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St. Paul's Hospital Millennium Medical College

ASSESSMENT OF KNOWLEDGE, ATTITUDE AND
PRACTICE TOWARDS GENDER BASED VIOLENCE
AMONG HEALTH PROFESSIONALS IN ST PAUL'S
HOSPITAL MILLENIUM MEDICAL COLLEGE AND
GANDHI MEMORIAL HOSPITAL

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A RESEARCH PROPOSAL SUBMITTED TO ST PAUL'S
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GYNECOLOGY.

Assessment of Knowledge, attitude and practice towards gender based violence among health professionals in SPHMMC and Gandhi memorial hospital, Addis Ababa, Ethiopia

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SUMMARY

BACKGROUND: Gender based violence is violence directed against an individual based on sex or gender, which results in psychological, physical, or sexual trauma and is one of the most widespread, underreported, and unsolicited human rights violations in the world and has no social, economic, or national boundaries. Anyone can be a victim of sexual violence, but the majority of victims are women. Violence against women is a major public health problem affecting more than one-third of all women worldwide.

Objectives: The main objective of this research is to assess the KAP towards GBV among health professionals in SPHMMC and GMH.

Methodology: Hospital based cross-sectional study was conducted from 1st May to 31 June 2024. After the minimum sample size is determined using single population proportion formula and assuming a margin of error to be 5%, proportion event occurrence (proportion of people who have good knowledge) at 50% , 95% level of significance and adding a 10% none response rate, sample size became 285. By using a standardized pre-tested questionnaire, data was collected and entered using Epi info 7 version 3.4.3 and exported to SPSS version 25 for analysis and bivariate and a multivariate logistic regression analysis were conducted.

Result: Majority, 82.4% of the respondents had high knowledge level and 63.4% had a positive attitude on gender based violence. Reporting cases of gender based violence to legal authorities were low, at 28.9% among the health professionals. A statistically significant relationship was observed between respondents' level of knowledge and their attitude towards gender based violence ($p = 0.002$), their level of attitude and reporting practice ($P = 0.003$) and no significant association was found b/n attitude level and confidence level of reporting and screening.

Conclusion: Knowledge and attitude level of health professionals were high. However, their screening for and reporting practices of gender based violence to legal authorities were insufficient and inadequate respectively. Training and ongoing sensitizations in gender based violence is recommended to improve the situation.

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ABBREVIATIONS AND ACRONYMS

GBV	Gender based violence
GMH	Gandhi memorial hospital
HCWs	Health care workers
IPV	Intimate partner violence
KAP	Knowledge, attitude and practice
NGO.....	Non-governmental organization
SPHMMC	Saint Paul Hospital Millennium Medical College
SSA.....	Sub-Saharan Africa
UN	United Nations
WHO.....	World Health Organization

1. INTRODUCTION

1.1. BACKGROUND

According to the United Nations(UN) (1993), Gender based violence (GBV) refers to "any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women or men, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life"(1). The phrase "gender-based" emphasizes the significance of comprehending violence in light of women's and girls' subordinate place in society. Some of the types of GBV are:-1.Physical violence: the deliberate use of physical force having the potential to result in death, disfigurement, harm, or injury.2: Sexual assault: the act of engaging in sexual activity without permission 3: psychological/emotional abuse: acts of compulsion or the use of abusive words (2).

GBV is one of the most prevalent type of violence worldwide. It is observed happening in the broader public as rape, sexual abuse, sexual harassment, intimidation at work and in educational institutions, trafficking in women, and forced prostitution as well as in families (as beatings, sexual abuse of children, dowry-related violence, marital rape, etc.). The most prevalent types of GBV, however, are intimate partner violence and sexual violence (3).

There is growing recognition worldwide of the public health burden of GBV that cuts across class, race, religion, and ethnicity. It is a human rights violation in addition to being a public health problem affecting millions of women, men, girls, and boys of all ages (WHO, 2012) (4).A little over one-third, or 35%, of women worldwide have experienced physical and/or sexual intimate partner violence or non-partner sexual violence, according to statistics reported by the World Bank (2019), which has identified GBV against women as a global pandemic that affects 1 in 3 women in their lifetime (5).

Having this huge burden, health systems have an important role to play in a coordinated multi-sectoral response to violence against women. However, there are significant barriers that prevent HCWs from identifying abuse and providing appropriate care and support to women affected by violence (7).

The Health sector is in a valuable position to support survivors and change social attitudes about GBV. It participate in the prevention of GBV at all levels: 1. Primary prevention by community awareness, 2. Secondary prevention by early identification and treatment, 3. Tertiary prevention by long term counseling, rehabilitation and referral to socio economic and legal support(3).

Studies have suggested that health care workers(HCWs) lack of awareness, skills, prejudicial attitudes towards and stereotypes of violence against women as major factors responsible for preventing abused women from accessing quality healthcare(8).

1.2. STATEMENT OF THE PROBLEM

GBV is an imperative public health concern that draws the attention of a wide spectrum of professional health care workers. GBV affects women's wellbeing with adverse health outcomes consequently leading women who are abused to extensively seek health services (5).

GBV has detrimental effects on the health and well-being of women. They range from fatal consequences such as homicide, suicide, maternal deaths, and AIDS-related deaths to non-fatal consequences such as physical harms, psychological problems, and reproductive health issues and psychological problems such as fear, anger, post-traumatic stress disorder, chronic pain syndrome, and low self-esteem (3).

According to the WHO, GBV is a global public health issue, and providing care for women who experience violence inside the health system is crucial. The prevalence of violence perpetrated by intimate partners is higher among female health service users, since they seem to repeatedly have a pattern of behavior of greater frequency of health service usage, because of the chronic effects of aggression on their health (9).

Violence in gender relationships is typically not taken into account when diagnoses are made, and medical practitioners describe it as an issue that is very challenging to solve. Studies have indicated that professionals frequently help women who are subjected to violence, yet many professionals report feeling uneasy managing such situations (9).

Many African nations have recently started to realize how crucial it is to combat GBV and provide for the needs of survivors on a national basis. However, these national programs have a tendency to adopt effective tactics from high resource contexts in Europe and North America since there is a lack of a solid, regionally appropriate research base. In nations where governmental and individual resource limitations make it difficult to obtain even the most basic medical treatment, the usefulness and sustainability of such techniques are not well proven (10).

Studies have shown that HCWs typically view issues related to violence as falling outside the purview of security and justice; because of fear of getting engaged in these issues, they restrict themselves to healing physical wounds. Additionally, it has been observed that when confronted with clinical instances of violence, healthcare personnel' conduct is defined by refusing to do what is required or by referring patients to specialists, neither of which usually results in a suitable answer to the women's demands(9).

In light of these, a cross-sectional study was conducted with the aim of evaluating the KAP that HCWs in SPHMMC and GMH have towards GBV. The outcome of the findings is expected to help in the improvement KAP of HCWs towards GBV by continuous trainings, specific refresher courses, (including on-site practical sessions, professionals' mentorship, and supervision) and revision and implementation of policies on the provision of GBV health services among HCWs.

