

# What Works?

## Integrating Gender into Government Health Programmes in Africa, South Asia, and Southeast Asia

CASE STUDY SUMMARY REPORT:

Gender-based violence  
service provision in the  
primary health care  
system in Ethiopia



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# Regional promising practice project overview

Strengthening health systems in order to improve health and gender-equality outcomes requires robust country leadership and governance. Widespread commitments have been made to integrate gender into health, yet substantial gaps remain in intent, level of investment, and implementation. There is a pressing need for more contextualised, practice-based evidence of the pathways along which gender integration can be institutionalised and sustainably resourced in government health programmes.

The United Nations University International Institute for Global Health (UNU-IIGH), in partnership with the School of Public Health at the University of Western Cape in South Africa, and the Public Health Foundation of India through the Ramalingaswami Centre on Equity and Social Determinants of Health in India, co-led a collaboration to document and analyse six diverse and promising practices of gender integration in government health programmes. The resultant case study series consists of six stand-alone summaries with key findings spanning policy, systems, institutional, and community levels. Detailed case study reports are forthcoming.

Gender based violence service provision in primary health care, Ethiopia (systems level)

Gender integration in medical education in Maharashtra and other states, India (systems level)

Right to safe abortion, Nepal (policy level)

Gender integration in Baguio General Hospital and Medical Center, Philippines (institutional level)

The “Ecole des Maris” programme – bringing men into reproductive health, Niger (community level)

The Gender Guidance Clinics of Tamil Nadu – meeting the healthcare needs of the transgender community, India (institutional level)

# Gender-based violence service provision in Ethiopia

This study focuses on two key initiatives spearheaded by the Ministry of Health in Ethiopia, which have contributed to improving gender equality in primary healthcare (PHC): (1) a gender mainstreaming manual; and (2) the PHC response to gender-based violence (GBV). This case was selected as a promising practice because of the significant government leadership and ownership involved in advancing gender integration within a government health system.

The study was led by Anchinesh S. Mulu and Fikir M. Asaminew, with support from Michelle De Jong and Asha George. Based on in-depth analyses of interviews and published materials, it documents the context, a number of enabling factors and challenges encountered, and some of the outcomes achieved and lessons learned, including those that might be transferable to other contexts (see Figure 1).

## 1. Background

### GBV in Ethiopia

Ethiopia is a landlocked country with a total population of 126.5 million. Though the country is considered a low-income country, with a gross domestic product per capita of 857 US dollars in 2022 (Trading Economics 2022), it has registered remarkable economic growth in the past two decades and aspires to become a low-middle income country by 2030.

However, despite the progress made so far, women and girls continue to face significant socio-economic challenges that make them vulnerable to discriminatory practices and violence. GBV impedes women's and girls' development, health, way of life, and physical and emotional well-being, and may take many different forms in Ethiopia. Of women aged 15–49, 23 per cent of women have faced physical violence and 10 per cent have faced sexual violence (CSA and ICF 2016). Among ever-married women, 35 per cent reported physical, emotional, or sexual violence from an intimate partner (CSA and ICF 2016). However, only 23 per cent of women

aged 15–49 years who have experienced physical or sexual violence have sought support (CSA and ICF 2016). It is estimated that the median age of first marriage for women is 17 years and some 6 per cent are married before the age of 15 years, with the prevalence of female genital mutilation (FGM) at 16 per cent among girls aged 0–14 years (CSA and ICF 2016). In the last 3 years, the COVID-19 pandemic and internal conflict have increased incidents of GBV in the country.

### The gender mainstreaming manual

To address gender dimensions within health systems, including GBV, the first national gender mainstreaming manual was developed by the Ministry of Health (MOH) in 2002, and subsequently revised in 2013 and 2021. Under the leadership of the minister, the 2013 revision was a turning point in integrating gender into all components of the health system. It was envisaged to serve as a resource for gender focal officers at all levels, but also aimed to foster collaboration with government ministries, agencies and development partners (MOH

2013). The 2021 version of the manual emphasises gender analysis, auditing, and budgeting, with a focus on the following objectives (MOH 2021):

- building MoH’s capacity for gender analysis in all health sector transformation plans (e.g. HSTP II), programmatic interventions, operations, and leadership;
- bringing gender into the mainstream of the planning cycle of health actions and performance reporting;
- promoting the use of sex-disaggregated data and gender analysis; and
- establishing accountability at all levels.

