

Assessment of Post Rape Care Services in Gandhi Memorial Hospital Addis Ababa

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Abstract

Gender-based violence is a serious public health and human rights violation that women and girls of all ages across various cultures and classes experience. Survivors of gender based violence have various needs including health, psychosocial, legal and protection needs that require to be met in order to recover and heal. If survivors are able to receive timely services they need and are treated in an empathic, supportive manner, then service providers can help facilitate survivors' recovery. The study attempted to assess the availability and accessibility of services for survivors of rape in Mahatma Gandhi Memorial Hospital. A qualitative research method was used and among the five approaches of qualitative research method, an instrumental case study approach was applied. The research explores services being rendered in the center for survivors in line with standard GBV guidelines for service provision. The study area is the one-stop integrated services center for gender based violence survivors within the hospital. Purposive sampling method was used while selecting the study area and key informant interviews, focus group discussions and observation were used for data collection. The data gathered was then analyzed thematically. It has been found that Gandhi Memorial hospital integrated center provides health, psychosocial support, legal assistance and referral services. Not all service providers working in the center are trained on specialized GBV trainings for working with survivors, including child survivors. Furthermore, linking survivors with the option of rehabilitation and group support programs is a gap. This study is believed to have a contribution towards the improvement of quality of services rendered for survivors of rape and gender based violence in Ethiopia.

Acronyms

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DEVAW	Declaration on the Elimination of Violence against Women
FDRE	Federal Democratic Republic of Ethiopia
GBV	Gender Based Violence
GBVIMS	Gender Based Violence Information Management System
GTP	Growth and Transformation Plan
IASC	Inter-Agency Standing Committee
IRC	International Rescue Committee
VAW	Violence against Women
VAWG	Violence against Women and Girls
WHO	World Health Organization

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Chapter 1 - Introduction

1.1. Background of the Study

The United Nations Declaration on the Elimination of Violence against Women (DEVAW, 1993), which Ethiopia has ratified, defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women.” DEVAW emphasizes that the violence is “a manifestation of historically unequal power relations between men and women, which have led to the domination over and discrimination against women by men and to the prevention of the full advancement of women.” Gender discrimination is not only a cause of many forms of violence against women and girls but also contributes to the widespread acceptance and invisibility of such violence—so that perpetrators are not held accountable and survivors are discouraged from speaking out and accessing support. (Inter Agency Standing Committee, 2015).

Global estimates published by WHO (2013) indicate that about 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. In light of these data, the evidence is unquestionable – violence against women is a public health problem of epidemic extent. It pervades all corners of the globe, puts women’s health at risk, limits their participation in society, and causes great human suffering.

According to a meta-analysis study conducted on the prevalence of violence against women in Ethiopia, (Getachew & Amanuel , 2018) , nearly half of Ethiopian women have experienced VAW, with substantial levels of physical, sexual, or psychological violence.

Violence against women and girls has a long and short term psychological, physical and social consequences on the well-being of survivors and while promising commitment to respond

to, and prevent violence against women and girls exists at both local and global level, it is still difficult to conclude women and girls have adequate access to coordinated multi-sector services to address the short and long-term consequences of experiencing violence.

1.2. Statement of the Problem

Violence against women/gender based violence has a physical, psychological and social consequence that needs to be addressed in a timely manner. These include HIV and other sexually transmitted diseases, fistula, unintended pregnancy, complications of pregnancy and childbirth, maternal mortality, unsafe abortion, death, insecurity, depression, anger, anxiety, fear, self-hate, shame, self-blame, mental illness, suicidal thoughts/ attempts, blaming the survivor, social stigma, social rejection and isolation, loss of ability to function in a community.

Accordingly, due to the wide range of needs of survivors, no single institution, organization or agency alone possesses all the knowledge, skills, resources and mandate to respond to the complex needs of survivors of gender based violence or can try to attempt the task of preventing violence against women and girls alone.

It is necessary to address GBV in a multi-disciplinary and multi-sector approach in order to help survivors recover and heal properly. A multi-sector approach is used by more than one sector, organization and discipline working together to address an issue that needs the involvement of all organizations to achieve a common goal.

Survivors of GBV including survivors of rape might not always be provided with quality services to help them heal. Instead they might further be traumatized by lack of quality services. They may face further trauma or become re-victimized while accessing services because of long waits, untrained staff or even by being denied or forced in access services.

There has been researches conducted in the region in the past in Kenya and Zambia with the goal of assessing effectiveness of different one stop centers in terms of health and legal outcomes for survivors, and cost-effectiveness as well as to identify lessons learned in implementation with recommendations for both start-up and scale-up (Keesbury et al., 2012).

Looking at researches conducted in Ethiopia thus far, as explored below, the researcher came to realize that there was a gap that needed to be assessed focusing on service provision for rape survivors specifically since post rape services for survivors are life saving if provided in a timely Manner. While there are few research studies conducted on Gender based Violence and rape in general in Ethiopia, none of them specifically focused on services rendered by different institutions for sexual violence survivors including rape. Researches in the past conducted included, gender based violence and its relation to HIV infection (Gulelat, 2005), pregnancy outcomes of gender based violence among pregnant women admitted to labor and delivery units (Tadele, 2014), sexual coercion among Addis Ababa University female students (Seblework, 2004) and marital rape from a human rights perspective (Kebkab , 2007).

1.3. General objective of the Study

The general objective of this study is to explore and assess services rendered to rape survivors in Gandhi Memorial Hospital integrated services for survivors center.

1.4. Specific Objectives of the Study

To examine services rendered for rape survivors in Gandhi Memorial hospital in comparison with international standards and best practices including the World Health Organization's Clinical Management of Rape Survivors (2005).

To assess the availability and accessibility of services to survivors of rape in the hospital and draw findings and recommendations in line with international best practices that will help

improve service provision for post rape care survivors which can be used for future advocacy purposes.

1.5. Research Questions

The research questions of the study are as stated below:

- What kinds of services are available for survivors in Gandhi Memorial hospital Integrated Services Center for survivors?
- Does staff working in Gandhi Memorial hospital Integrated Services Center for survivors adhere to Gender Based Violence Guiding Principles for working with survivors and are they trained accordingly?
- Is health care for rape survivors comprehensive and provided in one place within the health care facility so that survivors don't have to move from place to place?

1.6. Scope of the Study

This study assessed service provision for rape survivors only in Gandhi Memorial hospital integrated services center for survivors. The study explored service provision within the center. Individuals who have been survivors of rape were not directly interviewed and all required information to assess service provision was obtained without directly involving survivors.

1.7. Significance of the Study

Quality, timely services to survivors of gender based violence, including rape survivors are lifesaving if provided as per international best practices and guidelines. Providing comprehensive integrated services to survivors of GBV is relatively new in Ethiopia and the first ever one-stop center for survivors was piloted in 2008. Thus, findings of this study can be used by service providers to narrow gaps in service provision and improve service quality. Findings of

this study can also be used for future advocacy purposes and can help contribute towards accountability of institutions and service providers.

1.8. Definition of Terms

Gender : A term used to describe differences between men and women which are socially determined.

Gender Based Violence : an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between male and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. (Inter Agency Standing Committee, 2015)

Violence against Women and Girls : Any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. (DEVAW, 1993).

Rape : Non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.

Sexual Assault : Any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. FGM/C is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. This incident type does not include rape, i.e., where penetration has occurred. (GBVIMS, 2019)

Physical Assault: An act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that *results* in pain, discomfort or injury. This incident type does not include FGM/C. (GBVIMS, 2019)

Forced Marriage: The marriage of an individual against her/his will.

Denial of resources, opportunities or services : Denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services.

Psychological/Emotional Abuse: Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

Survivor: A person who has experienced gender-based violence. The terms “victim” and “survivor” can be used interchangeably. “Victim” is a term often used in the legal and medical sectors while “Survivor” is the term generally preferred in the psychological and social support sectors as it reflects resilience. Throughout this research the term “survivor” is used instead of “victim” to highlight the strength and resilience of those who experience gender based violence.

Perpetrator: A person, group or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will.

Case management: The systematic process of assessing the needs of a survivor, providing information on available resources, arranging and advocating for services, and encouraging the

survivor's recovery by modeling a survivor-centered approach in all interactions with the survivor or other service providers.

Multi-sectored Approach: An approach used by more than one sector, organization and discipline working together to address an issue that needs the involvement of all organizations to achieve a common goal.

