GBV AND TRAUMA-SENSITIVE HEALTH CARE IN AFGHANISTAN

A BASELINE STUDY

Medica Afghanistan
مؤسسه حمایت از زنان

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

medica mondiale

THOUSAND PLATEAUS

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PHOTOS: MEDICA AFGHANISTAN

ACRONYMS

AFGA	Afghan Family Guidance Association
AGO	Attorney General Office
AFN	Afghani (currency)
AIHRC	Afghanistan Independent Human Rights Commission
ALCS	Afghanistan Living Conditions Survey
AMA	Afghanistan Midwives Association
BiH	Bosnia and Herzegovina
BPHS	Basic Package of Health Services
CCTIC	Creating Cultures of Trauma-Informed Care
CHC	Comprehensive Health Centre
CHW	Community Health Worker
CSO	Central Statistics Organization
DHS-Data	Demographic and Health Surveys
DoWA	Department of Women's Affairs
EPHS	Essential Package of Health Services
FGD	Focus Group Discussion
FPC	Family Protection Centre
FRU	Family Response Unit
GBV	Gender-Based Violence
IPV	Intimate Partner Violence
KAP	Knowledge, Attitudes and Practice
LEVAW	Law on the Elimination of Violence Against Women
MA	Medica Afghanistan
Mm	Medica Mondiale
MoI	Ministry of Interior
MoPH	Ministry of Public Health
MoPH	Ministry of Public Health
MoWA	Ministry of Women's Affairs
NAPWA	National Action Plan for the Women of Afghanistan
OBGYN	Obstetrics and Gynaecology
NGO	Non-Government Organization
NGO	Non-Governmental Organization
NHA	National Health Accounts
NRVA	National Risk and Vulnerability Assessment
MHI	Mental Health Inventory
OOP	Out of Pocket
OPD	Outpatient Department
PSHP	Psychosocial Health Programme
RCT	Randomized Control Trial
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infection
THTP	Transitional Health Training Program
ToT	Training of Trainers
TSA	Trauma Sensitive Approach
USD	United States Dollars (currency)
VAW	Violence Against Women
WAW	Women for Afghan Women
WHO	World Health Organization

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EXECUTIVE SUMMARY

THE TRANSNATIONAL HEALTH TRAINING PROJECT (THTP) AIMS AT INCREASING ACCESS TO HEALTH CARE SERVICES FOR WOMEN AND GIRLS AFFECTED BY GBV THROUGH INTRODUCING A TRAUMA-SENSITIVE APPROACH TO CARE IN HEALTH INSTITUTIONS OF THREE PROVINCES IN AFGHANISTAN. THE PROJECT IS ALSO CONDUCTED IN COORDINATION WITH MEDICA ZENICA IN BOSNIA HERZEGOVINA (BIH). AND WILL BE IMPLEMENTED BY MEDICA AFGHANISTAN IN AFGHANISTAN AND MEDICA ZENICA IN BOSNIA HERZEGOVINA. IN AFGHANISTAN. THE PROJECT IS FUNDED BY THE SWISS DEVELOPMENT COOPERATION.

The overall goal of the project is to contribute to improving the health sector response to violence against women (VAW) and thus to the empowerment and stabilization of women survivors of sexual and gender based violence (SGBV). The objective is to increase access to healthcare services for women and girls affected by SGBV through improving the quality of care of the healthcare services at the local and national level. The project aims at sensitizing the Ministry of Public Health (MoPH) at the national and provincial level on the need for improved knowledge, skills and attitudes regarding trauma and its consequences for women and their children.

The present baseline study, commissioned to Thousand Plateaus Consultancy Services, was designed to inform medica mondiale and Medica Afghanistan about the current situation regarding the quality of care for survivors of SGBV. The baseline study collected quantitative and qualitative data through exit surveys with female patients, KAP surveys and FGDs with health staff, health facility check-lists, FGDs with women in shelters, and interviews with key stakeholders.

KEY FINDINGS

- In the exit survey with women, 7% of patients had been treated for abuse-related health concerns in the services they had received that day at the facility; 3% for injuries sustained during physical or sexual abuse; 8% for self-inflicted injuries; 7% for emotional consequences of abuse; and none for a mandated virginity exam. 12% reported that their healthcare provider had asked them questions regarding whether they were experiencing physical or sexual abuse.
- Only 4% had reported abuse to their healthcare provider where two said that their healthcare provider had encouraged them to report their abuse, and one that their healthcare provider had reported their abuse to authorities. Two had received information regarding laws that protect them from abuse from their healthcare provider. Only one woman had received information regarding physical consequences of abuse, regarding the mental and emotional consequences of abuse, and regarding supportive services available.
- 22% of patients surveyed had been treated for abuse-related health concerns, 23% for self-inflicting injuries, 7% received treatment for the emotional consequences at some point in their life.
- 28% of patients surveyed agreed with some justification for SGBV and among the patients surveyed 84% are at risk of domestic abuse.
- 81% of patients agreed that the facility is always open and staff is present during its normal operating hours; 86% of patients interviewed in the

exit survey agreed that there are female staff members available when they need to seek health services at the facility; 37% of patients disagreed that sometimes the healthcare treatment and support that health providers at the facility provide are not in line with cultural norms related to gender, religion, or society.

- 47% of patients reported that there was some type of monetary cost associated with the services they had received. Of those who reported having to pay fees, 9% paid for services, 78% for medication, and 10% for tests or laboratory fees.
- The majority of patients interviewed were Dari-speaking (95%), and services were mainly reported to be given in Dari (92%), with very few reporting receiving services in other languages. 11% of patients reported that in the past year, there had been a time when they wanted to see a doctor, nurse, or other healthcare worker but were unable to because their family member/s didn't allow them to seek treatment.
- 60% of patients surveyed agreed that if there is no female healthcare professional available, it is okay for a woman to seek treatment from a male healthcare professional. 19% agreed that if a woman is being abused by her husband, it is a private family matter and she should not seek help from public facilities.
- 45% of patients surveyed agreed that they would feel offended if a healthcare provider asked them about physical or sexual abuse. Only 55% agreed that they would feel comfortable seeking treatment at a healthcare facility if they experienced abuse from a family member and 51% agreed that they would feel comfortable seeking mental health treatment.
- The physical and emotional safety of patients and staff is low with hospitals scoring below 50% with Malalai hospital in Kabul scoring only 13%. Safety was seen as a major problem for hospital staff where patients generally feel safe at the health facilities.
- Trustworthiness, that is supported by clear information sharing practices and having policies in place that ensure services are clear, including establishing boundaries, informed consent, and clear establishment of roles and responsibilities for both clients and staff, scored between 50 and 60%, which could be interpreted as moderate level of trustworthiness. Patients felt trustworthiness as higher, which could be interpreted as lack of comparison in terms of what constitutes quality of services due to a disrupted health system till at least a decade ago.
- In terms of choice and control, the CCTIC framework looks at to what extent the program's activities and settings maximize both client and staff experiences of choice and control. Facilities in Kabul scored between 60 and 70%, with facilities in Herat and Balkh scoring around 50%. In terms of choice, on a scale from 0 to 5, on average patients rated the health services they had received a 3.72, suggesting a generally high level of perceived choice with the lowest recorded in Balkh.
- In terms of collaboration, the CCTIC framework looks at to what extent the program's activities and settings maximize collaboration and sharing of power between staff and clients, and to what extent the program's activities and settings maximize collaboration and sharing of power among staff, supervisors, and administrators. Health facilities scored low in terms of collaboration, with scores between 30 to 35% in Kabul and with even lower scores - below 20% - in Balkh and Herat. On the other hand, exit surveys with patients conclude on high collaboration in the relationship between patients and health staff.
- In terms of empowerment activities and settings prioritize both client and staff empowerment and skill-building and the extent to which staff members have the resources necessary to do their jobs well. Hospitals scored mostly over 60% with a relatively high staff and patient empowerment with the exception of Malalai hospital in Kabul, which scored only 28%. The exit surveys with patients revealed a high level of perceived empowerment of patients.
- Trauma screening practices scored low in all hospitals, with only Rabia Balkhi scoring 27% and the remaining facilities 0%. The finding is also compounded by the KAP survey with health staff, who showed varying levels of appropriate practice when working with a survivor of GBV.
- Based on the findings of the health staff KAP survey, 17 respondents (81%) reported receiving training on trauma prevalence, impact, and recovery. When asked about training specific to Creating Cultures of Trauma-Informed Care (CCTIC), the participants overall reported low levels (less than half) of training.
- Health workers' attitudes relating to SGBV are of concern and these mostly did not report appropriate attitudes.
- Four health workers felt that preventing, detecting and managing GBV is not part of the work of a health provider (19%) and three that violence against women is a family matter and not a matter of public health policy (15%). Eight (38%) believe that

health service providers do not have time to inquire about GBV. Notable is the discomfort in health providers for addressing IPV as almost half do not feel comfortable discussing IPV or sexual violence with patients as over half (11 respondents, 52%) think that asking patients about IPV could offend them.

- Other worrisome responses provided from health workers were related to knowledge of the prevalence of SGBV in Afghanistan, consequences of GBV specifically related to HIV/AIDS, and risk factors related to women experiencing and reporting violence. Only 52% of surveyed health workers accurately identified that Afghanistan has specific laws on GBV/IPV.
- Health workers demonstrated mixed competency in terms of practice related to GBV. There were mixed findings in terms of how providers should assess risks of GBV, with the majority of respondents (95%) indicating they should ask the client if she has ever been hurt, 86% asking if she is currently in danger, and concerning is that 81% indicated they could ask what she may have done to be abused as to avoid it in the future. However, only around half of the respondents indicated they could assess risk by asking the woman if violence has increased in the past year (52%) and asking if she worries about the safety of children (62%).
- Health workers scored high in terms of compassion satisfaction, which is related to satisfaction of one's ability to be an effective caregiver in their job.

RECOMMENDATIONS:

- Considering the limited knowledge that health providers showed in screening related to trauma, additional trainings of health providers are needed.
- Health facilities could consider implementing targeted training, recognizing that specific cadres or characteristics of health workers may require more tailored training (i.e. staff who have worked for many years may need more attitudes and practice training).
- Ensure appropriate length of time for and between refresher trainings by implementing minimum standards.
- Ensure that trainings are not just targeting one cadre of health workers, or health workers that have already been trained. As the findings showed, many of those, who were trained had a refresher but less than half were ever trained in the first place.
- Trainings should incorporate a stronger mental health component, ensuring not just knowledge of mental health but working to change perceptions and attitudes.
- More specifically, knowledge on suicide and drug abuse is needed among health practitioners as these are related to GBV and are generally high in Afghanistan.
- Trainings need to evaluate their holistic teachings to SGBV, as many respondents had concerning responses to the KAP survey. Of grave concern is the reported attitudes towards SGBV of health workers. Specific topics of concern are sexual violence (rape), mental health, and family (husband-wife) dynamics. Trainings need to ensure they are targeting social perceptions of SGBV in order to ensure systemic changes in practices and attitudes relating to SGBV, as well as knowledge on proper procedures.
- Trainings should also include referrals to better cater for the needs of GBV survivors.
- Issues of sustainability for the THTP programme need to be carefully considered, especially in relation to staff turn-over. This may include ensuring the following occur: detailed records of staff trained and their refreshers, with frequent follow-ups to see if they have switched facilities; consideration of 'training champion' model within each facility, where one staff member is responsible for the monitoring of other staff; and ensuring that training and activities are collaborated with, and supported by, the MoPH.
- Working with survivors of SGBV, especially in resource constrained contexts, can take a toll on health workers and other support staff. While the findings from this survey indicate that health workers are reporting positive psychosocial wellbeing in the workplace, this may change with increased training and/or practice in the field of SGBV. It is recommended that the THTP programme regularly assesses their health workers' wellbeing to ensure individuals are not experiencing negative consequences, which may result in burn-out (health worker attrition and turn-over), decreased performance, and mental health issues for health workers.
- Mainstreaming GBV screening and treatment practices into regular health worker duties should be given attention in order to ensure sustainability of programme and that women are receiving the appropriate and supportive care.
- Programmes targeting potential service users that work to educate them on their rights and the procedure of disclosure and treatment may work to

decrease any misconceptions and increase the acceptability of services.

