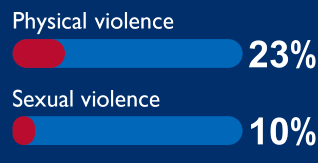
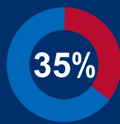
GENDER-BASED VIOLENCE LANDSCAPE ANALYSIS OF ETHIOPIA'S PRIMARY HEALTHCARE SYSTEM

Ethiopian women **aged 15-49**:[1]



Among **ever-married women** in Ethiopia,



reported physical, emotional, or sexual violence from an intimate partner.[2]

In Ethiopia, girls and women face many forms of gender-based violence (GBV) rooted in unequal power dynamics between women and men, which hinder women's and girls' development, health, livelihood, and physical and mental well-being. To address these challenges, the Transform: Primary Health Care project conducted a GBV landscape analysis to understand the Ethiopian primary healthcare system's existing GBV prevention and response mechanisms, and identify opportunities for the project to support the Ministry of Health in improving them.

METHODOLOGY

The research team developed a mixed-methods design using qualitative and quantitative data collection tools and participatory data analysis to answer the study's overarching question: *What opportunities does the Transform: Primary Health Care project have to develop and implement innovative interventions to prevent and respond to GBV?* A team of data collectors visited one primary healthcare network per each project implementation region to complete a total of:

53 semi-structured interviews with health service providers and health extension workers

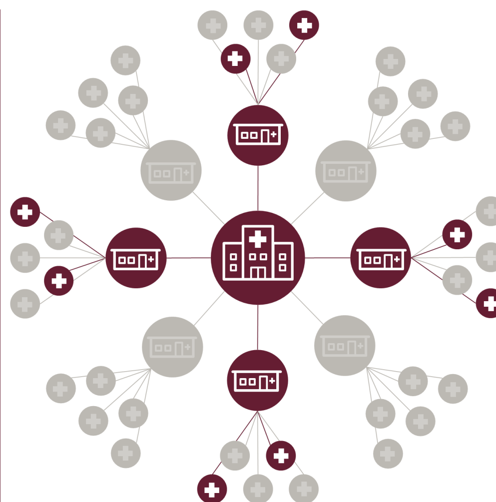
40 observation checklists at health facilities where semi-structured interviews were conducted

AMHARA

1 Primary Hospital
1 Health Service Provider

4 Health Centers
8 Health Service Providers

8 Health Posts
8 Health Extension Workers

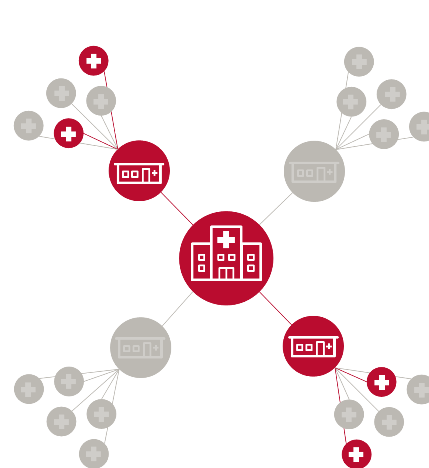


TIGRAY

1 Primary Hospital
2 Health Service Providers

2 Health Centers
4 Health Service Providers

4 Health Posts
4 Health Extension Workers

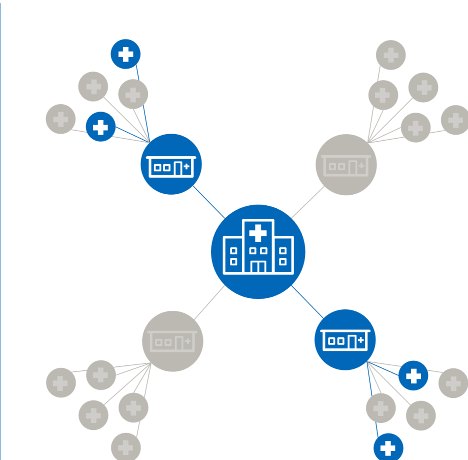


OROMIA

1 Primary Hospital
1 Health Service Provider

2 Health Centers
4 Health Service Provider

4 Health Posts
4 Health Extension Workers

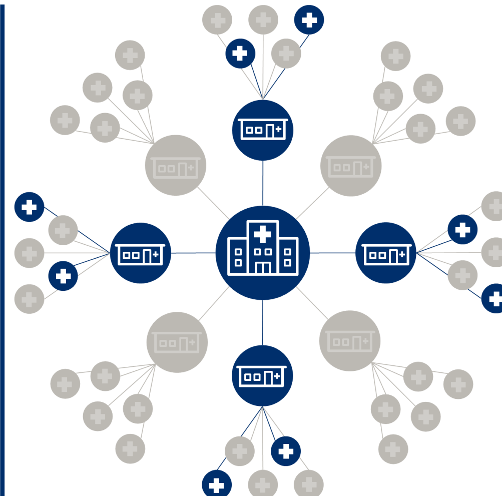


SNNPR

1 Primary Hospital
1 Health Service Provider

4 Health Centers
8 Health Service Providers

8 Health Posts
8 Health Extension Workers



[1] Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.
[2] UNICEF. 2016. *State of the World's Children*. New York, NY: UNICEF. (Note: The data only reflect reported cases and do not include child marriage and female genital cutting/mutilation.)

