

A Rapid Gap Assessment Report

In Some Selected Woredas of Amhara and Afar Regional State



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PART ONE

Report on the

Status of the felt needs of healthcare providers on psychological support skills of SGBV survivors', skills on self-care and burnout management at OSCs and PHCUs

1. INTRODUCTION

On November 4, 2020, fighting broke out in the Tigray Region of Ethiopia between the Ethiopian National Defence Force and the Tigray People's Liberation Front. The violent conflict and war, initially largely contained within the Tigray Regional State, spread to many zones of the Afar and Amhara Regional States following the rejection of a unilateral ceasefire declared by the Federal Government on June 28, 2021 (UN Office of the High Commissioner for Human Rights, 2021). Following this expansion of the war, there was massive human rights abuse, killings of civilians, taking civilians hostage, recruiting child soldiers, destroying civilian infrastructure (hospitals, banks, churches, and schools), and gross sexual abuse and rape in Afar and Amhara Regional States. The people migrated in millions. The escalation of conflict in northern Ethiopia has caused an increase in gender-based violence.

GBV service providers play a crucial role in responding to SGBV in humanitarian settings. They provide essential services to survivors, including medical care, psychosocial support, and legal assistance. They also work to prevent SGBV by raising awareness of the issue, educating communities about their rights, and advocating for change. Effective SGBV service providers are essential for ensuring that survivors receive the support they need and that SGBV is prevented in humanitarian settings.

As of February 2023 according to UNFPA, it is estimated that the escalation of the Northern conflict led to an increased number of people in need of GBV services from 3.5 M in 2021, to 6.7M in 2023 across conflict-affected regions. The type of Gender Based Violence experienced due to this conflict has a multitude of Sexual and physical violence, which was very different from other regions of the country. The UN Secretary-General 2021 report documented different forms of sexual violence including rape, gang rape, oral and anal rape, insertion of foreign objects into the female reproductive organ, and intentional transmission of HIV (UNSG,03/29/2022). As the report states, outrageous types of Gender Based Violence specifically sexual violence have been reported by victims. The multitude of Gender Based Violence in these regions was not compatible with the available service and service providers. In addition to the gravity of GBV experienced by the victims, being overburdened and overwhelmed by the needs of the victims can expose the service providers to burnout, stress, and feelings of hopelessness and helplessness. Moreover, there were also various challenges faced by the service providers which put them at risk of various Psychological well-being problems, they were subjected to threats and attacks, causing the closure of essential services, including emergency post-rape care and sexual and reproductive health care, for victims of sexual violence. To address the need various humanitarian actors are working to provide GBV services for survivors, starting from providing various supports to deploying service provider professionals. All nations & international actors responding to an emergency must protect those affected by the crisis; this includes protecting them from GBV. To save lives and maximize protection, essential actions must be undertaken in a coordinated manner from the earliest stages of emergency

preparedness. Sexual and Gender-based Violence is very common & a serious problem in humanitarian settings. It can have devastating consequences for survivors, including physical, psychological, and social harm. It can also determine the effectiveness of humanitarian interventions and make it more difficult to achieve humanitarian goals.

2. STATEMENT OF THE PROBLEM

War has a devastating effect on an individual's overall health and well-being. For instance, conflict situations cause more mortality and disability than any other significant disease (Ormhaug, Meier, & Hernes, 2009). Children and adults pass through long-term physical and psychological suffering as a result of the conflict. Health practitioners are exposed to a variety of potentially stressful circumstances through their work, such as rape, sexual assault, injuries, shootings, murder, accidents, and attempted or successful suicide (Shen, Martelli, Clarke, & Roberts, 2020). It has been proven that exposure to potentially stressful situations or witnessing injury to others increases stress, anxiety, and PTSD consequences (Vanderploeg et al., 2012).

Healthcare professionals all over the world are sent out to address the urgent medical needs of populations in conflict areas. International humanitarian law (IHL) requires the safety of patients, health facilities, and vehicles. Healthcare professionals are also granted protection as long as they carry out their responsibility and don't harm the enemy (International Committee of the Red Cross, 1977). In civil conflicts, these rules of healthcare professionals' neutrality are overlooked and healthcare workers, as well as their patients, become targets (Physicians for Human Rights, 1996). As a result, healthcare professionals are confronted with chronic stressors and risks that can result in poor mental health outcomes consisting of post-traumatic stress disorder (PTSD), anxiety, and depression (Dewane, 1984).

As GBV service providers have been in this system for nearly three years of working under stressful conditions, they face a higher risk of burnout. The term burnout was first used by Freudenberg in 1974. It was used to refer to workers' reaction to exposure to chronic stress, and is assumed to be common in professions that involve human interaction, of which one is the health care profession. Burnout is a psychological condition that is identified by emotional exhaustion, depersonalization, and feeling of reduced personal accomplishment in daily work life (Maslach, Jackson, & Leiter, 1996). Among healthcare workers, emotional exhaustion is attributed to the sense of being strained and depleted of physical and emotional resources, causing them to feel worn out. This results in a negative, hostile attitude and detached feeling toward their patient at the same time, treating them as objects than a human beings. This phenomenon was termed depersonalization. Diminished personal accomplishment refers to the feeling of being inept and inadequate in their work. In accordance with the literature, health care professionals may be dealing with burnout as a result of numerous factors such as a discrepancy between the effort exerted and the reward gained in the workplace (Patel, Bachu, Adike, Malik, & Shah, 2018). Prolonged and

unresolved stress often results in the psychological syndrome of burnout (Maslach, 2003). Burnout has also been shown to affect doctors with PTSD more than those without PTSD (Einav et al., 2008). Burnout negatively affects service providers as well as their clients. It can also induce emotional exhaustion, cynicism, depersonalization (or distancing from clients), and reductions in personal achievement. In addition to this since the nature of Gender Based Violence experienced in this region is new to the society as well as to the service providers it can expose them to severe forms of Mental health problems, such as Depression, Post-traumatic stress disorder, Stress, Depression, Emotional Numbness and Anxiety.

Mental health problem is usually an unnoticed public health issue in war areas. Studies indicate that PTSD, anxiety, and depression are some of the consequences of war that healthcare workers face (Pham, Vinck, Kinkodi, & Weinstein, 2010; Vinck & Pham, 2010). The high-stress environment and functioning in low resource setting will lead them to develop chronic psychological symptoms (Gibbons, Hickling, & Watts, 2012), which, later on, lead them to experience burnout and loss of their occupational commitment (Maslach & Leiter, 2008). Eventually, mental distress can also have an impact on their performance, leading to diminished efficacy in providing treatment for their patients (Alden, Regambal, & Laposa, 2008).

Post-traumatic stress is a pattern of symptoms that occurs due to delayed solutions to acute stress and life-threatening situation, specifically exposure to conflict areas (Lavoie, Talbot, & Mathieu, 2011). Being exposed to conflict in a war zone not only meet the requirement for experiencing symptoms of trauma but also consists of multiple traumatic (Rossignol & Chandler, 2010). The symptoms begin to appear, either immediately after or several days later following the life-threatening event. In the beginning, the person responds to the event by displaying extreme fear, and helplessness and later on start to show responses featured by continually reliving the event with consequential symptoms of numbness, avoidance, and hyperarousal (Risser, Hetzel-Riggin, Thomsen, & McCanne, 2006). After going through a traumatic event, one commonly develops nervousness, anxiety, and sleep disturbance, and 50% of those who suffer from posttraumatic nightmares may have dreams that are similar to the lived traumatic event (McCarthy, 2001; Wittmann, Schredl, & Kramer, 2007). They may also have difficulty concentrating and avoidance of any reminders of the event.

Similarly, it has also been reported that individuals who assist in the recovery from war are more likely to develop PTSD symptoms later in life than those who do not, and, even with specific training and no combat experience, PTSD symptoms worsen with increased exposure to human remains (McCarroll, Ursano, Wright, & Fullerton, 1993). Frequent death exposure, such as that experienced by those processing the war dead, has been linked to considerable psychological discomfort, including post-traumatic stress disorder (Gibbons et al., 2012). Furthermore, frequent deployments have been observed to increase the risk of psychological disorders among military members who have completed many tours of duty, which also happens to military healthcare workers (Shen et al., 2020).

The combination of the challenges of the hospital environment in the time of war, and healthcare workers' personal experience outside of work could make healthcare workers susceptible to numerous traumatic stressors that afterward could result in PTSD (Hodgetts, Broers, Godwin, Bowering, & Hasanović, 2003). Two studies of stress among healthcare workers in the US military during the Vietnam war have identified that more than 30% of the nurses experienced symptoms related to PTSD (Paul, 1985), and 3.3% of the nurses who were still on active duty had PTSD almost twenty years after the war (Stretch, Vail, & Maloney, 1985). Witnessing other person's death and severe injury has also been reported to be adequate to cause PTSD (Carson et al., 2000).

The Psychological and Mental health of the service providers will directly affect the quality of service being provided to victims of GBV. A 2020 study conducted after the pandemic that asked Lebanese, Syrian, and Palestinian women about barriers to seeking GBV-related psychosocial support services, noted a lack of qualified practitioners and previous mistreatment or negative experiences with health service providers as primary barriers. To maintain quality services and address the needs of GBV survivors, service providers need continuous support, including self-care and regular training to build and maintain skills, confidence, and empathy in caring for others.

To address the need various humanitarian actors are working to provide GBV services for survivors, starting from providing various humanitarian supports to deploying service provider professionals. The provision of this kind of service is mandatory, but only setting up a safe space for reporting and assigning professionals will not ensure the provision of quality service. Enhancing the program quality by supporting staff safety and care is crucial. Ensuring the physical and psychological health of the staff must be the focus of humanitarian organizations. Staff working on GBV may face additional and unique safety risks due to the nature of their work, which will in turn put them at risk of psychological health problems. Working with GBV survivors can be particularly stressful. It is common for staff to experience everyday stress, cumulative stress, burnout, vicarious/secondary trauma, and critical incident stress. Vicarious/secondary trauma may be identified by a change in the staff member's ability to engage with survivors and a decreased ability to cope with stress; this is a result of accumulated problems that build over time after several exposures to other individuals' suffering. Being aware of the staff's stress levels, and establishing mechanisms to acknowledge and provide support for their well-being is expected of the organizations.

In summary, the recent crisis has created a drastic deficit in psychosocial, medical, legal and security assistance for GBV victims in northern Ethiopia while needs have proliferated. Frontline workers face inordinate risks and distress yet systemic support for their welfare and capacity is totally inadequate. Strategic action must target these service personnel first so they can in turn play their indispensable role in rehabilitation and justice for survivors.

