GENDER-BASED VIOLENCE LANDSCAPE ANALYSIS – OROMIA CASE STUDY

USAID/ETHIOPIA TRANSFORM: PRIMARY HEALTH CARE PROJECT

June 2019

This publication was produced for review by the United States Agency for International Development (USAID). It was prepared by EnCompass LLC for the Transform: Primary Health Care Project (Cooperative Agreement No. AID-663-A-17-00002). The views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

CONTENTS

ACRONYMS AND ABBREVIATIONS.......II
INTRODUCTION.......3
CONTEXT.......4
FINDINGS.......5
CONCLUSIONS.......17
RECOMMENDATIONS.......19

ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral therapy
FGM/C	Female genital mutilation/cutting
GBV	Gender-based violence
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

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 services. 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 Oromia region.

---

[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 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

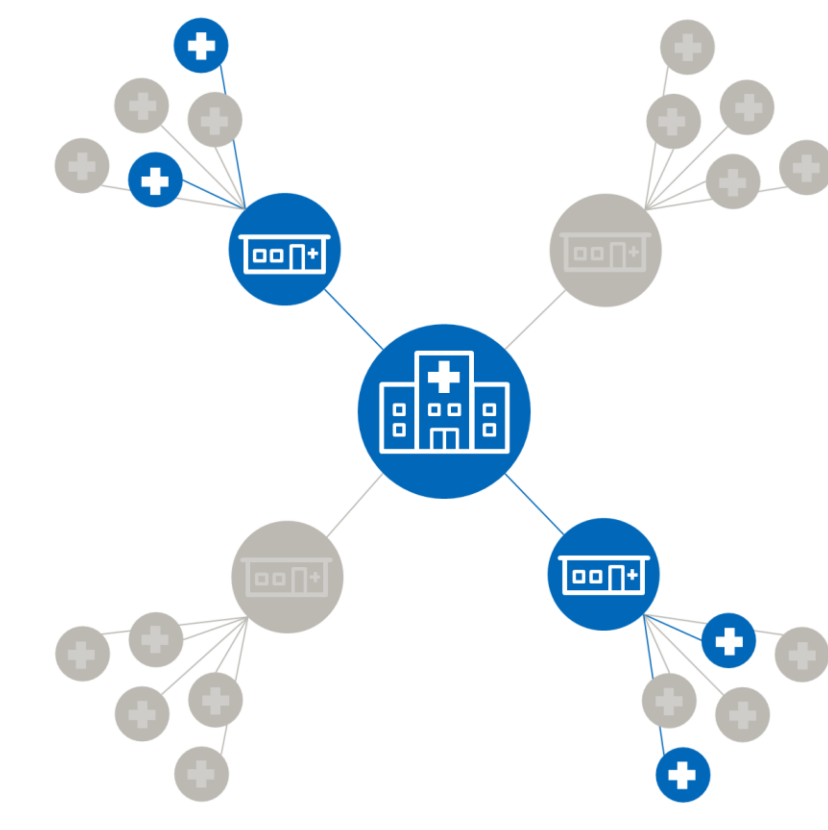
The health network in the selected learning/demonstration *woreda* of the Oromia region consisted of four health centers. The sample was comprised of one primary hospital, two health centers, and four health posts (two under each health center). The interview sample included one health service provider 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 Oromia case study.

Exhibit 1: Oromia research sites

1 Primary Hospital
1 Health Service Provider

2 Health Centers
4 Health Service Providers

4 Health Posts
4 Health Extension Workers



FINDINGS

This section presents the GBV landscape analysis findings in the Oromia region by evaluation question, organized by overarching themes that emerged from the data.

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: Respondents had a broad understanding of what constituted GBV, but most frequently saw cases of rape, early marriage, and physical violence.

All respondents defined GBV as including physical and sexual violence. Respondents specifically mentioned abduction, forced marriage, and female genital mutilation/cutting (FGM/C). Beyond sexual violence, most respondents defined GBV as having social dimensions based in gender inequality that led to differing economic, social, and educational opportunities for men and women. Many included psychological and emotional mistreatment, and social harassment.

> *It is largely perpetrated against women or young girls. GBV includes physical violence (intimidation, threats, insults and abuse during labor), sexual violence (rape, domestic violence by intimate/non-couples and elder abuse), psychological mistreatment, underage marriage and harmful customary practices, such as tonsillectomy, forced marriage or abduction, and female genital mutilation or cutting. —Female health extension worker, health post*

> *It is highly deep-rooted in the society's custom, practice, and norms. These communal values and practices gave way to unequal power relationships between men and women in the spheres of politico-economic, cultural and social affairs. —Female health extension worker, health post*

Majority of health service providers and health extension workers indicated that they most frequently saw cases of rape, physical violence other than rape, and early marriage at the facility. However, two health service providers (one female from a health center and one male from the primary hospital) shared that GBV was rarely reported.