- Ensure health worker practices are aligned and sensitive to women's wants and needs. This should include a needs assessment for women, and training for health workers that focus on understanding patient rights.
- Implementing training programmes for health workers without running complementary initiatives that work to target barriers to SGBV service utilization fails to consider the complex nature of SGBV and the comprehensive, systems thinking approaches required to address it. Partnering with other organizations that work in these areas, ensuring harmonization as opposed to duplication of services, may help to address these concerns in a resource-responsible manner.
- While having control groups was later on revealed as not being a feasible approach due to the lack of hospitals that would be appropriate as control groups in terms of size and scope, the mid-term evaluation and/or outcome/impact evaluation should rather focus on collecting data from a representative sample of health professionals from the treatment hospitals only, especially considering the fact that the approximate number of health staff is now known (and included in the present report). In order to determine the attribution and/or contribution of Medica Afghanistan's programme, questions on the practitioner's change in knowledge and the main institution behind the change should be also administered to health personnel. Other tools adopted for the baseline, such as the facility check-list, records related to GBV, and the exit survey, should be also administered for the evaluation. The exit survey should also include additional questions exploring the perceptions of changes in terms of trauma and SGBV – related services.
- Pre and post training tests should also include some scenarios as these better measure on how knowledge gained during trainings could be employed and disclose whether ideas were simply grasped or whether a change in attitudes and practices occurred.

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INTRODUCTION

1.1 ABOUT MEDICA AFGHANISTAN

medica mondiale began its work in Afghanistan in April 2002 right after the collapse of the Taliban regime and has been building up the program 'medica mondiale Afghanistan' since then. In December 2010, medica mondiale Afghanistan registered as the Afghan NGO 'Medica Afghanistan' with the Afghan Ministry of Economy and now operates as a self-contained national organization, run by Afghan women for Afghan women. medica mondiale continues to support Medica Afghanistan on the level of capacity building, financial support and project cooperation.

Medica Afghanistan is a non-profit, non-governmental Afghan women's organization working towards the elimination of violence against women through the provision of legal aid, psychosocial support, capacity building and advocacy. It seeks to improve the quality of women's lives through direct psychosocial and legal services, while also raising awareness and building capacity in the fields of health, education, and law. Medica Afghanistan is headquartered in Kabul with sub-offices in Mazar-e-Sharif and Herat.

Medica Afghanistan provides a range of different services for women and girls, including psychosocial counselling, legal representation, family mediation, social support, literacy classes, and referrals for health care, economic opportunities, and other appropriate services as needed. Medica Afghanistan also builds capacity in the fields of health, education and law and it seeks to raise awareness of women's rights and sensitize all those who deal with women at risk, regardless of gender. Medica Afghanistan offers advanced professional training to male and female lawyers, doctors, social workers, religious leaders, and police personnel on the multiple aspects and consequences of VAW. Medica Afghanistan advocates publicly and lobbies politically for women's rights with the aim of bringing long-term, sustainable change for women and girls within a peaceful Afghanistan.

1.2 THE TRANSITIONAL HEALTH TRAINING PROJECT (THTP)

BACKGROUND

MA has been offering certified courses to medical professionals and counsellors working with traumatized women and girls. A training manual titled "Training manual for health professionals: a trauma-sensitive approach (TSA)" was developed in 2011, which was designed to improve the professional skills of health professionals both within and outside of hospitals for working with patients who are suffering from the psychological and physical consequences of violence, and also to offer them more options for dealing with violence and trauma. These skills and knowledge were

meant to enable medical professionals to reduce the danger of re-traumatization, implement services with awareness of professional boundaries, increase referrals for necessary services, increase empathy for patients, and to exercise effective self care practices.

The MA PSHP team also networks with multiple stakeholders including government, national, and international civil society organizations. The MA PSHP program and its counsellors are certified by MoPH, and MA has regular coordination with MoPH and relevant stakeholders in advocacy and work on policy and programming including the National Mental Health Strategy. In addition to training activities, MA also undertakes case supervision and monitoring, and makes referrals for women and girls to needed services. These networking activities have made it possible to build up excellent relations and exchange with hospitals in Kabul, Mazar-e Sharif, and Herat, particularly the facilities at which MA is currently providing PSHP services.

PROJECT APPROACH

The Transnational Health Training Project (THTP) aims at increasing access to health care services for women and girls affected by GBV through introducing a trauma-sensitive approach to care in health institutions of three Provinces in Afghanistan. The project is also conducted in coordination with Medica Zenica in Bosnia Herzegovina (BiH), and will be implemented by Medica Afghanistan in Afghanistan and Medica Zenica in Bosnia Herzegovina. In Afghanistan, the project in funded by the Swiss Development Cooperation; in BiH, it is partly funded by the German Federal Foreign Office and private donators.

PLANNED PARTICIPANTS IN AFGHANISTAN

According to the project description, the target population of the program in Afghanistan includes:

- 20 health professionals of the public hospital in Kabul, Mazar and Herat through training of trainers (target group a1)
- at least 80 health professionals working in the public hospitals of Kabul, Mazar and Herat (target group a2)
- 6.000 female clients of health facilities who benefit from an increased quality of care by health professionals (target group a3)
- 10 MA staff (refresher training)
- TSA kick-off training for hospital management and MOPH mental health taskforce

Key indirect participants targeted by the program include at least 13,000 family members, including children, of GBV survivors (in both Afghanistan and BiH).

PROJECT GOAL AND PLANNED OUTCOMES

The overall goal of the project is to contribute to improving the health sector response to violence against women (VAW) and thus to the empowerment and stabilization of women survivors of sexual and gender based violence (SGBV). The objective is to increase access to healthcare services for women and girls affected by SGBV through improving the quality of care of the healthcare services at the local and national level in Afghanistan. The project aims at sensitizing the Ministry of Public Health (MoPH) at the national and provincial level on the need for improved knowledge, skills and attitudes regarding trauma and its consequences for women and their children. Through comprehensive results monitoring in the project area data will be collected throughout the project (2016-2018) that will be used for policy dialogue and advocacy, and the national health authorities will be aware of the need for a trauma-sensitive approach in health services. For the results chain, please see Annex A.

1.3 STRUCTURE OF THE REPORT

The present report outlines the context related SGBV and health care in Afghanistan, followed by the methodology, methods, sampling, and study limitations. The findings section outlines the SGBV – related health provision, explores whether the health facilities are trauma informed, and health personnel's knowledge, attitudes, and practices related to SGBV.

Expected Results	Activities (Afghanistan Only)
1: Health professionals in BiH and Afghanistan are able to provide training in trauma-sensitive approach to health care staff of different professions.	• To train 20 health professionals as future trainers from Kabul, Balkh and Herat provinces in training unit(s) of 3 days. • To conduct refresher training for MA staff on replicability of TSA.
2: (Related to BiH)	NA
3: 80 health professionals in Afghanistan provide trauma-sensitive treatment and care for women who survived SGBV, according to national guidelines and protocols.	• To develop training curricula, including a workshop between MA and mm • TSA kick-off training for hospital management and MoPH Mental Health Task Force • To train 26 female health professionals (doctors, midwives and Nurses) from the public hospital in Herat in a trauma-sensitive approach. • To train 26 female health professionals (doctors, midwife and Nurses) from the public hospital in Mazar in TSA (second group). • To train 28 health staff from 3 hospitals in Kabul in a trauma-sensitive approach. • To train 20 previously trained health professionals in a trauma-sensitive approach (refresher training). • To conduct 5 peer-group meetings between the training modules among trainees • To develop a training manual for trainers in Dari and English.
4: The initial situation as well as outcome and effects of the trainings (incl. institutional barriers) are known and will be used for advocacy at the national level as well as for future project design.	• To adapt the data base for the use of this project • To conduct baseline study in Afghanistan to assess the quality of care related to GBV in the project areas • To develop monitoring plan and instruments (pre- and post- tests for project area and control group). • To conduct pre- and post-tests with target groups (assessing knowledge and attitude towards SGBV) •To conduct an external evaluation at the end of the project
5: Good practices are shared at the national and cross-regional level with a view to up scaling the project to other countries/regions	• To conduct regular meetings with national MoPH and inter-sectorial working groups to inform and discuss data and insights gained through the project. • To conduct national workshops to share experiences and good practices with government and research institutions as well as other NGOs and representatives from other (non-project) regions. • To conduct an international conference with representatives from Afghanistan, BiH and additional countries with a view to upscale the project to other cantons / provinces of Afghanistan and BiH and potentially other countries.
6: National and cantonal health authorities are aware of the need for a trauma- sensitive approach in health services. This is reflected in national policy guidelines.	• To sign protocols with MoPH in Afghanistan to assure that the trainings and training manuals are approved and eventually integrated in curricula of medical faculties. • To submit recommendations to MoPH based on the database, project results and evaluation. • To conduct awareness raising activities (through radio, newspaper)

GBV AND HEALTH-CARE IN AFGHANISTAN

2.1 AFGHANISTAN GBV TREATMENT PROTOCOL AND STANDARD OPERATING PROCEDURES (SOPS)

The Gender-Based Violence Treatment Protocol for Healthcare Providers in Afghanistan[1] was developed through cooperation between MoPH, WHO, and UN Women in 2014, based on the WHO global guidelines launched in 2013. Afghanistan was the first country to develop the guidelines into a country-specific protocol.[2] It includes general sections on definitions, care for GBV survivors, and general considerations for the care of GBV survivors including priorities, the legal framework (the Law on the Elimination of Violence Against Women (LEVAW)), setting, organization of patient-flow, confidentiality, security, provision of rape treatment kits, and documenting and reporting. It also includes a section on survivor-cantered care, which includes attitude, effective listening, and empowerment.

It includes specific operating procedures for the primary survey for life-threatening injuries, identification (conditions associated with GBV for men, women and children, asking about GBV, and response when patients disclose violence), first-line support, taking the history, medico-legal evidence, physical and genital examination, management of wounds, management of burns, and clinical management of rape. It also includes a section covering care for the healthcare provider.

MoPH also developed the Standard Operating Procedures (SOPs) for Healthcare Sector Response to Gender-Based Violence in 2013 with technical support from UNFPA. This is meant to clarify referral procedures and guidelines for healthcare providers as part of the Implementation Package of the Multiagency Coordination Model.[3] The procedures described in the document present the delineation of specific roles and responsibilities for GBV prevention and response including identification, documentation, evidence collection and referral of GBV cases within health sector. The procedures include elements securing coordination with other actors involved in multi-agency response to GBV. Thus safety and ethical considerations as well as coordination present a cross-cutting element incorporated in various types of procedures. The SOPs cover: detection and disclosure of GBV; general rules of conducting examinations in terms of protecting GBV victim's dignity, security and confidentiality; consent and information sharing; providing medical assistance to GBV victims; evidence collection; referrals; documentation of examination results and medical history; information sharing; and ethical and safety considerations. They are also accompanied by a Health Service Provider Data Collection Form, Consent Form, sample medical record format and check lists featuring the clinical conditions that should alert healthcare provider to the possibility of GBV.

1 MoPH, WHO, "UN Women, GBV Treatment Protocol", 2014, http://applications.emro.who.int/dsaf/EMROPUB_2015_EN_1882.pdf?ua=1

2 Ibid.

3 UNFPA, "SOP Health Sector Response to GBV, n. g., https://www.humanitarianresponse.info/system/files/documents/files/SOP%20Final.pdf

The treatment protocol covers survivor-cantered care as a standard of care to ensure that the patient/survivor is at the centre of care. It covers attitude—directing staff to show respect, not to judge, guarantee confidentiality, be empathic, show patience, and adjust their attitude according to the characteristics of the survivor. It also addresses effective listening in order to explore the survivor's complaints, to understand the individual, to ensure shared decision-making and to enhance the patient-healthcare provider relationship. This section instructs healthcare providers on how to attend to body language, listen attentively and actively, asking questions, accepting physical and emotional reactions, and specific considerations for children. Lastly, it addresses empowerment in terms of maximizing patient choice, involving her/him in or giving her/him more control over decisions the interventions or forms of care that she/he may receive, in order to empower and enable her/him to participate more fully in her/his healthcare.

Though the directives on survivor-cantered care and other areas of the treatment protocols and SOPs cover aspects of trauma-sensitive service provision, there are no specific directives for healthcare providers on trauma-informed care. Additionally, though the treatment protocol and SOPs include mental and psychological symptoms associated with SGBV, there is minimal reference to the need for referral for mental health problems for SGBV survivors. The guidelines mention that referrals can be made, but in the context of a lack of understanding regarding mental health and counselling services and absence of qualified psychosocial service providers, they do not adequately explain these, and further guidance for healthcare providers regarding psychosocial support and referral for mental health treatment related to SGBV is likely needed.