A technical working group of seven Ethiopian champions across government ministries, UN agencies and international NGOs supported the 2013 and 2021 revisions. The development and subsequent revisions of the gender mainstreaming manual led to a number of reforms within MOH. It provided the grounding for many gender-equality interventions to emerge, including the PHC response to GBV.

## GBV responses in PHC

Preventing and responding to GBV has been a priority for the Ethiopian national government for many years. With respect to the PHC level, in 2016 package of health worker training manuals were developed by MOH in collaboration with the World Health Organization (WHO), the International Center for AIDS Care and Treatment Program, Columbia University (ICAP), the United States Centers for Disease Control and Prevention (CDC), and other development partners. Since 2017, the MOH, in collaboration with WHO, has undertaken training of trainers at the national level for medical schools and regional health bureaus, followed by regional level training of trainers. With funding from CDC and the World Bank, Oromia and other regional states have implemented GBV survivor-centred health responses at PHC level using multi-disciplinary approaches. The TRANSFORM PHC project under Pathfinder International (funded by USAID) undertook an assessment of 45 health centres across four regions to strengthen the implementation of health responses to GBV survivors at PHC level.

## 2. What has been achieved?

Based on interviews and reviews of documents, a number of successful achievements have been identified with respect to an improved response to GBV in the PHC system. Notably, support from MOH, WHO, CDC, World Bank and Pathfinder-Transform PHC and others has been critical in terms of:

- **Policy reforms**

- MOH banned the medicalisation of FGM in all public and private medical facilities in the country. As per the circular passed on 4 January 2017, medical personnel who engage in any form of FGM in medical facilities will be subject to legal action.

- MOH issued a circular exempting fees for GBV health response services to all regions. While this has been implemented at one-stop centres, application at the PHC level is less consistent.

- **Health facility reforms**

- Coverage of health facility readiness for GBV and sexual violence has increased from 3.5 per cent in 2020 to 21 per cent in 2022 for PHC using a multi-disciplinary team approach. According to the data compiled by WHO in 2022, some 819 PHC centres (out of 3,826 centres) have been equipped to provide

GBV services through a multi-disciplinary team approach, fulfilling the minimum criteria of trained health workers, providing HIV testing and treatment, emergency contraceptives and safe abortion services, and basic laboratory facilities (serology tests and urine analysis), as well as psychological support and linkages to other support services. Health facilities have designated outpatient service rooms for patients who have experienced violence, and information guides containing standard operating procedures and GBV care protocols have been distributed (Stones 2022).

- **Training healthcare providers on:**

- foundational GBV concepts and national GBV healthcare guidelines, standards and procedures;
- clinical skills for responding to sexual violence, including forensic data collection and psychological care;
- GBV referral programmes that connect survivors to appropriate psychosocial, secondary or tertiary level healthcare, legal services and shelter;
- preventing and responding to workplace harassment, sexual exploitation, and abuse.

- **Confidential GBV registration and reporting systems**

- Registries developed by MOH and WHO are now available at all one-stop centres and primary healthcare level facilities providing GBV services. These registries record confidential data of clients by sex,

age, disability, and type of violence, which facilitates the disaggregated analyses.

- GBV-related indicators were formally introduced in the national health management information system in April 2021.

- **Multisectoral collaboration**

- Collaboration between sectors of health, justice, police, women and social affairs, and education, as well as the Ethiopian Women's Lawyers Association and development partners co-convened by the Ministry of Justice (MoJ) and Ministry of Women and Social Affairs (MoWSA).
- Development of a shared understanding of coordination mechanisms and protocols. Response services are now expected to be comprehensive and timely, as roles and responsibilities for each sector have been outlined, and communication and monitoring mechanisms have been established in various strategic plans and strategies (National Coordinating Body, 2011 & 2021 and Elshaday et al. 2018).

- **Advocacy and community awareness**

- Public messaging has been directed through social and mass media, while community mobilisation activities have been conducted by health extension workers to address prevailing negative attitudes, beliefs, and biases towards GBV survivors. Awareness has been raised on improving health-seeking behaviours, and ending child marriage and FGM through community and faith-based organisations (MOH 2022a).

