EXPERENCES OF WOMEN SURVIVORS OF GENDER-BASED VIOLENCE WITH SURVIVOR-CENTRED APPROACH, A CASE OF ASSOCIATION FOR WOMEN'S SANCTUARY AND DEVELOPMENT (AWSAD) ETHIOPIA

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DECLARATION

This research paper is my original work and has not been submitted for examination in any other university.

Signature________________ Date_______________

Lemma Selamawit Mengistu

N69/77284/2015

This research paper has been submitted for examination with my approval as the university supervisor.

Signature_________________ Date_______________________

Dr. Dalmas Omia.

DEDICATION

To the women who are suffering in silence, my husband George, my son Kidus , my parents Ato Mengistu and W/o Mulu and my sister Beza,

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ABSTRACT

This is a cross sectional descriptive study on experiences of women GBV survivors with survivor –centered approach while receiving care and support at AWSAD in Addis Ababa, Ethiopia. The study examined the services women GBV survivors receive, survivors' perception of safety and security, participatory, confidential and non-discriminatory nature of the services as well as the challenges survivors encounter while receiving services at AWSAD. The study reached 22 women GBV survivors. Data was obtained through semi-structured interviews, case narratives and key informant interviews and analyzed thematically in line with the specific study objectives. The human rights- based approach theory stating that women GBV survivors are the determinate factor of an effective response intervention guided the study. As such, the survivors hold fundamental human right to decide what is acceptable and what is not hence imposing duty on service providers to uphold survivor's right to opinion, choice, and decision-making power, access to quality service, information and safety in an empowering, non-discriminative, legal and accountable manner. The findings indicate that women survivors of gender based violence suffer physical, mental, economic and social consequences following abuse. Therefore, they require survivor-friendly comprehensive services to adequately address their needs. AWSAD provides a holistic service (i.e. clinical care, psychosocial support, legal follow-up e.t.c) for women survivors of gender based violence at the shelter and outside through referral network with the government and other service providers. Majority of the women survivors of GBV are able to access medical/clinical care both at the shelter and other health centers, counseling support, legal follow-up and vocational training. Women survivors of GBV are empowered through the participatory and confidential counseling, skill development training and accommodation services that appreciate and value their idea, decision and action. That enables them to take part on their recovery process by naming their needs, addressing their problems and move on from their abuse in an environment where they no longer feel fear, shame or stigma. Some women GBV survivors however face challenges in accessing counseling service, legal support and vocational trainings due to language barriers, un-engaging attitudes of particular service providers at the shelter, inexperienced investigation skill of the police and delay of justice on the side of the judiciary. The study concludes that providing survivor-friendly intervention for women survivors of gender based violence is vital for a successful recovery as survivors-centered service restores the agency of survivors hence they are able to voice their concerns and desires in shaping their pathway to recovery. AWSAD holds the front line in outspreading internationally acclaimed survivor-centered response intervention to women GBV survivors in Ethiopia, it is therefore commended that the government works with AWSAD to better comprehend obstacles women face in accessing justice and fortify the coordination between AWSAD and different government sectors like that of health , justice , education and financial sector to adequately address the health, legal, education and economic needs of women GBV survivors. The study also proposes survivor-centered model comprehensive service to be provided by all rehabilitation and reintegration service centers. The study finally recommends strengthening of psychological care into comprehensive service to respond to the overlooked psychological effects of GBV on women survivors of GBV.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AWSAD	Association for Women's Sanctuary and Development
CEDAW	Convention on the Elimination of Discrimination against Women
DEVAW	Declaration on the Elimination of Violence against Women
EDHS	Ethiopian Demographic and Health Survey
FGC/M	Female Genital Cutting/ Mutilation
FIGO	International Federation of Gynaecology and Obstetric
IGA	Income Generating Activity
GoE	Government of Ethiopia
HIV	Human Immunodeficiency Virus
HRBA	Human Rights Based Approach
MEL	Monitoring, evaluation and Learning
MOH	Ministry of Health
MOJ	Ministry of Justice
MOWCYA	Ministry of Women, Children and Youth Affair
SCA	Survivor Centred Approach
SGBV	Sexual and Gender Based-Violence
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
SV	Sexual Violence

UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
VAW	Violence against Women
WB	World Bank
WHO	World Health Organization

CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Gender-based violence (GBV) is an umbrella term for any harm that is perpetuated against a person's will and the result from power inequalities that are based on gender role (Holmes & Bhuvanendra, 2014). There is no single definition for gender–based violence. However, countries and researchers use the definition given by the UN declaration on the elimination of violence against women (DEVAW) in which gender-based violence (GBV) is defined as "*Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women*" (UN, 1993:19). Such violence also extends to deprivations of liberty/denial of freedom, whether these acts occur in public or in private life. The Fourth World Conference on Women in its Beijing Platform included forced sterilization, forced abortion, coercive or forced contraceptive use, female infanticide and prenatal sex selection, women's human rights violations in situations of armed conflict particularly murder, systematic rape, sexual slavery and forced pregnancy-in to the compass of gender-based violence (UN, 1995: Art.113-117).

Gender-based violence can occur throughout a woman's lifecycle, and can include everything from sex-selective abortion, early childhood marriage and genital mutilation, to sexual abuse, domestic violence, legal discrimination and exploitation (UNHCR, 2003:16-18). This demonstrates that GBV violates human rights standards enacted under international human rights instruments, including the right to life; the right to security of person; the right to bodily integrity; the right to the highest attainable standard of physical and mental health; and the right to freedom from torture or cruel, inhuman, or degrading treatment (Terry, 2007:14).

Most of the GBV experienced by women and girls are usually perpetuated by their family members, close relatives and loved ones (UN Women, 2012). A multi-country demographic and health survey report on domestic violence shows that more than 40% of women in Bolivia, Cameroon, Columbia, Kenya, Peru and Zambia have ever experienced violence by spouse or partner (Population Reference Bureau, 2010). WHO (2013) estimates that nearly one-third (30%) of all women worldwide who have ever lived in a relationship have experienced physical and/or sexual violence from an intimate partner. Out of all women who experienced physical and/or sexual violence by an intimate partner, 42% experienced injuries. According to UNODC (2014) while more women do represent about 20% homicide victims worldwide, they make up almost two thirds of all persons killed by an intimate partner and other family members while UNFPA estimates that the annual worldwide number of 'honour killing' victims may be as high as 5,000 women (UNFPA,2014).

In the United States, more than one in three women have experienced rape, physical violence and stalking by their partner. Nearly one in five women have been raped at some point in their life time and 51% reported for having been raped by their intimate partners while 40.8% by an acquaintance. On the other hand one in six women have been stalked either by either current or former intimate partner which left them fearful or in belief that they or someone close to them would be harmed or killed (Black et al., 2011:15-29). On a typical day, domestic violence hotlines nationwide receive approximately 20,800 calls (National network to End Domestic Violence, 2015).

Women and girls who encounter gender based violence face serious consequences ranging from fatal outcomes, such as homicide, suicide and AIDS-related deaths to non-fatal outcomes such as

physical injuries, chronic pain syndrome, gastrointestinal disorders, and complications during pregnancy, miscarriage and low birth-weight of children (Bott et al., 2005). Pregnancy is among the leading causes of death for girls aged 15-19 worldwide. Girls younger than 15 years of age are five times more likely to die in child birth than women in their 20s (Morris & Rushwa, 2015:42). GBV also poses significant cost on the economies of developing countries, including lower worker productivity and incomes, and lower rates of accumulation of human and social capital (IRC, 2014).

Violence against women and girls in Ethiopia is widespread, with regional variations. A multi – country study conducted in one of the provinces revealed that the country had the highest percentage of physical assaults of all 22 countries surveyed across the world, 71% of women in Ethiopia reported physical and/or sexual violence by an intimate partner in their lifetime (WHO, 2005). The 2011 Ethiopian Demographic and Health Survey conducted by the Central Statistics Agency indicate that the median age at first marriage for women is 17.1, which is below legal the age of marriage that is 18 years. One UNICEF (2013) study shows that 41 % of girls in Ethiopia are married before age 18 and 74% of women have undergone female genital mutilation.

The government of Ethiopia recognizes GBV as a public health problem, a human rights violation, and an impediment to development (MoWCYA, 2013). Therefore, it has adopted, ratified and further revised various legislation and policy documents specifically addressing violence against women. Notable among these are: the 1995 Constitution of Ethiopia, the 2000 Revised Family Law and the 2005 Revised Criminal Law. The government's commitment to gender equality and to combat violence against women is also translated in various policies and

such as the 1993 National Policy on Women, the 2006 Ethiopian Women's Development and Change package, the 2009 Strategic Plan for an Integrated and Multi-sectoral Response to VAWC and Child Justice in Ethiopia focusing on prevention, protection and response mechanisms and the 2013 recently adopted National Strategy on Harmful Traditional Practices (MoWCYA, 2013). The legal and policy frameworks criminalize all acts of violence against women including all forms of harmful traditional practices and provide sanctions for their practice (UN Women, 2013).

Women and girls who are survivors of GBV need access to a full range of multi-sectoral services and responses that respond to both their immediate and their long-term needs (CARE, 2013). The GoE established a national coordinating committee in 2008, in recognition of the need for an integrated and multi-sectoral approach which formalized partnership among the different actors of justice, health, social and education sectors to address SGBV from different angles (i.e., prevention, response and support) and at a different level in a systematic and victim/survivor friendly manner. The committee later formed a protocol that guides health professionals, case managers, counsellors, police officers, prosecutors and centre coordinators on how to manage and perform their duties and the behaviour they need to portray while providing service to victims/survivors or handling their cases (Keesbury & Askew, 2010).

1.2 Problem Statement

Caring for women survivors of GBV requires compassionate, confidential and non-discriminatory support system in order for survivors and their family to recover and heal from the devastating impacts of GBV (WHO, 2013). Women survivors of GBV can be affected by the attitudes of the person helping them. Culture and social norms may influence service provider's view towards women and women survivors of GBV and negative reaction from service providers can traumatize and further victimize women survivors of GBV who come to seek support. Therefore, service providers working in service providing agency tasked with the responsibility of case management, health care and legal support are expected to equip themselves with skill and knowledge that will best meet the needs of women survivors of GBV (Keesbury et al., 2010).

In Ethiopia limited numbers of GBV victim recovery centers are established by both government and non-governmental organizations. However, there is a limited documentation on the function, service being offered and the overall impact of these centers. Practical experience with running of shelter is also limited in Ethiopia. Many studies, for example, Population Council and UNFPA (2010), and WHO (2005) have highlighted the increased rate of VAW especially, those aged 25-34 years. Other studies, for example, Abeya et al. (2012) and Boyden et al. (2012) have examined cultural tolerance of violence against women. A few studies, for example, Keesbury and Askew (2010), Amenu and Hiko (2014) and Richards et al. (2014), have highlighted response to GBV by the referral hospitals in Ethiopia. While the latter studies have examined overall treatment and social response to GBV survivors, none of these studies has investigated the implementation of the survivor-centred approach in Ethiopia.

Hence, this study seeks to evaluate the care and support provided at AWSAD and its impact on women survivors of GBV receiving service at the centre on the basis of the survivor-centred approach principles. To do this, the study will be guided by the following research questions:

i. What services are provided to women survivors of GBV at AWSAD?
ii. What are the perceptions of women survivors of GBV towards services provided at AWSAD?
iii. What are the challenges women survivors of GBV face in seeking help from AWSAD?

1.3 Objectives of the study

1.3.1 Overall objective

To explore the experiences of women survivors of GBV with the survivor-centred approach at AWSAD, Ethiopia.

1.3.2 Specific objectives

i. To describe the services provided to women survivors of GBV at AWSAD.
ii. To establish the perception of women survivors of GBV towards the services provided at AWSAD.
iii. To identify the challenges women survivors of GBV face while seeking help at AWSAD.

1.4 Assumptions of the study

i. Women survivors of GBV receive multiple intervention services at AWSAD.
ii. Women survivors of GBV have different perceptions on services provided at AWSAD.

iii. Women survivors of GBV face challenges while seeking help or receiving at AWSAD.

1.5 Significance of the study

By examining the practical experience of women survivors of GBV in existing rehabilitation centre, the study findings showcase the availability and accessibility of essential services i.e. health, legal and policing, social service and coordination, the UN joint global program on essential service for women and girls to violence identified with the aim to ensure the delivery of high quality service for women and girls experiencing violence living in low and middle income countries in particular. The study further helps to evaluate whether Ethiopia fulfilled her promise to establish comprehensive, coordinated, interdisciplinary, accessible, sustainable, adequately resourced and effective multi –sectoral service for women GBV survivors based on their needs using available technologies as per the agreed conclusion adopted by the commission on the status of women at its 57th session. Finally since majority of the previous research findings conducted in Ethiopia on the issue of GBV focused on the different types, prevalence and consequence of GBV rather than service delivery, this study play a key role in drawing researchers attention to GBV response assessing the effect of using Survivor-centred approach in addressing women GBV survivor's need to guarantee full recovery and rehabilitation by as well as gaging individual service provider's knowledge on survivor- centred service and their ability to provide compassionate, non-judgmental, engaging and secure environment for women survivors of GBV.

1.6 Scope and limitations of the study

The study only documented the experience of women GBV survivors with survivor-centred approach at AWSAD shelter. It explicitly looked the service provided to women GBV survivors, their insight on the existing service and the challenges they come across while receiving care and support at AWSAD. Thus, the experiences of women survivors with other government established one-stop centre was beyond the scope of the study. The study was qualitative in nature and did not expansively document the quantitative trend and practice the women GBV experienced with survivor-centred approach at AWSAD shelter. However, triangulation of data collection methods compensate for limitation associated with single –line inquiries. Whereas the study dealt with survivor of GBV who are reluctant to share their experience, study participants were guaranteed of anonymity through the study phase so to gain informed consent before their participation.

1.7 Definition of key terms

Domestic violence: - are violent acts (behaviours) between family members in which one person attempts to dominate and control the other.

Essential services:- encompasses a core set of services provided by health care, social service, police and justice sector. .The service must, at minimum secure the right, safety and wellbeing of any women who experiences gender based violence.

Gender based violence: - any act that causes or is likely to cause physical, sexual, economic, or physiological harm, that is perpetrated towards a person's will and that is based on socially ascribed (gender) differences between males and females.

Intimate partner violence: -refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, and psychological abuse and controlling behaviours.

Multi-sectoral approach:- Multi-sectoral coordination refers to deliberate collaboration among various stakeholder groups (e.g., government, civil society, and private sector) and sectors (e.g., health, security, justice) to jointly address the needs of GBV survivors.

One-stop centre: - is a centre that provides quick and appropriate services to survivors of gender- based violence (GBV) in a single location.

Shelter: - in this study is space where women GBV survivors can access accommodation from short-long-term duration, along with service that assist the rehabilitation and reintegration process

Survivor-centred approach: - is an approach that requires that those who are engaged in GBV programmes prioritize the rights, needs and wishes of survivors to create an environment where survivors can make informed decisions.

Referral system: - in this study is a comprehensive institutional framework that connects various entities with well-defined and delineated mandates, responsibilities and power in to a network of cooperation, with the overall aim of ensuring the protection and assistance of women GBV survivors, to aid in their full recovery and empowerment and the prosecution of perpetrators.