Chapter 2- Literature Review

2.1. GBV Core Concepts

Gender is a term used to describe differences between men and women which are socially determined. Gender determines power differences between males and females in any culture or society. Sex is a term to describe the biological characteristics that distinguish males and females. Gender roles change over time and vary from culture to culture however an individual's Sex remains the same. Accordingly, GBV is a term that describes any harm that is perpetrated against someone's will, and that results from power inequalities based on gender roles. (Siebert and Cole, 2008)

Gender-based violence is a serious public health and human rights violation that women and girls of all ages across various cultures and classes experience. The defining characteristic of gender-based violence directed at women is that women are particularly exposed to certain forms of violence because they are women. Gender-based violence takes many forms. It includes rape, sexual exploitation, sexual assault and abuse as well as other forms of sexual violence, domestic violence, trafficking of women and girls, forced prostitution, sexual discrimination and harassment, and denial of rights. There are also other forms of violence that are specific to cultures and societies such as female genital mutilation.

Gender based violence is a complex issue that can only be addressed by understanding how it is related to women's social and economic disadvantage and discrimination. This requires us to challenge gender inequality, as well as, promote women's rights and create social, political and economic environments that empower women to enjoy their basic human rights. In order to do this, we will need to implement changes and adaptations in our social, political and economic

structures and systems. It is also important to ensure the availability of services and assistance for individual and groups who have suffered from gender based violence.

2.2. Gender Based Violence versus Violence against Women

Feminist theory and practice affirm the fundamental understanding that addressing the problem of VAWG requires attending to the structural gender inequalities that reinforce and perpetuate this violence. Women's rights activists have sought to highlight this understanding by framing VAWG as "gender-based violence" (COFEM, 2017). The term "gender-based violence" arose within the women's rights movement to articulate women's exposure to violence in the context of patriarchy. The term was first taken up in the UN Declaration on the Elimination of Violence against Women (DEVAW, 1993).

Thus the terms "gender-based violence" (GBV) and "violence against women" (VAW) are often used interchangeably. Rights advocates introduced the language of GBV to articulate the problem of VAWG for many practical and strategic reasons. First and foremost, this language underscores the importance of dismantling the global gender hierarchy because it is the unifying foundation for multiple forms of violence women experience, often at the hands of people intimately known to them and typically multiple times over the course of their lifespan. (COFEM, 2017).

2.3. GBV Case Classification

It has been challenging to collect, classify and analyze Gender-Based Violence (GBV) - related information in a way that produces comparable statistics. At present, it is nearly impossible to compile and analyze data across programs and sites. This cannot be solved without taking a new approach to how types of GBV are classified. To address this problem, the UN Population Fund (UNFPA), the International Rescue Committee (IRC), and the UN High

Commissioner for Refugees (UNHCR) have developed a GBV classification tool strictly for the purposes of standardizing GBV data collection across GBV service providers. (Gender Based Violence Information Management System, 2019). Accordingly the six core GBV types were created for data collection and statistical analysis of GBV (GBVIMS, 2012) which are Rape, Sexual Assault, Physical Assault, Forced Marriage, Denial of Resources, Opportunities or Services, Psychological / Emotional Abuse.

Intimate Partner Violence/Domestic Violence, Child Sexual Abuse, Early Marriage, Sexual Exploitation / Transactional Sex, Sexual Slavery and Harmful Traditional Practices were not included as core types of GBV in the classification tool since they can be analyzed indirectly. For example, Intimate Partner Violence is defined by the relationship between perpetrator and survivor and may include multiple forms of violence (rape, sexual assault, physical assault, psychological / emotional abuse), which can lead to inconsistencies in the recording of incidents (GBVIMS, 2012).

2.4. Theoretical Perspective

Violence against women and girls is a gendered phenomenon. Unequal power between women and men produces and reinforces VAWG (COFEM, 2018). This study uses a feminist social work theoretical lens. Dominelli, (2002), defines feminist social work as a form of social work practice that takes women's experience of the world as the starting point of its analysis and by focusing on the links between a woman's position in society and her individual predicament, responds to her specific needs, creates egalitarian relations in 'client' worker interactions and addresses structural inequalities. Thus meeting women's particular needs in a holistic manner and dealing with the complexities of their lives including the numerous tensions and diverse forms of oppression impacting upon them, is an integral part of feminist social work. Dominelli

(2002) further elaborates, by putting gender on the social work map; feminist social workers have challenged the gender neutrality regarding this social division usually upheld in traditional social work theories and practice.

Feminists have questioned the traditional status quo that takes men as the standard for measuring women's experiences since this approach denies women's specific experiences in the everyday life. Feminist theory and practice is anti-oppressive in nature. Feminist social work practice has a commitment to social change where women and men are given equal access to opportunities and resources. It seeks to challenge gender-role stereotypes that oppress women by intervening on the personal, interpersonal and societal levels (Dominelli, 2002).

Since Feminist social work practice is based on empowerment, social workers should seek to work with women in order to challenge the inequalities and oppression experienced by them. The aim should be to empower women to use their strength and assess available resources. Thus, the scope of social work interventions for survivors could include a mix of a client centered approach and a strength based approach to promote survivors' wellbeing, recovery and resilience. Feminist social work practice is not just for women; it can also be used with men. Men can also experience negative consequences due to societal expectations of their gender role (Teater , 2010).

2.5 International and National Legal Frameworks

2.5.1 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Adoption of the CEDAW Convention in 1979 was a landmark achievement that added a gender perspective to the international human rights law and integrated "women rights in human rights" by establishing clear commitments and obligations for States Parties to work on the elimination of all forms of discrimination against women (Simonovic, 2012).

Violence against women and domestic violence in particular has been treated as a private family matter. However in recent years this has started shifting to a new way of thinking which, rightly, views violence against women as a matter of public concern.

The international human rights framework from the Universal Declaration on Human Rights (1948) to the two Covenants on Civil and Political Rights (1966) and on Economic, Social and Cultural Rights (1966) which started with gender neutrality regarding human rights of women were silent on discrimination against women within a private area. It was also silent on violence against women and especially domestic violence that was considered by many as a private act and was committed with widespread impunity. Today, even if a specific global convention on prevention of violence against women doesn't exist there is an engendered international human rights framework established by the adoption of the UN Convention on the Elimination of all forms of Discrimination against Women in 1979 (the CEDAW Convention). The CEDAW Convention is a gender specific human rights treaty that protects women from all forms of discrimination including violence against women. This change of attitudes and legal response happened gradually at the global and regional levels over the last three decades. Violence against women including domestic violence should be treated as a human rights violation. Traditionally states had only been held accountable for violations of human rights committed by their agents while today they have obligation under the due diligence principle to prevent human rights abuses by non-state actors. We can observe this development and application of this due diligence standard from the adoption of the UN CEDAW Convention in 1979. We can also observe a transformation of the international human rights framework from a gender neutral set of human rights norms to gender specific norms. In this international global framework on violence against women the UN CEDAW Convention adopted in 1979 is the

central or key international instrument for the elimination of discrimination against women and violence against women. But this was not the case from its inception (Simonovic, 2012).

However it is important to note that the CEDAW Convention does not contain an explicit article on violence against women or domestic violence.

2.5.2 Declaration on the Elimination of Violence against Women (DEVAW)

United Nations Declaration on Violence against Women (DEVAW) adopted by the General Assembly in 1993 is a global instrument on violence against women. It recognizes that violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position. It calls UN Member states to pursue by all appropriate means and without delay a policy of eliminating violence against women including due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons. DEVAW affirmed that violence against women constitutes a violation of the rights and fundamental freedoms of women and impairs their enjoyment of those rights and freedoms (DEVAW, 1993).

The Declaration seeks to repair some of the problems in the Women's Convention and other instruments. First, the Declaration defines violence against women broadly and attempts to locate some of its socio-cultural causes. Second, the Declaration urges governments to adopt measures to protect women. In addition, the United Nations hopes to reach intimate violence by proscribing violence in the home as a human rights violation. Significantly, the Declaration also

condemns the invocation of custom, tradition, or religion to condone violence against women and support attitudes of female inferiority (Etienne, 1995).

