SHELTERS FOR WOMEN AND GIRLS WHO ARE SURVIVORS OF VIOLENCE IN ETHIOPIA

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UN WOMEN

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National Assessment on the Availability, Accessibility, Quality and Demand for Rehabilitative and Reintegration Services

UN WOMEN ETHIOPIA
Addis Ababa, January 2016

UN WOMEN

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
AWSAD	Association for Women's Sanctuary and Development
BFA	Beijing Platform for Action
BIGA	Bright Image for Generation Association
BOFED	Bureau of Finance and Economic Development
BoJ	Bureau of Justice
BOLSA	Bureau of Labor and Social Affairs
BOWCYA	Bureau of Women, Children and Youth Affairs
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CSA	Central Statistical Agency (Ethiopia)
CSOs	Civil Society Organizations
DV Vic	Domestic Violence Victoria
ECO	Ethiopia Country Office
EGLDAM	Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber
ESOG	Ethiopian Society of Obstetricians & Gynecologists
EWLA	Ethiopian Women's Lawyers Association
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FMOH	Federal Ministry of Health
FSA	Family Service Association
GBV	Gender-Based Violence
GTP	Growth and Transformation Plan
HTP	Harmful Traditional Practices
IASC	Inter-Agency Standing Committee
IFSO	Integrated Family Service Organization

KII	Key Informant Interview
MCRC	Mother and Children Rehabilitation Center
MoE	Ministry of Education
MoJ	Ministry of Justice
MoLSA	Ministry of Labor and Social Affairs
MoU	Memorandum of Understanding
MoWCYA	Ministry of Women, Children and Youth Affairs
NO	Number
OB/GYN	Obstetrics/ Gynecology
OPRIFS	Organization for Prevention, Rehabilitation and Reintegration of Female Street Children
PoA	Plan of Action
RTD	Real Time Dispatch
SGBV	Sexual and Gender-based Violence
SNNP	Southern Nations, Nationalities and Peoples
SOPs	Standard Operating Procedures
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNHCR	United Nations Higher Commissioner for Refugees
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UWONET	Ugandan Women's Network
VAW	Violence against Women
VAWC	Violence against Women and Children
VAWG	Violence against Women and Girls
WHO	World Health Organization

FOREWORD

Violence against Women and Girls (VAWG) is one of the most systematic and widespread violations of human rights globally. It may occur against any woman or girl regardless of nationality, age or socio-economic status. In Ethiopia, violence against women and girls continues to be a major challenge and a threat to women's empowerment. Women and girls face physical, psychological and sexual abuses that undermine their health and ability to earn livelihoods; disrupt their social systems and relationships; and particularly for girls, robs them of their childhood and education.

According to the 2011 Ethiopia Demographic Health Survey (EDHS), two of every three women (68%) and one of every two men (45%) believe that wife beating is justified under specific circumstance. The survey also indicated that 41% of Ethiopian women aged 20-24 had been married before they reached 18 years of age, while 8% of those aged 15-19 years were married before their 15th birthday.

The Federal Democratic Republic of Ethiopia (FDRE) has put in place appropriate and effective legal and policy provisions to promote the rights of women and girls; and these are enshrined in the Constitution (1995). Ethiopia has also ratified many of the international and continental instruments that promote and protect women's rights, including among others, the Convention on the Elimination of Discrimination against Women (CEDAW) and the Protocol to the African Charter on the Rights of Women in Africa. In addition, the FDRE has established specific legal measures and actions to address VAWG, including, inter alia, the Revised Family Law (2000), and Revised Criminal Code (2005). In this connection, the government has also put in place the requisite institutional mechanisms at federal and regional levels, including (i) the establishment of Women, Children and Youth Affairs Offices, (ii) the Child and Women Protection Units within the various police units, (iii) a Special Bench for VAW cases within the Federal Criminal Court, (iv) Child-friendly courts, and (v) Child crime investigations units within the Ministry and Bureaus of Justice.

However, despite these legislative and institutional provisions, support for the rehabilitation and reintegration of survivors of violence is still limited. Women and girls still lack access to coordinated, quality essential services, and as a result, continue to be affected by the psycho-social impacts of violence, which in some cases has resulted in death by suicide or from depression. In the absence of effective rehabilitative and psycho-social support, women and girl-survivors of violence have found very little incentive to report the violence and seek justice against the perpetrators. UN Women and other development partners have been supporting a number of initiatives and Civil Society Organizations (CSOs), but this support has not had sufficient scale to effectively address the challenges faced by women and girl-survivors of violence in a holistic manner and in accordance with international standards.

It is against this background that The United Nations entity for Gender Equality and the Empowerment of Women (UN Women) commissioned this assessment on "the Availability, Accessibility, Quality and Demand for Rehabilitative and Reintegration Services for Women and Girl- Survivors of Violence in Ethiopia". The assessment will add to the evidence-base for planning and development of appropriate interventions by state actors and other development partners, by identifying and mapping the existing rehabilitative and reintegration service centers; and compiling an inventory of their services, gaps and current barriers.

UN Women would like to underline the opportune timing of this assessment which comes at a time when the country has launched its Second Growth and Transformational Plan (GTP), which for the first time has prioritized ending VAWG, and includes specific targets for the

establishment of shelters for survivors within the sectoral plan of the Ministry of Women and Children's Affairs (MoWCA). The assessment will also provide important baseline data for the United Nations Development Assistance Framework (UNDAF) 2016 – 2020, which also has targets for establishing rehabilitation and reintegration centres.

On behalf of UN Women, I would like to express our gratitude to our civil society partners who provided invaluable information throughout the course of the research. We would like to say a special 'thank you' to the women and girl survivors of violence in the various shelters who had the courage and passion to relive their ordeals and walk us through their frustrations and hopes for the future.

We would also like to express our sincere appreciation to the MoWCA, Ministry of Justice (MOJ), Ministry of Health (MOH), Federal Police Commission (FPC), as well as their respective regional bureaus for their valuable contribution and comments to enrich the report. UN Women also wishes to thank all the participants of the validation workshop, held in Addis Ababa on November 16, 2015, including Government, UN agencies development partners and civil society organizations.

I wish to take this opportunity to thank the team of consultants – Ms. Meron Genene (team leader), Ms. Tsion Yohannes and Ms. Senait Bitew – who undertook the assessment on behalf of UN Women. I also wish to acknowledge the contribution of United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF) experts for their useful comments and review of the first draft. Our special thanks also go to Dr. Meron Teferi for the final editing of the draft; and to Systron Advertising PLC for the graphics and design.

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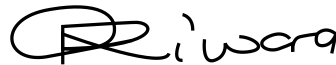


Ms Letty Chiwara

UN Women Representative to Ethiopia,
AU and UNECA

EXECUTIVE SUMMARY

Violence against women continues to plague communities despite strong legislative and institutional provisions in Ethiopia. Violence of different forms are still widespread, and women and girl-survivors of violence are left with many psycho-social needs that often go unmet because of limited resources to support their rehabilitation and reintegration. To contribute to the evidence base on the topic, UN Women commissioned this assessment, primarily to map out the availability, accessibility, quality and demand for rehabilitative and reintegration services for women and girl survivors of violence in Ethiopia.

The assessment further examines the existing referral systems, both at national and regional levels, along with other response mechanisms in place; current good practices and major challenges compounded with recommendations. It further outlines recommendations for a good model of comprehensive service. The nationwide assessment employed a range of qualitative tools for the assessment participants including survivors, staff members in shelters, service providers, government representatives, civil society organizations, UN agencies, and donors that came up with the following key findings:

Availability and Accessibility: An estimated 12 shelters were identified in the country, which provide rehabilitation and reintegration services for women and girl survivors of violence. While the majority of available shelters are found in Addis Ababa (five), few other shelters were distributed across the regions, albeit uneven. Regions that witnessed the establishment of shelters include: Benishangul Gumuz (two), Amhara (one), Oromia (two), Dire Dawa (one) and Southern Nations, Nationalities and Peoples Region (SNNP) (one). Out of the 12 shelters identified, only the one in Dire Dawa was managed and fully funded by the government.

The eligibility criterion for admission varied from one shelter to another. For instance, Integrated Family Service Organization (IFSO) and Organization for Prevention Rehabilitation and Reintegration of Female Street Children (OPRIFS) accept only children. In view of the rising number of sexual violence on men, some shelters had also considered admission of boys, as in the case of IFSO and Mother's Children Rehabilitation Center (MCRC.)[1] Some shelters do not accommodate survivors with mental illnesses, for example AWSAD of Oromia and BIGA.[2] It was interesting to also note that the BIGA shelter did not accommodate pregnant women. In terms of shelters' capacity, majority of the shelters had capacity to accommodate in the range of 14-50 survivors. However, due to the rising demand, the shelters tended to accommodate survivors beyond their holding capacity. The fact that there were few shelters available across the country in general indicated that shelter services were not accessible to the large majority of the population. In addition, the identified shelters were located in the regional capitals and were not necessarily accessible to women living in the rural areas. Accessibility to shelters was also constrained by a number of other factors including, eligibility criteria of some shelters that excluded women with physical disabilities, mental health problems and on the basis of pregnancy. Pertaining to the availability of comprehensive services, the assessment also revealed that some shelters provided services, including basic needs (food,

1 The lack of shelter for male sexual survivors was noted as a big challenge, in the case of Dire Dawa, Harari, to mention a few.

2 This is due to safety reasons for other residents in the shelters coupled with lack of capacity to cater for the special needs of mental illnesses.

shelter and other supplies), health care services, economic empowerment initiatives, counseling and therapeutic activities, and referral to legal aid services.

Demand for Services: Key informants from the different regions outlined the major causes for the high demand for shelters, which included poverty, increase in commercial sex work and addiction in the case of SNNP, migration and trafficking of children in Amhara region, rape, abduction and domestic violence in Harari, migration, trafficking as well as economic violence in Afar region. In Somali region, incidents of rape, Female Genital Mutilation (FGM), early marriage, domestic violence, and trafficking were reported, while in Gambella there was underage marriage, polygamy, and domestic violence. Despite the presence of a One-Stop center that catered to the needs of rape survivors (both female and male) in Dire Dawa City Administration, the demand for shelter services was noted to be high given the incidents of violence such as rape, domestic violence, sexual violence on boys, and early marriage.

The assessment revealed that there was a high demand for shelters across all parts of the country, and specially higher demand in Gambella, Somali, Tigray, Harari and Afar where women and girl survivors of violence had no access to rehabilitation and reintegration services by either governmental or non- governmental organizations. In regions where shelters were available, such as Amhara, Benishangul Gumuz, Oromia and SNNP and Dire Dawa and Addis Ababa City administrations, the demand was still unmet given the fact that the survivors accommodated in the shelters exceeded the holding capacity and plan. In some regions like SNNP, Harari, Amhara and Oromia and in city administrations of Addis Ababa and Dire Dawa, incidents of sexual violence against males were also repeatedly mentioned as an emerging challenge in the target communities.

Quality: Given the difficulties in rating the quality of services provided at the shelters due to lack of national standards, a review of some standards in Africa was undertaken in order to identify quality benchmarks. Using these as indicators, the assessment identified gaps in accessing tailored and regular trainings in some of the shelters, along with shelters' constraints in finding qualified professionals to work with survivors of violence. In addition, the issue of technical capacity for fund raising, and cutback in funding opportunities constrained the efforts to improve the services and accommodations.

Most of the contacted shelters had written and unwritten codes of conduct for their staff on how to interact and work with survivors, and rules of conduct for shelter residents. Review of the shelter documents also revealed that some of the shelters had proper documentation practices for individual cases, with background stories, information on counseling sessions and reflections from the survivors. In the case of AWSAD, a case management form was in place and was used whenever an individual was referred to a specific kind of service. Other indicators for minimum standards of accommodation that were considered included, cleanliness of the accommodation, orderliness, size of rooms and their appropriateness for living including if there were beds, dining area, and space for other activities. Some of the shelters, such as AWSAD, MCRC and BIGA had sufficient rooms to handle the number of residents currently present in the shelters; but used mattresses when additional residents joined. With the exception of BIGA, other shelters including IFSO, AWSAD, OPRIFS Amhara and MCRC had sufficient space for dining, green area and additional space for rehabilitative and healing activities for residents. Pertaining to the issue of linkages of shelters with community structures, gaps were noted in some shelters, while others like AWSAD and BIGA provided community services such as awareness programs through community conversations and psycho-social counseling , hence linking their programs with communities. Some initiatives by shelters such as in AWSAD to institutionalize and formalize child protection using child protection policy and procedure were found to be encouraging.

Reintegration: Having gone through rehabilitation, survivors would eventually have to leave the shelters and become reintegrated back into the society, family and community. However, reintegration was often one of the greatest challenges for survivors because of the stigma attached to the incidence of sexual violence, regardless of how the violence occurred. The assessment indicated that most survivors, in particular sexual violence survivors from the regions, did not have the intention of going back to where they came from, but rather preferred to start a new life elsewhere. It was further observed that majority of the survivors did not maintain contact with their families or relatives. In the absence of support from their families, many women and children required skills to sustain their livelihoods. Despite the difficulties inherent in reintegration, successful strategies include gradual reintroduction into the community, job training, and seed money to establish a self-sufficient livelihood.[3] In this regard, some shelters, as was the case for IFSO, AWSAD, MCRC, and BIGA, provided survivors with seed money, in addition to skills training, and covered survivors' rent for a limited period of time. The assessment indicated that there was in general little done on follow up of reintegration of survivors to the society, community and family. Majority of the shelters, AWSAD, MCRC, BIGA, IFSO and Mujejegwa had a specific budget or seed money for reintegration of survivors. To this end, the assessment noted that while the first stage of reintegration was being realized by organizations venturing on reintegration of their survivors, further impact assessment might be required to assess the level of survivors' integration to their family and community.

Referral Systems and Coordination Mechanism: In response to the need for prevention as well as provision of coordinated assistance to women and children survivors of violence, a national coordinating body was formed in 2008 (2001 EC). Three years later in 2011 (2004 EC), participating institutions in the national coordination body formalized their cooperation based on a Memorandum of Understanding (MoU) followed by development of a strategic plan and a three-year Plan of Action (PoA) 2011/12-14/15. Efforts were made to ensure broad-based membership of government, non-government and international organizations. The formation of a national coordinating mechanism with components of both prevention and response to VAWG is indeed a remarkable step taken on referral mechanism among others. The MoU signed among stakeholders further formalized the formation of the coordination and enhances members' accountability. In addition to the national coordinating body and referral mechanism, the overwhelming majority of the regions had established referral systems for Violence against Women and Childern (VAWC) prevention and response, which was not necessarily subsidiary to the national coordination body. While nearly all the referral mechanisms in the regions were established at macro level in the regional capitals, some of the regions had also established referral systems at zonal and Woreda levels. Lack of awareness on the referral linkages and the various services delivered was also among the challenges identified.

