GENDER-BASED VIOLENCE LANDSCAPE ANALYSIS – SOUTHERN NATIONS, NATIONALITIES, AND PEOPLES' REGION (SNNPR) CASE STUDY

USAID/ETHIOPIA TRANSFORM: PRIMARY HEALTH CARE PROJECT

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CONTENTS

ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral therapy
FGM/C	Female genital mutilation/cutting
GBV	Gender-based violence
IPV	Intimate partner violence
MCH	Maternal and child health
NGO	Nongovernmental organization
OPD	Outpatient department
PEP	Post-exposure prophylaxis
SNNPR	Southern Nations, Nationalities, and Peoples' Region
STI	Sexually transmitted infection
SOP	Standard operating procedure
UNICEF	United Nations Children's Fund
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 (SNNPR), and Tigray. This report presents findings, conclusions, and recommendations of the Transform: Primary Health Care project's GBV Landscape Analysis in the SNNPR.

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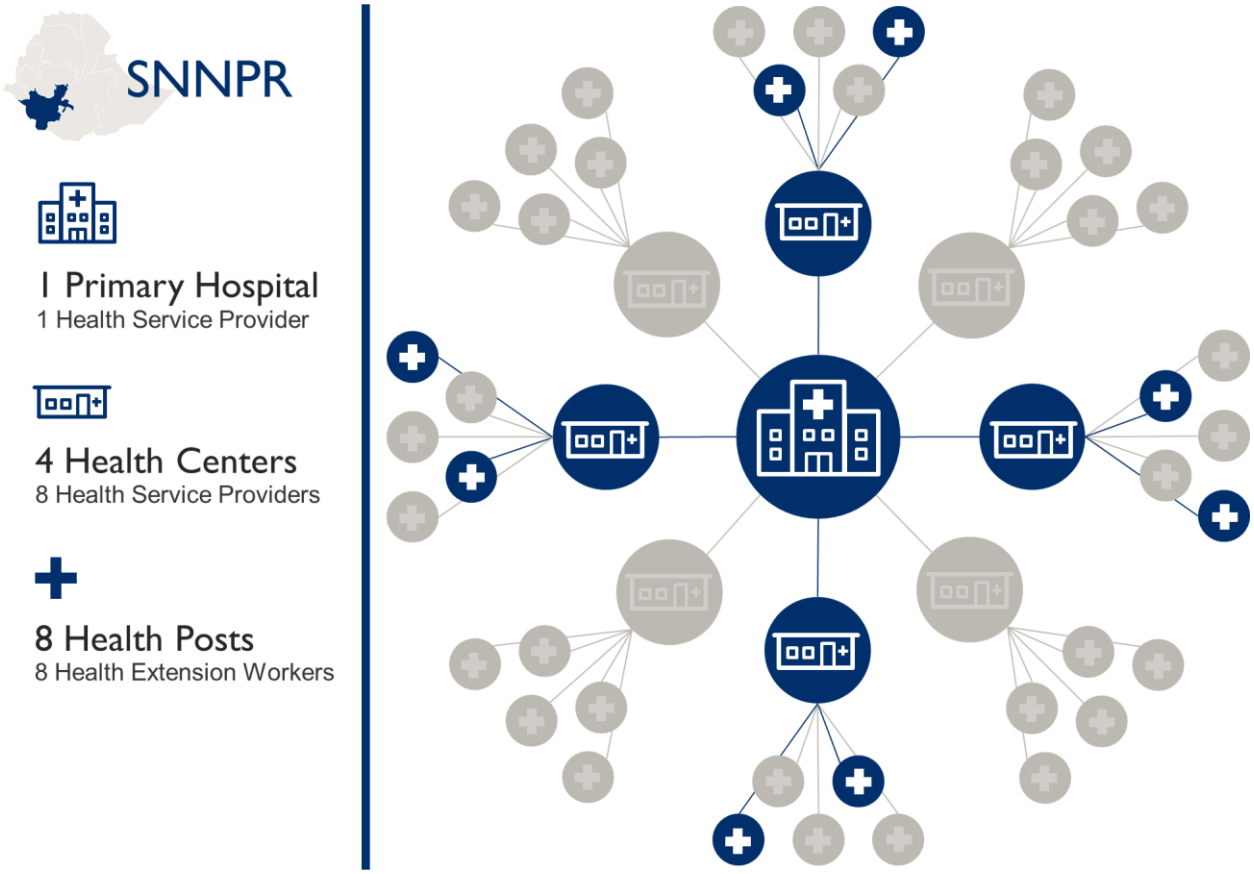
[1] Federal Democratic Republic of Ethiopia Ministry of Women, Children and Youth Affairs. 2013. *National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia*. Accessed October 3, 2018: http://www.africanchildinfo.net/clr/policy%20per%20country/2015%20Update/Ethiopia/ethiopia_htp_2013_en.pdf.
[2] The United Nations Children's Fund (UNICEF) 2016
[3] Central Statistical Agency and Inner City Fund 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 SNNPR 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 SNNPR case study.

Exhibit 1: SNNPR research sites



FINDINGS

This section presents the GBV landscape analysis findings in the SNNPR 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: Health extension workers and health service providers conducted GBV prevention activities in collaboration with community organizations, such as the Women's Development Group, the Women's Affairs Office, and the local government; however, they had little or no training and limited resources.

Health posts and health centers both conducted awareness-raising activities at the community level, including reaching students through teachers or school clubs, such as those focused on HIV, Malaria, The Red Cross, Girls empowerment, or general school clubs. Although these groups were active in providing prevention sessions, the sessions generally centered on health and hygiene issues and less on GBV prevention.

Respondents frequently reported that health extension workers collaborated with community volunteers, such as the Women's Development Group and the *One to Five* household groups, on community prevention efforts. Additionally, religious leaders, specifically pastors and elders, also provided prevention sessions; however, again, the respondents mentioned these sessions were focused more on overall health issues, rather than GBV.

> *We meet with Women's Development Armies every fifteen days. The Women's Development Armies participate in a number of activities such as vaccination, they prevent circumcision of girls and inform us of those who circumcise girls, and they bring pregnant women to us. There are local elders who work on educating the community for prevention of GBV; religious leaders teach at Mosque about prevention of GBV. The principal of the school has also gotten training with us and works on prevention of GBV at school. There are HIV and girls' club at school that work on GBV prevention. The Women's Development Army also works on prevention of GBV within the community. —Female health extension worker, health post*

One health extension worker mentioned that health centers provided guidance to the health posts on activities. Health service providers also noted that the youth-friendly services (YFS), outpatient department (OPD), and maternal and child health (MCH) department delivered health education sessions as part of GBV prevention, and they identified health extension workers, nurses, and other healthcare workers as health education providers. In addition to awareness creation for GBV prevention generally, respondents also identified education on harmful traditional practices (early marriage and female genital mutilation/cutting [FGM/C]) and efforts to change harmful cultural perceptions as topics covered in awareness-raising activities.

Six respondents also identified the health office and government officials as providers of awareness-raising activities. One respondent called for the government to pay more attention to prevention work, noting that at the time, the *woreda* did not give enough attention to prevention work.

The woreda *does not work on prevention, nor does it give attention to prevention work. That is why I said to you that there is a generation which is forgotten in the middle. It would be better if government gives attention today; it will be good for tomorrow. —Male health service provider, health center*

Despite these efforts, prevention activities were often led by providers with little or no training, and with limited resources. While three respondents said that those conducting prevention work had some training, four respondents noted that there had been no formal training. Several respondents mentioned they had little or no resources for awareness creation. Some resources included posters, brochures, and manuals, but many providers used their own knowledge to deliver awareness-creation activities.

We do not have any teaching aid resources other than our knowledge. We only have the human anatomy structure, and we use it to educate the community. We do not have flyers; we do not have audios or videos. —Female health extension worker, health post

FINDING 2: Healthcare workers stated they used several different methods to identify GBV survivors and when identified, they received priority treatment. The approach was similar for survivors of physical and sexual violence.

Respondents stated they could identify GBV survivors through observation, medical histories, and physical examinations. They reported that they observed facial expressions and behavior, which helped them recognize survivors. Health service providers also stated that physical examinations were important to help establish whether the survivor had experienced physical and/or sexual violence. No respondents reported using standardized forms or checklists to identify GBV survivors.