TRAINING FOR HEALTH PROFESSIONALS AND MONITORING THE IMPLEMENTATION OF THE GBV TREATMENT PROTOCOL

A comprehensive training package has been developed by WHO/UNFPA to train healthcare providers in using the GBV treatment protocol.[4] Between 2015 and 2020, 6,500 health care providers[5] will be trained by WHO in the use of the GBV treatment protocol to provide services to survivors of GBV, and health facilities will be equipped to provide GBV services. The GBV protocol and training modules will be integrated into existing medical curricula, and information materials (e.g. IEC materials and job-aids, protocol and clinical handbook) will be distributed to health facilities and to communities.[6]

According to a call for proposals issued by WHO, a two-year project was planned to be initiated in October 2015 to provided training to healthcare providers on the GBV Treatment Protocol in Badakhshan, Balkh, Bamyan, Herat, Kabul, Nangarhar, and Parwan provinces, in the first of three phases of the GBV program being implemented by the WHO with support from USAID. This project would include a training of trainers (ToT) for master trainers on the protocol, and the subsequent rollout of the training to the provinces by the master trainers and the training of 2,880 healthcare providers (doctors, nurses, and midwives) and over 80 health managers utilizing the training materials that have been developed, translated, and printed by WHO/MoPH. Each training would consist of five-day training workshops covering the contents of the GBV Treatment Protocol, including how to administer survivor-cantered care, conducting primary survey, the correct procedures for the identification of GBV, medical history taking, conducting physical and genital examinations, managing wounds, burns and rape cases and basic psychosocial counselling skills and referrals. The project would also provide on-the-job mentoring and support for facilities and healthcare providers who have received training.

The partner organization selected for the project would also ensure close monitoring of healthcare provider trainings and performance of facilities in terms of providing standard and good quality services to GBV survivors, based on specific criteria agreed with WHO and MOPH according to the GBV Treatment Protocol.[7] At the end of the first phase of the programme in 2017, an evaluation will be carried out to gauge lessons learned and areas for improvement for the second and third phase.[8] The evaluation will not only focus on individual trainees and the capacities of healthcare providers but it will adopt a systemic approach to assess how well systems have been modified to enable high- quality provision of GBV services. The assessment will look into whether services are being provided, procurement systems and referral mechanisms are in place and operational procedures and policies for safety, confidentiality, privacy as well as supervisory, mentoring and supportive efforts are in place and implemented. The assessment will also look into whether service uptake has increased. The evaluation following phase one will also

4 WHO, Addressing Violence against Women in Afghanistan: The health system response, N. G. https://extranet.who.int/iris/restricted/bitstream/10665/201704/1/WHO_RHR_15.26_eng.pdf

5 According to the 2014-15 Statistical yearbook from CSO, there are 16,436 health associate professionals and 9,954 doctors.

6 WHO, Addressing Violence against Women in Afghanistan: The health system response, N. G.

7 MoPH, WHO, "UN Women, GBV Treatment Protocol", 2014

8 USAID, Program contribution Agreement, N. G., https://www.usaid.gov/sites/default/files/documents/1871/AID-306-IO-15-00005%20WHO%20GBV.pdf

include a KAP study to measure any improvements that have occurred since the first KAP study was conducted in six provinces by UN Women in 2013.[9]

A GBV information database is currently being developed by MoPH.[10] Previously, different projects have supported the collection of data on GBV. In 2012, the BSC asked healthcare providers questions on their sensitivity and skills to treat a woman who has experienced GBV. MoWA has also established a GBV Information Management System database with support from UN Women, and GBV survivors' cases from various entry points (MoWA, AIHRC, MoI) is meant to be documented in this system, though it is unclear to what extent this is coordinated with MoPH.[11] UN Women has already supported the MoWA to establish an off-line database for VAW cases nationwide, and the database was recently upgraded to an online web-based system under the overall umbrella of NAPWA database. This system is capable of tracking the number of VAW referrals, along with the number of subsequent registered cases and any other actions taken, including prosecutions and related judicial outcomes.[12] UN Women, UNFPA, and WHO are also developing a GBV referral system to link services and providers to GBV survivors.[13]

FAMILY PROTECTION CENTRES (FPCS)

Recognizing that survivors are often unable to speak of their ordeal without repercussions, MoPH, UNFPA and partners chose hospitals as sites for Family Protection Centres (FPCs). These centres are designed to offer survivors basic services, including psychosocial and medical support, help in collecting evidence, information, and referrals. Since they are located inside hospitals, they are likely more accessible entry points for survivors of VAW, as women can access them with less risk from male family members. FPCs were established in 2013 with support from UNFPA in Kabul and Nangarhar provinces, which were followed by the establishment of four more centres in Herat, Balkh, Bamyan, and Baghlan provinces. In the first year, these facilities supported over 450 survivors of SGBV, and in 2015,[14] FPCs registered over 1,900 cases of VAW.[15]

In 2015 to 2019 programming, UNFPA plans to assess support for the six existing FPCs and expand to 12 provinces. UNFPA is also training health workers from target provinces on integration of GBV prevention and response into maternal health services such as family health houses, the Basic Package of Health Services (BPHS), Essential Package of Health Services (EPHS), and in community health programming.[16] UNFPA is also supporting the training of health service providers to address the psychosocial needs of survivors. Since 2010, UNFPA has supported training for more than 600 health service providers in psychosocial counselling skills and since 2013, counselling has been a component of the services offered by FPCs to attend gender-based violence survivors.[17]

2.2 5A MODEL

Access to health care is a concept often referred to and which has been the subject of many discussions. As conceived by Penchansky and Thomas, access reflects the fit between characteristics and expectations of the providers and the clients. They grouped these characteristics into five As of access to health care: affordability, availability, accessibility, accommodation (or adequacy), and acceptability. Affordability is determined by how the provider's charges relate to the client's ability and willingness to pay for services. Availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. Accessibility refers to geographic accessibility, which is determined by how easily the client can physically reach the provider's location. Accommodation or adequacy reflects the extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client. Of greatest concern are hours of operation, how telephone communications are handled, and the client's ability to receive care without prior appointments. And finally, acceptability captures the extent to which the client is comfortable with the more immutable characteristics of the provider, and vice versa. These characteristics include the age, sex, social class, and ethnicity of the provider (and

9 Ibid.

10 WHO, "Addressing Violence against Women in Afghanistan: The health system response", N. G., https://extranet.who.int/iris/restricted/bitstream/10665/201704/1/WHO_RHR_15.26_eng.pdf

11 Laili IIIrani, "Gender Data inside MoPH", Health Policy Project, 2013, http://www.healthpolicyproject.com/pubs/852_IraniAfghanistanMOPHLandscapeAnalysiForKM.pdf

12 UNDP, "National Data Analyst, Job Posting", N. G., http://jobs.undp.org/cj_view_job.cfm?cur_job_id=58743

13 UN Women, "UN women in Afghanistan", N. G., http://www2.unwomen.org/~/media/headquarters/attachments/sections/executive%20board/2015/as%2015/un-women%20afghanistan%20background%20one%20pager-pdf.pdf?v=1&d=20150624T220306

14 UNFPA, "Involving the Health Sector", 2013, http://countryoffice.unfpa.org/afghanistan/2015/02/15/11469/involving_the_health_sector/

15 UNFPA, "New Collaboration Launched to Provide Much Needed Support to Women and Girls, ho Have Survuved Violent Ataack", 2015, http://countryoffice.unfpa.org/afghanistan/2015/12/09/13247/new_collaboration_launched_to_provide_much_needed_support_to_women_and_girls_who_have_survived_violent_attacks/

16 UNFPA, Untitled, 2015, http://countryoffice.unfpa.org/afghanistan/drive/UNFPA-GOIRA-CPAP-2015-2019-EN.pdf

17 UNFPA, "Involving the Health Sector", 2013.

of the client), as well as the diagnosis and type of coverage of the client.[18] In the present section the 5A model, which is adapted to the Afghan context, is used to assess access to health care for women and wherever data is available access specifically for survivors of SGBV.

AVAILABILITY

Especially for women, availability of health facilities is also limited by the sex of staff members. Nationally, 45% of Afghans have access to female community health workers (CHWs). 56% (90% in urban areas and 43% in rural areas) have access to female doctors in a public clinic and 65% to female nurses (93% in urban areas and 55% in rural areas). 90% can access a female doctor at the district/provincial level (99.6% in urban areas and 86% in rural areas) and 89% a female nurse (99.6% in urban areas and 86% in rural areas).[19] Though still a considerable limitation for women, it is important to note that according to data from the Central Statistics Organization (CSO), there have been improvements since the 2007-08 National Risk and Vulnerability Assessment (NRVA, national survey preceding the ALCS). Female public clinic staff has increased by more than 20% over this period, and the increase in female CHWS in health posts is estimated at 48%.[20] Another study further confirmed that the lack of female health care workers and separate waiting areas at health facilities are barriers for women, which echoed findings of previous studies in Afghanistan and was reported by both men and women.[21] Additionally, the majority of women working in health care delivery in Afghanistan are working in the area of midwifery with training on prenatal and antenatal care.[22]

The World Health Organization (WHO) carried out a health facility readiness assessment in 2015 in seven provinces of Afghanistan focusing on existing practices, knowledge and attitudes, challenges, institutional framework and infrastructural readiness. A total of 280 health facilities were surveyed, and in-depth interviews were conducted with 770 healthcare providers and 1300 female clients, the report of which is still forthcoming.[23] This assessment found that only 10% of health facilities are well-prepared to address GBV. Only a quarter of the 280 health facilities had private examination rooms, less than half had emergency contraceptives available, and only 2% of facilities had a written protocol for providing care to survivors of GBV.[24] In a 2013 KAP survey conducted by UN Women among health facility staff in six provinces, on average 22 women had visited health facilities as survivors of SGBV in the month prior to the survey, and most were reported in CHCs followed by district hospitals.[25]

Even when health services are available, there are considerable institutional barriers that compromise the availability of health services for SGBV. In the 2013 KAP survey, health professionals were asked about the barriers that make it difficult to ask women about GBV. 74% mentioned cultural barriers that prevent them from asking about GBV from patients; 69% mentioned a lack of referral facilities in the province for GBV survivors or having little or no options for referral; 67% reported that they give more emphasis to other health issues; 66% reported not having enough training to handle such issues; 57% a lack of space in the clinic to ensure the privacy of women; 46% of health professionals mentioned time limitations; and 28% do not ask about GBV to avoid police proceedings.[26] 55% of health professionals also mentioned insecurity and fear of the husband and family as a barrier to providing SGBV treatment. 13% also mentioned illiteracy and lack of awareness, and 9% that the victim is usually accompanied by family members and this prevents them from reporting GBV.[27]

Availability of services related to SGBV is also related to the infrastructure and supplies available at health facilities. 74% of health personnel in the 2013 KAP survey reported that there is visual privacy in their health facility, and 71% reported having auditory privacy. 84% of health facilities had pregnancy testing kits, less than 10% reported that there is a protocol for the administration of emergency contraception, and only a quarter of facilities had protocols for STI testing and prophylaxis. Only 13% of respondents reported that their facility has a directory of local organizations offering services to survivors of SGBV and

18 Leon Wyszewianski and Catherine G McLaughlin, Health Serv Res. 2002 Dec; 37(6): 1441–1443. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1464050/#b6

19 CSO, "Afghanistan Living Conditions Survey 2013-14, 2015, http://cso.gov.af/Content/files/ALCS%202013-14%20Main%20Report%20-%20English%20-%2020151221.pdf

20 CSO, "Afghanistan Living Conditions Survey 2013-14, 2015.

21 WHO, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery", 2013, http://applications.emro.who.int/dsaf/EMROPUB_2013_EN_1585.pdf?ua=1

22 WHO, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery", 2013

23 WHO, Addressing Violence against Women in Afghanistan: The health system response, N. G.

24 Ibid.

25 Dr. Abdul Rasheed and Mr. Mokhlesur Rehman, "Assessment of Knowledge, Attitude and Practices (KAP) of Health Personnel on GBV Case Management in six provinces (Badakhshan, Balkh, Bamyan, Herat, Nangarhar, and Parwan provinces," UN Women and Youth Health and Development Organization (YHDO), 2013.

26 Dr. Abdul Rasheed and Mr. Mokhlesur Rehman, "Assessment of Knowledge, Attitude and Practices (KAP) of Health Personnel on GBV Case Management," 2013.

27 Ibid.

only 10% have a mechanism in place to follow-up the referral cases in the facility. Only 14% of facilities have a written policy on sexual harassment available within the health facility.[28]

Though mental health services have been incorporated into the Basic Package of Health Services (BPHS) and Essential Package of Health Services (EPHS), it has not been fully integrated at the delivery level because of financial and human resource constraints. Lack of human resources (psychiatrists, psychiatric nurses, psychologists and social workers) is a big challenge for mental health care service delivery in the country.[29] According to 2011 data, only 182 people out of every 100,000 were treated in mental health facilities, and only 29% were women.[30] In a 2013 WHO report, healthcare providers also reported insufficient training and medicines for delivering quality mental health services.[31] According to one report from the World Bank, in 2011 there were only two internationally recognized psychologists in Afghanistan, neither of which were practicing,[32] though another report cited 42 psychologists in the entire country.[33] Only 44% of respondents in the 2013 KAP survey reported that psychological support services are available in their health facility.