Special Investigation and Prosecution Unit: In an effort to respond to VAWC in a coordinated manner, and in addition to the aforesaid services, special investigation and prosecution units were established. While the units were sometimes stationed within the police commissions as women and children unit, there were instances where they were located at Bureau of Justice/prosecution offices, as in Somali region. A typical special investigation unit was comprised of investigation police officers and a prosecutor while in some instances it included social workers that provided psycho-social counseling. The

3 Chatterjee, P. and Chakraborty, T., Srivastava, N., Deb, S. (2006). Short and Long-Term Problems Faced by the Trafficked Children: A Qualitative Study. Social Science International, 22 (1), 167-182.

Crawford, M. and Kaufman, M. R. (2008). Sex Trafficking in Nepal: Survivor Characteristics and Long-Term Outcomes. Violence Against Women, 14 (8), 905-916. Retrieved from http://vaw.sagepub.com.ezproxy.lib.vt.edu:8080/cgi/reprint/14/8/905

establishment of the unit not only enhanced the coordination between investigation and prosecution of cases for survivors but also reduced the time consumed in the referral of cases between the two offices.

One-Stop Center: A one-stop center was piloted at Gandhi Hospital in 2008 in order to provide a comprehensive response mechanism on VAWG. The Center was modelled on lessons and experiences learnt from the Thuthuzela Centers of South Africa and the Agaseke one-stop Center in Rwanda. The one-stop center approach has indeed been seen as a key ending VAWG response strategy by the National Coordination Body. To that effect the Coordination Body highly recommended the expansion of the one-stop center model to other hospitals of Addis Ababa, Yekatit and Alert. The attention given to one-stop center was also evident by the target set in the upcoming Growth and Transformation Plan II, which includes expanding one-stop centers in other parts of the country.

Conclusion

The policy and legal frameworks for addressing violence against women are in place. This was a positive step in the provision of rehabilitation and reintegration services for survivors of violence. The assessment identified the remarkable contribution of the existing shelters that provided lifesaving services to thousands of survivors of violence in the country. However, gaps were observed in terms of access to comprehensive services for women and girl survivors of violence, along with the absence of national standards in Ethiopia for establishing shelters with provision of comprehensive services. The assessment found high unmet need for comprehensive services, and especially shelters in the country, especially in regions such as Gambella, Harari, Afar, Tigray and Somali. Emerging issues with regards to the demand for shelters was the case of reported incidents of violence against men and boys in some regions and city administrations like Addis Ababa, SNNP, Dire Dawa, Harar, Amhara and Oromia. In general, the assessment identified commendable efforts in establishing a national coordination mechanism with a MoU signed, and planned activities on prevention and reduction of violence against women (VAW), which includes establishment, and expansion of one-stop centers.

Recommendations

Availability and Accessibility of Services: In order to enhance the availability and accessibility of shelters, it is recommended to establish shelters across all the regions of Ethiopia, especially in regions such as Gambella, Afar, Harari, Somali and Tigray; to ensure the accessibility of services for all women and girl survivors of violence, without any conditions, such as disability and pregnancy using referral linkages; create awareness about the services available; properly identify the need and budget programs activities in shelters, enhance the availability and quality of psychosocial services at the shelters; replicate the effort made by one region in establishing government-owned shelters and in others through allocation of land for Civil Society Organizations (CSOs); facilitate inter-regional experience sharing visits to shelters and create linkages between shelters and other service providers, for example through empowerment programs, legal aids, counseling, etc.

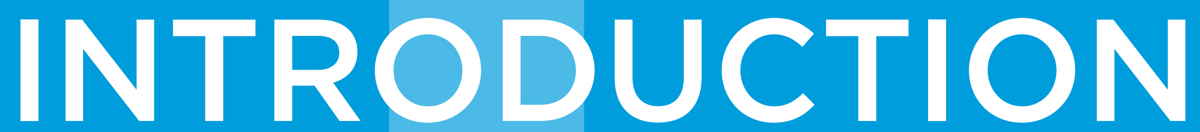
Quality: In order to improve the quality of services, there is a need to design national standards for monitoring the quality of shelters. Further recommendations include: preparation of shelter guidelines outlining employment of qualified staff, type of staff needed and the types of services that will be provided; reintegration guidelines; engagement of reintegration officers and regular/ongoing/ refreshment trainings and guidelines for staff working in different responsibilities in shelters. It is also important to establish a case management system in all the shelters. In responding to the challenges of VAW, the national coordination body should also facilitate the establishment of a national database.

Referral Pathway: It is recommended to identify a clear referral pathway supported by a standard for the various stakeholders involved; create awareness on the referral mechanism, and create coordination between the national coor-

dination body and the regional ones. It is further recommended to establish a special court for women/victim-friendly benches- due to the stigma attached to sexual violence that makes reintegration of survivors difficult. In an attempt to ensure accountability, it is necessary to enforce penalties for service providers of who do not undertake their duties. In addition, there is a need to facilitate the revision of family laws lacking conformity to the federal one and international commitments in order to enhance protection of women and girls from further violence.

Capacity building for Service Providers: With regard to capacity building, it is recommended to improve access to training for service providers at all levels on the available laws and provisions on VAWG. Furthermore, actions should be geared towards expanding the basic components of VAWG services (comprehensive services) to include a holistic response to the physical, psychosocial, and economic needs of survivors.

Above: *MCRC shelter / Meron Genene*



1 INTRODUCTION

This chapter provides some background on VAWG in Ethiopia and details the methodology of the study. Definition of terms used is also found here.

1.1. Introduction

"Across the world, violence against women and girls remains one of the most serious – and the most tolerated – human rights violations. It is not acceptable. It is not inevitable. It can be prevented."[4]

Ethiopia has adopted national and regional policies and legal frameworks on prevention and response to VAWG, including the Convention on the Elimination of All Forms of Discrimination against Women (1981), Beijing Platform for Action (BFA) of 1995 and national instruments - the revised Family Law (2000), the revised Criminal Law (2005), among other national strategies.[5]

Nonetheless, women in Ethiopia are still subject to various forms of sexual and gender-based violence (SGBV). The existing power imbalance between women and men, hampers women and girls' development, health, physical and mental wellbeing. Studies have indicated that a large proportion of Ethiopian women are subject to FGM or cutting, early marriage and domestic violence along with the widespread acceptance of violence against women by the society.[6]

In response to these challenges, the government, with support from several development partners have put in place various institutional mechanisms at the federal and regional levels to provide support for women and girl survivors of violence. Along this vein, the second Growth and Transformation Plan (GTPII),[7]outlined strategies for addressing violence against women as part of the next five-year multi-sectorial plans.

However, despite the presence of these legal frameworks, there is still a gap with regards to accurate information on the existing response mechanisms to address violence against women and girls, especially with regards to rehabilitation and reintegration services provided by various actors.

This assessment therefore intends to map out the services available on response to VAWG in Ethiopia. More specifically, it aims to assess the availability and accessibility of existing rehabilitation and reintegration centers that provide comprehensive services to women and girl survivors of violence; identify the existing needs and challenges with a view to increasing the availability and enhancing quality of services provided to women and girl survivors of violence. The assessment further intends to guide policy makers as well as implementers on the type and standard of services required.

1.2. Assessment Aims and Objectives

The aim of this assessment was to assess the availability, accessibility, quality, and demand of rehabilitation and reintegration services for women and girl survivors of sexual violence. The assessment will help UN Women, state actors and other development partners to identify existing centers, their accessibility and quality of existing services; gaps and current barriers. This is intended to ensure the survivors' fundamental rights to access services, including establishment of additional rehabilitative services.

4 UN Women Executive Director Phumzile Mlambo Ngcuka, Statement at the International Day for the Elimination of Violence against Women, 20 November 2015.

5 As cited from FDRE, National Report on the Implementation of the Beijing Declaration and Platform for Action (1995) and the Outcome of the 23rd Special Session of the United Nations General Assembly (2000).

6 Population Council and UNFPA (2010), Ethiopia Young Adult Survey: A Study in Seven Regions; UNFPA and Population Council (2010), Ethiopia Gender Survey: A Study in Seven Regions, Population Council Inc.; CSA (2011), Ethiopian Demographic and Health Survey.

7 GTP II document

The specific objectives of the assessment were:

- To determine the demand and relevant needs of women and girl survivors of violence and identify areas with greater demand;
- To assess the effectiveness and efficiency of existing centers, identify gaps and capacity needs;
- To assess the availability and accessibility of services to survivors of violence thereby map out existing rehabilitation and reintegration services, including non-formal services;
- To assess the effectiveness and efficiency of existing referral systems/partnership arrangements between the safe houses and other stakeholders e.g. police, women's affairs, hospitals, etc.;
- To document current good practices and major challenges;
- To propose a good model of comprehensive services to be provided by all rehabilitation and reintegration service centers;
- To recommend measures that should be taken to expand on new service centers and strengthen the existing services.

1.3. Scope of the Assessment

In line with the above objectives, the assessment was conducted in all regional states and two city administrations.[8]

The assessment reviewed guidelines and procedures around service provision; mapped available response mechanisms at the federal and regional levels pertaining to rehabilitation and reintegration; identified areas with high unmet demands for comprehensive services, and challenges faced by shelters, staff, other providers and survivors of violence; and assessed the effectiveness and efficiency of referral systems and partnership arrangements between the safe houses and other stakeholders, such as police, women's affairs offices, one-stop centers and health service providers. The assessment further reviewed international and local good practices along with a model for comprehensive services that could be replicated by UN Women, government and other relevant partners.

1.4. Data Collection Methods

The assessment focused on women and girl survivors of violence in all eight administrative regions and two city administrations of Ethiopia. Various data collection tools were employed, including literature review, key informant interviews, in-depth- interviews, focus group discussions, case studies and observation by developing individual checklists for a range of stakeholders. Participants/respondents in this assessment ranged from women and girl survivors of violence, shelter staff, other service providers and government stakeholders - police, the justice and health sectors, and community representatives. The data collection methods are detailed as follows.

1.4.1. Desk Review

As per the objectives of the assessment literature review was carried out with the view of assessing shelter standards available in the country and across the different regions, legal provisions and regulations pertaining to response to VAWG, and assess guidelines for the provision of comprehensive services for survivors of violence. Existing international standards were also reviewed to serve as a basis for recommendations and setting quality benchmarks for shelters.

1.4.2. Key Informant Interviews

Key informant interviews were undertaken with a range of relevant government stakeholders including, officials from the Federal and Regional Bureaus of Women, Children and Youth Affairs, Health, Justice and Police sectors. In addition, interviews were undertaken with development partners and key service providers such as CSO representatives working directly on prevention and response to VAWG across the regions and

8 Afar, Amhara, Benishangul-Gumuz, Gambella, Harari, Oromiya, Southern Nations Nationalities and Peoples, Somali and Tigray; and Addis Ababa and Dire-Dawa city administrations.

city administrations of Ethiopia. Interviews were also undertaken with shelter managers/ heads in order to obtain insights into the modes of operations, history of the shelters, and challenges and good practices.

1.4.3. Focus Group Discussions

Various focus group discussions (FGDs) were carried out with a range of stakeholders including survivors of violence, shelter staff, community representatives and other service providers in the regions. This was instrumental in obtaining quality and in-depth information on the quality of various response mechanisms, especially shelters, the needs of survivors of violence, and challenges identified by different stakeholders for the provision of comprehensive services.

1.4.4. Case Stories

Individual case stories of successful interventions in rehabilitation and to some extent in reintegration were identified and documented. This method helped to identify what worked and what did not, and informed development of recommendations consistent with the needs of survivors.

1.4.5. Observation

Direct observation was used based on an observation checklist that was developed for shelters. This instrument was key in assessing the quality of accommodation along with identification of core services that are provided at the shelters.

1.4.6. Data Analysis

Qualitative data collected using key informant interviews, FGDs, observation and case stories were analyzed in accordance with the set objectives. This included recorded data, triangulation of information gathered by the different methods and thematic analyses in accordance with the main objectives of the assessment.

Below is the illustrated number of data collected through the above data collection methods.

Table 1:
Size of data collected through different methods

Respondents from	Total number of data collected through each method	Remark
Shelters (visited / observed)	8	Addis Ababa (3), Adama, B.Dar, Hawassa, D. Dawa, Asossa
FGDs conducted	13	All Regions
KII conducted	76	All Regions
Case studies	6	From MCRC and AWSAD and Konjit Adama AWSAD

As shown in Table 1, a total of 8 shelters were observed and 13 FGDs conducted with different groups, shelter residents, community groups, service providers. In addition, 76 key informant interviews were undertaken with different service providers, including shelter staff, government representatives, civil society organizations, UN agencies and donors.

1.5. Ethical Considerations

As per World Health Organization (WHO) ethical recommendations regarding research on violence against women, strict confidentiality and privacy was observed, to ensure the physical safety of respondents and interviewers from potential retaliatory violence by the perpetrators. The assessment was also designed in a manner so as not to increase distress on participants.

All the participants who took part in the assessment were informed about the process, and how their identity will not be disclosed unless they were willing to do so. The data collection process was undertaken with due attention to respecting the rights and dignities of all participants, and when relevant referring the participating individuals and even organizations to the right services.

1.6. Limitation and Challenges of the Assessment

The assessment methodology faced a number of challenges and limitations. Firstly, as this was the first assessment of its kind, it was difficult to develop a comprehensive list of shelters, especially at federal level. Most of the known shelters targeted children or other mixed target groups, thereby making it difficult to identify the exact number of all-female shelters for women and girl survivors of violence. Secondly, not all FGDs planned with survivors were carried out, especially in Dire Dawa and Benishangul, because there were no survivors available at the shelters during the time of visit. To mitigate these limitations, the research team adopted alternative data collection tools, including triangulation of various sources.

1.7. Definition of Terms

Comprehensive Services: Includes services that enable survivors to be fully rehabilitated and reintegrated back into the society through provision of support to address their physical, emotional and social needs, including overall healing and empowerment of survivors.

Economic Violence: A form of violence to control and limit the victim's access to financial resources, in order to make victim financially limited or dependent if he/she chooses to leave the relationship. As a result, victims of economic violence are often forced to choose between staying in an abusive relationship or facing economic hardship and possibly extreme poverty and homelessness. Types of economic abuse include abuser denying the victim access to money or the means of obtaining it, interfering with or preventing education, job training, and the ability to find and keep a job, and refusing to pay the victim court-ordered child or spousal support.[9]

Gender-based Violence: An umbrella term that refers to any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females.[10] It is any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and men because of being women or men respectively, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[11]

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

Rehabilitation: Services that provide healing for survivors of violence through a range of activities such as psychosocial support, medical care, education and awareness, as well as specialized skills that enable the survivors to become confident.

Rape/Attempted Rape: An act of non-consensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Any penetration is considered rape. Efforts to rape someone, which do not result in penetration, are considered attempted rape.

A Referral System: A comprehensive institutional framework that connects various entities with well-defined and delineated (albeit in some cases overlapping) mandates, responsibilities and powers into a network of cooperation, with the overall aim of ensuring the protection and assistance of survivors, to aid in their full recovery and empowerment, the prevention of VAWG and the prosecution of perpetrators (the so-called 3 p's).[12]

9 Economic Abuse. National Coalition Against Domestic Violence. http://www.uncfsp.org/projects/userfiles/file/dce-stop_now/ncadv_economic_abuse_fact_sheet.pdf

10 IASC (2002), Guidelines for Gender Based Violence Intervention in Humanitarian Settings.

11 Expanded Definition of Sexual and Gender-based Violence used by UNHCR and implementing part- ners, based on Articles 1 and 2 of the United Nations General Assembly Declaration on the Elimination of Violence against Women (1993)

12 UNFPA (2010), Strengthening Health System Re- sponse to Gender Based Violence in Eastern Europe and Central Asia. A Resource Package.