I can determine whether s/he is a survivor of GBV by doing physical observation on her face, her facial expression where in most cases GBV survivors cry. She shows me a bad facial expression if she is GBV survivor. I will also take her medical history. —Female health extension worker, health post

Most interviewees said GBV survivors needed to identify themselves or inform healthcare workers in advance if they were to receive priority treatment. If survivors did not identify themselves, they were treated like any other client and not given priority. Others mentioned priority was given to mothers and children, or those who were physically injured or bleeding. One health service provider mentioned there was a "separate window at the card room where emergency, delivery, and GBV cases are received."

We give her priority if the GBV survivor informed us in advance as she is a GBV survivor. Otherwise she will get the service similarly to other clients. —Female health extension worker, health post

Within the health center, priority is given for mothers and children treatment. Since GBV survivors do not tell us their problem when they come, priority is not given. If GBV survivors tell us they are survivors of gender violence, we will give them priority. —Male health service provider, health center

One health extension worker mentioned that, as a result of the implementation of the new community-based health insurance, more people went straight to the health center and this allowed for priority attention to GBV cases at health posts, because fewer clients were coming there. However, one health extension worker stated that because survivors went directly to the health center rather than the health post, she rarely encountered a GBV survivor outside of home visits.

They don't come to the health post. We informally hear the information and during our house-to-house visits. Since there is a community-based health insurance scheme, they just go to the health center. I have faced only one female who was raped during the last six years. —Female health extension worker, health post

There was little reported difference in how respondents approached survivors of physical and sexual violence. Only one health service provider noted that counseling would be different depending on the type of violence, but did not provide specifics. One health extension worker said there was no special approach for different types of violence because they were not able to offer comprehensive services at the health post.

For GBV survivors, be it sexual, physical or other types of violence, we deliver psychological counseling and we deliver antibiotics. —Male health service provider, health center

Two health extension workers noted they would offer counseling in response to physical violence cases, and one health service provider said they would provide first aid and treatment for wounds. Three health extension workers stated they would refer physical violence survivors to the health center, and two health extension workers mentioned they would report a physical violence case to be handled by the *kebele* administration or the elders.

A few respondents also shared their approach to working with survivors of sexual violence. Two health extension workers said they would refer these survivors to the health center, and one health extension worker mentioned she would provide counseling. A health service provider at a health center said the response would be to provide HIV, sexually transmitted infection (STI), and pregnancy testing, along with emergency contraception. Two health extension workers stated they would report sexual violence cases—one would report to the *woreda* leadership that comes to the *kebele*, and the other said she would work with the *kebele* administration to report to the police and work with the Women and Children's Affairs Office. However, one health extension worker noted that sexual violence survivors did not go to the health posts because treatment was not available at that level.

If the girl/woman is survivor of sexual violence, I first counsel her and refer her to health center. If the girl/woman is survivor of physical violence, I counsel her, give her first aid, then I refer her to health center. For those survivors who are severely affected, I refer them to the health center. —Female health extension worker, health post

For the woman who faces physical attack, I will report to the concerned body, i.e., to the kebele *administration and to the chairman. I counsel her and deliver first aid. To the woman/girl who faced sexual violence, I will refer her to health center. I do not have any inputs to support her at the health post level. Then I will report to the leaderships that come from the* woreda *to the* kebele*. —Female health extension worker, health post*

FINDING 3: Many healthcare workers held a broad understanding of GBV, yet did not view intimate partner violence (IPV) and physical violence cases as GBV.

Respondents gave a range of examples of what constituted GBV. Overall, many considered GBV to entail anything done to women and girls without consent. More specifically, respondents frequently cited sexual violence, with one respondent mentioning a particular traditional or cultural practice: if a groom cannot attend their own wedding, he will designate another man on his behalf to take the virginity of his wife. Most respondents mentioned abduction as a form of GBV, often listing forms of physical violence

that came along with abduction. Other acts of physical violence, involving cases of IPV, were also listed. Additionally, respondents noted various manifestations of gender inequality as forms of GBV, including forced labor for women, not being able to attend school, and the uneven distribution of housework. Tonsillectomy and chewing khat to suppress appetite were also considered forms of GBV.

> *GBV is discrimination of sex, i.e., when human rights of women/girls are not implemented, when a woman/girl is unable to get education, and when a woman is made not to access a job. —Male health service provider, health center*

> *In this locality chewing khat has greater contribution for GBV, i.e., rape. For the first time, in my work at outpatient department, I saw women of the locality chewing khat. When women come for delivery, they chew khat. Here it is women who work most of the activities for a family. I advise women at mother and children health department to consume the food they prepared. However, in the locality, women first feed their husbands before they eat. Women in the locality may get food only once in a day. Then after chewing khat, the whole day is easy for them. Women also buy khat from the local town. It is better if more is done on this issue. —Female health service provider, health center*

Despite such broad understandings of GBV, many respondents said that while they did receive IPV and physical violence cases, they did not categorize these as GBV in most instances, especially when they occurred between husband and wife. Some healthcare workers stated that survivors usually worked it out with their husband, and mentioned advising survivors to have better attitudes toward their husbands who often beat them "out of love, not hate." Health extension workers and health service providers reported counseling the survivor and the husband together, and some health service providers discouraged survivors from seeking justice, stating that when some survivors chose to take legal action, they advised against it.

> *We reconcile husbands and wives when there is conflict and we also counsel them together. —Female health extension worker, health post*

> *… If for example the perpetrator is her husband, since she lives with him in the future, I work on brainwashing her. I advise her, as her husband did that because he loves her not because of the hate on her. First, I identify the cause of the conflict and conduct conflict resolution and reconcile them on the spot. Hence, I make the woman change her perception of her husband. I advise her if they are living in conflict, what can their children learn from them? I advise her to have a better attitude for her husband. Then I give her medical treatment as per the ethics of medical profession. —Male health service provider, health center*

> *Last time, one lady came to our health center with complaint of beating by her husband after she visited another health center which is found in our woreda. I tried to convince her that she is ok, but her intention was to go to the court. —Male health service provider, health center*

FINDING 4: GBV survivors were motivated to access GBV prevention and response services at facilities that offered a variety of medical care, quality services, and a medical certificate.

Overall, respondents spoke of several key motivators for GBV survivors to access services in their facilities. Many healthcare workers reported that clients appreciated a welcoming approach, confidential and private services (particularly in the YFS room), and receiving information and treatment, including first aid and counseling. Another motivating factor cited was the fact that some of the healthcare

workers were from the same communities as clients, which allowed them to have close relationships with the people visiting their health facility. One respondent mentioned that youth also received materials, such as leaflets, and were able to watch videos at the YFS Center. Healthcare workers also noted that clients appreciated accessibility of health facilities and services, including healthcare workers working late.

> *We have good care and a welcoming approach and good facial expression. The health post is open at any working time. We train them how to apply the pill and condom; it is not only the youth who use condoms; adults who are married also take condom from us. Confidentiality of service delivery—we deliver the service within the office privately. If I examine her and take her out of office without keeping her privacy, she may not come another time. So, I have to keep confidentiality as well as privacy of clients. —Female health extension worker, health post*

> *The youth-friendly service room is separated from other service delivery rooms; this makes it attractive as GBV survivors can privately get the service. —Male health service provider, health center*

> *We have good care and a welcoming approach for the community. And also, since we are born and grown up within the community, they have good intimacy and motivation to visit the health post. —Female health extension worker, health post*

However, some respondents mentioned that health centers were not accessible to everyone because GBV prevention and response services were not free of charge, unlike YFS or MCH services that were free. One interviewee stated that this situation caused further harm for GBV survivors who could not afford the treatment or medication. Some healthcare workers reported that clients did not come for services at all, and merely sought a medical report or certificate for the legal process.