ACCESSIBILITY

There are a number of factors influencing the accessibility of healthcare services in Afghanistan. Health literacy, or the ability to identify symptoms and necessary responses, is moderate,[34] compounded by limited access to information and knowledge and widespread illiteracy, particularly among women, where only 19% of women aged 15 years and older can read and write.[35] However, health actions have been found to be less certain and less timely for symptoms of hopelessness or sadness.[36]

Even when symptoms are identified, the patient needs time away from work or care and domestic responsibilities, transportation, and sufficient funds to cover the costs in order to actually access services.[37] According to the most recent Afghanistan Living Conditions Survey (ALCS) covering 2013-14, 80% of Afghans (99% in urban areas and 77% in rural areas) can access a district or provincial hospital within two hours, 90% (100% in urban areas and 88% in rural areas) a public clinic within the same timeframe, and 90% (only relevant in rural areas) can access a health post in less than two hours. On average, accessing a health post would cost the patient approximately 102 AFN (1.5 USD), a public clinic 143 AFN (2.07 USD), and a district or provincial hospital 277 AFN (4.02 USD) only in transportation costs.[38] The same study found that for rural women, the distance to a health facility was considered as important of a factor as the costs involved for about 35% of women. Overall, for 28% of women distance is the primary reason for not seeking treatment for health problems.

AFFORDABILITY

It is important to note that though public health services are meant to be provided free of charge by law and should be fully subsidized by the government with support of international donors, the 2011-12 National Health Accounts (NHA) estimated that the out-of-pocket (OOP) burden of healthcare is around 73.3% of healthcare costs in Afghanistan in the form of direct payments made at the point of service delivery.[39] The largest patient of OOP funds was retail sale and other suppliers of medical goods (35%), followed by outpatient care services including both outpatient care services and medical and diagnostic laboratories (30%), hospitals (22%), and other ancillary costs related to their healthcare such as transportation (13%).[40]

In urban areas, 55% cited the costs involved with healthcare as the most important reason they would not seek care. Overall, for 39% of women expenses for treatment,

28 Ibid.

29 WHO, "Afghanistan Mental Health", N. G., http://www.emro.who.int/afg/programmes/mental-health.html

30 WHO, "Afghanistan: Mental Health Atlas 2011," Department of Mental Health and Substance Abuse, World Health Organization, 2011, h p://www.who.int/men- tal_health/evidence/atlas/pro les/afg_mh_pro le.pdf.

31 WHO, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery," World Health Organization, 2013.

32 Ghulam Dastagir Sayed, "Mental Health in Afghanistan," 2011.

33 CW4W, "Women & Mental Health in Afghanistan," Canadian Women for Women in Afghanistan, n.g.

34 WHO, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery," World Health Organization, 2013.

35 CSO, "Afghanistan Living Conditions Survey (ALCS) 2013-14", 2015.

36 WHO, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery," World Health Organization, 2013.

37 CSO, "Afghanistan Living Conditions Survey (ALCS) 2013-14", 2015.

38 Ibid.
olent Ataack"ue to a disrupted italy 2013-14, 2015, port to Women and Girls, ho Have Survuved Violent Ataack"ue to a disrupted

39 MoPH, "Afghanistan National Health Accounts with Subaccounts for Reproductive Health 2011-2012," Ministry of Public Health, Islamic Republic of Afghanistan, October 2013, http://www.healthpolicyproject.com/pubs/262_AfghanistanNHAReportFINAL.pdf.

40 Ibid.

travel, and other health-related costs are the primary reason for not seeking treatment for health problems. This should be taken in context of approximately 39% of the Afghan population living below the poverty line, where approximately two out of five Afghans are unable to meet the minimum consumption levels considered necessary to satisfy basic food and non-food needs.[41] In the 2015 Survey of the Afghan People, the average monthly household income reported was 11,214 AFN (175 USD), with considerable variance between urban (15,980 AFN or 246 USD) and rural areas (9,672 AFN or 150 USD).[42]

ACCEPTABILITY

In Afghanistan, for health-related decision-making, the findings of a 2013 WHO study were unanimous that women cannot take independent decisions on their own health and often need accompaniment for seeking health services. The heads of households (most commonly men) make these decisions for women and this inhibits their timely access to health care services. Delays are further incurred when women need a chaperone once permission is granted, and many studies have consistently found that restrictions on women's mobility and autonomy delay and negatively impact their access to health services.[43] Though there are no findings specifically related to SGBV, it can be reasonably assumed that this is an even larger barrier for women when abuse is involved.

The 2013-14 ALCS asked about care seeking behaviour among women, though not specifically related to SGBV. 43% of women over the age of 14 reported that they had been sick or injured in the last 30 days before the survey, and among those who had been sick or injured 26% had not sought medical treatment, with little differences between women in urban and rural areas. The reasons cited for not seeking care were most commonly that the health problem was not serious enough to seek help (23% as primary reason and 2.6% as secondary)). Other reasons included having no one to accompany them (2.3% as primary reason and 6% as secondary), security concerns (2.0% as primary reason and 4.5% as secondary), no female medical personnel (1.8% as primary reason and 2.2% as secondary), traditional constraints (1.3% as primary reason and 1.1% as secondary), or the husband and family not allowing treatment (0.9% as primary reason and 1.7% as secondary).[44]

Acceptability can be an even bigger issue for women seeking healthcare services related to SGBV. Nearly 3 out of 4 health professionals surveyed in the 2013 KAP survey said that cultural barriers would prevent them from asking patients about SGBV.[45] Additionally, 26% said that victims are unwilling to disclose family issues in public and treat it as a shameful act, which is a barrier in terms of asking about GBV related issues.[46] 66% of health professionals felt that the majority of GBV victims would deny abuse if they were asked about it, 55% of health professionals agreed that they feel uncomfortable in asking about GBV-related issues to patients, and 55% agreed that women would feel offended if they were asked about GBV. Perhaps most concerning, 74% of health professionals felt that some women are to blame for GBV because of their inappropriate behaviour.[47] However, the survey also found evidence of perceived acceptability in the provision of GBV-related services in the health sector. 70% agreed that health professionals should ask their female clients about GBV, and 76% agreed that it is the responsibility of health professionals to ask patients about GBV.

Regarding mental health and psychosocial services, the stigmatization associated socially with mental health disorders is the greatest barrier for addressing this important global health issue. The stigma and violations of human rights is not only directed towards people with mental, neurological and substance use disorders, but by extension it affects the mental health care providers in the formal and informal sectors further compounding the problem. Mental health is misunderstood by society and the donor community alike. Not many donors allocate funds for mental health projects. Often mental health is not part of health programming budgets. The avoidance of mental health issues does more harm to societies than investing into proper care.[48] A 2013 WHO report found that there was a perception that basic health units did not have mental health care services and depression could be treated with home remedies,[49] and treating mental illness through religious or traditional means is still widespread practice.[50]

41 CSO, "Afghanistan Living Conditions Survey (ALCS) 2013-14", 2015.

42 "Survey of the Afghan People 2015," The Asia Foundation, http://asiafoundation.org/where-we-work/afghanistan/survey/.

43 WHO, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery," World Health Organization, 2013.

44 CSO, "Afghanistan Living Conditions Survey 2013-14"

45 Dr. Abdul Rasheed and Mr. Mokhlesur Rehman, "Assessment of Knowledge, Attitude and Practices (KAP) of Health Personnel on GBV Case Management," 2013.

46 Ibid.

47 Ibid.

48 WHO, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery," World Health Organization, 2013.

49 Ibid.

50 Sue Engel Rasmussen, "Afghanistan tackles hidden mental health epidemic," The Guardian, 2 September 2015.

ADEQUACY

In the 2015 Survey of the Afghan People, 10% of Afghans cited healthcare as one of the two biggest problems in their local area. When asked about the quality of health-related goods and services in their area, 49% of Afghans were satisfied with clinics and hospitals in their area (64% in urban areas and 44% in rural areas), and 42% with medicine (55% in urban areas and 38% in rural areas). In a 2013 study, for women in Afghanistan, factors that influenced their positive or negative impressions of health services included respectful health provider services, and confidence in trust, privacy and confidentiality. Both men and women in the gender assessment perceived unfriendly behaviour on the part of health providers, although this sentiment was expressed more often by women. In confirmation, the Balanced Scorecard 2008 noted provider–patient communication as one area that continued to score low and needed improvement. Findings furthermore showed that providers often did not adequately discuss with patients their conditions and treatment in the consultation.[51]

Health care workers in the gender assessment overwhelmingly reported low capacity and comfort levels when treating patients on gender-sensitive issues such as physical and sexual violence, mental health or child neglect. Only 16%–20% of the doctors questioned in 16 basic health units expressed capacity to treat sexual violence.[52] In a 2015 study of 22 Afghan women living in the Kabul Women for Afghan Women (WAW) shelter for victims of GBV, participants reported that they had experienced multiple forms of abuse and the majority had received medical treatment for abuse-related concerns. Nearly half were treated for injuries sustained during physical abuse, and nearly half for self-inflicted injuries or attempted suicide. Two had undergone police-mandated virginity exams. However, less than half reported the abuse to healthcare providers, and of those only half were asked about the context of their injuries.[53] Only one was provided with information on the laws protecting her from abuse, and none were informed about supportive services available to her.[54]

In the 2013 KAP survey, only about half (55%) of health professional respondents reported having asked female patients if they were victims of GBV, which was most common among midwives (68%) followed by doctors (55%) and least common among nurses (44%). 61% of female health professionals reported having asked female patients about GBV compared to only 33% of male health facility personnel.[55] Additionally, the study found that newer professionals had asked this of patients more commonly than those with more years of experience. 71% of health professionals had asked about GBV if the patient showed bruising or other signs of violence, 70% as part of a routine examination, and 53% for other reasons.[56] Around 77% of health personnel reported that a patient had mentioned physical violence to them, most common among midwives (86%), followed by doctors (75%) and nurses (71%), and more common among female (84%) than male (69%) health professionals.[57] 29% said a patient has mentioned being the victim of sexual assault, also more common among midwives (38%) and among female (38%) than male (18%) health professionals.[58] 83% said a patient has reported being the victim of emotional violence, also more common among female (89%) than male (76%) health professionals.[59]

In the referenced study, a composite score was calculated to assess the awareness level about the symptoms of GBV. Health professionals were asked if 'Pelvic inflammation', 'Low birth weight', 'Difficulty in access to health services', 'Isolation from family and friends', 'Depression' and 'Difficulty in working' are possible symptoms of GBV. The score was categorized as 'No awareness' having 0 point, 'Poor awareness level' having 1-2 points, 'Average awareness level' having 3-4 points and 'Good awareness level' having 5-6 points. The average score on overall awareness about the possible symptoms of GBV was 4.33. 50% of respondents scored in the range indicating good knowledge, 38% average knowledge, 10% poor knowledge and 1% no knowledge.[60]

Health providers were asked in the survey about how often they provided specific types of support in the past year to clients suspected of experiencing GBV who visited the health facility. 73% reported that they were able to identify at least one GBV-affected client within the past year. 81% claimed they had listened and provided psychological support; 66% informed clients about their rights regarding GBV; 66% informed their clients about the effect and risk of violence on health; 65% informed them about referral ser-

51 WHO, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery," World Health Organization, 2013.

52 WHO, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery," World Health Organization, 2013.

53 Sonya Stokes, Andreea L. Seritan, and Elizabeth Miller, "Care Seeking Patterns Among Women Who Have Experienced Gender-Based Violence in Afghanistan," Violence Against Women, Jun 16;22(7):817-31. Epub 2015 Dec 16.

54 Ibid.

55 Dr. Abdul Rasheed and Mr. Mokhlesur Rehman, "Assessment of Knowledge, Attitude and Practices (KAP) of Health Personnel on GBV Case Management," 2013.

56 Ibid.

57 Ibid.

58 Ibid.

59 Ibid.

60 Ibid.

vices for medical services; 58% informed the victims about available psychological services; 56% referred the victims to other medical services; 49% referred their patient for psychological services; 44% informed or referred the patient to legal assistance services; 39% referred patients for other services from the community; 30% informed the survivor about services available from DoWA; 24% referred their patient for legal assistance; 17% referred the patient to DoWA for more services.[61] However, it is important to note that this was a self-report measure and it was not specified whether health professionals were provided with prompts for this question, which could potentially bias responses to an over-reporting of "positive" behaviours.

