hospital with advice to collect the medical certificate from the hospital and report to the Women's Affairs Office for legal aid. Her father who accompanied her helped me in history taking and my professional background helped me to provide clinical service, and the information I have about the Women's Affairs Office helped to provide advice to seek legal support. —Female health service provider, health center

In my opinion, it is possible to get the best result if the health extension workers work on prevention tasks together with the Women Development Army. The reason is they tend more closely to the community, but they focus on ANC [antenatal care] and delivery. —Male health service provider, health center

FINDING 12: Health extension workers delivered GBV prevention messages, often within the context of other health-related awareness-raising efforts; health service providers tended not to engage in prevention efforts.

In some *kebeles*, limited work was being done to provide health education and raise awareness of GBV issues. Where this was happening, typically health extension workers included GBV information in health education sessions conducted in communities and schools. A few health extension workers and health service providers indicated that some GBV messages were integrated into community health education sessions that included a range of topics, such as family planning, hygiene and sanitation, pre-term births, and MCH. In addition, a few health extension workers and health service providers described awareness sessions conducted in schools, while most suggested awareness sessions took place in community locations other than schools.

When we provide health education, we do not independently give the education on GBV. We provide health education on a range of issues such as FP [family planning], hygiene and sanitation, pre-term births, child and maternal health, etc. This education may be given in church, different social gatherings and home-to-home visit, especially during campaign. —Female health extension worker, health post

We provide awareness raising to the community. I have posted, as you can see it over there, types of GBV such as physical, sexual and psychological, and we provide awareness raising on these issues to the community during any opportunities like associations, churches and meetings. We provide education as prevention of GBV. —Female health extension worker, health post

Generally, there are minimum service packages of youth-friendly service and GBV is included here. We meet every month in schools and kebeles *through peer educators and discuss not only on GBV, but generally on health issues of the youth such as abortion, family planning, counseling, GBV, etc. So, we communicate every month with students and we ask the students what problems they faced. —Male health service provider, health center*

I and my colleagues are providing training to males on GBV prevention. We both attended the World Vision training and carry out the training for both males and females using the manual provided by World Vision. —Female health extension worker, health post

Raising awareness was consistently recommended as a way to encourage the community to access GBV prevention and response services. Health extension workers and health service providers who recommended steps to encourage the community to access GBV prevention and response services all

suggested awareness raising for the community. This included raising awareness about the services the facilities offer and health risks associated with GBV, and working with youth in schools.

> *Promotion and health education by strengthening communication with the health extension workers and providing education to the youth is necessary. The youth can inform the victims in the school so that the survivors will come to health facility. —Female health service provider, health center*

> *I don't know which groups are visiting or not visiting health facility to access GBV-related services. I think most community members do not seek health service for GBV and prefer not to report. I think it is important to increase community awareness and encourage seeking GBV service from health facilities. —Male health service provider, health center*

FINDING 13: Healthcare facilities lacked the infrastructure to keep GBV survivor's information confidential.

Both health service providers and health extension workers ensured GBV survivor's confidentiality by not disclosing information to others in the same manner as they would for non-GBV patients. One health service provider specifically mentioned it was their professional obligation as healthcare workers to keep patients' information confidential.

> *The medical service by itself orders to keep confidentiality of any client not only GBV cases, for instance there are ART clients, STI clients to keep their confidentiality. So, like other clients we keep confidentiality of GBV cases. We do not disclose their information. —Male health service provider, health center*

> *By the way, a health professional must keep confidentiality. Keeping confidentiality is one of the principles to be adhered. —Female health extension worker, health post*

> *However, we don't keep their cards in separate and locked cabinet (although I think that is appropriate). —Male health service provider, primary hospital*

> *This health post is not in a position to ensure the confidentiality. Let alone for GBV survivor, it is difficult for women to seek family planning service to access from our health post due to husband opposition. Specifically, the health post is situated closer to the government office where many people queue for loans for small-scale trade and women fear that these people might see and think they came to health post for contraceptive and would tell their husband. —Female health extension worker, health post*

None of the health service providers reported having a designated room for GBV survivors; however, they used separate rooms, such as YFS rooms, to conduct examinations and counseling sessions, but this was not always guaranteed. Many health service providers stated they did not have any options for a separate room for GBV survivors.