> *It would have been better if she gets service free of payment. This is because she is expected to pay for examination, laboratory, and medicine. She might not have such money. Hence, she would be happy if she had gotten treatment free of payment. Her perception also changes when she gets assistance here. Otherwise, the violence is one burden and unable to get the medication because of lack of finance is another harm to her. —Male health service provider, health center*

> *GBV survivors first demand to get medical certificate to take the case to legal charges. We advise them that treatment is needed first. They come here being nervous. They report that they are beaten, raped, and wounded. When they come, they request a medical report immediately. I remember a person whose wife was beaten, and he came with her here at the health center, and he was simultaneously applying legal charge with the help of another person at the district capital. The main interest of GBV survivors is to get the medical report for legal charge. Then after, I made him and his wife to become calm. —Male health service provider, health center*

With regard to the specific types of medical services GBV survivors initially sought, most respondents reported that many, particularly victims of rape and sexual assault, first asked for emergency contraception or post pills to prevent pregnancy. Health service providers also mentioned girls seeking psychosocial counseling for depression after receiving medical services. In cases of physical violence, providers found that survivors wanted first aid medical treatment or painkillers and then, occasionally went to the police to report the case, but often failed to do so.

> *There are girls/women who are severely beaten and visit our health facility only for treatment, but they do not want to have medical certificate report for police or Women Affairs. Such survivors just only demand*

treatment. Even GBV survivors do not want other people know they are beaten or raped. —Female health service provider, health center

FINDING 5: GBV survivors accessed services through a variety of avenues and sometimes, came alone or accompanied by others.

Healthcare workers reported that GBV survivors primarily accessed and received services through health extension workers, the Women's Development Group, and sometimes the police; at times, survivors did not seek services at all. Health service providers stated that GBV survivors often went to health extension workers for services, primarily to receive counseling. Health extension workers and the Women's Development Group conducted house-to-house visits, where the counseling often took place. Sometimes survivors were referred to the health center for additional services. One respondent said there were no GBV prevention and response services at the community level, and the Women's Development Group provided some level of counseling and care, such as supporting survivors to access legal aid. The local administration also provided support for GBV survivors in court.

The local administration gives support for survivors and brings [the perpetrator] before the court. The women development army supports the survivor in bringing her to the health post and help in becoming and organizing witnesses for the legal aid. —Female health extension worker, health post

Another respondent told a complex story of a girl who was raped by a relative, so the girl was not brought to the health facility until after she had given birth. Later, the family tried reporting the case to the police. Other than that, GBV survivors were primarily accessing services through health extension workers and the Women's Development Group.

When accessing services through these venues, GBV survivors might be accompanied by a number of different individuals or attend alone. Some healthcare workers reported that GBV survivors, particularly young girls, were accompanied by their friends to keep cases secret from their families, especially in rural areas. One respondent reported that she had come across 13/14-year-old boys who were rape survivors and also accompanied by their friends. Another interviewee noted that one girl was accompanied by another woman, but she did not specify whether the woman was a friend, neighbor, or family member. Many of the respondents stated that a girl who was a GBV survivor was generally accompanied by her friends or female family members, such as her mother, and less often by her father or brother.

A girl can come with her girlfriend; a girl does not come alone to the hospital. A girl does not want to inform the case to family especially in rural areas. It is so taboo and do not talk such things with family members. —Male health service provider, primary hospital

A few healthcare workers mentioned women coming with their husbands who had physically abused them; the men did not view such abuse as violence. One respondent made a distinction between women coming with their brothers and husbands, and noted there was a different perception depending on who accompanied her. There were also respondents who stated that some women visited the health post with their kids or alone, especially wives who were survivors of GBV.

Most survivors of physical violence who are women come with their husband who beats her. Wives come with their husbands, after the husband beat her. Husbands assume as it does not have any problem if husband beats his wife. —Male health service provider, health center

Respondents reported that men/boys seldom accessed GBV prevention and response services.

> *A man would usually come [to the health center] with two or three of his friends; he does not worry about privacy and does not fear. I did not get any man who is above 18 years old. I only faced boys who are raped at the age of 13/14 years. No boy/man other than such boys came to the health center because of rape. —Female health service provider, health center*

FINDING 6: GBV response services were provided at all levels, but the types of services varied depending on facility type.

Most health service providers from the hospital and health centers said staff from all departments provided response services. This included health officers, nurses, physicians, and other medical personnel. All health extension workers also reported providing GBV response services along with other health extension workers at their health post.

> *The health workers within the health post deliver the response. The resource that we have is the commitment and the knowledge that we have. We do not have any other resources. —Female health extension worker, health post*

> *Such services are delivered by health professionals such as health officers, nurses, clinical nurses, etc. They have medicine, laboratory equipment, family planning commodities, emergency pills. None of health workers receive training on GBV. —Male health service provider, health center*

Most respondents reported services were provided in the OPD, but several noted that YFS, emergency department, MCH, and antiretroviral therapy (ART) also provided services to survivors depending on survivors' needs. For example, several providers said that survivors between the age of 10 and 24 were seen in YFS; severe cases went to the emergency department; HIV-positive survivors would go to ART; and survivors with pregnancy-related issues would be seen by MCH.

While most respondents stated they were able to provide GBV response services to survivors, health extension workers were limited in their capability due to lack of resources available to them. They reported they could provide counseling to survivors and basic first aid medical treatment. If the survivor needed further treatment, they provided referrals to the appropriate health facility (usually the health center) so that the survivor could access needed medical supplies and treatment, or they would refer the survivor to other necessary services (e.g., legal services).

> *Once I identify the GBV survivor, I give her counseling service and refer to health center since I cannot deliver her medical treatment. I only give her counseling service. She must be referred to health center as the GBV survivor might be exposed to HIV, sexually transmitted diseases, and unwanted pregnancy. I cannot conduct pregnancy test at the health post level. There is no emergency contraceptive pill at the health post. —Female health extension worker, health post*

> *Then, since there is no treatment here in the post, if she demands treatment, I will refer her to health center. If the survivor demands to make legal charge, I will refer to the manager of the* kebele*. I first let her to become stable, and then counsel her. Then, I let the administration and manager of the* kebele *know the case. This is because the administration of the* kebele *should know the case. Then I refer to health center for medical treatment. It is after she is referred to health center that can be proved as she is raped. —Female health extension worker, health post*

We just give her only first aid if there is bleeding and will send her to health center. In addition, we counsel her. We do not have emergency contraceptive. We refer her to health center. —Female health extension worker, health post

Health service providers had access to more resources, which enabled them to provide more services to survivors. In addition to counseling and first aid treatment, health service providers also supplied examination, treatment, and testing (including HIV, pregnancy, and STI testing), emergency pills, contraception, and medical certificates survivors could take to the police. If health service providers could not treat survivors, they provided referrals to healthcare facilities that were better equipped. Some noted providing referrals for special cases, including abortions and fistulas. One mentioned providing ART in cases of a positive HIV test, and another referenced counseling.

Medical examination is given for survivors of gender violence, medical examination for rape, treatment on wounds, sexually transmitted diseases test and treatment, and counseling service. If the gender-based violence survivor is identified as HIV-positive, the health facility closely follows up the GBV survivor and provides antiretroviral service. We also deliver medical information to the concerned body. —Male health service provider, health center

The observation checklist data also suggested disparities between health posts, health centers, and the primary hospital in terms of what services they could provide to their patients. While almost all of the health posts, health centers, and the primary hospital reported the availability of multiple forms of contraception, including implants, injectables, and combined or oral contraceptives, none of the health posts provided intrauterine devices. With regard to HIV testing services, three of the health centers and the primary hospital possessed an HIV testing services counselor. Among these, all provided HIV testing services and counseling, while the primary hospital and two of the health centers also administered HIV comprehensive care (including ART, prevention of mother-to-child transmission, care, and support). Interestingly, one of the health centers reported it did not have an HIV testing services counselor, but still noted it provided HIV testing services and counseling.

In addition to the GBV responses provided at all levels of the health system, the majority of respondents identified other community actors who supplied or supported the supply of services in some way. This included support and monitoring from the *woreda* or *kebele* administration, identification of survivors and counseling provision by Women's Development Groups, and support from Women's and Children's Affairs Office. A few respondents also mentioned the services Family Guidance Association provided, but they were not sure whether it still operated. Some respondents also noted there were private clinics that provided services. As previously mentioned, respondents also cited religious leaders, *One to Five* groups, and other actors, including Save the Children and Transform project.

Woreda *Women Affairs, police, Save the Children and Transform: Primary Health Care support services for survivors of gender violence. As to the health sector, the district hospital and health post deliver services for gender violence survivors. The response that the government gives for survivors of gender violence is by far lower. It will be better if government delivers response to gender-based violence survivor together with NGOs. More has to be done at the community level. —Male health service provider, health center*

The district health office assists for GBV response via provision of medicine; the health insurance also helps GBV survivors a lot in getting treatment. There is family guidance association of Ethiopia, but now I heard that family guidance association of Ethiopia terminated its operation. I do not know whether there is another institute that gives response for GBV survivors. —Male health service provider, health center

FINDING 7: Healthcare facilities did not provide a comprehensive range of HIV services.