Reintegration: - in this study is enabling women GBV survivors to go back into the society, the family or even to the community

Violence against women: - is an act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on the experiences of women GBV victims with a survivor-centred approach in Ethiopia. The review is done using the following sub-headings: the magnitude of GBV in Ethiopia exploring the type, its prevalence and consequences, the legal and policy response to eliminate impunity, the medical, psychosocial and legal response to GBV, and challenges in addressing the needs of victims/survivors. The chapter later on concludes by discussing the Human rights-based approach as a theoretical framework and its relevance to the study

2.2 Magnitude of GBV in Ethiopia

Women in Ethiopia have a low status in society due deep-seated attitudes stemming from the cultural legacy that looks down upon women. Most traditional customs and practices appear to be overly discriminatory towards women and girls, inevitably resulting in an unprecedented development gap between men and women, and boys and girls. The Global gender gap report 2010 ranks Ethiopia at 121 out of 134 countries in terms of the magnitude and scope of gender disparities. Such subordination hampers countless opportunities to obtain knowledge through educational training, acquire gainful employment, access and control over resources, take part in decision-making or involve in policy formation which further place them in a vulnerable position to poverty and violence. As result of such power imbalance Ethiopian women suffer a great deal of GBV from their family members, intimate partners and the society as a whole (UN Women, 2013).

Violence against women in Ethiopia takes the form of female genital mutilation (FGM), early marriage, and forced marriage, abduction, domestic violence, rape, and women trafficking for

casual labour or sexual exploitation within or outside of the country. Women in Ethiopia face various types of harmful traditional practices; more than 74 % of Ethiopian women of all ages for instance, have been subjected to FGC/M. According to Boyden et al. (2012), most Ethiopian communities practices FGC/M to constrain errant sexual behaviour, for the girl to remain virgin and to safeguard marriageability. The same research findings reveal that over half of girls have been circumcised in Amhara region while Oromia region has over a third of girls circumcised. Other regions such as Somalia and Afar also exercise FGM/C. As per the country profile (OXFAM, 2012), it is estimated that four out of five women in Somalia region and three out of five women in Afar region have undergone infibulation. FGC/M is a procedure that has no medical justification but affects girls/women's reproductive health.

Early marriage is another HTP that is rampant in Ethiopia which stands at 54% national rate. The 2011 Ethiopian Demographic and Health Survey by Central Statistics Agency record the median age for a girl at first marriage to be 17. These types of marriage are usually arranged by either one or both of the couple's family to strength family tie or acquire wealth. Amhara region has the highest prevalence with 48% of rural married women and 28% urban married women having married before the age of 15. Girls who are given up for a marriage on a tender age are forced to quite their education which takes away the possibility to gain knowledge and pursue a professional career. This makes the girls economically dependent on their husbands and further exposes them to other forms of gender-based violence such as sexual violence and abuse. Almost 8% of currently married women between the ages of 15-49 reported to have been abducted (Boyden et al., 2012), and since abduction is followed by rape, girls are forced to marry their abductor. Irrespective of the existence of provisions that criminalize such acts, the practice

of abducting girls continues in the southern and western parts of the country, Amhara and Oromia (Pathfinder International, 2007).

Women are frequent targets of both physical and sexual assault not only by strangers but by an intimate partner or acquaintances. Ethiopia has one of the highest numbers of sexual violence in the world for nearly 60% of girls/women have experienced sexual violence (WHO, 2005). According to a survey conducted by CARE in four woredas (districts) in Ethiopia, sexual violence by non-partners differs from place to place but the most common forms include rape, abduction and sexual harassment within and outside school setting or on the a way to a market. Physical violence in this aspect is often linked with request for sex or marriage from young girls or women (CARE, 2008).

A current study in Ethiopia show domestic violence as the most common form of violence perpetrated against women and girls. Semahegn and Mengiste (2015) systematically reviewed research works on domestic violence from 2000-2014 and found that more than half (50.5 %, 78 %, 72 %, 64.7 %) of women experienced physical, sexual and psychological violence, respectively. The life time domestic violence against women by husbands or intimate partners ranged from 19.2–78.0 % (mean value of 60.6 %). The life time physical violence by husbands or intimate partners against women or wives ranged from 31 to 76.5 % (mean value of 47.7 %) in different parts of the country. The life time sexual violence against women by husbands or intimate partners ranged from 19.2 to 59 % (with mean value of 39.6 %). Of these, one in five women experienced forced sexual intercourse by her husband/intimate partner (Semahegn and Mengiste, 2015).

Ethiopians are patriarchal societies where many communities, particularly in rural areas, embrace violence against women (Abeya et al., 2012). The culturally transmitted assumption about men's dominance over women contributes greatly to the increase of physical and sexual violence again a female partner in the country. In a gender survey conducted by the population Council and UNFPA (2010) in seven regions of Ethiopia, 58% of the respondents felt that a man has a right to have sex with his wife whenever he wants, 61% stated that a wife should never refuse to have sex with her husband, while 32% believed that the husband is justifies to beat the wife if she refuses him sex. Forty-five per cent of rural women insisted that a man is justified to beat his wife if she argues with him, is disrespectful, cannot bear children or perform her household duties properly; i.e. burns food. The 2005 Penal Code of Ethiopia seems to reinforce the same belief by failing to recognize marital rape as violence against women. Even though the country enacted other laws that strictly prohibit the conduct of customary/traditional practices or any gender-based discrimination/violence which inflicts physical, mental, sexual or economic harm to women/girls in response to GBV, because of the deeply entrenched culture that tolerates violence, GBV remains a concern for the health and wellbeing of women and girls in Ethiopia.

2.2.1 Legal and policy responses to GBV in Ethiopia

Over the past two decades Ethiopia has shown relative progress, setting in place legal and policy frameworks by adopting, ratifying and further revising various legislation and policy documents to specifically address violence against women. The government enshrined the principle of equality in the constitution of the country as well as other relevant subsidiary legislations. The FDRE constitution (GoE, 1995) in its chapter of fundamental rights and freedoms contains a number of rights which have direct relevance to the right of women to be protected from all forms of gender-based violence. Article 35 of the constitution bestows on women equal rights

with those of men in all aspects of life, where *sub article 4* imposes responsibility on the state to enforce the rights of women to eliminate harmful laws, customs and practices that cause bodily and mental harm. Further, *Article 9(4)* of the constitution calls for the integration of internationally agreed standards as part and parcel of the Ethiopian law. Accordingly, the international instruments ratified by Ethiopia like CEDAW and DEVAW constitute part of the laws of the land (Demissew, 2014).

The Ethiopian Revised Family Code (GoE, 2000) has shown a radical change to the parts of the Civil Code dealing with marriage and abolished most of the discriminatory provisions in the Code concerning marriage. Some of these improvements are those rules which require respect, support, assistance and fidelity between spouses and one that mandates joint management of the family (Fite, 2014). In addition, the criminal law (GoE, 2005) addresses violence against women in different forms by expanding the existing vague provisions, introducing new offences, redefining the elements of these offences, adding aggravating circumstances, and revising the penalties applicable in cases of violation. The Penal Code incorporated a series of provisions dealing with sexual abuse, as well as grave and common wilful injuries which have a lot to do with the physical violence women/girls suffer from. Accordingly, the code criminalizes most forms of violence against women and girls including rape, trafficking women, prostitution of another for gain, and physical violence within marriage or in an irregular union, abduction, female genital mutilation, and early marriage (Mengistab, 2012).

The Civil Servant Proclamation No.515/2007 on the other hand addresses some forms of GBV that occur at work places. The proclamation explicitly integrates sexual violence as one offense imposing rigorous penalties. The proclamation further strictly prohibits acts like those of

initiating physical violence and committing an immoral act at the work place which result in physical and psychological violence against women (Mengistab, 2012).

In addition to the legal framework, the country has adopted the 1991 National Policy on Ethiopian Women with the objective of ensuring the democratic and human rights of women, and modifying or abolishing existing laws, regulations, customs and practices which aggravates discrimination against women. The government in 2009 also set up various working strategies such as the Strategic Plan for an Integrated and Multi-sectoral Response to VAWC and Child Justice in Ethiopia focusing on prevention, protection and response mechanisms and the recently adopted National Strategy on Harmful Traditional Practices (2013) (Mengistab, 2012)

2.3 Services provided for women GBV survivors

Gender-based violence causes several reproductive and mental health impacts which subject women and girls to short or long term health consequence including death. Acts of GBV such as rape, abduction, FGM, trafficking, physical and psychological torture, violate a number of human rights principles enshrined in international, regional and national human right instruments. Women and girls who experience GBV in their life time avoid themselves engaging in community and social affairs for fear of stigma and to avoid embarrassment. This compromises their productivity exposing survivors to further victimization by placing them into the hands of many perpetrators (Terry, 2007).

The GoE has been proactive in providing comprehensive care for SGBV victims/survivors by establishing specialized structures within health institutions and law enforcement bodies dedicated to addressing violence against women. In health service institutions the government has set up a one-stop GBV centres that provide coordinated and comprehensive services such as

medical treatment, legal support, psychological treatment and shelter for survivors of violence, mainly sexual violence victims (MoWCYA, 2013).

2.3.1 Medical Care

The consequence of SGBV for women's health and well-being ranges from fatal outcome such as homicide, suicide and AIDS-related death to non-fatal outcomes, for example, physical injuries, gastrointestinal disorder and chronic pain syndrome (Morrison & Orlando, 2004). The physical injuries, range from cuts and bruises to more serious conditions like broken bones and loss of consciousness (Mengistabe, 2012). Gynaecological complications such as vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, and pain during intercourse, chronic pelvic pain and urinary tract infection, have been consistently found to be related to forced sex (WHO, 2003).

Girls/women who undergo FGC/M face haemorrhage and shock, pain, infection, and septicaemia, tetanus, dislocations and fractures, retention of urine, injury to surrounding tissues, delayed healing, scar formation, labial fusion, narrowed vaginal opening, pelvic inflammatory diseases (PIDs), infertility and psychological and social problems, dysmenorrhoea (difficult and/painful menstruation), hematocolpos (collection of menstrual blood in the vaginal canal),urinary tract infections, problems in childbirth and fistula. Under-age girls who are given for marriage experience sexual abuse, vaginal and perineal tear early and unwanted pregnancy, maternal morbidity, i.e., fistula and mortality, haemorrhage, obstructed labour, etc. (WHO, 2005).

Rape and sexual assault, usually results in unwanted pregnancy, with 60 million girls aged 15-19 giving birth every year. Coerced sex reported by 10% who first had sex before age 15,

contributes to unwanted adolescent pregnancy (Morris & Rushwa, 2015). A study on adolescent girls in Ethiopia found that among those who reported being raped, 17% became pregnant. Compared to older women, adolescent girls face a higher risk of complication and death as a result of pregnancy. Complication from pregnancy and child birth are the major causes of death in girls aged 15-19 years (ibid). A serious health complication also arises from illegal abortions to terminate unwanted pregnancy. GBV also subject women sexually transmitted diseases (STDs), including HIV/AIDS, since women and girls do not hold the power to negotiate for safe sex.

Healthcare providers play a vital role in responding to cases of sexual violence. They pay particular attention to recording details of the survivor's history and injuries, collecting evidence of recent trauma and/or sexual contact, providing care to prevent sexual transmitted infections (STIs), evaluating and addressing the risk of pregnancy and, if needed, referring the victim to appropriate psychological services. The management and provision of health care to victims includes the physical documentation and patient history, medical treatment, collection of forensic evidence, and psychosocial care (Amenu & Hiko, 2014).

Medical treatments include treating immediate injuries and STIs and preventing HIV transmission, pregnancy, tetanus and Hepatitis B and C. Victims of rape are given antibiotics to treat gonorrhoea, chlamydia, and syphilis. Post-exposure prophylaxis (PEP) is also given to a victim to prevent HIV, depending on the nature of the sexual assault (for example, whether there was penetration and/or if injuries were sustained). Emergency contraceptive pills are given to prevent pregnancy. If emergency contraceptive pills are unavailable, multiple oestrogen/progesterone or progesterone-only birth control pills can be taken in its place. Victims

of sexual violence should seek medical attention within 72 hours of the incident to treat STIs since treatment is limited if victims show up at the centre after 72 hours. Most protocols also recommend that forensic evidence including sperm, blood, hair, and saliva samples, be collected no more than 72 hours after the incident with the full consent of the victim (Amenu & Hiko, 2014).

One-stop GBV centres located in hospitals like that of Gandhi Memorial Hospital and three other hospital-based centres e.g. Adama, Jimma and Dire Dawa general hospitals, provide the above health services to GBV victims/survivors while NGO owned one-stop model service centres like that of AWSAD use referral network that links the facility to the health sector in AWSAD's case to Gandhi Memorial Hospital in Addis Ababa (Keesbury & Askew, 2010).

2.3.2 Psychosocial Service

Gender-based violence against women has also long-lasting psychological impact such as post-traumatic stress syndrome, eating and sleeping disorder, psychosomatic disorders, phobias and panel disorder, depression and anxiety, and low self-esteem as well as behavioural outcomes such as alcohol and drug abuse, sexual risk-taking, and a high risk of sexual victimization. Often the psychological needs of victims of sexual violence are overlooked, even in settings that offer medical services (Morrison et, al., 2004).

For care professionals to provide the right diagnosis, they should be aware of the factors that influence the psychological impact on victims of sexual violence. They should, therefore consider whether the victim is a child or an adult, a victim's socio-biological characteristics, a victim's perception of their rights and their status, prior history of trauma (sexual or otherwise), prior mental health issues, the relationship of the offender to the victim, a victim's appraisal of

the circumstances of the violence (e.g., threat to life, self-blame), a victim's coping mechanisms, positive social support, cultural background, perceived and actual response of society, including any formal services approached, and disclosure of sexual violence (Harris & Freccero, 2011).

Counselling is an important part of GBV service given in all one-stop enters to reduce the psychological stress experienced by victims/survivors. Approaches providing this critical service include one-on-one individual counselling or group therapy, where children are involved, both children and their caregivers can be counselled. The counselling begins as soon as victims/survivors report to the centres in order to deal with the immediate trauma of violence. It also prepares them for HIV and pregnancy tests which in turn inform the clinical response (Keesbury et al., 2010).

Some one-stop centres provide psychosocial service such as temporary shelter accommodation to ensure victims/survivors would not return to a potentially dangerous situation. However since support are cost-effective most one-stop centres including Gandhi general hospital reefer victims/shelters to AWSAD and other NGOs who provide safe house to GBV victims/survivors (Keesbury & Askew, 2010).

2.3.3 Legal Services

Gender-based violence against girls and women violates their basic and fundamental human rights such as the right to dignity, bodily integrity, safety, the right to reproductive health, and so forth. Different international human rights treaties recognize GBV as a crime and violation of fundamental human rights that deserve the duty of the state to prevent and protect women/girls from such violations. In cases of violations, the state is obliged to take appropriate measures to rehabilitate victims and punish perpetrators. Hence, the failure to protect women is considered as

violation of the states' international obligation that emanates from international treaties (Mengistab, 2012).

In Ethiopia, apart from enacting laws that criminalize different forms of GBV, the government has established child and women protection units in police stations responsible for cases of VAW, and child friendly and victim friendly benches within Federal as well as regional courts that handle cases of VAW so as to avoid secondary victimization. In addition to the law enforcement bodies, the Women, Children and Youth Affairs offices have been assigned legal officers that provide advice to women on several rights related issues including on VAW, at various levels (federal, regional and woreda). Similarly, women's associations provide legal advice services to their members and the wider community at large. Further, a national level legal aid programme has been rolled out by the Human Rights Commission in collaboration with higher educational institutions of the country (MoWCYA, 2013: 69-72).