> *Though GBV cases reported to the facility are minimal, in the rural areas, it prevails in the forms of sexual assault, physical assault (causing body injury and skin burn), psychosocial or emotional abuses. —Male health service provider, primary hospital*

FINDING 2: Facilities provided HIV services to varying degrees and only hospitals provided comprehensive HIV services to GBV survivors.

The observed health centers and primary hospital all possessed an HIV testing services counselor, and the counselor or the healthcare facility all offered HIV testing services and counseling. Only the primary hospital provided HIV comprehensive care (including antiretroviral therapy [ART], prevention of mother-to-child transmission [PMTCT], care, and support). Neither the health centers nor the primary hospital met the minimum package for HIV post-exposure prophylaxis (PEP). Only one health center and the primary hospital had at least one physician/health officer/nurse trained in PEP who was assigned as a focal person for the facility. Only the primary hospital had 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. None of the facilities were found to have PEP

starter packs, including antiretroviral drugs, available inside the health facility and accessible to all staff, 24 hours and 7 days a week. Only one health center and the primary hospital had the provider support tool algorithm for determining the severity of exposure (exposure code) and PEP register available.

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

SERVICES AVAILABLE	HEALTH CENTERS (N=2)	HOSPITALS (N=1)
HIV testing services counselor	2	1
If yes, the counselor or the healthcare facility offer the following services:		
• HIV testing services	2	1
• HIV counseling	2	1
• HIV comprehensive care (including ART, PMTCT, care, and support)	0	1
The healthcare facility meets the minimum package for HIV PEP:		
• A 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	1
• PEP starter packs, including antiretroviral drugs, available inside the health facility and accessible to all staff, 24 hours and 7 days a week	0	0
• Provider support tool algorithm for determining severity of exposure (exposure code) and PEP register available	1	1

FINDING 3: Healthcare workers recognized the importance of raising awareness of GBV issues as a means of prevention and in some cases, worked with community actors to provide GBV prevention services. However, the testimony was inconsistent, and the most common response was that the respondents and their health facilities were not involved in GBV prevention.

Respondents recognized creation of GBV awareness within the community as important; it was the most commonly referenced prevention activity. Specific awareness-creation activities included training for youth on GBV and sexually transmitted infections (STIs); mobilizing the community to discuss and engage in GBV prevention; and awareness raising on GBV, HIV/AIDS, human rights, and services offered at the health facility.

> *As GBV problem remains deep-rooted and prevails at grassroots level, creating public awareness requires a huge task, and it needs to be incorporated in school curriculum and community mobilization schemes. — Male health service provider, health center*

Across *kebeles* and facilities, there was a range of healthcare workers engaged in GBV prevention services, including nurses, physicians, health officers, midwives, focal persons, and health extension workers. Their reported roles in prevention efforts were variable. These actors worked alongside community groups, such as the Women's Affairs Office, Women's Development Group, and the police, as well as less frequently mentioned religious leaders, community elders, school clubs, community organizations, teachers, and agricultural development agents. Respondents noted that GBV prevention activities were done alongside other awareness-raising efforts on health issues more broadly, such as family planning or harmful traditional practices.

Health extension workers, we often give training on health packages and GBV-related prevention activities. —Female health extension worker, health post

We have permanent schedules on community-based GBV protection activities by creating awareness at schools every week and among the community on a monthly basis. Throughout the schools within the district catchment areas, the health center has been working in collaboration with girls and youth clubs. —Male health service provider, health center

There was inconsistency in respondents' involvement in prevention efforts at the facility. Some reported they and their facility were not involved in prevention, while others indicated that prevention activities were available in healthcare facilities, but the type of facility varied. Some said prevention programs were based out of health posts, still others suggested that prevention activities were the domain of the health centers and primary hospitals. They characterized regional and national-level facilities as minimally involved. The *woreda* health office often provided supervision of these activities.

Mostly the health post provides GBV-related prevention services to the local communities… However, local religious leaders, community elders, Women's Development Groups, and Women's Affairs [Office] contribute immensely in awareness creation and alerting the community on the response to GBV and other related issues. —Female health extension worker, health post

Little GBV prevention services exist in the health center, and we work jointly with the police and women and children affairs offices at the district level. —Female health service provider, health center

There are hardly any health systems ranging from national to zonal levels that are providing GBV prevention services. —Female health extension worker, health post

Only referral and primary hospitals have been rendering GBV-related prevention and clinical services. —Male health service provider, health center

Interestingly, respondents shared examples of successful GBV response services that became a mechanism for raising GBV awareness, thereby having an indirect effect on advancing GBV prevention. This includes referral to or working directly with other actors (e.g., Women's Affairs Office, education officials, and the police).