The war in the northern part of Ethiopia that started on November 03, 2020, had a devastating impact on large proportions of the population living in the Afar, Amhara, and Tigray Regional States. Civilian infrastructure, particularly schools and healthcare facilities, has been severely damaged in these three Regional States. More particularly, Michelle Bachelet (2022), the UN High Commissioner for Human Rights, reiterated a report by the Ethiopian Ministry of Health that 36 hospitals and more than 2,100 other healthcare facilities have either been partially or completely destroyed or looted in Afar and Amhara Regional States.

In line with the literature presented above, it can be assumed that combat exposure, resulting from the recent war in Ethiopia, has put healthcare providers in Afar and Amhara Regional States in a unique position to face military trauma. Healthcare professionals are not immune to deployment stressors, and the current military climate, which includes deployments to post-war, and in some cases active war zones, necessitates a closer examination of healthcare providers' exposure to potential mental health risks. As large parts of the two Regional States have been affected by the war, it is apparent that many healthcare professionals in these areas have been exposed to a potentially traumatic event. Thus, the relevance of conducting a rapid need assessment on this issue is to identify the challenges and felt needs that were created by the conflict in the north of Ethiopia and to design and implement an intervention program based on an empirical study to address the impact on the psycho-social, health, and career-related well-being of SGBV survivors service providers through an effective professional capacity strengthening project. These individuals play a crucial role in supporting victims and require adequate resources and support to effectively carry out their work.

3. OBJECTIVES OF CONDUCTING THE RAPID NEED ASSESSMENT

The purpose of conducting RNA is to comprehensively assess the current SGBV service provision in selected woredas in the Afar and Amhara regional states in order to develop a manual to integrate psychological therapeutic techniques into sexual and gender-based violence case management as well as prepare a separate self-care skills and burnout management training manual. To meet the main objective of this rapid need assessment, the following specific study objectives were developed.

- Assess the types of psychological therapies that are available and used by service providers during SGBV case management.
- Analyse the current knowledge and skills of SGBV service providers in trauma-informed psychological therapies.
- Identify barriers or challenges that face SGBV service providers in delivering effective psychological therapy.
- Identify areas of improvement to strengthen the knowledge and skills of SGBV service providers in providing psychological therapy.

- Assess the existing supervision for implementing psychological interventions for SGBV survivors and support systems and resources.
- Identify the referral mapping of the existing SGBV service provisions in the selected woredas, identifying gaps and areas for improvement.
- Assess the prevalence of burnout among health care professionals in post-conflict areas in the Afar and Amhara regions.
- Assess the self-care skills and lifestyle balance strategies of health care providers.
- Assess the effectiveness of holistic services provided to survivors of SGBV.
- Mapping out (referral and service mapping) the existing SGBV service provisions in the selected woredas, identifying gaps, and areas for improvement.

4. METHODOLOGY

4.1 Survey Design

The purpose of this assessment was to examine the status of SGBV service provision at the selected woredas of Chifra from Afar and Were Ilu, Lalibela, and Weldiya from Amhara regional state, so as to identify the gaps and design a working intervention manual that integrates psychological therapeutic approaches into SGBV case management, a training guide for self-care skills and burnout management, and a supervision guide to improve the service so as to address the needs of its existing and potential service users. The data for the assessment was obtained from primary and secondary sources. Concerning the primary source, relevant data was collected from health care providers and the management team. Regarding the secondary source, relevant documents related to the study topic were reviewed. In order to achieve this objective, a survey was employed.

4.2 Population and Sampling

The participants of the study were all healthcare professionals working in government healthcare facilities in the selected woredas of Afar and Amhara Regional States, i.e., the woredas severely affected by the war in the northern part of the country were the population of the assessment. More specifically, healthcare professionals living and working in areas within the severely affected zones of the Afar and Amhara Regional States were the target population.

Accordingly, as per the report of the Ethiopian Human Rights Commission (EHRC, 2022), the zones affected by the war in Afar Regional State are Fenti Resu, Kilbety Resu, and Awesi Resu zones; while North Gondar, North Wollo, South Wollo, North Shoa and Oromo Administrative zones are the affected zones in the Amhara Regional State. Additionally, the Wag Hemra zone in the Amhara Regional State is another zone affected by the war. Therefore, healthcare professionals working in government healthcare facilities in the abovementioned zones are considered to be members of the target population. Due

to accessibility issues stemming from the large geographic coverage of the war-affected zones in the two Regional States, healthcare professionals working in government healthcare facilities located in relatively medium to large urban centers will be selected as participants for the research.

As the term 'healthcare professionals' contain a large number of professionals such as doctors, nurses, pharmacists, laboratory technicians, physiotherapists, Mental health professionals, etc.; it is necessary to specify potential participants of the research. Therefore, the current research focuses on doctors, nurses and other healthcare providers from the totality of healthcare professionals working in government healthcare facilities in the abovementioned zones of the Afar and Amhara Regional States

<i>S.N</i>	<i>Region</i>			<i>Zone</i>	<i>Woreda</i>	<i>Health Institutions</i>	<i>No of Healthcare providers</i>
1	Afar National Regional State			Zone 1	Chifra Woreda	Chiefra Primary Hospital	47
						Jara PHCU	11
						Mesgid PHCU	26
						Woama PHCU	15
						Total	99
2	Amhara State	National	Regional	Debub Wollo Zone	Were Ilu Woreda	Were Ilu Queen Zeweditu Memorandum General Hospital	102
						Were Ilu PHCU	43
						Chisa Bori Kebele PHCU	32
						Kabie Kebele PHCU	29
						Aregaye Kebele PHCU	13
						Dolu Keble PHCU	18
						Akale Meda Kebele PHCU	13
						Total	250
3	Amhara State	National	Regional	North Wollo Zone	St. Lalibela City Administration	St. Lalibela PHCU	37
						St. Lalibela General Hospital	142
						St. Lalibela General Hospital-OSC	4
						Total	183
4	Amhara State	National	Regional	North Wollo Zone	Woledia City Administration	Woledia PHCU	54
						Gonder Berr PHCU	28
						Woledia Referral Specialized Hospital	379
						Woldia City OSC	4
						Total	465
						Grand Total	997

4.3 Data collection Instruments

Data were collected through a questionnaire and a key informant interview (KII). The primary data collection tool was a self-report questionnaire with seven sections. The first section contains questions asking for socio-demographic information about the participants, such as gender, age, marital status, educational level, profession, years of experience in providing services for SGBV survivors, and the like. The second section provides general assessments of the status of SGBV services. Each of the subsequent three sections of the questionnaire contained two psychometric scales that measured the research variables, and the other one was service effectiveness.

In the present assessment, the overall data collection methodology involved four approaches:

- 1) Qualitative assessment involving key informants, i.e., hospital administrators from selected health care providers from selected woredas, to examine the existing SGBV services, such as the felt needs in the psychological services provided to SGBV survivors, major problems encountered by SGBV service providers, types of services provided by the SGBV treatment unit, support systems and resources, referral and networking, etc. the culture of self-care, and burnout prevention and management skills of health care workers at one-stop centres (OSCs) and primary health care units (PHCUs) so as to design appropriate training and supervision manuals, practical trainings, and clinical supervisions to address SGBV service providers' needs and concerns.
- 2) Quantitative assessment a self-administered questionnaire was adopted in the present assessment to examine the relevant variables. The questionnaire fall in to seven categories listing as follows.

2.1 Demographic /background information

Participants completed demographic questions relating to gender, age, marital status, educational level, profession, years of experience in providing services for SGBV survivors, position or role of the respondent in the health care facility, and type of healthcare facility.

2.2 The Maslach's Burnout Inventory-Human Services Survey (MBI-HSS)

The Maslach Burnout Inventory (MBI)-Human Services Survey has been widely recognized for over a decade as the leading measure of burnout in different human service settings (Maslach & Jackson, 1981). Thus, in this rapid assessment the Maslach Burnout Inventory (MBI)-Human Services Survey developed by Christina Maslach, Susan E. Jackson and Michael P. Leiter was used. The MBI has been taken from the Maslach Burnout Inventory Manual (Third Edition, 1996).

In the manual, three versions of the MBI have been discussed. The Maslach Burnout Inventory-Human Service Survey (MBI-HSS; Maslach et al., 1996), the Maslach Burnout Inventory-Educator Survey (MBI-ES; Maslach et al., 1996), and the Maslach Burnout Inventory General Survey (MBI-GS; Maslach et al., 1996). The original MBI-ES was constructed for the use of educators, and the MBI-GS was designed for the use of workers in other occupations. Moreover, MBI-HSS was developed for

human service professionals from a wide range of occupations such as mental health workers, psychologists, psychiatrists, counselors, nurses, social workers, and correctional officers. Accordingly, this assessment adopted the MBI-HSS survey to assess health care providers' level of burnout.

Burnout is perceived as a three-dimensional syndrome, such as being Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA), and each of these dimensions is measured by a separate subscale (Maslach et al., 1996). The scale has 22 items related to how frequently health care providers were burned out in the last 12 months. From the 22 items, the emotional exhaustion subscale has nine items, which are used to assess the feeling of being overextended and exhausted by their work. The depersonalization subscale has five items to measure negative feelings towards recipients of services, care, treatment, or instruction. The rest of subscale of personal accomplishment has eight items to assess the feelings of competence and successful achievement in the work with people. The frequency of health care providers' experiences and feelings on each dimension is assessed using a seven-point Likert scale where a response ranges from never (0) to every day (6).

Burnout is not defined dichotomously as either present or absent. Instead, it is conceptualized as a continuous variable, ranging from a moderate to a high degree of experienced feeling (Maslach et al., 1996). The scale defines a high degree of burnout when there is a high score on the emotional exhaustion and depersonalization subscales and a low score on the personal accomplishment subscale. An average degree of burnout is reflected in average scores on the three subscales. A low degree of burnout is reflected in low scores on the emotional exhaustion and depersonalization subscales and high scores on the personal accomplishment subscale. Furthermore, Maslach et al. (1996) suggest the following composite index for determining and categorizing levels of burnout scores is described below. (See Table 1).

Composite index of Dimensions of burnout scores	Sub scales	Scores	Cut of points	Level of Burnout
	Emotional Exhaustion (EE)	High score	≥ 27	High degree burnout
		Average score	17-26	Average degree burnout
		Low score	0-16	Low degree burnout
	Depersonalization (DP)	High score	≥ 17	High degree burnout
		Average score	7-12	Average degree burnout
		Low score	0-6	Low degree burnout
	Personal Accomplishment (PA)	Low score	0-31	High degree burnout
		Average score	32-38	Average degree burnout
		High score	Over 39	Low degree burnout

2.3 Self-Care and Life Style Balance Inventory

The self-care and lifestyle balance inventory (SCLB) is a self-assessment tool that individuals can use to evaluate their self-care practices and the balance they maintain in various areas of their lives. It helps individuals gain insight into their well-being and identify areas that may require attention or improvement. The SCLB Inventory consists of 28 items, and the total score range is 0 to 112, where

- Scores ranging from 0-29 would be considered poor Self-care and lifestyle balance.
- Scores ranging from 30-59 would be considered average Self-care and lifestyle balance.
- Scores ranging from 60-84 would be considered good self-care skills and lifestyle balance.
- Scores ranging from 85 -112 would be considered good self-care skills and lifestyle balance.