The justice and legal components of one-stop centres is valuable in ensuring that survivors receive sound legal advice, take legal action if they so desire, and that the perpetrators of GBV are prosecuted. For legal action to be taken against proprietors, victims/survivors' cooperation with medico-legal service and police is vital (Keesbury et al., 2010).

In all one-stop centres in Ethiopia free legal service is provided to GBV victims/survivors who wish to get legal advice or obtain justice. Forensic evidence collection serve as an important link between health and criminal justice as proper documentation, collection and processing of samples and medical evidence form the basis for successful prosecution (Keesbury & Askew, 2010).

2.4 Survivor - centred approach to women GBV victims/survivors

Victims/survivors of GBV are individuals with diverse experiences, beliefs, behaviours, and agency. All victims/survivors do not suffer equally nor do they respond in the same way. Some suffer, some simply survive, and some build invisible communities of support and some resist. Effective response to GBV take the agency of victims/survivors into account in survivor-based approach and avoids further marginalizing or re-traumatizing victims/survivors by presenting them solely as powerless victims (Baldasar, 2012).

A survivor-centred approach plays a great role of prioritizing the rights, needs and wishes of the GBV survivor. This requires in particular, efforts to ensure the patient's safety, dignity, privacy and confidentiality, as well as empowerment, autonomy and participation. It is essential that competent service delivery actors have the appropriate attitudes, knowledge and skills to prioritize the survivor's own experiences and input. By using this approach, professionals can create a supportive environment in which a survivor's rights are respected and in which she is treated with dignity and respect. A survivor-centred approach helps to promote a survivor's recovery and to reinforce their capacity to make decisions about possible interventions. This means ensuring that survivors have access to appropriate, accessible and good quality services including health care, psychological and social support, security and legal services (UNFPA, 2010).

All actors working to prevent acts of GBV and those working with survivors must use guiding principles on GBV as standards for their behaviour, intervention, and assistance. The principles are designed to guide professionals regardless of their role in their engagement with persons who have experienced GBV. The main guiding principles are respect, confidentiality, safety and security and non-discrimination. The actions and resources of all actors must be guided by a

fundamental *respect* for the wishes, the rights and dignity of the victim/survivor. Respecting the victim/survivor means appreciating and valuing the survivor and her experience, ideas, decision and actions. With regards to *confidentiality,* information of the victim/ survivor or their family should be kept confidential at all time. Such information can only be shared in a need to know bases in order to provide assistance and intervention, as requested and agreed by the victim/survivor. Strict confidentiality should be maintained unless the victim/survivor or case worker faces imminent risk to their well-being, safety and security. *Safety and security* on the other hand should be extended to victim/survivor if she is frightened and may need assurance that she is safe. In all cases service provider need to ensure that victim/survivor is placed in at risk of further harm by the perpetrators or their family and service should also reach to survivors with *no discrimination* based on age, status, ethnicity or religion (UNFPA, 2010).

The National Coordinating Committee established by the Ethiopian government in 2008 for the prevention and response to GBV against women and children, come up with a protocol that serves to guide health professionals, case managers, counsellors, police officers and prosecutors in GBV response centres on how to manage GBV cases. According to the protocol the above service providers are duty-bound to extend comprehensive service to GBV victims/survivors irrespective of their ethnics, nationality, language, religion, economic status, age or sex, without discrimination. The protocol further specifies that service providers should become fully aware of detailed regulations listed under the protocol. Under the protocol, service providers should always seek to validate and empower the survivors without judging their actions, opinions and decisions, but rather affirm that they are not to blame for the violence or abuse experienced. Empowering the survivors means letting them know that they are brave for sharing their story and for coming for help, that the service providers are here to listen and support them. Service

providers should let them make the decision that is best for them, and trust that they know what is best for them. In this way SGBV survivors are able to use the response service set up for them without hesitation (Keesbury & Askew, 2010).

2.5 Challenges in meeting the needs of women GBV victims/survivors

Among those women/girls who experience GBV, only small proportion seeks any type of institutional care and support. The most common barrier is victim/survivor and their family's preference to resolve the issue at home. This usually is due either to culture, fear of stigma or the desire for compensation. Local leaders or family members frequently encourage the victim/survivor to request remuneration from the perpetrator especially when the perpetrator is well-off economically. And for those who seek care and support the service provider's capacity remains a challenge to quality and comprehensive service. In most public health facilities, for instance, there is an acute shortage of GBV trained medical staff and the trained personnel are generally unavailable (Keesbury & Askew, 2010).

Quality of support and care are also undermined by negative attitudes towards GBV victims/survivors. Health care professionals such as nurses or medical doctors and police officers often demonstrate bias against victims/survivors and hold them responsible for the attack questioning the way they dressed, for drinking, taking drugs, walking and talking provocatively and attending late night parties. Safe houses and temporary shelters heavily rely on donations from multiple sources in order to provide for the needs e.g. food, cloth, bed, etc., of dislocated victims/survivors. Such high maintenance costs and the need to ensure 24 hours securities for victims /survivors may serve as a challenge to long term sustainability of safe houses (Population Council, 2010). Other factors such as limited awareness of the law and procedures among the

right holder and duty bearers, lengthy and cost effective court proceedings, limited one-stop GBV centres and lack of medical equipment also serve as a challenge to provision of sufficient, timely and effective care and support for GBV victims/survivors (MoWCYA, 2013).

2.6 Comprehensive service to women GBV survivors at AWSAD

Efforts have been made by various organizations and institutions in Ethiopia to try and provide temporary shelter for women survivors of GBV. These efforts have mainly been of non-governmental organizations, both international and national. Recently, the GoE has joined hands with UN's agencies to establish one-stop crisis centres in the country. Today the GoE operates four one-stop centres in different regions of Ethiopia under the roof of specialized hospitals such as Ghandi memorial hospital, Jimma University specialized hospital, Adama Hospital and dire dawa hospital with the aim of providing health, police and social services in one place, allowing GBV survivors to access the necessary services easily and speedily, and avoid further trauma (MoWCYA, 2013).

Association for women's sanctuary and development(AWSAD) is a non-for-profit, resident charity association established with a vision to see violent free society through a mission to promote the socio-cultural wellbeing and economic independence of women by providing psycho-social support and advancing the economic and social development of women. The association was founded by Mrs. Maria Munir Yusuf who is the current director of the center and a former high court judge with the realization that women survivor of violence had few support services especially those were financially unstable. The association was first registered with the MoJ in Ethiopia in 2003 under the name of Tsotawi Tekat Tekelakay Mahiber (Organization against Gender Based Violence) and later re-registered as per the new Charities and Societies

Proclamation No. 621/2009 adopting, the current name of the association by the year 2009 (AWSAD, n.d.).

The association for a minimum of 3 months provides temporary shelter, medical care, and counseling and rehabilitation service to impoverished women and women who experienced GBV. AWSAD supports women survivors of GBV to rebuild their lives after experiencing violence by providing them with intensive counseling and medical care. Pregnant women survivors of GBV are provided with pre and post-natal medical care. Even though the association does not extend legal service to women survivors of GBV, it informs them what their rights are and also supports them throughout their court process (AWIB, 2016).

Currently, AWSAD runs two shelters in the capital city Addis Ababa and another in Adama town, Oromia region. The safe house in Addis Ababa was established in 2006 and has the capacity to accommodate 50 women. The main functions of the shelter includes safe house, food, medication, counseling, basic literacy (since majority of the survivors have low educational background) and skill development training. AWSAD is also involved in providing different training to the police, local community leaders and women affair officers on topics such as human rights, GBV and HTP with the aim of reducing violence against women and girls (UN Women, 2011).

Professional skills like that of cooking, computer literacy, hair dressing and sewing targets women survivors with low or no financial income. Such skill trainings are given for the purpose of elevating women survivor's economic autonomy to escape violence. After the enactment of the new Charities and Societies Proclamation, training given became limited reproductive health, life skill, peer education, counseling, and survivor case handling, parenting skill, communication

and burnout management. In the care of the association women survivors of GBV gain the confidence and skills needed to build and improve their lives once they leave the shelter (AWIB, 2016).

At the beginning AWSAD used to carry out its programs with volunteer individuals who were dedicated to prevent the prevalence of GBV in Addis Ababa. Today, forty-six technical and supporting staffs are engaged in different activities of the association. The association developed manuals on administration, strategic planning and finance, a child protection policy and a safe house implementation guideline in order to strengthen the performing ability of the association and make it more competitive and efficient in delivering service and rehabilitation to women and girls (AWSAD, n.d.).

Association for women's sanctuary and development (AWSAD) works in collaboration of with the police, Ethiopian women lawyers Association (EWLA), the Ministry of women's affairs, Ministry of Justice and others. The association gets support from international donors and individuals. Between the safe house in Adama and in Addis Ababa, two-thousand women survivors of GBV have escaped violence and poverty (UN Women, 2013).

2.7 Theoretical framework

2.7.1 Human right-based approach

A human rights-based approach (HRBA) is a conceptual framework that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights (UNCHR, 2006). It seeks to analyze obligations, inequalities and vulnerabilities and to redress discriminatory practices and unjust distribution of power that impede progress and destabilize human rights. Its aim is to ensure that major interventions should not only prevent harm, but also actively contribute to enhancing the promotion and protection of human rights (ibid). The term "Human rights-based approach" was coined in 1997 by the then UN's secretary general Kofi Annan when he called on all entities of the UN system to mainstream human rights into their various activities and programmes within the framework of their respective mandates. Since then a number of UN agencies have adopted a human rights-based approach to their development cooperation and have gained experiences in its operationalization (Goonesekere & Da Alwis, 2005).

A human rights-based approach ensures that human standards, as established in international law, are applied as a criterion for policy orientation and the solution of problems in specific areas. It introduces a normative basis which is obligatory for state parties, and thus requires a legislative response at the state level. A human rights based approach is about empowering people to know and claim their rights and increasing the ability and accountability of individuals and institutions who are responsible for respecting, protecting and fulfilling those rights (OHCR, 2006).

Human rights based approach is guided by five principles known as the **"PANEL"** approach. These are: *participation* in decisions which affect their human rights, *accountability* of those responsible for the respect, protection and fulfillment of human rights, *non-discrimination* and equality, *empowerment* to know their rights and how to claim them and *legality* in all decisions through an explicit link with human rights legal standards in all processes and outcome measurements (OHCR, 2006).

The approach recognizes that the cause of poverty, suffering and injustice lies in the violation of people's human rights and those who are denied to have the legally enforceable position from which to advocate for change. It therefore strives to empower the right-holders to hold the duty bearers accountable for non-performance of the said duties (OHCR, 2006).

Today many development initiatives use the approach and there is a growing body of research, tools and methods for using the approach (UNDP, 2006). A study conducted by Gulu (2010) on the usefulness of this framework in addressing gender-based violence identified the relevance of the human rights framework in making women's experiences and concerns visible and also revealing the unequal power relations in societal structures that are core to causing oppression and violence against women. The study further shows how the rights-based approach challenges the violation of women's rights, in both the public and private spheres, with the influence of the international law since the government carries the responsibility of implementation. It is also argued that the approach opened wide doors for women to participate in political spaces and legal structures. Instances include defining theories that place women at the centre of freedom to speak about discrimination, violence and women's rights (Gulu, 2010).

In response to GBV, human rights-based approach considers holistic approach as an appropriate strategy to prevent and suppress GBV. The approach takes the protection of the human rights of survivors of GBV as the genuine guiding principles for adopting measures, policy, and legislation in the fight against GBV. It focuses on the promotion and protection of survivor's rights. In the approach, the position of the survivors, the violations of their human rights and their vulnerable position are the starting point for taking countermeasures against GBV. Accordingly, it requires that GBV responses have to be centralized on the needs and safety of survivors of GBV (Goonesekere, n.d.).

2.7.2 Relevance of the theory to the study

Human rights–based approach emphases on a strategy that focus on the fundamental rights of women to best address the needs of women survivors of GBV. This helps to explain services that are appropriate and tailored to the practical need and specific of women survivors of GBV. The approach focuses on the importance of services that are participatory, non-discriminating, empowering, legal and accountable. In this case helps to explain how women survivors of GBV are key actors of their recovery process and that they are entitled to seek care and learn about their rights, get information on available resources and acquire power to make final decision on the course of action when dealing with their victimization. It further explains the standard criteria set for an acceptable service which enable us to underline the possible challenges women survivors of GBV may face in the absence of these principles in service delivery.

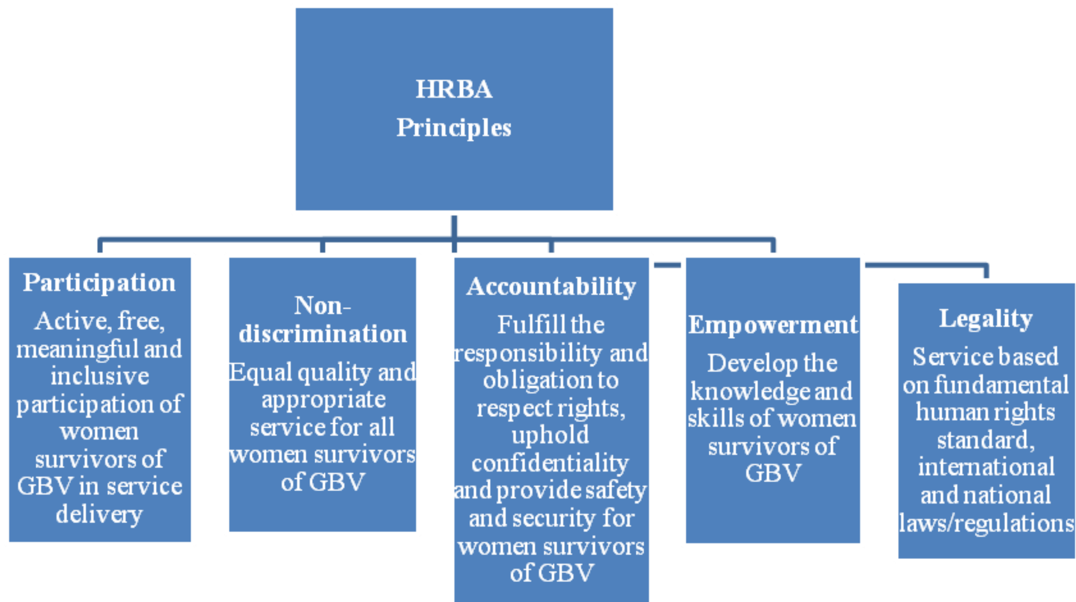


Figure.2.1 conceptual framework on HRBA principles

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter describes the research site, design, population sample and sampling procedures, data collection methods and tools, analysis and presentation of findings. The chapter later on concludes by discussing ethical consideration that helped guide, the study.