1.3. JUSTIFICATION OF THE STUDY

Health practitioners must have sufficient understanding of and abide by the execution of GBV-related clinical recommendations in order to properly execute GBV services and combat violence among teenage girls and boys. How well they are implemented will rely on how much knowledge they have and how frequently they are updated. In order to screen, evaluate, report, and manage GBV survivors appropriately, health professionals' KAP toward GBV must be at a high level (6).

Several African nations' experiences addressing violence against women in the health sector have revealed important insights. Not only may the lack of GBV screening among HCWs be seen as a manifestation of patriarchy in the health systems, but it could also be seen as an example of "institutional silence" on GBV. Interventions must go beyond training and curriculum reform and

adopt a system-wide strategy, involving adjustments to policies and practices as well as a focus on confidentiality and privacy (6).

The majority of healthcare facilities currently offer GBV survivors some kind of medical therapy. However, a thorough evaluation of the consistency of care offered to them throughout these hospitals has not been conducted. It is unknown if healthcare facilities adhere to any standard operating procedures or guidelines for treating GBV patients. Additionally, there is little knowledge about the capabilities of our healthcare professionals as well as the availability of the equipment and materials required for GBV services. It is crucial to gather information to learn more about the current systems or practices of service delivery to the survivors of GBV because health facilities are frequently the initial point of contact for GBV survivors (3).

There is no study to our knowledge that assesses the KAP of health care professionals towards GBV so far in our country and we also lack a well adhered institutional guideline. Therefore, the result of this study will give insight into appropriate institutional guideline and protocol with the expectation to update MOH and other relevant agencies on the current status of health sector responses to GBV, and eventually help policymakers, planners, and managers in strengthening the health sector response to GBV.

2. LITERATURE REVIEW

The survivors' health and well-being are negatively impacted by GBV. It is crucial that the health care system is prepared to respond to GBV cases because the initial response can reduce the severity of the effect (11).

Despite the paucity of data on GBV in Africa, estimates indicate that the problem is a significant one for the continent's development, human rights, and health. In Zambia, 48% of women between the ages of 15 and 49 have experienced physical abuse, and 1 in 5 have also experienced sexual violence (Zambia DHS, 2007). In Kenya, 39% of women between the ages of 15 and 49 have ever encountered physical abuse, while 21% have reported sexual violence. These national Demographic and Health Surveys (DHS) are likely to overestimate the frequency and incidence of violence due to complex stigma and reporting issues (13). The systemic review in Ethiopia has shown that the lifetime prevalence of domestic violence against women by husband or IPV ranges from 20 to 78% (6).

In Wolaita-Sodo, Ethiopia, a cross-sectional institutional study was carried out. Through the use of multi-stage stratified sampling techniques, a total of 604 female high school students were selected. WHO-validated GBV assessment method was used to evaluate GBV and other factors. GBV, sexual violence, and physical violence all had lifetime prevalence rates of 63.2, 37.2, and 56.3%, respectively. Before and after starting at the current school, as well as during the current academic year, there were 30.5, 37.2, and 22% prevalence rates for sexual violence, respectively. Having a regular boyfriend (AOR= 2.02; 95% CI:1.07-3.79), engaging in sexual activity (AOR = 6.10; 95% CI: 2.49-14.92), having friends who use alcohol (AOR= 2.18; 95% CI:1.26-3.77), seeing their mothers being physically abused by their partners or husbands (AOR= 1.92; 95% CI:1.19-3.11), and enrolling in a public school (AOR= 1.74;95% CI:1.11-2,76) were significantly associated with gender based violence(12).

Low educational attainment, higher alcohol and drug use, a history of child and family abuse, community attitudes toward violence, unemployment among women, and lower socioeconomic class were found to be individual, family, and community associated factors that increase the experiences of gender-based violence against women in Sub-Saharan Africa. In order to meet the

Sustainable Development Goals' deadline of 2030 for the abolition of all forms of violence, Sub-Saharan Africa must give top priority to developing a multifaceted intervention strategy (1).

A qualitative study that evaluated sexual and GBV against men in the Democratic Republic of the Congo showed that, like GBV against women, GBV against men is multifaceted and has serious detrimental effects on the male survivor and his family in terms of their physical, emotional, social, and economic well-being. In a conflict-affected area, Sexual GBV against men and boys is probably widespread, but it frequently goes unreported by victims and others due to cultural and social stigmas surrounding sexual assaults, including survivor shame and the fear of reprisals from attackers (14).

To determine the impact of intimate partner violence on both men and women's physical and mental health, a random-digit-dial telephone survey was conducted. In total, physical, sexual, or psychological IPV had been experienced by 28.9% of 6790 women and 22.9% of 7122 males. In contrast to men, women were less likely to report verbal abuse alone (RR0.8, 95% CI 0.7, 0.9) but substantially more likely to report physical or sexual IPV (relative risk [RR] 2.2, 95% confidence interval [CI] 2.1, 2.4) and abuse of power and control (RR1.1, 95% CI 1.0, 1.2). Physical IPV victimization was linked to a higher risk of future injury, depressive symptoms, substance use, chronic disease, and chronic mental illness for both men and women (15).

A study was carried out to evaluate the knowledge and attitudes of HCWs regarding GBV with the goal of improving care in the public health system in Ribeiro Preto (Brazil). A standardized questionnaire was used to interview 221 out of a total of 278 healthcare professionals. There were 77.0% doctors and 23.0% nurses. They had been in professional practice for an average of 12.5 years, and 68.8% had earned their degree from a public university. There is a need to teach HCWs because only 58.7% of people have acceptable general knowledge (good and high) regarding gender violence. HCWs identified the lack of institutional policies and the silence of women who do not disclose assault as hurdles to identifying violence. Young women in particular expressed more positive sentiments toward women who live in violent situations.

In conclusion, the majority of them have favorable attitudes toward women who experience abuse, and we deduce that, with the right training, they have a strong chance of providing adequate case management (9).

In Zambia, a local hospital conducted research to evaluate the screening, reporting, and awareness of HCWs about GBV. The majority of respondents, 79.9%, had a high level of understanding of gender-based violence. The percentage of health professionals who screen for and report cases of gender-based violence to legal authorities was low (54% and 31.4%, respectively). Despite the fact that the majority of them had not received gender-based violence training, health practitioners had excellent levels of knowledge. However, their procedures for identifying gender-based violence and informing the appropriate authorities were also lacking. To improve the situation, training or ongoing sensitization about gender-based violence is advised (5).

Knowledge, attitude and practice of HCWs trained in reacting to violence against women was the subject of a pre-post intervention study conducted in a tertiary hospital in India. From before to after training, the median score for clinical understanding of violence against women increased (8.89 vs. 10.00). It was discovered that the provision of support services, such as providing basic information about domestic violence (64.2% vs. 95.1%), offering supportive statements (81.5% vs. 100%), documenting cases (51.9% vs. 79%), and making external referrals (53.1% vs. 81.5%), had improved significantly ($p.001$) from pre to post (8).