2.5.3 The Protocol to the African Charter on the Rights of Women in Africa

One of the world's most comprehensive and progressive women's human rights instruments, the Protocol to the African Charter on the Rights of Women in Africa also known as the 'the Maputo Protocol' was adopted by Heads of State and Government in Maputo, Mozambique on 11 July 2003. The Protocol sets out rights of women in the public and private sphere. It explicitly calls for the protection of women against violence in public and private life. The Protocol guarantees extensive rights to African women and girls and includes progressive provisions on harmful traditional practices like early marriage and female genital mutilation, reproductive health and rights, roles in political processes, economic empowerment and ending violence against women.

Since The Maputo Protocol came into force in 2005, 49 of the 54 African Union Member States have signed on, and 37 have ratified it. The Protocol has one of the highest numbers of ratifications for an instrument in the African Union. (Equality Now, 2019). Ethiopia is among the countries that have signed the Protocol but has not ratified it.

2.5.4. Legal Framework under Ethiopian Law

The Constitution of the Federal Democratic Republic of Ethiopia under its Article 35 lists the rights of women. It states that women have equal rights with men in enjoying the entitlements of the constitution. Furthermore women have equal rights in marriage and are also entitled to affirmative measures taking in to account the historical legacy of inequality and discrimination suffered by women and in order to remedy this legacy. The State is also responsible to enforce the right of women to eliminate the influences of harmful traditional

practices. Accordingly, laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited under this provision.

The right to maternity leave with full pay in which the duration shall be determined by law taking into account the nature of the work, the health of the mother and the well being of the child and family is also recognized along with the right to full consultation in the formulation of national development policies, the right to acquire, administer, control, use and transfer property and land, the right to equal employment opportunity and the right to prevent harm arising from pregnancy and childbirth and the right to access to family planning services.

2.5.4.1 Rape of an Adult Woman

Under the Criminal Code of the Federal Democratic Republic of Ethiopia, whoever has sexual intercourse with a woman without her consent is punishable under with rigorous imprisonment from five years to 15 years. The punishment can go up to twenty years depending upon the circumstances stated under article 620(2). Where the rape has caused grave physical or mental injury or death, the punishment shall be life imprisonment.

“Article 620 – Rape (1) whoever compels a woman to submit to sexual intercourse outside wedlock, whether by the use of violence or grave intimidation, or after having rendered her unconscious or incapable of resistance, is punishable with rigorous imprisonment from five years to fifteen years.

(2) Where the crime is committed:

a) On a young woman between thirteen and eighteen years of age; or

b) on an inmate of an alms-house or asylum or any establishment of health, education, correction, detention or internment which is under the direction, supervision or authority of the accused person, or on anyone who is under the supervision or control of or dependent upon him,

c) on a woman incapable of understanding the nature or consequences of the act, or of resisting the act, due to old-age, physical or mental illness, depression or any other reason; or

d) By a number of men acting in concert, or by subjecting the victim to act of cruelty or sadism, the punishment shall be rigorous imprisonment from five years to twenty years.

(3) Where the rape has caused grave physical or mental injury or death, the punishment shall be life imprisonment.

(4) Where the rape is related to illegal restraint or abduction of the victim, or where communicable disease has been transmitted to her, the relevant provisions of this Code shall apply concurrently.”

It is important to note that if an act of rape occurred within a wedlock and a woman is raped by her legal husband, there is no legal remedy under Ethiopian law.

2.5.4.2. Compelling a Man to Sexual Intercourse

A woman who compels a man to have sexual intercourse with her is also punishable under the Criminal Code of Ethiopia with rigorous imprisonment reaching up to five years however in a different provision as quoted below and not under the provision of rape.

“Article 621- A woman, who compels a man to sexual intercourse with herself, is punishable with rigorous imprisonment not exceeding five years.”

2.5.4.3. Rape of a Minor under the Criminal Code of Ethiopia

Whoever performs sexual intercourse with a girl between the ages of 13- 18 years is punishable with rigorous imprisonment of three to fifteen years. And a woman who performs sexual intercourse with a boy between the ages of 13-18 years is punishable with rigorous imprisonment not exceeding seven years. In addition, performing sexual intercourse with a girl who is under the age of 13 years is punishable with rigorous imprisonment from thirteen years to

twenty-five years according to article 626 of the code. A woman who causes a boy under the age of 13 years, to perform sexual intercourse with her is also punishable with rigorous imprisonment not exceeding ten years according to the same provision.

2.5.4.4. Aggravating circumstances

In all the rape cases stated above if there are aggravating circumstances like that of the victim becoming pregnant, catching venereal disease which was intentional or if the victim commits suicide because of the incident the punishment will be rigorous imprisonment from five years to 25 years where there isn't other severe penalty stated under other relevant provisions.

This is stated under article 628 of the Criminal Code as quoted below,

“Article 628- Other Grounds Aggravating the Crime: In all cases involving rape or sexual outrage (Arts.620 -627), the punishment shall be rigorous imprisonment from five years to twenty-five years, where the relevant provision does not prescribe a more severe penalty:

a) Where the victim becomes pregnant; or

b) Where the criminal transmits to the victim a venereal disease with which he knows himself to be infected; or

c) Where the victim is driven to suicide by distress, anxiety, shame or despair.”

Other sexual contacts like attempted rape, unwanted kissing, fondling, touching of genitalia and buttocks that does not include rape as defined under the rape provision of the criminal code are covered under article 622.

“Article 622- Sexual Outrages Accompanied by Violence

Whoever, by the use of violence or grave intimidation, or after having in any other way rendered his victim incapable of offering resistance, compels a person of the opposite sex, to perform or to submit to an act corresponding to the sexual act, or any other indecent act, is punishable with

simple imprisonment for not less than one year, or rigorous imprisonment not exceeding ten years.”

2.5.4.5. Legal Provisions of Safe Abortion for Survivors

Knowledge of the law is essential to service providers not only to know what is expected of them but also to inform survivors and the community at large about their rights. Health workers involved in abortion care are expected to be well aware of the provisions of the Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia, which is an official interpretation of the law on safe abortion services as outlined below.

Article 551 of the Penal Code of the FDRE allows termination of pregnancy under the following conditions:

“1. Termination of pregnancy by a recognized medical institution within the period permitted by the profession is not punishable where:

a. The pregnancy is a result of rape or incest; or

b. The continuation of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother; or

c. The fetus has an incurable and serious deformity; or

d. The pregnant woman, owing to a physical or mental deficiency she suffers from or her minority is physically as well as mentally unfit to bring up the child.

2. In the case of grave and imminent danger which can be averted only by an immediate intervention, an act of terminating pregnancy in accordance with the provisions of Article 75 of this Code is not punishable.”

Accordingly, where the pregnancy is a result of rape or incest termination of pregnancy shall be carried out based on the request and the disclosure of the woman that the pregnancy is

the result of rape or incest. This fact will be noted in the medical record of the woman. Women who request termination of pregnancy after rape and incest are not required to submit evidence of rape and incest and/or identify the offender in order to obtain an abortion services.

Where the continuation of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother the provider should, in all good faith, follow the knowledge of standard medical indications that necessitate termination of pregnancy to save the life or health of the mother. The woman should not necessarily be in a state of ill health at the time of requesting safe abortion services. It is therefore the responsibility of the health provider in charge to assess the woman's conditions and determine in good faith that the continuation of the pregnancy or the birth of the fetus poses a threat to her health or life (Family Health department Federal Democratic Republic of Ethiopia, 2006).

If the physician after conducting the necessary tests makes the diagnosis of a physical or genetic abnormality that is incurable and/or serious, termination of pregnancy can be conducted. The provider will use the stated age on the medical record for age determination to determine whether the person is under 18 or not. No additional proof of age is required.

A disabled person is one who has a condition called disability that interferes with his or her ability to perform one or more activities of everyday living. Disability can be broadly categorized as mental or physical. It is therefore the responsibility of the health provider in charge to assess the woman's conditions and determine in good faith that the woman is disabled either mentally or physically. Termination of pregnancy under Article 551 sub-article 1D will be done after proper counseling and informed consent. (Family Health department FDRE, June 2006).

For all stated circumstances, the provider has to secure an informed consent for the procedure using a standard consent form. The provider shall not be prosecuted if the information provided by the woman is subsequently found to be incorrect. Minors and mentally disabled women should not be required to sign a consent form to obtain an abortion procedure. (Family Health department, 2006).