Though not in direct professional support, once I heard about an abduction case from a teacher neighbor and advised him to report the matter urgently to school principals and the Women's Affairs Office. These bodies made a successful intervention by helping the survivor receive medical treatments and counseling services, brought the suspect before the court of law, and created awareness to school communities on GBV and related health issues prevailing among the community. —Male health service provider, primary hospital

FINDING 4: Healthcare workers provided clinical care to GBV survivors, but perceived survivors as predominantly seeking psychosocial support services when they arrived at the health facility.

Most health service providers and health extension workers said that when GBV survivors came to their facility, they offered counseling and psychological support; however, there was some variation on the level of emphasis on counseling and by provider type. Some respondents stated outright that counseling and psychological support were their central function as GBV responders, and this service was what victims needed the most. At the same time, they paired counseling with other services. All health

extension workers reported that they provided GBV survivors counseling, first aid, and referrals to higher level facilities for testing and other medical services. Health service providers more frequently indicated they provided PEP and emergency contraception, and were less likely to mention first aid.

> *First and foremost, I establish close rapport and friendship with a GBV survivor. Then, I offer available services in the health post, such as first aids, counseling, and clinical services. I will try to build the confidence of the victim by ensuring privacy and confidentiality throughout services given and health systems visited as referral points. I insist survivor openly share GBV experiences and incidents encountered. I deliver first aids, psychosocial counseling services. —Female health extension worker, health post*

> *The major type of services given at the health post level is counseling and guidance. —Female health extension worker, health post*

> *The health center offers services to GBV survivors, such as to stop bleeding, prevent unwanted pregnancy by giving emergency pills, and allowing voluntary abortion, and provide post-exposure prophylaxis to prevent from possible HIV infections. —Female health service provider, health center*

Health service providers indicated that they most frequently used observation based on their experience and professional instinct to identify GBV survivors who came into the facility. No respondents reported use of checklists or other external standardized protocols in the observation process.

> *GBV survivors are visible and I can identify them easily. They feel distressed, dissatisfied, crying, isolated and cover their head/also bending down. —Male health service provider, health center*

> *My work experiences, repeated access to GBV survivors at the health post and this survivor's willingness to receive medical and counseling services enabled me to identify her. —Female health extension worker, health post*

FINDING 5: Healthcare workers cited welcoming and compassionate care as a main reason women and girls accessed GBV prevention and response services; girls also appreciated services that facilitated their return to school.

Most health service providers and health extension workers noted that women felt satisfied with the services they received because service providers were welcoming, compassionate, and confidential. Respondents also noted that girls appreciated timely services that facilitated their return to school.

> *A woman feels satisfied and safe if she is given timely and adequate services, has access to safe abortion, psychosocial counseling services and her privacy/confidentiality kept. —Female health service provider, health center*

> *Young girls who survived GBV are to receive urgent and successful services so that they can easily re-join their community and attend schools without their case being identified. —Female health service provider, health center*

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

FINDING 6: While most healthcare workers recognized the importance of keeping GBV survivors' information confidential, recordkeeping practices and security were generally weak.

Many health service providers and health extension workers stated they made efforts to keep GBV clients' information confidential and highlighted the importance of doing so. As noted above, they also noted that confidentiality was one of the qualities GBV response survivors valued the most. However, only one health service provider reported that the health center stored documents about GBV survivors in "safe and secret places, separate from other registry records."

> *At the health post, we are obliged to respect the privacy of victims and do not share their information to other unless their story is needed formally for legal and supportive evidences for referral and building cases for criminal investigation. —Female health extension worker, health post*

Most providers stated that there was not a separate registry for tracking GBV data and/or record keeping around GBV was generally weak. Recognizing this as a problem, one female health service provider at a health center said she tried to keep a personal record of GBV survivors. At the hospital level, the provider reported that while there was a separate registry card system for GBV cases, records were not kept in a separate location. At one health center, the provider noted that a GBV-related record tracking system had not yet been launched; at another health center, the provider reported that GBV cases were recorded in the health management information system, but was unclear whether the system had a place to record GBV-specific information.

> *At the health post level, information about GBV cases can be handled poorly due to lack of record registry, trained health extension worker, and organized system of documentation. —Female health extension worker, health post*

Facility observation checklist data confirmed that neither the health centers nor the primary hospital had a register for GBV cases. One health center noted that GBV case information was captured on the client card. Only the primary hospital stored medico-legal files, including GBV case files, in a lockable cabinet; none of these security measures were observed in health centers.

