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**ASSESSMENT OF PATIENT'S SATISFACTION AND ASSOCIATED
FACTORS - IN One Stop Centers, located at Addis Ababa, Ethiopia, during
2022**

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Declaration

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted at any university for a degree.

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Signature

This is to Certify that the thesis prepared by Rewina Gebremedhin, entitled ‘Assessment of Patient’s Satisfaction and Associated Factors - in OSCs, Addis Ababa, Ethiopia’ submitted in partial fulfillment of the requirements for the Degree of Master of Arts in Regional and Local Development Studies complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

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Dedication

Dedicated to my Beloved Husband, Segni Merga and my Parents: Gebremedhin Gebrehiwot and Lemlem Gebremeskel

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Abstract

This research investigates the satisfaction level (along with the related factors) of survivors coming to three One Stop Center's located in Addis Ababa, Ethiopia during the year 2022. These three OSCs namely are Gandhi Memorial Hospital OSC, Menelik Hospital OSC, and Tirunesh Beijing hospital OSC. Primary data was gathered from randomly chosen 90 patients that visited the OSCs. A pretested, structured questionnaire that was administered by an interviewer was used to gather the data. To deepen comprehension and triangulate the quantitative data, qualitative interviews were also used. The data were described using descriptive statistics, and relationships between dependent and independent factors were identified using logistic regression. P values below 0.1 were regarded as significant. Result and conclusion from both the qualitative and quantitative data are presented. Overall, around 80% of the survivors stated that they were either satisfied or very satisfied. Financial aspects and accessibility of the care were significantly related with overall satisfaction of the patients. The result of this study provides preliminary evidence that OSCs are giving a good service. With accessibility of care and financial confidence as factors that contribute to increased patient satisfaction. Major challenges spotted on this study that hinders the OSC's ability to deliver high-quality services include lack of a forensic team lack of medications and lab reagents, lack of a support group for the survivors, inadequate training, certain staff/sectors not working 24 hours, and lack of cash support for various emergency needs. In general, the OSCs in Addis Ababa are providing a good service and would be excellent if they address the gaps mentioned above.

Keywords: *Gender-based violence (GBV); patient satisfaction; One Stop Center (OSC), Associated factors.*

1. CHAPTER ONE: INTRODUCTION

1.1 Background

Gender-based violence (GBV) is a catch-all term for any damaging act committed against someone's will that is motivated by socially constructed distinctions between males and females. While various forms of GBV (especially sexual violence) are also experienced by men and boys worldwide, GBV disproportionately affects women and girls (Global Protection Cluster, n.d.). Violence against women and girls (VAWG) GBV disproportionately targets women and young girls. GBV causes psychological stress on a personal level, and survivors may experience psychological, behavioral, and physical repercussions. The high prevalence of GBV puts a significant load on the medical and legal systems, and many survivors are unable to work or otherwise function normally in society. (saferspaces, n.d.). This problem not only has severe effects on victims of violence and their families, but it also has high societal and financial implications. More than twice as much as most governments spend on education, violence against women is estimated to cost some nations up to 3.7 percent of their GDP (worldbank, 2019).

GBV management is a complicated subject that calls for involvement and commitment from all parties, including the government, civic society, and other individuals. Response and prevention strategies can be used to address GBV, respectively. Response services work in many ways to assist and support victims of violence (for instance medical help, psychosocial support, and shelter). Initiatives aimed at prevention examine ways to stop GBV from happening. Response services itself can help stop or stop violence from happening again. On a global scale, significant progress is being made about the best ways to assist and support victims of abuse. World Health Organization (WHO) guidelines explain a suitable health sector assistance to VAW – such as offering post-rape treatment and instructing medical personnel in these services. (World Health Organization, 2013)

The first "One-Stop Crisis Center" for battered women opened its doors in 1993 in Malaysia's Kuala Lumpur Hospital's accident and emergency department. Its purpose was to offer a coordinated interagency response to violence against women, allowing assault victims to address their medical, legal, psychological, and social issues in one place. The clinic initially only addressed domestic abuse, but it has subsequently broadened its focus to include rape and has

special protocols for rape victims. A crisis intervention team at Kuala Lumpur Hospital manages about 30 rape cases and 70 domestic violence cases each month. The team gets its expertise from the hospital itself and from different women's groups, the legal aid office, the department of medical social workers, the police, and the Islamic Religious Bureau (World Health Organization, 2002).

The Malaysian Ministry of Health made the decision in 1996 to expand this trailblazing healthcare approach and to set up comparable facilities in all of the nation's public hospitals. 34 such facilities had been established in just 3 years. In these facilities, rape counseling is provided by psychiatrists, counselors, and medical social workers. Some of the clients also enroll as outpatients in the hospital's psychiatric unit. A trained social worker must be available on call around-the-clock. As the "One-Stop Crisis Center" initiative evolved, a number of issues were exposed. One was the requirement for hospital employees to receive improved training in sensitively treating matters of sexual violence. Some hospital staff members were observed blaming rape victims for the abuse they had endured, while others looked at the victims with voyeuristic curiosity rather than focusing on offering care. Additionally, there were not enough protected housing units and forensic medical officers to care for rape victims. The program might be improved, and rape victims could receive higher-quality services because these issues were identified (World Health Organization, 2002).

The Sexual Assault Response Team (SART), Centers Against Sexual Assault (CASA), Sexual Assault Referral Center (SARC), Rape Crisis Centers, One Stop Centres/Shops, Sexual Assault Nurse Examiner Programs (SANE), Project Sapphire, Victim Support Units, Sexual Assault and Child Abuse Team (SACAT), and Victim Protection Units are just a few of the coordinated care approaches (including OSCs) that have emerged globally in the last twenty to thirty years (Daly, 2011).

One-Stop Centers offer survivors multi-sector case management, including welfare, counseling, health, and legal assistance all in one place. Through referral channels, they are connected to the police as well. These crisis centers are often found in hospitals' emergency rooms or as standalone buildings next to another hospital that collaborates with them. These facilities can either keep a core staff with specialists on call or can have specialists on duty. One-stop centers, in contrast to SARTs and SARCs, may concentrate their services on the problem of domestic violence or they may deal with both domestic violence and sexual violence. The first OSC was tested in 2008;

currently, in Addis Ababa, Ethiopia, we have three OSCs; namely: Gandhi Memorial Hospital OSC, Menelik Hospital OSC, Tirunesh Beijing hospital OSC.

1.2 Problem statement

Based on (worldbank, 2019), one in three women will experience gender-based violence (GBV) or violence against women and girls (VAWG) in their lifetime. 35% of women globally have been victims of non-partner sexual violence or intimate relationship violence, which is startling statistics. 7% of women worldwide have experienced sexual assault by a person other than a romantic relationship. Up to 38% of female homicides worldwide are the result of an intimate relationship. Women have undergone female genital mutilation or cutting in 200 million cases.

(Network of Ethiopian Women's Association, Ethiopian Women Lawyers Association, Human Rights Council, Sara-Justice From All Women Association) stated that there are no reliable statistics available at the national level on the number of GBV investigations, prosecutions, and convictions. A national database for GBV offences is not kept up to date by the government. Despite this, the Government of Ethiopia (GoE) informed the CEDAW Committee that 976 cases of crimes against women and children were tried at the federal level between 2014/15 and 2017, resulting in 552 convictions and 170 acquittals. According to (Central Statistical Agency , 2016), 35 percent of women who have ever been married say that their husband or partner has abused them physically, emotionally, or sexually at some point. Women report experiencing emotional violence 24% of the time, physical violence 25% of the time, and sexual violence 11% of the time.

Even though Ethiopia has been making good strides toward enhancing its citizens' quality of life throughout time. The COVID-19 epidemic and internal violent strife have drastically reduced the rate of economic growth, which had been consistently strong for several years. Although precise numbers are unavailable, it is likely that the pandemic and internal conflicts have also boosted the number of GBV cases.

The effects on reproductive, emotional, and social well-being are some of the more frequent effects of sexual violence. According to a survey on teenagers in Ethiopia, 17% of those who reported being raped went on to become pregnant after the rape. As early as childhood, the experience of being sexually abused or raped can cause suicidal behavior. In Ethiopia, 6% of schoolgirls who had been sexually assaulted had tried suicide. (World Health Organization, 2002). The problem not only has terrible effects on victims of violence and their families, but it also has high societal

and financial implications. More than twice as much as most governments invest in education, it is estimated that violence against women costs some nations up to 3.7% of their Gross Domestic Product (GDP). Future expenses will be high if this problem is not addressed. Numerous studies have revealed that children who experience violence as young children are more likely to go on to experience violence themselves or to commit acts of violence in the future (worldbank, 2019).

Response services, including as medical assistance, psychosocial support, and shelter, try to support and assist victims of violence in a number of ways. Centers like One Stop Center (OSC) provide integrated support of medical, legal, emotional support, and more to make these services easier on the victim. OSCs facilitate victim reporting, facilitate victim medical assessment, and coordinate support and investigation services. In Addis Ababa, Ethiopia, we have three OSCs; namely: Gandhi Memorial Hospital OSC, Menelik Hospital OSC, Tirunesh Beijing hospital OSC. The first OSC was piloted in 2008 but to the best of the researcher knowledge, there has been limited study that investigate and evaluate the performance of all three OSC; there is a similar study done on Gandhi but not particular to satisfaction rate and associated factor but rather assessment of post rape care services in general. To fill this gap, this research aims to investigate the satisfaction level (and related factors) of the survivor on these OSCs, and objectively see the challenges/flows in the service provided by these OSC in Addis Ababa.

1.3 Objective of Study

1.3.1 General objective

- The General Objective of the study is to measure the patient's satisfaction level and identify the associated factors - in OSC, Addis Ababa, Ethiopia by taking 30 (from each three OSCs) sample patients that visit the OSCs.

