GENDER–BASED VIOLENCE LANDSCAPE ANALYSIS – TIGRAY CASE STUDY

USAID/ETHIOPIA TRANSFORM: PRIMARY HEALTH CARE PROJECT

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ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral therapy
FGM/C	Female genital mutilation/cutting
GBV	Gender-based violence
HMIS	Health management information system
IPV	Intimate partner violence
MCH	Maternal and child health
OPD	Outpatient department
PEP	Post-exposure prophylaxis
SOP	Standard operating procedure
STI	Sexually transmitted infection
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, and Tigray. This report presents findings, conclusions, and recommendations of the Transform: Primary Health Care project's GBV Landscape Analysis in the Tigray region.

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[1] Federal Democratic Republic of Ethiopia Ministry of Women, Children and Youth Affairs. 2013. *National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia*. Accessed October 3, 2018: http://www.africanchildinfo.net/clr/policy%20per%20country/2015%20Update/Ethiopia/ethiopia_htp_2013_en.pdf.

[2] The United Nations Children's Fund (UNICEF) 2016

[3] Central Statistical Agency and Inner City Fund 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 Tigray region consisted of four health centers. The sample was comprised of one primary hospital, two health centers, and four health posts (two under each health center). The interview sample included two health service providers 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 Tigray case study.

Exhibit 1: Tigray research sites

1 Primary Hospital
2 Health Service Providers

2 Health Centers
4 Health Service Providers

4 Health Posts
4 Health Extension Workers

FINDINGS

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

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

FINDING 1: Most GBV prevention activities consisted of awareness-creation sessions at the health post level, facilitated by health extension workers in collaboration with community groups.

Within the health system, most prevention activities were awareness-creation sessions health extension workers organized and facilitated. These sessions largely focused on raising awareness of harmful traditional practices, such as early marriage and female genital mutilation/cutting (FGM/C), but many respondents noted they also covered topics related to safe pregnancy and male engagement in maternal health. There were no sessions specifically about violence prevention. Health extension workers often collaborated with community groups, such as Women's Development Group, to organize and deliver these sessions. Health extension workers put an emphasis on targeting students and young people, but also used other community platforms, such as community meetings, churches, and door-to-door visits, to disseminate these messages.

> *We educate the community about the consequences of early marriage and advise them to report any early marriage cases if they come across them. We use different platforms to transmit our message; we use gatherings like church and monthly meetings of women health development armies, and also [*kebele*] council meetings and schools. —Female health extension worker, health post*

> *The majority of the prevention activities are done at the health post level. Health extension workers do door-to-door activities. They teach the society about the consequences of early marriage, and female genital mutilation. They also teach the consequences of home delivery to those men who prohibit their wives from maternal healthcare. The health extension workers emphasize more male engagement in their activities; this is because the probability of women seeking prenatal and postnatal care is highly dependent of the willingness of their husbands. Health extension workers also push* kebele *leaders to be involved in the activities they do. This is because people tend to listen and act upon the information disseminated by* kebele *leaders. —Female health service provider, health center*

Respondents noted that collaboration with community groups such as Women's Development Groups, the Women's Affairs Office, and women's leagues strengthened prevention efforts. For example, Women's Development Groups organized people for awareness-creation sessions, and various groups helped identify cases and refer people to health facilities or other local resources for help. Respondents emphasized the importance of engaging with local government officials, such as *kebele* administrators and the police, because the community was more likely to listen to these authorities.

> *Women development armies give awareness on female genital mutilation and early marriage. They teach women to not sit at home if violence is committed against them. They advise them to report their cases to the police. Beside this, in collaboration with health extension workers, they engage in door-to-door teaching and in doing so, they identify gender-based violence cases. —Female health extension worker, health post*

> *Collaborative work is also important, not only with health extension workers and women development army, but also with government officials.* Kebele *administrators have high acceptance among the community members and if they are involved in the preventive activities, we can ensure fruitful work in short period of time. —Female health service provider, primary hospital*

There were also several instances of community members informing health service providers of child marriage cases for intervention.

> *In addition, her father was doing it for his daughter's own sake, he didn't think early marriage would harm her and when we told him about the disadvantage, he didn't waste time to halt the wedding. This shows you that people do harmful traditional practices due to lack of awareness, and awareness creation to the community can take us a long way in alleviating harmful traditional practices. We didn't think he would change his mind that fast. In here, the role of the neighbor also should not be overlooked, if she hadn't exposed the violence, we wouldn't have known about it. Members of the community are alert when it comes to early marriage cases, and this is helping us in encountering the problem. —Male health service provider, health center*

> *The road I have passed through as being a girl has helped me to help these girls. In addition, I wouldn't have found out about the early marriage case if it wasn't for the peer educators; so, peer educators have played a key role in the achievements. —Female health service provider, primary hospital*

Some health centers also collaborated with the health posts and community groups on prevention activities, but most health centers and hospitals did not conduct any prevention work outside their respective facilities. Health center and hospital staff hosted morning sessions with patients, which various providers from different departments facilitated. These sessions mostly covered prevention of harmful traditional practices, including early marriage and FGM/C.

> *– What issues do you raise during the morning session?*
>
> *– About family planning, communicable diseases like HIV/AIDS, about harmful traditional practice like that of early marriage and female genital mutilation. There is no specific session dedicated to gender-based violence, but we teach them about it when we cover harmful traditional practices.*
>
> *—Female health service provider, primary hospital*

In all cases, the health extension workers and health service providers facilitating these sessions had little or no training in GBV. Providers also reported being unaware of preventive services available at other levels of the health care system.

> *Our former director and the focal person at OPD [outpatient department] have taken training on gender-based violence; I also took training on gender-based violence. But the rest of the health providers haven't yet taken any training related to gender-based violence. —Female health service provider, primary hospital*

> *We have no resource. Majority of us didn't take any training on gender-based violence, we only give training based on the limited knowledge that we have. —Female health service provider, primary hospital*

FINDING 2: The most commonly reported GBV response services were psychological support and basic medical services, but many health facilities also provided HIV and pregnancy testing, contraception, and referrals.