Reintegration: Enabling the survivors to go back into the society, the familyor even into the community they came from.

Secondary Victimization: Behaviors and attitudes of social service providers that are "victim-blaming" and insensitive, and which traumatize victims of violence who are being served by these agencies. Institutional practices and values that place the needs of the organization above the needs of clients or patients are implicated in the problem. When providers subjugate the needs and psychological boundaries of rape victims to agencies' needs, victims feel violated.[13]

Shelter: A space where women and girl survivors of violence can access accommodation from short to long- term duration, along with services that assist the rehabilitation and reintegration process.

Safe Homes: Alternatives to shelters and usually provide temporary shelter for survivors, from one to seven days.[14]

Survivor/Victim: A person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably. "Victim" is a term often used in the legal and medical sectors. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resilience.

Violence against Women and Girls: Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[15] VAWG can take different forms including physical, sexual, psychological and economic forms.

Above: *Children at AWSAD Oromia, Adama town / Paula Mata/ UN Women*

13 Raja and Campbell (1999), Secondary Victimiza tion of Rape Victims: Insights from Mental Health Professional Who Treat Survivors of Violence. https:// mainweb-v.musc.edu/ vawprevention/research/ victimrape.shtml

14 Gierman, Liska and Reimer et al. (2013), Shelter for Women and Girls at Risk of or Survivors of Violence, Canadian Network of Women's Shelters and Transition Houses.

15 UN Declaration on the Elimination of Violence against Women.

2

This chapter provides a brief overview of the literatures reviewed.

2.1. Prevalence of Violence against Women

Some studies undertaken at the national level,[16] indicate that violence against women in Ethiopia is still pervasive and that there is a need for due attention from a range of stakeholders, including legislative and judiciary organs as well as government and CSOs.

Women in different parts of Ethiopia experience violence in various forms. For example, a large proportion, 25 percent of Ethiopian women experienced their first sexual experiences under coercion as indicated in a study conducted in 2010 in seven regions of Ethiopia.[17] The study further indicated that 92 percent of the perpetrators in these cases were spouses, while 6 percent were boyfriends or fiancés, and 2 percent were acquaintances or classmates. The study also showed a high level of acceptance of violence against women, where 35 percent of the women said that domestic violence was justified if the woman argues with her husband; 32 percent said it was acceptable if the woman refused to have sex; and 31 percent said it was justified if the woman neglected a child. Overall, 69 percent of the respondents in this national survey agreed that any one of these reasons could be enough to justify beating a woman. Similarly, men have a high acceptance for wife beating with highest acceptance rates among men in Somali (58 percent) and SNNP (56 percent).[18] In a study undertaken in 2010 on young adults aged 15 to 24 years,[19] it was found that physical domestic violence was experienced by 10 percent of married women in the study group. In 2010, a national Gender Survey also showed that 7 percent of ever-married women had experienced psychological abuse and insults. Though there is some statistics on early marriage, FGM and to some extent on reported cases of civil and crime cases, it is also worth noting that other forms of violence such as economic and psychological violence may be underreported or even not recognized.

2.2. Drivers of VAWG

VAW is caused by different factors, including social, economic and political. Community perceptions about women as well as existing gender relations in the community and the family play an important role in determining the way women are valued, treated and subjected to violence.

Violence can also be perpetrated through societal values and practices such as for example, the practice of early marriage and other harmful traditional practices. In the context of Ethiopia, early marriage is one of the driving factors behind women and girls' exposure to violence. The median age for marriage is highest in Addis Ababa at 21.4 years, while it is only 14.7 years in Amhara.[20] Regional variations of VAWG were also recorded, with the highest prevalence rate in Amhara (44.8 percent); Tigray (34.1 percent); and Benishangul Gumuz (31 percent).[21] The reasons behind early marriage included various economic and social factors, including loss of virginity before marriage and the intention to strengthen family ties.[22] Another study indicated that families also had big roles in arranging marriages, with the majority (82 percent) of early marriages being arranged by families.[23]

Given the various types of sexual, psychological, economic and political forms of violence prevalent in different communities, there are multiple

16 Population Council and UNFPA (2010), Ethiopia Young Adult Survey: A Study in Seven Regions, UNFPA and Population Council (2010), Ethiopia Gender Survey: A Study in Seven Regions, Population Council Inc., and CSA (2011), Ethiopian Demographic Health Survey

17 UNFPA and Population Council (2010), Ethiopia Gender Survey: A Study in Seven Regions, Population Council Inc.

18 CSA (2011), Ethiopian Demographic Health Survey

19 Population Council and UNFPA (2010), Ethiopia Young Adult Survey: A Study in Seven Regions

20 CSA (2011), Ethiopian Demographic Health Survey

21 EGLDAM (2008), Follow up National Survey on the Harmful Traditional Practices in Ethiopia. Addis Ababa.

22 Ibid.

23 UNFPA and Population Council (2010), Ethiopian Gender Survey: A Study of Seven Regions.

factors that drive VAWG. These include various actors and institutions, such as the family, community groups and members, and even state actors such as police and government officials. Other driving factors for VAWG include alcohol or drug use, poverty, lack of security and protection, absence of strong laws sanctioning VAWG, unequal power relations in societies, and conflict contexts.

2.3. Impacts/Consequences of VAWG

Violent experiences endured by women and girls can have long lasting and detrimental effects on their overall wellbeing. Among these are low self-esteem, lack of trust in others, lack of confidence, feelings of shame and guilt, and other lasting effects including trauma, stress disorders, depression and even suicidal thoughts.[24] Women could also face physical harm including bodily injury, lasting physical disability and even death.

Early marriage and rape could result in early childbearing that has an impact on the general wellbeing and health of the mother, including problems in delivery and fistula. This is especially a reality in a country like Ethiopia, where early child bearing is observed among 38 percent of women aged 25 to 49 by the age of 18; and 9 percent by the age of 15.[25]

In addition, the long-term effects of VAWG affects the life choices of women, their educational attainments and performance, self-confidence and their actions for personal and societal development.

2.4. Response Mechanisms for VAWG

Following the incidence of violence, there are various response mechanisms including immediate protection and care for survivors that can be provided through different sectors and service providers. The following are some of the responses outlined.

2.5. Response by Police and Justice Sector

One of the initial responses to violence could be provided by police and justice sectors, particularly with regards to prevention and early response. At these levels, various interventions including investigation, prosecution, community policing, advocacy, awareness creation, establishment of specialized units and courts to handle cases and other legal interventions could be employed.

In order for the services provided by the police and justice sectors to be effective, there needs to be a strong coordination with the health sector, to provide forensic evidence on violence perpetrated.

2.6. Roles of the Health Sector

Engagement of the health sector is necessary in the initial stages, including screening of survivors and health care, in order to address immediate as well as long-term effects from the violence. In addition, counseling and psychosocial support, especially psychiatric care could also be included as part of the services. In order to undertake these roles effectively, health service providers should have appropriate and relevant skills to identify and screen survivors, as well as referring them to the right places. At the grassroots levels, health service providers such as Health Extension Workers should also be able to identify and target women and girls who are at risk, and when necessary refer them to other service providers such as police, justice sector, shelters or organizations that provide psycho-social and economic empowerment programs.

24 United Nations General Assembly (2012), Report of the Office of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissions and the Secretary-General: Thematic Study on the Issue of Violence against Women and Girls and Disability. Human Rights Council Twentieth Session, Agenda items 2 and 3.

25 CSA (2011), Ethiopian Demographic Health Survey.

2.7. Role of National Machineries

To complement the services provided by the police and health sector, women and children's affairs bureaus at different levels can also play important roles in availing information to survivors. These national institutions have the key role of providing counseling and referral services to rehabilitation centres. The collective effort of the different stakeholders should therefore be coordinated in such a way that they avail comprehensive services that meet the different needs of survivors of violence.

2.8. Rehabilitation Services through Shelters

According to international standards, a shelter can take different forms, including emergency shelter, second stage transitional housing or subsidized housing. The emergency shelters usually provide short to medium- term accommodation for few days to few months.[26] Current literature indicates that in such scenarios psychosocial support, referral services and accommodation are provided for the women. In the second stage of transitional housing scenario, survivors stay for a longer duration - six months to a year or more - and receive shelter, referral and reintegration services back into the community. In the third stage, women are supported with subsidized housing and referrals along with continuous emotional support and follow up.

Safe homes are similar to shelters, in that they also provide temporary and emergency accommodation ranging from one to seven days for survivors of violence. These spaces are especially important in rural areas where women do not have access to alternative long term shelters. It is important to note that safe homes are temporary and may not have personnel with multiple sectorial backgrounds. Another category identified as "emergency safe space" was found in the communities, and this includes religious institutions, hospitals and hotels that could be developed and prepared for such services. As literature indicates such facilities provide temporary shelter and physical protection for women and girls fleeing from violence.[27]

Shelters can be instrumental in facilitating economic empowerment schemes for survivors of violence. Shelters are especially relevant in cases where the violence is perpetrated by intimate partners or family members. However, it is particularly important for shelters to be accessible for women with disabilities as this group could be more exposed to different forms of violence.

Furthermore, shelters could also have an important role in invoking social change through enhancing community awareness about VAWG and its effects on society in general and women in particular.

2.9. Reintegration of Survivors

Following the rehabilitation of survivors, the next stage is their reintegration back into society, their family and the community. Literature[28] indicates that there are three stages of reintegration including, within the family, and at a higher level with the community. The first stage of reintegration entails going back into the society and learning to blend and manage one's own livelihood. The second stage of reintegration includes returning to the family and being accepted; while the last stage involves going into the community.

Proper reintegration into the society can be attained through provision of comprehensive services that address the different needs of the survivors. As such, it is recommended to strengthen social integration along with economically empowering positions for survivors.[29] As the literature indicates, such reintegration can be attained through activities that will ensure

26 Gierman, Liska and Reimer et al. (2013), Shelter for Women and Girls at Risk of or Survivors of Violence, Canadian Network of Women's Shelters and Transition Houses

27 Ibid

28 ibid

29 Gierman, Liska and Reimer et al. (2013), Shelter for Women and Girls at Risk of or Survivors of Violence, Canadian Network of Women's Shelters and Transition Houses

economic independence among survivors, such as skills and professional development programs, income generating activities, and other support to enable survivors to access stable housing and employment opportunities.

In this regard, successful response to VAWG therefore requires an integrated and multi-sectorial approach to rehabilitation and reintegration; including physical, sexual and psychological support. This entails provision of health and psychosocial services, shelter/safe haven, legal, social and economic empowerment schemes, etc., and requires action by key government sectors - police, judiciary, health, social, as well as civil society.

2.10. Comprehensive Services

Core services are those activities that support the survivor with access to basic services, including shelter, food, accommodation, and information on service providers such as counseling, housing, legal aid, and physical and mental healing services. With regards to counseling, core services include, education about the effects of trauma, listening, assistance with coping strategies and skills, and establishment of support groups and peer groups that will help to share experiences, lessons and methods of problem solving.[30]

On the other hand, comprehensive services include all these core services as well as additional support with screening of available service providers in the area, and providing enhanced referral to specialized health care such as obstetrics/gynecology, physical therapy, etc. Furthermore, it entails provision of planned and tailored intervention for the survivor, preparing ongoing counseling and therapy using specific methods by trained professional counsellors or therapists. Comprehensive services could establish support groups for different kinds of survivors such as age specific groups, violence specific groups, people with disabilities, and same language groups.[31]

However, such holistic healing is not regarded as part of core services, but rather part of comprehensive services as indicated by the literature. This service provides healing opportunities for survivors through different forms of therapeutic activities such as arts, music, creative arts, dance, etc.

In this context, comprehensive services can be defined as assistance that addresses the different social, health, legal and empowerment needs of women and girl survivors of violence, and rehabilitate them to go back and function inside the society.

Among the comprehensive services that could be provided to survivors, economic empowerment schemes are important in enabling women to leave the perpetrator, improve their social status in the community, household and sustain their livelihoods. Studies on such economic empowerment programs, such as the Grameen Bank and BRAC (an international development organization) in Bangladesh have demonstrated that women's vulnerability to violence is reduced as a result of their economic empowerment programs and increased access to economic resources.[32]

Comprehensive services should target women from all parts of the society, and women with disabilities that are exposed to different forms of violence. As studies indicate, women with disabilities experience higher levels of violence from different segments of the society. This 'disability-based violence' also exposes them to repeated incidences of violence.[33] Hence, response mechanisms should ensure that these groups who are most at risk are properly addressed, rehabilitated and reintegrated into the society.

30 Sexual Assault Demonstration Initiative, Enhancing Sexual Assault Services: Building Comprehensive Sexual Assault Services Programs

31 Ibid

32 Schuler et al. (1996), in Bott et al. (2005), as cited from Responding to Gender-Based Violence: A Focus on Policy Change - A Companion Guide.

33 Woodlock Delanie, Healey Lucy, Howe Keran, McGuire Magdalena, Geddes Vig and Granek Sharon: Voices against Violence Paper One: Summary Report and Recommendations (Women with Disabilities Victoria, Office of the Public Advocate and Domestic Violence Resource Centre Victoria, 2014).

2.11. Legal and Policy Frameworks

National and international commitments of Ethiopia indicate that the country has taken legislation and policy moves towards ensuring the rights of women in relation to protection from different forms of violence. Ethiopia has ratified important conventions such as the Convention on the Elimination of All Forms of Discrimination against Women (1981), endorsed the principles of Beijing Platform for Action (BFA) of 1995 and, national instruments including the Federal Democratic Republic of Ethiopia (FDRE) Constitution, the revised Family Law (2000), the revised Criminal Law (2005), the Strategic Plan for an Integrated and Multi-Sectorial Response to Violence Against Women and Children, and Child Justice in Ethiopia (2009) and the National Strategy on Harmful Traditional Practices (2013) by the Ministry of Women, Children and Youth Affairs.[34]

Among the national instruments, the Revised Family Law outlines the equal rights of men and women pertaining in marriage, divorce, inheritance and ownership of property. The law further sets the minimum age for marriage at 18 years. The revised Criminal Code (2005) sets sanctions for violence against women, specifically wife battering, rape and harmful traditional practices such as abduction, child marriage and FGM.

In conjunction with the legal and policy frameworks, institutional structures are also established to facilitate implementation of national strategies. Among these are: one-stop centers, children and women units in federal and some regional police commissions and child- friendly investigation units and child-friendly courts.