1.3.2 Specific objective

- To identify patient's level of satisfaction on the OSCs located at Addis Ababa, Ethiopia.
- To identify factors that influence the satisfaction of patients on the OSCs located at Addis Ababa, Ethiopia.
- To objectively assess the challenges in the services provided by the OSCs located at Addis Ababa, Ethiopia.

1.4 Research question

- What is the level of patients' satisfaction at OSCs located at Addis Ababa, Ethiopia?
- What are the factors that influence the satisfaction of patients at OSCs located at Addis Ababa, Ethiopia?
- What are the challenges in the services provided by the OSCs located at Addis Ababa, Ethiopia?

1.5 Significance of the study

Integrated services to survivors of GBV is relatively new in Ethiopia- 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. Discoveries of this study can also be used for future advocacy purposes and can help contribute towards accountability of institutions and service providers.

1.6 Scope of the study

This study only assessed satisfaction of OSCs patient in Addis Ababa, Ethiopia, using only six determinates found in Patient Satisfaction Question III (PSQIII) questioner survey-originally developed by Willis H. Ware and his colleagues (Ware, Snyder, and Wright, 1976). These are: technical quality, accessibility of care, financial aspects of care, communication, time spent, and interpersonal manner. Patients visiting the OSCs during the period of the study are the only population that are considered.

1.7 Organization of the study

This study is organized into five chapters. The first chapter is about the background of the study, statement of the problem, the objective of the study and scope and limitation of the study. The second chapter presents a review of related works of literature on gender-based violence, one stop centers, and one stop centers patients' satisfaction. The third chapter discusses the methodologies and procedures followed for the data collection, analysis, and interpretations. The fourth chapter deals with the analysis of data and discussion of findings. The last chapter carry conclusion, and recommendations.

2. CHAPTER TWO: LITERATURE REVIEW

2.1 Theoretical Review

2.1.1 Violence and Gender Based Violence- Definition and Concept

A detailed "typology of violence" has been constructed based on the WHO definition of violence, which describes several categories and forms of violence as well as the connections between them (allowing for a holistic approach to intervention). Violence and crime are frequently synonymous and closely related concepts. But one shouldn't mistake the two. Some crimes are violent by definition (such as those involving weapons or physical contact, such as homicide, assault, and rape), whereas others don't even remotely entail physical violence (such as tax evasion or illicit drug use). Similar to how not all forms of violence are criminal, there are various forms of psychological violence in addition to the aforementioned structural violence. In other words, not all violent crimes are violent acts, and not all violent acts are crimes (saferspaces, n.d.).

Due to the ingrained gendered power disparities in our society, all of these forms of violence can be - and usually always are - gendered in origin. Gender-based violence (GBV) is when a person is victimized or disproportionately affected by violence because of their gender. Violence against women is defined as any act of gender-based violence that causes or is likely to cause physical harm, sexual harm, psychological harm, or economic harm or suffering to women. It is also regarded to be a violation of their human rights and a form of discrimination against them. Domestic violence against women, men, or children residing in the same domestic unit is included. GBV mostly affects women and girls, but it also seriously harms families and communities. Gender-based violence can take a number of different forms, including: Physical: It causes illnesses, distress, and injury. Physical abuse commonly takes the form of beating, strangulation, pushing, and the use of weapons. Sexual: encompasses activities that are directed against someone's sexuality without that person's consent. It also includes attempts to elicit sexual favors. Psychological: comprises manipulative, coercive, economic violence, controlling and extortionally abusive acts. (European Union, n.d.)

GBV affects women and girls more than other groups. Sexual exploitation and abuse, including female genital mutilation/cutting, sexual harassment, trafficking, child marriage, dowry/bride price abuse, deprivation of inheritance or property, domestic or intimate partner violence, honor killing, and elder abuse are a few examples of GBV throughout the life cycle. (Global Protection Cluster, n.d.)

2.1.2 Gender Based Violence Theories

A micro-level or individual-level perspective is used in explanations of violence against women that concentrate on the traits of specific individuals. The social learning theory, psychopathology, psychological, and physiological explanations, resource theory, and exchange theory are some of the theoretical justifications for violence against women that take the micro perspective into consideration. One of the most prevalent explanatory models for violence against women, social learning theory, contends that people acquire behavior via exposure to and experience with violence. According to a psychopathological theory, those who are violent toward women may have a personality problem or mental condition that prevents them from having typical restraints against violent behavior. Men, who are naturally motivated to reproduce as much as possible, will turn to rape when they are unable to locate willing female partners, according to biological and physiological theories for why violence against women occurs. Researchers have also noted that violence against women frequently includes alcohol. According to the exchange theory, people engage in particular actions to obtain rewards or to avoid punishment. According to this theory, men's aggression against women can be seen as a way for men to uphold their status in society. Exchange theory, which holds that men use violence inside the family to seize control over women in family dynamics when other means of persuasion are insufficient, serves as the foundation for resource theory. Macro or sociocultural theories, in contrast to micro theories, concentrate on the social and cultural contexts that increase the likelihood of violence against women. Many theories that attempt to explain why violence against women occurs might be categorized as macro-oriented theories. These include a subculture of violence, structural stress, patriarchal or feminist worldview, and cultural acceptance of violence. Sociocultural theories have made an effort to incorporate both social structure and family processes as they address the impact of social location (social class, education, and income) on violence against women. More recently, the development of multidimensional theories of violence that take into consideration both societal structural

variables and individual traits has been the trend in theory development surrounding violence against women (Claire M. Renzetti, 2011).

2.1.3 Gender Based Violence-Drivers and Effects

2.1.3.1 Drivers of GBV

The causes and factors that support GBV are known as drivers of GBV. In the end, patriarchy-based gendered power disparity serves as the main cause of GBV. In countries where there is a culture of violence and when male supremacy is accepted as the norm, GBV (and IPV in particular) is more common. A belief in male superiority can appear in men feeling entitled to sex with women, rigid reinforcement of gender roles and hierarchy (and punishment of transgressions), women having low social status and authority, and connecting masculinity with control of women. Many drivers, including social standards (which may be cultural or religious), low levels of women's empowerment, a lack of social support, socioeconomic disparity, and substance misuse, interact with these issues. Men's violence against women is socially acceptable in many countries when used in specific contexts or circumstances, which makes it difficult to successfully address GBV (Jewkes, 2002)

2.1.3.1 Impact/Effect of GBV

One in three women will experience gender-based violence (GBV) or violence against women and girls (VAWG) in their lifetime. The statistics are startling: 35% of women globally have been victims of non-romantic sexual violence or intimate relationship abuse, including physical and/or sexual assault. Seven percent of women worldwide have experienced sexual assault by a person other than a romantic partner. Up to 38% of female homicides worldwide are the result of an intimate partner. Women have undergone female genital mutilation or cutting in 200 million cases (worldbank, 2019).

GBV is a serious violation of human rights that has a significant social and developmental impact on victims of violence, their families, communities, and society at large. GBV causes psychological stress on a personal level and can have negative effects on survivors' minds, behaviors, and bodies. Many survivors are unable to get the assistance they need since formal psychosocial or even medical care is difficult to acquire in many areas of the country. Indirect trauma can also affect survivors' families and loved ones, and many do not know how to support

survivors in a helpful way. Significant economic implications of violence are also present. The high prevalence of GBV puts a significant load on the medical and legal systems, and many survivors are unable to work or otherwise function normally in society (saferspaces, n.d.).

Rape does not always involve the use of physical force, and bodily harm is not always the result. It is well recognized that rape-related deaths do occur, albeit the frequency of these deaths varies considerably around the world. The effects on reproductive, emotional, and social well-being are some of the more frequent effects of sexual violence. Obstetrical and gynecological problems are what rape can result in, although the likelihood varies depending on the environment and, in particular, how often non-barrier contraception are used. According to a survey of teenagers in Ethiopia, 17 percent of those who reported being raped went on to become pregnant as a result of the rape. This percentage is comparable to the 15–18 percent recorded by rape crisis centers in Mexico. The national rape-related pregnancy rate among victims aged 12-45 years was 5.0% per rape, resulting in more than 32 000 pregnancies among women nationally each year, according to longitudinal research conducted in the United States involving more than 4000 women followed for three years. In many nations, rape victims are compelled to carry the child or risk their lives by getting an illegal abortion. Early exposure to compelled sex diminishes a woman's perception of her sexuality as something she can control. As a result, an adolescent girl who has been pushed into sex is less likely to use condoms or other types of contraception, which raises the possibility of her getting pregnant (World Health Organization, 2002).

Forced sexual initiation was found to be the third most strongly connected factor in a study evaluating risk factors for teenage pregnancy in Cape Town, South Africa, after frequency of sexual activity and usage of contemporary contraception. Among adult women, forced sex can potentially lead to unplanned pregnancy. A study of married males conducted in India found that those who reported forcing sex on their spouses were 2.6 times more likely to have been the cause of an unexpected pregnancy than those who did not. Forced intercourse has frequently been linked to gynecological issues. These include genital discomfort, fibroids, decreased libido, vaginal bleeding or infection, pain during sex, chronic pelvic pain, and urinary tract infections. In general, women who endure both physical and sexual abuse from intimate partners are more likely to develop health issues than women who only experience physical abuse. Rape has known repercussions, including sexually transmitted diseases like HIV infection and others. Women who

experience both physical and sexual violence from intimate partners are much more likely to have had sexually transmitted infections, according to research on women in shelters. HIV and other sexually transmitted illnesses are likely to present a particularly high risk for women who have been trafficked into sex industry. The connections between Human Immunodeficiency Virus (HIV) and sexual assault as well as the appropriate prophylactic measures. In a population-based study, the prevalence of symptoms or signs suggestive of a psychiatric disorder was found to be 33 percent in women with a history of adult-onset sexual abuse, 15 percent in women with a history of intimate partner physical abuse, and 6 percent in women who had never been sexually abused. Physical violence's negative impacts on mental health are made worse by sexual assault committed by a close partner. Compared to non-abused women, abused women who report having engaged in forced sex are considerably more likely to have depression and post-traumatic stress disorder. Injury sustained during the rape, a history of depression, or alcohol misuse all increase the likelihood of developing post-traumatic stress disorder after rape (World Health Organization, 2002).