4.4 Qualitative Data Sources

For qualitative data sources, namely, SGBV service providers, and key informants from hospital administrators were used. The purpose of this data collection was to gather information and perspectives from various stakeholders involved in addressing SGBV, including service providers, and key informants from hospital administrators.

1) SGBV Service Providers

From the selected woreda health posts, centres, and hospitals, SGBV service providers in each SGBV service provider's institution were sampled for qualitative data. The sampling method was purposive sampling, where the criteria was the willingness of the SGBV service providers to participate in filling out the questionnaire. After the SGBV service providers were identified, they were notified as to the purpose of the assessment and were invited to fill out a questionnaire.

2) Hospital Administrators

Hospital administrators in each of the four selected woredas, only four administrators were sampled for qualitative data to be collected through a semi-structured questionnaire.

3) Documents

Document review was conducted, and the selection of documents was based on their significance to the objective of the need assessment. The desk review covered the examination of documentation on the issue, mainly focusing on, but not limited to, the existing inputs for the services of SGBV, e.g., administrative features, human power, materials, financial and technical inputs, etc.

4.5 Quantitative Data Sources

Quantitative data sources, specifically SGBV service providers from selected woredas hospitals, were used as a sample to measure the status of psychological wellbeing using adapted psychological standardised tools (the Maslach's Burnout

Inventory-Human Services Survey (MBI-HSS) and the Self-Care and Lifestyle Balance Inventory) from each selected woredas hospital (e.g., level of stress, burnout, vicarious trauma, and job satisfaction). SGBV service providers in each selected health centre were sampled for quantitative data to be collected through a self-administered semi-structured questionnaire. The sampling method was purposive sampling where the criteria were the willingness of the SGBV service providers to participate in the RNA. After the SGBV service providers are identified, they are notified of the purpose of the assessment and invited to fill out the questionnaire. In total, 30 questionnaires were collected, that is, 10 from Chifra, 4 from Woldia, 14 from Lalibela, and 3 from Were Ilu PHCU/OSC.

4.6 Voluntary Participation

All data were collected after the respondents agreed to participate in the assessment. Thus, the data collection was wholly conditional to the volition of the data sources to participate as data sources, thus, voluntary.

5. DATA ANALYSIS

SECTION I: GENRAL PROFILE OF THE RESPONDNETS

1.1. General Profile of Respondents

The following table illustrates the general profile of the respondents. Based on the data, the respondents' general profile was analysed based on the study site, name of One-Stop Centre, gender, age distribution, marital status, educational level, professional role, role of the respondent, years of experience, and type of health care facility.

Variable	Category	Frequency	Percentage
Study Site	Chifra, Zone One, Afar Regional State	10	32.3
	Lalibela Town, N/Wollo, Amhara Regional State	14	45.2
	Woldiya City, N/Wollo, Amhara Regional State	4	12.9
	Were Ilu, Debub Wollo, Amhara Regional State	3	9.7
	TOTAL	31	100.0
Name of One-Stop Centre/ PHCUs	St. Lalibela PHCU	13	41.9
	Woldiya PHCU	3	9.7
	Jara PHCU	3	9.7
	Were Ilu PHCU	2	6.5
	Were Ilu Nigist Zewditu Primary Hospital	1	3.2
	Gonder ber PHCU	1	3.2
	Mesgid PHCU	3	9.7
	Chiefra PHCU	4	12.9
	TOTAL	31	100.0
Gender	Male	17	54.8
	Female	14	45.2
	TOTAL	31	100.0
	< 25	2	6.5

Age Distribution	25-34	19	61.3
	35-44	6	19.4
	45-54	4	12.9
	55+	0	0.0
	TOTAL	31	100.0
Marital Status	Single	18	58.1
	Married	13	41.9
	TOTAL	31	100.0
Educational Level	Diploma	13	41.9
	Bachelor	16	51.6
	MD	0	0.0
	Specialist	0	0.0
	Subspecialist	0	0.0
	Master's	2	6.5
	PhD	0	0.0
	TOTAL	31	100.0
	Doctor	0	0.0
Professional Role	Nurse	16	51.6
	Midwife	5	16.1
	Pharmacy	1	3.2
	Social Worker	0	0.0
	Psychology	2	6.5
	Counselor	1	3.2
	Health Officer	6	19.4
	TOTAL	31	100.0
	OPD	10	32.3
Role of the Respondent	FP	3	9.7
	Injection	1	3.2
	VCT	1	3.2
	MCH/CPH/CSOP/Health Care	5	16.1
	Professional	3	9.7
	Other	8	25.8
	TOTAL	31	100.0
	< 5 years	24	77.4
Years of Experience	5-10 years	3	9.7
	10-20 years	2	6.5
	20+ years	2	6.5
	TOTAL	31	100.0
Type of Health Care Facility	One-Stop Centre (OSC)	5	16.1
	Primary Health Care Unit (PHCU)	25	80.6
	Other (if any)	1	3.2
	Total	31	100.0

Table 3: General Profile of the Respondents

Study Site: The data was collected from four different study sites. The majority of respondents were from Lalibela Town (45.2%), suggesting a higher concentration or more accessible population in this area. Chifra also had a significant representation (32.3%), indicating another key location for data collection. Woldiya City (12.9%) and Were Ilu (9.7%) had fewer respondents, which may reflect smaller populations or less accessibility and engagement in these district.

Name of One-Stop Centre: Respondents came from various One-Stop Centres, with the highest number from Lalibela Health Centre (41.9%). Other centres had smaller but equal representations, such as Woldia Health Care (9.7%), Jarra Health Centre (9.7%), and Chifra Primary Hospital (12.9%), while some had very few respondents, such as Warra Ilu Zewuditu Memorandum General H (3.2%) and Gonderbar Health Centre (3.2%). This distribution highlights potential focal points for intervention and resource allocation, particularly in centres with higher participant numbers.

Gender: The gender distribution was relatively balanced, with a slight male predominance (54.8% male, 45.2% female). This suggests a fairly equal representation of male and female participants, which is beneficial for gathering diverse perspectives and experiences related to SGBV service provision.

Age Distribution: The majority of respondents were aged between 25 and 34 years (61.3%), indicating a relatively young workforce. This youthful demographic may bring energy and new perspectives but may also lack extensive experience. The absence of respondents over 55 years old (0%) could suggest early retirement or a lack of older professionals in these regions.

Marital Status: More than half of the respondents were single (58.1%), with the remaining being married (41.9%). This distribution might reflect the age group of the respondents, as younger professionals are more likely to be single. Marital status could influence respondents' perspectives on work-life balance and self-care practices.

Educational Level: Most respondents held a Bachelor's degree (51.6%), followed by those with a Diploma (41.9%). Only a small fraction had a Master's degree (6.5%), and none had higher qualifications like MD, Specialist, Subspecialist, or PhD (0%). This educational distribution suggests that most participants have foundational or intermediate-level qualifications, which might impact their capacity for advanced clinical practice and decision-making.

Professional Role: The predominant professional role among respondents was that of nurses (51.6%), with no doctors present (0%). Midwives (16.1%) and health officers (19.4%) also had significant representation. The absence of social workers (0%) and the low numbers of pharmacists (3.2%) and counselors (3.2%) suggest potential gaps in the multidisciplinary approach required for comprehensive SGBV care.

Role of the Respondent: The majority of respondents worked in Outpatient Departments (32.3%), followed by various other roles. A significant portion fell under the 'Other' category (25.8%), which might include diverse or unspecified roles within the healthcare system. The distribution suggests a wide range of responsibilities among respondents, potentially leading to varied experiences and insights into SGBV service provision.

Years of Experience: A significant portion of respondents had less than five years of experience (77.4%), indicating a relatively inexperienced workforce. The small number of respondents with more than five years of experience highlights a potential need for mentoring and professional development to build capacity and expertise within the healthcare system.

Type of Health Care Facility: The vast majority of respondents were working in Primary Health Care Units (80.6%), with fewer working in One-Stop Centres (16.1%). This distribution indicates that most SGBV service provision is occurring in primary care settings, which may influence the availability and comprehensiveness of services provided to survivors.

SECTION II: CURRENT KNOWLEDGE AND SKILLS

2.1. In-Service Training and Supervision Needs

Regarding the participation in professional capacity-building training, the study revealed that a significant portion (74.2%) of respondents had participated in professional capacity-building training programs related to trauma-informed psychological therapy for survivors of Sexual and Gender-Based Violence (SGBV) between 2014 and 2016 E.C. These programs covered various topics including Cognitive Behavioral Therapy (CBT), SGBV Psychiatric Therapy, Self-care, psychosocial support, Case management and PSS, MHPSS, and Clinical management of Rape.

In the case of confidence level in providing psychological therapy, the majority of respondents rated their confidence as 3 or above (74.2%). Specifically, one respondent (3.2%) expressed a high level of confidence (5), while nine (29%) and fourteen (45.2%) respondents rated their confidence levels as 4 and 3 respectively, indicating good to moderate confidence. However, a notable proportion of respondents expressed lower confidence levels, with 22.6% rating their confidence as 2 or below, indicating a need for targeted training and support.

While expressing the need for additional training, a vast majority of respondents (more than 95%) expressed a need for further training in advanced psychological therapy techniques and self-care strategies, as well as refreshment training on SGBV, psychosocial therapy, play therapy, and humanistic approaches or skills. Additionally, there was a strong interest among respondents for obtaining informed consent when providing psychological therapy.

In providing effective psychological support approaches, respondents shared several examples of effective psychological support approaches, including communication strategies and interest in psychological therapy training. Cultural sensitivity in the practice of SGBV services was emphasized, with techniques such as health education, community awareness campaigns, legal support for case development, provision of separate healthcare for SGBV victims, confidentiality assurance, and individual counseling with respect and dignity being mentioned.

With regards to the evaluation of service settings, a majority of respondents (65%) reported that their facilities provided a safe and private environment for survivors, indicating a positive aspect of service provision.

2.2. Barriers and Resources

Several barriers were identified that hinder the provision of effective services for survivors of Sexual and Gender-Based Violence (SGBV). These barriers include:

- Threat to survivor confidentiality: Survivors expressed concerns about the confidentiality of their cases, fearing potential breaches.
- Fear of perpetrator revenge: Survivors reported fearing retaliation from perpetrators, which can deter them from seeking help.
- Survivor helplessness: Many survivors report experience feelings of helplessness, which can impede their ability to access support services.
- Lack of GBV training: Service providers often lack adequate training on addressing GBV issues, leading to gaps in service delivery.
- Environmental setup: Environmental factors, such as the physical layout of service facilities, may not be conducive to providing safe and supportive environments for survivors.
- Financial constraints: Survivors often face financial limitations, preventing them from accessing essential services and support.
- Cultural beliefs and stigma: Cultural norms and societal stigmas surrounding GBV can discourage survivors from seeking help or speaking out.
- Lack of trained personnel: Insufficiently trained personnel in GBV response and trauma-informed therapy can limit the quality of care provided to survivors.
- Inadequate Drug Availability: Shortages of necessary medications for treatment further hinder the provision of comprehensive care.