Respondents stated they treated their patients urgently and with care, regardless of the type of violence they had experienced. The providers reported it was important to treat survivors promptly to clean wounds, or if the patient needed post-pills or testing. The most commonly reported services provided were psychological support, usually to help "calm down" a survivor, followed by first aid and medicines for pain relief. Respondents also noted survivors often came seeking justice, either by requesting a medical certificate for the police or asking for referrals for other legal services.

> *If it is physical violence, the victim should get medical service immediately. The same is true for sexual violence, she needs to get tested for HIV, STI [sexually transmitted infection], and pregnancy, and get post pills immediately. —Female health extension worker, health post*

> *In my opinion, what they need is psychological support. At first, the psychological trauma is more unbearable for them than the physical pain. They want to calm down first before proceeding to the treatment. Nonetheless, this doesn't mean they don't need practical support. —Female health service provider, health center*

The provision of other services differed depending on the type of violence. Sexual violence survivors more often got priority and received a wider range of services and referrals, including HIV, sexually transmitted infection (STI), and pregnancy testing, post pills, post-exposure prophylaxis (PEP), and abortions. Survivors of physical violence usually only received first aid to treat any injuries and medicine for pain relief. Healthcare workers noted that although the services provided may be different, they approached all survivors in the same way—by speaking to them in a friendly manner and providing them with appropriate medical care. If a given facility was unable to provide a survivor with a treatment or service they needed, they would refer the survivor to the appropriate facility.

> *Maybe I might give high emphasis to sexual violence victims as I am a woman and I sympathize with them. Whereas the physical violence is not a big deal around this area, it is considered as something normal, maybe this is the reason why I don't give that much emphasis to it. —Female health service provider, health center*

> *We give service that is filled with kindness to gender-based violence victims. We also provide medical treatments and psychological support. If it is sexual violence, we run different tests like HIV, pregnancy, and STI. We also provide post pills and abortion services, and if the case is beyond our capacity, we refer them to the primary hospital. If it's physical violence, we stop the bleeding first and if there is a fracture, we refer them to the primary hospital. —Female health service provider, health center*

FINDING 3: GBV response services were available at all health facilities within the healthcare system, but services provided depended on the department, the survivor's needs, and the resources available at a given facility.

Healthcare workers reported that survivors could receive care and treatment at all levels of facilities within the healthcare system in Tigray. Depending on survivor's needs, they might be referred to one or more other facilities, because the services provided depended on the resources available at each health facility. Health posts reported only being able to provide basic first aid and referrals to help survivors

seek justice. Health centers were able to provide HIV, STI, and pregnancy tests, as well as medical certificates for the police or referrals to other resources to pursue legal action. Hospitals, where the most services and resources were available, provided the same services as the health centers, as well as post pills and PEP. Both health centers and hospitals provided all HIV services and contraception educational materials required in the standard operating procedures (SOPs) (see *Exhibit 2*). For more sophisticated procedures, such as rape confirmation exams or fistula repair, survivors must go to a general or referral hospital.

> – *Even if they don't do screening for rape, health centers provide HIV test, STI screening, post pills and they also refer cases to us if it is beyond their capacity.*
>
> – *What about primary hospitals?*
>
> – *We examine gender-based violence cases and we provide medication. We have HIV test, STI screening, contraceptive/post pills, we also do stitches.*
>
> – *What about at the general hospital?*
>
> – *General hospitals have a gynecologist. They are the ones who confirm rape cases and write medical certificates to the police.*
>
> – *What about at the referral hospital?*
>
> – *They deal with the more sophisticated cases like that of fistula.*
>
> – *Female health service provider, primary hospital*

Exhibit 2: Health centers' and hospitals' performance on HIV services indicators per SOPs

SERVICES AVAILABLE	NO. OF HEALTH CENTERS (N=2)	NO. OF HOSPITALS (N=1)
The health care facility has an HIV testing services counselor	2	1
If yes, the counselor or the health care facility offer the following services:		
• HIV testing services	2	1
• HIV counseling	2	1
• HIV comprehensive care (including ART, prevention of mother-to-child transmission, care and support)	1	1
The healthcare facility has pamphlets or brochures on different contraception options	2	1

At health centers and the hospital, survivors would receive treatment from the department where their needs were best met. Physical violence survivors and those with severe bleeding were typically referred to emergency services. Maternal and child health (MCH) departments provided STI testing, abortions, PEP, and post pills. Non-severe cases or those in need of psychological support were sent to the outpatient department (OPD), unless they were young, in which case they were sent to youth-friendly services (YFS). Survivors may also be sent to antiretroviral therapy (ART) for HIV testing or PEP. All healthcare workers, therefore, might treat GBV survivors. No respondents mentioned a specific healthcare worker in charge of providing GBV response services.

> *If there is bleeding associated with the violence, the services she needs are found at the emergency department; if she is sexually assaulted and she wants a pregnancy test, she can find the service at MCH department. There are some women who came late to the health facility after the incident, and for these women, the service they need is found at OPD. —Male health service provider, health center*

FINDING 4: Respondents said they used observation, questioning, and physical exams to identify survivors, but typically were not trained. Once identified, providers prioritized providing survivors with appropriate medical care.

Overall, rape, early marriage, and physical violence were reported at most facilities; rape was reported at all facilities. Respondents stated that when a survivor entered their facility, they first determined the type of violence the survivor had experienced. Most health service providers and some health extension workers said they were able to identify whether a patient was a GBV survivor through observation and by asking questions about what had happened, noting the patient's facial expressions, demeanor, or behavior. Several others reported they could identify GBV survivors by asking patients about why they were visiting their health facility. A few providers mentioned corroborating their observations with a physical exam. However, one female health service provider said it was important to do physical examinations along with asking questions because some female patients might provide false allegations. Another female health service provider said physical examination was important because some women refrained from providing details or simply did not want to speak about such traumatic experiences. Physical examinations were also conducted because they helped the provider assess the particular types of services the patient needed.