### 3. What contextual factors facilitated the integration of GBV services in PHC?

A broad set of contextual factors facilitated the integration of GBV services. Importantly, the Ethiopian government established a firm commitment to mainstream gender across all line ministries, agencies, private institutions, and communities by adopting international commitments, such as the Beijing Platform for Action of 1995, CEDAW in 1981, and the Maputo Protocol in 2018. Mainstreaming gender within the

various programmes and institutions followed these commitments. As the seat of the African Union, Ethiopia prides itself in playing a regional leadership role.

#### National policies

The table below summarises a number of supportive national policies.

Date	Policy/document title	Description
1993	National Policy on Ethiopian Women	This policy institutionalises the political, economic, and social rights of women by creating appropriate structures in all sectors to empower women for equal opportunity and equitable access to resources and ensure equitable development for all Ethiopian men and women. It also envisages educating the public on harmful practices against women.
1995	Constitution of the Federal Democratic Republic of Ethiopia	Article 35 guarantees equality between men and women in all spheres of political, social, and economic efforts and benefits.
Revised in 2000	Federal Family Code	This amendment raised the legal marriage age from 15 to 18 and emphasised equality in relation to managing the household and raising children.
2005	Criminal Code of 2005	The law criminalises rape (article 620) and other forms of sexual violence (article 622), violence against a marriage partner or those cohabiting in an irregular union (article 564 and articles 555–560), FGM (article 566), marriage by abduction (article 587), child marriage (article 648), trafficking in women and children (article 597), and child sexual abuse (article 626-627).
2005/06–2009/10	Health Sector Development Plan (HSDP) III	Promotes training for health extension workers on GBV prevention as a key strategic activity.
2006–10	National Action Plan for Gender Equality	This plan aims to contribute to equality of men and women in social, political, and economic development by mainstreaming gender in all policies and programmes. It aims to reduce violence against women.
2011	Strategic Plan for an Integrated and Multi-Sectoral Response to Violence against Women and Children and Child Justice in Ethiopia	“[I]t has galvanised shared thinking around the merits of an integrated approach to addressing violence against women at policy level and across sectors, and created a shared platform on how to advance such an approach” (Elshaday et al. 2018).

Date	Policy/document title	Description
2015	Ethiopia's Second Growth and Transformation Plan (GTP II 2015)	The GTP II aims to eliminate violence and harmful traditional practices through measures including, public education and awareness creation programmes, public mobilisation particularly engaging women in the efforts against such practices, and swift enforcement of legal measures against harmful practices against women.
2016	Practical Handbook for Health Workers to Translate CEDAW into the Public Health Approach of Health Response to GBV/SV	Developed by the MOH in collaboration with WHO Ethiopia (through the Delivering Results Together (DRT) fund of the Joint Policy Initiative for Women's Health Rights' Project 2016) as a "pocket guide" for health workers.
2016	Health Response to Survivors of GBV/SV (in-service training manual)	Developed by the MOH in collaboration with WHO Ethiopia and ICAP Ethiopia. The training manual is intended to facilitate 5-day training programmes for health workers.
2020-2025	National Strategic Plan and Action Plan on the Health Sector's Response to GBV: 2020-2025	The MOH has committed to respond to GBV through this national strategic and action plan. Development was overseen by a technical working group, consisting of MOH-WCY Directorate, WHO Ethiopia, USAID Transform: Primary Healthcare Project/Pathfinder, UN Women, and the Ministry of Women, Children and Youth (MoWCYA). The World Bank provided financial support for the development of the plan.

## Institutional structures and champions

The government has also put in place institutional structures at the federal and regional levels, which have facilitated the integration of GBV services in PHC. These include:

- **The Ministry of Women and Social Affairs**, formerly known as the Ministry of Women, Children and Youth Affairs.
- In turn, in 2008, each ministry was required to establish a directorate of women and social affairs. **The Women and Social Affairs Inclusive Implementation Executive Office (WSAEO) within MOH** was therefore established. The office is part of the senior management team and is responsible for leading most of gender, child, youth, and disability-related activities of the health sector, working closely with other directorates, federal hospitals, and agencies, as well as regional and city administration health bureau structures.

- **Annual performance review meeting of WSAEO.**

This involves relevant ministries and the standing committee of parliament on women and social affairs. It focuses on the performance of WSAEO. The meeting place rotates regionally.