- Lack of organizational support: Some service providers raise the lack of sufficient organizational support, including resources and infrastructure, to effectively address GBV issues.
- Insufficient training on relevant areas: Service providers raise the need for additional training in critical areas such as trauma-informed therapy to enhance service delivery.
- Discrimination by society: Survivors may face discrimination from society, which can exacerbate their trauma and reluctance to seek help.
- Cultural norms: Cultural beliefs and practices may interfere with survivors' access to support services and their willingness to engage in therapy.
- Lack of allocated budget and resources: Limited funding and resources allocated to GBV response programs constrain the implementation of effective interventions.
- Refusal to open up: Some survivors may hesitate to disclose their experiences due to fear of judgment or retribution.
- Religious intervention: Religious influences may sometimes interfere with the provision of therapy, affecting survivors' access to appropriate care.

With the regards to resources required for trauma-informed therapy, respondents identified specific tools and resources necessary to enhance the provision of trauma-informed therapy to SGBV survivors. These include:

- Ongoing training: Providing continuous training opportunities for service providers to enhance their skills and knowledge in trauma-informed therapy.
- Public awareness campaigns: Using leaflets, banners, and other promotional materials to raise awareness about GBV issues and available resources.
- Developing guidelines: Creating comprehensive guidelines to standardize trauma-informed therapy practices.
- Informational brochures: Producing educational materials in the form of brochures to disseminate information about available services and support.
- Stakeholder meetings: Holding regular meetings with stakeholders to coordinate efforts and address emerging needs.

For any available external support, respondents noted a lack of specific external support from organizations or institutions dedicated to addressing GBV-related challenges. This highlights the need for collaboration and partnerships to leverage external resources and expertise in supporting survivors effectively.

2.3. Feedback and Improvement Suggestions

In response to the findings, several feedback and improvement suggestions were provided by the respondents:

- **Addressing GBV training needs:** Concerned bodies, including professionals in Psychiatry and Midwifery, should prioritize training on GBV awareness and response to ensure a more comprehensive approach to addressing survivors' needs.
- **Self-Care and burnout management:** Training programs on self-care and burnout management are essential to support the well-being of service providers, enabling them to maintain resilience and effectiveness in their roles.
- **Trauma-Informed approaches:** Training in trauma-informed care, Psychological First Aid (PFA), and Psychosocial Support (PSS) should be incorporated to equip professionals with the necessary skills to effectively support survivors.
- **Cultural sensitivity training:** Training programs should focus on cultural sensitivity to ensure that services are respectful and responsive to the diverse needs of survivors.
- **Financial support:** In addition to psychological support, providing financial assistance to survivors can help address practical needs and empower them to rebuild their lives.
- **Prevention mechanisms:** Implementing prevention mechanisms is essential to address the root causes of SGBV and reduce its prevalence in communities.
- **Creating job opportunities:** Creating job opportunities for survivors can contribute to their economic empowerment and facilitate their integration into society after experiencing GBV.
- **Specific SGBV Case Management Training:** Specialized training in SGBV case management should be provided to equip professionals with the knowledge and skills needed to effectively address the complex needs of survivors.

2.4. Supervising and Support

A significant finding from the study is that only 38.7% of respondents reported having access to clinical supervision or support for implementing psychological therapy interventions for survivors of Sexual and Gender-Based Violence (SGBV). Furthermore, respondents did not indicate any engagement in supervision or consultation to address clinical challenges or improve their skills in providing therapy for SGBV survivors.

Interestingly, when asked about the potential benefits of additional forms of supervision, mentoring, or peer support for enhancing psychological therapy practice with SGBV survivors, respondents did not provide any suggestions. However, it is worth noting that such forms of support could play crucial roles in various aspects of practice, including decision-making, experience sharing, refreshment training, regular meetings, and day-to-day monitoring and evaluation.

These findings underscore the importance of establishing robust support systems within organizations and professional networks to ensure ongoing learning, skill development, and emotional well-being among service providers working with SGBV survivors. Access to supervision, mentoring, and peer support can significantly contribute to the quality and effectiveness of psychological therapy interventions, ultimately enhancing the outcomes and experiences of survivors seeking support and healing.

2.5. Referral Process

In the context of providing support to survivors of Sexual and Gender-Based Violence (SGBV), the referral process typically involves the initial administration of Psychological First Aid to newly arriving victims. If deemed necessary, and with the client's consent, they are then referred to nearby referral hospitals for further medical and psychological assistance. The referral hospitals mentioned include Chifra Referral Hospital and Dessie Referral Hospital. This process ensures that survivors receive comprehensive care and support tailored to their needs, including both immediate and long-term medical and psychological interventions.

SECTION III: BURNOUT MANAGEMENT AND SELF-CARE

3.1 Burnout Levels

Based on the data collected the following common burnout dimensions were analysed; Emotional exhaustion, depersonalization, and reduced personal accomplishment.

Dimension	Items	Average Scores	Composite Index	Cut-off Points	Burnout Level
Emotional Exhaustion (EE)	1, 2, 3, 6, 8, 13, 14, 20	1.87, 2.42, 2.06, 2.32, 1.90, 1.00, 3.77, 1.65	17.99	Low: 0-16 Average: 17-26 High: ≥ 27	Average degree burnout
Depersonalization (DP)	4, 10, 11, 15, 22	3.45, 1.23, 1.48, 1.06, 0.97	8.19	Low: 0-6 Average: 7-12 High: ≥ 17	Average degree burnout
Personal Accomplishment (PA)	5, 7, 9, 12, 17, 18, 19, 21	2.61, 3.29, 4.03, 3.58, 3.32, 4.19, 2.90, 3.77	27.69	High: Over 39 Average: 32-38 Low: 0-31	High degree burnout (low personal accomplishment)

Table 4: Burnout Level

Based on the results presented in the table, the following analyses can be made for the three burnout dimensions:

1. *Emotional Exhaustion (EE)*

Composite Index	Burnout Level
17.99	Average degree burnout

The Emotional Exhaustion dimension of burnout assesses feelings of being emotionally overextended and exhausted by one's work. The composite index for EE, based on the average scores of items 1, 2, 3, 6, 8, 13, 14, and 20, is 17.99. According to the cut-off points, this score falls into the "average degree burnout" category, indicating that respondents feel a moderate level of emotional exhaustion in their jobs. This suggests that while they do experience fatigue and stress, it is not at an extreme level.

2. *Depersonalization (DP)*

Composite Index	Burnout Level
8.19	Average degree burnout

The Depersonalization dimension measures an unfeeling and impersonal response towards recipients of one's care or service. The composite index for DP, derived from the average scores of items 4, 10, 11, 15, and 22, is 8.19. This score places it within the "average degree burnout" category, showing that respondents have a moderate level of depersonalization. This indicates that while they may occasionally view clients or patients in a detached manner, it is not a pervasive issue.

3. *Personal Accomplishment (PA)*

Composite Index	Burnout Level
27.69	High degree burnout (low personal accomplishment)

The Personal Accomplishment dimension assesses feelings of competence and successful achievement in one's work with people. The composite index for PA, calculated from the average scores of items 5, 7, 9, 12, 17, 18, 19, and 21, is 27.69. This falls into the "high degree burnout" category, as per the cut-off points, meaning respondents feel a low sense of personal accomplishment. They may perceive themselves as ineffective and lacking achievement in their work, which significantly contributes to their overall sense of burnout.

Overall, the results from the Maslach Burnout Inventory (MBI) indicate that respondents experience an average degree of emotional exhaustion and depersonalization, but a high degree of burnout in terms of personal accomplishment. This suggests

that while they are moderately fatigued and sometimes detached from their clients, the most significant issue is their low sense of achievement and effectiveness in their roles. Addressing this low personal accomplishment might be crucial in reducing their overall burnout levels.

3. 2 Self-Care Techniques and Life Style Inventory

Techniques varied, with some respondents reporting effective personal strategies and others highlighting a lack of organizational support for self-care.

Self-Care and Lifestyle Balance Score Range	Number of Respondents	Percentage of Respondents (%)
0-29 (Poor)	0	0%
30-59 (Average)	12	40%
60-84 (Good)	16	53.3%
85-112 (Excellent)	2	6.7%
Total	30	100%

Table 5: Self-Care and Life Style Inventory Results

Based on the data collected from 30 respondents (one missing value), the distribution of self-care and lifestyle balance scores can be analyzed as follows:

- 1) **Average Self-Care and Lifestyle Balance (30-59)**
 - **12 Respondents (40%)** fall into this category.
 - This indicates that a significant portion of the group has an average level of self-care and lifestyle balance, suggesting that while they may be meeting some basic needs, there is room for improvement in their self-care practices and overall balance.
- 2) **Good Self-Care and Lifestyle Balance (60-84)**
 - **16 Respondents (53.3%)** are in this range.
 - The majority of respondents are maintaining good self-care habits and lifestyle balance. This group generally follows healthy practices and is likely to handle stress and life demands effectively. However, there is still potential for further enhancement to reach an excellent level.
- 3) **Excellent Self-Care and Lifestyle Balance (85-112)**
 - **2 Respondents (6.7%)** achieved scores in this range.
 - A smaller portion of respondents has excellent self-care and lifestyle balance. These individuals likely have well-established routines and practices that support their overall well-being and are able to manage stress and life challenges very effectively.

4) Poor Self-Care and Lifestyle Balance (0-29)

- **0 Respondents (0%)** fall into this category.
- None of the respondents are in the poor range, indicating that all participants have at least some level of self-care and lifestyle balance.

Generally, the majority of respondents (93.3%) fall into the average to good range. Targeted interventions, such as workshops on stress management, time management, and self-care practices, could help those in the average range to move towards good or excellent self-care. For those in the good range, reinforcing existing positive habits and introducing advanced self-care techniques could help elevate their scores to the excellent range. The small group in the excellent range should be encouraged to maintain their practices and potentially mentor others in the group. Moreover, specific items with lower average scores (e.g., "I exercise for at least 25 minutes five days a week" and "At work I take a brief break every two hours and switch tasks") suggest common challenges. Addressing these areas with focused programs could improve overall scores.