International instruments such as CEDAW address the protection of women's rights and outline the state's obligations to protect women from discriminations and violations of rights such as all forms of trafficking and the exploitation and prostitution of women. In line with this, the Committee on CEDAW, through its general recommendation states: *"State parties should establish or support services for victims of family violence, rape, sexual assault and other forms of gender-based violence, including refuges, specially trained health workers, rehabilitation and counseling."* [35] Along with this, the BFA (1995) also called for an increase in the role of states in the elimination of violence against women, ending discrimination and promoting health, education and economic opportunities for women. Among the priority areas identified in the 2014 National Report on the Implementation of Beijing Declaration and Platform for Action and the Outcome of the 23rd Special Session of the United Nations of General Assembly (2000) were actions to reduce the prevalence of gender-based violence including Harmful Traditional Practices (HTPs). Furthermore, the BPA (Section 126 (a) calls on states to "provide well funded shelters and relief support for girls and women subjected to violence, as well as medical, psychological and other counseling services and free or low cost legal assistance, where it is needed, as well as appropriate assistance to enable them to find a means of subsistence."

During the presentation of the 6th and 7th periodic report with regard to the CEDAW in the 49th Session of Conference of the Committee held in New York, Ethiopia was commended for the establishment of victim-friendly benches in federal courts and special units to investigate and prosecute crimes against women in some regional prosecution offices , as well as the steps taken to train judges, prosecutors and police officers on the application of the Criminal Code and on women's rights. However, the Committee also expressed concerns about the lack of conformity of the regional family laws with the Federal Family Law, and recommended for the state to amend the 2005 Criminal Code in a way that will "increase penalties for FGM in Articles 561-562, 567 and 569-570; repeal Article 563;

34 As cited from FDRE, National Report on the Implementation of the Beijing Declaration and Platform for Action (1995) and the Outcome of the 23rd Special Session of the United Nations General Assembly (2000).

35 Gierman, Liska and Reimer et al. (2013), Shelter for Women and Girls at Risk of or Survivors of Violence, Canadian Network of Women's Shelters and Transition Houses, p. 83.

criminalize marital rape; and exclude the applicability in domestic violence cases of the extenuating circumstances set out in Article 557 (1) (b) (gross provocation, shock, surprise, emotion or passion). Pertaining to the issue of rehabilitation support for survivors of violence, the committee also noted the need for enhancing victim assistance, establishing victim support centers in regional states, and directing efforts to strengthen legal aid services by the state.

In the second GTP,[36] addressing violence against women is outlined as one of Ethiopia's multi-sectorial priorities. In the next five years, the plan sets to reduce HTPs and VAWG, including trafficking, female circumcision and abduction. Furthermore, during the GTP II, Ethiopia will establish hotlines for children in violence, including setting up 11 one- stop centers while also strengthening the already existing centers. The sectorial plan of the Ministry of Women and Children Affairs has already outlined indicators for the establishment of these shelters; and as noted during this assessment, the Addis Ababa City Administration Women and Children Affairs Office will also construct a shelter for survivors.[37]

Above: *AWSAD Safe House in Adama /The Domino Effect*

36 GTP II draft document

37 Key informant interview at Addis Ababa, BOWCYA

KEY FINDINGS

3

This chapter presents the key findings of the assessment.

3.1. Availability and Accessibility of Rehabilitation and Reintegration Centers

As one of the response mechanisms for VAWG, rehabilitation and reintegration centers or shelters have a great role to play in the provision of secure accommodation for women and girls who are at risk of or have been subjected to violence. Shelters are basic elements in providing protection services and resources which enable women and girls who have experienced violence, sexual abuse, etc., to recover from the traumatic violence experiences, rebuild their self-esteem, and take steps to regain a self-determined and independent life.[38] Indeed, the significant contribution of shelters in a society like Ethiopia, where VWAG is widespread is clearly noted. However, the shelters available in the country are remarkably small in number as compared to the magnitude of the problem. This cannot be explained better than the statement from a key informant at the Federal Police Commission, who stated, *"The shelters we have are too few that it is better to say we do not have shelters in this country, given the demand we have."*

There are an estimated 12 shelters currently in Ethiopia, which provide rehabilitation and reintegration services for women and girl survivors of violence. While a majority of the shelters available are found in Addis Ababa (five), few other shelters are found across the regions, albeit unevenly. Among the regions that established shelters include: Benishangul Gumuz (two), Amhara (one), Oromia (two), SNNP (one) and in the city administration of Dire Dawa (one). Of the available shelters in Addis Ababa, four were randomly selected for this assessment along with all other shelters available in the regions. However, as the two shelters available in Benishangul Gumuz were 145 kilometers apart from each other [39], it was not possible to visit both, hence the study covered the one in Asossa. Apart from that, all the visited shelters in the regions are all located in the regions' capitals. Of all the available shelters (Table 2), the one in Dire Dawa is the only one managed and fully funded by the government.

TABLE 2:
Shelters for survivors of SGBV

Region	Shelter Name
Addis Ababa	AWSAD
	MCRC
	IFSO
	Family Service Association
	OPRIFS
Amhara	OPRIFS
Oromia	AWSAD Oromia AWSAD Adama
SNNP	BIGA
D.Dawa	D.Dawa Women's Rehabilitation Center
Benishangul	Mujejegwa Asossa Shelter
	Mujejegwa Metekel

The findings of this assessment indicate that there was a high demand for shelters in Tigray, Harari, Somali, Gambella and Afar regions since none of them have a single rehabilitation center. The forms and degree of cases of violence against women might differ from region to region but nearly all regions reported incidence of rape, abduction, domestic violence, and early marriage (mostly in Amhara), exchange marriage[40] (in the case of Benishangul), trafficking and migration (nearly in all regions) and sexual violence on boys/men (by men: Addis Ababa, Amhara, Oromia, Harari and Dire Dawa, etc.).

Most of the key informants and FGD participants from these regions highlighted the various forms of violence inflicted on women and girls, ranging from sexual and domestic violence to harmful traditional practices (HTPs).

38 Gierman, Liska and Reimer et al. (2013), Shelter for Women and Girls at Risk of or Survivors of Violence, Canadian Network of Women's Shelters and Transition Houses, p. 83.

39 While one is located in Asossa city, the other is found near Gumuz Area where sexual violence is widespread.

40 Brothers exchanging their wives without the consent of the wives.

For example, amid the numerous cases reported, there was an incident in Tigray that outraged the community leading to street protests, where a 13 year old girl was subjected to sexual violence that resulted in the amputation of both of her legs. Not only was the girl subjected to early marriage but also to domestic violence, a common manifestation of VAWG in these societies.

While explaining about the need for shelter, an FGD participant who is also a development army member stated that, "If we had a shelter in our area we would have referred this girl there, where she could be safe and rehabilitated." Explaining about this case, another informant from the Women's Affairs Office indicated: "It was very difficult for this girl to go back home after she got treated at the hospital. There was no shelter around to send her to...." This case explains the dire need for shelter where in the absence of it, survivors' safety and wellbeing is highly jeopardized.

The eligibility criterion for admission varies from one shelter to another. For instance, IFSO and OPRIFS accepted only children. In view of the rising number of sexual violence on men, some shelters have also considered boys admission, in the case of IFSO and MCRC.

Some shelters did not accommodate survivors[41] with mental illnesses, for example AWSAD of Oromia and BIGA, also physical disability in BIGA.[42] It is interesting to also note that there were shelters where pregnant women were not accommodated, e.g., in the case of BIGA. Prior to being admitted to the shelter, women undergo further screening for tuberculosis, physical disability and pregnancy. The justification given by BIGA is that the shelter is not disability-friendly; and there is no antenatal care (ANC) at the shelter that caters to the needs of pregnant women and girls. Therefore, BIGA refers pregnant women and girls to other facilities where they can get the services they require and readmits them after delivery. Apart from MCRC and AWSAD, nearly all the shelters covered in this assessment do not accommodate survivors with disabilities, mental or physical, the reason being lack of disability-friendly facilities and services, such as wheel- chairs. Among the common screening criteria to the shelters included, someone who is a victim of violence, has no place to go; and with no social support.

Most of the shelters selected for this assessment are local CSO's and are supported by donors, except the shelter in Dire Dawa that is government-funded through the Bureau of Finance and Economic Development (BOFED). The Dire Dawa City Administration has further allocated land for the shelter's construction[43] and the Bureau of Women, Children and Youth Affairs (BOWCYA) was mobilizing funding for construction. Similar undertaking was also made by the Asossa City Administration, in Benishangul Gumuz, where not only land was allocated for the setting-up of a government (BOWCYA)-coordinated shelter, but also the budget for construction was provided. This constitutes a good practice that should be replicated by other regional administrations.

In terms of the carrying capacity of shelters, majority of the shelters had capacities that ranged from 14-50 survivors. However, due to the rising demand, the shelters were obliged to accommodate survivors beyond their holding capacity. For instance, Mujejegwa, AWSAD and BIGA used mattresses in order to accommodate higher number of survivors when the need arose. The same holds true in Dire Dawa. Even though there was no survivor available at the shelter during the time of the study/ visit, it was noted that they usually carried beyond 14, evident by the available mattresses. Having recognized the demand, the newly launched shelter in Adama, AWSAD of Oromia, has already increased its capacity, from the outset, to 50 survivors, which is among the highest carrying capacity of shelters visited.

41 The lack of shelter for male sexual survivors was noted as a big challenge in the case of Dire Dawa, Harari.

42 This is due to safety reasons for other residents in the shelters coupled with lack of capacity to cater for the special needs of mental illness.

43 On the basis of BOWCYA's request

It was also observed that some shelters (IFSO, OPRIFS, AWSAD, MCRC, AWSAD of Adama) were fully occupied, while other shelters (FSE and AWSAD of Oromia) had unoccupied beds when visited[44] and the Mujejegwa Asossa shelter was barely occupied, which was attributed to the lack of information on the type of services the shelter provides as well as its target groups.

Since nearly all the shelters visited paid rent to accommodate survivors, it goes without saying that their operation cost was high. The limited funding coupled with sky rocketing rent prices, most shelters highlighted the difficulty of their costly operation. Consequently, the need for government support in allocating land for the construction of shelters is strongly recommended. This sentiment was also shared by donors where there is a strong conviction that the government should subsidize this effort in recognition of the challenges. With regards to this, the government's commitment or plan for the establishment of a government-run shelter for survivors of violence in Addis Ababa[45] is promising and should be replicated in other parts of the country.

Regarding visibility of shelters, it was observed that most stakeholders were aware of the shelters' operation in their regions and about the services they provide for women and girls survivors. Since majority of the referrals to the shelters are made by the police, Women's Affairs Office and at times the Justice Office, a good working relationship was observed between shelters and these stakeholders. In areas where women CSO's such as Ethiopian Women's Lawyers Association (EWLA) and one-stop centers were available; these organs also made referrals to the shelters. However, none of the survivors that were interviewed were aware of, or had ever heard about the availability of shelter services. As one survivor from AWSAD stated: "Had I known about this service, I would have reported right away…" She further indicated the reason behind not reporting immediately after she was raped, by her relative, was because she did not have anywhere else to go to.

Moreover, there were also shelters, including for example, Amhara and Benishangul Gumuz, which were not known to the local government in their regions, let alone by the general public. This was particularly true in Amhara where the shelter, Organization for the Prevention, Rehabilitation and Integration of Female Street Children (OPRIFS), was not known by most stakeholders for the service it provides for girls survivors of violence, except by the police, as both FGD and key informant interviewees indicated. The same holds true in Mujejegwa Asossa where there was little information about the shelter and the services given; since the shelter was initially targeting fistula patients.

Clearly, there was little effort made to publicize many of the available shelters, leading to gaps in awareness about shelter services among community members. Even though there were some shelters that make deliberate attempt to do outreach to publicize their shelter, like in the case of Dire Dawa, through radio, pamphlets, and TV programs, it is not a strategy that is commonly employed by shelters. Taking into account the possible danger of publicizing, which could compromise the safety of survivors, caution should be taken not to disclose the exact location of the shelters. The services available should, however, be visible to the various involved stakeholders including women groups.

There were no self-referrals made to the shelters by a survivor. One would say this is attributed to the lack of women's awareness about the services available. It is striking to also note that there is a deliberate attempt being made by shelters not to make themselves known given their lack of capacities to cope with the demands. It was further learnt that some shelters do not allow self- referrals due to the agreement made with stakeholders which only allows them to accept referrals from relevant stakeholders such as police, one-stop center, Women's Affairs Offices, and others.

44 This could be attributed to the fact that AWSAD Oromia is quite new and staff of the shelter indicated that they expect a lot more soon.

45 Key informant interview at Addis Ababa BOWCYA

The services provided at the shelters range from shelter, food, and counseling to medical care, skills training,[46] and day care services (AWSAD and MCRC). Some shelters went to the extent of providing self-defense training (Taekwondo) for survivors, for personal safety reasons, as in the case of AWSAD and MCRC. The types of skills trainings provided by the majority of shelters included hairdressing, baby-sitting, embroidery, tailoring, cooking, etc.

The skills training is intended to help survivors generate income which in turn eventually contributes to their economic empowerments. A limited number of the shelters provide art therapies for children, as in the case of IFSO, OPRIFS (Amhara) and MCRC. OPRIFS further utilized drawing, drama, music, and handicrafts activities for children, as a way of teaching self-expression and trauma healing. In general, the majority of the shelters observed seemed to provide core services like shelter, food, skills training, and day care services.

The duration of stay at a shelter varied from one case to another, as well as from shelter to shelter. Survivors in general stayed in the shelters from two weeks (as in the case of Dire Dawa) to a year. More often than not, survivors over-stayed at the shelters beyond the allotted time, due to lengthy trials, and engagement in formal education, that does not allow them to access other trainings and generate income.

In terms of provision of security to the shelters, nearly all of the shelters visited were guarded by female security guards, aside from the women's rehabilitation center in Dire Dawa and MCRC. The fact that there were no men in all-female shelters made the survivors feel safe and at ease given their traumatic experience.

It was striking to note that the majority of the survivors in the visited shelters were minors, aged on average from 2-16 years, and more often than not, happened also to be rape survivors. Most of the FGD discussants indicated that their perpetrators were relatives and close family members.

46 Nearly all shelters provided these services except the rehabilitation center in Dire Dawa

Among the shelters visited, MCRC seemed to have a higher standard in every aspect of the services provided. Survivors in MCRC were provided with various services, such as education in private schools, along with the supply of necessary materials, dance classes by a hired professional dance teacher, Taekwondo, and music classes. Given that the majority of the residents were children, they were provided with snacks in between meal times. It should also be noted that both male and female were accommodated at MCRC, with separate sleeping quarters, although they mingled freely when receiving the other services.

Among the all-female shelters visited, AWSAD was observed to be providing a comprehensive service evident by the positive impact observed on survivors. Interviewed survivors, in particular sexual violence survivors, indicated the feeling of hopelessness, self-hate, self-blame, anger, and outrage when they first joined the shelter, as expressed by one survivor, "We usually come here hopeless but now we have hope. [47] It was indeed impressive to see how rehabilitated, assertive, and hopeful nearly all the survivors involved in the FGD discussions were, which was particularly true in AWSAD.

Some shelters not only cater to the needs of the residents, but also to their children given that most of the survivors have children born out of rape. Among the services given to their children include food, shelter and day care services. The day care services were given not only to residents but also to ex-residents, in the case of AWSAD and MCRC. During the FGD discussion with survivors, it was clearly observed that most of them had brought their children along; while some were pregnant.