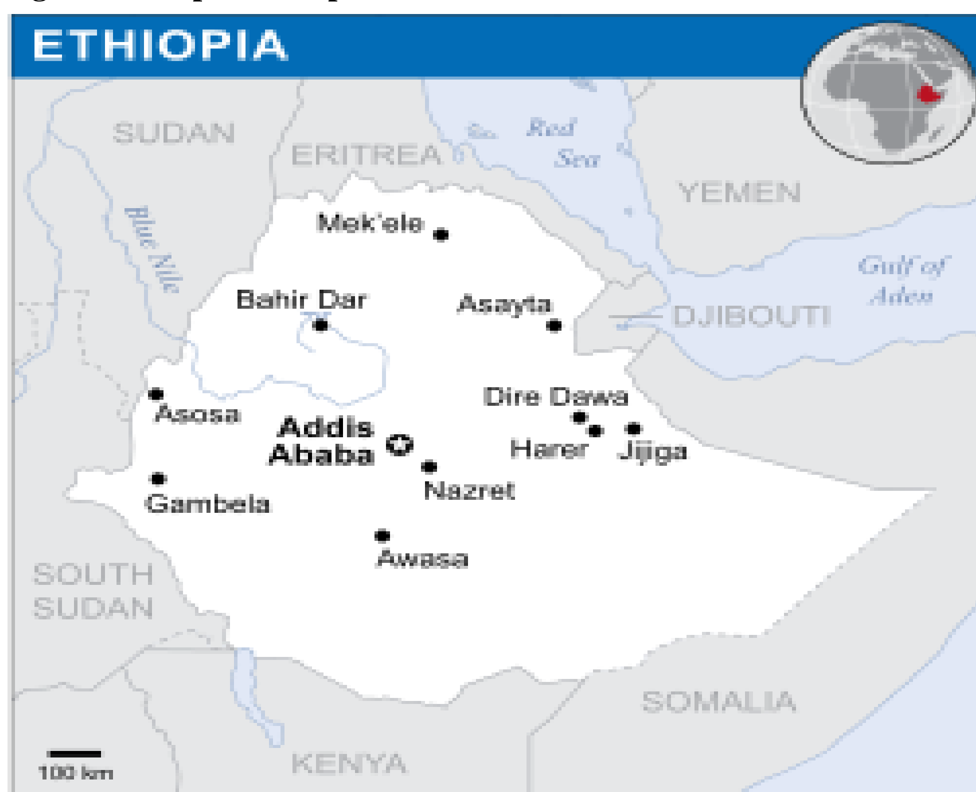
3.2 Research site

The study was conducted at the Association for Women's Sanctuary and Development (AWSAD) shelter from January to February, 2017 in Addis Ababa, Ethiopia. Ethiopia is the second-most populous country in Africa and is located in the horn of Africa sharing borders with Eritrea to the north and northeast, Djibouti and Somalia to the east, Sudan and S. Sudan to the west , and Kenya to the south. Addis Ababa, the capital city of Ethiopia is a seat to AU and UN World economic commission for Africa and has a population of over 3 million (3,352,000). The city is divided into 10 boroughs, called sub-cities and 99 wards. Addis Ababa also hosts numerous international and local NGOs whose presences are critical for the vulnerable members of the society.

AWSAD, formerly known as Tsotawi Tekat Tekelakay Mahiber (gender based violence prevention association) is an Ethiopian resident charity association established to advance women's social and economic development and provide support for women and girls that faced physical and psychological harm. The association was first legally registered with the Ministry of Justice of Ethiopia in 2003 and with the issuance of the new Charity Societies Proclamation (CSP); AWSAD re-registered and adopted its new name in November 2009.

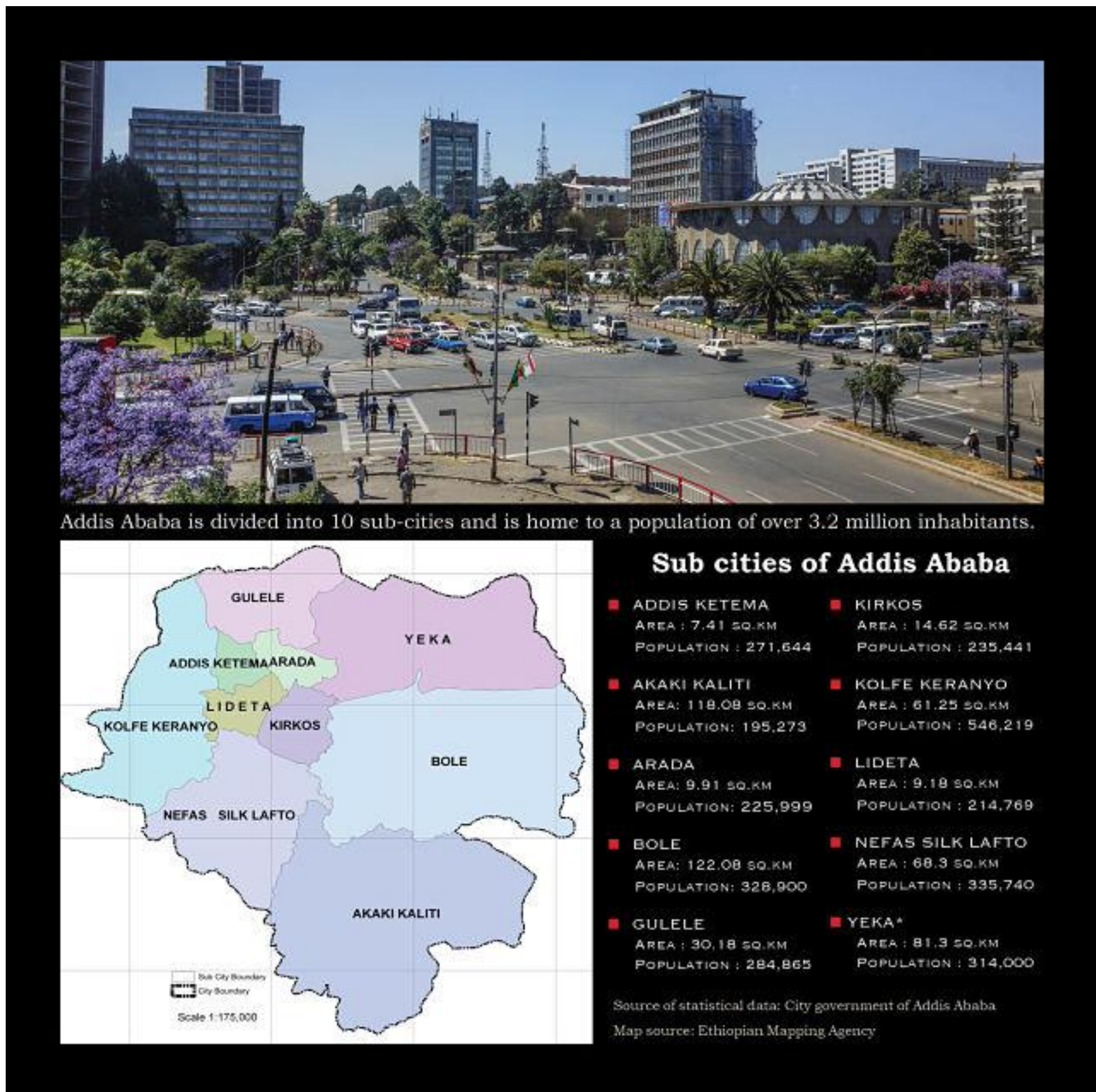
AWSAD is engaged in three programs namely safe house, training and skill development. The Safe house provides a transitional shelter for survivors of violence and their children by providing them with holistic service in terms of temporary shelter, medical service, counselling, legal follow up, skill training and basic literacy education. AWSAD has two safe houses in Addis Ababa established in 2006 and in Adama established in 2011. The other program focuses on the provision of trainings and capacity building to enhance the capacity of community and government institution in providing quality services for women and girls. The third program is that of the skill development which targets women and girls survivors of physical and psychological harm as well as women with low income.

Figure 3.1 map of Ethiopia.



Source: map data 2013

Figure 3.2 map of Addis Ababa city



Source: map data 2015

3.3 Research Design

A cross-sectional descriptive research design was adopted using qualitative data collection methods. Accordingly, data was collected using Semi-structured interviews, case narratives and key informant interviews. The researcher began by conducting semi-structured interviews with selected women GBV survivors receiving service at the shelter. Case narratives were also introduced to give detailed experiences on survivor-centred holistic service while getting care and support at the shelter. Key informants interview was employed to bring in expert opinion on the objectives of the study. The interview guides was translated from English into Amharic for the respondents and key informants by the researcher and the interview was held in Amharic language. The data collected was analysed in line with the study objectives. Verbatim quotes were used during data presentation to represent the voices of the informants.

3.4 Study Population and Unite of Analysis

The study population was comprised of women survivors of GBV seeking services at AWSAD. The unit of analysis was the individual woman survivor of GBV.

3.5 Sample Size and Sampling Strategy

The initial sample population consisted of 30 respondents since it's considered as representative and inclusive in quality of demographic (Collis and Hussey, 2003). The researcher however, was able to get 22 participants due to the fact that higher numbers of GBV survivors receiving service at the shelter are women under the age of 18.

Upon arriving at the shelter the legal follow-up and documentation officer and a counsellor were reached who then introduced the researcher to women survivors of GBV who were willing to

take part on the study. The inclusion criteria were only limited to women survivors of GBV who are receiving care and support at AWSAD shelter in Addis Ababa.

Seven key informants were purposively selected for interviews based on their work with women survivors of GBV at the shelter.

The informants to case narratives were purposely drawn from AWSAD. They were sampled based on their experience for the duration 2 years, 1 year and 3 months, and 10 months stay at AWSAD shelter receiving care and support and their willingness and availability to deliver more into discussing issues they faced during their violence recuperation/healing process at the shelter.

3.6 Data collection methods

3.6.1 Semi- structured interviews

Semi-structured interviews were used conducted with 22 women GBV- survivors drawn from AWSAD. The method was important in digging out a data from women GBV survivors on their experience with GBV, how they sought help, what service they received at AWSAD, how they rate the attitudes of service provider and the service in terms of confidentiality, non-discrimination, participation/respect, and safety and security and if they ever face challenges while receiving service at AWSAD. The semi-structured nature was important in probing deep in to the specific experience of women GBV survivors with survivors-centred service as well as the reaction attached. Counselling service stood out as an effective intervention followed by health and skill development. Whereas inadequate investigation by the police, low priority for GBV case and delayed justice by the judiciary and seldom un-engaging attitude of some service providers served as a challenge women GBV survivors face while receiving care and support at

AWSAD. Semi-structured questionnaire (Appendix 2) was used to collect the data. The interview guide was prepared in English then translated into Amharic for informants.

3.6.2 Key informants interview

Key informants were selected on the basis of their knowledge and their interaction with women survivors of GBV at AWSAD shelter. Interviews were carried out with the safe house counsellor, nurse, legal follow-up and documentation officer, income generating activity (IGA) coordinator, monitoring, evaluation and learning (MEL) officer, house coordinator and the house mother. The key informants provided information on how they communicate and provide care and support for women GBV survivors, how they conduct risk management process, shelter's code of conduct, recovery/rehabilitation/development monitoring and evaluation tools (eg. Outcome star), their knowledge on GBV, how they promote principles of survivors-centred approach (participation/respect, confidentiality, non-discrimination, and safety and security) while providing care and service and finally how they deal with challenges while rendering service. They also gave suggestions on how to improve access to a holistic service for women survivors GBV. The interview guide was prepared in English then translated into Amharic for key informants. A key informant interview guild (Appendix 4) was used to collect the data.

3.6.3 Case Narratives

Three women GBV survivors who sought comprehensive services at the shelter and finished their stay were purposely selected with the help of the index persons. The survivors were willing to dig dip and share their experiences. The women survivors gave information on their experience with GBV, their recovery process while receiving care at the shelter and how AWSAD helped them deal with their victimization. Transport money 200 birr which equivalent to 1000 Ksh was refunded to each case narrative respondent as they faced the trouble of traveling

long distance to the safe house where the interview took place leaving behind their work and businesses. The interview guide was prepared in English then translated into Amharic for the survivors. A case narrative guide (Appendix 3) was used to guide the process of inquiry.

3.7 Data Processing and Analysis

The audio-taped data collected from semi-structured interviews, key informants interviews and case narratives were transcribed in Amharic while the memory was fresh so as not to lose crucial data then translated into English. After interviews were transcribed and translated themes were identified in line with the study objectives. The data was arranged in accordance with the research questions and the themes that emerged. Pseudonyms were later used to make the information discrete. Verbatim quotes were used during data presentation to amplify the voices of the women survivors of GBV and to convey actual meaning intended in the discussions.

3.8 Ethical consideration

Research permit was obtained from Ministry of Science and Technology in Ethiopia before embarking on fieldwork. During fieldwork, informants were duly briefed on the purpose, the selection procedure, duration of the study, and potential use of the research result. An informed consent from (Appendix 1) was signed by the informants as surety of their understanding and acceptance to take part in the study. Recruitments were done based on informed consent of women GBV survivors. The rights of informants to withdraw at any point of the study were explained. The study participants were assured their anonymity by use of pseudo names during presentation. Informants for case narratives were given compensation for their transport fair.

CHAPTER FOUR: THE EXPERIENCES OF WOMEN SURVIVORS OF GBV WITH SURVIVORS–CENTRED APPROACH

4.1 Introduction

The chapter begins by presenting the types and consequences of GBV; further the findings are presented and discussed in line with the study objectives which include: the available services for women survivor at the shelter, women survivors view on the services, and challenge they encounter while getting the service. Discussions are carried out along the following sub-thematic area: participation, confidentiality, non-discrimination and safety and security.

4.2 Types and consequences of GBV among study participant

Types of GBV in this context are physical, sexual, psychological and economical abuses imposed upon women survivors of GBV. Women survivors of GBV reported to have suffered various forms of violence's by a stranger, a close relative, an employee and even by their husband/ intimate partner they loved and trusted. The common violence's study participants reported includes rape by a stranger, denial of baby, exclusion from home and physical abuse by their husband/ intimate partners.

"I was heading home one night after accompanying my aunt to a taxi station when I came across a guy. Like always he offered to give me a ride home so I went into the car. He had three guys at the back sit that night. He drove some miles and made a stop saying he will be back. Soon after he left the car, the three guys at the back sit covered my mouth and rushed me to a nearby forest then raped me" (SI with19yr.old Yetimwork.

"I found out that my husband had sexually abused our daughter when she was 3 years old. He locked us out of the house when he found out that I filed a criminal lawsuit against him" (SI with 24yr. old Selam)

A key informant who coordinates the safe house's accommodation service noted most of the women survivors they welcome are originally from upcountry. They made their ways to the capital Addis Ababa to look for jobs. Many however, end up being victims of rape by agents who promise to find them jobs. On other occasions the women GBV survivors were raped and at times tortured by their employers or relatives.

"I lost my husband of 5 years. We had one child together I gave my son to my in-laws and came to Addis Ababa looking for a job. I then got a job as a nanny. My employer's brother raped me while I was working there" (SI with 20yr old Etalem).

"*When I arrived to Addis Ababa, I never knew anything or anyone. A guy approached me as I was walking around he asked if I am looking for a job I said yes so he told me to follow him. I never knew my way around the city so I followed him. Little did I know he took me to a forest and raped me" (SI with 25 yr. old Amarech)*

These findings coincide with results from previous studies where several study participants shared violence cases. A study conducted by Mahlet Getachew (2015) acknowledged rape and sexual harassment as some of the abuses female housemaids faced by a stranger, an employer and broker. This signifies how having a low socio-economic status placed women GBV survivors in a vulnerable position to various forms of GBV.