CONCEPTUAL FRAMEWORK

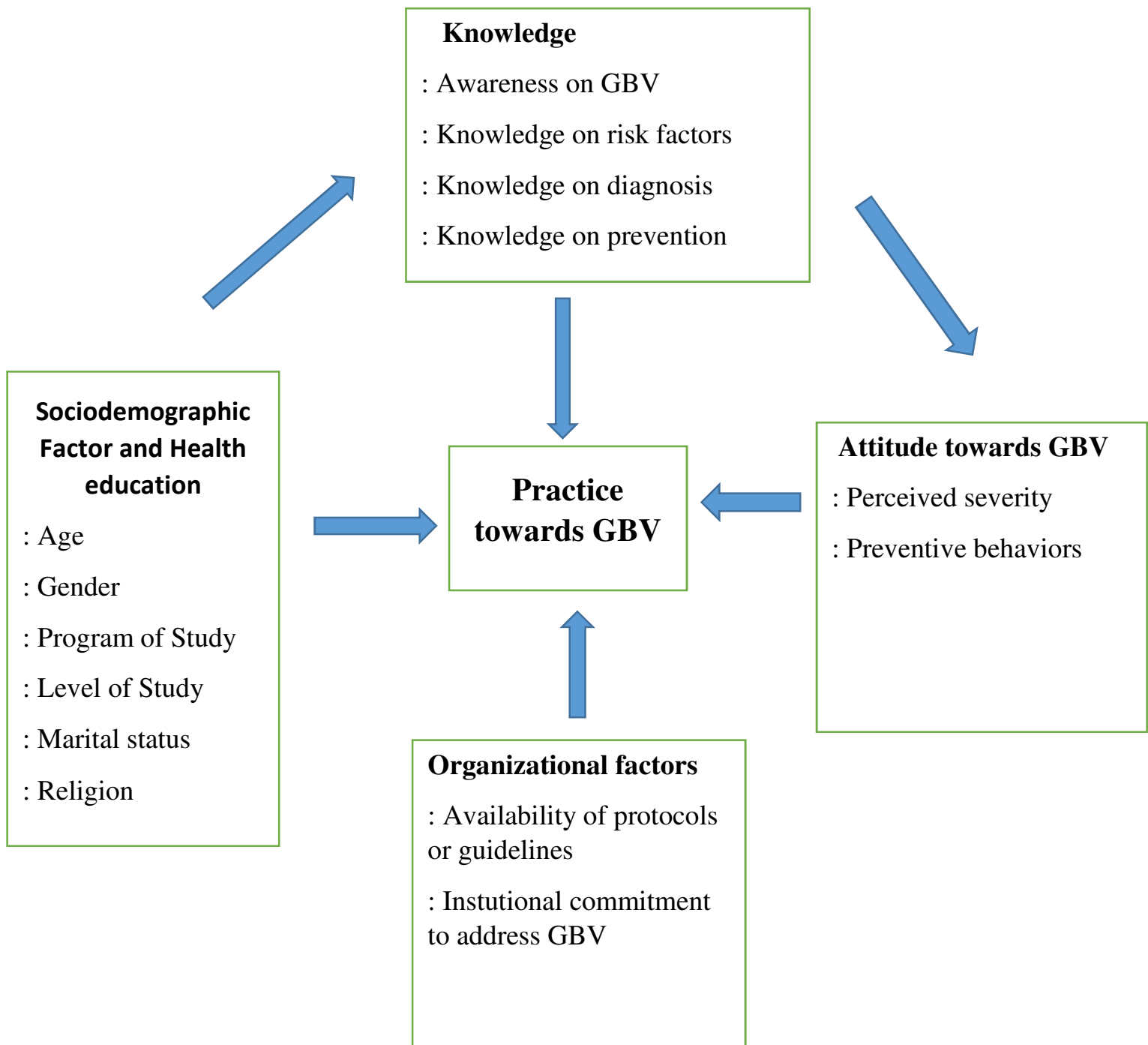


Figure 1 Conceptual framework

3. Objectives

3.1 General objective

- To assess and identify the factors influencing knowledge, attitude, and practice of health professionals towards gender-based violence in St. Paul's Hospital Millennium Medical College and Gandhi Memorial Hospital.

3.2 Specific objectives

- To determine the level of knowledge among health professionals in St. Paul Hospital and Gandhi Memorial Hospital regarding gender-based violence.
- To explore the attitudes of health professionals in St. Paul Hospital and Gandhi Memorial Hospital towards gender-based violence.
- To examine the practices of health professionals in St. Paul Hospital and Gandhi Memorial Hospital in addressing and responding to gender-based violence.
- To identify the factors influencing the knowledge, attitude, and practice of health professionals in St. Paul Hospital and Gandhi Memorial Hospital towards gender-based violence.

4. METHODS AND MATERIALS

4.1 STUDY SETTING AND STUDY PERIOD

The study will be conducted at SPHMMC and GMH considering the high flow of survivors of GBV to SPHMMC and GMH having the largest one stop center. Both are located in Addis Ababa, Ethiopia's capital city. Undergraduate, master's, specialty, and subspecialty programs are available at SPHMMC. These programs are available in a variety of subjects. The SPHMMC's Obstetrics and Gynecology department was one of the first in the college to start a residency program. It was founded in 2012-13G.c. The program's capacity has gradually risen, and the average number of admissions each year is now 28. Maternal-Fetal Medicine, Family Planning, Gynecologic Oncology, Reproductive Endocrinology, and Infertility are among the subspecialties offered by the department. GMH is a governmental hospital that specializes in maternity services. The hospital serves as a teaching center and is found in kerkos sub city and the inpatient capacity is 350 beds and more than 1000 outpatient and emergency clients visit the hospital daily. This research will be conducted from 1st May to 31 June 2024.

4.2 STUDY DESIGN

Hospital based cross-sectional study was employed.

4.3 SOURCE POPULATION

All Health professionals working at SPHMMC, OBGYN department and Gandhi memorial hospital.

4.4 STUDY POPULATION

All selected HCWs working at SPHMMC, OBGYN department and Gandhi memorial hospital.

4.5 ELIGIBILITY CRITERIA

INCLUSION CRITERIA

- Health professionals who are willing to participate in the study and provide informed consent

EXCLUSION CRITERIA

- Health professionals who are not directly involved in patient care (e.g., administrative staff)
- Health professionals who are currently on leave or not actively working at the hospitals during the data collection period

4.6 SAMPLE SIZE

The required sample size is determined using a single population proportion formula and by assuming a margin of error of 5%, a proportion of event occurrence at 50 % and 95% level of significance. Based on the above assumption, the minimum sample size required for the study is 384. After applying correction formula and adding 10% for none-response rate the final sample size becomes 285.

$$n = \frac{(Z \alpha/2)^2 p (1-p)}{d^2}$$

Where: -

N= Total Population size

n = calculated sample size

Z = Confidence interval [95%]

p =0.5

d = marginal error [5%]

$$n^* = \frac{(1.96)^2 \times 0.5 [1-0.5]}{(0.05)^2} = 384$$

$$\text{Correction} = \frac{n^*}{1 + (n^* - 1)/N} = 248, \text{ by adding 10\% none-response rate} = 273.$$

4.7 SAMPLING PROCEDURE

A stratified random sampling was used among the participants working at SPHMMC and GMH in which sample size was proportionally allocated to the study sites.