2.6. Guiding principles when working with GBV Survivors

When a survivor comes forward requesting support after experiencing an incident of GBV, all responsible actors involved in providing services to the survivor should follow certain standards of conduct and behavior. This standard treatment is called the guiding principles. GBV guiding principles were established to ensure that the key actors working to respond to and prevent gender based violence provide service without causing additional harm to the survivor unintentionally or intentionally. Guiding principles are considered as internationally accepted minimum standards to ensure a survivor receive the best care possible. The following are the guiding principles when providing services to survivors:

Ensure the physical safety: ‘Safety’ refers to both physical safety and security, as well as to a sense of psychological and emotional safety for people who are highly distressed. It is important to consider the safety and security needs of each survivor, her family members and those providing care and support. (Interagency Gender-Based Violence Case Management Guidelines, 2017). In addition to the traumatic side effects that can affect an individual’s physical, emotional, social and psychological well-being, individuals who experience incidents of GBV often have security and safety concerns. In many cases, the perpetrator may threaten the individual if she reports the abuse. In other situations, the survivor might perceive that a threat still exists. In most cases violence against women and girls is perpetrated by their own family

members or people in the community with whom they are well acquainted with which puts their security and safety at higher risk. Service providers, who support survivors of violence, need to be aware of the safety and security risks before intervening or assisting a client. The actions taken by service providers may worsen the safety and security concerns especially if they are not thoughtful of the consequences. Therefore, the safety and security of the survivor should be prioritized by all service providers. It is important to ensure that the survivor and the service provider are not placed at risk or further harm by the perpetrator. The service provider should be conscious of any harm that the survivor may inflict on herself as well. Accordingly, establishing a safety plan with the survivor will help identify safety concerns.

Guarantee Confidentiality: Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Breaching confidentiality can put the survivor and others at risk of further harm. If helpers do not respect confidentiality, other survivors will be discouraged from coming forward for help (IASC, 2017).

Confidentiality is the foundation of support for a survivor of GBV. The survivor's anonymity should be maintained at all times. The personal information and any identifying information should not be disclosed without the survivor's consent. Accordingly, all written information about the survivor must be kept locked and secured from others.

Respect the wishes, the rights and dignity of the survivors: GBV is an assault on the dignity and rights of a person, and all those who come into contact with survivors have a role to play in restoring dignity and self-determination. For example, survivors have the right to decline case management services or choose whether or not to access legal and other support services. Failing

to respect the dignity, wishes and rights of survivors can increase their feelings of helplessness and shame, self-blame, reduce the effectiveness of interventions and cause re-victimization and further harm (IASC, 2017).

When survivors come forward to disclose their experience they take the risk of being humiliated again. It is important therefore that service providers treat the client with respect and does not judge the survivor or the situation. By avoiding judgment and respecting the survivor's wishes service providers will build trust and confidence. This also empowers the survivor and plays a great role in coping with her situation.

Non-discrimination: All people should have the right to the best possible assistance without unfair discrimination on the basis of gender, age, disability, race, color, language, religious or political beliefs, sexual orientation or social class (IASC, 2017).

2.7. Multi-Sectoral Services for GBV Survivors

Gender based violence is a problem that affects individuals, communities, and institutions. Given these complexities, it is best addressed by multiple sectors, organizations and disciplines working together. GBV has physical, psychological and social consequences that needs to be addressed in a timely manner. These include HIV and other sexually transmitted diseases, fistula, unintended pregnancy, complications of pregnancy and childbirth, maternal mortality, unsafe abortion, death, insecurity, depression, anger, anxiety, fear, self-hate, shame, self-blame, mental illness, suicidal thoughts/ attempts, blaming the survivor, social stigma, social rejection and isolation, loss of ability to function in a community. Accordingly, due to the wide range of needs of survivors, no single government authority, organization or agency alone possesses all the knowledge, skills, resources and mandate to respond to the complex needs of survivors of gender based violence or can try to attempt the task of preventing violence against women and girls

alone. It is necessary to address GBV in a multi-disciplinary and multi-sector approach in order to help survivors heal. A multi-sectored approach is used by more than one sector, organization and discipline working together to address an issue that needs the involvement of all organizations to achieve a common goal.

GBV survivors often need various type of care and support to help them recover and heal and to be safe from further violence. Some of the most common services that survivors have the right to receive are:

Medical treatment and health care: To address the immediate and long-term physical and mental health effects of GBV. This can include initial examination and treatment, follow-up medical care, mental health care, and health-related legal services, such as preparation of documentation and provision of evidence during judicial and related processes (IASC, 2017). The health sector should screen clients for gender-based violence; ensure same-sex interviewers for individuals who have been exposed to gender-based violence; respond to the immediate health and psychological needs of the woman or girl who has been exposed; institute protocols for treatment, referral and documentation that guarantee confidentiality; provide GBV-related services free of charge; and be prepared to provide forensic evidence and testimony in court when authorized to do so by the survivor (GBVAOR, 2010).

Psychosocial care and support: The main objective is to assist with healing and recovery from emotional, psychological and social effects. This includes crisis care as well as longer-term emotional and practical support for the survivor and her/his family, information and advocacy, case management, and educating family members so that they can support the survivor's healing and recovery. These psychosocial support services are often provided through the case management process, or through other individual and group services provided by the same

organization. In addition, through case management a survivor can be supported to identify family members and friends who they can reach out to for support (IASC, 2017). The psychosocial sector should be able to provide ongoing psychological assistance which requires training and supervision of social workers and community services workers; confidentially gather and document client data; and facilitate referrals for other services (GBVAOR, 2010).

Safety and protection: This can include safe shelters, police or community security, relocation, or in the case of children, alternative care arrangements. Safety and security personnel should be educated about gender-based violence; held to zero-tolerance codes of conduct; and trained on how to appropriately intervene in cases of gender-based violence. Police should have private rooms for meetings with individuals who have been exposed to gender-based violence; ensure same sex interviewers; institute protocols for referrals to other sectors; collect standardized and disaggregated data on incidents; and create specialized units to address gender-based violence (GBVAOR, 2010).

Legal and Law enforcement services: The main objective is to help survivors to claim their legal rights and protections. This includes criminal investigation and prosecution, legal aid services and court support (IASC, 2017). It should be able to provide free or low-cost legal counseling, representation and other court support to women and girls who have been exposed to gender-based violence; review and revise laws that reinforce gender-based violence; and monitor court cases and judicial processes (GBVAOR, 2010).

Accordingly, overall minimum multi-sectored response for survivors of gender based violence including rape should include the below integrated services. It is also important to note that not all survivors will need all of these services however services should be available and accessible regardless.

Table 1: Basic Multi-Sectored Response for GBV Survivors

<p><i>Health</i></p> <ul style="list-style-type: none"> • Emergency contraception • Treat injuries • Treat STIs • Post-exposure Prophylaxis (PEP) 	<p><i>Psychosocial</i></p> <ul style="list-style-type: none"> • Emotional support • Income generation activities • Skills training • Social reintegration, social support
<p><i>Safety and Security</i></p> <ul style="list-style-type: none"> • Physical safety • Safe house or temporary housing • Police report and investigation 	<p><i>Legal</i></p> <ul style="list-style-type: none"> • Legal protection and assistance • Prosecution, adjudication • Apply appropriate laws, hold perpetrators accountable (job of police, courts, prisons)

2.8. Caring for Children

The World Health Organization (WHO, 1999) defines child sexual abuse as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person (WHO, 1999).

Sexual abuse of children is most often perpetrated by someone close to the child, resulting in the betrayal of the child’s trust. Therefore, use of physical force is often unnecessary to engage a child in sexual activity because children trust and often depend on adults they are close to. Children are taught not to question authority and may believe that adult behaviors are always correct, or the adult has unchallengeable authority. Perpetrators of child sexual abuse take advantage of these vulnerabilities in children (IRC, 2012).

Working with children is complex and service providers providing services must have specialized care for child survivors. There must be supervision systems and staff training programs in place prior to need. Service providers providing services for child survivors of sexual abuse should adhere to guiding principles for working with child survivors and should understand how they are applied in direct practice. These guiding principles are internationally recognized best practices for working with child survivors of sexual abuse (IRC, 2012):

1. Promote the Child's Best Interest

A child's best interest is central to good care. A primary best interest consideration for children is securing their physical and emotional safety in other words, the child's wellbeing throughout their care and treatment. Service providers must evaluate the positive and negative consequences of actions with participation from the child and his/her caregivers (as appropriate).