The findings also tracked cases of intimate partner violence where the study participant reported to have been physically and economically been abused to the point of being chased away from their marital home.

"I met my second husband through my cousin. I decided to marry him thinking he would be a good supporting husband and father to my daughter. He however was disrespectful and unsupportive throughout our marriage. He used to cause a lot of problems to make me leave the house. He even asked me to get an abortion while I was 3 month pregnant saying he was tricked into marring me thinking I had money in the bank working from Arab countries. He used to blame me for leaving his first wife thinking I had money. I decided to leave after multiple

harassments and torcher from him and his son including a death threat" (SI with 22yr. old Semira).

Derbe et al (2012) identifies physical and economic abuse as some of the violence recounted by women GBV survivors who had controlling partner.

"My husband and I agreed that I would return to school once our two children grow up. The boys grow up and started school. I told my husband that I want to go back to school and do some work side by side as we have planned. But he refused saying we have everything and if there is anything missing he would provide. I tried to change his mind myself and through other people he however refused to let me study and work"(SI with 22 yr. old Hellen)

"*My husband and I usually bicker over money I send to my siblings who at the time were in higher educations. One day as we were arguing he kicked me on the stomach while I was 8 month pregnant with our second child. I was rushed to have an emergency C-section. After that I was not able to conduct my business and support either myself or my family as I was ordered by doctors to refrain from work but rest''.* (*SI with 23 yr. old Sara)*

This finding show how power imbalance, the need to control and dominate by the other partner which is reinforced by traditional belief, violent behavior or other factor can result to violence against women in a private set up.

Almost all study participants stated that they have experienced a cycle of GBV throughout their life.

"My first husband abducted me when I was very young so I was forced to marry him. He was much older than me. He never wanted me to go outside and socialize with neighbors. He used to come home late at night drunk and torcher me a lot. I married my second husband out of free will. We lived together for 5 years and had a child. Things took a wrong turn when we came to Addis Ababa to live with his family. His family never liked me and he did not do nothing about it to make matters worse he one day joined hands with them and beat me up while I was 2 months pregnant with our second child" (SI with 20 yr. old Kidist).

"Soon after my father's death my mother started looking for an in-law to plight her land. I was very young and eager to go to school when they married me to that man. So I run away from the man. I then bought pen and writing paper for myself using the money my uncle gave me and head to school. I spend the whole day in school then returned home only to find my furious step-father who was waiting for me at the gate. He beat me up that day until the stick broke into

pieces saying 'who you to live a marriage for school'. From that day on I never set a foot in school. My life never turned out well ever since" (SI with 25 yr. old Sewnet)

According to Toggia et al (2010) no section of Ethiopian society is as exposed to all forms of violence and discrimination as women and girls are. Even though GBV has a debilitating consequence that causes a clear physical, mental, legal and developmental harm upon survivors, the act is considered common i.e. as a form of moulding women and girls to become obedient and disciplined. Such trend accounts largely to the generally oppressive and under-developed attitude towards women and girls.

4.3 Services provided to women GBV survivors at AWSAD

Women survivors of GBV suffered long lasting consequences on their wellbeing, health and safety along with economic problems due to abuse. The violence experienced also affected their education and productivity. All needed a comprehensive service that responds to their overall health, psychosocial and legal needs to recover from their victimization and reintegrate back to the society as a self-reliant productive member of their community. From the structured interviews the researcher was able to learn respondents are able to accesses most of the needed services at AWSAD shelter. As constructed from both respondents and key informants interviews, women survivors of GBV are able to attain holistic service (shelter, health, counseling, legal-follow up and vocational training) under one roof at the shelter and other centers through a coordinated referral network.

4.3.1 Shelter

Shelter in this context is a safe and secure rehabilitation and reintegration space where women survivors of GBV access temporary accommodation along with services that assist their recovery process. According to Barrett &Pierre (2011) women survivors of GBV do not seek help from formal service providers and authorities due to several reasons. And those who flee their home

due to domestic violence end up being homeless. Abused women and their children are normally subjected to homelessness. The study participant reported being homeless due to abuse

"My husband locked me and my two children out of the house after I filed a lawsuit against him. We slept on the street for some time before we come to the shelter "(SI with 24yr. old Selam)

"I came to Addis Ababa when my father chased me away after finding out that I was pregnant. I had no place to stay therefore i was living on the street. There were times where i have gone without food for 3 days, while breastfeeding my child "(SI with 18yr.old Serkalem)

"I did not know i was pregnant after I was raped my employer fired me when she noticed my growing belly. I got another job as a house help. They let me work until i was 7 month and let me go. Since i had no one to go to I went on the street and usually sleep on church grounds" (SI with 18yr. old Zahra).

The care and support offered by shelters address barriers by encouraging women GBV survivors to seek assistance. This finding indicated that study participants who sought help are able to access protection, essential service and resource which enabled them and their children to recover from violence

"My husband disappeared after he hit me. Doctors told me not to work so I was not able to pay rent or provide for my two children therefore i went to the local municipality told them mu situation they then referred me to this shelter along with my two children "(SI with 23 yr. old Sara)

"*I filled a lawsuit against my husband without him knowing and came to this place when they served him. He would never let me live after knowing that I sued him. He will kill me without any hesitation. I have lived with him to know what he is capable of". I will be here until my divorce case is finalized.(SI with 22 yr. old Hellen).*

Shelters are critical components of a holistic response for women GBV survivors as they link survivors with medical, psychological, legal and other required services. The findings indicates that study participant are offered essential services like accommodation, health care, counseling, legal follow-ups, and vocational trainings are also sorted out to extend care and support for women survivors of GBV along with skill training to help empower them economically.

"There are a lot of services here. Women who suffer abuse are immediately taken to get a clinical treatment. They also give counseling service. A woman who came here depressed recovers at the time of leaving the shelter" (SI with 22yr. Hellen)

"They gave me cloths, bed, soap. My son is growing for free" (SI with 25y. old Amarech)

"The shelter provides many things starting from accommodation to several vocational training like that of embroidery and sewing, food preparation and hair dressing whereas trainings like that of leather and wood work/bamboo along with business skill training".(SI with 18yr. old Yesimwork).

The safe house entertains its own rule and regulation that details as to how the living conditions are and women survivors are duty bound to abide by it.

"We have our own regulation. Boys who accompany their mothers cannot stay at the shelter after the age of seven. The duration of stay at the shelter is from 1 month – 3month.Even though it is there in the regulation women survivors will stay for the duration of their pregnancy or until their court cases are finalized or if they are a student with a promising grads and they don't have anywhere to go getting vocation training and other services unless they have disciplinary issue" (KI with Eyerusalem a house mother at AWSAD)

4.3.2 Clinical care

Health care in this context is medical service provided to women GBV survivors who suffered physical injuries and reproductive health problem as a result of abuse including other treatments. Gender based violence imposed a significant impact on women survivors factoring health problems like physical injuries, adverse pregnancy outcomes and STD.

"My husband hit me on my stomach when i was 8 months pregnant. So I was forced to deliver prematurely through an emergency C-section" (*SI with20yr. old Sara*)

"My husband brock my nose some time ago and misshaped it. He also infected both me and my daughter with STD"(SI with 24yr. old Selam).

Globally, studies cited by WHO (2013) documented pregnancy rates after non-partner rape ranging from 5% among women in the USA to 17% among adolescents in Ethiopia. As to

Dessalegn et al (2008) young, unmarried and economically independent women are the once who are vulnerable to rape related pregnancy. Most study participant with experience of sexual violence reported unwanted pregnancy.

"My aunt's husband used to wait until my aunt goes to work she usually works at night and abuse me sexually and got me pregnant" (SI with 18 yr. old Yesimwork.)

"I conceived my daughter due to rape" (SI with 20 yrs. old Trikwa).

Dessalegn et al (2008) further noted women GBV survivors who gets pregnant after rape opt to terminate using safe or unsafe abortion services. And those who continue with the pregnancy don't go for antenatal checkups.

"After my employer told me to leave her house due to my pregnancy I went on the streets. I used all the money i had to terminate the pregnancy but it was not successful. I was 8 months pregnant when I joined the safe house and I have never gone for checkups it's here at the shelter where I started my antenatal care"(SI with 19 yr. old Zahra)

According to a fact sheet (2017) on induced abortion and post abortion care in Ethiopia an estimated 620,300 abortion were performed in 2014. Although the fact sheet does not provide statistics on abortion resulting from rape data showed a significant increase in abortion among women aged from 15-49 throughout the years. An annual rate of 28 abortions per 1000 women aged 15-49 showed an increase from 22 per 1000 in 2008. Ethiopian health professionals estimate 40% of women who have abortion outside of a health facility experience serious complications.

As per WHO clinical and policy guideline on responding to intimate partner violence and sexual violence against women (2013) and the agreed conclusion from 57th session of the commission on the status of women (2013), different forms of health interventions i.e. first line support, treatment of injuries, psychological and mental health support , and for rape victims emergency

contraceptive, safe abortion, PEP for infection and diagnoses and treatment for STIs should be facilitated along with GBV sensitized medical professionals.

Findings from an interview conducted with a key informant who is a nurse at the shelter show the clinic at the shelter predominately provide first aid care i.e. emergency contraceptive, PEP and minor injuries resulting from physical abuse including random screening on transmitted diseases and supply of medication including prenatal and postnatal check-up due to lack of space.

"*Our clinic here at the shelter is a mini-clinic. It only has two rooms so it does not hold the status to provide clinical care other than first aid service. We however provide prenatal and postnatal care to residents who need that care. We conduct typhoid and typhus screening on both residents and staff as the shelter is a common living space. We moreover provide medication. We just got license to buy medicines so we have quite a collection of meds for survivors" (KI with Sofia a nurse at AWSAD)*

Study participant confirmed the usefulness of the clinic at the shelter

"The nurses at the clinic give contraceptive and HIV prevention pills for rape survivors in case where the abuse took place in less than 24hrs. They also do first aid work like that of covering and fixing wounds. They make sure we take our medicines on time if we have any medications prescribed for us" (SI with 18 y. old Yesimwork).

"They checked my HIV status here at the clinic. I was so worried but they said its okay I am free" (SI with 19 yr. old Zahra)

As to the findings, respondents referred by the police however usually receive medical care at a one- stop center run by the government.

"The women GBV survivors who we receive from the police already get first aid service from one-stop center. What we do here when they come is to make sure they take their med's properly and take them to the same center for check-up" (KI with Sofia a nurse at AWSAD).

"*The police took me to Gandi hospital that's where I got both contraceptive and PEP pills" (SI with 19yr. old Meron).*

According to the national assessment conducted by UN Women Ethiopia (2016) shelters in Ethiopia are not mandated to provide health service other than emergency care for women GBV survivors. AWSAD therefore takes women survivors of GBV to either government or private health centers to access appropriate and adequate medical treatment.

"*Risk assessment is conducted along with other service providers whenever a survivor joins the safe house. During the assessment i take notes while survivors disclose information about their abuse. I also conduct visual screening to see for e.g. if STIs symptoms appear on the survivor. This helps me identify the medical needs of the survivor and provide care accordingly either here at our clinic or other medical centers when it's beyond our capacity" (KI with Sofia a nurse at AWSAD).*

The case narrative bellow further reinforces the medical care an ex-resident received during her stay at shelter.

Mekedes, narrated the medical care she received while staying at AWASD's shelter "*it was 2003 (Ethiopian calendar), my husband hit me on my head…. the injury was very serious …. Half of my body became paralyzed…. my hand and leg suffered series injuries. I could not move therefore I was confined to a bed someone had to move me and change my close everything. I came to the shelter with my two children. I was not able to care for either myself or my children as my injuries where serious. I hated myself and my children especially my son as I picture him in the image of his father. I came to AWSAD through women's affair. The nurses at the safe house made sure I get the medical attention I needed by taking me to Zewditu Hospital. The nurses were by my side the whole time when I was getting physiotherapy treatment for one and half year supporting me encouraging me providing medicine and a crunch to walk as well as counselling service for both my children and me. Within two years I was able to walk and recovered completely thanks to AWSAD. They saved three people me and my children. My children were also cared for at the shelter. I would know what I would became if it was not for AWSAD (sobbing). I always cry when I think of the support I get from AWSAD (CI with 32 yr. old Mekedes)*

Mekdes narrated that she has been physically abused by her husband and she was incapable to care for her children and herself. This shows the devastating fact of domestic violence in a marriage where less attention is given to it under the view that it's a private matter. It also exhibits the health, psychological and economic effect domestic violence, has on both women

and their children. She then narrates she was able access holistic support and care through AWSAD along with her children. This shows how multi-sectoral response to GBV can address the different needs of women GBV survivors and speed up their recovery. Mekedes continues how the nurses at the shelter were beside her throughout her healing process providing her with the needed medication as well as emotional support and how the shelter took the responsibility of looking after her children. This indicates how compassionate survivor- centred care and support are vital for women GBV survivors to feel worthy and valued (something which most survivors' question after an abuse) and insert hope in the lives of women GBV survivors, all over again.

4.3.3 Counseling service

Counseling service in this context is a psychological health intervention provided for women survivors of GBV to help them deal with and heal from their abuse led emotional trauma. The consequences of GBV on women GBV survivors' health are manifold. Women survivors of GBV experience a vast emotional and psychological reaction i.e. depression, anxiety and post-traumatic stress disorder (PTSD) after an abuse.

"Everything is dark for me now ...(sobbing)…. I don't think I will live after this. My mind is not stable…. I forget things easily since I stress over many issues" (SI with 24yr old Selam).

Depressed women survivors of GBV normally feel a prolonged sadness and hopelessness. They also lose appetite and are usually unhappy.

"I was depressed when i came here. i never wanted to be with any one therefore i used to sit alone. I cry every night inside my bed and also refused to eat" (SI with 19 yr. old Yetimwork).

In extreme cases of depression study participant stated they experience suicidal thought and / attempt.

"I felt restless….. My thoughts where all over the place before I came here. I wanted to kill myself whenever I think of the horror I went through in my marriage". (SI with 22yr. old Semira).

Depression also affected the study participants behavior and relationship with other people.

"I was angry at my sister so I left nazraite that's where she lives and came to Addis Ababa" (SI with 25yr. old Ansica).

"The police and nurses where I delivered my baby told me to go to my parents but since i was ashamed i refused" (SI with 25yr old Sewent).

Through counseling service the study participant stated they are able to deal with their emotion, build self-esteem and develop coping skills.

"My heart was broken and my spirits were down when i first came to the shelter. I used to ask my -self why this thing happened to me. I had lost hope i never though i could be or became anything. I am a different person now counseling changed me. I now believe in myself. i used to be very shy now i have developed a skill to talk in public".(SI with 18 yr. old Yesimwork).

A key informant who is a counselor at AWSAD shelter stated with a reliable support, understanding, validation and information from a counselor, women GBV survivors will be able to break their silence and release secretes and shame they have been carrying inside them for long time.

"Women who experience GBV ends up with a severe psychological trauma, these women need someone who recognizes the horror they went through as an abuse. Counseling creates an environment for the survivor to voice her frustration, pain and stress. Counseling is a sheer discussion not making decisions for the survivor. What we do is point them to their choices in order for them to make their own decisions"(KI interview with Meaza, a counselor at AWSAD).