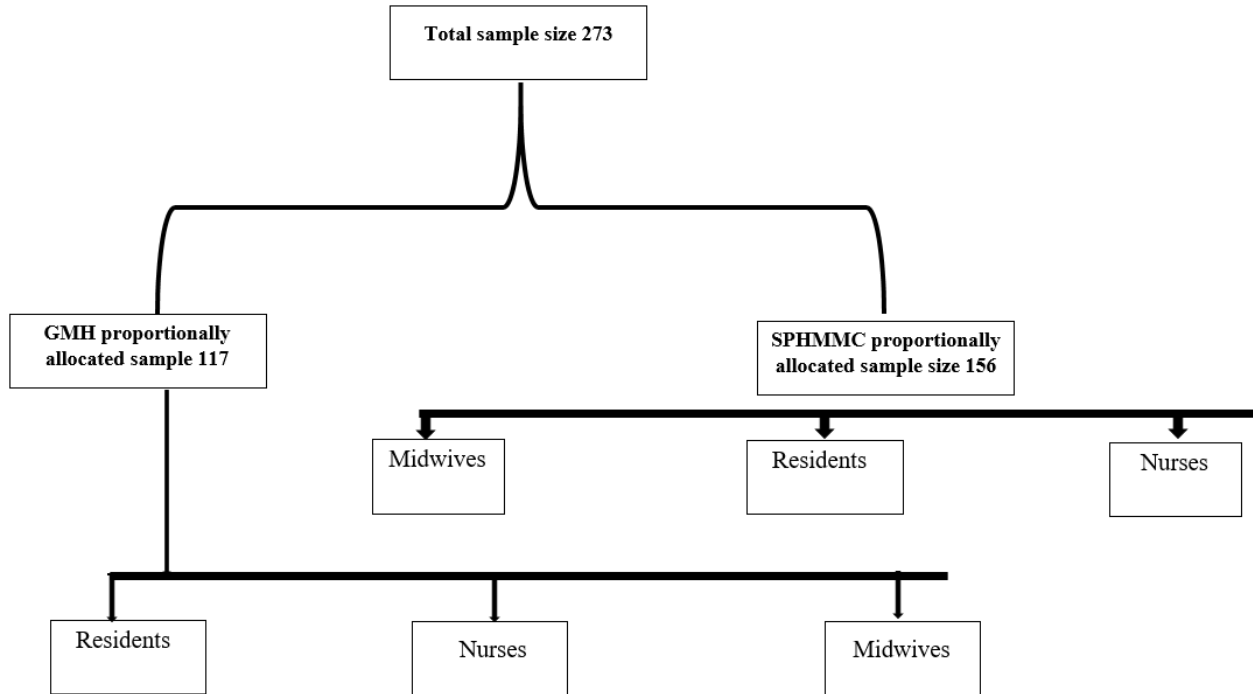


Figure 2: Sampling procedure

4.8 VARIABLES IN THE STUDY

Dependent variables

- Knowledge about gender-based violence
- Attitude towards gender-based violence
- Practice in addressing gender-based violence

Independent variables

Sociodemographic Factor

Age

Gender

Marital status

Religion

Profession related factors

Years of experience

Professional qualification

Training or formal education programs on GBV

Organizational factors

Availability of protocols or guidelines

Institutional commitment to address GBV

4.9 DATA SOURCE

The data used is primary data which is retrieved by tools which was constructed by the researcher after reviewing related literatures from HCWs who are actively involved in clinical activity.

4.90. Measurements

Knowledge: In this study, knowledge refers to the understanding on GBV, the risk factors, diagnosis, and prevention of GBV. It was assessed by ten questions and all of them are true or false questions. Respondents who got all correct responses have a maximum of 10 points, higher points indicate good knowledge. Based on the total score and distribution, knowledge on GBV was categorized into inadequate (< 5 scores) and adequate (≥ 5).

Attitude

In this study, attitude encompasses perceived severity and preventive behaviors towards GBV. It was assessed by 10 questions. Based on the total score and distribution, attitude towards GBV was categorized into negative attitude (< 5 scores) and positive (≥ 5).

Practice

In this study it refers to actions based on knowledge and attitude of the participants in reporting cases of GBV to legal authorities. It was assessed by three questions with a total score of six. Based on total score and distribution, practice on reporting to legal authorities was categorized into sufficient (< 4 scores) and insufficient (≥ 4) practice.

4.91 Data collection, entry and quality assurance

Data was collected from HCWs using a self-administered structured Questionnaire prepared in English. The Questionnaire will have FOUR parts: (1) sociodemographic factors, (2) knowledge,

(3) attitude and (4) practice. The data collection Questioner was assessed by OBGYN specialist for clarity and comprehensiveness of contents. A pilot study was employed on 5% of randomly selected HCWs in another hospital and all the necessary modifications were included in the final data collection Questionnaire. The quality of data was assured by proper designing and pre-testing of the Questionnaire and by giving training for the data collectors before the actual data collection. Appropriate modifications were made after viewing the pre-test result and overall supervision was made by the principal investigator.

4.92 Data analysis procedures

The extracted data was entered and checked using Epi info 7 version 3.4.3 and then it was exported in to SPSS version 20 for analysis. Frequencies, proportions and descriptive statistics were used to explain the study population with the relevant variables. Binary logistic regression was used to analyze factors that affect the outcome variable. Variables with p- value < 0.2 with bivariable analysis were included in multivariable analysis. Explanatory variables which have p-value < 0.05 in multivariable analysis were identified as a significant factor affecting the outcome variable with a 95% confidence level.

4.93 Operational definition

1. **Gender** is a social construct that defines the norms, roles and relations for males and females in the process of socialization.
2. **Sex** is the biologic difference between men and women.
3. **Survivor** refers to the subject or target of the incident.
4. **Gender-based violence** includes all forms of violence involving women and men in which the female is usually the victim. The term ‘gender-based’ is used to highlight the need to understand violence within the context of women’s and girl’s subordinate status in society.
4. **Perpetrator** is the doer or committer of the action(s). The perpetrator could be a person, group, or institution that inflicts, supports, or condones violence or other forms of abuse against a person or group of persons.
5. **Physical violence** is defined as the intentional use of physical force with the potential to cause Death, disability, injury, or harm.

6. **Sexual violence/abuse** is the act of sexual activity without consent and/or any sexual act on a person who could not give consent, such as children and persons with disabilities.

7. **Psychological/emotional violence/abuse** and neglect are acts of coercion or use of abusive language (e.g. verbal assaults) and arbitrary deprivation of liberty, whether occurring in public or in private life.

8. **Intimate partner violence** refers to behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, and psychological abuse and controlling behaviors.