> *Besides asking, I can also pick up something from her face. Violence always leaves psychological trauma to the victim's life and this is expressed in their face. Without asking her a question, if you see a victim's face, you will read helplessness in her face. That's why I always look at the facial expression of a woman if she refuses to tell me what happened. —Female health extension worker, health post*

> *I do physical examination and run different tests. If it is physical violence, I will inspect whether it is partial or deep. In short, I can determine by using her words and by doing physical examination. Some women might be scared and refrain from telling me what exactly happened, and this makes it tough for me to determine, unless there is something otherwise visible in their body. —Female health service provider, primary hospital*

The majority of respondents stated they looked for signs of either physical or sexual violence. The survivors were then treated based on those needs.

> *How I proceed depends on the types of violence. If it is a sexual violence, I run HIV test, STI screening, provide post pill and PEP. I also appoint them to come after three months so that I can rerun HIV test. Beside this, I also provide counseling service… If it is physical violence, I do cleaning and dressing first… —Female health service provider, primary hospital*

When identifying survivors of GBV, respondents stated that education and previous experiences were the most valuable resources they relied on. While one health service provider from a primary hospital said that their previous training on GBV helped them identify GBV survivors, most respondents reported they had not had formal training prior to working in positions that provided GBV prevention or response services. A few respondents mentioned receiving training on harmful traditional practices or gender from the Women's Affairs Office.

Respondents reported that when they knew a patient was a survivor of GBV, they would give the patient priority treatment in their health facility. However, several providers noted it could be hard to identify survivors if they did not tell providers; consequently, survivors often waited with other patients.

Health service providers noted that sexual violence survivors received priority over physical violence survivors, because it was more difficult to determine the nature of the physical violence.

> *If the victim tells the card room personnel that she is a victim of gender-based violence, she will get a priority; but if she didn't say anything and if there are no physical injuries associated with the violence, she will not get priority as we cannot differentiate her from the rest of the patients. Despite this, after we find out that she is gender-based violence victim, we always give priority to her in every service that we provide. —Female health service provider, health center*

> *The way we approach them is the same for all, but we give priority to sexual violence cases because a woman with sexual violence must be tested for different things first. In addition, we must also give her post pill. Post pill will not work if it is provided after 72 hours, so we must be careful when it comes to sexual violence cases. Nonetheless, those who are physically attacked will be treated with the rest of patients. No priority is given to them because we cannot be sure if the violence is done by the opposite sex or the victim is just lying to get compensation. —Male health service provider, health center*

FINDING 5: Health facilities had basic medical supplies, such as first aid kits, medicines for pain relief and contraception, and lab equipment as resources for GBV response services.

All health facilities reported having basic medical supplies to treat GBV survivors. Respondents from the health centers and the hospital noted having medicines like PEP, post pills, and antibiotics, as well as the lab equipment needed for screening and testing. Health posts reported fewer resources. All health extension workers interviewed noted having a first aid kit, but the availability of other supplies varied across health posts. The checklist data showed that all health facilities possessed all the contraceptive options required in the SOPs with the exception of the copper T intrauterine device (see *Exhibit 3*).

> *We have all the medicines, like that of post pill, the antibiotics, and the likes. We also have the needed laboratory equipment for screening and testing. In the emergency department as well, we have materials needed for stitching including first aid kit. —Female health service provider, primary hospital*

> *We only have first aid kit and post pill, we don't have anything else. —Female health extension worker, health post*

Exhibit 3: Health centers' and hospitals' performance on contraceptive stock indicators per SOPs

HEALTH FACILITY STOCKED WITH THE FOLLOWING CONTRACEPTIVE OPTIONS	NO. OF HEALTH POSTS (N=4)	NO. OF HEALTH CENTERS (N=2)	NO. OF HOSPITALS (N=1)
Emergency contraceptives (only required for health centers and primary hospital)	n/a[6]	2	1
Implants	4	2	1
Injectables	4	2	1
Combined or oral contraceptives	4	2	1
Copper T intrauterine device (IUD)	1	2	1

[6] The availability of emergency contraceptives was not assessed in health posts for this study.

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

FINDING 6: Health service providers and health extension workers had little to no GBV-specific training for prevention and response.

Health service providers and health extension workers indicated they had limited training on gender issues, and most respondents said they had not received any GBV-specific training. Respondents who said they had received some training during their university studies noted that such training only covered the basics of GBV and gender inequality. The majority of respondents reported the training sessions were short and not in-depth. Respondents cited the training some of them received from the Bureau of Health as the most in-depth of all of the training courses they had received.

> *I am a level three health extension worker. During my study, I have taken a course where there is a subsection about gender equality. This section has taught us about equality. We have also taken a chapter on adolescent reproductive health and in this chapter, they touched upon harmful traditional practices that existed and the negative consequences to female reproductive health. —Female health extension worker, health post*

> *I have taken YFS training and in that training, they briefly told us what harmful traditional practices are, types of violence, and about gender equality. This training was not a detailed training; it only showed us a glimpse of what gender-based violence is. —Female health service provider, health center*

Respondents also mentioned that training was the most desired resource/additional support they needed to successfully conduct GBV prevention and response activities. Of the types of training described, the respondents reported that training on providing psychosocial/psychological support or counseling, as well as training to diagnose/identify different types of GBV were the most called for. One respondent also mentioned they would like to receive legal training.

> *A training on how to diagnose rape and other types of gender-based violence cases and provision of psychological counseling for gender-based violence victim will ensure me to have a successful outcome for those victims who come to this facility. —Male health service provider, health center*

> *I need training on response mechanisms for gender-based violence. It would be great if I get training on how to effectively respond to the needs of the victim, how to treat her, how to psychologically support her, and the likes. —Female health service provider, primary hospital*

Respondents called for GBV training on prevention activities, treatment of GBV victims, detailed and in-depth knowledge of GBV, and best practices for communication with community members. They also asked for training and increased engagement of *kebele* administrators and law enforcement officials. They emphasized the importance of collaboration across sectors for effective prevention efforts.