## Civil society engagement

Civil society organisations (CSOs) working on women's rights issues, including health issues, have contributed to progress in the health sector. In 2019, the 2009 law that restricted access to foreign funding by local organisations was lifted by Ethiopia Civil Societies Proclamation, Proc. No. 1113-2019. CSOs continuing to sustain attention on gender issues, include the Consortium of Reproductive Health Associations, Ethiopian Midwives Association, Ethiopia Medical Women's Association, Ethiopia Society of Obstetricians and Gynecologists.

## Women's political representation

The change in women's political representation is visible, with Ethiopia electing a female president for the first time, and appointing female ministers in frontline ministries, including MOH in April 2018. As of October

2021, women held 8 out of 22 ministerial positions at the federal level, and one third of cabinet positions, a regression from parity in 2018. Following the 2021 general election, the number of female parliamentarians reached 42 per cent, up from 38.7 per cent in the previous parliament.

# 4. What catalysed GBV service provision in PHC?

In Ethiopia, the public health multi-disciplinary approach to GBV at the PHC level gained attention in 2017 drawing off prior work focusing on violence against children, particularly in tertiary care. Although both violence against children and GBV are human rights and public health problems with overlapping root causes and risk factors, they have distinct vulnerabilities (e.g., gender-based) and obstacles, with often siloed research, policies, and funding sources (Guedes et al. 2016).

Efforts to address violence against children gained momentum in Ethiopia in the early 2000s, largely based on a social justice framing and support from the Ministry of Justice, involving the health sector at tertiary level. This work provided the foundations, including certain catalytic factors, which opened windows of opportunity seized by specific actors to begin GBV service provision at the PHC level. These catalytic factors included:

## Leveraging work addressing violence against children

In the 2000s, St. Paul and Yekatit hospitals pioneered work dealing with sexual violence against children. In 2001, the Child Abuse and Neglect Unit (CANU) was established, with a multi-disciplinary team within Yekatit Hospital responsible for responding to GBV

against children. The team brought together medical professionals, a clinical psychologist, a paediatric social worker, and local police to investigate child abuse and neglect. This was supported by Save the Children of Norway and Sweden (MOH 2016). This initiative attracted other CSOs to work together with the government to help establish a one-stop centre for children, which also specialised in sexual violence, in Adama Hospital in Oromia, and Dil-Chora Hospital in Dire Dawa. An experience-sharing programme, organised by Save the Children Norway, facilitated an Ethiopian delegation to visit similar initiatives in South Africa and Zimbabwe in 2003. Although this was largely focused on the justice sector, it also provided learning to strengthen the quality of service provision in hospitals. The delegation from Ethiopia included representatives from CANU at Yekatit Hospital, the Juvenile Justice of Federal First Instance Court, the Federal Police Commission, and the Women's Department from Ministry of Labor and Social Affairs.

In 2004, Gandhi Memorial Maternity Hospital started a one-stop centre for women and girls and rolled it out to various parts of the country. The one-stop centre expanded service provision from children to include sexual violence against adult women as well.



## Establishment of a multisectoral coordinating body on GBV led by government entities

Based on the work of CANU at Yekatit Hospital, the OAK Foundation led the establishment of a coordinating body in 2004/5. This coordinating body is convened by the Ministry of Justice and the Ministry of Labour and Social Affairs and includes the Forum for Street Children (provision of care for children living on the street), the Association for the Prevention of Child Abuse and Neglect (provision of legal assistance), the Organisation for Prevention, Rehabilitation and Integration of Female Street Children (provision of women and girls' shelter), and a juvenile justice project. This coordinating body became a model for a multisectoral coordinating body on GBV led by government entities, which was established in 2009/10 at national level. This national coordinating body on GBV is called the National Coordinated and Comprehensive Prevention and Response to Violence against Women and Children, and Children in Conflict with the Law. It is co-convened by Ministry of Justice and Ministry of Women and Social Affairs and has 18 members such as MOH, the Ministry of Education, the Police Commission, development partners and CSOs like Ethiopian Women's Lawyers Association. UNICEF provides funding support for the coordinating body through the Ministry of Justice and more recently UN Women has also provided financial support.