Generally, all the interviewed survivors highlighted the added value of the shelter for their survival, safety and well- being. Given that most of the survivors were raped by their close relatives and family members, it was crucial for them to find a safe place to stay to prevent recurrence of abuse and violence. Majority of the survivors rated counseling as highly valuable while some pointed out the benefits of the health services

47 A survivor at AWSAD

and economic empowerment program as the most useful. For mothers with infants and young children, support with child care and the daycare service were very much valued, in particular for the ex-residents that were also employed. The available entertainment were also highly appreciated, especially in IFSO, OPRIFS, AWSAD and MCRC. They also highlighted the importance of peer counseling in therapeutic healing, thus indicating that a multi-sectorial approach should be utilized to address the needs of survivors.

In describing the benefits of the shelters, one sexual violence survivor stated that: "If this shelter had not been available, I couldn't imagine what my future would have been...I might have died since I was thinking of killing myself. It was the Women's Affairs Office who brought me here and saved my life. After I came here, I got hope and dreamed again about continuing my education, which I got to do. In the shelter, they gave me counseling on several issues and most importantly on how to love my child, since I was planning to give him away. I never imagined loving my child this much ... to have a child from a person who repeatedly raped me was very difficult to accept... but because of this place I learned to love my child and learned other important life skills for my future..."

3.1.1. Accessibility of Shelters

The fact that there were few shelters available across the country in general indicates that shelter services were not accessible to the large majority of the population. In addition, the identified shelters were located in the regional capitals and therefore not necessarily accessible to women living in the rural areas. Accessibility to shelters was also constrained by a number of other factors including, eligibility criteria by some shelters that exclude women with physical disabilities, mental health problems and on the basis of pregnancy.

Shelters should be accessible to survivors of violence 7 days a week and 24 hours a day. However, survivors were referred to the shelters through police, the Women's Affairs Office or Justice Bureau, and hence cannot be self-referred to access shelter services anytime. This stemmed from the lack of sufficient space to accommodate the needs of survivors, which notably limits women's access to emergency shelter. Along with this, lack of information about the availability of shelters and limited visibility of shelter services is a constraint for accessibility. Furthermore, the Charities and Societies Agency guideline on Administrative and Operational Costs of NGOs known commonly as "70/30" regulation which defines salaries, transport fees and training related costs as project administrative costs constrains shelters availability and expansion.

3.2. Availability of Comprehensive Services

"Comprehensive services provide the core services as well as additional opportunities for survivors to heal and communities to prevent violence. These include additional services that address the physical, social, emotional, and spiritual needs of sexual assault survivors and their allies.

These services go beyond the most immediate, pressing needs to support more in-depth healing, empowerment and integration." [48]

In line with the definition above, the assessment explored the kind of services available at the shelters, for women and girls, and to what extent they met the standards of a comprehensive service.

Among the services that should be provided by a shelter are: basic necessities such as food, clothing and sanitary items. Although the quality and quantity of food varied from shelter to

48 Sexual Assault Demonstration Initiative, Building Comprehensive Sexual Assault Programs ,http://www.nsvrc.org/sites/default/files/nsvrc_publications_article_sadi_building-comprehensive-sexual-assault-programs.pdf

shelter, the general response from the residents, in all the shelters, was overall positive. The discussions undertaken with shelter residents in AWSAD, MCRC, and BIGA revealed that the residents were happy with the kind of service such as food, sanitary items and clothes provided. In addition, residents of some shelters, particularly in AWSAD, BIGA, MCRC, and IFSO, noted that they took part in food preparation and serving, and therefore were partially responsible for the quality of food served. In all the shelters visited, the residents also indicated the fact that they provided feedback about food quality and other services in the shelters, in their general meetings. In some shelters like AWSAD, it was also observed that the residents and staff shared the same food, in order to avoid discrimination, as well as to regularly monitor the quality of food served. Despite these field observations, there were claims that some shelters did not provide sufficient and quality food.

The findings[49] of the assessment also indicated that in almost all the shelters visited, cloths were donated by charitable individuals and organizations. Though this strategy is effective in shelters like MCRC which have constant supply, it was presented as a challenge in others, which do not have sufficient supplies. Hence, whenever relevant, this should be properly planned and budgeted in program activities.

Given the absence of standards for monitoring the quality of shelter/safe house services provided for survivors of violence in Ethiopia, the assessment also researched on the standards in other African countries. In South Africa, for example, there are minimum standards that outline the needs for health, social and legal services, along with placement in a shelter as part of the care and development of survivors; while in the case of Ethiopia, shelters were not mandated to provide legal aid services. Despite this constraint, some organizations like AWSAD were trying to mitigate this problem by linking with legal aid service providers such as EWLA. The assessment noted that the various shelters available in the country required support towards creating and strengthening their linkages and coordination with other service providers.

Shelters in Ethiopia are also not mandated to provide health services, but rather emergency care in the shelter. Most of the visited shelters took their survivors to government and in few cases to private health providers in order to ensure the physical and mental wellbeing of the residents. Among the constraints faced by the shelters was the lack of capacity and skills on handling women with severe psychiatric problems. In such cases, some shelters noted that they sent the survivors back to where they were referred to, usually police, while others, as was the case of AWSAD, made an effort to engage psychiatrists to help them with their programs. While this was feasible in the capital, Addis Ababa, it may be difficult to get access to the required care and services from other service providers in other regions.

Another indicator of a quality comprehensive service is the availability of economic empowerment services so that women who leave the shelters will be sustainably reintegrated back into the society and hence not be exposed to further economic and other forms of violence. In this regard, shelters like IFSO, AWSAD and MCRC have gone to the extent of arranging short-term training programs for survivors while at the shelter as well as out of the shelter when necessary. Along with this, women who were reintegrated back to the society were provided with initial start-up capital to cover their rent. Some of the interviewed ex-resident women noted that they had put this money to good use to start up businesses.

As inferred from the data, different shelters in Ethiopia have different modes of operations and vary in the kinds of services provided. For example, in some shelters such as BIGA and OPRIFS, short-term training such as cooking, hairdressing and handicrafts were given in-house, while other shelters such as IFSO, AWSAD and MCRC provided in- house training sessions and also linked their residents to other training centers. In

49 Key informant interviewees at Addis Ababa Police Commission and Ministry of Justice

the case of other shelters, e.g. in Dire Dawa, none of these services are provided.

Along with the economic empowerment programs, it was also commendable to see the different therapeutic activities undertaken for survivors in some of the shelters. For example, music and art therapies were employed in MCRC, whereas in AWSAD survivors were engaged in dancing, drama and singing as a means of entertainment and therapy. Pertaining to counseling services, it was possible to note that many of the shelters, AWSAD, BIGA, and MCRC, used individual counseling sessions as well as group discussions whenever relevant. In the case of IFSO and AWSAD, professionals provided counseling and therapy sessions assisted by guiding materials. While this was the case in IFSO and AWSAD, it was also noted that other shelters mostly provided the counseling service through nurses, who had prior experiences on counseling on HIV and other issues. It is again worth noting that counseling should be provided as part of core services, through different interventions such as listening, provision of coping strategies and skills, establishment of support groups, etc.. In the context of comprehensive services, counseling services should be designed to use trained professional counselor or therapists, and whenever relevant, engage group sessions for different target groups, such as age groups, violence specific groups, etc. as per the interest of the survivors, and in a way that does not jeopardize confidentiality issues.

3.3. Reintegration

As indicated in the literature, the first stage of reintegration is going back into the society and learning to blend and manage one's own livelihood. The second stage of reintegration includes returning to the family and being accepted; while the last stage involves going into the community.

Having gone through rehabilitation, survivors would eventually have to leave the shelters and become reintegrated back into society, family and community. However, reintegration is often one of the greatest challenges for survivors because of the stigma attached to the incidence of sexual violence, regardless of how the violence occurred. The assessment indicated that most survivors, sexual violence survivors from out of Addis Ababa in particular, did not have the intention of going back to where they came from, but rather prefer to start a new life elsewhere. It was further observed that majority of the survivors did not maintain contacts with their families or relatives, as one survivor said - "This thing ruins the relationship you have with your family" - since most of the perpetrators are family members and relatives. Nonetheless, there was one FGD discussant who revealed her intention of going back to her community in order to save other lives. In her words, "I want to go back to where I came from and teach my community about sexual violence and its consequences. There are so many women out there who are victims like me that I want to save."[50]

To economically empower survivors that are ready to reintegrate into the society, some shelters - IFSO, AWSAD, MCRC, and BIGA provide survivors with seed money, in addition to skills training, and cover survivors' rent for a limited period of time. Survivors are then required to find jobs and continue to pay their house rents. Some shelters arranged trainings and provided seed money which some ex-residents have used to start businesses.

In addition, some organizations such as IFSO and AWSAD were making efforts to follow up on the reintegrated survivors. For example, AWSAD had established ex-residents groups, recruited a Reintegration Officer and when possible visited them in their homes. Further, ex-residents met with survivors, once a month, to share their experiences including challenges and opportunities in their quest for reintegration with the society. This was done in order to gradually introduce survivors to the society through the experiences they gain from the ex-residents, who were once 'residents/survivors like them.' While some shelters (AWSAD, MCRC, and IFSO) conducted follow

50 Survivor in AWSAD

up visits to their ex-residents, some of them e.g. BIGA and Dire Dawa, were yet to do similar follow up due to lack of capacity, limited staffing and budget constraints.

The recent move by AWSAD of Oromia to recruit a Reintegration Officer at its newly established shelter is indeed a manifestation of the attention given to the matter. For the women's rehabilitation center in Dire Dawa, reintegration was indicated as one of their priority areas of intervention in the upcoming year. Others like BIGA noted that they did not have sufficient human resources to follow up on the reintegrated women, and hence lack sufficient information about most of the reintegrated women.

In general, there was very limited follow up of reintegration of survivors to the society, community and family. Majority of the shelters, AWSAD, MCRC, BIGA, IFSO and Mujejegwa have specific budgets or seed money allocated for reintegration of survivors. In view of the above, the assessment notes that while the first stage of reintegration is being realized by organizations venturing on reintegration of their survivors, further impact assessment might be required to assess the levels of survivors' integrations to their families and communities.

3.4. Demand for Services

The qualitative assessment undertaken in all regions and city administrations of the nation revealed that there was a high demand for shelters across all parts of the regions, and especially in emerging regions like Gambella, Somali and Afar. In these regions, women and girl survivors of violence had limited access to comprehensive VAW response services by either governmental or non- governmental organizations. In regions where shelters were available, demand for services was still greater than supply. In a majority of the shelters, the number of survivors currently accommodated, was more than their holding capacity. This was particularly high in AWSAD of Addis Ababa, BIGA and MCRC. Women in SNNP, Gambella, Afar, Tigray and all the other regions reported the various forms of violence they were facing including economic, sexual and physical violence. In some regions and city administrations like Addis Ababa, SNNP Dire Dawa, Harari, Amhara and Oromia, incidents of sexual violence against males were also repeatedly mentioned as an emerging challenge in the target communities. In Addis Ababa and Harari, the need for shelter for men/boys sexual survivors was equally identified as a growing concern.

Some key informants in SNNP noted that poverty, increase in commercial sex work and drug addiction were exposing women to sexual and physical violence in the region, especially in the city of Hawassa. Because of this, the existing shelter, BIGA, was unable to meet the demands from the city as well as the rural areas. Survivors also require rapid justice processes - Real Time Dispatch (RTD) justice, given that most of the rural women could not afford the costs of traveling to regional courts and following up their cases.

In Amhara region, migration and trafficking of children had resulted in high demand for shelters. Similarly in Afar region, the growth of industries like the Sugar factory had increased the influx of migrants to the region. Secondly, the Afar-Djibouti route was used by illegal migrants and traffickers in exploitation of women. The assessment revealed that the demand for shelter was higher among women who migrated to the region in search of jobs, rather than the natives of the area. The assessment also found that the Family Law in Afar was under revision and was expected to amend the legal age of marriage. This could be an important step, since early marriage is institutionalized and not considered a sexual offence in the region. Similarly, in the case of Somali Region, the fact that early marriage was not prohibited by law, but was condoned under Sharia Law along with the practice of FGM, has put women's health and overall wellbeing at risk. This indicated that there was a need to support the revision of legal frameworks in these regions.

Another form of violence reported by assessment participants in Tigray, SNNP and Afar was economic violence. Women and girls who were

facing economic violence said that they not only required justice, but also needed access to accommodation in order to follow up on their cases. Afari women were exposed to economic abuse/ violence due to their financial dependence on men - husbands, fathers, uncles, brothers and relatives. Whenever cases were referred to the Woreda and Zonal courts, women were obliged to abandon or settle their cases as they could not afford to pay for their accommodation and rent. Hence, the demand for shelter was noted to be very high in this region, especially given the absence of any institutionalized support in the area.

As mentioned earlier, all emerging regions, including Somali and Gambella revealed high demand for shelters. In Somali Region, incidents of rape (including date rape),[51] FGM, early marriage, domestic violence, and trafficking were reported, while in Gambella there was underage marriage, polygamy, and domestic violence. Participants noted that sexual violence used to be uncommon, but it was now being reported more as a result of various factors, including increased reporting, increased migration to the regions and the refugee crisis in Gambella. Similarly in Somali Region, the fact that the area borders neighboring countries in the east had allowed it to be a route for trafficking. In Somali Region, trafficked women and girls were particularly subject to sexual violence. Rape cases were also rampant in some Woredas mainly where there were refugee camps, such as Aweber and Kebarebeya. Again, the limited response by governmental and non-governmental organization to address the demand for such services in regions such as Gambella and Somali continued to limit women's access to rehabilitation, reintegration and justice.

In the case of Dire Dawa City Administration, while there was a one- stop center that catered to the need of rape survivors (both female and male), the demand for shelter services was noted to be high given the incidents of violence such as rape, domestic violence, sexual violence on boys, and early marriage. The assessment also indicated that most survivors of sexual violence were minors ranging from 4 to 16 years.[52]

Similarly, in Harari the assessment groups stressed a huge need for shelter services, in the absence of safe spaces to rehabilitate survivors that are vulnerable to secondary victimization. The most common forms of violence reported in Harari by the assessment groups included rape, attempted rape, abduction, domestic violence and some incidents of sexual violence against men; while fathers' unwillingness to pay child support was also noted to be the most prevalent form of violence in the area.[53]

The assessment also confirmed that even in those regions which had shelters such as Amhara, Oromia and SNNP, there was demand for more shelters since the existing ones were unable to meet the demands in the regional cities, let alone the rural areas. In general, the demand for shelters was visible in all the regions, with the highest demand found in Gambella, Somali, Afar, Harari, Tigray and where women and girl survivors of violence had no access to shelter services through either governmental or non-governmental interventions.

3.5. Quality of Services

One of the limitations of the assessment was its inability to rate the quality of services due to lack of national quality standards measurements in Ethiopia. A review of some standards in Africa was undertaken in order to identify benchmarks for quality. It was however, interesting to note that a Global Guideline on Essential Services is currently being developed at the global level,[54] which could serve as the benchmark in the future.