> *As we have professional obligation, we are ready to do everything possible to ensure confidentiality of patients, including GBV survivors. For example, to ensure confidentiality we dedicated separate room for provision of youth-friendly service. Although there is no separate room for GBV, we can provide service to GBV survivors in the room used youth-friendly service, and the information reveled to the health worker will also remain confidential. —Male health service provider, health center*

Observation revealed major deficiencies across all areas assessed with regard to infrastructure. None of the health centers or the primary hospital were found to have the following: (1) rooms or areas where

GBV survivors can rest and/or a stabilization room that is private, clean, quiet, and comfortable; (2) a designated location to examine GBV cases that ensures the confidentiality and privacy of survivors; (3) discrete signage inside and outside the facility; (4) a child-friendly room complete with toys, coloring books, pictures, or anatomical dolls.

Some health service providers indicated that their facilities did not have a locked or secure room for patient records, although they acknowledge it was needed. None of the observed health centers and primary hospital kept medico-legal files, including GBV case files, stored in a lockable cabinet. Two health centers noted that GBV patient files were stored the same way as for other clients. The primary hospital also did not have a lockable cabinet, and their GBV patient files were stored in the same manner as other clients' files.

Exhibit 6: Infrastructure for patient confidentiality

INFRASTRUCTURE	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
Rooms or areas where GBV survivors can rest and/or a stabilization room that is private, clean, quiet and comfortable	0	0
A designated location to examine GBV cases that ensures the confidentiality and privacy of survivors	0	0
Discrete signs inside and outside the facility (i.e., instead of *Rape Center* signs should say *Wellness Center* or *One Stop Center*)	0	0
A child-friendly room in the healthcare facility and has the following:		
Toys	0	0
Coloring books	0	0
Pictures	0	0
Anatomical dolls	0	0
Medico-legal files, including GBV case files, stored in a lockable cabinet	0	0

FINDING 14: Healthcare workers believed that GBV survivors would be satisfied with services if their confidentiality/privacy were respected and they received compassionate care.

Health service providers and health extension workers described a number of factors as important for women to be satisfied with their care. These factors included the facility's ability to provide the necessary services in a timely fashion, respect for the patient's privacy/confidentiality, and receiving welcoming and compassionate care. A few health service providers and health extension workers also mentioned the services provided within the same facility and action taken against the perpetrator.

> *In my view, the most important reasons for women's satisfaction from the service include (1) receiving all the services from one place and (2) receiving the service within short period of time. Because women in rural areas have a lot of responsibilities and are extremely busy, they cannot have time to visit different places for different service and wait too long for service. One of the reasons that rural women like the current health insurance is that they can get all the service they want and reduce waiting time. —Female health extension worker, health post*

The first is privacy or class and environment. This means if for instance, a raped girl comes, she should not be served around other clients. Instead, she should get service in different place or room not visible and there should be a provider who is competent and can provide appropriate service. —Male health service provider, health center

A woman will feel satisfied if the professional is welcoming, reassuring the client, treats the client especially psychologically, counsels the client well and informs her of any necessary issue, informs her he will support her closely for any support she needs, and in general treats the client by applying the principle of CRC (compassionate, respectful and caring) treatment. —Male health service provider, health center

Both health service providers and health extension workers largely indicated that young girls would be satisfied with the care they received for the same reasons as adult women. They highlighted privacy and confidentiality as especially important factors for young girls. In addition, healthcare workers indicated that fast and urgent service was important, and a few health service providers and health extension workers stated they were unsure whether the reasons for girls' satisfaction with services would be different from those of adult women.

The main thing for young girls is if you keep their privacy. She will be satisfied if she becomes sure that her secret will not be disclosed to anybody. —Female health service provider, health center

Most health service providers and some health extension workers indicated that male GBV survivors (both men and boys) would be satisfied with their care for the same reasons as women. Other reasons—such as learning their health status, having evidence, and returning to their life unchanged—were perceived as desirable attributes of services delivered to male GBV survivors.