> *There is a separate registry card system for GBV cases, but [it is] not kept in a separate cabinet. —Male health service provider, primary hospital*

> *GBV-related record tracking system in the health center is not yet launched and no registry system is in place. So far, I came across a single GBV case and tried to keep a personal record of the survivor in a separate registry sheet. However, the registry failed to include disaggregated standard format by the type of violence, sex, and age of the survivor and kind of services rendered at the health facility. —Female health service provider, health center*

Further, all facilities lacked consent forms for GBV survivors and/or the parent/guardian of the survivor.

FINDING 7: Dedicated space within the facility for GBV treatment was generally limited.

None of the observed health centers or the primary hospital had rooms or areas where GBV survivors could rest, or a stabilization room that was private, clean, quiet, and comfortable. In the absence of dedicated spaces, health service providers used other locations within the facilities, such as emergency rooms, ART clinics, and adult outpatient departments. No facilities had a designated location to examine GBV survivors that ensured confidentiality and privacy, discrete signage, and child-friendly rooms.

> *There is no separate room to provide adequate GBV services to the victims and others willing to visit services given at the facility. —Male health service provider, health center*

> *There is no separate room allocated for GBV response services within the hospital; however, the service is available in the ART and in the HIV departments. —Male health service provider, primary hospital*

FINDING 8: A lack of resources (financial, human, and medical equipment and consumables) hindered the provision of quality GBV prevention and response services.

Across *kebeles* and facilities, resource limitations impaired the provision of both GBV prevention and response services. Respondents stated that the lack of resources (specifically financial, medical, and human) resulted in inefficient, inconsistent, or incomplete GBV prevention and response services.

> *The health center has inadequate resources to provide GBV prevention services throughout the district catchment areas. We received unsatisfactory financial, medical, and human resource supports both from the health office and from other levels of the health systems. —Male health service provider, health center*

> *Although we planned to carry out GBV prevention services at the local level, we are constrained by the lack of adequate budget, human resources, and medical materials to reach out [to] all community with the health post catchment area. —Female health extension worker, health post*

Most of the health posts had first aid kits (although one health post mentioned they did not have the full kit), and all health posts reported the availability of multiple forms of contraception, including implants, injectables, combined or oral contraceptives. Intrauterine devices were reportedly not available in any of the health posts.

Observation of health centers and the primary hospital found a number of deficiencies in resources necessary for the provision of GBV response services. All facilities lack pediatric blood pressure cuffs, supplies for administering the Hepatitis B immune globulin vaccine, and numerous key medicines (including pethidine, fentanyl, morphine hydrochloric, cefixime, and Darunavir, among others). All facilities were equipped with all forms of contraception: emergency contraceptives, implants, injectables, combined/oral contraceptives, and intrauterine devices; they also had clean gowns for patients.

Exhibit 3: Equipment and supplies available at health centers and hospital

EQUIPMENT AND SUPPLIES	HEALTH CENTERS (N=2)	HOSPITALS (N=1)
The healthcare facility's patient room has the following supplies:		
Adult BP cuff	2	1
Bandages	2	1

EQUIPMENT AND SUPPLIES	HEALTH CENTERS (N=2)	HOSPITALS (N=1)
Gauze	2	1
HIV PEP	2	1
Pediatric BP cuff	0	0
Rape kits	0	0
Rubber gloves	2	1
Scale	2	1
Specula	2	1
Sphygmomanometer	2	1
Splints	2	1
Thermometer	2	1
Antibiotics	2	1
Booster tetanus vaccination	2	1
Sutures	2	1
Tetanus anti-toxoid	2	1
Pain medicine	2	1
Acetylsalicylic acid	1	1
Diclofenac sodium	2	0
Ibuprofen	0	1
Pethidine 50mg 100mg	0	0
Tramadol hydrochloride	0	1
Paracetamol	2	1
The healthcare facility has the tools needed to conduct a radiologic investigation:		
X-ray machine	0	0
Ultrasound machine	1	1
The healthcare facility is stocked with supplies to treat emergency, severe, and/or life-threatening conditions:		
Operating room	0	1
Scalpels and operating tools	0	1
Respirators	0	1
Oxygen	0	1
Supplies and expertise to treat dental issues	0	1
Ear perforation	0	1

With regard to developing forensic evidence, both health centers and the primary hospital lacked rape kits, and large envelopes and tape for placing evidence; however, all facilities possessed cameras for taking photos of wounds or other injuries. In terms of the laboratory supplies needed to collect samples during physical examinations, all facilities possessed containers for collecting urine, stool, or other bodily fluids; pregnancy tests; and syringes and vials for collecting blood for STIs, HIV, and Hepatitis BsAg. Only the primary hospital was found to have oral and vaginal swabs. While all facilities have freezers or refrigerators that are regularly monitored, none of the facilities have an on-site laboratory capable of evaluating forensic evidence. Respondents infrequently (twice) referenced using evidence-gathering procedures or technology.