## Experience-sharing programmes on GBV in other countries

In 2008, an Ethiopian delegation, including representatives from the Federal Supreme Court, Ministry of Justice, Police Commission, Regional Justice Bureaus and NGOs, visited South Africa to better understand the measures taken to address violence against women and children. These measures had received attention from the United Nations, as well as

countries wanting to improve their response to GBV. The visit resulted in a number of recommendations, including the need for a coordinating body on violence against women (established in 2009/10). This body developed the first comprehensive prevention and response programme for dealing with violence against women and children, titled The Strategic Plan for an Integrated and Multi-Sectoral Response to Violence against Women and Children and Child Justice in 2011, as well as a document of standard operating procedures. The second recommendation was to set up "one-stop centres", similar to the Thuthuzela centres in South Africa, to assist survivors of violence with their medical, legal, and psychosocial needs (Elshaday et al. 2018). While this was not a PHC intervention, the visit to South Africa and the resulting actions demonstrated the government's renewed commitment to addressing GBV and providing comprehensive services for survivors.

## Key evidence on GBV services in PHC

Between 2017 and 2018, USAID, as part of the Transform Primary Health Care programme, in collaboration with Federal Ministry of Health's Women, Children and Youth Affairs Directorate, conducted a "gender analysis", which identified gaps in the response to GBV. Recommendations from the analysis included the need to enhance health worker skills and knowledge, and address resource shortages. These were then integrated into the activities of the USAID programme. Based on the findings, USAID then conducted a "GBV landscape analysis" to "map and comprehensively understand the Ethiopian health system's existing GBV prevention and response mechanisms, and identify opportunities to support the Ministry of Health in improving them" ([USAID/Ethiopia Transform: Primary Health Care Project, 2019](#)). These key pieces of evidence provided an overview of the current state of GBV services in the health system and identified key areas for improvement, which helped to provide the rationale and direction for GBV interventions at the PHC level.

# 5. What actions allowed changes to be sustained over time?

- **Institutionalisation and governance structures.**

The key for gender integration in Ethiopia has been the institutionalisation of gender work through supportive legal frameworks. These have made gender mainstreaming a legal obligation, not an optional activity. The institutionalisation of gender mainstreaming was achieved by incorporating it into various national policies and plans. This then facilitated the integration of GBV services within primary healthcare facilities.

Accountability structures at the MOH and agency level is another element that has strengthened coordination around gender mainstreaming. For example, the WSAEO at MOH reports directly to the minister. According to a gender audit, it has “a high level of decision-making power, which guarantees gender issues to be raised and considered in top management discussion”. As such the WSAEO at MOH has been instrumental in leading all initiatives on GBV. The assignment of gender focal persons in some health facilities has helped to institutionalise gender activities. Additionally, the government has developed various documents that provide guidance on gender mainstreaming to respond to GBV. The Annual performance review meeting of WSAEO also serves as an accountability mechanism. The 2021/22 annual review meeting was attended by 160 participants, and financially supported by WHO.

Other government platforms that continuously review progress, include the following:

- **Gender mainstreaming and women’s empowerment technical working group** at MOH, with 7-10 members. This was created in 2012 and meets monthly.

- **Bi-annual gender and health forum,**

convened by MOH, with WHO as coordinator. Since 2019, this has opened an opportunity for information exchange, sharing best practices and lessons learned in mainstreaming gender at the federal and regional levels. Participants include development partners, all health stakeholders, MoWSA, the Ministry of Tourism, and regional health bureaus.

- **Women’s forum.** This is a voluntary arrangement, focusing primarily on the welfare of female employees within MOH and its structures. It serves as a space for women to share experience, undertake charitable work, generate income, and advance their education and leadership skills.

- **Leadership commitment and support.**

Government leadership and support has played a key role in successfully integrating gender into the health sector, and creating an enabling environment to improve GBV responses in PHC. Passionate leaders with strong personal motivations, as well as sufficient power to make decisions, have been crucial to the improvements seen in GBV services.

- **Technical and financial support from development partners.**

While the Ethiopian government leads all reforms, healthcare financing is also supported by different development partners. The health and gender technical working group has also played a key role in supporting the government, technically and financially.