There is no difference for the man and the woman it is all the same. The main thing is providing the services that they desire. —Male health service provider, health center

The first is priority service and then getting fast service. The other is private room for GBV service and availability of trained person who can keep privacy and treat psychological trauma in the room. Besides, if the professional has good approach and is caring, the client will feel safe and satisfied. —Male health service provider, health center

I think the man will be satisfied if we keep his privacy, give him evidence, and let him know, his health status. —Female health service provider, health center

FINDING 15: Survivors, particularly young girls, were perceived as not accessing GBV prevention and response services due to religion/culture, societal perceptions, concerns about confidentiality, and lack of quality services.

Both health service providers and health extension workers indicated that young girls and rape survivors were not visiting facilities to access GBV prevention and response services. Healthcare workers—mostly health extension workers and a few health service providers—described three main reasons young female GBV survivors might not access treatment: religion/culture, lack of awareness of available services, and fear of sharing their experience due to societal perceptions.

In my view, young women who experienced forced sex from boyfriend are unlikely to visit health facility due to fear that information would reach to her parents. In addition, married women who experienced physical

violence from partner might not visit health facility due to culture that encourages family affairs secret. I think increasing awareness would help to encourage them. —Female health extension worker, health post

Small number of GBV survivors came to our health center. However, this doesn't mean that only few people experience physical or sexual violence in the community, but people in the community do not know where to go and what health and legal services are available to them and we did little to make them aware. This is mainly due to lack of attention to the problem and absence of specific policies, guidelines, protocols, and training for health workers on GBV prevention and response. —Female health service provider, health center

In general, there has not been a case on GBV. The GBV may be committed in the community, but community does not come to our facility probably due to cultural influence and settling the problem in the community's custom and tradition. —Male health service provider, health center

Many health service providers and a few health extension workers viewed quality services as a main motivator for the community to access GBV prevention and response services. Healthcare workers usually stated some aspects of the quality of services as a motivating factor, such as clinical services, providing quality medical advice and information, and professionals' competency. Some health service providers also indicated that obtaining evidence or a certificate for the police stimulated survivors to access GBV prevention and response services, and highlighted that the police sometimes referred survivors to the health center. A majority of health service providers working in health centers mentioned other motivators, including access to emergency contraception, confidentiality, and referrals from the Women's Development Group.

What we do is providing counseling, referring to a health center and giving advice to the survivors to report to police or Women's and Children's Affairs Office. So, probably survivors are motivated to come to us for we can provide them counseling service and advice. —Female health extension worker, health post

We provide quality health service to patients as much as possible, and most community members also perceive that we provide quality service and know that also we also refer to the right health facility for services which are beyond capacity. These might motivate community members to access GBV service if we provide and if they made aware that we provide GBV service. —Male health service provider, health center

What motivates them is getting medical evidence for commitment of violence given by the health facility when they are referred to us by police for evidence. —Male health service provider, health center

Concerns about confidentiality, lack of willingness to come forward, and limited or unavailable GBV prevention and response services hindered some community members' access to facilities, particularly health posts. Health extension workers at health posts noted restricted and unorganized service as the primary reason for not having seen GBV survivors. Both health extension workers and health service providers cited lack of community awareness and GBV being hidden within communities as other factors that influenced survivors' low access of GBV prevention and response services.

I think there is nothing that motivates community members to come to health post for GBV service. They know that health posts provides [sic] very limited healthcare service and usually community members directly go to health center. I think this is one of the main reasons why no GBV survivor came to health post. —Female health extension worker, health post

I don't think that is there is motivation for the community members to access GBV services from this health post due to limited services we provide and concern related to confidentiality. I think confidentiality, availability of service within short distance, and rapid service delivery might motivate people to seek GBV service from health facility. —Female health extension worker, health post

Evaluation question 3: Which services do healthcare workers refer GBV survivors to (e.g., police, legal, psychosocial, shelter)?

FINDING 16: Some healthcare workers reported that they had not encountered GBV cases; therefore, they had not given referrals to GBV survivors.