The key informant further explained the two methods used to address the psychological needs of women GBV survivors at the shelter

"We offer the counseling services using two methods which are: individual counseling and support group counseling. Individual counseling is a private counseling session where a survivor talk about her abuse freely and address all of her issues one by one and its confidential. A support group counseling on the other hand is a discussion where a group of 10 individual women survivors have on several topics and share experiences, speak in front of people, and also to know that they are not the only one who have been subject to abuse" (KI interview with Meaza, a counselor at AWSAD).

Majority of the study participant highlighted on the effectiveness of the formal counseling services in addressing their psychological needs and that it also gave them the courage to voice their opinion.

"I am a beneficiary of counseling service, it is very good. Their treatment is good. It helps you have vision in life in order for your future to take shape. Both the individual and group counseling is very good. It helps you became strong" (SI with 19 yr. old Netsanet).

"i have faced a lot in life after the death of my father. I suffered a lot when i was working in Arab country and in my second marriage. The private counseling helps me to feel at peace."(SI with 22yr. old Semira).

These finding shows through individual counseling with a counselor, women GBV survivors are given the opportunity to take part in their own healing process respecting their decision making right and ability to think through their option rather than deciding for them. The support group counseling on the other hand reduced women survivor's feelings of isolation; help them learn from each other's experiences and gain additional support from others experiencing similar events. The following case narrative further display the experience of former resident with counseling service while receiving care at AWSAD shelter.

"Melat illustrate how her experience at the shelter changed her life around. "i never knew my parents it's my aunt who raised me . When I was in grade 8 going to high school my aunt told she can no longer support me and asked me to leave. I came to Addis Ababa. I did not know anyone here so I lived on the streets for about a year and a half. Life on the street is full of horror especially for a handicap person like me on top of that I was raped by a guy I did not know and became pregnant. The police tried to look for him but could not find him. Well God

works in a mysterious way they communicated with women's affair and women's affairs brought me to the shelter. I was a trouble maker when I first came to the safe house. Imagine i am handicapped... victim of rape..., pregnant and secluded from society for long time. Because of that my behaviour was not suitable to live with other people. We used to give the counsellor a hard time we yell at her give her a bad eye but she used to treat us patiently she tells us to be strong that we are able . When she teaches us and makes us feel calm we started to forget about everything and picture new life ahead. Counselling does really change people. I am a humble person now I have learned how to approach, how to be honest, lovable and how to live with people peacefully" (CI interview with 20 yr. old Melat).

The above narrative from Melat is a clear illustration how GBV affects vulnerable members of the society and how each survivor copes with their abuse. Melat became a violent person as a result of abuse. Her abuse coupled with her physical disability and poverty not to mention the responsibility to care for a child conceived through an abuse set her even further apart from society. However through patience and compassionate counselling service she is able to deal with her frustration and anger one by one and later on became a positive, sociable and self-reliant women breaking her physical, emotional economic and, social barriers.

4.3.4 Legal follow-up

Gender based violence perpetrated against women and girls, violets a whole bunch of fundamental human rights. Study participant's reproductive rights, the right to education, the right to employment and economic prosperity, the right to self-determination and bodily integrity, the right to safety and security were violated.

The abuse experienced hampered majority of the study participant's opportunity to carry on with their education

"When my aunt found out that i reported to the police what her husband have been doing to me, she wanted to kill me. The police brought me here for my safety and I had to quit school."(SI with 18yr. old Yesimwork).

‘Me and my brother used to live with our mom and dad. My dad died in an accident my mom died later since she had a heart problem. My brother for unknown reason had disappeared even before our parents died. My dad’s sister lived in Addis Ababa so she took me….. I started to live with her. I was later diagnosed with diabetes and became physically weak to do household chores. Following my diagnoses my aunt started to grow hatred towards me so she started hitting me and…… burns my body hitting a spoon and fork. She one day locked me out of the house when I came from school. I waited for two days at the neighbour house she did not show up” (SI with 19 yr. old betty).

Majority of the study participants reproductive rights on when, with whom to have child were snatched off of their hands and handed with a responsibility to raise children they conceived through sexual abuse and exploitation.

“I used to work as a house help. My employer had two children and his wife lives out of the country. One night he came into my room covered my mouth and raped me. I conceived following the abuse and filed a lawsuit to get child support but I could not trace the man” (SI with 19yr. old Emebet).

*“I used to work at a factory in Nazret. The father to my first child whom I met and know through Facebook ended up being a married man. I found out about it when I was 7 month pregnant. So I decided to raise my baby by myself. I then met another guy. We only spoke over the phone. He used to sweet talk me into believing that we will live together as a family. He came to Nazrte so i went with my friend to meet him. We spend the day together then later he took me away leaving my friend with his driver. They made me drink that day for the first time so I was drunk and did not know what I was doing and ended up conceiving. I told him that I was pregnant he said okay. He then started to use multiple phone numbers, refuse to receive my calls even disappear. He told me to come to Addis Ababa when iwas 9 months pregnant i came but left me money with someone. I called him soon after I deliver he told me to meet him at a place called Taytu hotel I went carrying my one month old baby and 1 year old son but he never showed up until this day. I never knew why he did this to me” (SI with 25.yrs old Ansica)***.**

Globally, incorporating legal service with other response interventions i.e. medical and psychological care with in a shelter for survivors is believed to be a best practice that increases access to a comprehensive care and facilitate timely access to justices for women GBV survivors. However since shelters in Ethiopia are not mandated to provide legal aid services women GBV survivors at the shelter can only receive case follow-up service.

"We receive 90% of our funds from foreign donors and according to the Ethiopian charity and society's proclamation number 621/2009 so we cannot intervene on advocacy. This means we don't have the mandate to either pursue the ladies cases or fully represent them in the court of law. What we do is follow up on their legal matters by taking them to the police stations when they want to file a lawsuit against their abuser, if those who were brought by the police have already started their court process; we bring them to court on the appointed days. We also prepare survivors psychologically so that they would not fear while giving their testimony in court" (KI with Byoushe- legal follow up and documentation officer).

Women survivors of GBV who would like to file civil cases on the likes of child support, divorce, property and compensation are refereed to other legal aid service providers.

"There are women with children and those who give birth while living at the safe house we tell them what the child is entitled to and all about child support including divorce and such. We don't force them to sue we just point to them where they should go to get the legal support they are seeking for. For example we work with child justice project office located at yeka tribunal court therefore we refer the women there" (KI with Byoushe- legal follow up and documentation officer)

Most participant particularly the once who have been referred by the police noted that they have filed lawsuit against their abuser and benefited from the legal follow-up service they receive at the shelter

"I filed a child support claim in court of law against my husband for our two children. Women's affair and the shelter jointly helped me by following up on my case. I used to go to court only on the appointed days. With their help I am happy I finalised my case with the court granting me to receive a child support" (SI with 23 yr. old Meseret).

"Bayoush is a professional she tells us whenever they call her from the police station on our court appointment and they bring a car and take us there. They advise us not to worry and feel hopeless if our cases take long. My case has been presented to court and it's handled by a prosecutor. The court is going to give judgment on the next trial I don't know how many years he will get. The legal follow-up here is very good. If we keep silent about our abuse our little sisters will be subject to such abuse and the violence will keep spreading" (SI with 19yr. old Meron).

4.3.5 Vocational training

Women GBV survivors usually ends up becoming the sole bread winner of their children after fleeing violence, being abandoned or being expulsed from their matrimonial home. Therefore, they are likely to struggle to bring ends meal for their family with menial casual jobs due to their limited skills. And that can again place them in a vulnerable position where they can be subject to further abuse and exploitation. Women GBV survivors therefore, need to get vocational training on new and different marketable skills. Such skills not only upgrade their previous skill but also facilitate their healing process and increase their self-sufficiency.

Women GBV survivors at the shelter are offered with hairdressing, food preparation , embroidery and sewing, bamboo and leather making skill training so as to build their self-esteem and earn an income from it after leaving the shelter.

"We have in-house and outside trainings. The in-house trainings at the safe house consist of embroidery and sewing, food preparation and hair dressing whereas trainings like that of leather and wood work/bamboo are given outside the safe house" (KI with Yewebnesh –IGA coordinator at AWSAD).

"I am currently taking training on bamboo work. The place is located outside the shelter. Four other residents are taking the training with me from this shelter. Even though I don't know where they are from there are other women like us who take the training. Our trainer is an old mature men, He is like a father and is happy with our work too. Visitors at times come to our workshop and buy the items we make" (SI with 20yr. old Kidist).

Some of the study participated stated they are able to get a skill they always wanted to have at the shelter

"There are numbers of trainings here. I took training on bamboo work and almost done with food preparation. I have always wanted to train on these skills but was not able to do so with my former job" (SI with 25 yr. old Ansica).

Other study participant said they feel confident with the skills they garnered from the vocational trainings that it would allow them acquire jobs with earnings that would meet their children and their needs.

"I was not like this when i come. i had lost hope so i never though i would be able to work for a day . I am a changed person i now learned a lot i have acquired different skills. I feel confident now that I can support myself and my two children when i leave the shelter" (SI with 23 yr. old Meseret).

The study participants also shared that taking the vocational training helps them to deal with their abuse and have hope for the future

"I have received training on food preparation. The training took 6 months. I now am thinking of my life ahead putting my abuse behind" (SI with 19yr.old Meron).

The study participants also mentioned that they receive life skill and business skills trainings on how to maintain or keep jobs, drive profit from a business in order to attain sustainable income for themselves and their families.

"There are professionals who come from outside to give us training on life skill and business skills" (SI with 19 yr. old Betty).

Furthermore, women GBV survivors are assisted to find jobs when they leave the shelter through the connections AWSAD established with government organs and small-scale enterprises.

"Through the connections we make with the government and small-scale businesses we are able to find some jobs for women GBV Survivors who are about to leave the shelter. Former residents landed a job in a factory and other private businesses like a hair salon through such network"(KI with Yewebnesh –IGA coordinator at AWSAD).

Women GBV survivors who would like to engage in business also receive a financial aid as a business start-up. They are also funded money for a household expense including house hold

item and rent until they are able to stand on their two fit. Ex-residents social and economic progress on the other hand is also monitored through monthly meeting and filed visits.

"When they leave the shelter their first month rent will be paid , we will provide house hold expense and house hold items like bed, cooking utensils and the likes as well as items for their business if they want to engage in trade"(KI with Amelewerk shelter and food preparation a coordinator at AWSAD)

"We visit ex-residents in our field trips to see how they are holding. They also hold money meetings here at the shelter to learn from each other" (KI with Girum MEL officer at AWSAD).

4.4 Perception of women GBV survivor on service provided at AWSAD

4.4.1 Participation

Participation in this context is involvement of women GBV survivors in the planning, implementation and evaluation process of service delivery. Women survivors of GBV are the key actors in their own recovery process. They acquire the ability to find the best solution to their problems. Service providers need to promote survivors ability to identify and express their needs and wishes reinforcing their capacity to make an informed decision about possible interventions.

Payne (2009) on a victim experience review unveil how women GBV wants to be believed, treated with dignity, to be reassured that it was never their fault, to feel in control and to be able to make informed choice. Similar comment emerged from a key informant who provides counselling service to women GBV survivors.

"We try to make sure the women receive survivor-centered service. Even though more works needed to be done on that area we ask residents what they want/need and if there is anything lacking. The woman wants to be heard more than anything they need someone who recognizes what they went true as an abuse. So we make sure they take part in every service delivery process. On the individual counseling for instance we let them take the lead and empower them to make decision for themselves. The group discussion on the other hand is there for them so that they are able to express their self and to enhance their public speaking skills in the way" (KI with Meaza a counselor at AWSAD).

“The freedom here is very nice it makes you feel a responsible person” (SI with 20 yr. old Tarikwa).

The findings from all study participants interviewed revile service delivery is conducted based on their interest and choice.

“They first ask you what you really want and based on that information they arrange things and let you know” (SI with 19 yr. old Betty).

“I have the freedom to ask what i need” (SI with 19yr. old Meron).

“Everything here is done through consultation. They give you information they tell you the importance and benefit of a certain activity and seek your opinion on it. Everything here is done based on your interest. They never object your action. They don’t make your decision” (SI with 25 yr. old Sewenet).

The findings from both structured and key informant’s interview further show that women survivors of GBV are regularly invited to participate in the monitoring and evaluation process of service delivery and are highly encouraged to file complaint against any service provider when they are not satisfied with the quality of the service.

“When we conduct survey on service we interview the residents what they think about each and every service at the shelter. On the interview we ask them if they encounter problems or challenges while receiving service if there is problem they will tell us since the interview is confidential”(KI with Girum MEL officer at AWSAD.)

“There is a way where we report if a service provider treated us badly or cause harm on us. There was even a time where the founder of the shelter came and talked to us alone in groups about one service provider who received complaint and she was sacked afterwards (SI with 18yr. old Mihret).

Majority of the study participant stated the whole experience changed their attitude towards women, inspired them to engage in GBV response activities in the future and also gave them courage to face their fears.

"I used to think of men when they say a 'manger' or "country leader" I never thought there would be a female manager or leader I even never heard of it. I have now realised that women can reach a higher level and also be a doctor even a country leader. I don't know.. I have many dreams. I want to be a role model just like Maria" (SI with 20yr. old Tarikwa).

"I use to think that men can go anywhere and survive but women cannot since we don't hold any value. I use to think women don't have anything to offer. I now feel proud of myself I even empower other resident whenever I see them cry by telling them we women are equal with men" (SI with 20yr. old Kidist)

"I used to be shy and scared of talking to people but I have started talking now "(SI with 19yr. old Yetimwork)

Involving women GBV survivor in a decision making process not only promote their wishes, rights and dignity but also appreciate and value their experience, ideas, decisions and actions. Active participation place women GBV survivors at the center of holistic multi- sectoral service and that as Durham and Gurd (2005) noted means, the rights and needs of survivors are pre-eminent , in terms of access to respect and supportive service , guarantees of confidentiality and safety and the ability to determine the course of action for addressing GBV incident.

4.4.2 Confidentiality

Confidentiality in this context is an act of keeping secretes and privacy of women GBV survivors. Women GBV survivors usually refrain from either reporting or sharing their experience of abuse to any service provider or member of their community in fear of facing stigma and isolation. Many survivors as a result tend miss out on getting the essential services that responds to their physical, psychological, economical and legal needs. Confidentiality is one of the principles of survivor centered approach in a GBV response intervention that bridge such gap.

A key informant explains how the confidentiality of women survivors are respected at the safe house at all times.

"We ask survivors to tell us about their life and experience of abuse in detail when they come to the safe house. We don't force them to disclose any personal information but advise them to tell us in order to help them cope with their abuse by confirming the confidentiality of any information they give to us. When they do we document it in a file along with their picture. That document is placed in file cabinet then will be locked. The only one who holds the key and has a total access is none other than the documentation officer. A counsellor might access the document on a need to know bases". Other service providers also have files for each survivor these files are also confidential. We don't tell survivors the confidentiality of their information for the sack of telling, we do that because that's the ethics and discipline every staff member follows in the safe house" (KI with Bayoush - A Legal follow-up and documentation officer at AWSAD).

Findings from interviews conducted with key informants and study participants show women GBV survivors tend to disclose any information and carry on to talk about their abuse when they discovery non- judgmental privacy guaranteed environment.