French research of teenagers discovered a connection between having been sexually assaulted and present sleep issues, depressive symptoms, somatic complaints, nicotine use, and behavioral issues (such as aggressive behavior, theft and truancy). Negative psychological consequences have been found to linger for at least a year after a rape in the absence of trauma counseling, while physical health issues and symptoms typically lessen during this time. Up to 50% of women still have stress-related symptoms after counseling. Suicidal Women who have been sexually assaulted as children or adults are more likely than other women to try or die by suicide. Even after adjusting for sex, age, education, post-traumatic stress disorder symptoms, and the presence of mental diseases, the connection persists. Suicidal behavior can develop as early as childhood after being the victim of sexual assault or rape. Six percent of schoolgirls who had been raped in Ethiopia admitted to trying to kill themselves. Prior sexual abuse was found to be a major predictor of numerous health risk behaviors, including suicide ideation and attempts, in a study of Brazilian teenagers. Serious sexual harassment incidents can also cause emotional distress and suicidal thoughts and actions. In a Canadian study of female adolescents, it was discovered that 15% of those who had experienced frequent, unwanted sexual contact had engaged in suicide behavior in the previous six months, as opposed to 2% of those who had not. In many societies, it is widely believed that men cannot control their sexual urges and that women are to blame for inciting men's desire for sex. Current

views on sexuality and the status of women influence how families and communities respond to rape incidents in these contexts. In some cultures, the "solution" to rape is for the victim to wed the perpetrator, saving the woman's and her family's integrity by legalizing the union. The laws of some nations allow a man who commits rape to be forgiven of his crime if he marries the victim, reflecting such a "solution". In addition to marriage, families may exert pressure on the victim to focus on collecting monetary "damages" from the rapist's family rather than filing a report or pursuing a case. Men may reject their spouses if they have been sexually assaulted, and in some cultures, as was previously indicated, regaining lost honor necessitates the woman's expulsion or, in the worst circumstances, murder (World Health Organization, 2002).

This problem not only has severe effects on victims of violence and their families, but it also has high societal and financial implications. More than twice as much as most governments spend on education, it is estimated that violence against women costs some nations up to 3.7 percent of their GDP. Future expenses will be high if this problem is not addressed. Numerous studies have revealed that children who experience violence as young children are more likely to go on to experience violence themselves or to commit acts of violence in the future. Gender-based violence is a problem that needs to be tackled in both developed and developing nations since it has no regard for social or economic borders and affects women and girls from all socioeconomic levels. The reduction of violence against women and girls necessitates a community-based, multifaceted strategy and ongoing collaboration with several partners. The most successful programs tackle underlying risk factors for violence, such as social norm re gender roles and the normalization of violence (worldbank, 2019).

2.1.4 Gender Based Violence Prevention and Response

2.1.3.1 Gender Based Violence Prevention

Few projects combating sexual violence have been assessed, and there aren't many of them. The majority of interventions have been created and put into practice in industrialized nations. It's unclear how useful they might be in other contexts. The developed interventions fall into the following categories.

Individual approaches: psychological support and care Following sexual assaults, programs such as counseling, therapy, and support groups have been found to be beneficial, particularly when there may be complicating elements connected to the violence itself or the rehabilitation process.

Programs for offenders: The few programs that do target sexual assaulters typically target men who have been found guilty of assault. Life-skills and other educational programs: In recent years, a number of programs for advocating sexual and reproductive health, notably those fostering HIV prevention, have started to address the subject of sexual and physical violence targeting women as well as gender problems. Developmental approaches: To prevent sexual violence, research has emphasized the significance of promoting caring and healthier, more gender-balanced parenting.

Health care responses, medico-legal services- In many nations, the health sector is required to gather medical and legal evidence to support the victim's cases or to assist in identifying the perpetrator when sexual violence is reported. Training for health care experts: All health service personnel, including psychiatrists and counselors, need to get instruction on issues related to sexual violence in both their basic training and in specialized postgraduate courses. Prophylaxis for HIV infection: Particularly in nations where HIV infection rates are high, the likelihood of HIV transmission during rape is a serious worry. The application of antiretroviral therapy after rape and how it could be included into patient care in middle-income and low-income nations.

Centers offering comprehensive care for sexual assault victims: In some instances, specially trained nurses have been used to treat victims of sexual assault due to the lack of doctors in many nations. In Canada, nurses who specialize in treating victims of sexual abuse are called as "sexual assault nurse examiners". Community-centered, prevention campaigns: In an effort to alter public perceptions about sexual violence, the media has run advertisements on hoardings (sometimes known as "billboards"), in public transportation, and on radio and television. Community activism by men: A group effort by men is a crucial component in preventing sexual and physical abuse of women. School-based programs: It is crucial to take action in schools to reduce sexual and other types of violence. Legal and policy responses: legal reform, reporting and management of sexual assault cases, and international treaties (World Health Organization, 2002)

2.1.5 Gender Based Violence Response

Given that IPV poses a significant risk for a number of health issues, there is an increasing understanding of the need for health professionals to be better equipped to respond to cases of violence they encounter, identify women who are experiencing abuse, and refer them to specialized resources. This referral is very vital, as various women experiencing violence will not seek help from a legal or stand-alone service but will possibly go to a health service throughout their adult

life. Women may use a variety of potential entry routes into the healthcare system and may present with a variety of health problems. Some women who have experienced partner abuse will seek primary care, while others who have suffered major injuries may go to hospital emergency services. An additional potential entrance point is prenatal and postnatal care, family planning, or post-abortion care, given the prevalence of coercive sex and violence during pregnancy. In order to effectively provide health-related services to victims of abuse, the health sector must also make it easier for these women to access non-health services. While some women may readily report abuse without being asked, others could withhold the source of their present problems. The health sector's response has generated much discussion about whether women should be "screened" for violence and whether such interventions will affect women's futures (World Health Organization, 2008).

The first "One-Stop Crisis Center" for battered women opened its doors in 1993 in Malaysia's Kuala Lumpur Hospital's accident and emergency department. In just three years, 34 similar centers had been established. These centers provide counseling on rape by counselors, psychiatrists, and medical social workers, and some of the clients enroll as outpatients in the hospital's psychiatric division (World Health Organization, 2002).

The list below attempts to outline some of the coordinated care approaches (including OSCs) that have emerged globally in the last twenty to thirty years. (UN Women, 2013)

Table 2.1 Care Approaches

Response Name	Country it Originated from	Originating Sector	Description	Primary Aims
Sexual Assault Response Team (SART)	USA	Multi-sector in the sense that SARTs often have their own premises	In parallel with SANE (see below), SART began in the 1970s. In many US jurisdictions, SART now incorporates SANE, but it may also rely on staff from normal hospitals. A victim advocate, a police officer, and a nurse or doctor make up a team (sometimes, a prosecutor is also	1. Facilitate victim reporting 2. Facilitate victims' ease access to

			involved). A victim is typically led to SART's own location by a police officer or victim advocate. All team members show up at the SART office where the victim is interviewed, the medical examination is done, and the victim is given support (counselling and referrals).	medical examinations 3. Organize support and investigation services.
Sexual Assault Referral Centre (SARC)	England/Wales	Usually located in hospitals	The English name for SARTs is SARCs, and it was initially introduced in 1986. The majority are partnerships between the police, the health sector, and the nonprofit sector. They are typically found in medical facilities. In addition to receiving medical attention from a qualified healthcare professional, victims also receive counseling, legal representation, are interviewed by police, and go through a forensic examination. The service is offered every day, all day long. Although they are not required to, victims of assault are free to self-refer or be recommended by police. Before determining whether or not to report, they can speak casually to a police officer. Additionally, SARCs provide up to six months of ongoing medical and psychological assistance to victims.	1. Facilitate victim reporting 2. Facilitate victims' ease access to medical examinations 3. Organize support and investigation services.
One Stop Centres/Shops	Originating in Malaysia now in several countries in South Asia and Africa	Located usually in health facilities	One-Stop Centers offer survivors multi-sector case management, including welfare, counseling, health, and legal assistance all in one place. Through referral channels, they are connected to the police as well. These crisis centers are often found in hospitals' emergency rooms or as	1. Facilitate victim reporting 2. Facilitate victims' access to medical examinations

			standalone buildings next to another hospital that collaborates with them. These facilities can either keep a core staff with specialists on call or can have specialists on duty. One-stop centers, in contrast to SARTs and SARCs, may concentrate their services on the problem of domestic violence or they may deal with both domestic violence and sexual violence.	3. Organize support and investigation services.
Rape Crisis Centres	Various	Community-based NGO	Rape crisis centers are typically run by NGOs and offer victims support (such as counseling and a phone helpline) as well as information on the judicial system. In multidisciplinary responses to sexual assault like one-stop shops, SARC, or SART, staff and volunteers frequently take part. They might also support victims when they report to the police or have their forensic evidence examined.	1. Help and assist the victim 2. Give the victim information and counseling
Centres Against Sexual Assault (CASA)	Australia	NGO Sector, now linked to multi-sectoral services with autonomy	CASAs offer victims assistance (counselling, a phone helpline, and legal knowledge). Members of the CASA team take part in professional and community education as well as multidisciplinary responses to sexual assault. They aim to facilitate research, lobby for legal reform, and influence governmental policy.	1. Sexual assault response integration
Sexual Assault Nurse Examiner	USA	Health sector	Nurses have received specialized training in victim care, forensic evidence gathering, and victim examination. In addition to doing the forensic examination, SANEs also offer medical services like STD	1. Boost forensic evidence gathering 2. Facilitate victims'