4.94 Ethical considerations and consent

The study was conducted after ethical approval letter was secured from the research committee of the OBGYN department as well as the institutional review board of the College and was conducted according to the institutional and ethical rules concerning research. The information obtained from the chart is kept strictly confidential.

4.95 Method of dissemination

The result of the study will be made available to the SPHMMC, OBGYN department and GMH and Federal Ministry of Health and other stake holders. Although health professionals in the OBGYN department are the main recipients of any new findings, the study will also be available to health policy makers, health care providers, and public health advocates so that all necessary measures will be conducted to address the issue of gender based violence. There will be attempts to publish the outcome of this study in relevant national and international journals.

5. RESULT

The data was collected via electronic questionnaire from 273 HCWs found in SPHMMC and GMH. The response rate was 100%.

5.1: SOCIO-DEMOGRAPHIC DATA OF RESPONDENTS

The socio-demographic data include age, gender, and profession, working area, level of residency, religion, marital status and year of experience of the respondents. In terms of age distribution, a significant majority of respondents fall within the 27 to 37 age range (71.8%), while those below

26 years account for 24.2%, and a mere 4.0% are aged 38 to 48 years. The gender composition indicates a slight majority of females (56.4%) compared to males (43.6%)

TABLE 1: SOCIODEMOGRAPHIC DATA OF RESPONDENTS

Variable	Category	Frequency (N)	Percent (%)
Age Range	BELOW 26	66	24.2
	27 TO 37	196	71.8
	38 TO 48	11	4.0
Gender	Female	154	56.4
	Male	119	43.6
Religion	Catholic	5	1.8
	Muslim	57	20.9
	Orthodox	125	45.8
	Protestant	86	31.5
Marital Status	Divorced	1	0.4
	Married	130	47.6
	Single	142	52.0
Profession	Midwife	125	45.8
	Nurse	82	30.0
	Physician	66	24.2
If OBGYN resident	Year 4	24	8.8
	Year 1	20	7.3
	Year 2	15	5.5
	Year 3	7	2.6
Working Area	ALL	21	7.7
	LW	80	29.3
	MW	54	19.8
	OPD	82	30.0
	OR	36	13.2
Experience Range	UNDER 5	221	81.0
	5 TO 10	52	19.0

5.2: HEALTH 5.2 PROFESSIONALS' KNOWLEDGE LEVELS OF GBV

The statement that gender-based violence is a component of sexual violence received a strong incorrect response, with 84.2% believing it to be incorrect. Conversely, a smaller percentage, 15.8%, recognized it as correct. The notion that GBV occurs due to power imbalances favoring men also garnered attention, as 74.0% of respondents correctly acknowledged this factor, while 26.0% held an incorrect view. Generally, among 273 respondents 82.4% of the respondents in the current study had a high knowledge level of GBV while 17.6% had low knowledge levels of GBV.

TABLE 2: PARTICIPANTS' RESPONSE TO KNOWLEDGE ASSESSMENT QUESTIONS ABOUT GENDER BASED VIOLENCE (N=273)

Variable	Category	Frequency	Percent
1. Gender based violence is one of the components of sexual violence.	Incorrect	230	84.2%
	Correct	43	15.8%
2. GBV occurs due to power imbalances that usually favor men.	Incorrect	71	26.0%
	Correct	202	74.0%
3. Domestic violence is part of GBV that occurs in a family.	Incorrect	48	17.6%
	Correct	225	82.4%
4. Sodomy (intentional anal sexual intercourse with a male) is one form of gender based violence.	Incorrect	93	34.1%
	Correct	180	65.9%
5. GBV in children is an unlawful act only if it results in physical, sexual, or psychological harm or suffering.	Incorrect	103	37.7%
	Correct	170	62.3%
6. Violence is the use of force that is based on unequal power distribution and includes actions that influence the free and voluntary decision-making of an individual.	Incorrect	44	16.1%
	Correct	229	83.9%
	Incorrect	137	50.2%

7. In managing any GBV survivors, the overriding priority should be the collection of all forms of evidences.	Correct	136	49.8%
8. Adherence to ethical codes of conduct is particularly relevant when dealing with survivors of interpersonal violence.	Incorrect	67	24.5%
	Correct	206	75.5%
9. Health facilities should be organized and equipped with optimal standards of care for GBV survivors; however, not all cases of GBV survivors should be treated as urgent.	Incorrect	154	56.4%
	Correct	119	43.6%
10. If an adult freely consented to the sexual action, the use of excessive force during the act may not be regarded as GBV upon complaint of the adult.	Incorrect	126	46.2%
	Correct	147	53.8%

5.3: HEALTH PROFESSIONALS' ATTITUDE LEVELS OF GBV

The analysis of attitudes toward gender-based violence (GBV) among respondents reveals significant insights into public perceptions regarding the prevalence, disclosure, and treatment of GBV victims. For the statement, "A woman is more likely to be assaulted on the street by unknown men than in her own home by her husband," 49.8% of participants expressed a negative attitude, while only 41.8% perceived it positively. Out of the total 273 respondents 63.4 % (173) have a positive attitude and around (100)36.6% of respondents have a negative attitude towards gender based violence.

TABLE 3: PARTICIPANTS' RESPONSES TO SELECTED ATTITUDE ASSESSMENT QUESTIONS ABOUT GBV (N: 273)

Variable	Category	Frequenc y (N)	Percent (%)
1. A woman is more likely to be assaulted on the street by unknown men than in her own home by her husband.	Neutral	23	8.4
	Negative	136	49.8

	Positive	114	41.8
2. GBV is very rare among women seeking health services at health institutions.	Neutral	25	9.2
	Negative	87	31.9
	Positive	161	59.0
3. Domestic violence affects all sectors of society irrespective of social, economic, cultural and religious values.	Neutral	2	0.7
	Negative	49	17.9
	Positive	222	81.3
4. Most women victims of GBV would not disclose GBV as the source of their injuries to Health Care Providers.	Neutral	23	8.4
	Negative	72	26.4
	Positive	178	65.2
5. It is mandatory for Health professionals to report identified cases of GBV to police even if the victim has not agreed or consented to reporting.	Neutral	54	19.8
	Negative	131	48.0
	Positive	88	32.2
6. Victims of GBV are required to obtain a police medical report form (medico-legal examination report form) from the police before provision of medical services (except in emergencies).	Neutral	38	13.9
	Negative	111	40.7
	Positive	124	45.4
7. It is the role and responsibility of Health professionals to enquire about gender based violence where the victim tries to conceal it.	Neutral	32	11.7
	Negative	71	26.0
	Positive	170	62.3
8. Clinical care for survivors of GBV require Health care Professionals to obtain an informed consent from victims for any notifications or referral.	Neutral	28	10.3
	Negative	61	22.3
	Positive	184	67.4
9. Sexual violence towards boys and men is not a concern in our country.	Neutral	14	5.1
	Negative	95	34.8
	Positive	164	60.1
	NEUTRAL	16	5.9

10. Male survivors of GBV should be approached and managed the same way as female survivors.	Negative	177	64.8
	Positive	80	29.3

5.4: HEALTH PROFESSIONALS' PRACTICE LEVELS OF GBV

Section 5.3 presents information on HCWs reporting practices of GBV cases to legal authorities. The HPs' reporting practices of GBV were measured by a "yes" and "no" response to a question that sought to find out whether HPs report for GBV, the type of reporting and frequency of reporting in the past year.