With respect to human resources, facilities lacked a dedicated staff or focal person responsible for and trained in GBV prevention and response service provision. In one health center, this resulted in everyone being expected to deliver GBV prevention and response services, from the health professionals to the laboratory technicians.

There are no officially and legally stated job descriptions to provide GBV services. —Male health service provider, health center

The health center staff as a whole is expected to provide service to GBV victims. —Female health service provider, health center

FINDING 9: SOPs, guidelines, and protocols for healthcare workers, as well as written materials for GBV survivors were generally unavailable at most facilities.

Both observation and interviews revealed that all types of health facilities lacked almost all essential materials designed to support healthcare workers in delivering GBV prevention and response services, including the *Standard Operating Procedures for the Response and Prevention of Sexual Violence in Ethiopia, 2016*. There were more available materials that support the provision of HIV and STI services, although two of the four health posts did not have these materials either. Importantly, not all respondents were aware of documents that existed at the national level.

GBV guidelines should be drafted at the national level and need to be distributed to all levels of health systems and service providers. —Female health extension worker, health post

Health extension workers are not aware of any GBV-related policies. So far, no efforts were made to help us to be well informed of any of these protocols. If there are any working national or regional GBV policies, they should be disseminated to all health systems and facilities. —Male health service provider, health center

Respondents viewed policies and guidelines as contributing to accountability.

For the future, we need… policy guidelines (for accountability, and to boost commitment and give directions on how to handle/treat GBV survivors). —Male health service provider, primary hospital

No facilities had a written policy in place to govern who could access patient files, medico-legal forms, and forensic evidence. In the absence of such a written policy, two health centers reported that the health center head accessed such materials; the primary hospital noted that the medical director accessed these files.

Exhibit 4: SOPs, guidelines, and other job aids available at facilities

SOPS, GUIDELINES, AND OTHER JOB AIDS	HEALTH POSTS (N=4)	HEALTH CENTERS (N=2)	HOSPITALS (N=1)
Pathway for Initial Care After Assault poster available	0	0	0
Code of Medical Ethics or Ethical Code of Conduct visibly displayed	1	0	1
National protocols for referral for STIs available and visible	2	2	1
National guidelines for HIV counseling available and visible	2	2	1
Checklist or document on the general signs and symptoms of GBV or sexual violence easily seen by and accessible to healthcare workers	0	0	0
A checklist, post, or set of guidelines existing 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
Checklist, SOP, or set of guidelines available for healthcare workers to reference or use on how to conduct:			

SOPS, GUIDELINES, AND OTHER JOB AIDS	HEALTH POSTS (N=4)	HEALTH CENTERS (N=2)	HOSPITALS (N=1)
Prevention activities	2	N/A	N/A
Referral	2	N/A	N/A
Recording of GBV cases	0	N/A	N/A
A vaginal examination for different age groups	N/A	0	0
Recording of vaginal examination	N/A	0	0
Recording of hymeneal examination	N/A	0	0
Recording of anal examination	N/A	0	0
Written policy in place to govern who can access the family folder and any register at the health post	0	N/A	N/A
Written policy in place to govern who can access patient files, medico-legal forms, and forensic evidence	N/A	0	0
National guidelines for Hepatitis B vaccines available and visible in the healthcare facility	N/A	2	1
Diagrams for female and male genital examination	N/A	1	0
Diagrams depicting normal hymeneal variation and abnormal hymeneal findings	N/A	0	0
Stock of body maps	N/A	0	0
Stock of sexual violence medical certificates	N/A	0	0

With respect to materials for GBV survivors, all the observed health centers and the primary hospital had brochures or pamphlets on HIV PEP and its risks available, while only one health center and the primary hospital had pamphlets or brochures on different contraception options. None of these materials came with any information connecting them specifically to GBV response. No facilities were found to have (1) visible GBV-focused information, education, and communication materials available to patients, such as posters and/or pamphlets on key topics in high-traffic areas (what to do in case an individual has experienced GBV, GBV laws and rights, available GBV prevention and response services in the facility); (2) diagrams depicting normal hymeneal variation and abnormal hymeneal findings; or (3) a copy of the *Pathway for Initial Care after Assault* poster.

FINDING 10: While some health service providers—particularly female providers—had received GBV training, there was a desire for comprehensive GBV-related training.