> *Detail[ed] knowledge and guideline on how to prevent gender-based violence from occurring would help me ensure that all of our gender-based violence prevention activities are as successful as the one I told you [about] before. —Male health service provider, health center*

Trained staff will have ample opportunity in preventing gender-based violence as well. If the staff in here are trained, not only will they create awareness creation to the patients that come to the facility, but also to the people that are near to them, it could be their families or neighbors. —Female health service provider, primary hospital

Respondents also clearly indicated their desire to receive training on managing GBV cases more broadly—more in-depth training on what constitutes GBV, how to interact with survivors, what response and prevention look like, and how to properly manage cases. One respondent noted the training should be longer than 3 days to provide sufficient time to understand the material; another requested a training manual she could refer to and said it would be useful for new staff in her facility.

In other words, what to do if we come across a rape, fistula, or other cases? In general, how to manage gender-based violence cases that come to our facility. These training [sessions] must be comprehensive and supported by practical cases. The training I took was a 3-day training and you cannot capture exhaustively the contents of the training in just 3 days; ample time must be allocated for these types of training so that we can have a full picture of gender-based violence. —Female health service provider, hospital

FINDING 7: Majority of respondents were unable to identify and use protocols, guidelines, and policies.

All respondents said they were not aware of any policies/guidelines/protocols currently in place with regard to working with GBV survivors. Two female health service providers from a primary hospital mentioned that two people from their facility had taken a training and brought back the guidelines. However, the office copy of these guidelines was locked in one of the training attendee's office and she had not read the copy given to her. Other respondents noted that there were a few people in their respective facilities who had taken the training, but did not bring back the materials (i.e., any documents containing guidelines, policies, or protocols). Health service providers suggested there could be policies, guidelines, or procedures, but they had not read them.

There are no polices or guidelines on gender-based violence that are available at this center. The director has taken training on gender-based violence, but she hasn't brought any written documents from the training. —Male health service provider, health center

Yet, all respondents saw a need for policies/guidelines/protocols to be in place for them to do their jobs effectively. Most respondents would like a manual that encompasses all aspects of GBV cases (i.e., medical treatment, psychosocial support, legal aspects, etc.). While every respondent mentioned at least some different features they would like in such a manual, there was a general consensus that there should be definitions of different types of GBV and guidelines on how they should respond.

The protocols that we need are: medical procedures for gender-based violence; how to provide psychosocial support, or counseling guideline for gender-based violence victims. These manuals should clearly state what is needed for each type of violence. It is also good if these manuals are pictorial as well. —Female health service provider, primary hospital

The use of observation checklists in these facilities also demonstrated a general lack of visible or accessible protocols, guidelines, and policies for working with GBV survivors. For instance, the *Pathway for Initial Care after Assault* poster, a code of medical ethics/ethical code of conduct (only available in one health post), national protocols of referrals for STIs, and national guidelines for HIV counseling were absent from health posts.

Furthermore, health posts were found not to have checklists or documents on the general signs and symptoms of GBV or sexual violence that were easily seen and accessible. They also did not have a checklist, post, or set of guidelines that laid out the process for evaluating survivors of GBV, including the SOPs for the *Response and Prevention of Sexual Violence in Ethiopia, 2016*. Similarly, they did not have a checklist, SOP, or set of guidelines available to healthcare workers on how to conduct prevention activities or referrals.

FINDING 8: Health service providers and health extension workers reported that communities lacked awareness about GBV prevention and response activities, but when health facilities carried out awareness-raising activities, the community members were more likely to seek services.

Almost all respondents cited awareness creation and education as an important strategy to encourage individuals in their communities to access GBV prevention and response services. Respondents noted that people needed to be educated about what to do following the incidence of GBV, what services are available, and how to access them. Many also spoke about providing general education on GBV for young people to prevent violence from occurring in the future.

> *Awareness creation is very important to encourage girls to seek help from health facilities. We must teach them about the consequences of not seeking health services after such kinds of incidents. We should also create awareness as to what they must do if they face these kinds of violence. —Female health service provider, primary hospital*

> *Awareness creation is important. Those gender-based violence victims who are not seeking help from us, it is because they think reporting their cases is a taboo or they don't know they can report their cases to health facilities, like that of early marriage cases. To alleviate both these problems, awareness creation is mandatory. —Female health extension worker, health post*

Although respondents recognized the need for awareness creation, the observation checklist data revealed a dearth of relevant materials for raising awareness around GBV and available services. Health centers and the primary hospital lacked visible GBV prevention- and response-related information, education, and communication materials for clients. Only one health center possessed brochures or pamphlets on HIV PEP, and only the primary hospital had a copy of the *Pathway for Initial Care after Assault* poster.

FINDING 9: Health service providers and health extension workers said they attempted to safeguard confidentiality; however, they were not consistently and confidentially documenting survivors' information and data.

When information about GBV survivors was recorded, respondents suggested they recorded it on regular patient cards. More specifically, the observation checklist data indicated that health posts used patient cards to disaggregate patients' information by name, address, age, date of birth, and sex. No health posts used GBV-specific patient cards.

> *There is no special registration form or a separate card for gender-based violence cases. We have the same kind of patient card for every type of case that is brought to here —Male health service provider, health center*

Except sexual violence cases, the rest of gender-based violence, like that of physical violence, are registered as any disease. —Female health service provider, health center

In different ways, health service providers and health extension workers strived to ensure the confidentiality of patient information. They made sure to only discuss a patient's situation when it was necessary. Most workers indicated they had taken an oath at the time of their graduation to not violate patient's confidentiality. In addition, restricted card rooms were in use at health centers and the primary hospital; only card room personnel could access materials from these rooms.