2. Ensure the Safety of the Child

Ensuring the physical and emotional safety of children is critical during care and treatment. All case actions taken on behalf of a child must safeguard a child's physical and emotional well-being in the short and long terms.

3. Comfort the Child

Children who disclose sexual abuse require comfort, encouragement and support from service providers. This means that service providers are trained in how to handle the disclosure of sexual abuse appropriately. Service providers should believe children who disclose sexual abuse and never blame them in any way for the sexual abuse they have experienced.

4. Ensure Appropriate Confidentiality

Information about a child's experience of abuse should be collected, used, shared and stored in a confidential manner. In situations where a child's health or safety is at risk, limits to confidentiality exist in order to protect the child.

5. Involve the Child in Decision-Making

Children have the right to participate in decisions that have implications in their lives. The level of a child's participation in decision-making should be appropriate to the child's level of maturity and age. Listening to children's ideas and opinions should not interfere with caregivers' rights and responsibilities to express their views on matters affecting their children. While In cases where a child's wishes cannot be prioritized, the reasons should be explained to the child.

6. Treat Every Child Fairly and Equally (Principle of Non- Discrimination and Inclusiveness)

All children should be offered the same high-quality care and treatment, regardless of their race, religion, gender, family situation or the status of their caregivers, cultural background, financial situation, or unique abilities or disabilities, thereby giving those opportunities to reach their maximum potential.

7. Strengthen Children's Resiliencies

Each child has unique capacities and strengths and possesses the capacity to heal. It is the responsibility of service providers to identify and build upon the child and family's natural strengths as part of the recovery and healing process. Factors which promote children's resilience should be identified and built upon during service provision.

Accordingly, the scope of social work interventions for survivors could include a mix of a client centered approach and a strength based approach to promote survivors' wellbeing, recovery and resilience. Services could potentially be coordinated with institutions working

towards achieving the same objectives of prioritizing survivor's right to access quality health, psychosocial, legal and protection services.

Chapter – 3 Methodology

This chapter gives details of the method of research used in this study. It details the research design, study area, study participants, sampling technique, data collection tools and procedures, method of analysis and ethical consideration.

3.1. Research Design

For the purpose of exploring post rape care services in Gandhi Memorial Hospital integrated services for survivors center a qualitative research method was used. A qualitative research method was found to be more suitable by the researcher to purposefully select participants and documents in order to better understand the problem and the research question as well as to assess and map out available services. This research method also offers a unique opportunity to gain in-depth insight from service providers. Qualitative research is conducted because a problem or issue needs to be explored and when a complex, detailed understanding of an issue is needed (Creswell , 2007).

In addition, among the five approaches of qualitative research method, an instrumental case study research approach was used as it was found to be more fitting for the study. A case study research is a qualitative approach in which the investigator explores a bounded system (a case) or multiple bounded systems (cases) overtime, through detailed, in-depth data collection involving multiple sources of information (eg. Observations, interviews, audiovisual material and documents and reports), and reports a case description and case-based themes. For example, several programs (a multi-site study) or a single program (a within-site study) maybe selected for study (Creswell, 2007). A case study approach involves the study of an issue explored through one or more cases within a bounded system (i.e., a setting, a context). Accordingly, instrumental case study approach was applied.

3.2. Study Area

The study area is the one-stop integrated services center for gender based violence survivors in Gandhi Memorial Hospital, Addis Ababa. Purposive sampling method was used while selecting the study area. The study area is where gender based violence survivors including rape survivors are referred to and is the first of its kind in Ethiopia in providing integrated services for survivors of gender based violence. The one-stop center within the hospital was piloted in 2008 in order to provide a comprehensive integrated response for survivors and it was modeled on lessons and experiences learnt from the Thuthuzela Centers of South Africa.

3.3. Sampling Technique

The best and most ethical way to collect information on sexual violence is through specialized service providers (IRC, 2014). Target populations of this study are service providers in the one-stop integrated services center for GBV survivors in Mahatma Gandhi Memorial hospital. To select the participants of the study, purposive sampling method was applied. The factors taken in to consideration to select the samples were the roles and responsibilities of the service providers, consent to take part in the assessment and experience rendering services to survivors of gender based violence in the hospital.

As sampling in qualitative study tends to be with small number of people nested in their context in order to explore in-depth, 4 key informant interviews were conducted with the health, legal, protection and psychosocial sector representatives of the center, 2 focus group discussions were conducted with groups consisting of health and legal/security professionals, 2 introductory interviews were conducted with the Medical Director of the institute and Ministry of Justice, Women and Children Affairs bureau. Furthermore, a thorough observation service mapping was conducted in the institute by the researcher to further triangulate data gathered through focus

group discussions and key informant interviews and to get firsthand experience of pathways survivors take when accessing services.

3.4. Method and Procedure of Data Collection

Three types of data collection methods were used in this study: key informant interview guide for service mapping, focus group discussion guide and observation guide (all were semi structured) to collect primary sources of data. In addition, secondary sources of data were collected through reviewing the center's protocol, previously conducted related studies, journals and books.

Data was collected from interviewees and focus group discussion participants by going to the study site. Formal communication was made with Federal Democratic Republic of Ethiopia Ministry of Justice (as it is the ministry the integrated services center directly reports to), Addis Ababa Police Commission and Gandhi Memorial Hospital to get consent and support with a formal letter from Addis Ababa University Department of Social Work. After the introductory interview with Ministry of Justice and the Medical director of Gandhi Memorial hospital, the researcher got authorization to commence the data collection procedure. Observation visits were also conducted by the researcher to experience firsthand referral pathways survivors would take and to explore services after getting authorization.

3.5. Methods of Analysis

In this study the recorded data from key informant interviews, focus group discussion and observation checklist was transcribed and analyzed. Preparing data for analysis, reading through all available data, coding based on themes and descriptions, interrelating themes and descriptions and then interpreting the meaning (Creswell, 2009).

Data gathered through interview, key informant interviews and observations were all analyzed thematically. The researcher categorized the data based on the common thematic areas. Then the information was reduced by separating essential data from nonessential ones. Finally themes were analyzed in terms of making significant input to answering the research questions.

3.6. Ethical Considerations

Formal communication was made with Federal Democratic Republic of Ethiopia Ministry of Justice (as it is the ministry the integrated services center directly reports to), Addis Ababa Police Commission and Gandhi Memorial Hospital to get consent and support with a formal support letter from Addis Ababa University School of Social Work. The purpose of the study was clearly communicated with all participants. Informed consent was obtained prior to beginning any data collection. Participants were informed clearly that their participation was on voluntary basis and that they could stop the interview or leave the focus group discussions at any moment.

The highly sensitive nature of sexual violence poses a unique set of challenges for any data gathering activity that touches on this issue. A range of ethical and safety issues must be considered and addressed prior to the commencement of any such inquiry. Failure to do so can result in harm to the physical, psychological and social well-being of those who participate and can even put lives at risk. It is essential therefore to ensure that the case for collecting data is legitimate. Furthermore, when collecting and using information about sexual violence, it must be done in such a way so as to avoid further harm to those who are part of the process. This includes not just the survivors and their families and supporters, but also communities, organizations working with survivors, and those involved in gathering the information itself (WHO, 2007).

Throughout this study the safety and ethical recommendations of WHO's Ethical and safety recommendations for researching, documenting, and monitoring sexual violence guide

was followed. Accordingly, individuals who have been survivors of rape were not directly interviewed and all required information to assess service provision was obtained without directly involving survivors. This is mainly because the benefits of documenting survivors' experience of sexual violence must be greater than the risks survivors face.

Information gathering and documentation was done in a manner that presents the least risk to respondents, is methodologically sound, and builds on current experience and good practice. The safety and security of all those involved in information gathering about sexual violence was of paramount concern and the confidentiality of individuals who provided information about sexual violence was protected at all times. Also, additional safeguards were taken to make sure all those participating were above 18 years of age.