The observation checklist data highlighted the fact that a comprehensive range of HIV services were not available within all facilities in SNNPR. While attempting to confirm the availability and visibility in the health posts, the data collectors were informed that such materials were not available, because the health posts did not provide any HIV testing or counseling services. Similarly, most of the health centers (three out of four) were found not to possess the necessary supplies for HIV post-exposure prophylaxis (PEP); data collectors found that only one of the health centers and the primary hospital provided PEP.

Taking this information into account, only the primary hospital and one health center were found to meet the minimum package for HIV PEP. This package includes four components: (1) having at least one physician/health officer/nurse trained in PEP assigned as focal person for the facility; (2) having 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; (3) having PEP starter packs, including antiretroviral drugs, available inside the health facility and accessible to all staff, 24 hours and 7 days a week; and (4) having a provider support tool algorithm for determining the severity of exposure (exposure code) and PEP register available. One health center met one of the for requirements—having at least one physician/health officer/nurse trained in PEP assigned as a focal person for the facility.

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

FINDING 8: Health extension workers noted community groups' support for GBV prevention activities, whereas reported support for GBV response services varied.

Health extension workers stated that they received support from a variety of community actors to carry out GBV prevention activities, including the Women's Development Groups, *kebele* leaders and the administration, the health office, the health center, and school teachers and clubs. Only one service provider from a health center mentioned working with community groups and local government to do prevention work. One health service provider also said that health center leadership's support was key in having the time and resources to conduct successful prevention activities.

> *We have seen reduction on female genital cutting and tonsillectomy. For this, the health center,* woreda *health office, and* kebele *administration support and follow up contributed a lot for the achievement. —Female health extension worker, health post*

> *The second thing that helped me is head of the health center is my friend. I tell him all things that I want to do frankly. He accepts my ideas, gives me permission and encourages me to work more. The encouragement and permission that he gives me support me to do my prevention on GBV well. Had he not supported me, I would not have been successful. He also supports me by covering my work with other staffs of the health center and enables me to teach at schools and health posts with the health center. He also advises me, which created conducive [environment] for my work. I did not use the brochures that I get from the* woreda*. Since there is none as inputs. It would have been better if there are inputs to deliver the education well. —Male health service provider, health center*

For response activities, however, reactions varied. Some stated they had no resources or support from local groups or nongovernmental organizations (NGOs), the district health office, or other actors. Others mentioned that they relied on collaboration between departments or with other community actors, including NGOs, the *woreda* health office, and the health center. One respondent reported receiving assistance from the *kebele* administrative unit and the health center for essential logistics, and support to conduct monitoring visits. None of the respondents referenced getting support from the Women's Affairs Office, and one provider noted participating in Transform-sponsored training.

FINDING 9: Respondents identified many opportunities and resources that would help them better provide GBV prevention and response services.

In an effort to increase awareness and encourage GBV survivors to access services at the health facility, healthcare workers made strategic suggestions to conduct awareness-raising activities for the community, including the *kebele* and household level. A few providers recommended the activities be led by the Women Development Group, health extension workers, the health office, and additional stakeholders, such as schools, religious leaders, police, health center, and hospitals.

> *Awareness on GBV should be created for the community and what to do after the incident happened. Health workers need to have a good approach and relationship with girls to avoid the fear of girls. Awareness for family is needed to bring them to the health facility and legal aid.* Kebele *and police should also be trained and be aware to help the survivors. —Female health extension worker, health post*

> *The following should be done to encourage GBV survivors: A clear GBV policy is needed; Different stakeholders should be involved in it. Unless more awareness is created in the community, survivors will not come to the health facility only because the service is there. Awareness should be given at school, family and community level, as there is the service at health facility; more integration should be made from top to bottom at the community level. —Male health service provider, primary hospital*

Most interviewees also expressed a desire for educational materials to help them with GBV prevention activities, such as posters, flyers, and brochures.

> *We need more teaching aid materials for GBV like posters. The teaching aid material that we get from the health center is not enough. It will be better if the leadership on health from the district and above assisted us. —Female health extension worker, health post*

Most respondents agreed there was a need for additional supplies, equipment, or facility improvements. Healthcare workers expressed the need for first aid materials and medical equipment, including gloves, alcohol, bandages, gauze, stationary materials, posters, and emergency contraceptive pills; they even mentioned the need for a separate registration format. Some health service providers and health extension workers identified the need for separate treatment areas, particularly to treat and counsel GBV survivors and ensure the clients' privacy.

> *We do not have a separate place for privacy in the health post to examine and talk with GBV survivors. It is difficult to counsel and give treatment if there are several people within the health post. As the result, GBV survivors return back to home if they see other people around the health post. During vaccination campaign day, there are a number of people in the health post, so it would be better if another person independently handles the case. —Female health extension worker, health post*

Financial support for GBV survivors was also a common suggestion. One respondent suggested that community-based health insurance should cover expenses for survivors, including transportation, which would help motivate survivors to access GBV prevention and response services and conduct GBV response activities.

> *In MCH department, the beneficiaries get examination, tests and medicine free of charge. Just like this, it would be better if government makes free of payment for the services GBV survivors get. Sometimes, medicine and services for GBV survivors become beyond their purchasing power. The price of one cut gate is 41 birr, the price of one surgical glove is 9 birr, together it becomes 50 birr only for sewing the wound. In addition to this, antibiotic is needed since they are severely beaten. In addition to violence GBV faced, they are economically harmed when they pay for the services they get from the health center. The CBHI (community-based health insurance) does not cover service for those who come beaten and raped. The law for CBHI says, the perpetrator attacks GBV survivor as s/he is the insurer for medical expenses of GBV survivor. So, the perpetrator should pay the medical cost of GBV survivor. So, CBHI does not serve for GBV survivors. It would have been better if CBHI covers the cost of medication for GBV survivors. It would be better if GBV survivors get free medication. When GBV survivors come to the health center facing violence, you watch them when they are unable to cover cost of medication. We help them the maximum that we can do. This is because they should not be victim in a number of ways. —Male health service provider, health center*

> *A number of gender-based violence survivors suffer since they are unable to cover cost of medication as the health center charges. So, it is better if such survivors have access to free medication. There are cases where some survivors of gender-based violence that cut into pieces the prescription given to them since they cannot afford to buy the medicine. Gender-based violence survivors should be supported financially since some of them are expected to travel to distant places for abortion, since the service is not delivered at our health facility. Survivors of gender-based violence are expected to travel to [another] town for abortion. When they are expected to go [to that] town, there is cost of transport, they spend nights there and there is cost of accommodations, cost of abortion and medication. So, it would be better if such survivors are supported with these costs or provide the service near to them. —Female health service provider, health center*

Healthcare workers were unaware of any GBV policies, guidelines, and/or protocols, or said they did not exist; however, most recognized the importance of having policies in place and called for a system-wide mechanism to ensure healthcare workers were aware of policies. There were several suggestions for new policies, including increasing awareness of early marriage and FGM/C, stronger punishment for perpetrators, integrating GBV into the youth policy, and increasing the level of effort dedicated to GBV.

> *It would be better if closer support and follow up is made on police/guidelines/protocol is made for us more to have awareness on it. And also better if there is quarterly monitoring and evaluation. Closer follow-up from the* woreda *is needed and also top other offices should work with us in integration. —Female health extension worker, health post*

> *It will be good if more attention is given for GBV and measures have to be taken after having laws for it. The punishment should be strict and stronger for those who commit the crime. We should not be reluctant in implementing the policy because if the first person who commits the crime gets punishment, others will learn from him and it helps to stop them later. Sometimes they rape and hide themselves from the community and the case is resolved with elders. There are rumors as girls give birth after they are being raped. Those who commit such raping say it is not a problem, we will resolve it via elders. It would have*

been better [that] those who commit such GBV crime be punished as per the law. —Female health extension worker, health post

FINDING 10: Healthcare workers reported little to no GBV-specific training.