A composite score was calculated regarding supportive services provided considering 'never' or 'no response' answers as 0 and otherwise 1 totalling 14 possible supportive services provided, and the average score was 6.49. It was found that 18% of respondents did not provide any supportive services to their clients with GBV during the last one year, 10% 1-3 services, 21% 4-6 services, 31% 7-10 services, and 21% more than 10 services to GBV victims who visited the clinic in the past year. It was also found that on average, midwives provided more supportive services (7) followed by doctors (6) and nurses (6). Female health professionals also provided more supportive services (8) in comparison to men (5) in handling GBV cases.[62]

Over half of health professionals surveyed in the 2013 KAP survey felt that they do not have enough training to handle issues related to SGBV.[63] 20% of health professionals surveyed reported having received training on handling GBV cases within the past three years. Of the respondents who had received training on GBV issues, 43% reported that it from international NGOs or development partners, 23% from government organizations and 21% from local NGOs, while 22% could not recall who the training was from. Regarding the issues covered in the trainings, 76% reported having received training on handling all kinds of violence, 35% on gender issues/rights, 15% on mental health, and 7% on other related issues. It was also found that, training on mental health issues was covered only in the health facilities of Herat and Mazar among the surveyed provinces.[64]

More than half of the health professionals surveyed reported that they are not trained in talking to a patient who has experienced physical or sexual violence. 38% were not trained in managing cases of physical violence, 34% regarding emotional violence, and 67% regarding sexual violence. 51% reported that they are not trained in providing care to GBV victims, 64% regarding referral services for GBV cases, and 44% regarding addressing the reproductive health needs of those who have experienced sexual violence. 61% reported that they are not trained regarding helping GBV victims to develop a safety plan.

64% reported that they are not trained in documentation of cases with safety and confidentiality, and 67% in recording details about GBV in the clinical history form.[65] Only 23% of respondents reported having forms to record case details and care provided to survivors of SGBV. Regarding the priority of documenting GBV cases in comparison to other health and social problems, 28% of health professionals considered it to be of high priority, whereas 41% classified it as being of moderate priority.

86% of health professionals were aware that a law exists in Afghanistan for addressing GBV cases. 59% believed that health providers have a legal obligation to support victims of GBV. 55% believed that health service providers are obligated to give proper treatment to the victims, 20% giving necessary counselling, 20% making appropriate referrals, 8% identifying the degree and causes of violence, 7% informing the victims about their rights in the existing laws, and 5% recording of the complaints.[66]

Health personnel were asked if there is a written protocol for caring for GBV victims available in the health facility. 18% reported that the protocol is not available in the health facility though it is supposed to be given to the health facility, and 73% reported that no such protocol is available. 9% of respondents wrongly mentioned that it is available, as they were referring to other available operational guidelines in the health facilities.

61 Ibid.

62 Ibid.

63 Ibid.

64 Ibid.

65 Ibid.

66 Ibid.

DESIGN, METHODOLOGY, AND METHODS

3.1 OBJECTIVE AND BASELINE QUESTIONS

OBJECTIVE

The consultancy is to design and conduct a baseline study informing medica mondiale and Medica Afghanistan about the current situation regarding quality of care for survivors of SGBV. Specifically, the objectives of the baseline study are to:

- Gather relevant baseline data for the key program indicators in cooperation with Medica Afghanistan and medica mondiale in order to enable changes in quality of services to be measured over the course of the program;
- A checklist for health facilities included in the project will be an integral part of the baseline study;
- Furthermore, the design of the study needs to identify samples that enable the program to track key changes and effects amongst target groups from the baseline stage and at future points in time;
- Finally, the baseline study will serve as a basis for monitoring and evaluation during the course of the project as well as for a final evaluation in 2017.

BASELINE QUESTIONS

The main questions the baseline seeks to answer are:

- To what extent can the organizational culture of MoPH and the targeted facilities be said to be trauma informed? To what extent is it perceived to be trauma informed by patients?
- What are the Institutional barriers and supportive drivers for implementing the TSA approach in the public health sector in Afghanistan, and providing psychosocial support for survivors of SGBV?
- What are healthcare staff members' knowledge, skills and attitudes regarding SGBV (focusing on provision of trauma informed services and psychosocial support for survivors of SGBV)?
- What financial resources/policies/ implementations/regulations are in place at MoPH relating to trauma informed services and psychosocial support for survivors of SGBV?
- To what extent are trauma-sensitive SGBV-related health services acceptable?
- To what extent are trauma-sensitive SGBV-related health services adequate?

(See Annex A: Baseline Matrix)

3.2 METHODOLOGY AND METHODS

The present section outlines the overall approach to the study, the research methods, sampling, and study limitations.

METHODOLOGY

This baseline study is framed around the 5As access model selected by mm and MA. The model, which was already

outlined above, distinguishes between 5 dimensions of access: availability, accessibility, affordability, acceptability and adequacy. It is important to note that within the scope of the baseline study, the focus within this framework will be on SGBV and particularly the behaviour and trauma-sensitivity of health professionals and services provided.

Dimension	Description
Availability	Refers to the extent to which a system provides facilities and services that meet the needs of people. Availability also deals with access to specific gen-der of medical personnel (e.g. female health workers), access to medical stores, laboratory or other equipment. Organizational access can be seen as sub- component of availability. This means, if people have adequate physical access to the facility, there might be other factors creating barriers (e.g. like length of time in getting appointments, waiting time before getting treat-ment, language barriers with the facility professional).
Accessibility	Is most commonly related with the geo-graphic location of patients to the lo-cat-ion of facilities (e.g. distance, travel time, mode of transportation used to reach the facility).
Affordability	This dimension looks into direct costs (e.g. doctor's fee) as well as indirect costs (e.g. travel and medical costs). Other factors, like possession and cov-erage of health insurance, public supports (e.g. subsidized rate provided for pregnant women) are also incorporated into this dimension.
Acceptability	Deals with the cultural, including religious factors of people. Factors like gender, age, education level, or ethnicity determine the level of acceptability of service provision to a large extent. For example, if people have cultural preferences towards choosing certain healthcare facilities or if the service provider and people use a common language to communicate. This also depends upon the personal perception of people that might vary within a same religion or group.
Adequacy	Is seen from two ways: quality of service provided and personal treatment by the service providers. This dimension also include whether a specific group of people (e.g. women who survived SGBV) trust the services and/or the staff at the facility, if they are satisfied with the quality of service or personal behaviour of all facility personnel right from the point of entry to facility.

Additionally, since the baseline seeks to identify the trauma-sensitivity of healthcare provision for survivors of SGBV, the study also incorporated components of the Creating Cultures of Trauma-Informed Care (CCTIC) framework, which was developed to promote human service systems that seek "safety first" and commit themselves to "do no harm." This approach promotes an approach to organizational change built on five core values of safety, trustworthiness, choice, collaboration, and empowerment. If a program can say that its culture reflects each of these values in each contact, physical setting, relationship, and activity and that this culture is evident in the experiences of staff as well as patients, then the program's culture is trauma-informed.

FACILITIES

The hospitals included in the study are: Herat Regional Hospital, Balkh Regional Hospital, Malalai hospital in Kabul, and Rabia Balkhi hospital in Kabul. The number of health personnel at each hospital is provided in Table 3.

Additionally, since the baseline seeks to identify the trauma-sensitivity of healthcare provision for survivors of SGBV, the study also incorporated components of the Creating Cultures of Trauma-Informed Care (CCTIC) framework, which was developed to promote human service systems that seek "safety first" and commit themselves to "do no harm." This approach promotes an approach to organizational change built on five core values of safety, trustworthiness, choice, collaboration, and empowerment. If a program can say that its culture reflects each of these values in each contact, physical setting, relationship, and activity and that this culture is evident in the experiences of staff as well as patients, then the program's culture is trauma-informed.

Table 3: Hospitals and number of male and female personnel

Hospital	Herat Regional		Balkh Regional		Malalai Hospital		Rabia Balkhi	
Personnel	M	F	M	F	M	F	M	F
1. General physicians	2	3	2	25	1	1	5	4
2. Gynecologists-obstetricians		7	0	10		35		32
3. Surgeons	7	2	24	3		1	1	31
4. Nurses		130	120	180		17		31
5. Midwives		45	0	50		113		76

6. Auxiliary nurses/ midwives								
7. Community health - workers	30	10	10		10			
8. Patients (per day)	120 - 150		120 - 150		120 - 150		120 - 150	

METHODS

The baseline study adopted a mixed methods approach, comprising both quantitative and qualitative research methods, including Knowledge, Attitudes, and Practice (KAP) surveys and FGDs with health staff, a survey with women seeking health services, FGDs with women residing in shelters, health facility check-lists, and interviews with key stakeholders.

COMPONENT 1 – STAFF KAP SURVEY

A KAP survey was verbally administered by a female enumerator with a sample of pre-determined profiles of health personnel working at each health facility (See Background of Health Staff in Section 3.3). The supervisors informed the personnel in the morning and these on the same day voluntarily participated in a survey that lasted approximately 20 minutes. The survey asked health facility personnel to self-assess their facility and services and gauged their knowledge regarding SGBV as well as attitudes, perceptions, and willingness to work in this area in terms of their ability to recognize and/or do something about it. The KAP survey primarily focussed on trauma-sensitive approaches to psychosocial care for survivors of SGBV, in line with the TSA training manual utilized by MA. The KAP survey was administered prior to the FGD with health staff to mitigate any potential bias.

Table 4: Components staff survey

Domain	Measurement	No. of Items
Section A: Demographics		
Identity	Sex, Age, Ethnicity, Language	4
Occupation/economic activity	Profession, number of months in facility, num-ber of months as health worker	7
Education	Level of education and training	7
Section B: Beliefs/Opinions Related to VAW		
Perceptions/ Opinions Related to VAW	Adapted from Twubakane GBV/PMTCT Readiness Assessment Toolkit (Twubakane, 2008) with consideration to the Afghan context	12
Section C: Knowledge Related to VAW		
Rights and institution awareness	EVAW Law, institutions/resources (FRUs, AIHRC, DoWA, Special EVAW Unit of AGO, FPCs)	17
GBV-related knowledge	Adapted from Twubakane GBV/PMTCT Readiness Assessment Toolkit (Twubakane, 2008) with consideration to the Afghan context	11
Perceptions and Knowledge of Psychosocial Support	Psychological symptoms of GBV, coping strate-gies, triggers	3
TSA-related practice	Developed according to contents of TSA train-ing manual and principles of trauma-informed care	19
section D: Professional Quality of Life (Compassion Satisfaction, Burnout, and Secondary Traumatic Stress (STS)		
Professional Quality of Life	ProQual	30

COMPONENT 2 – FGD WITH FACILITY STAFF

FGDs were held with health facility personnel that mostly also participated in the KAP survey (with some other health staff joining depending on their availability), which included a hypothetical "walk-through" to gain an understanding of the process, guidelines, and policies in place from the woman's first point of contact with the facility and the services and referrals she receives, all that way to discharge and long-term follow-up related to SGBV as well as non-SGBV health issues. It also included a discussion around the various components of the CCTIC framework.

COMPONENT 3 – CLINIC OBSERVATION AND FACILITY CHECKLIST

A facility checklist was developed and was completed through observation by a Thousand Plateaus researcher at

each facility in coordination with facility staff. This facility checklist was also designed to collect information within the framework of CCTIC, as well as additional questions related to information gathering regarding practices at the facilities. The focus of the facility checklist is trauma-sensitivity, and it was intentionally designed to avoid duplication with the facility monitoring that will be undertaken with the rollout of the GBV Treatment Protocol, which focuses more explicitly on GBV capacity and responsiveness of the health sector.

COMPONENT 4 – PATIENT EXIT SURVEY

A female patient satisfaction and experience survey was conducted in the form of exit interviews. Exit interviews have become a popular way of assessing client satisfaction in developing countries. These exit interviews are useful for highlighting the inadequacies in health provision. The maximum 30 minutes long survey included a section on demographics, facility visit experience based on the 5As model, and experiences of violence and trauma (See Table 4). The latter were administered by female enumerators trained on GBV – sensitive research in Dari, which is the main language spoken in the selected research areas. Since the majority of questions were already pre-tested by Thousand Plateaus and other studies, a pilot was not necessary. Additionally, the questionnaires were also revised and discussed during the enumerator's training. Women were approached after seeking treatment where these were asked to participate in an anonymous survey on life experiences. In order to ensure privacy, the surveys were conducted in a private corner of the health facility or outside in the hospital park. Sensitive questions were administered at the end when trust between the surveyor and participant was higher. Trust was also ensured through confidentiality and anonymity outlined in the consent form that was administered prior to the survey.