No male health service providers reported receiving any kind of training on GBV prevention or response, but five of six female providers did. Half of the female health service providers reported attending training courses organized by outside organizations, and half reported that GBV-related topics were discussed as part of their college or university training. One female health service provider had both educational exposure and attended a training by an outside organization. Among the three female respondents who received training from an external organization, two—both health service providers—attended a 3-day training organized by the Transform project, and one—a health extension worker—attended a 3-day training organized by the Women's Affairs Office and Women's League. In delivering GBV prevention and response services, one health service provider noted the reliance on previous knowledge and experiences in the absence of formal training.

> *Very few on job-training opportunities [are] offered to health extension workers serving in very rural facilities. The chance of accessing such training provided by governmental and nongovernmental organizations is also rare and information reaches remote health facilities untimely. —Female health extension worker, health post*

GBV-related training [courses] are not given, but most of the staffs use their own knowledge and experiences. —Female health service provider, health center

Similarly, none of the observed health centers and primary hospital had a provider functioning as a GBV point person who was specifically trained in GBV prevention and clinical response.

Healthcare workers at all levels were interested in additional training or knowledge to help support GBV survivors. Topics of interest for training included prevention mechanisms, identifying GBV cases, medical treatments for GBV survivors, psychological support or counseling, legal aspects of GBV, data recording/documentation, peer-to-peer learning/knowledge management, and provision of reference manuals.

Further training and on-the-job experience sharing should be given on legal issues, medical/clinical treatment, data recording/documentation, confidentiality and legal protection for health service providers working on GBV cases. —Male health service provider, health center

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

FINDING 11: Healthcare workers reported that GBV survivors faced barriers to accessing justice and healthcare services in the formal system.

Interview respondents indicated that GBV survivors who had their cases settled through traditional institutions, often led by male community elders, did not tend to visit healthcare facilities due to cultural pressure and perceptions. For example, health service providers stated that young girls who suffered GBV were often forced to marry their offender, and young girls who were in early forced marriages were denied access to GBV prevention and response services at the health facility or through the formal legal system.

Due to cultural pressure and role of customary institutions over the medico-legal systems, raped girls are forced to marry their rapist. Such girls and their cases are ignored, and they do not have chance to visit the health post. —Female health extension worker, health post

Additionally, weak responses from local authorities, including a lack of police protection for healthcare workers who report GBV, might have hindered providers in referring GBV survivors.

However, the weakness of public offices leaking the case prior to the court proceedings to the perpetrator exposed our staff to receiving death threats. In the meantime, helpless to receive security from any public office, our staff member was forced to resign from his post and left the health center. —Male health service provider, health center

FINDING 12: Healthcare workers did refer GBV survivors to police, Women's Affairs Office and, to a lesser extent, other services. However, the data revealed some inconsistency in awareness of whether reporting GBV to police or other authorities was mandatory. These actors also referred GBV survivors to the health facility for care.

Almost half of interview respondents indicated they referred GBV survivors to Women's Affairs Office and one-third shared they referred them to the police. These responses differed by respondent type. All

health extension workers reported referring survivors to higher level facilities for testing and other medical services. Only one respondent from a health center indicated referring survivors to a higher level facility. Another respondent indicated that referrals were based on severity of injuries. One health post specifically mentioned providing referrals to different school clubs. Both health centers and the primary hospital indicated they offered referrals for safe abortion services.

> *GBV survivors are typically referred in accordance with the types of violence and level of severity of the health case. Accordingly, rape cases [are] referred to [general hospitals] for higher medical and counseling services. —Male health service provider, health center*

Interview respondents reported that they did not see male GBV survivors, but would offer them the same referrals as to women and girls.

Specific referral forms were used for GBV survivors in only one of the four health posts, and none of the health centers or primary hospital were observed to have a specific or standard referral form for GBV survivors. All participating facilities provided referrals to laboratories.

Exhibit 5: Referrals offered by facility type

REFERRALS OFFERED	HEALTH POSTS (N=4)	HEALTH CENTERS (N=2)	HOSPITALS (N=1)
Mental health counselors	0	1	1
Dental issues	0	1	0
Ear drum perforation	0	1	1
Emergency or severe life-threatening conditions	2	1	1
Eye problems	0	1	1
Laboratory	4	2	1
Safe abortion services	4	2	1
Physical injuries	N/A	2	1
PEP	N/A	2	1
Child protection services	3	1	1
Legal support	3	2	1
Police/law enforcement	4	2	1
Psychologists	0	1	0
Economic empowerment	1	1	0
Livelihood services	1	1	0
Support groups	1	0	0
Emergency shelter	0	0	0

One respondent shared that there were instances of reporting incidents of GBV, but not necessarily referring the survivor to other organizations.