Chapter 4 – Findings and Discussion

4.1 Overview of Gandhi Memorial Hospital Integrated Services Center

Survivors of gender based violence including rape survivors have various needs including health, psychosocial, legal and protection support. As part of an integrated multi-sectored response mechanism to gender based violence, a one-stop center was piloted at Gandhi Memorial Hospital in 2008 by the government of Ethiopia. It was based on the experience learned from South Africa's one stop integrated services center, Thuthuzela Care Center. The Gandhi Memorial Hospital in Addis Ababa is the first referral hospital where the one-stop center was piloted. The government of Ethiopia further plans to expand one-stop centers across various regions in the country and has set target accordingly in the Growth and Transformation Plan - Two. While the government covered staff salaries and provided the space for operation, other United Nations Agencies also provided support, in terms of providing office equipment. (UN Women, 2016)

The Gandhi Memorial hospital integrated one stop center is setup to provide services free of charge. Services include health and forensic evidence services, psychosocial support services and legal assistance as stated in the standard operating protocol of the center. The staffing structure of the center is expected to incorporate a medical doctor (on rotational basis), nurses, a case manager, a psychosocial support officer, police, a prosecutor (available on call) and a program coordinator.

To increase access to care and support, many countries have invested in improving the quality and quantity of services offered in public institutions. An increasingly popular strategy for doing this has been through the establishment of 'one-stop centers' (OSCs), which provide

integrated, multi-disciplinary services in a single physical location – generally, a medical facility (Keesbury et al., 2012).

It has been shown that when comprehensive one-stop centers are adequately resourced, staffed and managed, reporting and demand for services increases. For example, following the introduction of comprehensive post-rape care services, the reporting of rape was ten times higher in the following three months at a district hospital in Kenya (Taegtmeier et al., 2006 as cited by UN Women).

As Campbell (2013), explains, when survivors seek help, they place a great deal of trust in the legal, medical, and mental health systems by risking disbelief, blame, and refusals of help. How interactions with service providers unfold can have profound implications for survivors' recovery. If survivors are able to receive the services they need and are treated in an empathic, supportive manner, then service providers can help facilitate their recovery. However, when survivors do not receive needed services and are treated insensitively, then this will negatively impact their recovery by creating feelings of powerlessness, shame, and guilt. Post assault help seeking can easily become a secondary victimization to the initial trauma.

4.2. Findings

The below sections will discuss the findings of the study that relates to service provision. It has been identified that not all service providers working in the center or specified sector received specialized GBV trainings for working with survivors, including child survivors.

4.2.1. Health Services

The center has access to two Medical Doctors (both female) on rotational basis and 7 nurses (all female) assigned specifically for the center who work in two shifts, day and night.

If the rape incident reported happened within 72 hours (3 days) to 120 hours (5 days) the survivor will be able to receive Post-exposure prophylaxis (72 hours) to reduce the risk of getting HIV, Emergency contraception within (120 hours) to reduce the risk of unwanted pregnancy and forensic evidence collection to help with legal procedures which needs to be conducted within 48 hours.

Rape survivors seeking care more than 120 hours after the incident will still be provided with treatment for sexually transmitted infections. Additionally, if pregnancy has occurred as a result of the rape and if the survivor wants abortion this will also be provided accordingly as per the criteria set on the Safe Abortion Guidelines for Ethiopia.

Furthermore, laboratory tests can be done for sexually transmitted infections and pregnancy following the rape incident. HIV testing will be done as early as 6 weeks after the assault and will be repeated again after 3 months of the incident. Pregnancy testing is also available starting from one week after the rape incident.

However, those survivors that require surgery, fistula or rectal sphincter and advance mental health interventions treatment are referred to other health facilities outside of the center for such services as these services are not provided within the center.

4.2.2 Psychosocial Support

Experiences of GBV have a great impact on a person's emotional well-being, their ability to keep up with day-to-day tasks, their overall sense of safety in the world, and their ability to trust others (IASC, 2017). To facilitate survivors' recovery, psychosocial support provision should include basic emotional support and case management in order to support survivors develop and implement an individualized and specialized case action plan by setting service and recovery goals.

Psychosocial support services provided in Gandhi Memorial hospital integrated services centre for survivors includes listening to the concerns of the GBV survivor and informing the survivor of other available services that meet her stated health, legal, safety, and psychosocial needs. The centre has one psychosocial support officer to provide these services.

If the survivor is a child survivor there are toys available to help facilitate the interaction with the psychosocial support officer. When explaining the process of working with child survivors one service provider stated,

“If survivors are children I will use a play therapy technique to help them start talking about their experience.”

Working hours are only during weekdays (Monday- Friday until 5:30 pm), this is contrary to the center’s protocol that states services are available throughout the weekend and during both day and night shifts. Taking into account the emergency nature of rape cases and sexual violence in general, this could hinder timely lifesaving service provision for survivors. Psychosocial support officers are also expected to accompany survivors for other services if the survivor requests to do so however looking at the staffing structure this implies not having psychosocial support officer in the center if the psychosocial support officer respects the wishes of the survivor and decides to accompany her.

Another gap that exists within the psychosocial support service is providing survivors with the option of rehabilitation programs (also known as social re-integration programs) targeting survivors of GBV. These could include women’s centres, skills training programs, income generating and economic empowerment projects or peer support groups which are not linked in a referral system to the centre.

4.2.3 Safety and Security

Referral linkages to safe shelters are available for survivors who come to access the center and who have protection needs. The criteria for having an access to safe shelters located outside of the center include those survivors living with their perpetrators, survivors who have court appointments the next day and don't have a place to stay in the meantime, those survivors who don't have anywhere else to go or those who don't have relatives they can stay with.

The center has three referral linkage options for safe shelters. These are located in separate locations and women and girls are referred based on their age. Thus separate shelters are available for adult women, adolescent girls and a foster care arrangement for young children will be arranged accordingly. For survivors who report during weekends and during the night time, there is an emergency safe shelter within the center. This enables survivors to stay within the center for a maximum of three days until other durable options become available.

4.2.4 Legal Assistance

The center has 5 (all female) police officers who are assigned to the center permanently and a prosecutor (female, available on call). They facilitate free legal counseling, representation, monitoring and follow up with court cases and processes.

When survivors report incidents of rape, police officers in the center will record the survivor's word and will document it together with the survivor's medical record. The file then will be transferred to the survivors' respective sub-city. If the survivor has already been to a police station before coming to the center then the survivor will get medical treatment in the center and the police will deliver the medical records to the survivor's respective sub-city. Sometimes service providers working with GBV survivors assume that the person should report to the authorities because they think the perpetrator should be punished. The researcher has

found this to be the case among all service providers that took part in all key informant interviews. While this may be what service providers prioritize, it also needs to be taken in to consideration that there are great risks for a survivor in reporting to formal authorities. Often, responses from the police and legal systems can put the person at risk of harm from the perpetrator, family members or community. The process of taking legal action can also re-victimize the survivor. It may also take a long time. Sharing accurate information about the likelihood that a case reported to the police will actually proceed to court and/or result in conviction is also important (IASC, 2017). As the decision whether to pursue with legal procedures or not is an important one, and survivors need to have access to full information to think through such a decision without being pressured by service providers.

Discussing about the challenges she experiences, one service provider who helps with legal assistance said,

“Sometimes survivors think we are not here to help them when we repeatedly ask them to tell their stories. They are further traumatized.”

4.3. Applying GBV Guiding Principles

This section of the research discusses the findings of the study in relation to service providers who work in Gandhi Memorial hospital integrated services center for survivors and their adherence in following the GBV guiding principles. The findings have been categorized accordingly in four themes, safety, confidentiality, respect and non-discrimination.

Negative responses to survivors from those they turn to for help can lead to re-victimization, which is likely to exacerbate existing psychological distress and delay recovery. This major form of harm to a survivor is completely preventable (IASC, 2017).

Guiding principles while working with survivors of GBV are considered as the minimum standards to ensure a survivor receive the best care possible. The guiding principles were established to ensure that service providers working to respond to gender based violence, do so without causing further harm to the survivor.

4.3.1. Safety

The center has prioritized the safety needs of survivors by arranging an emergency safe house within the center and also by linking referral safe shelter services that can be accessed by survivors upon provision of a letter written by the center to the shelters, authorizing survivors to safe access. Follow up with these shelters are conducted through phone and as required in person. Additionally, there are security personnel assigned for the hospital however there is no security personnel specifically assigned for the center.

One of the most serious consequences of GBV is a survivor's risk of suicide. It can be expected that survivors will have feelings of wanting to die, end their life or disappear (IASC, 2017). In this regard service provision including psychosocial support within the center is not clear about steps staffs need to follow and does not have clear policies on how suicide risk cases will be handled. The center does not also have a clear mandatory reporting policy service providers refer to.