Programs (SANE)			testing, pregnancy prevention, and counseling referrals. Although they also serve as specialized nurses in normal emergency wards, SANEs typically participate in a team response to sexual assault (see SART).	easy access to medical examinations 3. Offer victims' medical attention
Project Sapphire	England	Police/ Security	The sexual offenses investigation teams under Project Sapphire, which was founded in 2001, are made up of officers trained in sexual assault first aid and an inspector whose sole responsibility is to look into major sexual offenses. Within an hour of notifying, a male or female "chaperone" officer gets in touch with the victim. Despite not being a part of the inquiry, the chaperone helps the victim, arranges for a medical test, contacts friends and family and support groups, and, if necessary, arranges for protection for the victim. The chaperone is also in charge of updating the victim on the case's progress. There is always an officer on duty. All front desk staff has received victim-specific communication and response training.	1. Facilitate victim reporting 2. Improve victim services 3. Enhance quality of investigation
Sexual Assault and Child Abuse Team (SACAT)	Australia	Police/ Security	SACAT, a specialized police unit for both adult and juvenile sexual assault, was established in 1988. It seeks to lessen additional trauma for victims and boost their confidence to take part in the court system. Staff members have received specialized training in handling victims delicately. While SACAT was first housed	1. Facilitate victim reporting 2. Enhance quality of investigation

			<p>in its own building, it is now part of a suburban police station that also has other specialized units. A medical suite, bedroom, living room, play area for young victims, and an interview room with video recording equipment are all included in the integrated environment it offers for victims. In order to keep victims informed of changes in their case, a Sexual Assault Victim Liaison Officer stays in touch with them. SACAT investigators undergo specialized training in sexual assault investigation.</p>	
Victim Support Units	Zambia	Police/ Security	<p>The Victim Support Unit oversees efforts to combat gender-based violence, dealing with offenders while also offering victims counseling and support (including the administration of PEP and EC). The units were created in 1994, went into full operation in 1998, and are now present in every province across the nation.</p>	
Victim Protection Units	East Timor	Police/ Security	<p>Victim Protection Units In addition to receiving complaints, these units are authorized to look into incidents including rape, attempted rape, domestic violence, child abuse, child neglect, missing persons, paternity, and sexual harassment. Each of the 13 provinces has one or more Units, which were initially founded in 2000 with UN assistance.</p>	

(Daly, 2011)

2.1.6 One Stop Centers-Definition, Concepts, and Impacts/Effects

The One-Stop Center provides survivors with access to a wide range of services under one roof, including health, psychosocial assistance, legal, and police services (UN Women, 2011).

One-Stop Centers offer survivors multi-sector case management, including welfare, counseling, health, and legal assistance all in one place. Through referral channels, they are connected to the police as well. These crisis centers are often found in hospitals' emergency rooms or as standalone buildings next to another hospital that collaborates with them. These facilities can either keep a core staff with specialists on call or can have specialists on duty. One-stop centers, in contrast to SARTs and SARCs, may concentrate their services on the problem of domestic violence or they may deal with both domestic violence and sexual violence (UN Women, 2013).

Generally speaking, coordinated care models (like the OSC) aim to maximize a multi-sectoral strategy and guarantee consistency in the implementation of fundamental guiding principles in all service delivery initiatives. Coordinated and synchronized care can refer to survivor services that connect sectoral responses inside standalone programs (where health, law enforcement, psychosocial, and legal assistance are all accessible in one place), or that connect sectoral responses through uniform referral pathways between programs (where health care providers, for example, provide a full array of response services within a health setting and then refer the survivor elsewhere for police and legal assistance) (UN Women, 2013).

If "one-stop" is understood to signify a single location where a survivor may receive the complete complement of multi-sectoral remedies, then the word is frequently misused in many development contexts. Many comprehensive care models in post-conflict and development contexts focus on medical care and referral, with some offering additional on-site psychosocial care and/or legal advice. This is in contrast to the SART and SARC approaches where police and legal aid workers are a standard part of the on-site response team. Some OSCs may be imaginatively linked to police in the lack of on-site police personnel (UN Women, 2013).

A more practical alternative to starting coordinated care in humanitarian settings than the resource-intensive SART/SARC-type approaches used in Western contexts that call for a corps of specialized staff operating in a dedicated structure is integrated approaches to medical (and psychosocial) care and referral.

Integrated treatment methods can provide a higher level of care but are less expensive and rely less on the capabilities of the legal and criminal justice systems to be successful. When compared to forensic-based services, which are provided by medical examiners who are affiliated with the police and/or work in criminal justice offices, health-related services may also draw more survivors, particularly in circumstances where working with the criminal justice system is highly stigmatizing or poses security risks (such as when police investigations are done without the consent of the survivor and impunity for perpetrators is the standard norm; or where the security sector is accountable for the abuse) (UN Women, 2013).

Importance of OSC are make victim reporting simpler by helping and encouraging the victim get information, facilitate victims' access to medical examinations, organize support and investigation services, integrate responses to sexual assault, enhance the gathering of forensic evidence, provide victims with medical care, and improve victim care (UN Women, 2013).

2.1.7 One Stop Centers Patients Satisfaction

The majority of service and manufacturing sectors have been focusing on customer happiness for decades. On the basis that patients lack the information and skills to comprehend what is happening inside themselves and between them and the providers, the health care industry is one of the large significant Industry that has excluded the consumer for years. Patient satisfaction surveys enable managers and practitioners in the healthcare industry to pinpoint areas and subjects for service enhancement, which should lead to improved outcomes in terms of both patients' satisfaction with the care they received and their recovered health status. Patient as active participant; responsiveness of services; customization; continuity of care and relationships; lived experience; communication; information; and support are some topics that should be taken into consideration for inquiry. "Keep it simple" is a fundamental guideline for questionnaire development. You should thus restrict your inquiries to the top three concerns related to: (a) the provision of high-quality healthcare; (b) access to care; (c) patient-healthcare organization interactions; and (d) attentive and courteous behavior with patients. (webgate.ec.europa.eu, 2013). 'There is no point providing a health service that is effective and cheap, if no-one wants it,' emphasizing the importance of finding out what patients think about their care⁶ (Anon., n.d.)

2.1.8 Determinant/Associated factors of One Stop Center Patient Satisfaction

Patient experience, reflecting a long tradition of research and policy initiatives which have emphasized the importance of patient-centered care, has become a key component of good quality care. (webgate.ec.europa.eu, 2013). Originally developed by Willis H. Ware and his colleagues (Ware, Snyder, and Wright, 1976), the long form patient satisfaction questionnaire PSQ-III emphasizes six determinants of patient satisfaction. These include general satisfaction, which addresses matters like those that could be improved or those that must be changed. The technical quality factors look at the accuracy of the diagnosis, the patient's risks, the doctors' skill, and general thoroughness. The second factor is interpersonal aspects, such as whether or not it is impersonal or businesslike. Likewise, consider the privacy and respect issues. The third is communication, and this investigation looks at issues with listening and explanation. The fourth, Financial Aspects, looks into whether care was provided without financial hardship and whether or not the bills were substantial or expensive. The fifth evaluates if the time spent with the doctor was of high quality or hurried, or whether it was simply convenient to access them. The final one deals with location accessibility (opening hours, waiting time). Additionally, the questioner included sociodemographic information to help understand which patient groups brought up a particular issue (webgate.ec.europa.eu, 2013). With modifications to fit the setting and include objective questions, this study employed the short form of the patient satisfaction questionnaire PSQ-III.

2.2 Empirical Review

2.2.1 Review and Discussions of similar Research Findings from Abroad

According to a study on multi - sectorial response services (or "one-stop centers") for gender-based violence in Kenya and Zambia, survivors of sexual and gender-based violence (SGBV) believed that medical care provided by OSCs effectively met their health needs, and that hospital-owned OSCs are best suited for helping survivors achieve the widest possible range of health and legal outcomes (Jill Keesbury, 2012). The health facility-based, hospital-owned OSC model is most fitted for attaining the widest range of health and legal results, according to the research. A multidisciplinary team of staff also assures the best health outcomes for survivors and emotional assistance. Other finding include: signing of the police medical report forms should take place within OSCs; OSCs services should include support groups for SGBV survivors; provision of legal services, including legal advice and court preparation, enhances legal outcomes; collection and

storage of forensic evidence by OSCs is critical; integration of medico-legal, psychosocial support and police services in one physical (but not ‘standalone’) location should be promoted; the requirements of child survivors of SGBV have to be well integrated into all levels of OSC services(Jill Keesbury, 2012).

In an evaluation of the prevention and management of gender-based violence in Rawanda, a case study of the Isange One Stop Center, the author suggested that the center take the following into account to ensure its long-term effectiveness (Hakomeza, 2014). Establish victim support groups, create comprehensive training plans, create coordinated awareness-raising campaigns, ensure that office spaces are managed well, establish shelter facilities, hire permanent legal counsel, improve the efficiency of service delivery, and create a map of the community's non-health services (Hakomeza, 2014)

A study titled “The implementation and effectiveness of the one stop centre model for intimate partner and sexual violence in low- and middle-income countries: a systematic review of barriers and enablers” shows that there are a number of obstacles that frequently impede the OSC model from being put into practice as planned and from producing the desired outcome of offering high quality, accessible, and acceptable multisectoral care. Before they can reach their ultimate goal of decreasing survivor re traumatization when seeking care, existing OSCs will probably need deliberate investment to overcome these particular impediments (Olson Rameck, 2020).