A number of healthcare workers stated they had not yet encountered GBV cases or provided referrals for GBV survivors. However, after further probing, the same healthcare workers described specific scenarios of survivors they had treated at their facilities. Healthcare workers also recalled instances where survivors of IPV came to their facilities and were "reconciled with their partners," but did not receive any referrals.

Healthcare workers also indicated they had not encountered any male GBV survivors.

To date, there is no male who came to our hospital due to GBV. If anyone comes, they can get appropriate response service and referral. —Male health service provider, primary hospital

As I told you, GBV cases reported to us are the dispute between the husband and wife and physical assault. When facing such things, we counsel, reconcile and send them home by resolving the issue but do nothing else. —Female health extension worker, health post

Related, some health service providers were largely unaware of the referral pathway for GBV survivors.

I don't know about the existing referral link for GBV survivors. But I refer them to the hospital for other health issues. —Male health service provider, health center

FINDING 17: Healthcare workers would or did refer GBV survivors to police, higher level health facilities, and Women's Affairs Office.

Even though some healthcare workers did not think it was mandatory to do so, the majority of health extension workers and health service providers commonly either provided referrals to or directly reported GBV cases to the police. Healthcare workers who had not encountered survivors said they would provide referrals to the same services in the event they did come across a GBV survivor. Both health service providers and health extension workers indicated they would provide male GBV survivors with referrals to the same services as female survivors.

When a GBV survivor comes, we will link to the trained health provider and for the case beyond the capacity of the trained person, we will refer the case to hospital. —Male health service provider, health center

There is violence that either physically or internally affected the survivor, we refer to a health center and if the victim says, "I am not affected but harassed or abused," we refer to police. —Female health extension worker, health post

Most health service providers reported they worked with the police by either sharing forensic evidence when requested or granting police access to patient documents.

> *We provide medical evidence to the police upon receiving a written official request. —Female health service provider, health center*

After identifying a survivor and determining their GBV response service needs, in addition to referrals to the police, healthcare workers also commonly provided referrals to counseling services, higher level health facilities, and Women's Affairs Office.

> *We also advise the survivors to report to police and Women's and Children's Affairs Office. There is no, however, an established referral linkage. —Female health extension worker, health post*

Interview data were corroborated by observational data, which indicated that health posts and health centers did not provide any of the types of referrals assessed, including referrals for emergency or life-threatening conditions, laboratory, and mental health counselors. There were gaps in the referrals the primary hospital provided; however, the primary hospital did provide referrals for mental health counselors, physical injuries including severe or life-threatening conditions, laboratory, safe abortion services, and PEP. None of the facilities provided referrals to child protection services, legal support, the police, psychologists, economic empowerment programs, livelihood services, support groups, or emergency shelters.

FINDING 18: There were no specific standard referral forms for GBV survivors or guidance for healthcare workers on how to provide referrals.

The observation checklists revealed that none of the health centers or primary hospital had a standard referral form for GBV survivors, and none of the health posts had a checklist, SOP, or set of guidelines (such as the one in the Ministry of Health's GBV training module) available for healthcare workers to reference or use for conducting referrals.

CONCLUSIONS

Conclusion 1: Limited knowledge and resources hindered healthcare workers' ability to provide comprehensive, quality GBV prevention and response services, and influenced their perceptions of services survivors sought.

The healthcare workers interviewed in Amhara generally had a narrow understanding of GBV, which emphasized physical or sexual violence against women. Other types of abuse, such as early forced marriage and other forms of inequality, were not featured in their understanding. However, there was some inconsistency in the definition respondents articulated and experiences they shared with clients who could be considered GBV survivors.

The impact of this narrow understanding, combined with a lack of training and dearth of resources and job aids to guide healthcare workers, was felt along the continuum of services—from identification of GBV survivors through referral and follow-up. The absence of SOPs and guidelines for identifying GBV survivors, including a screening checklist, forced healthcare workers to rely on their observation skills or patient disclosure. Without a specific GBV registry, there was no place for healthcare workers to document care and referrals for GBV survivors, and encourage follow-up with them.