SECTION IV: FINDINGS FROM THE KEY INFORMANT INTERVIEWS

4.1 Background of the Respondents for Key Informant Interviews (KII)

The respondents represent a mix of frontline service providers, administrative staff, and leadership positions within healthcare institutions. The presence of a GVB Focal Person suggests some level of institutional focus on addressing Gender-Based Violence (GBV) issues. The educational background of the respondents varies, potentially influencing their perspectives on SGBV survivor services and capacity-building needs.

No	Name of Institution Represented	Sex	Education Level	Profession	Position in Center/Care Unit/Hospital/Institution
1	St. Lalibela General Hospital-OSC	M	MSC	ESPS	GVB Focal Person
2	Lalibela Health Centre	M	MSC	MPH	H.C. Director
3	Were Ilu Health Centre	M	BSC	MWF	H.C. Director

Table 1: Background of the Respondents for Key Informant Interviews (KII)

4.2 Organizational Capacity-Building: Training Programs

Institutions varied in their capacity-building efforts, with some offering extensive training and others lacking structured programs. Based on the responses from the Key Informant Interviews (KIIs) regarding professional capacity-building training programs related to trauma-informed psychological therapy for SGBV survivors, skills in self-care, stress management, and burnout prevention for SGBV survivors service providers, here are the findings from each institution:

Accordingly, institutions varied in their capacity-building efforts, with some offering extensive training and others lacking structured programs, this can be illustrated by the following further analysis.

1) St. Lalibela General Hospital-OSC

Response: Yes, the institution has prepared, delivered, or organized professional capacity-building training programs related to trauma-informed psychological therapy for SGBV survivors, as well as skills in self-care, stress management, and burnout prevention for SGBV survivors service providers.

Description: The training programs include survivor-centered approaches, clinical management of rape, psychosocial support, and mental health services.

2) Lalibela Health Centre

Response: No, the institution has not prepared, delivered, or organized any professional capacity-building training programs related to trauma-informed psychological therapy for SGBV survivors, skills in self-care, stress management, and burnout prevention for SGBV survivors service providers from 2014 to 2016 E.C.

Plan for the Future: However, there are plans by Plan International to conduct training in this regard.

3) Were Ilu Health Centre

Response: There is no indication that any institution has prepared, delivered, or organized professional capacity-building training programs related to trauma-informed psychological therapy for SGBV survivors, skills in self-care, stress management, and burnout prevention for SGBV survivors service providers from 2014 to 2016 E.C.

Hence, St. Lalibela General Hospital seems to have actively engaged in capacity-building initiatives, offering a range of training programs aimed at enhancing the skills and knowledge of SGBV survivors service providers. Lalibela Health Centre acknowledges the lack of such training programs in the past but has future plans for capacity-building activities in collaboration with external partners like Plan International. However, the survey results from Ilu Health Centres seem to indicate a potential gap in capacity-building efforts within their sphere of influence. This raises the question of whether similar training opportunities are readily available to their staff and whether they feel adequately equipped to provide comprehensive support to SGBV survivors.

4.3 Professional Needs

Based on the provided information from the all KI participants, the key professional needs identified for SGBV survivors service providers include:

- a) **Advanced Training in Trauma-Informed Care:** There is a need for advanced training in trauma-informed care to equip service providers with the knowledge and skills necessary to provide effective support to survivors of SGBV. This training would likely focus on understanding the impact of trauma on survivors, adopting survivor-centered approaches, and implementing evidence-based therapeutic interventions tailored to their needs.
- b) **Self-Care and Stress Management:** Service providers require training in self-care and stress management techniques to prevent burnout and maintain their own well-being while working with survivors of SGBV. This training could encompass strategies for coping with the emotional toll of providing support to survivors, setting boundaries, and accessing support networks.
- c) **Psychological Management:** There is a need for training in psychological management techniques to enhance service providers' ability to address the mental health needs of SGBV survivors. This could involve training in conducting psychosocial assessments, providing counseling and therapy, and managing mental health crises effectively.

4.4 Challenges in Providing Psychological Services:

Common challenges included high caseloads, lack of resources, and insufficient training.

In the Key Informant Interviews (KI), participants discussed their experiences in providing psychological services to survivors of Gender-Based Violence (GBV) and the challenges they face in this work.

Experience in providing psychological services: Participants shared their collective experiences in providing psychological services to survivors of SGBV. They have encountered survivors with diverse psychological needs, including trauma, anxiety, depression, and Post-Traumatic Stress Disorder (PTSD). Their efforts aim to provide compassionate and survivor-centered care to address these challenges effectively.

Challenges in Providing Psychological Services: Common challenges faced by health providers in the institutions include:

- **High caseloads:** The overwhelming number of survivors seeking psychological support can strain resources and lead to burnout among service providers.

- **Lack of resources:** Limited access to mental health professionals, counseling services, and medication hinders the ability to provide comprehensive care to survivors.
- **Insufficient training:** Many service providers lack the necessary training and expertise to address the complex psychological needs of SGBV survivors effectively.
- **Survivors' psychological problems:** Survivors often present with complex psychological issues, requiring specialized training and support from service providers.
- **Lack of justice for victims:** The lack of justice for victims of SGBV contributes to ongoing distress and trauma, impacting the effectiveness of psychological services.

4.5 Support for Health Professionals

According to the interview report, recommendations for improving support included:

- **Enhanced on-the-job training programs:** Participants recommended the implementation of comprehensive on-the-job training programs to equip health professionals with the necessary skills and knowledge to provide effective support to survivors of Gender-Based Violence (GBV). These training programs should focus on trauma-informed care, counseling techniques, and psychological management.
- **Better regular supervision:** Participants emphasized the importance of regular supervision to support health professionals in their work with survivors of GBV. Supervision sessions should provide opportunities for reflection, feedback, and guidance to enhance the quality of care provided.
- **Establishing ongoing case management system:** Participants suggested the establishment of an ongoing case management system to ensure continuity of care for survivors of GBV. This system would facilitate coordination between different service providers and agencies involved in supporting survivors, improving the overall effectiveness of services.
- **Connecting mental health services to STI:** Participants highlighted the importance of integrating mental health services with other healthcare services, such as sexually transmitted infection (STI) clinics. This integration would ensure that survivors receive comprehensive care that addresses both their psychological and physical health needs.
- **More resources for self-care and burnout prevention:** Participants stressed the need for additional resources to support health professionals in practicing self-care and preventing burnout. These resources could include access to counseling service.

4.6 Self-Care Culture and Burnout Prevention

During the Key Informant Interviews (KII), participants shared valuable insights and recommendations regarding self-care culture and burnout prevention among health professionals working with survivors of Gender-Based Violence (GBV). The following ideas were reported:

- **Promotion of Self-Care:** Participants reported that their institutions promoted self-care through various initiatives, including training sessions at different levels of government offices such as Woreda level and program rotations. However, the effectiveness of these initiatives varied.
- **Organizational practices and policies:** Practices to promote self-care included workshops and support groups, but no specific policies aimed at reducing burnout were mentioned. Some participants reported training sessions on mental health problem gap management and burnout problem management.
- **Training needs:** Respondents recommended specific training programs focused on self-care, stress management, and burnout prevention, as well as psychosocial interventions, SGBV concepts, and STI management.
- **Current structure of clinical supervision:** There is no structured clinical supervision system in place, and no special qualifications are required from workers for clinical supervision. Some respondents mentioned quarterly review meetings by the Performance Monitoring Team (PMT).
- **Referral Mechanisms:** Participants reported the existence of referral systems for survivors to nearby referral hospitals for further investigation, one-stop centers for comprehensive care, mental health centers for psychological support, and ART centers for HIV risk management. While two respondents reported no significant gaps in the referral system, one respondent from Lalibela Health Centre highlighted concerns about survivors leaving the hospital due to fears of confidentiality breaches, suggesting the need for transportation and other supportive measures to ensure confidentiality.

Generally, these findings highlight the importance of promoting self-care, implementing effective organizational practices, providing necessary training, establishing structured clinical supervision systems, and ensuring robust referral mechanisms to support health professionals and improve the quality of care provided to survivors of Gender-Based Violence (GBV)

SECTION V: CONCLUSION

The findings from the data analysis and key informant interviews provide valuable insights into the current state of support for health professionals working with survivors of Gender-Based Violence (GBV), as well as the challenges they face and recommendations for improvement. Here are some key points for discussion and concluding remarks:

1. **Capacity-Building and training needs:** The majority of respondents have participated in professional capacity-building training programs related to trauma-informed psychological therapy for SGBV survivors. However, there is still a need for additional training in advanced techniques, self-care strategies, and refreshment training on relevant topics. Addressing these training needs is essential for ensuring that health professionals have the necessary skills and knowledge to provide effective support to survivors.
2. **Barriers and challenges:** Various barriers and challenges were identified, including threats to survivor confidentiality, fear of perpetrator revenge, lack of GBV training, environmental setup issues, financial constraints, cultural beliefs and stigma, discrimination, and inadequate resources. These challenges underscore the complexity of providing support to GBV survivors and highlight the need for comprehensive interventions that address both systemic and individual-level factors.
3. **Support and resources:** While some respondents reported access to support systems such as clinical supervision, mentoring, and peer support, others noted a lack of such resources. Establishing robust support systems within organizations and professional networks is crucial for ensuring ongoing learning, skill development, and emotional well-being among service providers. Additionally, respondents emphasized the importance of external support from organizations dedicated to addressing GBV-related challenges.
4. **Burnout and Self-Care:** The analysis revealed varying levels of burnout among health professionals, with emotional exhaustion and reduced personal accomplishment being significant factors. While many respondents expressed a need for further training in self-care techniques and stress management, some reported effective personal strategies. Promoting a culture of self-care and implementing organizational practices that prioritize staff well-being are essential for preventing burnout and maintaining the effectiveness of service provision.
5. **Referral:** The referral process for GBV survivors was found to involve initial administration of Psychological First Aid followed by referrals to nearby hospitals for further medical and psychological assistance. Strengthening referral systems and ensuring confidentiality and support throughout the process are critical for facilitating access to comprehensive care and support services for survivors.

In conclusion, supporting health professionals working with GBV survivors requires a multi-faceted approach that addresses training needs, organizational support, resource allocation, and collaboration with external partners. By prioritizing staff well-being, enhancing training programs, strengthening support systems, and improving referral processes, healthcare institutions and organizations can create an environment that fosters effective service provision and promotes the well-being of both service providers and survivors. Ultimately, investing in the support of health professionals is essential for addressing the complex needs of GBV survivors and working towards building safer and more resilient communities.

SECTION VI: SUMMARY AND RECOMMENDATIONS

In summary, the study highlights both the strengths and areas for improvement in the support provided to health professionals working with survivors of Gender-Based Violence (GBV). While there are existing training programs and a perceived high level of effectiveness in service provision, there are also notable challenges such as burnout, resource constraints, and gaps in organizational support.