Respondents frequently mentioned the desire for GBV-specific training for health service providers, health extension workers, and community groups, such as the Women's Development Groups. Some interviewees suggested training specifically on how to provide psychosocial counseling and medical support, such as prescribing medication to GBV survivors.

It will be better if training is given on GBV so that health workers deliver service based on skills having its own protocol. It will be better to train health staffs well so as to satisfy clients. Better to establish reporting system to different stakeholders and there is a need for network with different stakeholders. — Male health service provider, health center

The majority of respondents reported they had never received any GBV-specific training. A few providers mentioned receiving YFS, gender equality, or adolescent health training, one of which had a sub-section for GBV. Some respondents said that although they received GBV training, they could not remember the GBV components, and the training manuals or job aids were not available. One health center worker noted receiving training from Transform: Primary Health Care project. Only the primary hospital possessed a provider specifically trained in GBV prevention and clinical response, per the observation checklist data.

However, while training on youth-friendly services was delivered for five health workers of the facility in the past, a component on gender-based violence was included and training was given as a sub-topic. But GBV was not given for any of the workers independently. —Female health service provider, health center

We did not take any training on GBV independently. But we took GBV as part of other trainings. We took several trainings and within such trainings, as a sub-section we took on GBV. I do not remember exactly which type of training we took, but it has GBV component. I did not get any GBV-related education while I was at school. —Female health extension worker, health post

FINDING 11: Most health facilities lacked essential GBV-related job aids and forms, as well as educational materials for clients.

Several interviewees reported having no resources like job aids or teaching materials related to GBV. The checklist data corroborated this finding, demonstrating further that most of the essential GBV resources—including checklists on signs and symptoms, referral forms, consent forms, diagrams, and the *Pathway for Initial Care after Assault* poster for providers at health posts, health centers, and the primary hospital—were not available.

Exhibit 2: Job aids and forms required per national standard operating procedures (SOPs)

JOB AIDS AND FORMS REQUIRED PER NATIONAL SOPS	NO. OF HEALTH POSTS (N=8)	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
Specific referral form for GBV survivors	0	0	1
Consent form available for the GBV survivor and/or parent/guardian of the survivor	0	0	0

JOB AIDS AND FORMS REQUIRED PER NATIONAL SOPS	NO. OF HEALTH POSTS (N=8)	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
Copy of the *Pathway for Initial Care after Assault* poster	0	0	0
Checklist, post, or set of guidelines 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
Stock of body maps available	n/a	0	0

All of the health centers and the primary hospitals were found to lack essential visible information, education, and communication materials for clients, such as posters and/or pamphlets on the following topics in high-traffic areas: what to do in case an individual has experienced GBV; GBV laws and rights; and available GBV prevention and response services in the facility. Yet, pamphlets or brochures on different contraception options were largely available.

Exhibit 3: Educational materials required per national SOPs

VISIBLE INFORMATION, EDUCATIONAL, AND COMMUNICATION MATERIALS FOR PATIENTS IN HIGH-TRAFFIC AREAS AS REQUIRED PER NATIONAL SOPS	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
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
Pamphlets or brochures on different contraception options	3	1
Brochures or pamphlets on HIV PEP and its risks	0	1

FINDING 12: Healthcare workers had little awareness of guidelines, policies, and procedures; guidelines, policies, and procedures were not visibly displayed in most health facilities.

As mentioned above, most respondents said they did not know of any policies, guidelines, or protocols for working with GBV survivors. One health extension worker stated there was no policy on GBV, but there was a policy on sexual assault and wife-beating. Some respondents also mentioned they were aware of policies for other health services, but none existed for GBV.

> *We do not have protocol/guideline/policies. We know where to examine and there is keeping confidentiality of GBV survivor's information. —Male health service provider, health center*

Observation checklist data revealed that most of the existing guidelines, policies, and procedures were not available or visible in majority of health facilities.

Exhibit 4: Guidelines, policies, and procedures required by national SOPs

GUIDELINES, POLICIES, AND PROCEDURES REQUIRED BY NATIONAL SOPS	NO. OF HEALTH POSTS (N=8)	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
Code of medical ethics or ethical code of conduct visibly displayed	0	0	0

GUIDELINES, POLICIES, AND PROCEDURES REQUIRED BY NATIONAL SOPS	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 easily seen by and accessible to healthcare workers	0	0	0
A checklist, SOP, or set of guidelines on how to conduct a vaginal examination for different age groups (i.e., conducting a labial traction for pre-pubescent girls to prevent further harm) available for healthcare workers to reference and use	n/a	0	0
A checklist, SOP, or set of guidelines (such as the one in the Ministry of Health's GBV Training Module II on GBV) available for healthcare workers to reference or use on how to conduct:			
• A hymeneal examination	n/a	0	0
• An anal examination	n/a	0	0
• A vaginal examination		0	0
The national protocols for testing and treating STIs available and visible in the healthcare facility	0	4	1
The national guidelines for HIV counseling available and visible in the healthcare facility	n/a	2	1

FINDING 13: Respondents reported having basic medical supplies and equipment, but most health facilities lacked essential supplies and equipment for comprehensive GBV response services.

Most healthcare workers at all levels mentioned they had basic medical supplies and equipment to provide GBV prevention and response services. Health extension workers reported having first aid kit supplies. Health centers and the hospital had more sophisticated supplies and equipment, such as laboratory equipment, family planning commodities, and other medicines.

Data from the observation checklists echoed information from the interviews. The majority of facilities had supplies for basic care and treatment, but lacked most of the essential supplies and equipment required in the SOPs to provide comprehensive GBV response. Almost all health posts had first aid kits and most contraceptive options. Health centers and hospitals possessed most of the supplies to stabilize bleeding, manage pain, treat superficial wounds, and basic testing, but generally lacked supplies and equipment to develop and preserve forensic evidence, more sophisticated testing, and surgery. While the majority of facilities were stocked with most contraception options, stocks of other key medicines varied across facilities and PEP was notably missing from most.

Exhibit 5: Equipment and supplies required by the national SOPs

EQUIPMENT AND SUPPLIES REQUIRED BY THE NATIONAL SOPS	NO. OF HEALTH POSTS (N=8)	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
A first aid kit	7	n/a	n/a
Large envelopes and tape to put evidence into available in the patient room	n/a	0	0
A camera on site (for the purpose of taking photos of fresh wounds, bruises, etc. as forensic evidence)	n/a	0	0

EQUIPMENT AND SUPPLIES REQUIRED BY THE NATIONAL SOPS	NO. OF HEALTH POSTS (N=8)	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
Laboratory supplies needed to collect samples during the physical examination:			
• Containers for collecting urine, stool, other bodily fluids	*n/a*	*4*	*1*
• Oral swabs	*n/a*	*3*	*1*
• Pregnancy tests	*n/a*	*4*	*1*
• Syringes and vials for collecting blood for STIs, HIV, Hepatitis BsAg	*n/a*	*4*	*1*
• Vaginal swabs	*n/a*	*4*	*1*
A functional refrigerator or freezer to store specimens	n/a	3	1
A laboratory on site that is capable of evaluating forensic evidence	n/a	0	0
Tools needed to conduct a radiologic investigation:			
• X-ray machine	n/a	0	1
• Ultrasound machine	n/a	2	1
Stock of contraception options:			
• Emergency contraceptives	n/a	3	1
• Implants	8	4	1
• Injectables	8	4	1
• Combined or oral contraceptives	6	4	1
• Copper T intrauterine device (IUD)	0	3	1
Laboratory equipment and supplies to test for STIs:			
• Direct wet mount	n/a	0	1
• Culture	n/a	0	0
• VDRL	n/a	4	1
Minimum package for HIV PEP:			
• At least one physician/health officer/nurse trained in PEP assigned as focal person for the facility	n/a	2	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	n/a	1	1
• PEP starter packs, including ARV drugs, available inside the health facility and accessible to all staff, 24 hours and 7 days a week	n/a	1	1
• Provider support tool algorithm for determining the severity of exposure (exposure code) and PEP register available	n/a	1	1

FINDING 14: Most health facilities recorded and disaggregated patient information, but there was no standard format and no separate record for GBV survivors. Several health service providers said they did not use GBV information for any purpose, but a few respondents used the information to educate communities.