2.2.2 Review and Discussions of similar Research Findings in Ethiopia

According to a study titled "Sexual assault cases at a tertiary referral hospital in Department of Obstetrics and Gynecology, Saint Paul's Hospital Millennium Medical College, Addis Ababa, Ethiopia," there are problems with forensic evidence gathering, legal and medical care, and victims' presentations to hospitals are delayed. Therefore, there is a need to have standardized procedures for thorough evaluation and treatment of the survivors. It also says that in order to deliver effective and efficient medical, social, psychiatric, and legal services, a multidisciplinary strategy like a one-stop clinic must be used (Tolu LB, 2020).

Implementing a standardized case management system in the center to identify survivors' needs, inform patients of resources that are accessible, coordinate and advocate for services, and support survivors' recovery by exemplifying a survivor-centered approach in all contacts with survivors. Additionally, a review of the post-rape care services at Gandhi Memorial Hospital Addis Ababa

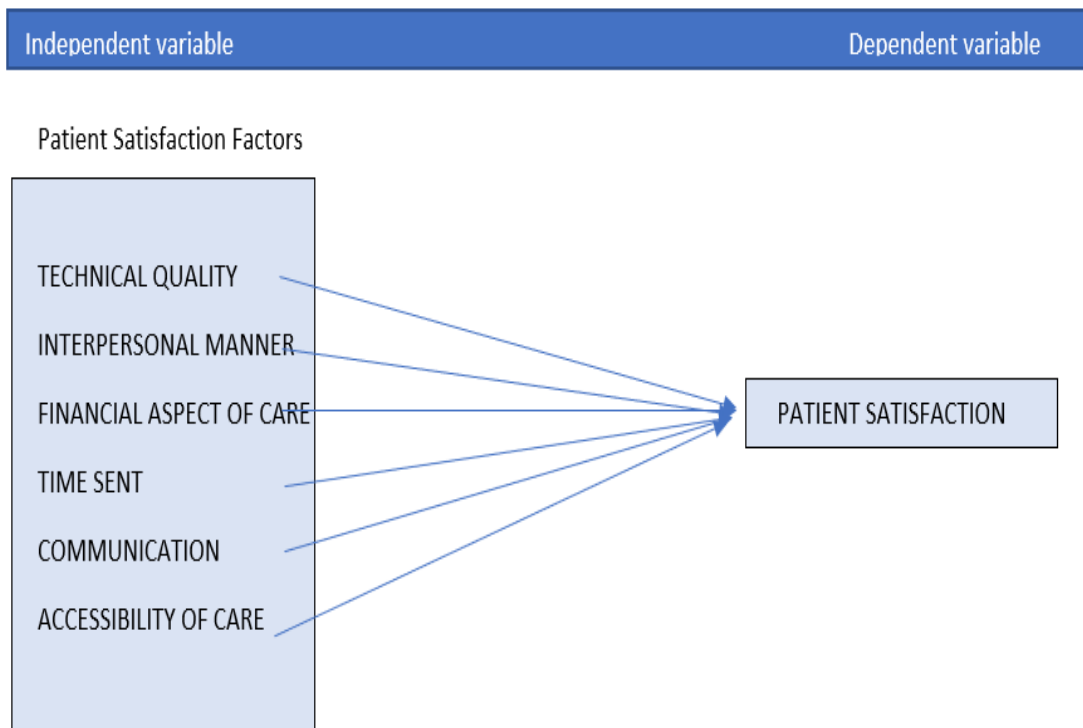
provided various recommendations, including creating a link to peer support groups, women's centers, skill-training programs, and income-generating activities for survivors (Mekonnen, 2019). But the researcher did not find a study regarding the investigation of the satisfaction rate of the patients. Thus, this research will investigate the patient satisfaction rate, and the associated factors (along with challenge in service delivery) for all three OSCs located in Addis Ababa.

2.3 Conceptual Framework

The conceptual framework seen below was used as the guide for the overall research study. It is developed from the literatures (theories and empirical results) discussed above. The logical structure below shows that there is a relationship and influence between variables.

The patient satisfaction factors (general satisfaction (GSAT), technical quality (TECH), interpersonal aspects (INTER), communication (COMM), Financial Aspects (FINAN), and time spent with doctor (TIME)), as shown in the figure below, are adopted from by Willis H. Ware and his colleagues (Ware, Snyder, and Wright, 1976) six determinants of patient satisfaction.

Figure 2. 1 Conceptual Framework



Source: Adopted from (Jill Keesbury, 2012)

3. CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

Chapter 3 documents the research methodology used for this study. Research methodology encompasses our entire approach to research. The chapter is organized into 7 sections as follows: research paradigm, approach, and design; population and sampling; data collection; data analysis; and finally ethical considerations.

3.2 Research Approach, and Design

3.2.1 Research Approach

To better comprehend by attaining information on various levels of conception and to increase the validity of research, this study uses a mixed-mode technique (with inferential quantitative). Both quantitative and qualitative approaches are included in the mixed mode technique.

3.2.2 Research design

The research design is a comprehensive strategy that outlines the techniques and steps to be taken in order to gather and analyze the necessary data (Zikmund, 2000). A research design can be either descriptive, correlational, explanatory, or exploratory depending on the aims. Since this study involves the assessment of patient's satisfaction level in OSCs, Addis Ababa, Ethiopia and factors affecting it, it therefore constituted descriptive and explanatory research.

3.3 Population and Sampling

This study's target population are patients visiting the OSCs during the period of the study. It is the only population that is considered. As per the rapid assessment conducted initially, an average of two to three GBV victims visit each of the 3 OSCs in Addis Ababa, Ethiopia (namely: Gandhi Memorial Hospital OSC, Menelik Hospital OSC, Tirunesh Beijing hospital OSC).

3.3.1 Sample Design

Convenience non-probability sampling technique is what is used -for when unit of analysis were patients (quantitative part) and purposive non-probability sampling technique is used for when staff were unit of analysis (qualitative part); six, two from each OSC respondent were interviewed accordingly.

3.3.2 Sample size

The aim of the sampling is to make a conclusion about the general population; this study aims to do so by using Robert slovin's formula. (sample size (n) = $N / (1+Ne^2)$) (Slovin, E., 1960). Considering e=10% error and total population N to be 3240 (3 patients average per day* 360days*3 OSCs) we get 97 number of patients to be the overall sample size from all 3 OSCs.

3.4 Data collection

The two forms of data to be taken into consideration while choosing the data collection method are primary and secondary data. The primary data are those that are gathered for the first time, making them original by nature. Secondary data are those that have already been gathered and subjected to the statistical process by another party. For when the unit of analysis is patients this study collected primary data with questioner. The questioner is modified but originally it is the short form patient satisfaction questionnaire PSQ-III- developed by Willis H. Ware and his colleagues (Ware, 1976); it asses the satisfaction rate (the dependent variable) using one direct, yes or no questions (result then expressed) in percent and asks different question to asses which independent variable (technical quality (TECH), interpersonal aspects (INTER), communication (COMM), Financial Aspects (FINAN), and time spent with doctor (TIME)), affects the dependent variable (satisfaction). For when 'staff' are unit of analysis, this study collected primary data using interview.

3.5 Method of Data Analysis

Software for Statistics and Data Science (STATA) is used to conduct relevant statistical analysis of the survey results. The main reason STATA was chosen was due to its track record of success as a highly regarded software tool for statistical analysis in the social sciences and other research fields. Both descriptive and inferential methods of data analysis is used for this study. Frequency, percentile and crosstabulation was used for descriptive analysis and ordered logit model was used to do inferential statistics, ordered logistic regression (ologit) in specific (as the dependent variable is measured in ordered Likert scale) is used to find out the significant independent variable.

3.6 Scale Reliability and Validity

3.61 Reliability of the Research

Reliability is the reparability of the study. If the study is having a stable measure, then the results should be alike. It is concerned with measurement consistency, which is the idea that survey questions used in research always provide the same kind of data under the same circumstances. (Golafshani, 2003). Cronbach alpha was used to evaluate the questionnaire's internal consistency for this sample. The Cronbach Alpha test developed in 0.8161 (alpha greater than 0.7 is valid for questions greater than 10) which means the questionnaire is reliable.

3.62 Validity of the Research

For this study, a modified version of the standardized questioner namely PSQ-III, developed by Willis H. Ware and his colleagues (Ware, 1976). Moreover, the questionnaire was sent to an adviser, a candidate respondent, a variety of people, and researchers to determine if it was clear and simple to comprehend and could gather the necessary information. Thus, the findings of this research can be considered valid.

3.7 Ethical Considerations

The researcher considered the ethical duties owed to the patients and professionals whose responses were used in this study. It was kept private and used only for academic research. Without being threatened, survey takers were free to decline to answer any questions they deem inappropriate. The anonymity of the responses was guaranteed to the respondents. Furthermore, the researcher received an ethical clearance from Addis Ababa City Administration Health Bureau (AACAHB) after critical review of the proposal.

3.8 Dissemination plan

The researcher aims to distribute the research findings to all three OSCs (Gandhi Memorial Hospital OSC, Menelik Hospital OSC, Tirunesh Beijing hospital) and Addis Ababa City Administration Health Bureau (AACAHB) in print and CD format.

4. CHAPTER FOUR: RESULT AND DISCUSSION

4.1 Introduction

In this chapter the data that has been collected is reported and continuatively the outcome of the analysis is presented. On the first section, after the description of demographic profile of the patients, the perpetrator, and the case; result regarding: services provided by the three OSC, satisfaction rate towards the five aspects/factors (technical quality, interpersonal manner, financial, time spent, communication, accessibility), relationship between these 5 factors and the overall satisfaction level and results from the interview will be presented. On the second section, the result will be thoroughly discussed along with findings of another research.