"They will not tell us what had happen to them at first. So we form bond with them so that they would trust us. We also guarantee to them what we discuss will remain a secret. They will then start to open" (KI with Meaza a counselor at AWSAD).

"I reviled my secrets to the counsellor on my private counselling session willingly. She advise me and tells me whatever I tell her will remain a secret between the two of us. None of my secrets are out until today. I trust the confidentiality of information here at the safe house" (SI with 20yr. old Mader).

Women GBV survivors has an absolute right to choose with whom to share or not to share their information, Their story and information should only be shared with their informed consent. According to the a key informant interview those survivors rights are uphold

"We don't force women survivors to share their history and experience with donors or media persons when they come to visit unless they consent to an interview. Donors or media personality are also not allowed to take residents picture without their consent to keep their identity confidential"(KI with Meaza a counselor at AWSAD).

Study participant stated that their secrets are safe with the service providers at the shelter

"I personally believe my secret is kept private" (SI with 18yr. old Mihret).

Some study participants indicated that the shelter had challenges with maintain confidentiality in the past years however was fixed

"Secrets are kept but previously we had issues on the matter and they had it fixed" (SI with 19yr. old Betty).

Findings from key informant interview show at times information about women GBV survivors are shared among other service providers when it's critical to provide assistance and intervention. Such information however is shared on a need to know bases as requested and agreed by the women GBV survivors.

"There are information's we cannot keep confidential. If for instance a survivor disclosed information that had to do with her health i will report the matter to the nurse so that the survivor can get medical treatment. We first however inform the survivor that we cannot keep such information as a secret and the information is passed on a need to know bases just the health aspect" (KI with Meaza a counselor at AWSAD).

Women GBV survivors are also made to understand the increased risk of disclosing personal information to fellow residents therefore are told to maintain a strict confidentiality at all times.

"We are told not to tell residents here what brought us to the shelter or the violence we experienced because when we fight the other lady will insult us saying you are this .....you are that. When this happen you will again become a victim to another abuse and this interferes with your recovery process" ((SI with 23yr. old Sara).

Prominently keeping women GBV survivor's secrets and privacy encourages other survivors to come forwards and break the barriers of help seeking behavior

4.4.3 Non- discrimination

Non-discrimination in this context is quality and fully accessible service to all women GBV survivors without discrimination on any ground. Service delivery should take place with a respect to the diversity of women GBV survivors. Women survivors of GBV should receive

same level of quality of care regardless of their age, ethnicity, and status taking into account their special needs.

Service providers are duty bound to guarantee equal access to essential service to women survivors of GBV to bridge the gaps and remove barriers of reporting abuse. The women survivors at the safe house came from different back ground. Their age, marital status, educational level, religion and ethnicity is different from one another. Some have lived in the safe house for a while whereas others joined currently. However according to all study participants and key informants, all services are given to survivors irrespective of their various backgrounds

"The first thing we do when a survivor joins us here at the safe house is to make her feel at home. We are here to serve every one of them equally. We are doing this for it's a morally right thing to do. Everyone is supplied with materials they need and no one get more or less based on friendly relations. The house has its own standards and every woman passes through those standards. Obviously there are times where we provide special care for survivors who require special attention in terms of the abuse they suffered or health status they are in. Women survivors who require special meal, bedding, etc. are served accordingly and we let other survivors know that we are not assigning a higher or lower status by trying to do this but to create an environment conducive for, all to access the available interventions" (KI with Bayoush- Legal follow-up and documentation officer at AWSAD).

"All of us here are equal. The service provided for violence victims and non-victims might vary but everyone is considered equal. They even advise to have that ethics in our relations with other residents" (SI with 20yr. old Mader).

"*There is no discrimination we celebrate every Christian and Muslim holidays. There is no such a thing as Oromo, Amhara we are seen equally by the service providers" (SI with 18yr. old Yesimwork).*

Non-discrimination is one of the globally promoted ethical principles of survivor centered approach service providers expected to undertake while providing care and support to women GBV survivors. Women survivors of GBV normally face stigma and isolation from their family,

community and society in general as a result of abuse. Experiencing similar or any amount of discrimination from the side of care givers can push survivors to the edge of hopelessness and hamper their right to receive appropriate service.

4.4.4 Safety and security

Service providers need to make sure women GBV survivors are safe at all times. The safety and security of the survivors must remain paramount in the works of service providers. Women GBV survivors might be shaken due to years of abuse and exploitation and frighten the perpetrator would attack them again for that they might need assurance that they are safe.

Women GBV survivors should not in any way be placed at a risk of further harm by the perpetrator or service provider. The finding indicates that the house the study participants reside in is purposively located in anonymous place. There is no sign attached to the door and it is purposefully placed in an area where no one would think it's a safe house for women GBV survivors.

"Nobody knows the where about of the shelter. I don't think i would face harm at the shelter" (SI with 20yr. old Samrawit).

"*Nobody can enter the shelter without being toughly checked. If we have to go out for either medical or legal matters there is always a staff accompanying us" (SI with 20yr. old Tarikwa).*

At the safe house safety and security measures are in place to prevent and mitigate possible harm on women GBV survivors.

"*We only accept women GBV survivors who are referred from different sectors whose true identity was identified by the authorities. We are doing this to protect residents from possible danger as most women living at the shelter are under witness protection. We also don't serve visitors including police and the family/relatives of survivors. We arrange for them to meet either at the police station or the main office to maintain the safety of the shelter. Survivors are also required to surrender some belongings like phone to make sure they don't disclose the address of the shelter"(KI with Bayoushe legal follow-up and documentation officer).*

“Nobody can enter the safe house they are asked why and where they are from” (SI with 19yr. old Yetimwork).

“We are not allowed to have phones over the fear that we would negligently tell people where the shelter is located. I support it because you might revile secretes”(SI with 19 yr. old Netsanet)

Study participant said they feel safe and at home in the safe house

“I am living here without any fear” (SI with 20 yr. old Mader)

4.5 Challenges women survivor of GBV face while receiving care at AWSAD

4.5.1 Availability and accessibility of service

Essential multi-sectoral services that provide much needed support and care to women GBV survivors of GBV should be available to keep them safe provide health care for their injuries, respond to their reproductive health needs as well as counseling and facilitating access to the police and justice system. These services shall be available and accessible, widely known, free of charge and regardless of ethnicity, language, level of literacy, disability or marital status (UN women,

The entire study participant stated they had no information about the true existence of such shelter and had never heard about it.

“I have never though there would be an organization where women victim of GBV are taken care of. It has been a year and a half since i came to Addis Ababa I never even heard of it” (SI with 25yr. old Sewenet).

“I have no idea about the existence of such service. When people say organization i used to think of a factor not a place where people stay in” (SI with 23yr. old Sara).

Even though these essential services are ought to be equitably distributed to women GBV survivors across the regions, study participant stated the lack of available multi-sectoral services

at their hometown and that they are able to access such service due to their move to the city center where number of service providers are located.

"Such serve is not available in other regions. For instance i have never seen such organization in Welo where i am from i was able to get the service since i am in Addis Ababa. There many cased of violence against women in the regions that are not addressed would like those women to receive the same service i am getting here" (SI with 20yr. old Tarikwa).

The entire study participants had to approach government agencies i.e. local municipality, police and women's affair before they finally receive services

"My neighbor who is a police told me about the shelter. I then went to my local municipality, them to the sub-city to access the safe house" (SI with 20yrs old Tarikua).

"Its women and children affairs that referred me to this shelter" (SI with 20yr.old Samrawit).

Where majority of study participants received 90% of services available at the shelter some women survivors fail to access the needed care and support due to language and institutional barriers

"I go to private counseling but cannot communicate with the counselor. I wanted to take training but I was not able to join due to language barriers. I also attend basic education class and group discussion but I don't know what they are saying. I was feeling pain in my ear so i told the nurse I don't know if we communicated well or not but I still did not get the treatment " (SI with 20yr. old Etalem).

The finding indicates that majority of the study participants hold a primary level education while some have never been to school. All of the study participants expressed great interest and enthusiasm to embark on their educational journey however stated what the shelter offers is not enough and does not meet their needs

"I want to get education at list to learn how to write my name. I register to attend basic education class but what we are tough is not that much moreover the class takes part once in 8 days. I want to learn that is what I cannot access" (SI with 18yr. old Zahra).

The researcher also observed the reluctance of some study participants to express their need or file a complaint upon service providers over a fear of being sent out of the shelter.

"It is this shelter that put a roof over my head and supported me when my blood relatives sent me on the streets therefore I am living in the shelter bowing my head down to everyone" (SI with 18 yr. old Serkalem).

"Most of us don't usually say much when we are asked if we have any problems either with the service or service providers since we fear" (SI with 18yr. old Mihret).

The study participants further noted their challenges with the justice system. Although the Ethiopian government put in place policies, laws and a national committee to address issues regarding GBV as well as open special investigation and prosecution unit on GBV to respond to GBV survivor's need towards justice, most study participants expressed their disappointment on both the police and the judicial system.

"My case did not turn out well. I used to ask the police what became of my case over and over again. After some time well…hmm there is nothing money would not do! They told me that they have released my abuser on bail. After that they told me he took off to another country and that they could not catch him" (SI with 18 yr. old Yesimwork).

Some study participant explained how the court gave less attention to their matter.

"The *legal system makes you lose hope I don't know! The court at first closed the file saying my husband is no were to be found. I told bayoush about my case and she told me I can have my file reopened. I went to the court to do that but the court sent me back saying they have lots of files at hand and they will deal with mine later" (SI with 20yr. old Kidist.)*

"I filed a lawsuit against my employer and the court issued summon for him to be present in court and I was told to give him the summon paper in the company of a police. We went to his place three times but find the house locked. One of the police managed to talk to him over the phone and asked him to come for questioning he said he will come we waited but he never showed up. The courts hearing was for DNA check-up orders so the judge say they can't pursue the case without his presence so they told me I am done" (SI with 19 yr. old Emebet).

The findings from the structured interview showcase how such fall outs imposed a negative impact on other study participants. Most show reluctance to pursue either criminal or civil lawsuit against their abuser due to lack of trust on the police, fear of lengthy and complicated trial and lack of evidence.

"The court ordered my husband to pay child support but since he could not do that he took my son to live with him I don't want to go to court and suffer with that long process" (SI with 24yr.old Selam)

"I know what the legal follow-up service office does here but I did not want to take my case to court. I did not want to sue" (SI with 20yr. old Mader).

"Bayoush told me about child support but since i don't know the where about of my child's father I did not sue" (SI with 25 yr. old Amarech)

The above findings concur with a country report (2011) by the US department of states on human right practices in Ethiopia. According to the report there are significant gender gaps in the justice system, inadequate investigation, and lack of special handling case involving women. Reports made to the department also reveal that domestic violence and rape cases are often significantly delayed and given low priority. As it can be observed from the above finding and report herewith it is no secret that the police and justice system remain to be the weakest link in addressing GBV over the years in Ethiopia..

Women GBV survivors attitude, knowledge on GBV including human rights as well as perception of their role could affect the quality of the service they receive. Women GBV survivors who demonstrate less understanding of GBV and fundamental human rights are more likely to have less control and decision making power over their recovery process. Survivors-centered comprehensive service places the right, needs and desire of women survivors of GBV as a center of focus of service delivery. Women GBV survivors should know their fundamental

right and be able to get information about services available to them   in order to be in control hence make informed decisions. Most study participants interviewed in defining GBV mentioned early marriage, FGM and rape only as an act of GBV. Only one study participant named economic abuse among the types of act that may be characterize as GBV. Moreover, none of the study participants, considered the care and support provided to them at the shelter a response they are rightfully entitled to get. This could reflect the lack of information and human rights training.

Another concern stated by the study participant was about their life after the shelter with the current living expenses as they heard some stories of ex-residents who went back to what they were doing before joining the safe house. The following case narrative illustrates challenges of self-reliance on women GBV survivors after leaving the shelter.

"Timinit narrates the challenges she faced after leaving the shelter "I used to live with my husband. We stayed married for two. His behaviour however started to change ever since I got pregnant that is when the argument between us started. He then one day took the entire household and disappeared. I waited for him for some time but he did not come. So I went to women's affair since I could not afford to pay with the money I used to gate roosting cornI needed a place to stay my daughter was 9 months old. Women's affair referred me to this shelter. I stayed at the shelter for 10 months. During my stay I received every essential service food, close, medical care for both me and my daughter. I was heartbroken when I came here counselling service build my confidence I can say they helped me recover psychologically; I also took skill training on embroidery and sewing. When I left the shelter they covered for me rent and household expenses for certain months. They organized us with other resident to engage in food business. But the business was unprofitable, so we all took our own path. I now wash clothes. I cannot do other job or go to school since I have no one helping me with my daughter. I had to take her to school bring her home after school plus I have a daughter I cannot trust anyone. It has been 3 years since I left the shelter life is not easy especially the first one month trying to reintegrate with the community is very challenging living in a shelter for long. But I am still determined to work with the skills I acquired from the shelter after my daughter is old enough to look after herself unless AWSAD help us with nursery service for our children"(CI with 24yr. old Timinit)

Timit narrated she was abandoned by her partner. She struggled to meet ends meal for herself and her daughter. She was in need of a shelter. She said she received all of the important services for her daughter and herself at the shelter. She said the counselling service really helped her to restore her psychological health. She further noted challenges of reintegrating into the community as well as running a business which crumbled. Even though she has embroidery and sewing skills, she is not able to use it due to her double responsibility i.e. raising her daughter and being the breadwinner. She also expressed fear of living her daughter under the supervision of another adult due to the GBV stories she heard about underage girls who experienced GBV receiving care at the shelter. And recommended nursery service for their children so that they can use the skill and make a good living out of it.

4.5.2 Attitudes of service providers

Service providers are expected to provide compassionate care for women GBV survivors by emphasizing respect on women GBV survivors' right rather than addressing culture driven believes. Negative and potentially harmful attitudes including survivor blaming and disbelieve on the side of service provider can pose as a barrier to women GBV survivors reporting and help seeking behavior.

Women GBV survivors first point of contact are often the police or medical person (nurse, doctor or health officer). These service providers can either begin the healing process or drive women GBV survivors away. Most health professionals and law officers lack the skill and resource to provide compassionate, confidential and competent service, despite their own desire to do so. As a result woman GBV survivors fail to receive high quality care that meets their need and international standards.

"The police found me after I was gang raped by three men and they took me to the police station. I spend the night at the police station. I was shaking the next morning when the lady officer was taking my word she shouted at me for not responding to her question" (SI with 19yr. old Yetimwork).

"The police don't give you proper information about the shelter. What they tell you and what you see coming here is totally different" (SI with 19yr. old Betty).

Attitudes can be reveled in once tone, body language, speech and action. Although most of the study participant praises service providers for their compassionate sisterly approach, some study participants find certain service providers attitude challenging.

"*Since she does not give me a positive answer and show me a good face I don't go to her office"(SI with 18 yr. old Yetimwork).*

"I don't want to mention her name but there was a time where one of the service provider used a degrading words to me when I asked a question" (SI with 24yr. old Selam).