Most respondents reported that patient information was recorded on the regular patient card, regardless of survivor status. This information was disaggregated by sex and age. One health extension worker mentioned they had separate registration for adults and children. Health extension workers stated they did not typically record GBV cases because they did not offer treatment to survivors; they referred them to other health facilities.

> *We do not have a record format. We find GBV survivors when we give home-to-home education to the community. Gender-based violence survivors do not come to the health post; rather, we get them during our home-to-home education. We do not register GBV survivors. There is no treatment service at the health post and we do not have medicine at the health post level. So, we recommend GBV survivors to go to the health center. —Female health extension worker, health post*

> *We do not have separate record format for GBV survivors. We are now recording GBV survivors on emergency record format. We record on the type of violence since the survivors will take the case to legal charge. If it is physical violence, we record it as physical violence. We do not have a separate record format for GBV survivors. —Male health service provider, health center*

Data from the observation checklists also showed that all health facilities complied with the required demographic information on patient cards, but did not have registers of GBV cases.

Several respondents from health centers said they did not use the information they collected with regard to GBV survivors who visited their facilities. Yet, one health service provider and one health extension worker noted this information was beneficial to their community education efforts.

FINDING 15: Confidentiality of GBV prevention and response services varied across facilities.

The checklist data showed that none of the health facilities possessed a written policy regarding access to client information, including GBV case files. Most interviewees stated they kept client information confidential and did not share it unless needed. Personnel at the hospital noted that medical ethics did not allow for sharing clients' information, and health center staff reported that only those involved in the support and care of the survivor could access records. However, all four health centers stated that health service providers and the police could access patient records. Two health centers mentioned that the Women's Affairs Office had access, and one indicated that individuals from the justice system could access the materials.

Many interviewees said that medical cards were not locked and other staff could access them, but several others said patient cards were kept in a locked cabinet or locker.

> *We keep the confidentiality of GBV survivors and clients. We strive to keep the confidentiality of GBV survivors. We do not share information of GBV survivors to anyone. No one can access the information from the health post. —Female health extension worker, health post*

Exhibit 6: Policies and practices for confidentiality per national SOPs

POLICIES AND PRACTICES FOR CONFIDENTIALITY PER NATIONAL SOPS	NO. OF HEALTH POSTS (N=8)	NO. OF HEALTH CENTERS (N=4)	NO. OF PRIMARY HOSPITALS (N=1)
A written policy in place to govern who can access patient files (including the family folder and all registers at the health post level, medico-legal forms, and forensic evidence)	0	0	0
Consent form available for the GBV survivor and/or parent/guardian of the survivor	0	0	0
Medio-legal files, including GBV case files, stored in a lockable cabinet	n/a	1	0

Most respondents stated there was no separate provision room for GBV prevention and response services, and no interviewed providers said one was available. Only one of the observed health centers was found to have rooms or areas where GBV survivors could rest and/or a stabilization room that is private, clean, quiet, and comfortable. The primary hospital indicated they did not have such rooms available because they faced a shortage of space to be used as classrooms; one health center made similar remarks about a lack of classroom space. One health center noted they did not maintain such a space because the number of GBV cases was not significant enough to assign a separate place or rooms for treating survivors. Comparably, another health center noted they used emergency or OPD rooms for treating survivors, because they did not feel it was necessary to have separate rooms for these patients. One provider said a separate provision room would be helpful to maintain survivor's privacy and confidentiality.

> *To keep the privacy of GBV survivors, there should be a separate examination. When GBV survivors get examination in outpatient department, they may not freely explain their problem since there are a number of people within that room. The room for service delivery for survivors should be attractive that helps them to be out of their trauma and explain their problem. The room should be well equipped with equipment for treatment of gender-based violence survivors and with a number of examination aid pictures and materials. —Male health service provider, health center*

Exhibit 7: Separate space for GBV survivors in facilities per national SOPs

SEPARATE SPACE FOR GBV SURVIVORS IN FACILITIES PER NATIONAL SOPS	NO. OF HEALTH POSTS (N=8)	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	n/a	1	0
A designated location to examine GBV cases that ensures the confidentiality and privacy of survivors	n/a	1	0

FINDING 16: Healthcare workers reported that female GBV survivors did not access services primarily for cultural reasons, but they were also deterred by lack of awareness and deficiencies at health facilities.

Most healthcare workers stated that young girls and adult women, particularly survivors of GBV and rape, did not visit the health facility or receive any treatment or care primarily because of fear of being stigmatized by society's perceptions of victims. Rape and GBV cases were often dealt with within the home and not brought to the health facility. Most healthcare workers mentioned that if the family or

survivor knew the perpetrator, such as a spouse, relative, close family member, or a friend, then it would not be reported and instead, would be handled quietly. Another respondent stated that disclosing personal family affairs or issues was taboo and culturally inappropriate, particularly for older women who experienced violence from their husband or partner.

> *Those girls who are raped and become pregnant, the case is handled by elders, and they do not come to us and do not report to police. Those who fear, those who do not have awareness and those who are shy do not come to the health post. Most of the time, girls who are raped and become pregnant do not come to the health post because of fear of the society, lack of awareness that the service is there, and sometimes such cases can be resolved through elders. Awareness on GBV should be created for the community and what to do after the incident happened. Health workers need to have a good approach and relationship with girls to avoid the fear in girls. Awareness for family is needed to bring them to the health facility and legal aid.* Kebele *and police should also be trained and be aware to help the survivors. —Female health extension worker, health post*

> *When girls are raped, they do not come to the health facility, rather they prefer to stay at home. We hear as rumor that they are raped. Six months before, a girl was raped, and her family expelled her from home. Her family was assuming her as decent, and she is so silent, but raped by relative. Had she come to the health post and got treatment, she would have not been pregnant. Family made the case a secret. The girl came back to family after she gave birth. When the girl came back, we went to their home and educated her family as it should not have been made this way. We made the baby get vaccination. Her family tried to hide the baby to not get vaccination. The case became hidden since she was raped by a relative. Had the rape been made by a non-relative, the case would have come to us since here, family demands to take the case to police. —Female health extension worker, health post*

Providers also noted that many, particularly adolescents, did not seek services due to a lack of awareness of types of services health facility offered, and because they might not identify what happened to them as GBV or rape. One provider reported that boys and men raped by other men also did not visit the healthcare facility for GBV response services due to fear of stigma and society's perceptions.

> *Those boys/men who are raped by men do not come because of the fear of the perception that others may stigmatize them. —Male health service provider, health center*

Those who could not afford procedures, medication, or treatment also opted out of GBV prevention and response services health facilities offered. One health extension worker noted that while community-based health insurance had reduced cost and increased access to services for women, it did not cover IPV.

> *However, there is problem in shortages of resources and the medical fee that GBV survivors are expected to pay is another problem to deliver the service, i.e., those who cannot afford cannot get the service. —Male health service provider, health center*

> *Community-based health insurance (CBHI) has contributed a lot and they come to the health center as soon as they get sick, but now renewal is taking place. The problem is that CBHI does not cover for fighting cases, and if a husband beats his wife, he is expected to cover the cost from his pocket. —Male health service provider, health center*

Most healthcare workers also reported community members were not inclined to access GBV prevention and response services due to the shortages of resources at health facilities, particularly

health posts. Because community members already knew that the facility did not provide certain types of treatment, medication, and specific procedures, such as abortions, they went to other health facilities for those services. One respondent mentioned that because there were no private rooms, GBV survivors were less likely to be motivated to access services, especially youth. Health service providers also recognized poor accessibility of the health center to the community members. One interviewee said the health center was not centrally located for all *kebeles*; therefore, it was not equally accessible to all community members.

FINDING 17: Healthcare workers reported that clients were satisfied when they received compassionate care and their confidentiality was respected.

Most healthcare workers reported that women were satisfied with the services they received when their privacy and confidentiality were protected, such getting treatment and examination in a separate room and keeping their medical information private.

Overwhelmingly, healthcare workers felt that providing a welcoming facial expression and compassionate care would contribute to women feeling satisfied with services. They also mentioned that when services were provided in a timely fashion without any mishaps, female patients were more pleased with the care. It was important that all the services were received within the same facility.