4.3.2. Confidentiality

Survivors have the right to have any information about them treated with respect. This promotes safety, trust and empowerment. Survivors should have the right to choose to whom they will, or will not, tell their story. Service providers should not disclose information about the survivor without the informed consent of the survivor.

The researcher has observed a written form of the principle of confidentiality has been posted on the center's notice board in Amharic language for all to see. In addition all service providers that participated in key informant interviews and focus group discussions cited the principle of confidentiality as an important guiding principle to be prioritized.

However, while conducting key informant interviews with service providers the researcher has been repeatedly offered access to survivors' personal case files without asking for it and without survivors' informed consent. Though the researcher has declined formally as this would be an unethical form of collecting data, it still amounts to a breach of the principle of confidentiality from the service providers' side. During a site visit the researcher also witnessed a child survivor who came to access services, whose case was being discussed openly in a non-confidential manner among service providers in the corridor/hallway of the facility and in the presence of the child and the guardian as well as others who came to access services.

The researcher has also observed the center is the first thing one sees when entering Gandhi memorial hospital facility. It is also commonly and widely labeled as the 'women and girls rape center' by the non-clinical and clinical personnel working outside the center but within the hospital, thus anyone sitting in the waiting area can easily be associated with having experienced some kind of GBV. This can have an impact in regards to ensuring confidentiality.

4.3.3. Respect

GBV is an assault on the dignity and rights of a person, and all those who come into contact with survivors have a role to play in restoring dignity and self-determination. For example, survivors have the right to decline case management services or choose whether or not to access legal and other support services (IASC, 2017).

Respecting the wishes of survivors includes believing survivors, providing survivors with all necessary information and respecting their decisions. Failing to respect wishes and rights of survivors can further increase their feelings of helplessness and shame and can reduce the effectiveness of services being provided. It also can cause re-victimization.

During interactions with service providers working in the integrated services center for survivors the researcher came to discover that the wishes of survivors may not always be prioritized. Some of the responses during key informant interviews, as quoted below, show that service providers may not always believe the survivor's story and may not always listen to her story respectfully.

“I will do my best to investigate which of the rape cases we receive are genuine and which are not. For example, sometimes women come to us and say they had a beer and the next thing they found themselves unconscious and that they got raped. In such instances I tell women they must speak the truth, that a single beer can't lead to rape and I try to convince them to tell the truth. After multiple investigations they will admit it was consensual and that they were lying. Sometimes they will stand by their word until the end no matter what, and then we will send their case file to the police station.”

Furthermore, service providers prioritize survivors getting legal assistance services over the survivor's wishes. During a key informant interview one respondent said,

“I am here to help support the legal process so I will make sure survivors are telling the truth. I will not be satisfied by just providing emotional support to survivors, there needs to be a legal prosecution”

In order to develop programming and interventions that have a sustainable and durable impact on the lives of women and girls, there needs to be an understanding of the dynamics, assumptions and beliefs that allow this violence to be so prevalent, so relentless and so widely tolerated. It needs to be recognized that staff providing support are not ‘outside’ the societies that raised them; that they also have their own beliefs and assumptions that shape how they understand and explain GBV. There needs to be an understanding how systems and institutions codify and give shape to ideas and attitudes that make women vulnerable and fail to protect them (Siebert and Cole, 2008).

4.3.4. Non-Discrimination

Survivors have the right to receive care without unfair treatment on the basis of their identity. This has been clearly stated as one of the rights of survivors’ accessing the facility and has been posted on the center’s notice board. Accordingly services within the center are provided free of charge for all women and children survivors visiting the center.

However, survivors’ come from various parts of the country to access services but the center currently provides all services in a single language of the country and does not have translators available that are able to communicate with survivors in different languages. Taking in to account survivors come to the center from across all directions of the country, this is a factor that hinders their access to quality services. Discussing how they try to narrow the gap in this regard, the center coordinator stated,

“We try to use nurses and prosecutors as substitute translators if they speak the language of the survivor; we do not want to use family members of the survivor as there is a high chance of miscommunication in those instances.”

4.4. Quality of Services, Supervision and Staff Care

In order to make sure services that are being provided to GBV survivors are up to standard and follow best practices it is known that there needs to be a well organized staffing structure, a quality check standard and mechanism and a supervision structure. There needs to also exist a staff self-care mechanism put in place for service providers.

The Gandhi integrated services center for survivors provides multi-sectored services for survivors of rape in particular and survivors of gender based violence in general. The center has a protocol listing roles and responsibilities of staff working in the center and the rights of survivors, to avoid confusions and to clarify roles and responsibilities. However, apart from the protocol, the center does not have tools to measure quality of services being rendered in the center which can be taken as a major gap in providing quality services.

In terms of staffing and supervision structure, the center has a coordinator at the top, who is responsible for the overall running of the center. However, taking in to account the fact that the center is a multi-disciplinary one it also requires a technical supervision and support structure available on a regular basis to provide monitoring and mentoring sessions to staff in their respective sectors.

For the center to be the effective and successful its staff plays a great role. Without committed and capable staffs to carry out tasks in the center, the integrated services center would not succeed. Working with survivors of rape is emotionally demanding, often not encouraged by others to undertake and also has a potential to be dangerous. There is also the risk of developing attachments with survivors. Thus supervisors and all staff concerned need to be aware of the physical, emotional, and psychological health impact. Secondary trauma is common among staff

working with survivors like other helping professions. Without a proper self-care mechanism there is always the risk for staffs to experience burn-out.

The researcher has explored the center does not have a specific self-care plan arranged for its staff. Furthermore women (and girls) in most cultures are usually socialized to take care of others first and often find that there is not enough time left to care for themselves. Below is a quote from a female key informant interview participant who is a service provider in the center that confirms the same.

“I don’t have a self-care plan. I barely get time for myself. I go to school in my spare time, that’s it.”



Picture 1: Child friendly materials for working with child survivors

Picture 2: Center Entrance

Chapter 5: Social Work Implication and Recommendation

5.1. Social Work Implication: Practice, Research and Policy

Principles of social justice and human rights are central to social work and its works towards engaging people and structures to address life challenges and enhance wellbeing. Social work promotes social change, empowerment and liberation of all people. Social workers are expected to uphold and defend each person's physical, psychological, emotional and spiritual integrity and well-being (International Federation of Social Workers and International associations of Schools of Social Work, 2004). Accordingly, this study is believed to have a contribution towards the improvement of services rendered for survivors of rape and gender based violence in general in Gandhi memorial hospital integrated services center. It explores services being rendered in the center for survivors in line with standard GBV guiding principles for service provision and gives recommendations.

As explored in depth in the study survivors of rape and gender based violence in general, have specific needs and require life saving, timely service provision. Thus, various social work interventions are required in order to meet these needs of survivors. In this aspect, the scope of social work interventions for survivors could include a mix of a client centered approach and a strength based approach to promote survivors' wellbeing, recovery and resilience. Services could potentially be coordinated with institutions working towards achieving the same objectives of prioritizing survivor's right to access quality health, psychosocial, legal and protection services. Furthermore, this study is believed to have a contribution towards moving forward the existing knowledge gap in research regarding response services for gender based violence survivors in Ethiopia.

In addition, as there is a plan to expand institutions that provide support to women and children throughout the country in line with the Constitution of the Federal Democratic Republic of Ethiopia - Article 35 and the Growth and Transformation plan- 2, the study can contribute towards improving structures of future centers.

5.2. Recommendation

Based on the findings of the study the following recommendations are suggested to help improve quality of services survivors receive in Gandhi memorial hospital integrated services center.

- Rolling out a standardized case management system in the center to assess the needs of survivors, to provide information on available resources, to arrange and to advocate for services, and to promote survivors' recovery by modeling a survivor-centered approach in all interactions with survivors.
- Establish a referral linkage to peer support groups, women centres, skills training programs and income generating activities for survivors.
- It is recommended staff providing services for child survivors receive specialized trainings on child protection and caring for child survivors as working with child survivors is even more complex and requires additional skills. There also needs to be a child safeguarding protocol in place.
- Not all service providers working in the center have received specialized GBV trainings for working with survivors (including child survivors) thus regular capacity development trainings and mentoring sessions for staff needs to be prioritized in order to provide survivors with the best care possible.