To address these challenges and further enhance support for health professionals and GBV survivors, the following recommendations are proposed:

- 1) **Tailored training:** Develop specialized training programs that address the specific needs of health professionals working with GBV survivors, including advanced techniques in trauma-informed care, self-care strategies, and burnout prevention.
- 2) **Organizational policies:** Implement organizational policies and practices that prioritize staff well-being, such as regular supervision sessions, access to counseling services, and opportunities for professional development and support.
- 3) **Referral system enhancement:** Strengthen referral systems to ensure seamless access to comprehensive care and support services for GBV survivors, addressing concerns around confidentiality, transportation, and coordination between different service providers.
- 4) **Community collaboration:** Foster collaboration with community organizations, NGOs, and other stakeholders to expand support networks for both health professionals and GBV survivors, leveraging additional resources and expertise.
- 5) **Research and service effectiveness:** Conduct further research to better understand the impact of support programs on health professional well-being and service effectiveness, using evidence-based findings to inform future interventions and improvements.
- 6) **Advocacy and awareness:** Advocate for increased recognition of the importance of supporting health professionals working with GBV survivors, raising awareness among policymakers, funders, and the general public to drive investment and action in this area.

PART TWO

SERVICE EFFECTVNESS MEASURE (SEM) REPORT

SECTION ONE: PROFILE OF RESPONDENT

Profile of respondent

Studying the profiles of health service providers in relation to the provision of SGBV (Sexual and Gender-Based Violence) related services, such as their age, sex, marital status, educational level, profession, and role within the organization, is critical for improving the quality and accessibility of care. Understanding these factors helps to assess the competency and preparedness of health providers in handling SGBV cases, as well as the potential biases or gaps in service delivery. For instance, providers' educational background and professional experience can influence their approach to SGBV care, while their role in the organization may determine their level of decision-making authority and involvement in critical cases.

1. Gender and Study Site of respondent

Gender/Sex	Frq/cy	%age
Male	45	52.9%
Female	40	47.1%
Total	85	100.0%

Study Site	Total No. respondent	Total %age	Male Frq/cy	Male %age	Female Frq/cy	Female %age
Chifra	20	23.5%	9	45.0%	11	55.0%
Lalibela	20	23.5%	14	70.0%	6	30.0%
Were illu	20	23.5%	13	65.0%	7	35.0%
Woldiya	25	29.4%	9	36.0%	16	64.0%
Total	85	100.0%	45	52.9%	40	47.1%

Out of a total of 85 participants, 45 (52.9%) were male and 40 (47.1%) were female. The majority, N = 25 (29.4%), were from Woldiya, including 9 males (36.0%) and 16 females (64.0%). The remaining 60 participants were distributed evenly among Chifra, Lalibela, and Were Illu, each site contributing 20 participants (23.5%). In Chifra, there were 9 males (45.0%) and 11 females (55.0%); in Lalibela, 14 males (70.0%) and 6 females (30.0%); and in Were Illu, 13 males (65.0%) and 7 females (35.0%). This demographic data is crucial for our analysis and understanding of the study population.

2. Age

Age	Total Frq/cy	Total %age	Male		Female	
			Frq/cy	%age	Frq/cy	%age
Upto_25	11	12.9%	4	36.4%	7	63.6%
26-30	39	45.9%	24	61.5%	15	38.5%
31-40	20	23.5%	7	35.0%	13	65.0%
41 and above	11	12.9%	9	81.8%	2	18.2%
Blanks	4	4.7%	1	25.0%	3	75.0%
Total	85	100	45		40	

A significant portion, 39 individuals (45.9%), fell within the age range of 26 to 30 years. Among these, 24 respondents (61.5%) identified as male and 15 (38.5%) as female. Additionally, 20 participants (23.5%) were within 31 to 40 age range, comprising 7 males (35.0%) and 13 females (65.0%). The younger demographic saw 11 respondents (12.9%), with 4 males (36.4%) and 7 females (63.6%) aged up to 25 years. Furthermore, another 11 participants (12.9%), with 9 males (81.8%) and 2 females (18.2%), were aged 41 and above.

Moreover, we noted that 4 individuals (4.7%) chose not to specify their age, which included 1 male (25.0%) and 3 females (75.0%). This data provides valuable insights into the age distribution of our respondents and highlights the diverse representation across different age groups, particularly among younger adults.

3. Marital status

Marital status	Total Frq/Cy	Total %age	Male		Female	
			Frq/cy	%age	Frq/cy	%age
Married	56	65.9%	28	50.0%	28	50.0%
Single	28	32.9%	16	57.1%	12	42.9%
Other (if any)	1	1.2%	1	100.0%	0	0.0%
Divorced	0					
Separated	0					
Widowed	0					
Total	85	100%				

The data reveals that a significant majority, 65.9% (n = 56), of the participants are married. This married group is evenly balanced between genders, consisting of 28 males and 28 females. This equitable representation suggests that marriage is similarly prevalent among both genders within our sample. Conversely, we observed that 32.9% (n = 28) of respondents identified as single. Within this group, there is a slightly higher proportion of males, with 16 single males compared to 12 single females. While this group is notably smaller, the gender distribution remains fairly close, indicating a modest representation of unmarried individuals. Overall, these findings provide a comprehensive overview of the marital composition among our respondents.

4. Educational level

Educational level	Total Frq/cy	Total %age	Male		Female	
			Frq/cy	%age	Frq/cy	%age
Bachelor's Degree	47	55.3%	29	61.7%	18	38.3%
Diploma	25	29.4%	7	28.0%	18	72.0%
Master's Degree	10	11.8%	6	60.0%	4	40.0%
Doctor of Medicine	2	2.4%	2	100.0%	0	0.0%
Speciality	1	1.2%	1	100.0%	0	0.0%
Subspecialty	0	0.0%				
PhD	0	0.0%				
Total	85	100%				

The educational level of the study participants varied, with the majority (55.3%, n = 47) holding a bachelor's degree, of which 29 were male and 18 were female. Diploma holders made up 29.4% (n = 25), including 7 males and 18 females. Additionally, 11.8% (n = 10) held a master's degree (6 males and 4 females), while 2.4% (n = 2) were doctors of medicine. There was also one male participant who was a specialist. The presence of medical doctors and a specialist highlights the diversity of qualifications within the study cohort.

5. Profession

Profession	Total Frq/Cy	Total %Age	Male		Female	
			Frq/cy	%age	Frq/cy	%age
Nurse	62	72.9%	26	41.9%	36	58.1%
Health Officer	13	15.3%	11	84.6%	2	15.4%
General Practitioner	9	10.6%	7	77.8%	2	22.2%
Emergency Surgeon	1	1.2%	1	100.0%	0	0.0%

Professionally, the majority of participants were nurses, accounting for 72.9% (n = 62), with 26 males and 36 females. Health officers comprised 15.3% (n = 13) of the participants, including 11 males and 2 females. A smaller group of 10.6% (n = 9) were general practitioners, of which 7 were male and 2 were female. Additionally, one male respondent was an emergency surgeon. This professional breakdown highlights the predominance of nursing staff among the participants, while also reflecting the presence of various other medical professionals, including health officers, general practitioners, and a specialized surgeon.

6. Position/role of respondent in the organization/institution

Position/Role	Total Frq/cy	Total %Age	Male		Female	
			Frq/cy	%age	Frq/cy	%age
Health Care Provider	81	95.3%	42	51.9%	39	48.1%
Facility Head- CEO	4	4.7%	3	75.0%	1	25.0%

In terms of Position/role of respondents in their organization/institution: 95.3% (81 participants: 42 Male, 39 Female) were health care providers and 4.7% (4 participants: 3 Male, 1 Female) were facility Heads (CEOs). This data highlights the majority of our participants are directly involved in providing health care services, reflecting valuable insights from frontline professionals. The inclusion of facility heads offers an additional perspective on leadership within health care settings.

7. Years of experience in providing services for SGBV survivors

Years of Experience	Total Frq/cy	Total %Age	Male		Female	
			Frq/cy	%age	Frq/cy	%age
1 Year	34	40.0%	19	55.9%	15	44.1%
1 to 3 Years	19	22.4%	10	52.6%	9	47.4%
Above 3 Years	15	17.6%	6	40.0%	9	60.0%
Blank	17	20.0%	10	58.8%	7	41.2%

The distribution of work experience among respondents providing services to survivors of Sexual and Gender-Based Violence (SGBV) shows a varied range of experience levels. A significant portion of participants, 40.0% (n=34), have up to 1 year of experience, comprising 19 males and 15 females. Those with 1 to 3 years of experience represent 22.4% (n=19), including 10 males and 9 females. Participants with more than 3 years of experience account for 17.6% (n=15), with 6 males and 9 females. Additionally, 20.0% (n=17) of respondents did not specify their work experience, consisting of 10 males and 7 females. These figures highlight the diverse backgrounds of respondents and their varying levels of experience in the field. As we move forward, recognizing these differences will be essential in tailoring training programs and support initiatives. Focusing on the needs of less experienced respondents, while offering advanced guidance for those with more experience, will help ensure that interventions are both effective and relevant to all participants.

SECTION TWO: FACILITY PREPAREDNESS

1. Training and Supervision of Staff

No	Item	Response	Total Frq/Cy	Total %Age	Male		Female	
					Frq/cy	%age	Frq/cy	%age
101	Have you received any in-service training, training updates or refresher training on topics related to SGBV?	Yes	33	38.8%	18	54.5%	15	45.5%
		No	52	61.2%	27	51.9%	25	48.1%

With regard to training and supervision of staff, specifically related to Sexual and Gender-Based Violence (SGBV). Out of the total respondents (n = 85), the findings reveal that a significant majority, 61.2% (n = 52), comprising 27 male and 25 female respondents, indicated that they have not received any in-service training, training updates, or refresher training on SGBV topics. This highlights a notable gap in our current training framework. Conversely, the remaining 38.8% (n = 33), consisting of 18 male and 15 female respondents, confirmed that they have received relevant training updates and refresher courses on SGBV. Given these statistics, it is essential for us to evaluate our training programs to ensure all staff members are equipped with the necessary knowledge and skills to effectively address issues related to SGBV.

2. Availability of Service Delivery Protocols and Client Education Materials

No.	Items	Response	Total Frq/Cy	Total %Age	Male		Female	
					Frq/cy	%age	Frq/cy	%age
201	Do you have or is there a service delivery protocol for SGBV survivors at your service point?	Yes	1	1.2%	1	100.0%	0	0.0%
		No	84	98.8%	44	52.4%	40	47.6%
202	Are there client education materials, brochures, leaflets, or other materials related to SGBV services in your service point?	Yes	23	27.1%	14	60.9%	9	39.1%
		No	62	72.9%	31	50.0%	31	50.0%

When assessing the availability of service delivery protocols for SGBV survivors, nearly all respondents, except one (n = 84), representing 98.8% (44 males and 40 females), indicated that there are no established protocols for delivering services to SGBV survivors at their respective service points. This lack of standardized guidelines suggests a significant gap in structured care for survivors, potentially leading to inconsistent service delivery across different providers.