In the case of Uganda, for example, a declaration was signed in 2011 for the establishment of "re-

51 Rape happening between couples on their date which automatically puts the blame on the women

52 Key informant interview with the police commis- sioner and prosecutor, Dire Dawa

53 Key informant interview, deputy inspector in Harari

54 Key informant revealed that AWSAD is taking part in the global discussion on international standard development

covery centers" that cater to the health, psychosocial and legal needs of survivors of sexual and gender-based violence, along with guidelines for the establishment of shelters with clear mission statements, objectives, and principles on how to work and what kinds of services to offer. The guiding approaches of the shelters could differ based on their principles. The most common approaches were: (a) welfare approach to address the basic needs of survivors, (b) feminist approach, which focused on empowering women, (c) religious approach, to meet the spiritual needs of survivors, and (d) therapeutic approach,to meet survivors' emotional needs. Any one of these approaches could be used independently or in combination with others.[55] In line with these approaches, the shelters set their objectives, and were then held to account accordingly, including through performance evaluations against their mission and objectives.

In South Africa, the assessment noted the existence of Minimum Standards on Shelters for Abused Women, which focused on specific issues such as staff accountability for delivering on quality service, the need for contextualizing the service in the community environment, and the delivery of integration services which cater to the needs of the survivors through engagement of multi- disciplinary teams of implementers.

Thus, the quality of individual shelters could be assessed against different indicators that measure the kinds of services that the shelters aimed to provide, be it core or comprehensive services. Operational standards were therefore important in setting out quality benchmarks for the different services provided for survivors. Depending on the type of services availed at the shelters; quality measurements also focused on whether or how services on emergency care, emotional/psychological support, accommodation services, psychiatry, sexual and reproductive health, medical support including maternal health and children care services provided were aligned to the guidelines of operation or Codes of Conduct.

55 UWONET (2012), Crisis Centers for Survivors of Gender Based Violence, Uganda Women's Network,Policy brief. No 1/2012

The national assessment revealed that there were no shelters for women and girl survivors of violence in Afar, Gambella, Tigray, Harari and Somali. Hence, quality of shelters was assessed only in the regions of SNNP, Oromia, Benishangul Gumuz, Amhara, and Dire Dawa and Addis Ababa City Administration.

In order to determine the quality of shelters, the assessment focused on an assessment of the services given and how these services were delivered. It also looked into the availability of spaces for different activities, appearance of the shelter (cleanliness, size of rooms and their appropriateness for living, including availability of beds, dining, and other facilities), availability of a waiting room and female security guards at women- only shelters. In addition, the assessment looked at whether the shelters had staff with the relevant qualifications and training to provide the services in the shelters.

Furthermore, the assessment explored whether the shelters had rules or codes of conduct to govern staff providing different kinds of services, as well as any written or unwritten standard operating procedures. The assessment also looked into the presence or lack thereof, of supervision on the quality of services provided by shelters and the responsible organs in this supervision.

3.5.1. Service Providers' Technical Capacity

A major indication of quality service was the availability of regular and relevant training and guidelines for staff that were working in different levels at the shelters. The assessment identified gaps in access to tailored and regular training in some of the shelters, while others like staff from AWSAD reported receiving training at different times. In addition, some of the shelters noted that they had budget constraints in finding qualified and willing professionals to work with the survivors.

Funding opportunities were declining due to other emerging challenges. These factors constrain the efforts to improve the services provided at the shelter, the type of available accommodation, and to provide relevant staff remuneration

and benefits. In conjunction with technical capacity, shelters' capacity to manage their program and raise sufficient funds to undertake their roles should be considered. In the case of some shelters like BIGA, the absence of sufficient administrative support was noted by the staff who claimed that there were times when they served without salaries. In such cases capacity gaps in raising funds from multiple stakeholders was also noted as a major challenge. Only a few of the shelters said that they were managing with available resources.

The assessment also revealed a challenge with respect to staff burn- out. In this regard, some of the shelters such as AWSAD undertook retreat programs not only for their staff but also for the shelter's residents, to rejuvenate and address the problems associated with burn-out. Hence, such activities should be properly budgeted in shelter programs in order to ensure the welfare of not only the residents, but also the staff.

In terms of training of shelter staff, while some shelter staff indicated that the training they received was pertinent to their duties, as in the case of AWSAD and OPRIFS, there were however, shelters like the one in Dire Dawa, where none of the shelter staff had ever received training to build their capacity. "We started off this work from nothing, we did not even have anything to refer to," stated the coordinator of the shelter of Dire Dawa while explaining the capacity gap that they were dealing with in an attempt to discharge their responsibilities effectively. When asked about it, BOWCYA indicated its intention to organize experience sharing with AWSAD in Adama to gather more experience of running the shelter.

In general, shelters need to identify the kinds of services they strive to provide, and assign multi-disciplinary teams of staff including health care staff, professional counselors or therapists, project managers and officers, child-care staff, trainers, reintegration officers and staff catering to the accommodation, nutrition and sanitation needs of the shelter, to provide the service as per the shelters' specific goals.

Code of Conduct

It is important for shelters to have clear codes of conduct for staff along with standard operating procedures for response. The presence of such guides will help to foster a positive work place environment as well as relevant and quality services to the survivors of violence. The assessment revealed that most of the shelters had written and unwritten codes of conduct on how to interact and work with survivors. Additionally, the shelters have codes of conduct for shelter residents. Usually residents are given orientation on the rules as well as what is expected of them while residing at the shelters.

Review of the shelter documents revealed that some of the shelters like BIGA have guidelines along with proper documentation practices. For example, individual cases are properly maintained and filed in AWSAD and BIGA with pictures, stories, information on counseling sessions and reflections from the survivors. In the case of AWSAD, a case management form is prepared and filled out whenever that individual is referred to a specific kind of service.

3.5.2. Minimum Standards for Accommodation

Indicators for minimum standards of accommodation are taken as cleanliness of the accommodation, orderliness, size of rooms and their appropriateness for living including if there are beds, dining area, and space for other activities. In line with these indicators, the assessment found out that some of the shelters, such as AWSAD, MCRC and BIGA had sufficient rooms to handle the number of residents currently in the shelters. However, in cases where the shelters were not able to meet the demand, shelters like AWSAD and BIGA tried to avoid turning away survivors by using mattresses. Others like MCRC also rented spaces beyond the shelters' premises in order to meet the demand for such services.

Observation of the shelters also revealed that IFSO, AWSAD, OPRIFS Amhara and MCRC had sufficient space for dining, including green area and additional space for other activities by residents. In the case of MCRC, separate spaces

Above: *From top left, clockwise: Baby cribs in MCRC shelter/ Meron Genene. Accommodation in AWSAD shelter/ The Domino Effect. Accommodation at BIGA, Hawassa/Meron Genene. Accomodation at MCRC shelter/ Meron Genene.*

and rooms were allocated for dining, art, music, library, dance, play and study.

However, in the case of BIGA, the shelter space was found to be rather small, allowing limited movement for the residents. Residents did not have a separate dining area, and had to sit outside their rooms during meal times. Pertaining to this, the assessment revealed that shelters like BIGA are functioning at minimum standards due to limited funds and capacity to raise sufficient resources.[56]

However, some of the shelters also had separate store-rooms for clothes and food supplies. However, in one of the shelters it was noted that there was lack of sufficient space to properly accomodated the different supplies. Hence, the store accommodates both edible and non-edible items, including cleaning materials, solutions and clothes. Additionally, nearly all shelters had waiting rooms as well as female security guards, which was commendable.

In general, given the importance of accommodation for the general wellbeing of survivors, and the importance of facilitating rehabilitation through a range of activities, shelters should be established with sufficient space for sleeping, dining, reading, counseling, storage, toilet facilities, laundry area, art and other play activities, and child-friendly spaces.

56 Focus group discussion with service providers at the Shelter in Hawassa (BIGA)

3.5.3. Eligibility Criteria

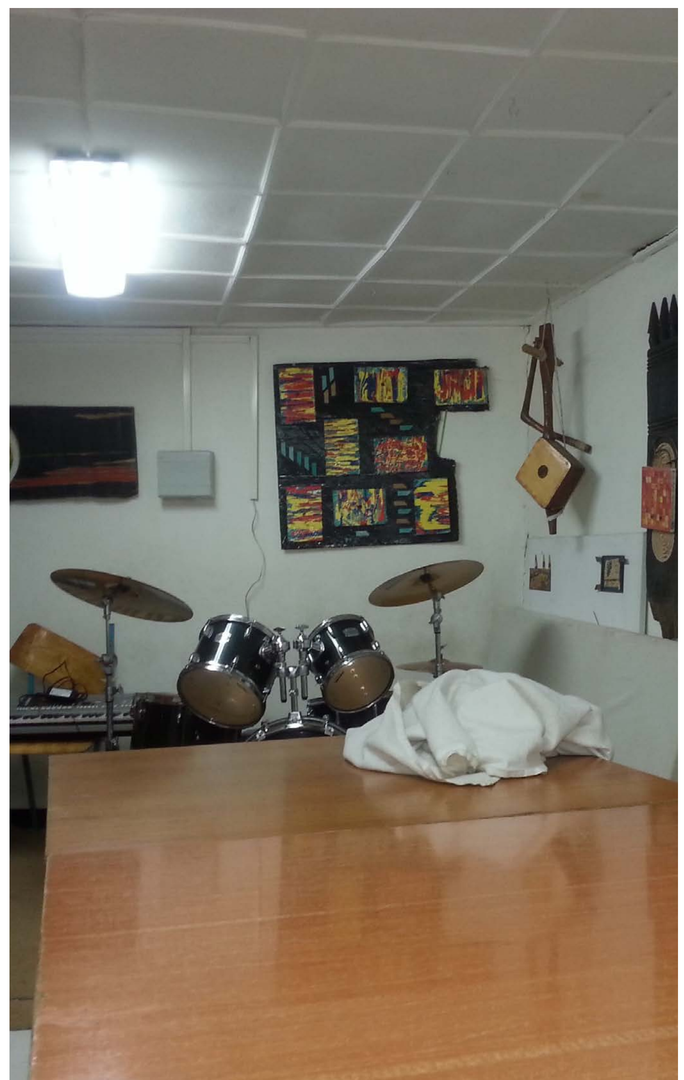
This assessment revealed that there were some shelters that excluded women with certain conditions, such as women with physical and mental disabilities, and pregnant women. For example, the staff in one shelter noted that they did not provide for such groups because of the limited human resource to handle such cases, and the unsuitable compound (space and facilities) for people with disabilities.[57] The staff also noted that the lack of mandate to provide emergency delivery services at the shelter along with absence of twenty four hour nursing care, limited them from accepting pregnant women into the shelter. Furthermore, in cases when women with severe mental disabilities were violent and could potentially harm other residents, the shelter sent these women back to the offices which referred them. In the case of other shelters like AWSAD and MCRC, women with severe mental problems were first sent to a psychiatrist and if not, they were referred out. Since such groups of women are the most marginalized parts of the community and most exposed to secondary victimization, turning them away from shelters without the provision of other alternatives seems to conflict with the purpose of establishing a shelter, and needs to be critically viewed. Therefore, referral linkages with other service providers that cater to the special needs of survivors should be strengthened.

3.5.4. Community Engagement

Another policy option set in the South Africa Minimum Standards was the need for using existing facilities and structures within the communities. Though, so far this has not been put in place in Ethiopia, shelters and other stakeholders along with the government structures should work towards establishing such mechanisms within the communities. In addition, it is important for shelters to secure land or other facilities that are available in the communities; while government, donors, CSOs working on the issue and other stakeholders should also contribute and advocate for community engagement.

57 FGD with service providers in BIGA

Pertaining to the issue of linkages of shelters with community structures, again gaps were noted in some shelters, while others like AWSAD and BIGA provide services such as awareness programs using community conversation and psycho-social counseling to other community members, hence linking their programs with communities. However, these were not indicative of the cooperation and linkage with community structures such as women groups, Iddirs (community-based associations) and women development army, etc. that could contribute to ensuring ownership, and disseminating



Above: *Music room in MCRC / Meron Genene*

information on availability of such services to other women in the community. Many of the women survivors who took part in focus group discussions in AWSAD (Adama) and BIGA (Hawassa) noted that they were not aware of the presence of such shelters, and would have left the situation of violence earlier if they had known. Many also noted that a lot of women lived in abuse and fear, because they could not see a way out, or the possibility of leaving and suing the perpetrators.

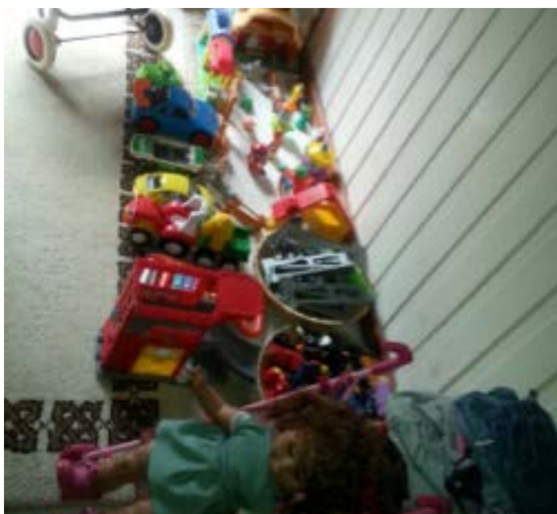
3.5.5. Child Care Services

One of the key points raised in the South Africa Standard was that shelters should link their resident children to childcare services, or otherwise, provide that service at the shelters. The assessment found out that most of the shelters in Ethiopia provided childcare support for infants and small children that join the centers with their mothers. Some shelters like MCRC specifically cater to the different needs of children by preparing various education and entertainment activities at the centers. Shelters like MCRC, IFSO and AWSAD (Addis Ababa) had also prepared a child friendly space. On the other hand, in shelters like BIGA there was lack of separate play space or any other activities that require movement for children. Literature also indicates that there needs to be an assessment of the children's conditions and efforts to enable the children to understand what is happening, in cases when grown up children join the shelter with their mothers who faced violence.[58]

Some initiatives by shelters like AWSAD to institutionalize and formalize child protection are found to be encouraging. AWSAD has prepared a child protection policy and procedure which aims to safeguard children who are in AWSAD's care. The guidelines outline education and training procedures and staff communication. when dealing with children. It also encompasses tools for staff to report on child protection concerns, along with emergency contacts.

3.6. Referral System/ Coordination Mechanism

In response to the need for prevention as well as provision of coordinated assistance to survivors of violence against women and children, a national coordinating body was formed in 2008 (2001 Eth.C.) Three years later in 2011 (2004 Eth.C.) participating institutions in the national



Above: *Toys in MCRC and Child friendly space in AWSAD shelter / Meron Genene*

58 DV VIC, Code of Practice for Specialist Family Violence Services for Women and Children: Enhancing the Safety of Women and Children in Victoria, Domestic Violence Victoria

coordination body formalized their cooperation based on an MoU followed by the development of a strategic plan and a three-year PoA 2011/12-14/15. An attempt was made to ensure broad-based membership of government, non-government and international organizations.