SUMMARY OF FINDINGS

Summary findings and conclusions suggest a number of key focus areas with direct implications for GBV prevention and response efforts in Ethiopia:

Healthcare workers are aware of **gaps in service delivery for GBV survivors** and want additional resources, training, and guidance to deliver quality care to GBV survivors.

While basic services exist, resource constraints, knowledge gaps among clients and healthcare workers, and weak multi-sectoral referral links create **disjointed and incomplete pathways of care for GBV survivors**.

Sociocultural norms that foster **stigma for survivors and normalize violence within partnerships** inhibit women's, men's, boys', and girls' access to comprehensive GBV care and treatment.

SPOTLIGHT ON KEY FINDINGS

Understanding, identification, and treatment of GBV, and implications for addressing intimate partner violence

Most healthcare workers reported that they had **little to no GBV-specific training** to provide quality prevention and response services, but expressed a desire for it.

Most healthcare workers reported they were not aware of or had limited knowledge of the existing national or facility-level **standard operating procedures and GBV-related policies/guidelines/protocols** for providing GBV prevention and response services, although they remarked that such tools would be helpful. Many healthcare workers also reported having limited resources, such as job aids or teaching materials, related to GBV.

Healthcare workers largely mentioned observation as a method to **identify GBV survivors**, in addition to questioning them and giving them physical exams. Most frequently, respondents defined GBV as incidents of sexual and physical violence. The cases they most commonly cited included rape, early marriage, and physical violence. While they recognized various forms of GBV, many healthcare workers often did not identify and treat violence within marriage as GBV. Other healthcare workers recognized that although they might consider violence within marriage to be GBV, the greater community did not, which hindered their ability to provide services. Additionally, in Amhara and Southern Nation, Nationalities, and Peoples' Region, healthcare workers even indicated that they responded to violence within marriage by reconciling and counseling the couple together.

Gaps and opportunities in referral pathways within and outside the Ethiopian healthcare system

Across all four regions, healthcare workers referred GBV survivors for assistance **within** the healthcare system. Many respondents also mentioned referring survivors **outside** the healthcare system, most commonly for legal services at the police or Women's Affairs Office. However, several interviewees noted that **connections between service delivery points were weak or nonexistent**, which was consistent with checklist data collected on referrals to outside services. Further, healthcare workers did not have a clear or consistent understanding as to whether reporting to the police was mandatory.

There was no formal mechanism, system, or procedure within or outside of the healthcare system to conduct **follow-up with GBV survivors** across all four regions. Most respondents noted there was no specific person responsible for following up with GBV survivors. Majority of healthcare workers across all four regions were also unaware of hotlines and shelters for GBV survivors.

RELEVANT RECOMMENDATIONS

Training and capacity enhancement: Incorporate GBV-specific training for health service providers and health extension workers in existing training programs, orient healthcare workers on current GBV standard operating procedures and guidelines, and ensure clinical training for at least one health service provider per facility

Service quality improvement: Introduce GBV screening tools, advocate for better infrastructure and supplies to ensure privacy and confidentiality, provide GBV job aids, and integrate GBV prevention and response considerations in routine quality improvement checks

Referral linkages: Establish and support multi-sectoral coordination platforms for GBV prevention and response, map services and referrals, and promote standard referral and feedback forms

GBV Referral System

SURVIVOR'S PERMISSION

Physical violence | Both | Sexual violence

MEDICAL CARE

- Physical violence: Medical care to treat physical wounds, if needed
- Sexual violence: Forensic exam and medical care:
  - **Within 3 days** for PEP
  - **Within 5 days** for EC/STI prevention

SUPPORT

- GBV counselling and advocacy
- Psychosocial support

Simultaneous **health referral** to a PHC or government hospital

SAFETY

For **safety risk** and **legal reporting:**
- Simultaneously refer to the police and counselling
- Help patient create a safety plan

FOLLOW-UP

After an immediate response, **follow-up services** may include:

- Ongoing counselling and psychosocial support
- Medical services
- Access to legal aid
- Police
- Shelter
- Additional opportunities for rehabilitation

In the absence of a formal referral mechanism:

- ❑ Use **follow-up appointments** to discretely check the patient's well-being.
- ❑ Consider establishing **basic services in-house—**for example, crisis intervention or support groups (IPPF 2010).
- ❑ When it is not safe for the woman to go home and no shelter exits, hospitals might admit the patient for an **overnight stay**.
- ❑ Refer the patient to known service providers using a **referral directory.**

Supported by UNFPA and WHO Standards

COMPONENTS OF AN EFFECTIVE REFERRAL SYSTEM:

- ✓ Joint vision
- ✓ Joint strategy and operational plan
- ✓ Standardized protocols and procedures
- ✓ Coordinator supporting the facilitation of participating organizations along key points of the referral system
- ✓ Sufficient resources, including financial and personnel
- ✓ Government and NGO representation
- ✓ Training of all professionals involved
- ✓ Workable structure:
  - Strategic group
  - Operational arm and thematic subgroups