There are three personnel at the cardroom. These personnel count each card before they give it to us, and they also count it back when we return it so that there is no card that goes missing. These three individuals are the only ones permitted in the card room. If you have seen the door of the card room, it says no one can enter except those who are authorized. At one time, we have lost a card and from that time onwards, we give due attention to patient cards. —Female health service provider, health center

I personally don't disclose patient information to other people. If it's something I can't handle, I will speak with other colleagues, but if I can handle the case by myself, I will not tell any information the victim told me. —Male health service provider, health center

However, some respondents reported that information about GBV survivors was recorded in an informal registration book, which made information openly accessible instead of secured in restricted card rooms. One health extension worker said their facility recorded GBV cases informally in an activity book, noting the survivors' name and the problem they sought services for. The respondent noted this was mainly done to help them remember the case.

FINDING 10: Reporting cases of GBV within the primary healthcare delivery system was inconsistent.

Health service providers reported that while cases of physical violence were reported to the emergency department, the providers did not always view these cases as forms of GBV. For instance, some respondents said they did not document physical injuries as physical violence, especially if it occurred between a husband and wife. Health extension workers also often failed to report violence between spouses.

One time, a woman came here after her husband hit her nose with a stick just because she asked him for money. Other women have also been here because they were beaten up by their husbands. When it comes to physical violence, in my opinion, compared to its prevalence, the number of reports is very small… physical violence is not considered as violence, it's something common that you find. Beside this, in marriage it is expected for the women to bear everything. —Female health service provider, health center

There was also a woman who came here after her husband hit her hand by stick. We didn't register this as violence. Even though it is violence, since it happened between husband and wife, we don't consider it as violence. —Female health extension worker, health post

The data also showed limited reporting of other types of GBV, as well as various deficiencies with regard to the ways information about GBV cases was recorded in hospital systems. The observation checklist data revealed that only the primary hospital had a register for GBV cases. While some information relevant to GBV incidents was recorded in the health management information system

(HMIS), the data were not recorded as specific to GBV. Respondents who registered cases in the HMIS noted that there were no specific questions related to GBV.

FINDING 11: The observed health centers and primary hospital were missing many elements of the SOPs and quality standards.

The observation checklist data revealed that the health centers and primary hospital in Tigray were missing many key elements of the SOPs and quality standards prescribed by the Ethiopian Ministry of Health and the World Health Organization, across most key areas assessed.

With regard to facility infrastructure, neither the health centers nor the primary hospital were found to have rooms or areas where GBV survivors could rest, and/or stabilization rooms that were private, clean, quiet, and comfortable. Similarly, there were no designated locations to examine GBV cases that ensured patient's confidentiality. Information from the key informant interviews corroborated such findings—respondents reported that GBV survivors were not put in separate service provision rooms and their facilities did not have such rooms. There was also a lack of discrete signage in all facilities. Only the primary hospital possessed a child-friendly room.

The primary hospital was found to have body maps, sexual violence medical certificates, relevant consent forms, and referral forms for GBV survivors. During the observations, no such materials were seen in the health centers.

The observation checklist data also revealed variation between the health centers and primary hospital with regard to stockouts of essential medicines and equipment for immediately assisting GBV survivors. No facility stocked acetaminophen—an essential medicine—and the health centers lacked operating rooms, scalpels, operating tools, respirators, and oxygen.

In terms of the equipment for testing, all health centers and the primary hospital lacked x-ray and ultrasound machines. For STI testing, one health center possessed a direct wet mount, and only one health center and the primary hospital were capable of conducting venereal disease research laboratory tests. No facility was equipped to conduct cultures. Only the primary hospital had the necessary supplies to test for Hepatitis B.

For the development of forensic evidence—critical for obtaining justice for survivors of GBV—all health centers and the primary hospital lacked rape kits; large envelopes and tape for placing evidence; and a camera for photographing wounds or other injuries. All facilities possessed at least some of the laboratory supplies needed to collect samples during physical examinations, as well as functional freezers or refrigerators. However, the temperature of these freezers or refrigerators was regularly monitored only in the health centers, and only the primary hospital had an on-site laboratory capable of evaluating forensic evidence.

FINDING 12: Healthcare workers reported that more survivors would access services if healthcare workers were compassionate and of the same age and sex.

Most respondents agreed that women would be satisfied with GBV prevention and response services if they received welcoming and compassionate care. They stated that compassionate care meant that people were friendly with them, treated them with kindness, and understood their situation. Most respondents also agreed women would be satisfied if their confidentiality was respected, and they had

access to privacy so they could receive care discretely and avoid negative social or cultural stigma. Two health extension workers mentioned specifically that confidentiality and privacy were important for younger survivors.

Six respondents also mentioned that women wanted to receive all services at the same facility without being referred to other facilities. Two health extension workers, however, mentioned that at the health posts, women would be more satisfied if they received a referral; one noted referrals to health centers and the other referrals to the primary hospital because they believed they would receive better treatment at the hospital. One health service provider and one health extension worker stated women would be satisfied if they were treated for pain relief. One health extension worker said that a woman would feel satisfied if another woman treated her. Additionally, one health extension worker mentioned a woman would feel satisfied if she received services close to her neighborhood.

> *They will feel safe and satisfied if they get the services they need, when we welcome them in a friendly manner, when they get to be heard very well, when the information they provide is kept secret, when [they] receive services on time, when they get all the services in one place without going to different departments, and when they find all the medicine from this pharmacy. —Male health service provider, health center*

> *In addition, she will feel safe if the information she provides is kept secret. As gender-based violence is a sensitive issue, we must keep the information as a secret, so that they can build their trust in us. —Female health extension worker, health post*

Many of the respondents agreed that the reasons a young girl would be satisfied with the care she received would be the same as those for an adult woman. All respondents agreed that the reasons men would be satisfied were the same as for women, and five respondents said boys would be satisfied for the same reasons as an adult man.