Having recognized the multi-sectorial dimensions of VAWC, about 17 institutions signed the MoU. These are: Ministry of Education (MoE), Ministry of Labor and Social Affairs (MoLSA), Ministry of Justice (MoJ), Ministry of Health (MoH), the Federal Police Commission, Federal Prison Commission, Federal Supreme Court, Federal First Instance Court, Coalition of Interfaith Institutions, the United Nations Children's Fund (UNICEF), EWLA, Addis Ababa Bureau of Health, Addis Ababa Police Commission, Oromia Bureau of Justice, Amhara Bureau of Justice, and Benishangul Gumuz Supreme Court. Participating institutions (partners in the referral network) are bound to present their yearly plans, in accordance with their mandates, and report on implementation and accomplishment accordingly. As per one key informant from MOWCYA who chairs the technical committee from MOWCYA, the question remains about whether plans were being accomplished. Among the activities planned, for instance, was the expansion of the One-Stop Center to other hospitals in Addis Ababa i.e., Yekatit and Alert Hospitals, which was yet to be realized.[59]

As stipulated in the MoU, the national coordination body's responsibility revolves around prevention and reduction of VAWC. It also intends to improve assistance services to survivors. Most of the activities concerning prevention rely on awareness creation whereas the response focuses on piloting and expanding one-stop centers.

The national coordination has a chair, vice chair and secretary, with its own secretariat, which is MoJ. MoJ is also the chair of the national coordinating body, while MOWCYA stands as vice-chair. MOWCYA further chairs the technical committee whose responsibility is to set the agenda of the various meetings and present issues that warrant discussion and decision. UN Agencies (UNICEF and UN Women) play a key role in funding the coordination mechanism.

As per one key informant from MoJ, the coordinating body intends to avoid duplication of efforts, overlapping and redundancy of members' activities, among others.

The formation of a national coordinating mechanism with components of both prevention and response to VAWC was indeed a commendable step taken for improving the referral mechanism. The MoU signed among stakeholders further formalizes the formation of the coordination and enhances members' accountability. However, the functionality of the coordination mechanism was in question, for many stakeholders involved, given that the committees do not have regular meeting. During the interview with MOWCYA, it was also noted that there was a need for the revision of the PoA along with its activities and timetable. The need to include more stakeholders to ensure broad-based membership was also emphasized. Having recognized this, UN Women had embarked on revitalizing the coordination body through capacity building training for its members.

Coordinating bodies need to meet regularly, in order to ensure ongoing implementation and monitoring of action plans and to address emerging issues in a timely manner. Ensuring broad-based membership of government and non-government organizations in coordination is desirable.

3.7. Referral Systems in Regions

In addition to the national coordinating body and referral mechanism, the overwhelming majority of the regions have established referral systems for VAWC prevention and response, which is not necessarily subsidiary to the national coordination body. While nearly all the referral mechanisms in the regions were established at macro level, regional capitals, there were also regions with referral systems in place at zonal and Woreda level.

59 It was learnt however that he budget for Yekatit Hospital was shifted to Adama where the establishment of One-Stop center was realized.

For instance, UNICEF has been supporting the setting up of a referral pathway on VAWC in four regions i.e. Amhara, Somali, SNNP and Afar. These referral mechanisms intend to provide comprehensive services by linking justice, health and psychosocial support, among others, and were formalized by a MoU; except in Amhara where the MoU was yet to be signed. The MoU guides the services to be provided and outlines the role of each actor in the referral mechanism.

A good multi-sectorial coordination approach was also observed in Afar between the Justice Bureau, police, Sharia court, BOWCYA and women's associations. These actors meet quarterly and monitor implementations of their respective plans/duties. The fact that women's associations are involved in this coordination also added value in making the referral linkages to the community accessible. The referral pathway between the justice sector, BOWCYA and police was also strong in this region, according to key informants interviewed. This referral mechanism along with its reporting system was especially strengthened in four selected Woredas (Asayite, Dubti, Awash and Amibara), owing to the financial support provided by UNICEF. An attempt was further made to make the referral pathway even stronger through the development of a standard form, for VAWC survivors, which require service providers to fill-in and exchange information, when needed. Ideally and if properly monitored, the standard form would help track the use of services by individual survivors and identify those who need further support and those who drop out. According to UNICEF, the form was developed in a consultative manner with the police, health service providers and attorneys, chaired by BoJ.

Amhara, SNNP, Afar and Somali were among the regions that witnessed the establishment of referral mechanisms not only at regional but also at selected Woreda level.

In Somali region, for example, referral mechanisms were established in Awbere, Shinele, Gode and Khrahey Woredas.[60] The referral mechanism, which is comprised of health, police, social workers, BOWCYA, and prosecution met regularly to discuss stakeholders role outlined in the MoU as well as following up on outstanding cases of survivors. An attempt to expand these services to other Woredas was, however, curtailed by limited resources.

In terms of establishing a referral mechanism in Amhara region, UNICEF indicated the challenges it encountered to creating referral linkages to the General Hospital in Bahir Dar, resulting in survivors covering the cost of their medical assessments, which many of them could barely afford. To many, this was attributed to the loose coordination between the actors involved[61] thereby issues that have to do with survivors bearing the cost of medical assessment were yet to be overcome. Exemption of medical charges for survivors however was realized in other regions where the coordination mechanism was strong. Somali and Dire Dawa were the few examples to cite.

Even though the 'comprehensiveness' of services provided in the referral pathway was observed to be relatively strong in the aforesaid regions, it had not been without impediments. The staff turnover of social workers in Somali region for instance was cited as one of the challenges; creating a gap in the psychosocial services that needed to be provided. The fact that the position of social workers was not salaried[62] by the Bureau of Justice (BoJ) was the major reason behind the huge staff turnover, the BoJ explained.[63]

Nonetheless, the setting up of the structure by itself was a step forward since the lack of psycho-social support for survivors was identified as a major gap in the response mechanism, more or less throughout the country. For instance, in Harari[64] not only was there no psycho-social support provided to survivors[65] but also the structures jeopardize the 'comprehensiveness' of the

60 During the interview with the Region's BoJ, it was learnt that aforesaid Woredas were selected on the basis of their high incidence of VAWC.

61 BOWCYA, Justice and Police in this case.

62 Social workers get incentives as opposed to proper salary

63 Interview with BOJ in Somali Region

64 Other Regions such as Amhara, Tigray, Addis Ababa could further be cited.

65 Which was indicated as a major challenge resulting post-trauma depression and suicide of some survivors of VAWG

services provided. This was attributed, inter alia, to the lack of clarity regarding the mandated institutions in the provision of psycho-social support in the referral pathways. Nonetheless, in areas where there was provision of psycho-social counseling e.g., SNNP it was observed that BoJ was the one doing it.

It is also noteworthy that there was limited uniformity in terms of structure of the referral mechanism and the frequency of their meetings. While BOWCYA led the coordination framework/ referral pathways in Dire Dawa, Harari, SNNP among others, BoJ coordinated the one in Somali, Afar, and Amhara region. The frequency of meetings of the referral mechanism also varied from every month in Somali Region to quarterly meetings in Dire Dawa and Afar. The average frequency of meetings was quarterly.

The added value of setting up a multi- sectorial cooperation mechanism and getting to know each other's counterparts in partner organizations was key to many involved stakeholders. A prosecutor in Somali region further illustrated this saying "Prior to setting up this coordination, we did not know who was doing what on VAWC but now we know each other and we do not duplicate efforts." In addition to avoidance of duplication of efforts, the key informant interviews indicated the added value of the referral mechanism in following up cases.

Notwithstanding the little effort, compared to the demand, made on UN agencies and others to build the capacity of the coordination framework in forms of training at both national and regional level, the capacity gap of service providers in supporting women and girl survivors of violence was noted as an impediment to the quality of services delivered.

Lack of awareness about the referral linkages and the various services delivered was also among the challenges identified. Furthermore, the lack of Standard Operating Procedures (SOPs) which benchmark the standard on VAWG response, was also identified as a challenge. While there was an attempt made by MoH, through Ethiopian Society of Obstetricians and Gynecologists (ESOG), to develop SOPs, it had yet to be endorsed by involved stakeholders. The key informants indicated the absence of stakeholder's engagement as among the reasons why the SOP was yet to be endorsed. Coordination should be budgeted, and in the event that it was not, either the police or Women's Affairs Office should bear the cost of taking survivors through the referral pathways. There was a case for instance in Benishangul Gumuz where The Women's Affairs was constantly asked by the police to cover the cost of a survivor's transportation from rural to urban areas for referral. Further, it was unusual to hear of the police covering the cost of survivors in many parts of the country.

While linkages between referral systems and shelters were observed in areas where both shelters and referral systems were operational, as was the case in Dire Dawa and Addis Ababa; majority of the regions, specified above, with referral systems in place did not have shelters, making it difficult to assess the linkages between the two. Nonetheless, the strong referral linkages between shelters and referral systems, special investigation unit as well as one-stop centers were clearly observed.

3.7.1. Special Investigation and Prosecution Unit

In an effort to respond to VAWC in a coordinated manner, and in addition to the aforesaid services, special investigation and prosecution units have been established. While the units were sometimes stationed within the police commissions as a 'women and children unit', there were instances where they were located at BoJ/prosecution offices; Somali region being the case in point. A typical special investigation unit comprised of investigation police officers and a prosecutor while in some instances it included social workers that provide psycho-social counseling.

The establishment of the unit not only enhanced the coordination between investigation and prosecution of cases for survivors but also reduced the time consumed in the referral of cases between the two offices. In most areas, this

unit received cases of sexual violence inflicted on women and children while in others, as is the case of Harari, any case of VAWC including domestic violence was entertained/ investigated. The fact that a majority of these units investigate only sexual violence, as opposed to all forms of VAWG, has been noted as a challenge. The special investigation and prosecution unit currently existed both at federal level and in many of the regions' capitals with the exception of Amhara and Tigray. At the federal level, the unit has been established in 10 sub-city justice offices as well as in Dire Dawa. Further, while this unit has nearly been established in 27 police stations in Addis Ababa[66], although the benefits had not yet trickled down to the Woredas, in many regions, thereby putting its accessibility in question. A deliberate attempt was made to appoint women among the service providers of the referral pathway especially at the special investigation and prosecution unit where nearly all of the prosecutors and police visited were women.[67]

This was based on the notion that sexual survivors felt more at ease reporting to female officers than men. But there were instances, as in Benishangul, where both the prosecutor and police officers were men, which were raised as a concern by women groups in the area.

At the community level, there was neither formal referral mechanisms established nor systems for case management. However, it was learnt that existing structures such as women's federation and women's development army, among others were being used by MOWCYA/BOWCYA in order to engage them in prevention; through awareness creation on VAWG, mostly on HTPs; as well as on response and referral of cases. Most of the interventions made on prevention focused on HTPs and there is little attention given to VAWG, as indicated. As was well articulated by a FGD participant in Harar, "Had we paid equal attention to VAW as we did to HTPs, we would have significantly reduced VAW as we did FGM." Among some of the areas where a considerable level of awareness on VAWG was registered were Dire Dawa where VAWG was highly reported and community members were increasingly willing to be witnesses, whenever required.

However, in areas where both shelters and special investigation units existed (Addis Ababa and Dire Dawa), strong linkages were observed. As a result, special investigation units, as indicated by key informant interviews, made most of the referrals to shelters indicating the strong partnership.

3.7.2. One-Stop Center

As part of a response mechanism on VAWG, and based on the experience acquired form South Africa, modeled in particular after Thuthuzela Care Center, a one-stop center was piloted at Gandhi Hospital in 2008.

"At the heart of the success of the Thuthuzela approach is the professional medical and legal interface and a high degree of cooperation between victim and service providers from reporting through investigation and prosecution of the crime, leading up to conviction of the offender."[68]

It was on the basis of the aforesaid notion, though contextualized, that the One-Stop Center was established which aimed at providing an integrated response to the burgeoning incidence of sexual violence on women and children, in the country.

The Gandhi Referral Hospital is the first hospital where the one-stop center was piloted, and is being run by the government.

As per ESOG, about 3,000 women have benefited from the three one-stop centers (Addis Ababa, Hawassa, and Adama) for three years (2010-2013).

Having realized the added value of the centers to survivors of sexual violence, the one-stop

66 As per key informant interview with Addis Ababa Police Commission

67 The case of Harari, Dire Dawa, Somali, Addis Ababa, Oromia, among others.

68 UNICEF (2008), UNICEF South Africa. http://www. unicef. org/southafrica/hiv_aids_998.html

center strategy was among the key VAWG response strategies of the national coordination committee, which intended to expand the center to other hospitals of Addis Ababa, including Yekatit and Alert Hospitals. The attention given to one-stop centers was also evident by the set target in the upcoming GTP II, which intends to expand one-stop centers to other parts of the country.

In view of the demand for the service, especially in areas where incidence of sexual violence was highly reported, one-stop centers were replicated in Adama and Hawassa, which were also currently run by the government.

However, the fact that it was run by the government did not necessarily mean that it was fully funded by the government. While government covered staff salaries and provided the space for operation, other UN Agencies provided support, in terms of office equipment. The effort made by the government to fully cover the running cost of the One- Stop center in Gandhi Hospital, which amounts to 75,000 USD per year should be applauded and taken up in other regions.

According to one key informant in BoJ, Adama was a place where there were considerable business transactions, and therefore crime rate including rape was high. Among others, "This is what necessitated the formation of rape clinics,"he stated. He further noted the multi-faceted impact of violence against women on survivors' lives hence the need for an integrated response. It is to "protect women from secondary victimization that we needed one-stop centers," he further added.

Attempts to expand model clinics[69] to other regions was also realized in Tigray (Mekelle), Amhara (Gondar) and Oromia (Jimma), which according to ESOG has already been handed over to government in December 2013.

Apart from that, some regions had taken their own initiative of setting up one-stop centers to respond to the steady increase of VAWG. This has been the case in Dire Dawa where BOWCYA championed, along with the region's referral mechanism, the setting up of a one-stop center at the city's referral hospital, Dil Chora Referral Hospital. Having shared experience from Dire Dawa, Harari was also preparing to establish one, at the time of this study.

According to the general manager of Dil Chora Hospital, the One-Stop Center was set up in an attempt to provide integrated services to rape survivors and in his words, "The demand necessitated the establishment." Given its relatively new operation, and compounded with the lack of outreach to make the services known to survivors, nearly all referrals to the clinic were made ether by the police or women's affairs.[70]

At the time of reporting, the center had one prosecutor, three investigation police and one doctor (who provided services on call). There was however no psychiatrist to provide counseling services as the position was vacant and yet to be filled.

The very essence of One-Stop centers was to provide to rape survivors all services in one location "rather than being shuttled around throughout the criminal justice system."[71]

While attempts were made to provide all services in one place, operation gap still existed. Most of the One-Stop centers, for instance, did not have psycho-social support provided to survivors. That aside, the fact that survivors had to give their statement twice, as was the case at Gandhi hospital, both at the One-Stop center and at their Sub-City; under the notion that the charges should be made at the sub-city where the violence occurred, indeed limits the very principle of one-stop center.