> *With the aim of preventing GBV recurrences in the future by compensating the victim and punishing the perpetrators, I will anonymously report GBV-related incidents to local Women's Affairs Office and local authorities working at* kebele *level, such as command post, village manager, and village administrator (cabinet). —Female health extension worker, health post*

There was inconsistency among respondents about whether reporting GBV incidents to the police was mandatory—some thought it was mandatory, others stated it was not required, and others shared that reporting requirements depended on the circumstances, such as in the case of an underaged victim.

Reporting the case to different government bodies and health systems is mandatory. Because reporting enables government ministries and other legal bodies to identify recurring GBV cases, draft relevant national policies and launch GBV prevention/response strategies. —Male health service provider, health center

Reporting should be mandatory, but so far not in standard written form. If I encounter GBV cases in my unit, I feel responsibility to give direction to the victim either to go to the police or referral hospital depending on the types of the case. —Male health service provider, health center

Case reporting may depend on: willingness of the GBV survivors/seriousness of the case to attend further medical treatment and counseling services and the victim's need to report to the police. —Female health service provider, health center

Health service providers also noted that they received referrals of GBV survivors from the police, Women's Affairs Office, and Children's Affairs Office.

FINDING 13: Healthcare workers reported inconsistency in follow-up practices; expressed little knowledge about GBV shelters and hotlines; and lacked relevant policies, SOPs, or other job aids.

While some respondents indicated that following up with GBV survivors occurred, others indicated that follow-up was rare.

Once we referred GBV survivors' cases to the concerned referral hospitals, there is no way to follow up with service delivery points and poor means of communication. —Female health service provider, health center

Some examples of follow-up mechanisms included phone calls, letters, personal contacts, visiting survivors in their villages, contacting relatives, and a "joint platform" of the Women's League, Women's Affairs Office, development agents, peace and security offices, and police departments.

Across the interviews, none of the respondents indicated there was a shelter operating in their communities, and were unaware of shelters at a regional or national level. Despite being unaware of shelters, respondents described emergency or temporary solutions that could be made for survivors, including working with the community, Women's Affairs Office, local militia, and police for emergency solutions or temporary waiting rooms; mobilizing community resources; and linking survivors with temporary communal shelters located inside *anelgilot* (a compound that offers multipurpose services).

As shelter facilities are not existing in the locality, services are not provided at all to the victims. —Female health service provider, health center

At the local level, although not in the formally organized shelters, community-based services are given to helpless and poor GBV survivors and other related health cases. Sometimes survivors are given temporary shelter in private rooms and public buildings constructed multi-community-based activities (called agelgilot). —Female health service provider, health center

Similarly, interview respondents either did not know of the hotline, or were aware of it but unclear of its purpose. Respondents noted that the community was also unaware of the hotline.

Hotline service is not available and even health service providers/health extension workers do not have information about it. —Female health extension worker, health post

Community members in and around the catchment areas of the health center do not have information about how to access services and existing resources given by the hotline. —Female health service provider, health center

CONCLUSIONS

Conclusion 1: Healthcare workers shared concern over GBV and provided compassionate response to survivors.

Healthcare workers the GBV Landscape Analysis team interviewed at all levels in Oromia shared a broad and consistent definition of GBV, and expressed a keen recognition that GBV was a common and significant problem in the region. As de facto first responders to the problem, they drew on their on-the-job experience to identity victims and saw themselves as responsible for providing the initial line to care. Their first and foremost response was to demonstrate compassion in the form of psychological counseling and calming, which they paired with medical/clinical response to the best of their abilities and with the resources available. Their jobs extended into the issuance of referrals to a wide range of external resources, from larger health facilities to police. They saw these external resources as essential to the struggle against GBV, even as they expressed varying confidence in these resources' ability to provide the care and support the victims of GBV needed. Driven by concern for these patients, they worked to provide follow-up on the victims' well-being when circumstances allowed.

Very few healthcare workers were directly involved in GBV prevention. Respondents expressed a desire to become more involved in prevention, but saw no opportunity to do so.

Conclusion 2: Lack of standardized procedures constrained optimized GBV prevention and response services.

Although Ethiopia has made strides in recent years toward national-level standardization of GBV prevention and response services, most healthcare workers at these levels did not have access to or employ these standards (Central Statistical Agency Demographic and Health Survey 2016, UNICEF 2010, UNICEF 2014). The result was a well-intentioned assembly of care that could be quite effective, but remained ad hoc and inconsistent in nature.