- **Information-sharing mechanisms and accountability.** The gender and health forum and the annual review of women and social affairs serve as entry-points for accountability through reporting. A gender audit of the health system has also been undertaken at the national level by MOH, health agencies, Ethiopia Pharmaceutical Supply Service (EPSS), Ethiopian Food and Drug Authority (EFDA), and Alert Hospital.
- **Accessibility of PHC services for GBV survivors.** Compared with one-stop centres, PHC services for GBV survivors are less expensive and improve the knowledge of a broader number of service providers, strengthening referral linkages across the health system, exempting fees for some critical services, and are geographically closer to the community..

## 6. What were the missed opportunities and challenges?

While important strides have been made with respect to integrating gender in GBV services at the PHC level, this analysis has highlighted a number of missed opportunities and challenges that remain, including the following:

- **Need to expand service to include other forms of gendered violence.** GBV service provision at the PHC level focuses solely on sexual violence against women and children. Other forms of gendered violence, such as intimate partner violence, for example, are handled via regular health services as physical injuries.
- **Inadequate funding.** While external support has been provided, the lack of adequate funding has limited the interventions to mainstream gender (gender audit, gender analysis and gender budgeting), and the scale-up of health responses to GBV.
- **Need for more gender mainstreaming and GBV expertise.** There remains a shortage of gender mainstreaming expertise in WSAEO, agencies and branch offices because of:
  - the high turnover of staff, especially those who have been trained to build their capacity;
  - an inadequate understanding and perception of gender mainstreaming;
  - a lack of uniformity in assigning gender focal persons at the sub-regional level.

Similarly, there remains a need for more GBV technical expertise as knowledge gaps among clients and healthcare workers remain.

- **Stereotypes against the Women and Social Affairs Inclusive Executive Office.** Misconceptions remain about the structures that are assumed to be used by the ruling party to mobilise women and youth for political purposes.
- **Limits of accountability mechanisms.** There is a lack of strong accountability systems to monitor progress in the delivery of GBV services, as well as in multisectoral collaboration.

- Inadequate utilisation of sex-disaggregated data and gender mainstreaming lessons.**

Despite efforts to improve sex-disaggregated data in health and GBV service provision, there is a lack of utilisation of such data in the health sector to inform strategic responses. According to an MOH gender audit, “some steps are in place to make gender-related information available in the health sector. Yet, in most cases, the collection and utilisation of such information is not done in systematic, structured and organised ways. Sex-disaggregated data are rarely available, and the gender impacts of projects and programmes are monitored and evaluated infrequently” (MOH 2022b). Hence, the lack of utilisation of sex-disaggregated data prevents further gender analysis. There is also an absence of documentation, especially on best practices and lessons learned on gender mainstreaming.
- Deep-rooted harmful socio-cultural norms.**

Socio-cultural norms that stigmatise survivors and normalise violence persist, requiring much longer-term investments to change. For example, according to the 2016 Ethiopian Health and Demography, 63 per cent and 28 per cent of women and men aged 15-49 years respectively, believe that a husband is justified in beating his wife if she commits the following five misconducts: burning food, neglecting children, refusing to have sex, arguing with her husband, or going out without telling her husband (CSA and ICF 2016). The normalisation of intimate partner violence further fuels lack of reporting and is likely linked to services not being provided.
- Effects of conflict on service expansion.** The internal conflict that engulfed the country over the past three years has limited the scaling up of PHC responses to GBV, especially in conflict affected areas.

## 7. Conclusions

The gender mainstreaming manual was a pioneering effort, which has led to numerous reforms in the Ethiopian health system, including the integration of GBV into PHC. Integrating comprehensive GBV services into PHC facilities is one crucial component of addressing the widespread problem of GBV in Ethiopia. A favourable policy context, strong leadership, and partnerships with development partners that provided technical and financial support have allowed the MOH, along with WSAEO to gradually improve GBV services offered at the PHC level. MOH is committed to maintaining the momentum that has been generated

to expand access to GBV services. Continuing capacity-building measures, along with improving accountability mechanisms and securing sustained funding, will be critical. Important gains have been realised in terms of making PHC services more responsive to women’s specific gender needs, based on foundations of institutionalising gender mainstreaming across the health sector. The latter rests on a strong architecture of legal obligations, organisational structures, and reporting and budgeting processes, as well as a number of champions working within the system.

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Figure 1: Key catalysts, contextual enablers and sustaining mechanisms for gender-based violence (GBV) service provision in the primary health care (PHC) system in Ethiopia