Table 5: Components exit survey with patients

Domain	Measurement	No. of Items
Section A: Demographics		
Identity	Sex, Age, Ethnicity, Language	5
Occupation	Occupation	1
Education	Level of education	1
Household	Household size (male/female), head of house-hold,	3
Income	Average monthly household income and per-sonal income earning status	2
Disability	Disability type and severity	2
Displacement	History/context of displacement	
Section B: Facility Visit Experience		
Current Visit	Previously visited the facility, services received	2
Availability	Perceptions, type of services, waiting time, sex of health personnel, type of room, language	8
Accessibility	Family member prevention from healthcare access	1
Affordability	Fee for services at current visit	3
Acceptability	Cultural and religious, gender, factors influence seeking healthcare for abuse	12
Adequacy	CCTIC framework—safety, trustworthiness, choice, collaboration, coordination, empower-ment , trauma screening, agency,	32
Specific questions related to SGBV	Asked about/reported abuse to healthcare pro-vider; awareness of physical and mental health consequences; report to authorities	18
	Information and strengths component of CCTIC	8
Section C: Experiences of Violence and Trauma		
Risk factors	GBV in family; agreeing with any justification for GBV; polygamous marriage; age of mar-riage (education and household financial status addressed in demographics)	7

Rights and resources awareness	EVAW Law, institutions/resources (FRUs, AIHRC, DoWA, Special EVAW Unit of AGO, FPCs)	14
Domestic Violence Screening	HITS Domestic Violence Screening (Sheridan, 1998)	4
Psychological Well-Being	Mental Health Inventory (MHI-5) (Ritvo et al, 1997)	5

COMPONENT 5: FGD WITH SGBV SURVIVORS

In each province, a focus group discussion was conducted with survivors of SGBV who are currently residing in shelters, coordinated through MA and partner organizations who operate shelters. The FGD focussed on discussing whether survivors' have sought healthcare services prior to coming to the shelter, whether they have been referred to healthcare services since arriving at the shelter, and survivors' experiences receiving healthcare services related to SGBV. The focus groups were 45 min long and included women residing in the shelter.

COMPONENT 6: KEY STAKEHOLDER INTERVIEWS

These staff FGDs were complemented by a series of stakeholder interviews with facility directors and stakeholders including the PPHD in each province, DoWA in each province, civil society stakeholders/partners at the provincial level (such as NGOs working in health and SGBV, shelters, etc.), and with MoPH, AFGA, and UNFPA at the central level. As a whole, these interviews serve to inform a situational/policy analysis at different levels of implementation. Using different methods at each stage to measure 'responsiveness,' these interviews serve to establish the wider contextual and structural framework, such as national policies and programs, sociocultural context, etc. They furthermore inform an understanding of the entire process of provision of SGBV services, from the time a woman is in need of SGBV-related health services, to her seeking services and assessing what is available at different levels, what happens when SGBV is recognized and referral mechanisms in place, linkages to other services such as protection and legal support, and issues such as cost and accessibility. It will also seek to inform an analysis of the general context regarding policymakers and their knowledge, attitudes, practice, and willingness to work in this area. The interview guide for the stakeholder interviews was adapted from the GBV/PMTCT Readiness Assessment Toolkit (Twubakane, 1998), a toolkit to assess the readiness of service providers, service facilities, the community and the policy environment to respond to GBV.

(See Annex B: Baseline Tools)

3.3 SAMPLING

The KAP survey was administered to 5 staff members in each health facility with a total of 20 surveys. One focus group was also conducted in each health facility with a total of 4 focus groups with 5 to 12 participants, which included health staff with varying levels of responsibility and participants previously selected for the KAP survey. In Herat Regional hospital the focus groups had 12 participants including a surgeon, midwife, counsellors, gynaecologists, and nurses. In Malalai hospital in Kabul, the FGD included 10 participants and among these a surgeon, a general medical practitioner, nurses, gynaecologists, and midwives. In Rabia Balkhi 12 female health personnel participated in the FGD, including midwives, gynaecologists, and nurses. In Mazar Regional hospital, the FGD included 5 participants: a psychiatrist, nurses, and a neurological surgeon. These were completed in an hour as health personnel is usually very busy in the mornings and often absent in the afternoons.

In total, 71 exit surveys were conducted with women exiting the hospitals with approximately 18 surveys in each facility. Ten key informant interviews were also conducted with various key stakeholders in Kabul and the provinces, including different departments of the MoPH and UN bodies. One focus group was conducted with 6 women from a shelter in Mazar – e – Sharif and another with 7 women from a shelter in Herat province, including an interview with the head of the shelter. In total, 12 women from shelters were interviewed.

3.4 ANALYSIS

Quantitative surveys were transported to Kabul for data entry under the supervision of the Field Manager and cleaning by the Lead Evaluators using SPSS statistical analysis software. Qualitative assessment tools were written in note form, translated and transcribed. Where consent was given, all interviews were recorded as backup to the written notes. Qualitative data were analysed in two rounds of coding using Dedoose computer-assisted qualitative data analysis (CAQDA) software.

3.5 LIMITATIONS

PARTICIPANTS

Similar to the low prevalence of SGBV reporting at health facilities as indicated by the 2013 KAP survey conducted by

UN Women discussed in the Context section, many patients surveyed in the health facility exit interview were patients, who did not seek treatment for SGBV-related concerns. Additionally, as per findings of the GBV recording information, these can be very rare as some hospitals were able to record only 1 GBV case in a month, which considerably lowers the chances of surveying women experiencing GBV. However, due to ethical considerations, patient confidentiality laws and compounding issues such as lack of mobile phone access and addresses, it would be impossible and illegal to recruit women who had previously come to the health facility for treatment for SGBV-related concerns. Considering that it was impossible to even locate the actual clients of MA PSHP services in a previous evaluation, Thousand Plateaus considers exit interviews as the only feasible approach to surveying health facility users, particularly in consideration of the need for a replicable sampling approach for monitoring throughout program implementation. While a lot of efforts were placed at briefing doctors and nurses on directing the enumerators to possible survivors of SGBV these were difficult to survey since women mostly do not reveal details on the causes of their condition and reasons for treatment to doctors. Frequently found in the literature is the underreporting of SGBV. This underreporting has a worldwide estimate ranging from 11 to 128 fold, depending on the region; however, Asian countries were found to have extremely low (around 2%) report rates to a formal source for GBV (Palermo et al, 2013). Barriers to formally reporting GBV are noted as: shame and stigma, resource limitations, lack of awareness and/or access to services, cultural beliefs and social norms, threats from family, fear of retaliation, perceived impunity for assailants, discriminatory legal practices, and distrust of health workers (Palermo et al, 2013).

FACILITIES

Another problem that arose during the fieldwork was a lack of exhaustive information on the hospitals that were recommended by MA as control hospitals (the study initially included treatment and control hospitals as per MA request), which led to selection of control hospitals that could not be compared to treatment hospitals due to their size, scope, and accessibility. Additionally, it was discovered only during fieldwork that there is a lack of hospitals that could be used as control hospitals in the provinces. These problems caused the overall elimination of control hospitals from the study approach. While this did not pose any limitations at baseline level, the evaluation will have to revise the study approach and the possible alternatives for determining the 'counterfactual'.

DATA COLLECTION

Collecting information on GBV recordings from each hospital represented a major challenge in terms of data collection. While recording is patchy and often does not capture the GBV aspect for the treatment sought, hospitals with FPC more consistently collect information on GBV. Additionally, the respective staff was reluctant and not cooperative in terms of sharing the GBV data as the study was not seen as a 'donor', who financially contributes to GBV programming. Information on GBV cases shared by the hospital staff was subsequently also compared to the same data collected by Health Net - an organization working on construction and rehabilitation of health care in areas disrupted by war or disaster - albeit only for GBV cases recordings in Herat and Mazar Regional Hospitals as the same information was not collected for Kabul hospitals by the same or other organizations working on GBV.

POTENTIAL BIASES

The findings of the evaluation should be also read against the backdrop of potential bias among the respondents in providing answers that they may believe will attract financial or other type of assistance, which can be especially problematic with marginalized groups. This potential limitation was mitigated through the clear explanation of the study and its purpose to each survey and interview participant. Another potential response bias is the tendency of the respondent to provide the answer they believe the facilitator wants them to give or that they believe will make them appear in the most positive light. Given this background, it is possible that respondents would provide answers that are consistent with what they believe the facilitator wants to hear rather than answers that reflect their actual realities and daily lives.

Women residing in shelters were accompanied to health facilities by a medical personnel working in shelters and therefore encountered mostly health personnel accustomed and trained in dealing with GBV survivors. Consequently, the information on the possible problems for accessing GBV health care were more difficult to establish as these women are guided through the more or less formal GBV channels.

Additionally, patients often rate services based on what they know and the quality they are used to. Considering that the health system was mostly disrupted and slowly rebuilt only after 2001 in Afghanistan, patients do not have experience of quality services upon which to compare the services they receive. This leads to biases in terms of quality ratings and these can be consequently high.

FINDINGS

The findings section explores SGBV – related health service provision, whether health-care is trauma informed, and knowledge, attitudes and practices among health professionals on SGBV.

4.1 SGBV-RELATED HEALTH SERVICE PROVISION

SERVICES PROVIDED

Of the 74 patients surveyed from the facilities that will be targeted for the THTP, 60% had previously visited the health facility.[1] 60% had come to the facility seeking treatment for illness, 17% a regular check-up, 6% postnatal care, 9% antenatal care, 13% mental health services or counselling, 1.5% for treatment related to emotional abuse, 1.5% for laboratory services, 4% family planning, 3% for pharmacy services, and 1.5% for nutrition-related services and for treatment for emotional abuse. 7% reported coming to the facility seeking services for other reasons.

Table 6: Type of treatment sought at health facility

Type of treatment sought	Percentage of women
Illness	60%
Check - up	17%
Mental health services or counselling	13%
Antenatal care	9%
Other non specified	7%
Postnatal care	6%
Family planning	4%
Pharmacy services	3%
Laboratory services	1.5%
Nutrition	1.5%
Treatment emotional abuse	1.5%

7% of patients (5 patients) had been treated for abuse-related health concerns in the services they had received that day at the facility; 3% (2) for injuries sustained during physical or sexual abuse; 8% (6) for self-inflicted injuries; 7% (5) for emotional consequences of abuse; and none for a mandated virginity exam. Only 12% (9 patients) reported that their healthcare provider had asked them questions regarding whether they were experiencing physical or sexual abuse.

Only 4% (3) had reported abuse to their healthcare provider. Of these, one was a case of physical abuse one emotional or psychological abuse, and the nature of the third case was undisclosed by the respondent. Of the three patients who had reported abuse, two said that their healthcare provider had encouraged them to report their abuse, and one that their healthcare provider had reported their abuse to authorities. Two had received information regarding laws that protect them from abuse from their health-

1 3% did not know or refused to answer

care provider. Only one woman had received information regarding physical consequences of abuse, regarding the mental and emotional consequences of abuse, and regarding supportive services available. The same respondent, who reported abuse had received a referral, which was for psychosocial counselling at a public facility.

RISK AND VULNERABILITY TO SGBV

22% of patients surveyed had been treated for abuse-related health concerns at some point in their life.[2] A surprising 23% had received treatment at some point in their life for self-inflicted injuries.[3] 7% had received treatment for the emotional consequences of abuse. None had ever received a mandated virginity exam or been treated for injuries sustained during physical abuse.