Regarding client education materials, such as brochures, leaflets, or other informative resources related to SGBV services, the majority of respondents (n = 62), accounting for 72.9% (31 males and 31 females), reported the absence of such materials at their service points. This highlights a lack of accessible information for survivors and communities about available services and support. Conversely, a smaller portion of respondents (n = 23), representing 27.1% (14 males and 9 females), confirmed that their service points do provide educational materials related to SGBV. This disparity underscores the need for improved access to client education resources to enhance awareness and empower survivors.

3. Training and Supervision of Staff

No	Items	Response	Total Frq/Cy	Total %Age	Male		Female	
					Frq/cy	%age	Frq/cy	%age
301	Do you have a consent form in your service point?	Yes	19	22.4%	12	63.2%	7	36.8%
		No	66	77.6%	33	50.0%	33	50.0%
302	Do you have history-taking sheets in your service point?	Yes	21	24.7%	13	61.9%	8	38.1%
		No	64	75.3%	32	50.0%	32	50.0%
303	Do you have a lockable cabinet for files which needs to be secured?	Yes	34	40.0%	22	64.7%	12	35.3%
		No	48	56.5%	23	47.9%	25	52.1%

Regarding the training and supervision of staff, a significant majority of respondents (N = 66, or 77.6%, with 33 males and 33 females) reported that they do not have a consent form available at their service point. In contrast, only 22.4% (N = 19, with 12 males and 7 females) indicated the presence of a consent form in their service area. This lack of standardized consent procedures may compromise the quality and legality of care for SGBV survivors, as obtaining informed consent is a critical aspect of ethical service provision.

Similarly, the majority of respondents (N = 64, or 75.3%, with 32 males and 32 females) stated that they do not have history-taking sheets at their service point, while 24.7% (N = 21, with 13 males and 8 females) indicated that they do. This lack of standardized documentation can hinder proper case management and follow-up care. Additionally, 56.5% (N = 48, with 23 males and 25 females) noted that they do not have a lockable cabinet for securing files, raising concerns about the confidentiality of sensitive information. However, 40.0% (N = 34, with 22 males and 12 females) confirmed the availability of secure storage for confidential files. These gaps in consent procedures, documentation, and file security reflect areas that need attention to improve the quality and safety of SGBV services.

4. Service Delivery Environment

No	Items	Response	Total Frq/Cy	Total %Age	Male		Female	
					Frq/cy	%age	Frq/cy	%age
401	Is there a screen/separate room for keeping privacy of SGBV survivors?	Yes	32	37.6%	20	62.5%	12	37.5%
		No	53	62.4%	25	47.2%	28	52.8%
402	Does the examination room enable to have a free discussion/counselling with client?	Yes	33	38.8%	21	63.6%	12	36.4%
		No	52	61.2%	24	46.2%	28	53.8%

In terms of service delivery environment, a majority of respondents (62.4%, n = 53, with 25 males and 28 females) reported that there is no separate room available to ensure the privacy of SGBV survivors at their service point. On the other hand, 37.6% (n = 32, with 20 males and 12 females) indicated that their facility does provide a separate room dedicated to maintaining the privacy and confidentiality of SGBV survivors. This lack of private spaces could negatively impact the survivors' comfort and willingness to disclose sensitive information.

Similarly, when assessing the suitability of examination rooms for free discussions or counseling sessions with clients, 61.2% (n = 52, with 24 males and 28 females) of respondents indicated that their rooms are not conducive to private, open discussions. In contrast, 38.8% (n = 33, with 21 males and 12 females) stated that their examination rooms are adequately equipped for conducting private discussions and counseling sessions. This gap highlights the need for improved infrastructure to ensure that survivors can have confidential conversations with health professionals, a crucial component of SGBV care.

SECTION THREE: SERVICE EFFECTIVENESS

1. Service Effectiveness Level of Participants

Range	Service Effectiveness Level		Frequency	Percentage
<=14.4	1	Very Low	1	1.18%
14.5-28.8	2	Low	80	94.12%
28.9-43.2	3	Medium	4	4.71%
43.3-57.6	4	High	0	0.00%
57.7-72	5	Very High	0	0.00%

Service effectiveness is measured by the number of responses provided by the interviewee. Each question may have a minimum of 3 possible responses, and if the interviewee selects all of them, they receive a score of 3, which is considered full credit for that question. This structured approach evaluates the completeness of responses, with a maximum achievable score of 72. For example, if a respondent accumulates 27 responses, this score would place them in the second range, indicating a low level of service effectiveness. The scoring system categorizes respondents into different levels, helping to identify areas for improvement and guide future interventions.

The calculation of service effectiveness involves counting the individual's responses from the available alternatives, with an emphasis on expected correct answers. The total number of correct responses is then summed to create an overall score, ensuring that the service effectiveness level reflects how closely the respondent's answers align with the expected correct responses. This provides a clear, quantitative measure of how effectively services are being delivered.

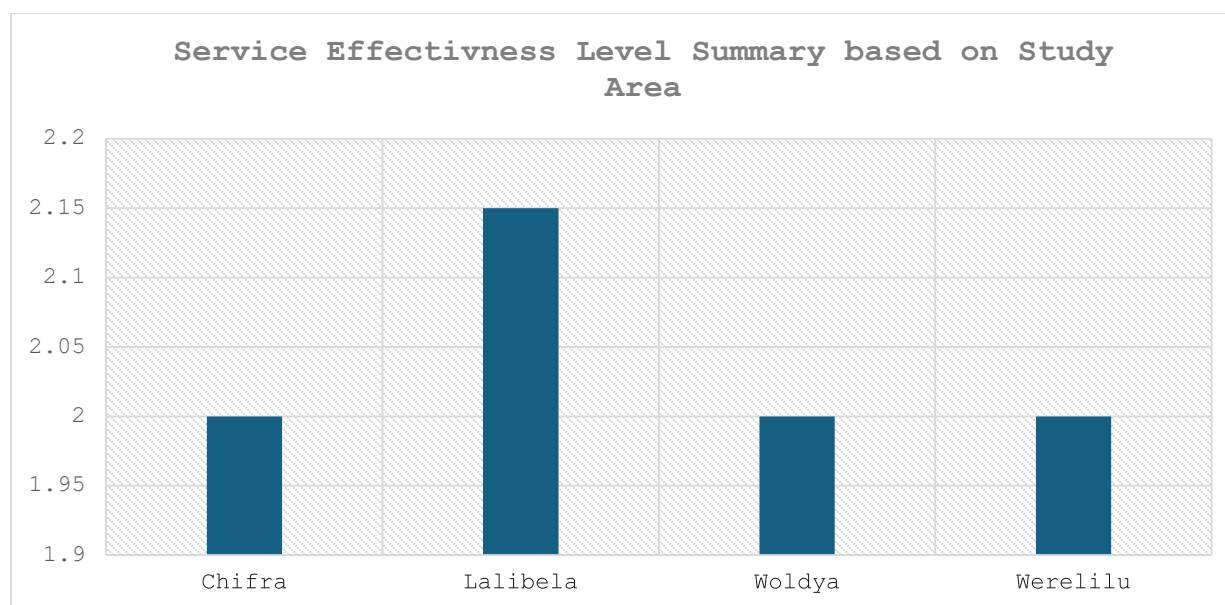
The aggregated score for each individual is then rated on a 5-point scale. The scale ranges from 1 to 5, with 1 representing a "Very Low" service effectiveness (a score of 14.4 or lower), 2 indicating "Low" (14.5-28.8), 3 as "Medium" (28.9-43.2), 4 as "High" (43.3-57.6), and 5 as "Very High" (57.7-72). This rating system allows for a clear classification of service effectiveness, helping to identify strengths and areas needing improvement within the service delivery framework.

Based on the aggregated results of each respondent's correct responses to the service effectiveness questions (Q23-Q43), the following outcomes were observed. The majority of respondents (n = 80), representing 94.12%, scored between 14.5 and 28.8 out of the 72 expected correct responses. These individuals were rated as having a low level of service effectiveness. Additionally, 4 respondents (4.71%) scored between 28.9 and 43.2, placing them in the medium service effectiveness category.

One respondent (1.18%) scored less than or equal to 14.4, ranking them at a very low level of service effectiveness. These results highlight the varying levels of service effectiveness among respondents and suggest areas that may need further attention to improve service delivery outcomes. No respondent was found to have a high and a very high service effectiveness level.

2. Service Effectiveness Level Summary based on Study Area

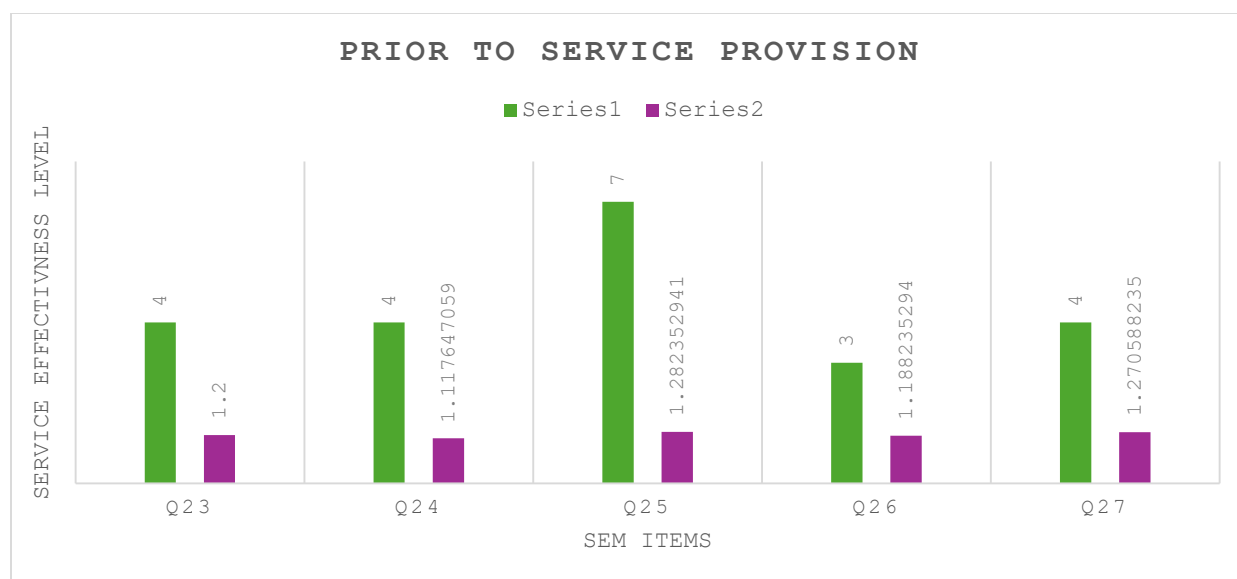
Responses	SEL
Chifra, Zone One, Afar Regional State	2
Lalibela Town, N/Wollo, Amhara Regional State	2.15
Woldiya City, N/Wollo, Amhara Regional State	2
Were Ilu, Debub Wollo, Amhara Regional State	2



Regarding the service effectiveness levels across the four designated study areas based on the summary table and the associated graph, it is evident that all four study areas exhibit a similar low level of service effectiveness. However, when we analyze the data on a relative scale, it becomes clear that Lalibela stands out as slightly more effective in terms of service delivery. This increased level of effectiveness may be attributable to several factors, including its geographical advantage. As one of the largest towns in the region, Lalibela benefits from a higher deployment of health professionals and more accessible facilities.