> *I don't think it will be any different for the men. Everyone who seek health services will feel safe and satisfied if they are cured; in other words, when they get all the services they need. —Female health service provider, health center*

Respondents specified, however, that survivors would want healthcare workers who were the same sex and similar in age. For young girls, five respondents stated they would prefer services from young healthcare workers, and another five said the same for young boys. Two respondents from health centers said girls would prefer treatment from female healthcare workers, and three respondents from health posts noted men would prefer services from male healthcare workers. Four respondents from health centers and health posts mentioned younger girls would be satisfied if their confidentiality was respected and they had more privacy.

> *…[B]ut men want to be treated by men, I don't think they will be comfortable to talk about gender-based violence with female health extension workers. —Female health extension worker, health post*

> *When it comes to the youngsters, they want more privacy and they want to talk to a physician of their own age. They sure will not be free talking to elders like me [laughing]. Also, when you tell them something, they want detailed information about it. —Female health extension worker, health post*

FINDING 13: Health service providers and health extension workers recognized various forms of GBV, but often did not identify or treat physical violence or violence within a marriage as GBV. They reported that a lack of understanding of GBV also impeded survivors' access to services.

Respondents referred to sexual violence, physical violence, and mental emotional abuse as different forms of GBV. However, some respondents said they did not consider physical violence to constitute violence in the traditional sense; rather, they considered it "trauma." Beyond sexual and physical violence, most respondents discussed a broader definition and perceived their society's negative view of women as a form of GBV.

> *Due to our culture, the society doesn't encourage women to go out of the house and participate in the public sphere. Women's roles are confined to the household chores and this affects women from showing their capability. The whole household chores are left for the women, it doesn't matter whether she is employed or not; at the end of the day, everyone in the house expect the female to put food on the table. This is a burden all women have to bear, whereas men don't consider this as violence. —Female health extension worker, health post*

Most respondents said that when accessing GBV prevention and response services, survivors would typically come with family members, while five respondents specified that survivors would come with their parents. Of those five, four noted that survivors would access such services with their mothers. One respondent from a health center said that survivors would come with their father to obtain legal assistance. Further, three respondents specified that survivors preferred coming with other women. Almost all respondents said there were also many cases where survivors came alone.

> *But I have noticed they all come with females. They don't want to come with their brother or fathers because they fear them, they think they will blame them for what happened. —Female health service provider, primary hospital*

> *The minor physical violence victims usually come here alone. We also send ambulance for emergency cases. If a young girl faces sexual or physical violence, they most likely come with their mothers. Nevertheless, if an adult woman faces physical violence from her husband, she will come with her neighbors. —Male health service provider, health center*

Four respondents specified that survivors came alone when they had experienced minor physical violence or when the pain was not severe, while another two respondents specified that adult women or married women came alone more often than younger women. Another two respondents noted that survivors came alone because they were afraid to tell anyone or did not want anyone to know about their experiences. Two respondents from health centers mentioned that women seeking abortions also came alone. Responses were very similar across *kebeles*.

The data suggest that survivors of GBV often did not seek services both because of cultural norms surrounding such violence and a lack of awareness with regard to what services were available. Adult women were the group the most cited as not seeking services, particularly those who were survivors of physical violence. Respondents agreed that these women did not request services either because they were not aware that physical violence constituted a form of GBV due to the fact that physical violence was considered "normal" in their communities, or because they were afraid of the social repercussions and "what people would say" after reporting such incidents. Two respondents also noted that young

girls who married early did not access services for similar reasons—either because they were unaware they could report early marriages or afraid of the potential social repercussions.

> *This is due to the culture and lack of awareness. They are afraid of what the people are going to say after they expose the violence. In addition, most women don't consider physical violence as a violence, so they don't go the health facility unless they can otherwise not endure the physical injury. They also believe their marriage will fall apart if they expose wrong doings of their husbands. —Female health service provider, primary hospital*

> *Maybe early marriage cases are not reported because the girls don't know if it is feasible and possible for her to report early marriage cases to the health post. The other reason can be, early marriage cases are handled without involving the girl. Hence, she will not report the case because she does not know she will be getting married. —Female health extension worker, health post*

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

FINDING 14: Health service providers and health extension workers mostly referred GBV survivors within the healthcare system and sometimes to other points of the referral system, such as the police or the Women's Affairs Office.

Respondents reported that almost all referrals occurred within the hierarchy of the health system—for example, to the general hospital or the referral hospital, and between health departments. Few referrals were made outside of the healthcare system, such as to the police or other support services for GBV survivors. According to the checklist data, the most common referral GBV survivors received was to the police/law enforcement for sexual and physical violence. GBV survivors were also sometimes referred to the Women's Affairs Office for early marriage and sexual violence. Respondents noted that hospital referrals were more common, especially if a case was beyond their capacity, but specific referrals to the police and Women's Affairs Office occurred significantly less often. Respondents also reported they provided referrals when they or their facility were unable to provide the appropriate service(s) to a GBV survivor, or did not have the necessary skills, mechanisms, or tools to respond.

> *There are cases that come to us saying their husband cheated on them, but since we don't have reliable information on that, we don't report such kinds of cases. Nonetheless, if it is physical violence, we immediately report to the police. We also report sexual violence, but since we cannot confirm sexual violence, we don't write a medical certificate about it. —Female health extension worker, health post*

> *It is mandatory for us to report cases to the women's affairs office, and they have the responsibility of reporting the cases to all the concerned bodies. —Female health extension worker, health post*

Several respondents made reference to a referral system protocol whereby patients were referred up the hierarchy of the health system—from health post to health center to primary hospital, and so on. However, many noted that the referral system protocols were not always followed. Many times, providers took a shortcut to be more efficient, or the patient would go to a facility other than where they were referred to go based on where they lived (proximity). Respondents also mentioned they might forego the protocol if the primary hospital did not have space or the capacity to treat the patient. It was also noted that some providers and patients did not think they would get quality services at a certain facility and thus, would go somewhere else for services.