> *In addition, the survivor satisfies if s/he gets examination and treatment with maximum privacy in a separated room and the environment of the facility should be attractive. —Male health service provider, health center*

> *Good, welcoming approach and good facial expression starting from salutation when she first comes to the health post gives her satisfaction. When she gets better services at the health facility, she can visit the health post again in the future. If she gets all the services, she would be satisfied. —Female health extension worker, health post*

When asked about young girls, most healthcare workers said they were also satisfied if they were treated privately and confidentiality was protected. Many respondents reported that young girls feared going to the health center when trying to access family planning services; thus, they received family planning support in secrecy from their families, especially unmarried girls. Two male health service providers also mentioned that young girls preferred obtaining services from female health service providers so they could feel more comfortable in sharing information and during the physical examination, because they did not want to show their private parts to men. One respondent stated that young girls could easily express their feelings to younger healthcare workers.

> *Girls understand us much better than other survivors of gender violence. Girls freely tell us all their feelings and what they faced transparently while others need more probing to identify their problems. We, health workers, are friendlier and they tell us their secret. We spend more time with girls, and they tell us lots of things. Girls usually demand the confidentiality of their secret, and we, health workers, keep their secret. Confidentiality and privacy are important for our visitors, and we also keep it, and it's good for our visitors. Some girls do not want to be seen at the health center because of fear. —Female health service provider, health center*

> *Girls do not come to the health center; when girls come, they come together with family. It is good when GBV survivor girls come to the facility and privately tell their problem to the health worker. I have one case where a 3- or 4-year old girl came to our facility for treatment with her family. Family brought her to the*

health center since she refused to go to school. Then she requested her family leave the room to tell her problem to me. Then I bought her candy, and she told me as she was raped and sick in her abdomen. Hence, let alone children at the age of 12 years old, children at the age of 5 years old want privacy to tell their problem. —Male health service provider, health center

Some respondents mentioned they had never witnessed a male GBV survivor, and one laughed when asked about it. However, most healthcare workers reported that a man would be satisfied with the services he received if he also had privacy and his confidentiality was protected, such as receiving treatment and examination in a separate room and keeping his medical information private. Most healthcare workers stated that offering a welcoming expression and compassionate care in a timely fashion would contribute to men feeling satisfied with services, similarly to women. Also, a distinction was made between men and women when accessing reproductive health services— respondents reported that girls or women were afraid when visiting the facility for STIs or to receive condoms, whereas, boys and men came into the facility more freely to get tested and for condoms.

I would give first aid and if referral is needed, refer him to the health center. I never heard of males raped. —Female health extension worker, health post

Men/boys are not afraid like girls/women who visit the facility. When he gets sexually transmitted diseases test, most of the time men are happy when you talk to them freely and when they get counseling service. They are happy when we advise them what to do about their problems. —Female health service provider, health center

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

FINDING 18: Respondents expressed limited knowledge of hotlines and shelters.

Healthcare workers did not have any knowledge or information regarding shelters, local or national, for survivors of GBV.

I do not know whether there is a shelter for GBV survivors or not. I only know of a shelter for pregnant women at health center. —Male health service provider, health center

I did not hear about a shelter for GBV survivors, and I do not have information on this. —Female health extension worker, health post

Healthcare workers also reported limited knowledge of hotline numbers; instead, they contacted other health facilities for information. A few healthcare workers mentioned the following hotline numbers: 994, 85, 8482, and 8560; however, they did not have any additional information or even know whether these numbers worked. One respondent had knowledge of the Ministry of Health's 952 number, but she suggested it was only for information on HIV and had never used it.

We just call the woreda *health office if we need any information. I don't know any. —Male health service provider, health center*

There is no phone line to access health information. 952 is only used for accessing information on HIV. I have never used 952 line to get information on HIV. —Female health service provider, health center

FINDING 19: Healthcare workers referred survivors within the health and legal system, even though they felt connections were weak.

Majority of healthcare workers identified other health facilities where they referred GBV survivors. Several health extension workers referred to the health center, for example, for medical examination and laboratory work. Health service providers referred GBV survivors to a number of different services depending on the type of violence, including the emergency department, OPD, laboratory, MCH, and family planning services. According to health service providers, a patient would usually go to the OPD and then, depending on the severity of her case, be referred to the emergency department if needed. Many providers referred GBV survivors to the hospital for additional services, such as x-rays and other services, particularly if they were beyond the capacity of the health center. Female GBV survivors were primarily referred to the laboratory for HIV/STI/pregnancy testing, and girls between the ages of 10 and 24 were referred to YFS.

Several respondents referred survivors for psychological counseling, and noted that counseling existed at health posts, health centers, and hospitals. Few healthcare workers referred survivors to abortion services and a laboratory for testing. A provider at the hospital also referred to a gynecological specialist for a "virginity test" in cases where the family wanted confirmation of rape.

> *For virginity test for girls who are raped, we refer them to gynecology specialist; this is most of the time when families demand to check whether the girl is raped or not. We cannot do virginity test in the hospital yet. —Male health service provider, primary hospital*

For services outside of the health system, almost all respondents referred GBV survivors to the police for legal aid. Some respondents only referred to the police if the survivor requested it or only dealt with the police in relation to a medical certificate. Majority referred survivors to Women's and Children's Affairs Office for legal aid, and a few health extension workers referred survivors to Women's Development Groups for counseling.

> *When the police formally ask us the medical information of GBV survivors, we formally give the information. So, it is a must for GBV survivors to get their medical information. We also inform GBV survivors as we give them their medical information when they report to police and when police formally requests it from us. In that case, we give the information to police. So, we inform GBV survivors to report the case to court or police to get their medical reports. —Male health service provider, health center*

> *Before we take the case to legal charge, we must understand the problem well. There was a time when I cried where a mother had many children. Her husband did not give money for household expenses. Due to this, she feeds her family borrowing from neighbors. One day, I went to their home, and there was nothing to be eaten. When I asked her, her husband took all food crops to store and did not give any to her. She told me crying. Her families were unable to resolve her problem. She went to Women's Affairs [Office] to get solution. Then Women's Affairs [Office] referred her to solve the problem via elders. Since her husband invites them in chewing khat with them, the elders were in support of him. Later, the elders blame her as if she is the one with the problem. When I asked her now, she told me relatively her husband is better now than before. —Female health extension worker, health post*

According to the observation checklist data, all of the observed health facilities indicated they did not offer referrals to child protection services (if necessary or when required by law); economic

empowerment; livelihood services; emergency services; or support groups. Only the primary hospital had a specific/standard referral form for GBV survivors.

Connections between service delivery points were limited or nonexistent, except for some healthcare workers who had a relationship with the police and sometimes, the Women's Affairs Office. For example, one respondent reported having consistent communication with the police and the Women's Affairs Office through steering committee meetings that discussed GBV cases.

> *We have connection with police only in delivering them information about GBV survivors. With others, we do not have any connections. Due to the severity of the problem, it would be better if there is connection to work together. There is no follow-up on GBV survivors once they are referred to police and Women's Affairs [Office]. —Female health service provider, health center*

> *It would be better if we worked with police and Women's Affairs [Office], which would be done after treatment is delivered for the survivor. But now there is nothing. —Female health extension worker, health post*

Many interviewees reported the desire to improve the links and relationships between response actors to create a network of services, from the Women's Affairs Office, health office, the police, to the community. Many also desired additional support from district leadership, the Transform: Primary Health Care project, the *woreda* health office, and the health center. Many specifically mentioned closer monitoring or follow-up from local government officials. One respondent suggested having a reporting mechanism so providers could work together through an operationalized system.

> *It will be good if there is more integration with other offices such as* kebele*, police and Women's Affairs [Office]. Women's Affairs [Office] organize the issue of legal aid/attorney. So far, I do not have connection with police. I have connection only with Women's Affairs [Office] and* kebele *administration. It will be better if anybody brings us together. I do not know any police who works anywhere. It will be better if we have connection with police. —Female health extension worker, health post*

> *There should be a strong network system in the community, more work has to be done on awareness of gender violence for the community, and handling of medical information survivors should be improved. It is better if all health facilities work together with police and Women's Affairs [Office]. —Male health service provider, health center*

FINDING 20: While healthcare workers often conducted follow-up with their own clients, they noted the lack of a mechanism to do so.

The healthcare worker who treated the GBV survivor usually conducted follow-up by asking survivors to come back during the subsequent visit or by visiting their homes. Some health service providers followed up with survivors with the support of local leadership or linkage focal person at the health center. In addition, health extension workers primarily conducted follow-up with GBV survivors through home visits. Only one respondent reported not providing any follow-up.