TREATMENT BECAUSE OF ABUSE OVER WOMEN'S LIFETIME

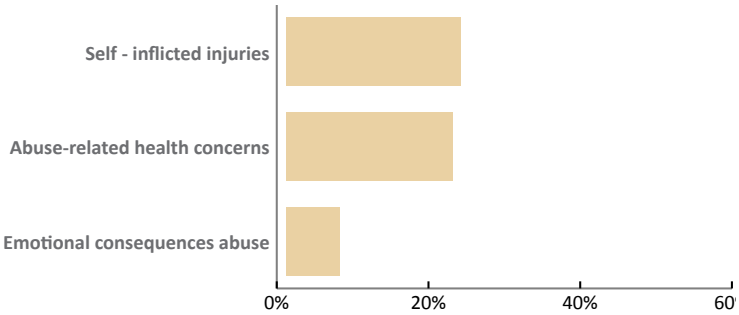

Chart 1: Treatments received because of abuse over respondent's lifetime based on exit survey data

According to a World Bank report, agreeing with any justification for wife beating increases the odds of experiencing intimate partner violence by 45%.[4] 28% of patients surveyed agreed with some justification for SGBV. 34% agreed or strongly agreed that a woman provokes her partner's violence because of her own behaviour. 28% agreed or strongly agreed that there are times when a husband is justified in beating his wife. The World Bank report also found that women whose fathers beat their mothers have a 2.5 times greater risk of experiencing IPV in their adult lives compared with women who did not witness IPV as children.[5] 45% of patients surveyed had witnessed their mother experiencing physical, psychological, or sexual abuse at some point in their life.[6]

GBV EXPERIENCES AND EXPOSURE

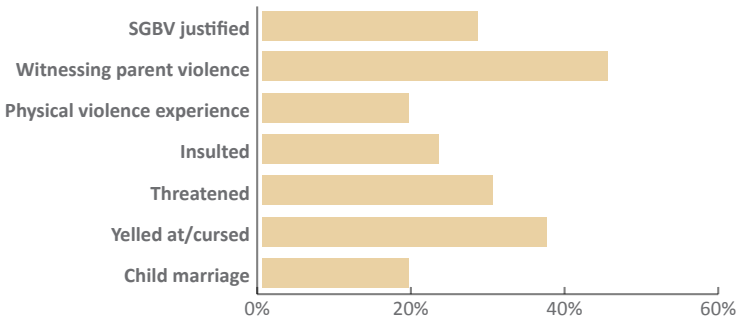

Chart 2: GBV exposure, experiences, and risks among women participating in the exit survey

81% of patients surveyed were married, 7% unmarried, 12% widowed, and none divorced. Of those who had been married, 24% were younger than 15 when they got married, and 53% were younger than 18 when they were married.[7] The World Bank report found that being married before age 18 increases the risk of IPV by 24%.[8]

53% of patients surveyed knew that it is false that preventing a woman from getting an education, from accessing medical services, or to work is allowed and is not regulated by Afghan laws. 60% knew that there are laws in Afghanistan that protect women from physical abuse, 58% that there are laws in Afghanistan that protect women from sexual abuse, and 60% that there are laws in Afghanistan that protect women from psychological abuse. Only 47% knew that based on Afghan law, husbands have no right to beat their wives, no matter what she did to him. Similarly, only 57% knew that in case of an illness or injury, a woman has the right to access healthcare, even if her male family members don't agree with it. 61% were aware that there are shelters in Afghanistan were women can go to escape violence. 70% of women were familiar with the Department of Women's Affairs, 19% with Family Resolution Units (FRU), 73% the Afghanistan Independent Human Rights Commission, 32% a Family Protection Centre at a healthcare facility, 53% a Women's Protection Centre (shelter), and 31% a Family Guidance Centre.

19% of patients reported that their partner and/or household members sometimes, fairly often, or frequently physically hurt them;[9] 23% that they insult or talk down to them;[10] 30% that they threaten them with harm;[11] and

2 3% did not know or refused to answer

3 4% did not know or refused to answer

4 VAWG, "Why VAWG Matters in Development Operations", N. G., http://www.vawgresourceguide.org/initiate

5 Ibid.

6 5% did not know or refused to answer

7 3% did not know or refused to answer

8 VAWG, "Why VAWG Matters in Development Operations", N. G.

9 4% did not know or refused to answer

10 4% did not know or refused to answer

11 4% did not know or refused to answer

37% that they scream, yell, or curse at them.[12] The Hurt, Insult, Threaten, Scream (HITS) scale is scored from 4-20, where scores over 10 suggest that someone is at risk of domestic abuse. Of the patients surveyed, 84% had scores on the HITS scale higher than 10 and consequently are at risk of domestic abuse.[13]

5 AS

AVAILABILITY

81% of patients agreed (32%) or strongly agreed (49%) that the facility is always open and staff is present during its normal operating hours.[14] 86% of patients interviewed in the exit survey agreed (58%) or strongly agreed (28%) that there are female staff members available when they need to seek health services at the facility.[15] 37% of patients disagreed (11%) or strongly disagreed (26%) that sometimes the healthcare treatment and support that health providers at the facility provide are not in line with cultural norms related to gender, religion, or society. However, 22% agreed and 15% strongly agreed with this statement.[16]

Chart 3: Availability of health services based on response provided by women in the exit survey

15% of patients had waited less than 10 minutes to receive services at the facility that day; 12% 10-30 minutes; 12% 30 minutes to an hour; 10% 1-3 hours; and 19% had waited more than 3 hours to receive services.[17] 49% saw a doctor, 27% a gynaecologist/obstetrician; 6% a surgeon; 4% a nurse; and 14% a midwife.[18] 37% saw only male healthcare providers, 45% female, and 11% saw both male and female healthcare providers.[19]

Chart 4: Waiting time at health facilities based on data from the exit survey

AFFORDABILITY

Almost half of the patients (47%) reported that there was some type of monetary cost associated with the services they had received. Of those who reported having to pay fees, 9% paid for services, 78% for medication, and 10% for tests or laboratory fees. 2% reported paying fees for other things. Of those who had paid fees, 8% paid less than 150 AFN; 7% 151 to 500 AFN; 8% 501 to 2000 AFN; 6% 2001 to 5000 AFN; 8% more than 5000 AFN. 11% were unsure how much they had paid. 8% of patients had an average monthly household income of less than 3,000 AFN; 18% 3,001 to 5,000 AFN; 46% 5,001 to 10,000 AFN; 7% 10,001 to 15,000 AFN; 14% more than 15,000 AFN.[20] Only 10% of patients surveyed personally earn any income.

The majority of patients interviewed were Dari-speaking (95%), and services were mainly reported to be given in Dari (92%), with very few reporting receiving services in other languages. Cultural norms can also be a barrier to the accessibility of health services. 11% of patients reported that in the past year, there had been a time when they wanted to see a doctor, nurse, or other healthcare worker but were unable to because their family member/s didn't allow them to seek treatment.

ACCEPTABILITY

60% of patients surveyed agreed (38%) or strongly agreed (22%) that if there is no female healthcare professional available, it is okay for a woman to seek treatment from

12 4% did not know or refused to answer

13 4% did not know or refused to answer

14 3% did not know or refused to answer

15 3% did not know or refused to answer

16 5% did not know or refused to answer

17 32% did not know or refused to answer

18 11% did not know or refused to answer

19 8% did not know or refused to answer

20 8% did not know

a male healthcare professional. However, 14% disagreed and 22% strongly disagreed with this statement.[21] 19% agreed (15%) or strongly agreed (4%) that if a woman is being abused by her husband, it is a private family matter and she should not seek help from public facilities.[22] 45% of patients surveyed agreed (38%) or strongly agreed (7%) that they would feel offended if a healthcare provider asked them about physical or sexual abuse.[23] Only 55% agreed (41%) or strongly agreed (14%) that they would feel comfortable seeking treatment at a healthcare facility if they experienced abuse from a family member,[24] and 50% agreed (30%) or strongly agreed (20%) the same if they experienced abuse from someone who was not a member of their family.[25] 51% agreed (39%) or strongly agreed (12%) that they would feel comfortable seeking mental health treatment at a healthcare facility if they experienced emotional abuse from a family member,[26] and 68% agreed (46%) or strongly agreed (22%) the same regarding emotional abuse from a non-family member.[27]

Table 7: Acceptability

Acceptability	Percentage of women (agreeing or strongly agreeing)
Male health provider	60%
Abuse as a private matter	19%
Feeling offended if health provider asking about abuse	45%
Seeking health-care after abuse family and non-family member at a health facility	55% and 50%
Seeking mental health treatment after abuse from family and non-family member at a health facility	51% and 68%

When asked about factors that would hypothetically influence whether they would seek healthcare services, 66% are influenced (27%) or strongly influenced (39%) by whether their family members approve of their seeking services;[28] 24% are influenced (20%) or strongly influenced (4%) by what other people in their community would think of them seeking healthcare services;[29] 40% are influenced (26%) or strongly influenced (14%) by a fear of the health-care provider reporting their case to the authorities;[30] and 35% are influenced (28%) or strongly influenced (7%) by a fear of the healthcare provider telling their family about the treatment.[31]

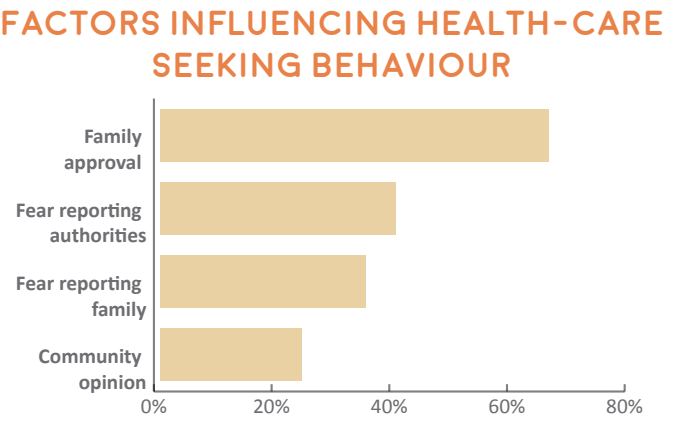

Chart 5: Factors that influence women in seeking health services based on responses from the exit survey

ADEQUACY

Adequacy refers to the quality of services provided and personal treatment by the service providers. It follows the different components of the CCTIC framework - safety, trustworthiness, choice, collaboration, empowerment, and agency of patients - and explores whether service provision is trauma – informed with high scores in all of the dimensions. Details on the adequacy of health service provision as perceived by the patients is explored in the related sections of the following chapter that provides an overall picture on whether facilities provide a trauma informed care.

4.2 TRAUMA – INFORMED CARE

The present section provides a closer look on the hospital's ability to provide a trauma informed provision of services. Each facility was scored on the different components of trauma informed care, including safety, trust, choice, collaboration, and empowerment of both patients and hos-

21 3% did not know or refused to answer

22 38% disagreed; 30% strongly disagreed; and 10% neither agreed nor disagreed with this statement.

23 20% disagreed and 10% strongly disagreed, and 20% neither agreed nor disagreed. 5% did not know or refused to answer

24 10% did not know or refused to answer

25 8% did not know or refused to answer

26 10% did not know or refused to answer

27 5% did not know or refused to answer

28 19% said they are not influenced by this at all.

29 22% not being influenced by this at all

30 28% are not influenced by this at all.

31 37% are not influenced by this at all.

Table 8: Facility Checklist Scores

Province	Kabul	Kabul	Balkh	Herat
Facility	Rabia Balkhi	Malalai Hospi-tal	Mazar Region-al	Herat Regional
Safety	48%	13%	41%	33%
Trust	60%	53%	61%	51%
Choice	72%	67%	47%	48%
Collaboration	32%	36%	16%	18%
Empowerment	65%	28%	63%	68%
Formal Service Policies	31%	31%	38%	38%
Administrative	0%	0%	0%	0%
Trauma Screening	27%	0%	0%	0%
Training	21%	0%	32%	22%
Human Re-sources	0%	0%	0%	0%
Total	36%	25%	33%	31%

pital staff. In addition to it, the check - list explores whether hospitals have different formal service policies in place, the administrative aspects of trauma informed care, trauma screening practices, the availability of trainings on trauma for staff, and some human resource aspects. (See Table 8 below). The facility checklists were also triangulated with findings from the KAP survey with health staff, focus groups with health staff at each facility, and the exit survey with patients to provide a comprehensive picture of whether health facilities provide a trauma – informed care. Overall, hospitals scored low in terms of trauma informed care with none scoring over 40% with some components of CCTIC higher than others with patients, on the other hand, showing high satisfaction rates in terms of the different components of the CCTIC framework.