4.2 Descriptive Analysis Result

4.2.1 Demographic profile of sample

Table 4. 1 Demographic profile of sample

Variable	Response	Frequency	Valid %
Sex	Male	3	3.41
	Female	85	96.59
Age	Children 0-14 years	35	39.77
	Youth 15-24 years	48	54.55
	Adults 25-64	5	5.68
Marital status	Single	80	90.91
	Married or domestic partnership	5	5.68
	Divorced	2	2.27
	Widowed	1	1.14

Education Qualification	Child	8	9.09
	Elementary	13	14.77
	High below 12	50	56.82
	High school 12 matriculation	8	9.09
	Technical trade /Apprenticeship	2	2.27
	Bachelor's degree	2	2.27
	Illiterate	5	5.68
Professional or Employment Status	Child	8	9.09
	A student	44	50
	Employed for wages	4	4.55
	Self Employed	4	4.55
	A homemaker	19	21.59
	Out of work, looking for work	6	6.82
	Out of work, but not looking for work	3	3.41
Relationship of perpetrator to survivor	Family Member	5	5.68
	Relative	5	5.68
	Friend	2	2.27
	intimate partner	29	32.95
	Colleague	1	1.14
	Employer	9	10.23
	Neighbor	9	10.23
	Stranger	28	31.82
Sex of the Perpetrator	Male	88	100
Was this case reported within 72 hours of	No	42	47.73
	Yes	46	52.27
Where did the survivor report the case first?	Police Station	35	39.77
	Health center	33	37.5
	OSC	20	22.73

Type of GBV (multiple responses possible)	Sexual assault	13	14.77
	Rape suspect	5	5.68
	Rape	69	78.41
	Early marriage	1	1.14

Source: Own computation from survey data 2022

The response rate of this study was around 97.7%. Out of the 88 sample victims, only 3 were male, the rest were female. Most of them (54.55 %) were youth ranging from age 15-24; around 39% were children aging 0-14, and only 5 sample aged 25-64. As more of them are children and youth, majority of the victims (90%) were also single, only 9% were either married, divorced, or widowed. Matching the information above, the education qualification of most (89.7 %) is below or equal to 12 grades. Out all, samples who had bachelor’s degree were just 2 in number; the others were technical trade /Apprenticeship (2%) or illiterate (5.68%). Consecutively for the most part, victim’s Professional or Employment Status was student, 50%. 5 victims were children that were under 4 years old. 21% were home makers/ house keepings. The rest were employed for wages, self-employed, out of work looking/not looking for work.

All the perpetrators were identified as male. 21.59% of the perpetrator were family member, relative or neighbor. 36.36 % were colleague, intimate partner, or friend. 10.23% were employers, these cases are related with housekeeping victims. The rest of the perpetrators (31.82%) were strangers that had no relation with the victims.

As seen above on the table, 52.27% of the cases were reported within 72 hours. The cases were first reported in police station, health center or OSC. Around 39% were reported at the police station; 33% were reported at the health centers and just 20% were reported straight to the OSCs. The majority (78.41) of the cases reported were rape, 5.68% were rape suspects and 14% were sexual assault. Only 1 was a case of early marriage.

4.2.2 An overview of the services provided at the One-Stop Centers

The type of service given by the OSCs are mainly 3 types: Legal/Police, Medical care, and counseling service. In medical care, the most dominant health care given are emergency contraception (EC), post-exposure prophylaxis (PEP), prophylaxis for sexually transmitted infections (STIs) and vaccination against tetanus and hepatitis; the patient might have to come

after a month for a pregnancy test and after 3 months for HIV test. For legal, the most prevalent service provided is case management. The staff can be a social worker representing the attorney general in which that individual manages the legal case of the patient until ultimate judgement is given by the judge. Police department is concerned about forming the allegations and making cases out of them in court. And as one of the way a GBV patient will need help on is mental health counseling services are given to the survivors. A counselor helps the patient get psychological first aid, if cases need further support, the counselor will refer the patient to the psychiatric department found in the hospital or maybe to a more sophisticated one like Ammanuel hospital.

4.2.2a Clinical and psychosocial support services provided at the various one-stop centers

Table 4. 2 Clinical and psychosocial support services

Services	GandhiMemorial Hospital OSC	TiruneshBeijing General Hospital OSC	MenelikIIHospital OSC
A: Clinical services			
HIV counselling and testing	Yes	Yes	Yes
Provision of PEP	Yes	Yes	Yes
Pregnancy testing	Yes	Yes	Yes
Provision of ECP	Yes	Yes	Yes
Treatment of physical injuries	Yes	Yes	Yes
Forensic examination	No	No	No
Signing of the police medical report form	No	no	No
B. Psychosocial support			
Trauma counselling provided	Yes	Yes	Yes
Referred to off-site safe house	Yes	Yes	Yes
Survivor groups	Yes	No	No

From all three OSC questioners, it was indicated that, if the survivor finished the examination given by the OSC, hospital/health facility records will be available for review. The result, as seen on the table above, shows that all three OSCs offer the following services: HIV counseling and testing, provision of PEP, pregnancy testing, provision of ECP, treatment of physical injuries and trauma counselling. And all three OSC don't give forensic examination thus don't have the police medical report as well. Rapid Plasma Reagent (RPR) test for syphilis and high vaginal swab (HVS) conducted to detect presence of sperm are also some of the tests/medical checks done for the partner.

In scenarios where the victims cannot go back to their original house because of the violation or any other financial reason, all three OSC give referral to safehouses for temporary sheltering. In addition, Gandhi Memorial Hospital OSC, hosts survivor's group/network counseling occasionally.

4.2.2b Police/legal services offered by the different OSC models

Table 4. 3 Police/legal services

Services	Gandhi Memorial Hospital OSC	Tirunesh Beijing General Hospital OSC	Menelik III Hospital OSC
A: Police			
Statement-taking from survivor	Yes	Yes	Yes
Statement-taking from others	Yes	Yes	Yes
Did the police physically visit the crime scene	No	No	No
Collection of forensic evidence	No	No	No
Arrest of the perpetrator	No	No	No
Issuing the police medical report form	No	No	No

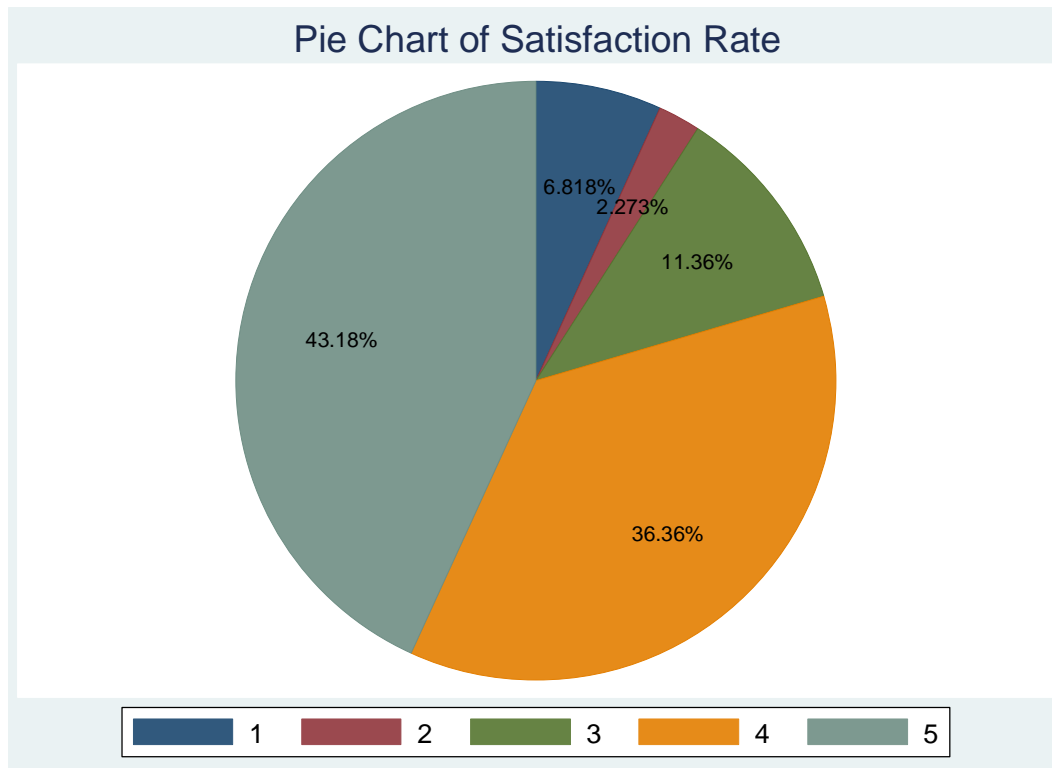
B: Paralegal

Opening a docket	Yes	Yes	Yes
Legal advice provided	Yes	Yes	Yes
Court preparation provided	Yes	No	No

The main service given by police is statement taking from the patient and others; others that come along with the survivor, especially when minor. The police at the OSC neither visit the site, nor collect forensic evidence; thus, do not have police medical report form. All the process after statement taking is done by police station. The Police at the OSC may arrest perpetrators that are caught red handed in the action/violation. Regarding the legal wing, statement taking along with the police and legal advice giving are some of the services provided. In addition, in Gandhi Memorial Hospital OSC, Court preparation is also provided.

4.2.3 Overall satisfaction on OSC services

Figure 3. 1 Overall satisfaction



As seen on the chart above 43.18% of the survivors stated that they were very satisfied with the services and 36.36 % stated they were satisfied, overall, around 80% of the survivors stated that they were either satisfied or very satisfied. Around 11.36 % said they felt neutral about the service given. 2.21% and 6.81% stated they were unsatisfied and very un-satisfied with the service respectively.