TABLE 3: REPORTING OF GBV BY HPS (N = 273)

According to table 3, close to one third, 28.9% of the HPs reported GBV to legal authorities. Types of reporting were on consent of the victim, 55.4% and without, 33.8%. The HPs frequency of reporting GBV was a few times, 16.1% and very often 0.7%.

Reports GBV	Responses	Frequency	Percent
1. In your practice do you ever report GBV to legal authorities?	No	194	71.1%
	Yes	79	28.9%
	Total	273	100%
2. Below is a list of statements on options for reporting GBV to Police or legal bodies.	I only report GBV if the victim has consented and wants to do so	47	17.2%
	I report GBV to Police even if the victim does not want or consent to reporting	32	11.7%
	Total	79	28.9%
3. In the past year how frequently did you carry out the reporting option chosen?	A few times	44	16.1%
	Never	9	3.3%
	Rarely	24	8.8%
	Very often	2	0.7%
	Total	79	28.9%

TABLE 4: HEALTH PROFESSIONALS REPORTING PRACTICES (N= 273)

Table 5 shows that majority, 71.1, of the HPs exhibited insufficient reporting practices of GBV.

Category	Frequency (N)	Percent
Sufficient practice	79	28.9%
Insufficient practice	194	71.1%
Total	273	100.0

TABLE 5: AVAILABILITY OF WRITTEN POLICY / PROTOCOL ON SCREENING AND REPORTING OF GBV (N=273)

Table 5 shows that 19.4% of the respondents indicated that they did not have written institutional policy or protocol on how to screen for GBV while 56% of the health professionals did not know whether their institutions had one. When asked if they had a written policy/ protocol on how to report GBV to legal authorities, the majority, 79.1% of the respondents indicated that there was none and 20.9% claimed there is a written policy.

Category	Responses	Frequency	Percent
4. Does your institution have a written policy on screening women for GBV?	I don't know	153	56%
	No	53	19.4%
	Yes	67	24.5%
5. What does the policy state about screening women for GBV?	Screening for GBV should be part of routine history taking for all women	39	14.3%
	Screening for GBV should be done on suspicion for GBV	25	9.2%
	Screening for GBV should be done upon self-disclosure	3	1.1%
6. Does your institution have a written policy on how to report GBV?	No	216	79.1%
	Yes	57	20.9%

7. What does the policy state regarding reporting GBV to police or legal bodies?	Health professionals should fill in a medico-legal examination form	18	6.6%
	Health professionals should fill in a medico-legal examination form only if consented	39	14.3%

TABLE 6: LEVELS OF CONFIDENCE ON SCREENING AND REPORTING GBV CASES (N = 273)

Among 273 respondents few of the HPs were very confident (7%) that they could screen women for GBV. Further, very few, 9.5% of the participants reported that they were extremely confident (0.4%) for reporting cases of GBV to legal authorities.

Category	Responses	Frequency	Percent
8. How confident are you that you can screen women for GBV?	Moderately confident	105	38.5%
	Not at all confident	49	17.9%
	Slightly confident	100	36.6%
	Very confident	19	7.0%
9. How confident are you that you can report GBV to Police or legal bodies?	Extremely confident	1	0.4%
	Moderately confident	77	28.2%
	Not at all confident	56	20.5%
	Slightly confident	113	41.4%
	Very confident	26	9.5%

5.4: ASSOCIATED FACTORS FOR KNOWLEDGE, ATTITUDE AND PRACTICE FOR AND TOWARDS GBV.

TABLE 7: KNOWLEDGE TOWARDS GBV AND DEMOGRAPHIC ASSOCIATION

Level of knowledge								
		Low knowledge		High knowledge				
Characteristic	category	Frequency	Percent	Frequency	Percent	COR 95%CI	AOR 95%CI	P-value
2.Gender	Female	32	66.7%	122	54.2%	1	1	0.007
	Male	16	33.3%	103	45.8%	1.689(0.877-3.250)	0.292(0.119-0.717)	
3.Religion	Catholic	2	4.2%	3	1.3%	0.343(0.053-2.224)	2.135(0.82-5.529)	0.019
	Muslim	18	37.5%	39	17.3%	0.495(0.227-1.079)	0.048(0.001-2.074)	
	Orthodox	12	25.0%	113	50.2%	2.152(0.962-4.817)	0.083(0.011-0.632)	
	Protestant	16	33.3%	70	31.1%	1	1	
4.Martial status	Divorced	0	0.0%	1	0.4%	40192(109312-0.000)	15.347(14.3-19.652)	0.001
	Married	39	81.3%	91	40.4%	0.158(0.073-0.342)	0.171(0.072-0.404)	
	Single	9	18.8%	133	59.1%	1	1	
7.Working area	ALL	0	0.0%	21	9.3%	1	1	0.033
	LW	5	10.4%	75	33.3%	8770(9130944-0.000)	21(20-23)	
	MW	9	18.8%	45	20.0%	8.478(2.733-26.305)	33.123(7.844-39.432)	

	OPD	21	43.8%	61	27.1%	2.826(1.053-7.585)	23.662(5.717-46.543)	
	OR	13	27.1%	23	10.2%	0.708-3.089)	2.643(0.905-7.718)	

TABLE8: ATTITUDE TOWARDS GBV ASSOCIATION WITH DEMOGRAPHIC VARIABLES (N: 273)

Attitude towards GBV								
Characteristics	Category	Negative		Positive				
		Count	Percentage	Count	Percentage	COR 95%CI	AOR 95% CI	P-value
Age range	Below 26	9	9%	57	32.9%	1	1	0.001
	27- 37	84	84%	112	64.7%	11.083(2.691-45.643)	11.332(2.709-47.407)	
	38 - 48	7	7%	4	2.3%	2.333(0.661-8.231)	2.577(0.715-9.286)	
Religion	Catholic	4	4%	1	0.5%	1	1	0.031
	Muslim	23	23%	34	19.6%	0.091(0.01-0.86)	4.676(0.488-44.799)	
	Orthodox	50	50%	75	43.3%	0.54(0.265-1.101)	4.774(0.515-44.264)	
	Protestant	23	23%	63	36.4%	0.548(0.302-0.995)	8.297-78.840)	

TABLE 9: REPORTING PRACTICE ASSOCIATION WITH DEMOGRAPHIC VARIABLES (N: 79)

Reporting practice of GBV						
		Bad practice	Good practice	COR 95% CI	AOR95% CI	

		count	percentage	count	percent age			P- value
Gender	female	8	88.8%	34	48.5%	1	1	0.034
	male	1	11.1%	36	51.4%	0.118(0.01 4-1.111)	0.048(0.00 5-0.449)	
Profess ion	Physians	1	11.1%	9	12.8%	1	0.189(0.01 8-2.000)	0.038
	Midwife	0	0	34	48.5%	0.495(0.22 7-1.079)	1	
	Nurse	8	88.8%	27	38.5%	0.375(0.04 1-3.424)	5.000(1.00 0-25.000)	