Multi-sectoral model for prevention and response to GBV recognizes the right and need of women GBV survivors in terms of accessing respectful and supporting service that guarantee confidentiality, safety and the ability to determine a course of action for addressing GBV incidents. Responding to GBV is a difficult task. Service providers need to be trained to ensure competent, compassionate and confidential care is delivered to women survivors of GBV.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study assesses the experiences of women GBV survivors with survivor-centred approach at AWSAD in Addis Ababa, Ethiopia. More precisely, the study undertook to establish the medical, psychological, economic and social needs and the interventions that are put forwards in order to respond to women GBV survivors based on their interests and wishes. As well as identify challenges they counter while receiving the service.

5.2 Summary

Women risk GBV in a situation of violent relationship, breakdown of family, insecure work place, limited access to resources and inadequate housing. Study participants experienced various forms of GBV by strangers and intimate partners/ husbands living them with feelings of shame, anger, unworthiness, unloved and a believe that they no longer have real control over their life and situation. They also ended up with physical injuries like that of bruises, broken nose/bones and diseases such as STDs. Study participants who experienced sexual abuse and exploitation are forced to carry the burden and responsibility of motherhood to a child conceived as a result of an abuse. These women lost all family ties and were homeless to the point of living on the street and church grounds begging for food and money. Therefore all of them had lost hope over life and many even opted to end their lives and miseries if it was not for AWSAD they say.

Association for women's sanctuary and development runs two safe houses in the capital of Ethiopia, Addis Ababa welcoming women who stuffed GBV along with their children. AWSAD's shelter is the first of its kind and an ideal safe house that offer comprehensive

services such as medical care, psycho-social and legal follow up including economic or vocational empowerment to equip women GBV survivors with the necessary skills to lead independent lives in future. Although the association began to extend care and support to women GBV survivor back in 2003, public knowledge as to the existence of such GBV response center or any other organization that works on GBV interventions for that matter is at infancy. Study participants had no prior information about the shelter before joining. This lack of information however did not last long as they were briefed on the available services, their rights and responsibilities. Key participant as confirmed by the study participant noted that service providers at the shelter are well trained professionals who embrace the ethical principles one required to have when providing service to GBV survivor.

According to respondents all survivors are treated equally and receive treatment in respect to their abuse without any discrimination on the bases of age, ethnicity, and religion, educational and economic status. They moreover are handed opportunities to participate in their own recovery process with rights to decide what service they will receive and choices to take on any vocational training that help build their skill. The safe house maintains ethical principle of confidentiality by making the communication between women GBV survivor and service provider privileged information. This personal records are kept in a secure area where no one can access unless on a need to know bases with the survivor's knowledge /permission. Survivors are taken out for a picnic to relax and enjoy new fresh of air and this made them feel normal.

Safety precautions are set to keep survivors safe from keeping the address of the safe house a secret to giving self-defense (Taekwondo) training for women survivors of GBV in order to prevent/fight back before or after violence/abuse occur. Survivors who believed to be at risk of

possible harm are accompanied by a service provider when making a trip to health center, police station or court. Any utensils or sanitary items that are likely to be used by survivors to cause harm up on the selves or others are on locks and used under supervision. The association further conducts re-assessments by service providers and monitor and evaluate its performance to make sure promises made to provide adequate care and support to women survivors of GBV are followed through. Women GBV are also provided with living costs and startup capital to help them settle when leaving the shelter. Ex-residents are invited to attend meetings organized specifically for them every month. They are also visited by AWSAD staff on field trips to see their progress.

The study participants said through their recovery processes not only they gained a physical strength and mental confidence but also saw a bright future. Many even aspire to fight GBV against women and girls through support and activism. However, even though the study participants embody a fighting spirit and determination to prevail all odds, survivors face various challenges in getting services they need. Most of the respondents for instance are desperately determined to change their educational status by getting a formal education they however, say what the shelter offering in terms of basic education does not match their desire and is not enough. Others face a language barrier which prevented them to interact with service providers making the pace to recovery very slow. In addition though all SGBV survivors want their abusers to get proper punishment for what they did to them, their trust on the justices system crumpled as their cases are significantly delayed and given low priority by police officers, prosecutor and judges. Although survivors are encouraged to report any complaints they may have towards services or service providers, the researcher noticed the fact that survivors have nowhere to go and that they need the support they can get from the shelter, they seem hesitant to

make such complaints over fear of being kicked out of the shelter. Moreover lack of space i.e. land, limited legal mandate to peruse legal support for women survivors of GBV and a not so successful settlement of ex-residents in businesses remain a big challenge for AWSAD as an organization.

5.3 Conclusion

Women GBV survivors have the right to get quality service to prevent immediate and long term threads against their physical, psychological , economic and social welling. Study participant confirmed receiving competent care at the shelter that prevented their risk of ongoing injury and suffering. The study participants identified the service to be compassionate, empowering, involving and confidential service. Majority of the study participant rated counseling while some pointed out the benefit of health and vocational training. Study participants to some extent ascertained the existence of challenges that prevented them to seek certain service at the shelter but mostly from law enforcement agencies and the justice sector. The study concludes that comprehensive survivor-centered service with an effective referral pathway in collaboration with government and other service providers help women survivors of GBV who lives were shattered by abuse and exploitation to recover and gain control of their life by adequately addressing their wide ranging needs, wish and choice .

Women survivors of GBV indicate that such service shall extend to sub-cities and other parts of the country particularly in a rural Ethiopia to reach many unfortunate victims of GBV. Women survivors of GBV as well as key participants further pleads government assistance to facilitate AWSAD services by provision of land so it expands its services to many more Women GBV survivors as well as called for other service provider’s intervention to ease AWSAD’s burden.

5.4 Recommendations

Coming from the above findings and in order to make GBV response interventions more survivors – centered, the researcher recommends the following undertakings:-

- Many women victims of various abuses don't seek the required services due to added social and cultural victim shaming and stigma, therefore any GBV response intervention should employ a human rights perspective in order to explicitly challenge prevailing norms that make violence acceptable with in a society.
- For AWSAD to provide training to women GBV survivors on human right so that they can understand the service they are seeking, the choice and decisions they are making are incorporated under their fundamental human rights.
- For AWSAD to design services in a way woman GBV survivors can access irrespective of different backgrounds e.g. hiring multi-lingual service providers with experience and knowledge of the required ethical procedures in caring and providing service women GBV survivors
- For AWSAD to provide random training for service providers on GBV, human rights of survivors, international standards on quality service including best practices as GBV response service is a demanding job which requires service providers to maintain compassionate, confidential and competent service at all times.
- For AWSAD to create awareness among the community about the service that are available at the shelter together with creating a working strategy that welcome self-referral made to the shelter by women GBV survivors without compromising the confidentiality and, safety and security of residents

- For the government of Ethiopia - There should be an effort (e.g. designing national quality service standards)to expand improve and coordinate survivor-friendly services like that of counseling, shelter, victim advocacy , women's support group , legal aid etc. for women GBV survivors.
- The government should engage in designing and enacting laws and policies that mandate comprehensive medical, legal and social service for women survivors of GBV. For example amend the current charity and civil society proclamation to enable GBV response centers offer legal support for GBV survivors making an exception on GBV matters.
- Community–based awareness campaigns e.g. Mass media, community policing, edir (traditional community organization) etc. Should be used to spread information about the existence of shelters for women GBV survivors
- There is a need for further research on multi-sectoral model response for women GBV survivors in order to document good practice and major challenges.

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Appendix 1: Consent form

Good morning/afternoon, my name is SelamawitMengistu, an MA student in Gender and Development Studies at the University of Nairobi. I am carrying out a study on the experience of women survivors of SGBV with survivor-centred approach in Ethiopia. You have been selected as a participant in this study by virtue of being SGBV survivors receiving service at AWASD having accessed to holistic service at the centre. There is no right or wrong answer to the questions that I will ask you, so feel free to express your opinion in their entirety. The interview will take about 30 minutes. However, if you do not want to answer some questions or any questions or don't feel like proceeding with the interview you are free to stop the interview at any time.

I would also request that you allow me to take notes or record the conversation for my data collection. I want to assure you that all of your answers will be kept strictly confidential. Any reference to your name will be of the record to honour the confidentiality agreement. Any information you will give me will be used for this study only and the notes will be destroyed afterwards.

Your participation is completely voluntary but your experiences could be very helpful to other SGBV victims through improving access to survivor-centred multi-sectoral service for SGBV victims. Do you agree to be interviewed?

Please sign here as evidence of your informed consent.

Sign_______________ Date _________________

Thank you for your cooperation.

Appendix 2: Semi-Structured Interview Guide
SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS.

Name of Respondent:	
Age:	
Sex:	**Female**
Marital Status:	• Single • Married • Divorced
Education Level:	• Primary • Secondary • Tertiary • University • Post-graduate
Place of Residence:	

SECTION B: SERVICE PROVIDED AT AWSAD.

1. What types of services are available at AWSAD?
    - How did you know about AWSAD?
    - What service were you looking for when you arrived at the Centre? Can you tell me why?
    - What services were you able to access at the centre?
    - What services were unavailable at the centre?
2. What do you think about the medical care provided at the centre?
    - Did you receive any medical care at the centre?
    - What types of treatments are available at the clinic? How is it set up?
    - Which treatments are not available at the centre? Were there options to access these treatments? What was that option?
    - Are the treatments and medication provided timely?
    - Who provides the medical care? (E.g. a medical doctor, midwife or a nurse.).
3. What is your opinion about the psychosocial service at the centre?
    - What procedures are used to conduct counseling? How is it set up?
    - What types of professional skill training are provided?
    - Who provides the service (E.g. a social worker, training professional psychologist or psychiatrist)
4. What do you think about the legal support service at the centre?
    - Is there an advocacy service at the centre?
    - What types of legal services are given at the centre?

- Who provides the legal service? (E.g. a lawyer, prosecutor or police).

5. Did you have any experience with shelters other than AWSAD?

   - Have you received any service from another shelter prior to AWSAD?
   - What service does AWSAD have that the former shelter did not and vice versa?
   - Which one meets your needs?

SECTION C: SURVIVORS PERCEPTION ON SERVICE .

1. What is GBV for you?
2. What form of GBV have you encountered? By who?
3. Which service do you think is more important to help you recover from your experience? Why?
4. What are the attitudes of service providers towards you? Positive? Negative? Why do you think that is?
   - Are service providers supportive?
   - Did you receive any information about the treatment and care you are entitled to get before you started your recovery process?
   - Were you able to make decision on the treatment and service you received?
   - How would you want service providers to approach you/how do you want to be treated?
5. Do you find the service at the shelter helpful?
   - Do you feel empowered? How?
   - Do you feel independent? How?
   - Do you feel safe and protected at the centre? Why?
   - Are the professional skills training provided at the centre enough? Why? Is there any vocational training you want the centre to consider? What? Why?
   - Do you feel that you overcome your victimization? How?

SECTION D: CHALLENGES

1. Are there requirements set to receive particular services? What are those requirements?
2. Did you receive equal treatment and care as the rest of women survivors at the shelter?
3. Did you find your recovery process active, free and participatory? How?
4. Did you experience challenges in accessing services at the centre? What are they?
    - Did you feel judged? How?
    - Did you feel pressured to disclose information? How?

5. How do you think these challenges could be addressed?

That is all of my questions for now. Do you have anything you would like to add or do you have any questions?

Thank you for your co-operation

Appendix 3: Case Narrative Guide

Thank you for agreeing to discuss your experience at AWSAD further and get into details that will benefit this study.

Please describe to me what brought you to AWSAD to seek care and support.

Generally, kindly share your experience at AWSAD.

Please feel free to include any suggestions of how the services at AWSAD would have been offered differently for easily of access of the SGBV victims.

Appendix 4: Key Informant Interview Guide

A. Monitoring and Evaluation Officer, AWSAD

1. How do you understand GBV?
2. Why do you think women and girls experience GBV more than men?
3. Do you think GBV relate to women's human rights? How?
4. Do you consider GBV to be significant enough to be a social problem?
5. What types of care and support do women survivors of GBV need?
6. Does the center provide these services?
7. How do women survivors of GBV seek help at the centre?
8. How long does the recovery process last?
9. How many women survivors of GBV received service at the centre?
10. How many women survivors of GBV completed their recovery process?
11. How many women survivors of GBV were satisfied with the service at the centre?
12. What challenges do women survivors of GBV face at the centre? How are the challenges addressed?
13. How do you understand survivor-centred approach?
14. Are services at AWSAD survivor-centred?
15. How do you promote equality, confidentiality, respect and safeguard survivor's safety?
16. How do you equip the skills and knowledge of your staff to best meet the needs of women survivors of GBV?

B. A Nurse, AWSAD

1. How do you understand GBV?

2. Why do you think women and girls experience GBV more than men?

3 Do you think GBV relate to women's human rights? How?

4. How do women survivors of GBV seek medical care? How do they express their experience? How do they understand their victimization?

5. What kind of care do you offer women survivors of GBV?

6. What method do you use to help survivors disclose their experience of violence without fear?

7. How do you understand survivor-centred approach? Explain?

8. Do you believe that women survivors of GBV need to be informed about their condition and the medical treatment or procedure they need to receive? Why?

   Do you provide such information?

9. Do you seek their consent before undertaking any treatment?

10. Do women survivors of GBV face challenges in assessing medical care? How do you address such challenges?

C. Councilor, AWSAD

1. How do you understand GBV?

2. Why do you thing women and girls experience more than men and boys?

3. How does GBV relate to women's human rights?

4. How many women survivors of GBV seek counseling support from the shelter

5. How important is counseling support for women GBV survivors?

6. What methods are used to help women GBV survivors recover from their psychological trauma

7. What is your understanding of survivors-centered approach? How do you promote/implement the principles while providing service?

8. What are the challenges you faced in providing counseling support to women survivors of GBV at the shelter? How do you address such challenges?

9. How many do you think recovered through counseling service?

10. Do you think what the shelter is offering in terms of counseling service is enough?

D. Legal Follow-up Officer, AWSAD

1. How do you understand GBV?
2. Why do you thing women and girls experience more than men and boys?
3. How does GBV relate to women's human rights?
4. How many women survivors of GBV seek legal support from the shelter?
5. Why do you think women survivors of GBV are hesitant to file legal complaint against the perpetrator?

6. What kind of legal service do you provide to women survivors of GBV at the shelter?
7. How many of their cases have you taken to court? What was the outcome?
8. How does the Ethiopian legal system respond to GBV in light of Ethiopia's obligation under instruments the country ratified? Is the justice system survivor-friendly?
9. What are the challenges of women survivors of GBV in accessing legal support? How did you address the challenges?

E. House Mother – AWSAD

1. How do you understand GBV?
2. Why do you thing women and girls experience more than men and boys?
3. What is the serving capacity of the safe house? How many survivors are receiving care and support at the shelter?
4. What forms of violence does survivors experience? By who?
5. How many seek the services available at the safe house?
6. How do you make sure services here are survivor friendly?
7. Do you thing the service offered at the safe house are enough?
8. What challenges do women GBV survivors face while receiving care and support? How do you address such challenge?

F. IGA (Income generating activities) officer, AWSAD

1. How do you understand GBV?

2. Why do you thing women and girls experience more than men and boys?
3. What skill development program does AWSAD has at the safe house?
4. Are there requirements to undertake vocational training at the safe house? Why?
5. How do you apply survivor-centered approach when providing vocational training?
6. How important are this skill development trainings are for women GBV survivors.
7. Do you think the vocational trainings that are available at the shelter are enough?
8. What challenges are women survivors of GBV are facing in taking these trainings? How do address such challenges?

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