The lack of awareness on the availability of services was evident, which resulted in the underutilization of the services available. 'We did not accomplish our plans', a key informant at ESOG

69 Model clinics are specialized health services provided for sexual violence survivors.

70 Model clinics are specialized health services provided for sexual violence survivors.

71 UNICEF (2008), UNICEF South Africa. http://www. unicef.org/southafrica/hiv_aids_998.html

stated while explaining about the under- utilization of services. Furthermore, accessibility of the service was also an issue. For example, One-Stop centers were currently run in only one Sub-City out of 10 sub-cities in Addis Ababa, which limits its accessibility to many. From a donor perspective, in particular UNICEF, One-Stop center is a 'very capital intensive undertaking' thus should be undertaken in areas where there are large cities. "It is cheaper to establish multiple referral pathways rather than a single One-Stop center"[72], noted UNICEF. In view of this, one should intensify efforts to setting up referral pathways given that it is not capital intensive.

In efforts to build the capacity of health care providers on Sexual and Gender- based Violence (SGBV) survivors, a standard training manual was developed by ESOG, which was later endorsed by MoH. Notwithstanding the effort made by ESOG, UNFPA and others, to train health practitioners on clinical care of survivors of VAWG, the assessment observed gaps with regards to trained physicians doing the medical examination notably in regions like Harari and Dire Dawa. It was however, noteworthy that ESOG had taken steps to include two credit hours of SGBV in medical school curriculum, a promising step towards curbing the aforesaid problem.

The one-stop centers have played a key role in curbing secondary victimization of survivors given that they get all the services required in one location, with the exception of the One-Stop Center at Gandhi Hospital. The one-stop centers have also played a pivotal role in speedy collection of medical evidence given that medical services are also provided at the center. As per one of the key informants at the center, "We are now giving better services to survivors of sexual violence."[73]

As rightly put by a key informant at the Police Commission, Addis Ababa, "The very establishment of One-Stop center is a big gain by itself," while the challenges need to be addressed.

In terms of linkages, it was observed that one-stop centers and shelters work closely together. Once survivors get the immediate services they require (psycho- social, medical, and justice), referrals are made to shelters for survivors that require further assistance, rehabilitation, on the basis of the criteria outlined by shelters. This was evident in Addis Ababa, Dire Dawa and Adama where both services were available. Majority of the referrals to shelters in these areas were also made by one-stop center indicating the linkages and good collaboration.

Above: Counseling room in Adama One Stop Center / Meron Genene

72 Not only that One-Stop center is capital intensive but also difficult to manage human resource wise since it is hard to find dedicated doctors that work in the One-Stop center, among others

73 Key informant at Dire Dawa One-Stop center

CHALLENGES, CONCLUSION AND RECOMMENDATIONS

This chapter presents key challenges, conclusion and recommendations drawn from the findings.

4.1. Key Challenges

- **Shelters:** Gaps in linkage of shelters with community groups such as community based structures and leaders were identified as one of the major challenges. Lack of sufficient space, including child-friendly places and dining areas in some of the shelters were also observed. Furthermore, the non-discrimination principle is not respected by some shelters, which do not accept people with disabilities and pregnant women for a range of reasons, including lack of suitable facilities. Gaps in some of the services include lack of play activities, retreat, shelter space, and storage area among others, resulting from lack of proper budgeting for shelter activities. Since nearly all the shelters pay rent to accommodate survivors, it goes without saying that their operation cost is high. Given the limited funding coupled with sky rocketing rentals, most shelters highlighted the difficulty of their costly operation. Consequently, the need for government support in allocating land for the construction of shelters is strongly recommended;
- **Gaps in provision of comprehensive services:** As per the standards for provision of comprehensive services to all survivors of violence free of discrimination, guided by a code of conduct and operational guidelines, as well as clear strategies for rehabilitation and reintegration frameworks, the assessment identified gaps in some of the services provided by different shelters. These range from discriminatory practices or exclusion of people with disabilities and pregnant women to lack of written code of conduct for staff and residents in some, lack of standardized psychosocial services through engagement of trained professional counselors in others, and the exclusion of therapeutic activities that will encourage the overall healing of survivors. Some shelters function at a minimum standard because of the limited technical capacity to raise sufficient funds, which in turn affects their effectiveness and quality of the services provided;
- **Quality of services:** Absence of a national policy, as well as quality/ standard measurements to monitor the quality of services given at the shelters. As a result, the services provided at these shelters had no SOPs, which make them difficult to measure the quality of services provided. This is attributed to the lack of SOP on shelter, and challenges with resources, among others;
- **Database for VAWG:** There is lack of proper database/information management system for VAWG cases at all levels;
- **Demand:** Given that there are inadequate victim-assistance services, especially shelters that cater for the needs of survivors; there is an excessive demand for shelters that does not match with the supply of services available. This was noted as a challenge by many service providers, which jeopardize the quality of services provided. The limited attention given by governmental and non-governmental organizations to address the demand for shelter services continues to limit women's access to justice;
- **Psycho-social support:** There was lack of trained counselors in general and tailored counseling services for women and girls survivors of violence in particular. The fact that there was little attention given to psychosocial support compounded with the lack of clarity on the mandated institutions to providing psychosocial support/counseling was identified as a challenge. There was therefore no position for counseling neither at the MoJ, police, nor at the MOCYA. However, the existing few social workers, counselors, available in some areas were appointed by the MoJ but the position in some instances was not salaried [74] thereby causing high staff turnover of

74 Social workers are given incentives, as opposed to salaries which attributes to the high staff turnover.

social workers, counselors, especially in Somali regions. Given the significance of counseling for survivors of VAW, adequate attention should be given to it;

- **Limited special courts for women and girls:** The assessment further indicated the lack of special courts for women as in the case for children. While there was an amendment on the structure made at the police level from 'children unit' to 'women's and children's unit', this was not done at the court level. Hence, the unit still stands as a 'special court for children' which marginalizes women. Due to the stigma attached to sexual violence that made reintegration of survivors difficult, the need for special courts for women where their privacy and confidentiality is preserved is reiterated. This was realized only in Somali region, the assessment further identified;
- **People with disabilities:** Lack of disability-friendly facilities in general and at the shelters in particular was observed. This resulted in marginalization and discrimination of people with disabilities from equally benefiting from the services, in some instances. Given the fact that people with disability were more vulnerable to violence, adequate attention should be given to the non-discrimination policy principle by shelters.
- **Justice:** The very slow trial of prosecution and conviction of perpetrators was noted as a major challenge throughout the FGD discussions as well as in the key informant interviews. While there were some regions that used RTD to prosecute perpetrators in a speedy manner, as was the case in Somali region, it was not applied throughout;
- **The Proclamation for the Regulation and Registration of Charities and Societies:** Which limits CSOs from working on the rights and advocacy issues with foreign funding had repercussions on the key interventions of the shelters, the case in point being legal aid;

4.2. Conclusions

While the policy and legal frameworks for addressing violence against women were all in place, gaps were observed in terms of access to comprehensive services for women and girls survivors of violence, along with the absence of national standards in Ethiopia for establishing shelters with provision of comprehensive services.

The assessment recognized that the services that were being provided by the shelters throughout the country had made a significant impact in transforming the lives of thousands of survivors of violence, by ensuring their successful rehabilitation and reintegration into the society.

Given the prevalence of various forms of violence against women and girls in the country, and the value survivors attribute to shelters for their safety and healing, the assessment identified the high unmet needs for comprehensive services, and especially shelters. In cases where shelters are available, such as in Amhara, SNNP, Oromia, Benishangul, Dire Dawa and Addis Ababa, the available spaces are inadequate to handle the referrals made from both urban and rural populations. In such regions as Gambella, Harari, Tigray, Somali and Afar where women and girls survivors of violence had limited access to any VAWG response services, the demand for shelters was found to be excessively high, hence calling for priority in interventions.

An emerging issue with regards to the demand for shelters was the case of reported incidents of violence against men and boys in some regions like SNNP, Harari, Amhara, Oromia and in city administrations of Addis Ababa and Dire Dawa, that indicated the need for shelters that cater to this group. In addition to the demand for shelters, the assessment also indicated the high demand for RTD for certain types of VAW cases.

With regards to coordination, there was a national coordination mechanism with a MoU and planned activities on prevention and response of VAWG, which included plans for the establishment and expansion of One- Stop Centers. This remarkable effort which enabled the avoidance

of duplication of efforts, should however be revitalized, given the gaps in implementation and follow up. It was also promising to see the different levels of coordination and referral mechanisms employed in the regions, ranging from regional and to some extent to Woreda levels. Other commendable efforts at the national level include; the setting up of special investigation units for VAWG; the coordination between investigation police officers and prosecutors, along with the engagement of social workers in some. At the regional level, the attempt made by Dire Dawa City Administration to establish a government managed and funded shelter compounded by an allocation of land for the shelter construction was among the best practices that should be replicated by other regions. Other regions that followed suit including Benishangul Gumuz also deserve praise.

4.3. Recommendations

Availability and Accessibility of Services

Establish shelters, both by government and CSOs, across all the regions of Ethiopia, and especially in regions such as Gambella, Harari, Tigray, Somali and Afar where there is a high demand for the services. Apart from availing more shelters, the services should be accessible to all women and girls survivors of violence, without any conditions, such as disability and pregnancy. In view of the high operational cost of existing shelters, the government should further subsidize the effort through allocation of land for shelters establishments as well as exempt construction materials, when needed;

- A child protection policy and procedure should be prepared for handling children who join a shelter with their mothers. It should also include training procedures, communication mechanisms, education and training needs, and codes of conduct;
- As little is known about the services that are available for VAWG in the community, survivors and even some government offices, there should be an effort primarily by shelters as well as government offices and other stakeholders to create awareness about the available services. Given the lack of technical capacity on fundraising and professional counseling services, government and development partners should work together in building the capacity of shelters;
- Shelters should properly identify the need and budget programs activities accordingly for the proper comprehensive provision of services;
- Enhance the availability and quality of psychosocial services provided at the shelters and One-Stop centers, among others, through engagement of trained professional counselors and therapists. Further, a responsible organ/institution, should be clearly designated along with the appropriate position for pyscho-social counseling created;
- The efforts made by some regions and city administrations, the cases of Dire Dawa and Benishangul Gumuz, in establishing government owned shelters through allocation of land, among others, should be encouraged and somehow replicated; Inter-regional experiences of sharing visits to shelters should be encouraged so as to share experiences and learn from each other's experiences;
- Create linkage between shelters and other service providers, e.g., empowerment programs, legal aid, counseling, etc.

Quality

- National standards for monitoring the quality of shelters should be designed, along with assignment of a responsible organ or sector at the federal and regional levels to monitor the quality of services. Standards for accommodation could include size of rooms, cleanliness, amount that should be spent on food per head/ per day, availability of beds, dining area, storage space, space for overall healing activities, such as arts, music, and other entertainment and skills building activities;
- Shelter guidelines should be prepared outlining employment of qualified staff, type of staff needed and the types of services that

will be provided for comprehensive response mechanisms. The standard guidelines for operation of staff should outline how to manage a shelter, staff responsibilities in different positions, types of services that should be provided and the standards required from those services, including qualified and professional counseling services;

- Establish reintegration guidelines, along with engagement of reintegration officers. It is also important to ensure the availability of standards for reintegration processes and services;
- Avail relevant and regular/on- going/ refreshment trainings and guidelines for staff working in different responsibilities in shelters;
- Establish a case management and users/clients/ survivors feedback system in all the shelters so as to provide comprehensive services and ensure uniformity and quality of the services provided;
- In responding to the challenges of VAW, the national coordination body should facilitate the establishment of a national database on the numbers and forms of VAW.

Referral Systems and Coordination

- Identify a clear referral pathway supported by standards for the various stakeholders involved;
- Create awareness on the referral mechanism available as an effective strategy to address identified gaps in the referral linkages. This could increase the reporting rate of incidence of VAWG;
- While there is a coordination mechanism in place, both at national and regional levels, these should be strengthened. There should be coordination between the national coordination body and the regional ones, as well as among regions, in order to share experiences, address emerging issues in a timely manner, and identify common challenges and best practices;
- Seek and foster partnerships between existing organizations and service providers working on VAWG (and other forms of violence, including violence against children); and strengthen coordination across these groups to ensure a tighter network of services and care;
- In order to make the coordination effective and enhance accountability, develop and adopt standard forms of reporting and tracking of records on VAWC, along with establishing database for monitoring;
- Scale up a special courts/Victim-friendly benches for women: due to the stigma attached to sexual violence that makes reintegration of survivors difficult, the need for special courts for women, where privacy and confidentiality is preserved, is highly recommended. Efforts made in realizing this in regions such as Somali should be scaled up. Other recommended actions that should go in line with this is the adoption of RTD for sexual violence cases;
- In an attempt to ensure accountability, enforcement of penalties for service providers of VAWG who do not undertake their duties as per the given ethics, standard and timeframe should be considered;
- Given the current discrepancy in revision of family laws, it is important to facilitate the revision of family laws lacking conformity to the federal one and international commitments in order to enhance Protection of women from violence;
- Establish linkages between private and public health referrals for survivors that report to private clinics.

Capacity building for Service Providers

- Provide training for all service providers (ranging from lowest to highest) on elements of the available laws and provisions on VAWG among others. This should be accompanied by periodic refresher training for service providers at all levels. The training should also be tailored to encompass the technical aspect of the specific services provided (health, police, justice, psycho-social, etc.);
- Expand the basic components of VAWG services (comprehensive services) to include a holistic response to the physical, psychosocial, and economic needs of survivors.

Above: Skills trainee at AWSAD/ The Domino Effect

RECOMMENDATIONS FOR THE PROVISION OF COMPREHENSIVE SERVICES IN SHELTERS

- Services should be provided free of discrimination and free of charge to all women and girls survivors of violence irrespective of their ages, and other conditions, such as disability;
- The multi-dimensional needs of survivors including psychosocial support, medical care, legal aid and economic empowerment should be addressed by shelters that aim to provide comprehensive services. Therefore, shelter mandates should be revised in such a way that they are able to provide legal aid and medical assistance when required. Standard psychosocial services should be provided through engagement of trained professional counsellors and therapists;
- Code of conduct for service providers, including integrity, confidentiality, and ethics should be part of the approach in service provision;
- Written codes of conduct for residents should be prepared in the languages of the survivors, and orientation should always be provided to new entrees about their rights and responsibilities along with information on available services in the shelters;
- Comprehensive services should also work towards linking the project with community structures by enhancing awareness about the kinds of services available at the shelter;
- Services provided at the shelter should be culturally sensitive and consider the needs of residents in relation to basic services such as clothing, food, etc.;
- A case management system should be established for women, as well as children who join the shelters with their mothers;
- Comprehensive shelter services should provide overall healing and empowerment of survivors, including shelter, food, accommodation, and referral to services such as legal aid, counselling, housing, specialized health care such as Obstetrics/Gynecology, and physical and mental healing services including counselling and therapy using specific methods by trained professional counsellors or therapists, age specific support groups or others including violence specific groups, people with disabilities, and same language groups; and therapeutic activities such as arts, music, creative arts, dance, etc.;
- Provision of comprehensive services could also be achieved through referring the survivors to the right service providers for the specific interventions, in cases when those services are not available at the shelters.

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