4.2.4 Crosstabulation Analysis

Cross tabulation analysis is a statistical method used to see the relationship between two categorical variables; for all indexes of dimensions of OSC (0-1), those that ranked greater than or equal to 0.5 were categorized as satisfied and the rest as unsatisfied. Consecutively, those that rated their satisfaction below 2.5 were considered unsatisfied and those equal to or higher were considered satisfied. The Cross tabulation is used to see if there is a relevant relationship between the dependent variable and the other variables. For the crosstabulation made, if their pr value is less than 0.1 it means the relationship is significant. The result obtained here will also be compared with the econometrics result later.

4.2.4a Crosstabulation with chi squared test between the overall OSC service satisfaction and satisfaction on the dimensions of OSC service

Table 4. 4 Crosstabulation

Dimensions of OSC service satisfaction	Overall satisfaction on OSC service
	pr
Technical Quality	0.85
Interpersonal Manner	0.85
Financial Aspect	0.02***
Time Spent	0.577
Communication	0.85
Accessibility of care	0.505

Source: Own computation from survey data 2022

***The correlation is significant at morlevel

As seen table above, dimensions like technical quality, interpersonal manner, time spent with the service provider, communication and accessibility of care didn't significantly affect the satisfaction of the survivors. But as for the financial aspect of the care, as presented below, had significant effect on the overall satisfaction level of the survivors on the OSCs services (with $p < 0.1\%$). You can see below that all that concluded that they were very unsatisfied with the OSC also said that they were not comfortable with financial aspect of the care.

4.3 Econometric Analysis Result

Here, we will observe to what extent independent variable/s affect/s the dependent variable. Accordingly, regression model called ordered logit model was used; the reason this model was applied is because the dependent variable of this study is 5-point Likert scale which is, ordered categorical variable.

4.3.1 Bivariate analysis of independent variables with overall satisfaction level

Table 4. 5 Econometric Bivariate Analysis

Variables	COR	P>t	95% Conf. Interval	
Technical Quality	81.58	0.002	4.41778	1507
Interpersonal Manner	6.685	0.156	0.4848	92.19
Financial Aspect	0.848	0	0.02855	0.252
Time Spent	8.65	0.014	1.5498	48.36
Communication	25.96	0.05	0.9942	678.3
Accessibility of care	8.97	0.001	2.55	31.52

Source: Own computation from survey data 2022

As seen on the table above all factors considered have p value of < 0.25 in bivariate regression. Thus all 6 variables are considered for the multivariate regression model.

4.3.2 Multivariate analysis of independent variables with overall satisfaction level

Table 4. 6 Econometric Multivariate Analysis

Variables	AOR	P>t	95% Conf. Interval	
Technical Quality	4.93	0.516	0.0398	610.6
Interpersonal Manner	0.48	0.677	0.1534	15.06
Financial Aspect	0.15	0.002	0.0465	0.489
Time Spent	2.56	0.446	0.2279	28.76
Communication	7.49	0.264	0.2187	256.76
Accessibility of care	6.25	0.007	1.6515	23.63

Source: Own computation from survey data 2022

Prob >chi2 value is less than 10% thus the model fits well. Two variables have significant influence on the overall satisfaction: namely the financial satisfaction and accessibility of care. For a one unit increase in financial satisfaction (a variable that measure the satisfaction level of the survivors towards the financial cost of the care proved by the OSC), the odds of high overall satisfaction versus the combined middle and lower overall satisfaction categories are 0.15 times greater, given the other variables are held constant in the model. Furthermore, for a one unit increase in financial satisfaction (a variable that measure the satisfaction level of the survivors towards the financial cost of the care proved by the OSC), the odds of high overall satisfaction versus the combined middle and lower overall satisfaction categories are 6.25 times greater, given the other variables

are held constant in the model. The regression had cut points 0.5, 0.9, 2, and 4; indicating where the latent variables cut to make the five groups that observed in the data.

4.4 Interview Result

All three OSC give 24 hours, seven days a week free service. Nevertheless, while operating 24 hours, not all staff are present. Counselors, represented from attorney general and the case manager work office hours, at Menelik II Hospital OSC, police representatives also work office hours; it is just the doctors, nurses, laboratory, pharmacy, and police (at Gandhi Memorial Hospital OSC Tirunesh Beijing General Hospital OSC) that work 24hrs, 7days, including holidays. Gandhi Memorial Hospital OSC used to have a 24-hour phone line, but it is not active anymore.

Aside from the response activities that they do, the OSC also try to contribute to prevention activities by being an active participant in interviews and media programs; but the respondents also stated that it was not enough. The OSC has a Standard operating procedure, nonetheless, it is not fully implemented. When the case manager position is occupied and is active, case conference is held every 2 weeks or a month. On the conference, cases are presented, and updates are given until cases are closed. The OSC is co funded by the different sectors including the hospital, police, and attorney general; each sector covers the salary of its representative but the equipment, and administrative staff are covered by the hospitals. Some NGOs also donate and contribute to the OSCs. Other than the administration staff, the staff composition of the OSC includes police-that take statement, attorney general -that does case management and statement collecting along with police, doctors, nurses, psychologists, and social workers that does the counseling. Furthermore, laboratory technicians and pharmacist do give services to the OSCs.

The respondents stated that the OSC are very helpful. Receiving all the services mentioned above confidentially at one place is extremely useful for a person that has been through violence. In addition, the service being free highly benefits those that have lower/no income source. They stated that case numbers have increased tremendously through time indicating that the community has accepted the OSCs and advocated about it. Even said, there are still areas that could use work, despite the center's many positive attributes. The respondents mentioned the following as an improvement point: medicines and laboratory reagents are not always available at the pharmacy thus patients might be obligated to buy the medicines or get laboratory results from outside the hospitals with an expensive price. Furthermore, though all services provided including pharmacy

and laboratories are free, patients necessitate more; for example: clothing, transport money to get the free counseling treatment, cash support to different emergency needs and so on. Aside from the 72 hours shelter the OSCs give, safehouses are available; Survivors that need protection and are not financially capable are referred to these safe houses. Though, getting into the safehouses might not be as easy. In addition, safe house admitted patients may not be permitted to leave, until the case is followed by the police and closed, which the patients may not be interested in as they mostly want to go back to work/school as soon as possible.

Moreover, less awareness in the society regarding counselling was mentioned as a challenge; victims rather come to the one stop centers just for medical attention-thus some patients don't finish the needed counseling. Also, victims that come to the OSCs speak different language, but employees only speak Amharic thus translators might be necessary. More trainings, all staff being 24 hours 7 days being present, recruiting more numbers of counselors so staff are not burnt out are the further recommendations received from the respondents.

4.5 Discussion

One of the major objectives of the study was to identify patient's level of satisfaction on the service of the OSCs located at Addis Ababa, Ethiopia during 2022. The study showed high level (with over 80% of the sample being satisfied or very satisfied) of patient satisfaction towards the OSCs services. This finding complements with the findings of (Jill Keesbury, 2012). According to the study on multi - sectorial response services (or "one-stop centers") for gender-based violence in Kenya and Zambia, survivors of sexual and gender-based violence (SGBV) believed that the care provided by OSCs effectively met their health need. In the case of this particular study, during the interview, it was indicated by the respondents that this high satisfaction possibly comes from the fact that survivors receive all the services for free in a confidential manner at one place. Furthermore, it was stated that the OSC benefits the survivors in a different manner. They won't spend a lot on transportation, make reporting easier for victims, make medical examination easier for victims, coordinate investigation and support services and many more. The second objective of the study was to identify factors that influence the satisfaction of patients on the OSCs. With this study, it was found that certain factors such as financial aspect and accessibility, contribute to increase over satisfaction. As per the interview, patients that come to the OSCs are financially very challenged thus find it very difficult to cover for any medicines and laboratory test (not accessible at the center for free at the time). The respondents mentioned that low-income reason also explains

the case of accessibility. Because there are only 3 OSCs in Addis Ababa, Ethiopia, patients can travel long way to get there and can be costly.

The third objective was to assess the challenges in the services provided by the OSCs. The study found several challenges that need to be addressed. Absence of forensic team, absence of support group, not enough training, certain staff not being available on 24 hours, missing medicines and laboratory reagents, and the lack of additional financial contribution for clothing, transport money to get the free counseling treatment, cash support to different emergency needs are one of the challenges noted. Moreover, less awareness in the society regarding counselling, language gap between victims and the staff, less numbers of counselors working in shift- which leads them to being burnt out are the further challenges captured from this study. The findings on this objective is supported by the findings of (Mekonnen, 2019), on the study titled ‘ a review of the post-rape care services at Gandhi Memorial Hospital Addis Ababa’, which stated that creating a link to peer support groups, women's centers, skill-training programs, and income-generating activities for survivors are some of the area the OSC should work on. Furthermore, a study by (Tolu LB, 2020), titled "Sexual assault cases at tertiary referral hospital in Department of Obstetrics and Gynecology, Saint Paul's Hospital Millennium Medical College, Addis Ababa, Ethiopia," stated that there are problems with forensic evidence gathering in the center.

Similarly, in an evaluation of the prevention and management of gender-based violence in Rawanda, a case study of the Isange One Stop Center, the author found that the center is challenged in establishing victim support groups, creating comprehensive training plans, creating coordinated awareness-raising campaigns, hiring a permanent legal counsel and suggested to be improved to increase in efficiency of service delivered.

5. CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATION

5.1 Introduction

This chapter will conclude the study and suggest recommendations. Additionally, the section will include limitation of the study.