We have referral sheet and we refer people using that sheet. I don't know whether there is a separate gender-based violence referral sheet or not. The referral structure is like health post[s] refer cases to health center, and health center refer[s] cases to primary health, and primary health refer[s] cases to general hospital, and general hospital refer[s] cases to referral hospitals. Sometimes, we don't adhere to this hierarchy. For instance, if we want test, we call the hospital and if they told us they don't have the chemical for the test, we refer cases to the referral hospital, but lately we are getting complaints for not following the hierarchical order. The reason they complain is when their center is flooded with patients. —Female health service provider, health center

FINDING 15: Health service providers and health extension workers noted significant challenges in receiving feedback, including delays or no feedback at all, from facilities where GBV survivors were referred.

All respondents reported having significant challenges in receiving feedback from facilities where they had made referrals, including weak connections, significant delays in their response, or no feedback at all. There was also no mechanism in place to ensure follow-up or feedback in a timely fashion. Providers expressed a need for a formal system or process that could provide accountability for follow-up. Health service providers who initially made the referral faced challenges in knowing whether their patients received adequate care when no follow-up was made; sometimes, when they had not heard back or there was a delay in response, they would call or go in person.

We only send the victims; we don't have any sort of mechanisms in place to check whether she gets the services she need[s] on time or not. The feedback is the only way we see whether she gets the service or not. —Female health service provider, health center

Even though they don't send us feedback, we call them and follow up on the victims. It would be great if they sent us feedback to ensure that follow-up is conducted in a timely manner and that survivors are able to access all of the services that they need. The current referral linkage doesn't ensure this as we are the only ones who send a referral sheet and the health center doesn't send us any feedback regarding the victim. If the health center refers the victim to the primary hospital, the likelihood of us knowing about the services she received is very low. Hence, feedback on the victim is very much needed. —Female health extension worker, health post

Respondents stated they followed up with patients they had treated or referred either by phone or in person. However, there were no assigned providers to conduct follow-up. It was the responsibility of everyone to follow up with GBV survivors. Follow-up was also carried out in the form of outreach/door-to-door activities or at a subsequent visit. Visits were performed more frequently when patients were in a nearby health facility.

FINDING 16: Health service providers and health extension workers were not aware of any information on shelters and had very little information regarding the national hotline.

Respondents did not have any knowledge or information about any shelters, either managed by the government or local nongovernmental organizations. They also had no knowledge or information regarding the 952 hotline number run by the Ministry of Health that includes GBV information, or any other hotline number, locally or nationally. One health service provider recalled seeing hotline information on the television, but could not provide details.

FINDING 17: Most healthcare workers stated that GBV reporting was not mandatory.

According to the SOPs, reporting is mandatory; however, the majority of respondents stated that reporting to police was not mandatory, and they did not think it was required by the law or policy.

> *I think the main responsibility of health extension workers when it comes to gender-based violence is ensuring women's health, I don't think reporting is mandatory for us. We report to the police to safeguard the women from the violence reoccurring. —Female health extension worker, health post*

> *I don't think it is not mandatory, but when we see a woman crying, we feel as it is mandatory for us to report. We report voluntarily. —Female health extension worker, health post*

FINDING 18: GBV referrals were made with the standard referral sheet. There was no specific form for referrals of GBV survivors.

Interview and observation checklist data both demonstrated that health service providers and health extension workers primarily used a general, standard referral sheet to connect GBV survivors to other health facilities. There was not a unique form for GBV survivors. All providers used the same referral sheet for all types of services and referrals, including specific types of diseases or health services.

> *We don't have a separate referral paper for gender-based violence cases. We only have a standard referral sheet and we use this sheet for every type of disease. —Female health extension worker, health post*

> *We don't have a specific referral form for gender-based violence victims. For all cases, we write on paper, which is not a formal referral form and sometimes, we use the telephone to get an ambulance for severe cases. —Female health extension worker, health post*

A referral sheet was not always required to connect a GBV survivor to other services. Service providers and health extension workers acknowledged using other forms of communication to make referrals. A few providers connected survivors to other health facilities via phone or in-person, particularly if health facilities were nearby.

> *Since it is very close, we have close working relationships with the health center. We don't write a referral letter, we just communicate with them over the phone and in person. Sometimes, if the victim comes to our facility alone, we go with them to the health center. —Female health extension worker, health post*

CONCLUSIONS

In February 2019, the analysis team convened during a 1-day session to review the data from the Tigray region, interpret emerging themes, and jointly develop findings and conclusions regarding GBV prevention and response services. Overall, the findings show that health service providers and health extension workers at the primary healthcare level are able to provide many basic services to GBV survivors or provide referrals if they are unable to accommodate survivors' needs. However, healthcare workers have limited training in GBV prevention and response, and many healthcare facilities lack resources and supplies to meet SOPs and quality standards.

Conclusion 1: GBV prevention activities were happening at all levels of the primary healthcare system; however, the scope of these activities was limited to awareness raising.

In general, GBV prevention activities at the primary healthcare level focused primarily on raising awareness. Health service providers and health extension workers recognized the usefulness of awareness-creation sessions for increasing community knowledge about GBV. Although health extension workers had limited GBV training, they worked closely with community members and provided awareness-raising activities on a variety of issues, such as intimate partner violence (IPV), FGM/C, child marriage, and other harmful practices. Respondents noted that collaboration with different organizations, such as Women's Development Groups, the women's association, and the women's league for prevention activities had improved their effectiveness in successful outreach at the community level. Findings reveal that some primary hospitals and health centers also provided prevention sessions for their patients, but these could be interrupted if there were not enough staff on hand or health service providers were needed for other requests.

Conclusion 2: All levels of the healthcare system offered GBV response services; however, the scope of these services varied depending on the facility.

The data showed that survivors could find GBV response services at all health facilities, but the scope of services facilities could provide varied. Health posts had minimal resources available. Although a few respondents mentioned having resources like post pills, health extension workers generally only had access to first aid kits for basic medical services. Health centers had a few more resources, expanding their scope of services. In addition to first aid kits, they were able to provide testing and screening for HIV, STIs, and pregnancy. Health centers could also provide medicine, including post pills and contraception, as well as psychosocial support. Primary hospitals encompassed all services health posts and health centers offered, and provided PEP, antibiotics, and supplies for stitches. All health facilities had the ability to provide referrals.