Finally, healthcare workers had variable access to the medical supplies needed to provide response services to GBV survivors. Most notably, the fact that none of the health posts were observed to have first aid kits contributed to health extension workers feeling they could not meet the needs of GBV survivors at the health post.

Conclusion 2: Healthcare workers were engaging in limited GBV prevention activities, but believed they could increase use of GBV prevention and response services.

Healthcare workers, predominantly health extension workers, engaged in awareness raising, often as part of other health-related awareness-raising efforts conducted in the community. However, there was widespread agreement that awareness raising as a prevention activity was needed and could serve to increase GBV survivors' use of response services, including potentially as a means of countering sociocultural perceptions of GBV. Healthcare workers wanted more training and support, as well as cognizance of other prevention activities that took place, to effectively coordinate with other actors in the community to deliver prevention messages.

Conclusion 3: Cooperative relationships between the health sector and police facilitated the provision of services to GBV survivors.

Healthcare workers noted that there was a cooperative relationship between the health system and other actors, which bolstered the provision of GBV-related services. In the absence of a functional referral system, healthcare workers and other actors found alternative, informal mechanisms for meeting the needs of GBV survivors. Healthcare workers referred and reported incidences of GBV to the police, sharing forensic and other information, even if there was no formal documentation of referrals and follow-up. This extended to the limited prevention activities where health extension workers were viewed as being well-positioned in the community to work alongside the Women's Development Group and the schools to deliver GBV messages, although these were often embedded in other health-related awareness-raising programs.

Conclusion 4: Weak processes in the provision of GBV prevention and response services inhibited healthcare workers' ability to maintain GBV survivors' confidentiality, which, in turn, may affect access to and use of GBV response services.

Healthcare workers recognized the importance of maintaining patient confidentiality and took steps individually to uphold their professional obligation in this regard by refraining from disclosing sensitive patient information to others. However, major deficiencies with regard to facility infrastructure—such as separate rooms for GBV survivors to rest and for GBV case examination, separate registers for GBV cases, and secure rooms or locked cabinets for patient records—have important implications for healthcare workers' ability to effectively maintain the confidentiality and privacy of GBV survivors. Without these necessary resources, healthcare workers were unable to implement processes and procedures that would improve patient confidentiality, such as a private space to speak with survivors about their experiences, and keeping GBV patient files secure and separate from the information pertaining to other clients.

These weaknesses in processes for patient confidentiality could, in turn, affect the degree to which survivors access the facilities for GBV prevention and response services. Healthcare workers widely expressed a perception that respect for privacy and confidentiality was a key factor for a GBV survivor to feel satisfied with their care—this was the case for women, men, boys, and particularly young girls. At the same time, healthcare workers reported that the main reason some community members, especially young girls, may not be accessing GBV prevention and response services at all was concern for their

privacy/confidentiality if they were to visit the health facility. Taken together, these insights indicate that the weaknesses in processes and infrastructure for ensuring patient confidentiality might have broader impacts on the community's willingness to access GBV prevention and response services, given the high value that many might place on this aspect of their care.

RECOMMENDATIONS

These recommendations were developed collaboratively with project staff based on overall findings from the study. Project staff operating within Amhara then selected priority recommendations for the region based on their region-specific findings and conclusions. These priority recommendations will be used to guide the development and implementation of activities in Amhara to address needs specific to the region.

Recommendation 1: The Transform: Primary Health Care project's Amhara regional office should provide orientation for healthcare workers on all types of GBV and SOPs related to GBV in collaboration with the Regional Health Bureau, *woreda* health offices, and cluster offices. This includes clinical training and training-of-trainers on GBV for at least one healthcare worker per facility.

Recommendation 2: The Transform: Primary Health Care project's Amhara regional office staff should increase community mobilization activities, including working with Women's Development Groups, school engagement activities, male engagement activities, and local community leaders, and strengthening GBV sessions in workshops. The gender officer should work closely with the social and behavior change communication team to integrate GBV in their activities and materials.

Recommendation 3: The Transform: Primary Health Care project's Amhara regional office should support the establishment and strengthening of referral systems within the primary healthcare units by mapping services, availing service directories, improving pre-referral communication, and promoting standard and systematic referral and feedback formats.