TABLE 10: ASSOCIATION BETWEEN KNOWLEDGE LEVEL AND ATTITUDE TOWARDS GBV

Attitude level							
		Negative attitude	Percent	Positive attitude	Percent	OR 95%CI	P-value
Knowledge level	Low	27	27%	21	12.1%	0.374(0.198- 0.705)	0.002
	High	73	73%	152	87.8%	1	

TABLE 11: ASSOCIATION BETWEEN ATTITUDE TOWARDS GBV AND REPORTING PRACTICE

Reporting practice

		Bad practice	Percent	Good practice	Percent	OR 95% CI	P-value
Attitude Level	Negative	8	88.9%	17	18.8%	1	0.003
	Positive	1	11.1%	53	88.3%	0.04(0.005-0.344)	

TABLE 12: ASSOCIATION B/N CONFIDENCE LEVEL OF REPORTING AND SCREENING CASES OF GBV AND LEVEL OF ATTITUDE

Confidence level of reporting and screening							
		poor level	Percent	good level	Percent	OR 95%CI	P-value
Attitude Level	Negative	67	36.6%	33	36.6%	1.002(0.594-1.692)	0.993
	Positive	116	63.3%	57	63.3%	1	

6: DISCUSSION

6.1 HEALTH PROFESSIONALS' LEVELS OF KNOWLEDGE ON GBV

The first Objective of the study was to assess HPs' knowledge levels on GBV. Sufficient level of knowledge on GBV is very cardinal for HPs to effectively identify and manage victims of GBV who seek health services for GBV related health consequences.

Overall 82.4% of respondents had a high level of knowledge. This is slightly higher than a research done in Zambia in which 79.9% of the respondents had high levels of knowledge on gender based violence (5). This is even higher than a study done in Brazil regarding knowledge and attitude towards GBV, about 58.7% had adequate general knowledge (good and high) about gender based violence(2).

However, the finding that 17.6% of participant exhibit low knowledge indicates a critical gap that cannot be overlooked. This minority may represent individuals who lack access to information or face barriers related to socio-economic status. Therefore, it is essential to tailor educational efforts to reach these groups, ensuring that resources and information are accessible and relevant. Engaging with HPs through workshops, interactive discussions, and localized resources could enhance understanding and foster a supportive environment for those affected by GBV.

Further, a statistically significant relationship was observed between respondents' levels of knowledge on GBV and their attitude towards GBV ($p = 0.002$). This means that those who had higher levels of knowledge have good attitude towards the pros and cons of victims of gender based violence which significantly improves the care and attention given to survivors.

6.4: HEALTH PROFESSIONALS' LEVELS OF ATTITUDE TOWARDS GBV

The second objective of the study was to assess HPs attitude levels on GBV. Sufficient level of attitude on GBV is very cardinal for HPs to effectively identify and manage victims of GBV who seek health services for GBV related health consequences.

Among the study participants 63.4% have positive attitude and 36.6% has negative attitude towards gender based violence. This is comparable to a research done in Brazil regarding knowledge and attitude towards GBV in which 60% of the study participants have a positive attitude (2). The study in Myanmar regarding response to GBV showed that 17.1% of the participants had a negative attitude, 73.9% were neutral and only 9% of them had a positive attitude (17).

The current study revealed that age ($P = 0.001$) and religion ($P = 0.031$) have significant association with attitude towards GBV. Further, it has found that there is a significant association b/n high level of positive attitude and good reporting practice ($P = 0.003$). This shows that group of HPs with good level of attitude regarding gender based violence are more likely to give the needed attention

and care to survivors of GBV and to report to legal authorities when needed. But significant association was not found between the level of attitude and confidence level regarding screening and reporting cases of gender based violence ($p=0.999$) showing that good level of confidence in managing cases of GBV requires a thorough understanding of the degree of the problem, good degree of trainings and preparations with adequate exposure to management of survivors.

6.5: HEALTH PROFESSIONALS SCREENING/REPORTING PRACTICE OF GENDER BASED VIOLENCE

Screening women for GBV is a critical step in identification of those victims of GBV who may want to conceal the root cause of their complaints. Health professionals who screen women who seek health care services at health facilities for GBV can help identify victims who suffer in silence and can reduce victimization and positively impact women's health and well-being (3).

The current study revealed that more than half (75.4%) of the health professionals never screened women for GBV. This finding means that screening for GBV is very low among the HPs. The majority, 14% of the HPs screened routinely followed by upon suspicion of cases of GBV, 9%. Several research studies have also reported low rates of screening for GBV. A Californian survey of 137 primary care physicians' self-reported screening practices revealed that only 14% of the health providers in their study always screened female patients for IPV, about one third of the health care providers appeared never to screen (10).

The possible explanation for this findings (Low screening rate) is that although the majority of the respondents had high levels of knowledge on GBV, the source of their information or knowledge on GBV was not known as such they could still be harboring some negative attitudes towards GBV victims and screening for GBV. The low screening rates could further be attributed to the HPs' low confidence levels on screening for GBV as the study showed that only few of these Health professionals reported that they were very confident, 7% or extremely confident, 0% that they could screen women for gender based violence. The other contributing reason could be lack of a policy / guidelines or lack of knowledge if one existed on GBV. Knowledge of policies and the implementation of an appropriate protocol increases the likelihood of screening for GBV (5).

The current study revealed that 19.4% of the Health professionals in the current study reported that they did not have a written policy (procedures and protocols) on screening women for GBV while

more than half 56% of the health care professionals did not know whether their institutions had written policies on screening for GBV. This numbers are shocking in that the majority of HPs who are expected to screen and manage cases of GBV have no clue about their institutional procedures or protocols. So it is expected from each institutions and FMOH in large to introduce the HPs about the institutional guideline's and protocols through repeated and timely seminars, presentations and trainings.

The current study also revealed that only 28.9% of the HPs reported GBV to legal authorities. The type of reporting engaged by the majority, 55.4% was on consent and 11.7% without consent. Overall, the HPs reporting practice for GBV to legal authorities were insufficient, 71.1% and sufficient practices in 28.9% of respondents. This is less than the study finding done in Zambia which is 87% (5). In the study done in Myanmar only 12.8% of the participants had experience of GBV case management (17). The finding of low reporting rates for GBV is in line with reports that GBV is under reported and that HPs are reluctant to report GBV to legal authorities even in nations where mandatory reporting laws exist (European Union Agency for fundamental Rights, 2016).

The possible reason for HPs low reporting rates of GBV and insufficient practices could be explained by lack of sensitizations, workshops, trainings and multidisciplinary team for managing cases of gender based violence which makes health professionals to be less confident in screening ,reporting and managing cases of gender based violence. This study also found that gender (p-0.034) and profession (p-0.038) was significantly associated with reporting cases of GBV. It is also found that having a positive attitude about GBV is associated significantly (p-0.003) with reporting practice of cases of GBV.