Conclusion 3: Health service providers and health extension workers had limited knowledge in GBV, and desired training on various aspects of GBV prevention and response.

Healthcare workers lacked formal training in GBV prevention and response. Findings show that service providers heavily relied on their previous education, such as university classes on MCH, and previous experience to identify and provide services to survivors. Providers also counted on observation, asking questions, and physical examinations to properly identify GBV and treat survivors. There was a clear need and desire among health service providers to build their capacity in all areas related to GBV prevention and response.

Findings show that health service providers would like training in the following areas:

- Diagnosing/identifying all types of GBV
- Psychological or psychosocial support
- Responding to GBV survivors' needs
- Laws and regulations regarding GBV

Furthermore, providers lacked supportive resources, and would like access to GBV resource documents and SOPs manuals.

Conclusion 4: Health service providers and health extension workers lacked awareness of GBV resources and services.

Findings show that health centers and primary hospitals lacked GBV-related resources to educate staff and patients. These resources include:

- Diagrams depicting normal hymeneal variation and abnormal hymeneal findings
- Diagrams for female and male genital examination
- Brochures or pamphlets on HIV PEP
- The *Pathways for Initial Care after Assault* poster
- Registers for GBV cases

No respondents in Tigray had any knowledge about shelters for survivors. Additionally, neither health service providers nor health extension workers were able to identify the Ministry of Health's 952 national hotline number to support survivors.

Conclusion 5: Sociocultural norms hindered recognition of IPV as a form of GBV.

Many health service providers and health extension workers disregarded or normalized IPV by stating it was a private issue between a husband and his wife. These sociocultural norms made it difficult to provide GBV survivors with the services they needed and created challenges for reporting violence in all its forms, rather than categorizing it as a form of general trauma or injury. Although healthcare workers were able to define GBV, both physical and sexual violence, they were not always able to apply those definitions in practice when GBV occurred between married couples. This limited health service providers' and health extension workers' ability to appropriately respond to all GBV cases.

Conclusion 6: Healthcare workers had limited or no knowledge of policies, guidelines, or protocols on GBV.

Healthcare workers' understanding of policies, guidelines, and protocols related to GBV prevention and response was either limited or nonexistent. Policies, guidelines, and protocols did exist to support GBV response services and GBV survivors, but were not implemented consistently across healthcare facilities. None of the respondents were aware of any existing policies, guidelines, or protocols. They did, however, see a need for policies and guidelines to be developed and implemented to effectively do their job in providing adequate support to survivors.

Not only did healthcare workers have limited knowledge of existing policies, guidelines, or protocols, health centers and primary hospitals lacked the necessary resources listed below, which hindered their ability treat and respond to GBV survivors.

- Stabilization or resting rooms specifically for GBV survivors
- Designated areas for examining GBV survivors
- Acetaminophen
- X-ray and ultrasounds machines
- Equipment to conduct cultures
- Rape kits
- Camera

The lack of resources at all observed health facilities showed that many elements of SOPs and quality standards were missing from these facilities. Existing policies, guidelines, and protocols were, therefore, not widely disseminated, well communicated, or enforced.

Conclusion 7: There were no efficient, standardized follow-up procedures or protocols.

Healthcare workers at health posts, health centers, and primary hospitals conducted follow-up; however, it was not always completed. Healthcare workers, particularly health extension workers, had difficulty receiving feedback from health centers or primary hospitals, with responses being delayed or not at all received. Referrals sheets were available and healthcare workers used them, but this did not guarantee they would receive feedback on their patients. This limited their ability to know the types of services their patients had received and when those services had been delivered. Findings show that healthcare facilities did not assign specific providers to conduct follow-up, leaving the responsibility to the healthcare worker or facility that had treated the survivor.

Follow-up was conducted in numerous ways—door-to-door outreach in the community, by phone, or by subsequent visit. Respondents mentioned they were not always able to update patient cards or even document follow-up visits, particularly during door-to-door activities when health extension workers did not carry patient history cards.

Conclusion 8: There were no consistent reporting mechanisms for GBV cases.

Findings indicate that there were no standardized reporting mechanisms for healthcare workers to follow. Reporting practices in healthcare facilities were inconsistent and most did not maintain GBV registers. Patient cards specifically for GBV cases were not used in any of the health posts, resulting in a lack of records on GBV cases. Although, HMIS collected disaggregated patient information, it failed to collect any information specific to GBV. Most respondents also said reporting was not mandatory, which was in direct contradiction to the national SOPs.

It was clear that healthcare workers understood the importance of confidentiality; yet, there was no protocol on it. Health centers and primary hospitals did make use of their restricted card room only designated personnel could access, which created a safe and confidential place for survivors' information.

Conclusion 9: Outside of the healthcare system, referrals were inconsistent; there was no pathway between health facilities, law enforcement, legal services, psychosocial services, and shelters.

Healthcare workers from all health facilities commonly used the healthcare hierarchy system to connect survivors to other health facilities when they were not equipped to deal with survivors' needs. Outside of the healthcare system, there were weak or nonexistent connections to other services.

Referrals were typically made to the police and law enforcement, but there was no mention of other referrals outside of the healthcare system. Findings show there were missed opportunities within the referral network to connect survivors to appropriate services in a coordinated and holistic approach, which prevented a multi-sectoral approach to GBV response.

RECOMMENDATIONS

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

Recommendation 1: The Transform: Primary Health Care project's Tigray 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 Tigray regional office should support the Ministry of Health's effort to standardize GBV prevention and response services by printing and disseminating more copies of job aids that detail the algorithm for the standard of care, as well as conducting follow-up visits to monitor use.

Recommendation 3: The Transform: Primary Health Care project's Tigray regional office should integrate an assessment of the availability of basic commodities and supplies during routine follow-up visits.