- It is vital to gauge quality of services being provided in the center thus a client satisfaction tool or a feedback receiving mechanisms needs to be put in place where survivors could provide their feedback voluntarily and anonymously.
- Because information sharing is sensitive at the same time crucial among service providers to provide quality service for survivors, there needs to be an information sharing protocol signed and approved by all sectors providing services, to ensure safe and ethical data sharing based on survivors' consent.
- The center currently provides all services in Amharic language. Service providers in the center have expressed this as a major gap in service provision as survivors who do not speak the language come from other parts of the country to access services. It is recommended to prioritize hiring and training part-time translators who speak multiple languages of the country in order to bridge this gap.
- As accessing timely services is lifesaving and critical for survivors, use various communication mechanisms like radio, television, news papers and brochures to create awareness within the community about available services for survivors in the center.
- To maintain confidentiality and to prioritize survivors' safety, there needs to be lockable case file cabinets for storing survivors' case information safely with only designated staff being able to access it.
- A clear mandatory reporting guideline should be in place for service providers to follow in order to standardize service providers' response concerning mandatory reporting, including dealing with suicide.

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Appendix

Annex 1: Consent Form

My name is Kidst Mekonnen, I am a prospect graduate student at Addis Ababa university school of social work. I am conducting this research for the partial fulfillment of the Master degree of Social Works (MSW) at Addis Ababa University.

The purpose of this study is to assess the availability and accessibility of services for survivors of rape in Mahatma Gandhi Memorial Hospital for academic purpose. The findings of the study can further be used as a reference for advocacy purposes in the future.

If you agree to take part in this research study, you will be interviewed with questions focused on the specified title. The interview should take 30-60 minutes. The questions will include background information, service availability within your sector, capacity development trainings and staff self-care plan. All information that you will provide will remain anonymous and confidential. Moreover, your participation in this study is consensual and based on your willingness. If you agree, we will start accordingly. You can also change your mind at any time during the interview/discussion. If you have any questions you can stop me at any time.

Thank you!

Code of participant _____

Signature of the researcher _____

Annex 2: Key Informant Interview Guide for Service Mapping

Note: This tool is for use during interviews with service providers. All sections may apply to some service providers, while for others (i.e., a health clinic) it may only be relevant to focus on one section.

1. What type of services do you provide to survivors of rape?

- Health
- Psychosocial / case management
- Legal
- Protection/ security
- Sensitization / prevention

Health

2. What type of medical personnel work for your organization here?

- Nurses: How many? _____
- Doctors: How many? _____
- Midwives: How many? _____
- Gynecologists: How many? _____
- Surgeons: How many? _____
- Other: How many? _____

3. Do you have GBV/Sexual Violence focal points? Yes No
If yes, who?

4. Have the medical personnel received any specialized training on clinical care for survivors sexual violence?
Yes No

If yes, who provided the training? When was the training provided?

5. Have the medical personnel received any specialized training on the provision of care for child survivors of sexual violence?
Yes No

If yes, who provided the training? When was the training provided?

6. Do you have complete post-rape kits available? Yes No

- PEP
- Emergency contraception
- STI medicines / antibiotics
- Hepatitis B vaccination
- Tetanus vaccination

7. Do you have trained social workers on staff? Yes No

If yes, how many? _____

8. Do they have a safe, confidential space to receive survivors? Yes No

If yes, request to see the space. Is it safe and confidential? Record your observations here:

Psychosocial

9. What specific services do you provide?

- Basic emotional support

- Case management
- Psychosocial support
- Group activities
- Other?

10. Do you have a safe, confidential space to receive survivors? Yes No

If yes, request to see the space. Is it safe and confidential?

11. Do you have a woman's center or other dedicated space to facilitate survivors' access? Yes No

If yes, request to see the center. Was the center busy? Was it filled with mostly women? Mostly men? Record your observations here:

12. Are your psychosocial services provided by:
- Trained volunteers If yes, how many? _____
 - Partners (NGO, CBO, etc.) If yes, how many? _____
 - Staff of your organization If yes, how many? _____

13. What kind of training have your volunteers and social workers received?

Safety and protection

14. What specific services do you provide?
- Safety and security planning for survivors
 - Safe houses
 - Community solutions (i.e., a safe house within the community)
 - Patrols
 - Others?

Difficulties / Challenges

15. What are the significant challenges your organization faces in service provision?

16. Do you turn away women and girls because of a lack of available resources? Yes No

Other Comments

Annex 3: Focus Group Discussion Guide

Date:

Sex of FGD participants: Male Female

Age of FGD participants:

- 10-14 years
- 15-19 years
- 20-24 years
- 25-40 years
- Over 40 years

Introduce Self

Present the purpose of the discussion:

- General information about the research
- Explain what you will do with this information and make sure that you do not make false promises
- Participation is voluntary
- No one is obligated to respond to any questions if s/he does not wish
- Participants can leave the discussion at any time
- No one is obligated to share personal experiences if s/he does not wish
- If sharing examples or experiences, individual names should not be shared
- Be respectful when others speak
- The facilitator might interrupt discussion, but only to ensure that everyone has an opportunity to speak and no one person dominates the discussion

Agree on confidentiality:

- Keep all discussion confidential
- Consent Form

Ask permission to take notes:

- No one's identify will be mentioned
- The purpose of the notes is to ensure that the information collected is precise

QUESTIONS

A. I would like to ask you some questions about the services and assistance available in this hospital for Sexual Violence survivors (rape):

17. What type of services do you provide to survivors of Gender Based Violence and rape in particular?
18. For services not provided by the hospital what are some of the alternative mechanisms you apply?
19. What referral pathways are currently in place in the hospital?
20. How does the regular admission procedure or treatment look like for a rape survivor?
21. Where do you refer gender based violence/sexual violence survivors within the hospital?
22. What are some of the specialized trainings in relation to sexual violence and caring for survivors that are provided for the hospital staff?
23. What are some of the specialized trainings provided for staff on caring for child survivors of GBV?
24. What do the regular available post-rape care service packages consist of in your Organization?

25. What do you think are some of the challenges and gaps in rendering quality service provision for survivor of rape in the hospital?

B. I would like to ask you some questions about options available in this hospital for survivors (rape):

1. What do survivors of sexual violence usually do after they have experienced sexual violence such as rape?
2. When a woman or girl is the victim of violence, where does she feel safe and comfortable going to receive medical treatment in this medical institution?
3. What are the other services or support available for survivors of sexual violence?
4. What other alternative mechanisms do survivors use in the absence of comprehensive post rape care services in the hospital?

C. I would like to ask you questions about a possible incident:

Sample case study: A young girl left her house during the night to use the latrine. She reached the latrine and entered, but while inside heard noises nearby. When she exited the latrine a man grabbed her, pulled her behind the latrines and raped her.

5. If a woman reported that she experienced violence similar to the woman in the story, how many of you would believe her story?
6. Why do women and girls hesitate to share experiences like this with other people?
7. Where could this woman go to receive appropriate assistance? What kind of assistance and support could she receive?

Annex: 4 Observation Checklist Guide

Health Sector Observation Checklist	Met	Not Met
Female medical personnel include clinical health workers trained in provision of clinical management of rape.		
Linkage with case worker/female social worker (internal/external)		
Complete supplies and medications for offering post-rape treatment are available		
•Post Exposure Prophylaxis		
•Emergency contraception		
•STI medicines / antibiotics		
•Hepatitis B vaccination		
•Tetanus vaccination		
Safe, confidential space for examining patients available		
Facility-level protocols in place for receiving GBV survivors and managing clinical care (linked to CMR trained medical staff)		
Non-identifying exit/entry into facility and examination spaces for GBV survivors		
Psychosocial Sector Observation Checklist	Met	Not Met
Safe, locked filing space to keep child records confidential exist		
Procedures are in place for working with child survivors		
Child friendly materials (toys, art materials, dolls) are available in counseling rooms for case management staff to use with child survivors		
Case management staff trained in on survivor-centered care		
Supervision systems exist for case workers		
Safe, locked filing space to keep case management records confidential exist		
Private counseling room is available		
Female case workers on staff		

Declaration

I, undersigned hereby declare that the work in this thesis is fully my own, has not been presented for the degree of Masters of Social Work or for any other purpose before and that all sources used for this research have been fully acknowledged.

Name: _____

Signature: _____

Date: _____

As a supervisor, I have approved this paper to be presented for defense.

Supervisor's name: Messay Gebremariam (Dr.)

Signature: _____

Date: _____