6.6: LIMITATIONS OF THE STUDY

The limitations for this study are as follows:

- The study was only conducted in two hospitals and therefore results cannot be generalized to others. There is need to conduct a similar study on a national scale to generalize the findings.
- The knowledge, screening and reporting practices were self-reported, therefore follow up questions were included as necessary to probe further and allow self- expression.

- There was no methodological triangulation for data collection, however a category under „any other“ was created where necessary to allow free self- expressive statements to supplement on the data or clarify issues.
- Doctors were very few in the study; a larger sample size was desirable however their responses have shed light on the subject.

6.7: CONCLUSION AND RECOMMENDATIONS

6.71: CONCLUSION

The findings showed that a high percentage of the HPs had high level of knowledge towards GBV. A statistically significant association was observed between high level of knowledge and level of attitude towards cases of GBV. Additionally the study found that there is high positive level of attitude among respondents which has significant relationship with the level of practice. But no association was found between level of confidence regarding screening and reporting cases of GBV and level of attitude.

The majority of the respondents indicated that they did not know whether there is a written institutional policy / protocol on how to screen for GBV while less than one third of the HPs said they had not. The study also revealed that few of the HPs were very confident or extremely confident that they could screen women for GBV.

Close to one third of the HPs report GBV to legal authorities using a variety of reporting types, less than third of the HPs report to legal authorities on consent while the rest not. Very few of the HPs reported GBV to legal authorities often, and very often. Overall, the HPs reporting practices of GBV were insufficient. Statistically significant relationship was observed between respondent's attitude level on GBV and reporting practices for GBV. When asked if their institution had a written policy/ protocol on how to report GBV to legal authorities, the majority of the respondents indicated that there was none. Further, very few of the participants were very confident, or extremely confident that they could report GBV to legal authorities.

6.72: RECOMMENDATIONS

As a measure to strengthen the role of HPs in the fight against GBV, the following recommendations are suggested:

1. MoH should review and periodically disseminate updated written guidelines / protocols on GBV management to all health institutions to keep HPs abreast on current GBV management practices.
2. Institutions need to address the gaps identified in screening women for gender based violence by including in depth information on screening and reporting policies and requirements on GBV.
3. Subsequent sensitizations, seminars, workshops and trainings should be planned to all levels of HCWs to improve the management of cases of GBV.

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ANNEXES-1: STRUCTURED QUESTIONNAIRE

PART I: SOCIO-DEMOGRAPHIC FACTORS

1. Age
2. Gender A. male b. female
3. Religion A. orthodox b. protestant c. Muslim d. other
4. Marital status A. single b. married c. divorced d. widowed
5. Profession A. physician b. nurse c. midwife
6. If OBGYN resident A. Year 1 b. Year 2 c. Year 3 d. Year 4
7. Working area A. OR b. LW C. OPD d.MW e. RGOPD F. other
8. Years of experience

PART II: KNOWLEDGE QUESTIONS

A list of quotes about gender-based violence is provided below. Please indicate whether the following claims are true or false.

No		TRUE	FALSE
1	Gender based violence is one of the components of sexual violence.		
2	GBV occurs due to power imbalances that usually favor men.		
3	Domestic violence is part of GBV that occurs in a family.		
4	Sodomy (intentional anal sexual intercourse with a male) is one form of gender based violence.		
5	GBV in children is an unlawful act only if it results in physical, sexual, or psychological harm or suffering.		
6	Violence is the use of force that is based on unequal power distribution and includes actions that influence the free and voluntary decision-making of an individual.		
7	In managing any GBV survivors, the overriding priority should be the collection of all forms of evidences.		
8	Adherence to ethical codes of conduct is particularly relevant when dealing with survivors of interpersonal violence.		
9	Health facilities should be organized and equipped with optimal standards of care for GBV survivors; however, not all cases of GBV survivors should be treated as urgent.		
10	If an adult freely consented to the sexual action, the use of excessive force during the act may not be regarded as GBV upon complaint of the adult.		

PART III: ATTITUDE QUESTIONS

The following is a list of claims regarding GBV, screening, and reporting. Tick the appropriate box to indicate whether you agree, disagree, or are neutral.

No		Agree	disagree	Neutral
1	A woman is more likely to be assaulted on the street by unknown men than in her own home by her husband.			
2	GBV is very rare among women seeking health services at health institutions.			
3	Domestic violence affects all sectors of society irrespective of social, economic, cultural and religious values.			
4	Most women victims of GBV would not disclose GBV as the source of their injuries to Health Care Providers.			
5	It is mandatory for Health professionals to report identified cases of GBV to police even if the victim has not agreed or consented to reporting.			
6	Victims of GBV are required to obtain a police medical report form (medico-legal examination report form) from the police before provision of medical services (except in emergencies).			
7	It is the role and responsibility of Health professionals to enquire about gender based violence where the victim tries to conceal it.			
8	Clinical care for survivors of GBV require Health care Professionals to obtain an informed consent from victims for any notifications or referral.			
9	Sexual violence towards boys and men is not a concern in our country.			
10	Male survivors of GBV should be approached and managed the same way as female survivors.			

PRACTICE QUESTIONS: PART III

1) In your practice do you ever report GBV to legal authorities?

A. Yes B. No IF 'No', go to Question no 4

2. Below is a list of statements on options for reporting GBV to Police or any legal bodies? Indicate the statement that best describes your practice by ticking against the option (choose 1 option only)

A. I report GBV to Police even if the victim does not want or consent to reporting

B. I only report GBV if the victim has consented and wants to do so

C. I only report if the injuries are severe and victim is at risk

D. Any other (specify) _____

_____.

3. In the past year how frequent did you carry out the reporting option chosen in question number 2 above?

A. Never

B. Rarely

C. A few times

D. Often

E. Very often

4. Does your institution have a written policy (procedures and protocols) on screening?

Women for GBV?

A. Yes

B. No

c. I don't know IF 'No' or 'you don't know' skip to Question 6

5. What does the policy state about screening women for GBV? (Choose 1 option only)

A. Screening for GBV should be done as part of routine history taking for all women

Who seek medical care?

B. Screening for GBV should be done on suspicion for GBV

C. Screening for GBV should be done upon self-disclosure, if the woman voluntarily

Brings up the topic D. Any other (specify) _____

6. Does your institution have a written policy (procedures and protocol) on how to report GBV?

A. Yes B. No IF 'No' or 'you don't know', skip to Question 8

7. What does the policy state regarding reporting Gender based violence to police or legal Bodies? (Choose 1 option only)

A. Health professionals should fill in a police reporting Form even if the victim has not given consent.

B. Health professionals should only fill in a police Reporting form if the victim has consented

D. Any other (specify)_____

8. How confident are you that you can screen women for gender based violence?

A. Not at all confident B. slightly confident

C. Moderately confident D. Very confident E. extremely confident

9. How confident are you that you can report gender based violence to Police or legal Bodies?

A. Not at all confident B. slightly confident

C. Moderately confident D. Very confident E. extremely confident

Thank you for participating, you have come to the end.