3. Prior to service provision

No. Of items	Expected Response	Observed Response	Average observed service effectiveness prior to service provision	Level of service effectiveness prior to service provision
Q23	4	1.2	1.2117646	Very Low
Q24	4	1.117647		
Q25	7	1.282353		
Q26	3	1.188235		
Q27	4	1.270588		
Aggr	22	6.0588235		



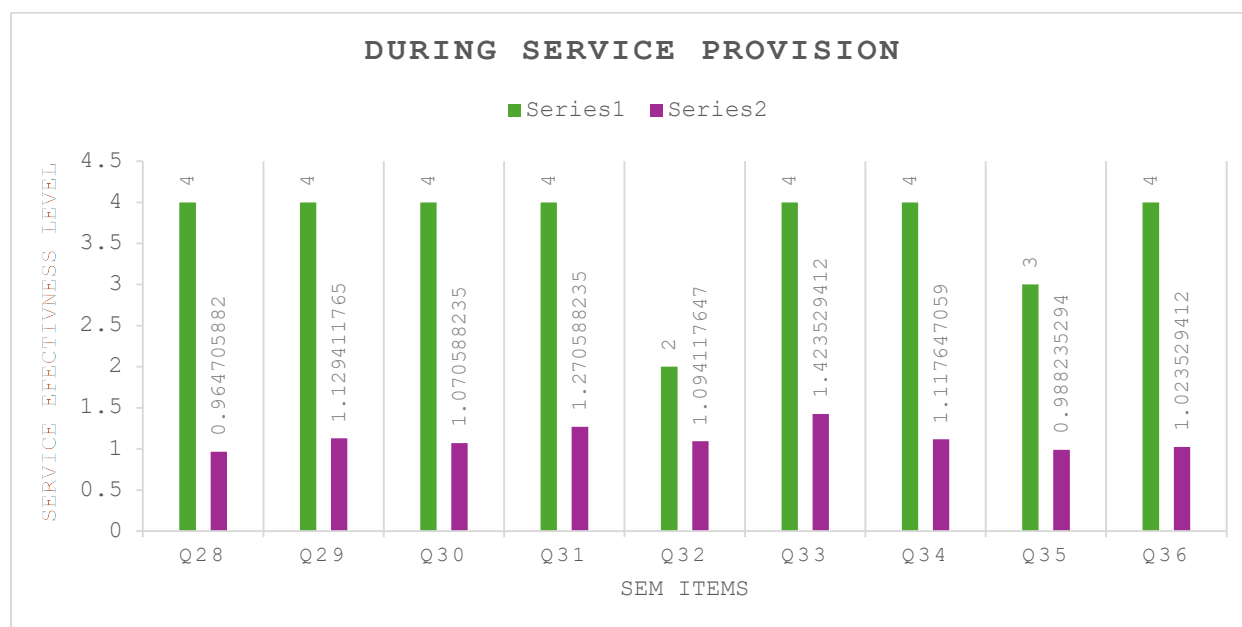
The study results prior to service provision revealed that participants had limited knowledge in key areas. For Q23 (What type of information would you provide when you get an SGBV case at your service point?), from a total of 4 expected correct responses, the observed average was only 1.2. Similarly, for Q24 (What forms do you use when you give a service to a SGBV survivor?), the observed average was 1.12 out of 4 expected correct responses. In Q25 (What type of people do you consider a special population in your service setting?), where 7 correct responses were expected, the observed average was 1.28. For Q26 (Who is typically responsible for reading an informed consent form and signing it on behalf of a special population such as a child or someone with cognitive disabilities?), the observed average was 1.19 out of 3 expected responses. Finally, for Q27 (Before conducting an initial assessment of a SGBV survivor, for which government offices would an expert typically fill out a form and report the case?), the observed average was 1.27 out of 4 expected responses.

In total, across the 22 expected correct responses, the average number of correct responses was 6.06. This suggests significant gaps in knowledge and areas for improvement in service provision. The average observed service effectiveness prior to service provision was calculated to be 1.21, which indicates a very low level of service effectiveness. These findings emphasize the need for further training and analysis to enhance the quality of services provided.

4. During service provision

No. Of items	Expected Response	Observed Response	Average observed service effectiveness during service provision	Level of service effectiveness during service provision
Q28	4	0.964706		
Q29	4	1.129412		
Q30	4	1.070588		
Q31	4	1.270588		

Q32	2	1.094118	1.120261	Very Low
Q33	4	1.423529		
Q34	4	1.117647		
Q35	3	0.988235		
Q36	4	1.023529		
Aggr	33	10.082353		

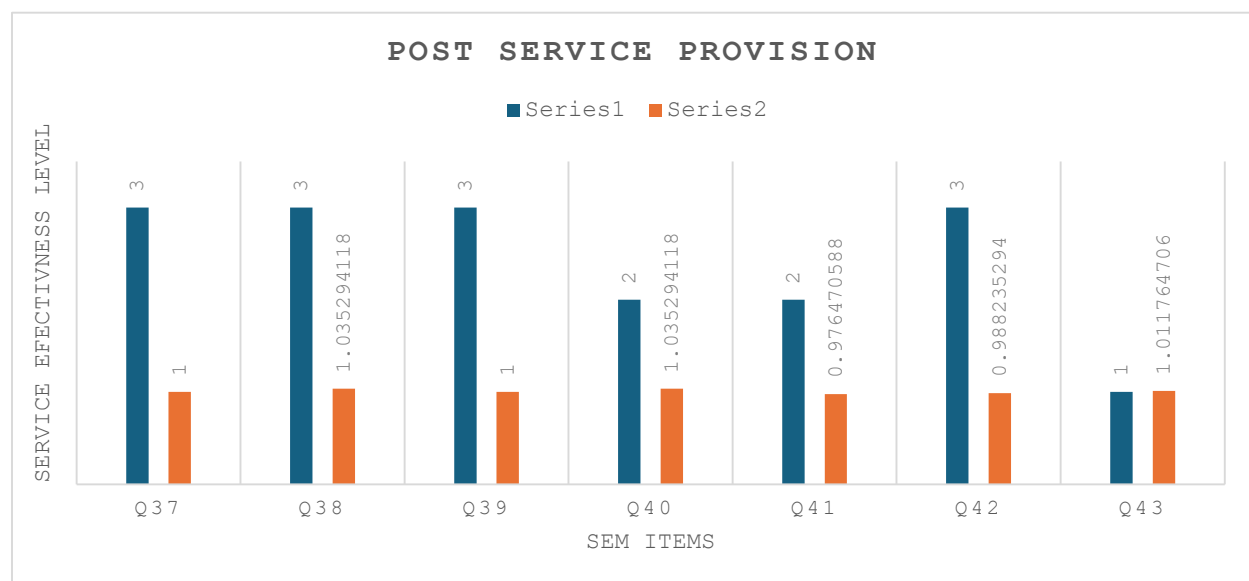


The study results during service provision highlighted significant gaps in the quality of services provided to SGBV survivors. For Q28 (What type of medical services do you provide to SGBV survivors?), the average correct response was only 0.96 out of 4 expected responses. Similarly, for Q29 (What type of psychological services do you provide to SGBV survivors?), the average correct response was 1.13 out of 4. In Q30 (What would be the key ethical principles maintained when providing SGBV services?), the average correct response was 1.07, while Q31 (What crucial qualities do you apply in a healthcare setting to support SGBV survivors' positive outcomes and build their trust and respect?) saw a slightly higher average correct response of 1.27. For Q32 (What fundamental principles are used to ensure that SGBV survivors are treated with respect and empowered?), the average correct response was 1.09 out of 2 expected responses, and Q33 (What kind of associated medical services are provided during SGBV services?) achieved the highest average of 1.42 out of 4. However, in Q34 (What types of crisis intervention strategies are used to address the emotional and psychological impact of SGBV?), the average correct response was only 1.12, and Q35 (What type of trauma-focused psychological therapy do you provide to help survivors cope with the impact of SGBV?) had a very low average of 0.99 out of 3. Lastly, for Q36 (What are some key practices for maintaining the cultural and religious beliefs of SGBV survivors?), the average correct response was 1.02 out of 4 expected.

In total, across 33 expected correct responses, the average observed correct responses amounted to just 10.08, reflecting a low level of service effectiveness during service provision. The overall service effectiveness score during this phase was 1.12, indicating that service quality remains inadequate. This points to the continued need for improvement in training and practical application to enhance the effectiveness of services provided to SGBV survivors.

5. Post service provision

No. Of items	Expected Response	Observed Response	Average observed service effectiveness after/post service provision	Level of service effectiveness after/post service provision
Q37	3	1	1.006723	Very Low
Q38	3	1.035294		
Q39	3	1		
Q40	2	1.035294		
Q41	2	0.976471		
Q42	3	0.988235		
Q43	1	1.011765		
Aggr	17	7.0470588		



The post-service provision results revealed low levels of effectiveness in referring SGBV survivors to appropriate services. For Q37 (Where do you refer survivors of SGBV if they require continued counselling or psychological therapy?) the observed average correct response was 1 out of 3 expected responses. Similarly, Q38 (To whom do you refer survivors needing to gather written reports and photographs for legal purposes?) yielded an average correct response of 1.04 out of 3. For Q39 (Where do you refer SGBV survivors for legal assistance?), the observed average was 1, and for Q40 (Where do you refer SGBV survivors in immediate danger or at risk of homelessness?), the average was 1.04 out of the expected responses. Other

referral areas showed even more room for improvement. In Q41 (Who do you refer survivors to if they need financial support for housing, medical care, or legal fees?), the average correct response was 0.98 out of 2 expected responses. For Q42 (Where do you direct survivors to connect with others who have had similar experiences?) the average response was 0.99 out of 3. Lastly, for Q43 (Where do you refer survivors for spiritual support?) the observed average correct response was 1.01 out of 1. Overall, from the 17 expected correct responses, the observed total was 7.05, leading to an average service effectiveness score of 1.01. These results indicate that the effectiveness of post-service provision remains very low, highlighting the need for continued training and improvement in referring survivors to the appropriate resources and services.

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