> *Together with the local leadership and others, I follow up with the survivor. I have the responsibility to follow up with the survivor. I must follow the survivor about what medicine does she take, what is her status, and the service she gets at the health center or hospital. I closely follow up with her at her home. —Female health extension worker, health post*

Healthcare workers had no mechanism or system to ensure their clients received follow-up services, except for directly asking them or conducting a home visit. They also did not have any coordination or monitoring system between stakeholders within and outside the health system to guarantee follow-up services or treatment for GBV survivors.

> *There is no mechanism to make sure that all services are provided to the survivors, but I will just check the information through asking the survivor. We have a meeting every 15 days to discuss different issues and sometimes, points may be raised about violence cases. —Female health extension worker, health post*

> *As I have told you earlier, there is no such system at the ground level, and there are no ways all these stakeholders meet and evaluate all service delivered to the survivors. We do the follow up by ourselves. —Male health service provider, health center*

FINDING 21: Healthcare workers were unsure whether reporting was legally mandatory, but they agreed it should be done, and many referred patients to legal and community actors.

Almost all healthcare workers stated reporting was not mandatory or were unsure whether it was legally required. However, several of these respondents implied it would be good or was morally required to report, particularly to the police. Few providers suggested reporting was legally required. One health extension worker stated that she was "accountable" if she did not report to the police.

> *Reporting is mandatory from the moral perspective, though it is not mandatory from legal point of view. —Female health extension worker, health post*

> *Reporting to police is mandatory because such GBV survivor should get solution for the violence she faced. The perpetrator should face legal charges. So, reporting is a must. I do not know whether reporting to police is mandatory legally. It might be mandatory legally to report to police when we get GBV survivor, but I do not do that. —Female health extension worker, health post*

> *It is mandatory to report it since no one should cause physical violence on other. This is a humanitarian right for the survivor not to face physical violence. Since here, the community has the trend of resolving such violence via elders, beating wife is considered as a norm or as a legal right of husband. On top of this, since the community develops this as a norm, there is room that you accept it just like the community. But I have the right to take to legal charge, if anyone causes physical violence on a mother or a child. It is also mandatory for health worker to report such violence case. But the system does not allow me to report such violence cases to police. —Male health service provider, health center*

Almost all healthcare workers stated reporting to the police was necessary; however, less than half of those who mentioned reporting to the police said they reported to police directly. Several respondents went to Women's Affairs Office, and some health extension workers reported to the *kebele* administration, who then pursued legal action. Most respondents relied on survivors themselves to report to the police. A few providers only interacted with the police to provide a medical certificate after a survivor had gone to the police first.

> *We first hold discussion with* kebele *administrative and the* kebele *administrator will report the case to police. Together with the Women's and Children's Affairs Office, we establish the legal process. The perpetrator should be punished, and if it is sexual violence case, it should be reported and it is mandatory to report. —Female health extension worker, health post*

CONCLUSIONS

Conclusion 1: Lack of provisions and resources available at health facilities for healthcare workers created varying scope of GBV prevention and response services.

GBV prevention and response services were available at all levels of the healthcare system, but the types of services and their scope varied depending on facility type. Many healthcare facilities and workers lacked job aids and provisions to provide sufficient GBV prevention and response services; essential resources needed for health facilities to align with SOPs and quality standards were missing. Health posts were the most limited in their ability to provide services due to minimal resources.

Findings show that survivors were satisfied with and accessed services if they received quality medical care, their confidentiality was respected, and they were met with compassion and able to obtain medical certificates. However, scarcity of adequate resources compromised the ability of healthcare facilities to meet those needs and expectations. Facilities lacked guidelines on how to conduct various examinations and job aids, such as diagrams and posters of the body, sexual violence medical certificates, and consent forms. Furthermore, health facilities missed proper resources to benefit survivors, such as the ethical code of conduct visibly displayed, documentation on the general signs and symptoms of GBV or sexual violence, as well as posters and/or pamphlets on GBV laws and rights, and available GBV prevention and response services at the facility.

Conclusion 2: Healthcare workers strived to provide quality GBV prevention and response services, but the dearth of GBV-specific training inhibited their ability to do so.

Healthcare workers at all levels of the health system engaged in supplying GBV prevention and response services, and strived to provide compassionate and quality care, but findings show that most had no formal training in GBV prevention and response. The few providers who had received GBV training were unable to remember the exact GBV components. Although healthcare workers often collaborated with community groups, religious leaders, elders, and schools to provide prevention sessions for community members, the effectiveness of these sessions was limited because they were led by either healthcare workers or other community members who had little knowledge of GBV prevention and response.

The varying levels of knowledge and understanding of GBV, limited to no GBV-specific training, and the deficit of clear guidance on how to effectively conduct prevention activities, and treat and refer GBV survivors impeded the healthcare workers' ability to provide holistic and comprehensive GBV prevention and response services. In addition, these gaps resulted in many healthcare workers not adequately adhering to "do no harm" principles—for example, when they discouraged married survivors from seeking justice or conducted what they perceived as "virginity tests" instead of collecting forensic evidence for prosecution of GBV perpetrators, including husbands. However, findings show that healthcare workers were aware they had limited knowledge of GBV and desired training to address this limitation so they could deliver quality GBV prevention and response services.

Conclusion 3: Healthcare workers did not adequately record or use GBV data.

Although providers wished for policies, procedures, and protocols, they had little to no awareness of any existing ones, and there was a lack of clear guidance in all areas of GBV prevention and response. GBV information healthcare workers collected had not been adequately recorded or used. For instance, most health facilities recorded client information and typically disaggregated it by sex and age, but there

was no standard format and no separate record for GBV survivors. In addition, healthcare workers had insufficient instruction on how to use recorded or tracked GBV data. Only health extension workers reported using collected GBV information to help them educate their communities; most health service providers said they did not use the GBV information for any purpose. These inconsistencies resulted in an inadequate record of GBV cases.

Conclusion 4: Multi-sectoral pathways were weak and there was a lack of a formal follow-up system.

While data show a variety of referrals, both medical and non-medical, were offered to GBV survivors, there were numerous deficiencies that suggested survivors likely did not access all the services they needed. Findings show health service providers and health extension workers referred survivors to the appropriate health facility if they were unable to treat them; yet, referral pathways outside the healthcare system were weak and key gaps existed. There was an inconsistency in healthcare workers' understanding of and engagement with law enforcement and legal services. Although many healthcare workers believed reporting GBV cases to the police should be legally mandatory, they were unsure whether it was.

The lack of a standard case management, referral, or follow-up system hampered healthcare workers' ability to develop formal links between the health system, community, and legal bodies, which prevented survivors from accessing comprehensive GBV prevention and response services. Healthcare workers, in particular health extension workers, often conducted follow-up with their own patients, but findings show there was no standard mechanism in place, which made it difficult to know whether all survivors received appropriate medical or non-medical services in a timely manner. However, findings show that health service providers and health extension workers wanted increased linkages between multi-sectoral services to better support survivors.

Conclusion 5: Social stigmas, cultural perceptions, and gender norms were barriers to providing and accessing GBV prevention and response services.

Social stigmas and gender norms, as well as traditional practices and cultural perceptions hindered healthcare workers' and clients' understanding of GBV, which impeded survivors' ability to access quality GBV prevention and response services. Healthcare workers reported that survivors often did not access GBV prevention and response services due to fear associated with how society would perceive them. In addition, healthcare workers often categorized physical violence as general trauma or injury, and IPV in particular, was not widely recognized as a form of GBV. This means survivors did not receive or access needed services when husbands perpetrated violence against them. Healthcare workers tended to treat IPV survivors differently than other GBV survivors—for example, counseling wife survivors of IPV together with their husbands, advising them to reconcile, and discouraging them from reporting these cases of abuse to the police for legal action.

RECOMMENDATIONS

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

Recommendation 1: The Transform: Primary Health Care project's SNNPR 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 2: The Transform: Primary Health Care project's SNNPR regional office staff should increase community mobilization activities, including working with Women's Development Groups, school engagement activities, male engagement activities, working with local community leaders, and strengthening GBV sessions in workshops. The gender officer should work closely with the social behavior change communication team to integrate GBV in their activities and materials.

Recommendation 3: The Transform: Primary Health Care project's SNNPR 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.