5.2 Conclusion

The findings of this study demonstrated that more than 80% of the patients were satisfied with the services provided by the OSCs, providing preliminary evidence that OSCs are giving a good service. Factors that contributed to increased patient satisfaction included accessibility of care and financial confidence. Major obstacles to the OSC's ability to deliver high-quality services by sector include the following. Police: lack of a forensic team; medical: lack of medications and lab reagents; counseling: lack of a support group for the survivors; overall: inadequate training, certain staff/sectors not working 24 hours, and lack of cash support for various emergency needs.

5.3 Recommendation

Based on the findings of the study, the following recommendations are forwarded.

5.3.1 Recommendations for practice

- a. Further OSCs should be available: there are only 3 OSCs in Addis Ababa, a city with over 5 million population. This study noted that patients had major financial challenge; including finance to get to the OSCs. If more OSCs are available victims won't be obligated to travel long distances. Thus, more OSCs should be available in Addis Ababa.
- b. Help survivors financially/ provide job opportunity: the OSCs should work on providing multipurpose cash for those that need financial assistance and try to work in linkage with those that can provide a job opportunity after they recover
- c. Establish support groups for victims: the One Stop Centre along with psychologists, administrative personnel, and social workers should work on coming up with a clear strategy in

setting up support groups support the victims themselves to overcome the psychological trauma caused by GBV. Compared to individual psychotherapy or long-term, support groups are a low-cost option and more extremely crucial.

d. Help survivors financially/ provide job opportunity: the OSCs should work on providing multipurpose cash for those that need financial assistance and try to work in linkage with those that can provide a job opportunity after they recover.

e. Have good stock of medications and lab reagents: the OSC should try to have plenty of stock of medications and lab reagents for the OSC as the findings indicate that the victims that come there don't usually have cash to get medication and laboratory result from outside.

f. Hire a translator: it was stated by the staff that one of the challenges were language. As there are only 3 OSCs, victims of GBV come from all different regions speaking different language and the center currently provides all services in Amharic language. Consecutively, to bridge this gap it is best if the OSC can hire a translator for the centers.

g. Develop a thorough training plan: the One Stop Centre long with concerned parties should with should produce a clear-cut training schedule with a training curriculum and other conditions for each sector of staff of the center.

h. Hiring a permanent staff from all sectors: The center must make the advocacy to the Ministry of Health, Police, and Justice to have a permanent respective staff all three sectors at the OSC. These staff should work in shift for 24-hour seven days in order to fully support the victims of GBV.

i. Have crime site visit and forensic team in place: The center must make advocacy to the Ministry of Police to do crime site visit and forensic analysis to support the cases of the victims within police at the OSC.

j. Develop a coordinated and robust awareness- the One Stop Centre and along with other stakeholders should do a comprehensive awareness raising activities to also work on prevention wing of GBV (rather than just response). There should be a short and long-term strategy and clear program.

5.3.2 Recommendations for further study

It is necessary to conduct further study and periodic evaluation of OSC services, particularly from the user's satisfaction viewpoint. The next study should consider making the data collectors from outside the OSCs to avoid biases.

5.4 limitation of the study

- For patient's underage, adults with them made the feedback thus may not reflect the patients purpose opinions
- Data collectors wearing part of the OSC thus might have resulted in some bias

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Annex
Annex1: Questionnaire

Name of the OSCs _____

Date _____

DEMOGRAPHIC DATA

Age of survivor: _____

Sex:

Male Female

Highest educational qualification *c*

High school—below Year 12 or equivalent

High school year 12 (matriculation)

Technical trade training or apprenticeship

Certificate/Graduate Certificate

Bachelor degree

Master's degree

Doctoral degree

Other qualification

Marital Status

Single, never married

Married or domestic partnership

Widowed

Divorced

Separated

Professional or Employment Status

Employed for wages

Self-employed

- Out of work and looking for work
- Out of work but not currently looking for work
- A homemaker
- A student
- Military
- Retired
- Unable to work

Section 1: General Question

- Was the OSC easily accessible? Yes No
- Was this particular case reported to the OSC within 72 hours of assault? Yes No
- Date when this particular case was first reported to OSC? _____
- Was this the first time the survivor reported any assault to this OSC? Yes No
- Where did the survivor report the case first? _____
- Type of GBV (multiple responses possible)
- Rape Defilement Physical Violence (non-sex) Property grabbing Record does not indicate Emotional abuse Early marriage Child neglect Child abuse (non-sexual or physical) Child support Other Specify _____
- Sex of perpetrator Male Female
- Relationship of perpetrator to survivor
- Rate your satisfaction level with the services you have received from one stop center.
- Very unsatisfied Unsatisfied Neutral Satisfied Very satisfied

Section 2: Medical Information

- Did survivor change clothes/bath following GBV? Yes No
- Was any clothing or debris collected from survivor's body as evidence? Yes No
- Is there a copy of the signed police medical report in the file? Yes No
- Was a pregnancy test (Gravidex) conducted? Yes No
- Was a Rapid Plasma Reagent (RPR) test conducted for syphilis? Yes No
- Was a high vaginal swab (HVS) conducted to detect presence of sperm? Yes No
- Are hospital/health facility records available to review? Yes No
- Was an HIV test conducted? (Elisa/Determine tests) Yes No
- Was PEP given to survivor? Yes No
- Was the emergency contraception pill (ECP) given to survivor? (Postinor-2, microgynon, COC=combined oral contraceptives) Yes No
- Did survivor experience physical violence? Yes No

- What type of physical violence was experienced? _____
- Did the survivor receive ANY medical treatment for the physical violence (i.e. antibiotics, sutures, ID=drainage, TT= tetanus toxoid, pain relief or analgesic (panado), Hepatitis B) Yes No
- Did the doctor's office have everything needed to complete medical care? Yes No
- Did you feel confident about the diagnosis of the doctor? Yes No
- Did you feel confident about the service given of the doctor? Yes No
- Did the doctor treat you nicely with courtesy? Yes No
- Did the doctor's/ service providers explain about the reason for the tests to be made? Yes No
- Doctors sometimes ignore what I tell them? Yes No
- Did the financial aspect of the care set you back from receiving care confidently? Yes No
- Did the doctor give you enough time? Yes No

Section 3: Police/Legal Services

- Did a VSU officer meeting with the survivor during the FIRST visit to the OSC? Yes No
- Did a paralegal officer meet with the survivor during the FIRST visit to the OSC? Yes No
- Was a docket opened? Yes No
- Did the police take a statement from the survivor? Yes No
- Did the police take statements from at least 1 other witness? Yes No
- Did the police physically visit the crime scene? Yes No
- Did the police collect at least 1 piece of evidence from the crime scene? Yes No
- Did the police arrest the perpetrator? Yes No
- Did the survivor receive at least 1 session of pre-court counseling from the paralegal? Yes No
- Did you feel confident about the service given by the police/legal person? Yes No
- Did the police/legal person treat you nicely with courtesy? Yes No
- Did the police/legal person ignore what you told them? Yes No
- Did the financial aspect of the legal service set you back from receiving care confidently? Yes No
- Did the police/legal person give you enough time? Yes No

Section 4: Psychosocial support

- Did a counselor meet with the survivor during the FIRST visit to this OSC? Yes No
- Was the survivor referred to a safe house or shelter (e.g. CIC or women's shelter)?

- Was the survivor referred to a survivor’s group/network? Yes No
- Did the survivor attend at least 1 survivor’s group meeting? Yes No
- Did you feel confident about the service given of the counselor? Yes No
- Did the counselor treat you nicely with courtesy? Yes No
- Did the counselor explain about the reason for the tests to be made? Yes No
- Did the counselor ignore what you tell them? Yes No
- Did the counselor give you enough time? Yes No
- Did the financial aspect of the care set you back from receiving care confidently? Yes No

Section 5: Follow-up care

- Was the survivor requested to return to the OSC for follow-up care? Yes No
- Did the survivor return to the OSC at least 1 time for follow-up care? Yes No
- What is the number of follow-up visits recorded? _____

Annex2: Interview Tool

I. Interview guide for OSC health care providers

1. What hours does the One Stop Centre operate? Opening time, closing time, working days
2. How many full times staff works at the One Stop Centre?
3. On public holidays during what hours does this One Stop Centre operate?
4. Does the One Stop Centre have a 24-hour phone line?
5. What services are provided at the One Stop Centre? -Clinical services, police, paralegal, psychosocial support, etc.?
6. What categories of gender-based violence does the One Stop Centre handle?
7. Tell me if victims of gender-based violence at the One Stop Centre have support groups: - Approximately how many were held each week?
8. What do you think are the benefits of providing gender-based violence care at the One Stop Centre?
9. For you, what have been the principal achievements that you have seen or experienced since the time you are here? Do you have any recommendations moving forward?
10. How do you perceive the results produced by the One Stop Centre?
11. Most of the patient answered that they were satisfied with the eservice they have gotten, why do you think that is?
12. From all the 6 factors assessed, accessibility of care and financial aspect are the only factors that are found to affect the level of patient satisfaction, please provide your feedback on this.

II. Interview guide for OSC administrative personnel

1. What types of professional (Staff) does the One Stop Centre have?
2. How is the One Stop Centre funded?
3. What kind of protocols does the One Stop Centre utilize? Is there a flow chart or other written guidelines?
4. How is the center managed on a day-to-day basis? Are there regular implementation meetings? If so, who attends?
6. Does the One Stop Centre offer follow-up to victims of gender-based violence?
7. How satisfied are you with the quality and consistency of services provided to victims at the center? What do you see as its primary benefits and primary challenges? How could services be strengthened?
8. What kind of outreach/prevention activities are you involved in at this center?
11. Most of the patient answered that they were satisfied with the eservice they have gotten, why do you think that is?
12. From all the 6 factors assessed, accessibility of care and financial aspect are the only factors that are found to affect the level of patient satisfaction, please provide your feedback on this.