The lack of standardization began with the process of identifying victims, which relied on workers' instinct rather than established checklists for symptoms. Treatment tended to be provided in space that rarely offered full confidentiality because facilities lacked dedicated space for GBV response service delivery. Confidentiality in GBV response was understood as important but enacted in irregular ways, some of which did not preserve full confidentiality. The range of staff charged with assisting GBV victims was highly variable and sometimes, included individuals with no formal clinical training. Referrals to a variety of external resources were always available, but inconsistently employed. One particularly critical form of referral—involving the police to pursue justice for the victim—was practiced effectively in some cases, but not others. Medical or legal standards did not guide any of these components of GBV response because healthcare workers were unaware of and did not have access to SOPs and other guidelines.

As noted above, most respondents had no opportunity to participate in GBV prevention efforts. Efforts that were noted were highly inconsistent. There was no consensus on the precise role healthcare workers should play in GBV prevention.

Conclusion 3: Inadequate professional resources constrained optimized GBV prevention and response services.

Varied but often profound lack of professional resources to provide effective care fueled the inconsistent response to GBV. In terms of physical resources, health facilities across all types lacked essential materials designed to guide healthcare workers in delivering responsible GBV prevention and response services, such as the *Standard Operating Procedures for the Response and Prevention of Sexual Violence in Ethiopia, 2016*. At the same time, facilities did not have consistent access to the medical supplies necessary for effective GBV response. Deficiencies ranged from first aid kits, to contraceptives, to HIV-related clinical supplies, and occurred across all facility types, from local health posts to the primary hospital. In addition, no facilities offered dedicated space for the treatment of GBV victims.

In terms of training in GBV response, healthcare workers recognized its importance to their work, but demand far exceeded supply. Some received GBV training as part of their medical education and some through the Transform project, while others had no GBV-focused training at all. None of the respondents felt their current level of training was adequate for all professional needs.

Striking lack of awareness about some of the existing resources compounded the deficits around professional resources. For example, there were two shelters for GBV victims in the Oromia region, as well as a national hotline for victims to seek advice (UN Women 2016); however, none of the respondents reported any knowledge of these resources.

The professional resources available for GBV prevention were reported as slim to nonexistent. As a result, almost none of the healthcare workers or their facilities were involved in GBV prevention.

Conclusion 4: Community-based response entailed both assets and hindrances to responsible GBV treatment.

Healthcare workers looked to the local communities for various additional support in the struggle against GBV. Other organizations and actors provided prevention services, predominantly through awareness raising, but also functioned as a linkage in GBV response between the community and the formal healthcare system by referring survivors to the facility for care.

At the same time, traditional/community-based actors served to undermine access to effective GBV care in the formal health sector. There were consistent statements to indicate that when community elders became involved in GBV cases, victims did not seek treatment in the healthcare facilities or remedies in the formal justice system. Indeed, these cases were not reported beyond the local community. Testimony suggested that these cases tended to be resolved in ways that worked against the victims' interest, such as girls being forced to marry their abusers.

Conclusion 5: Broader public resources offer both assets and hindrances to responsible GBV treatment.

Healthcare workers looked to the broader landscape and its variety of public/official resources for additional support in the struggle against GBV. The government-supported Women's Affairs Office, for example, was frequently cited as an effective resource for supplemental support and assistance in seeking formal justice against the attackers. Women's Affairs Office and other public organizations were also heavily involved in GBV prevention efforts. In addition, the police were cited, at least partly, as a necessary and effective resource in seeing cases of GBV to their rightful conclusion of judgement against the attackers.

At the same time, the police and the justice system were seen as inconsistent resources that sometimes worked against the interests of GBV victims. Respondents explained the "weakness of public offices" in a variety of ways—from failures to provide adequate security for victims and healthcare workers who reported GBV, to negligence in maintaining victims' confidentiality. In sum, respondents saw justice as available, but not consistently applied through the formal system.

RECOMMENDATIONS

These recommendations were developed collaboratively with project staff based on overall findings from the study. Project staff operating within Oromia 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 Oromia to address needs specific to the region.

Recommendation 1: Transform: Primary Health Care project's Oromia regional office should conduct GBV orientation sessions with healthcare workers, particularly health extension workers, in collaboration with the regional health bureaus and *woreda* health offices.

Recommendation 2: The Transform: Primary Health Care project's Oromia regional office should ensure clinical training and training-of-trainers on GBV for at least one healthcare worker per facility in collaboration with the regional health bureau and cluster offices.

Recommendation 3: The Transform: Primary Health Care project's Oromia regional office should strengthen multi-sectoral platforms for collaboration on GBV prevention and response. This can include providing financial support for the Women's Affairs Office's multi-sectoral quarterly reviews as a platform to coordinate *woreda*-level GBV prevention and response.