SAFETY

In terms of safety, the CCTIC framework looks at to what extent the program's activities and settings ensure the physical and emotional safety of clients and staff members. Overall, the physical and emotional safety of patients and staff is low with hospitals scoring below 50% with Malalai hospital scoring only 13%. Focus groups with hospital staff overwhelmingly confirms the finding as health facility staff mostly reported a lack of physical and emotional safety caused especially by the presence of patient's relatives, which were mentioned in 2 out of 4 focus groups that presented the health professional practice as ultimately dangerous:

> We are not safe in the hospital. Sometime ago, we had a patient, who was her giving birth for the first time. She suddenly gave birth in OPD. She had some people with bad behaviour accompanying her. Then those women started to shout and insult the midwife, who is a silent and kind girl. It was at 4 in the morning. She was alone to help the woman. When other doctors met her, she told them that there were 2 women who came with the patient, they threatened her and I think they even had some physical confrontations with her too. Then the doctors asked the police to intervene and police came to the hospital. Those women accompanying the patient were also armed and when police arrived they apologized. Then they signed a paper that they will not come to this hospital ever again, but after some days I saw one of those women who came there for her baby's vaccination. Even if they wanted to fire at her and kill her, they could do it. Therefore, we requested security staff for the hospital. They rejected and they said that police station is near the hospital. There are only 2 old men at the gate.[32]

Table 9: Patient Rating Safety[33]

Province	Facility	N	Mean	Standard Deviation
Kabul	Rabia Balkhi	18	4.46	.456
Kabul	Malalai	18	4.50	.227
Balkh	Mazar Regional	19	3.88	.502
Herat	Herat Regional	16	4.44	.232

On the other hand, patients feel very safe at the health facilities. On a scale from 0 to 5, on average patients rated the health services they had received a 4.31, suggesting a high level of perceived safety.[34] 97% agreed or strongly agreed that they feel physically safe in their treatment at the facility, and 97% that they feel emotionally safe. 96% agreed or strongly agreed that there are signs giving them helpful information, and 64% that the waiting area and treatment rooms are comfortable and inviting. Health facility staff also felt that patients are mostly safe at the health facility where it can be compromised by the lack of privacy during medical examinations (mentioned in 1 focus groups). The latter was additionally confirmed by the exit survey findings where 66% of patients were seen in an open room where others could see them. 12% were seen in an open room partitioned by a sheet or screen, and 12% in a private room.[35] According to health facility staff safety could be also compromised by the curiosity of other patients present at the facility since "when a woman comes with the police everyone wants to know about her case."[36]

TRUSTWORTHINESS

In terms of trustworthiness, the CCTIC framework looks at to what extent the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program. Trustworthiness is supported by clear information sharing practices and having policies in place that ensure services are clear, including establishing boundaries, informed consent, and clear establishment of roles and responsibilities for both clients and staff. Overall, the facil-

32 Kabul, Focus group with hospital staff, Malalai hospital

33 F(3, 67)=10.96, p<.001

34 N= 71, M=4.31, SD = .456

35 10% did not know or refused to answer

36 Herat, Focus groups with hospital staff, Herat Regional Hospital

ity score for trust lies between 50 and 60%, which could be interpreted as moderate level of trustworthiness.

In fact, boundaries between patients and staff can be sometimes blurred, considering that these also mentioned a lack of such policies - raised in 2 focus groups - with one focus group providing clear evidence on a lack of clear cut boundaries:

> Here is a friendly and kind relationship between doctors and patients. There is no policy regarding limitations or boundaries between them. The more we become friendly with patients, the more they trust us. We don't have much time to become very friendly with patients though.[37]

As in the previous quote, health facility staff from all focus groups mentioned the lack of time they have to dedicate to each patient due to the patient high numbers as a major obstacle for establishing trustworthiness:

> If patients are many, we may not have enough time to explain everything to them but we try to explain important things to them such as expenses, duration of the treatment, and other things.[38]

And:

> We inform patients about their disease and about the process of treatment. But after that the persons or relatives, who accompany the patient for treatment say that no one pays attention to the patient. Then when we check the files of the patient, we see that their disease has been diagnosed, they have completed the tests, and they have received the drug. And then who did all of this other than the doctor we ask?! They want one doctor for each patient when we have too many patients. This happens daily. Then of course the doctors get angry.[39]

Table 10: Patient Rating Trustworthiness[40]

Province	Facility	N	Mean	Standard Deviation
Kabul	Rabia Balkhi	18	4.14	.665
Kabul	Malalai	18	4.42	.243
Balkh	Mazar Regional	19	3.34	.522
Herat	Herat Regional	17	4.24	.463

Nonetheless, patients rated trustworthiness high at all facilities. On a scale from 0 to 5, on average patients rated the health services they had received a 4.02, suggesting a high level of perceived trust.[41] 86% of patients surveyed agreed or strongly agreed that they trust the people working at the facility. 64% agreed or strongly agreed that when they come to this facility they are provided with good information about what to expect from staff and services. 69% felt the same that people at the facility will do what they say they are going to do when they say they are going to do it, and 79% that the people who work at the facility act in a respectful and professional manner towards them. The difference in the experience of trustworthiness is again likely due to a lack of of comparison from the side of the patient, who had little or no access to health services till recent times.

CHOICE AND CONTROL

In terms of choice and control, the CCTIC framework looks at to what extent the program's activities and settings maximize both client and staff experiences of choice and control. Facilities in Kabul scored between slightly under 60 and 70%, with facilities in Herat and Balkh scoring around 50%. The finding is also compounded by focus groups where 2 mentioned choices of the health staff to attend work – shops and 2 focus groups mentioned their ability to change shifts in structures that allow limited choices for staff since "We can also change our shift with other doctors in emergency cases and the administration is cooperative in this case."[42]

Table 11: Patient Rating Choice[43]

Province	Facility	N	Mean	Standard Deviation
Kabul	Rabia Balkhi	18	3.89	.729
Kabul	Malalai	18	4.32	.410
Balkh	Mazar Regional	18	2.69	.389
Herat	Herat Regional	16	4.00	.447

In terms of choice, on a scale from 0 to 5, on average patients rated the health services they had received a 3.72,

37 Kabul, Focus group with hospital staff, Rabia Balkhi Hospital

38 Mazar, Focus group with hospital staff, Mazar Regional Hospital

39 Mazar e Sharif, Focus group with facility staff, Balkh Regional Hospital

40 F(3, 68)=16.94, p<.001

41 N= 72, M=4.02, SD = .64

42 Kabul, Focus group with health staff, Rabia Balkhi

43 F(3, 66)=34.26, p<.001

suggesting a generally high level of perceived choice with the lowest score recorded in Balkh.[44] 67% agreed or strongly agreed that staff offer them a lot of choices about the services they receive, and 59% that they have a great deal of control over the kinds of services they receive, including when, where, and by whom the services are offered. 71% agreed or strongly agreed that their priorities are taken into account when deciding which treatments they receive, and 59% that if they didn't want to do a specific test or treatment the health facility would respect their choice and provide them with alternative services. Hospital staff compounded the findings on patient's ability in terms of choices that was confirmed in 3 focus groups with hospital staff where these highlighted how decisions are always taken by the patients:

> The final decision always lies with the patients; doctors just explain options for treatment to them. If they want to leave the hospital and go to another place for treatment, then we take the signature of the patient or their family member that the responsibility lies with them if something happens to the patient. And we also explain the things that might happen to the patient. There is a specific form for this.[45]

Three focus groups also mentioned patient's limited choice in terms of relatives' presence and visits as space in hospitals can be limited:

> The problem is with those who come with patients, they have lots of expectations that the administration of the hospital should solve their issue. Only one person is allowed to stay with the patient in the room but in some cases, for special people, they have almost 5 – 6 people from their family. Then there is not enough space for other patients. [46]

COLLABORATION

In terms of collaboration, the CCTIC framework looks at to what extent the program's activities and settings maximize collaboration and sharing of power between staff and clients, and to what extent the program's activities and settings maximize collaboration and sharing of power among staff, supervisors, and administrators. Health facilities scored low in terms of collaboration, with scores between 30 to 35% in Kabul and with even lower scores - below 20% - in Balkh and Herat. Focus groups are telling on a rigid and hierarchical relationship between health staff and supervisors:

> "We are evaluated every year and we receive feedback. Then they make some changes in our salaries."[47]

Table 12: Patient Rating Collaboration[48]

Province	Facility	N		Standard Deviation
Kabul	Rabia Balkhi	18	4.00	.840
Kabul	Malalai	17	4.32	.351
Balkh	Mazar Regional	19	2.63	.620
Herat	Herat Regional	16	3.94	.479

On the other hand, exit surveys with patients conclude on high collaboration in the relationship between patients and health staff. On a scale from 0 to 5, on average patients rated the health services they had received a 3.69, with the lowest score recorded in Balkh, suggesting a generally high level of perceived collaboration.[49] 71% agreed or strongly agreed that the staff at the facility are willing to work with them rather than doing things for them or to them, and 71% that when decisions about their services or recovery plan are made they feel like a partner with the staff and that staff listen to what they want. 73% felt the same that staff at the facility really listen to what they have to say about things. However, only 39% agreed or strongly agreed that patients play a role in deciding how things are done at the facility.

EMPOWERMENT

In terms of empowerment, the CCTIC framework looks at to what extent the program's activities and settings prioritize both client and staff empowerment and skill-building, and the extent to which staff members have the resources necessary to do their jobs well. Hospitals scored mostly over 60% with a relatively high staff and patient empowerment with the exception of Malalai hospital in Kabul, which scored only 28%. Two focus groups with hospital staff also mentioned a lack of training availability.

Table 13: Patient Rating Empowerment[50]

44 N= 70, M=3.72, SD = .804

45 Kabul Focus group with hospital staff, Rabia Balkhi hospital

46 Kabul, Focus group with hospital staff, Malalai hospital,

47 Mazar, Focus group with hospital staff, Mazar Regional hospital

48 F(3, 66)=27.87, p<.001

49 N= 70, M=3.69, SD = .893

50 F(3, 66)=17.10, p<.001

Province	Facility	N	Mean	Standard Deviation
Kabul	Rabia Balkhi	18	3.96	.815
Kabul	Malalai	18	4.26	.415
Balkh	Mazar Regional	19	3.08	.566
Herat	Herat Regional	15	4.25	.366

While focus group with health staff was mostly unclear on the patient's empowerment aspect of service delivery, the exit surveys with patients revealed a high level of perceived empowerment of patients. On a scale from 0 to 5, on average patients rated the health services they had received a 3.86,[51] with the lowest score recorded in Balkh, suggesting a generally high level of perceived empowerment. 55% agreed or strongly agreed that health staff at the facility recognize that they have strengths and skills as well as challenges and difficulties, and 82% that the staff are very good at letting them know that they value them as a person. 71% agreed or strongly agreed that the staff at the facility help them learn new skills and information that are helpful in maintaining their physical and emotional health, and 66% that they feel stronger because of the support they have received when coming to the facility.

FORMAL SERVICE POLICIES

The availability of formal service policies explores whether the program has developed written policies that seek to eliminate involuntary or coercive practices; whether there are formal procedures for inquiring about patient's preferences to responding in crisis situations; on the establishment of a de-escalation policy; about the presence of policies on confidentiality; about the presence of documents on patient's rights and responsibilities; consent forms, and other relevant policies. Hospitals in general scored relatively low in this regard, between 30 and 40%. The low scores in terms of formal services are compounded by the focus groups discussions that raised the issue of virginity tests. While two hospitals mentioned that they have to refer virginity tests to forensic hospitals, health staff from one hospital implied that consent from women undertaking the test is not required: "We are not allowed to take hymen test in this hospital anymore. We can do it if the patients have a letter from the criminal sections such as the police, then we do it. Otherwise we are not allowed to do it. "[52]

TRAUMA SCREENING

Trauma screening practices scored low in all hospitals, with only Rabia Balkhi scoring 27% and the remaining facilities 0%. This aspect measures whether patients are asked about exposure to trauma, screening for psychological distress, whether these minimize stress for patients while administered; regarding identification of other programs offering trauma-specific services, and whether the letter are formalized in actual forms or included in institutional directories.

The finding is also compounded by the KAP survey with health staff, who showed varying levels of appropriate practice when working with a survivor of gender based violence. Many procedure and/or policy related practices were well known, such as collecting informed consent (100%), assessing mental health status (95%) prior to an exam, and that patients with life threating injuries should be referred immediately if necessary (100%). However, issues of re-traumatization and potential harm inflicted during an exam were very poorly reported. 67% of respondents did not recognize that SGBV survivors can be traumatized by an event other than the actual assault, and 71% stated that they cannot do any additional harm to the woman during the exam. Other worrisome topics include patient rights and confidentiality in that only 71% said they should refer a woman if they know her, 19% said they should tell a family member if a woman reports an abuse, and 43% said that in suspected cases of IPV and/or SGBV they should discuss with the man and woman together about violence in their relationship.

Table 14: Knowledge on re-traumatization among health staff

Question	Coding*	N True	% True	N	% False
I must collect informed consent before a physical exam	+	21	100%	0	0%
I should assess mental health status before doing a physical exam with a survivor of SGBV	+	20	95%	1	5%
Survivors of SGBV are only traumatised because of the assault itself	-	14	67%	3	14%[1]
It is important to empower survivors by allowing them choices in their health decision	+	21	100%	0	0%

51 N= 70, M=3.86, SD = ..75

52 Kabul focus group with health facility, Malalai hospital

During the exam I should act encouraging to the patient to tell me more information	+	21	100%	0	0%
A woman will tell me everything she wants me to know without me asking her specific questions	-	4	19%	17	81%
I cannot do any additional harm to the woman during the exam	-	15	71%	6	29%
If I know the patient I should refer her case and not be her health care provider	+	15	71%	6	29%
Some methods during the exam can result in secondary traumatisation of the woman	+	17	81%	4	19%
It will not do any harm to make her tell me what happened during the assault so that it can be documented properly	-	3	14%	18	86%
Patients should be referred immediately if they have life threatening conditions that your facility can't handle	+	21	100%	0	0%
The choices of the survivor should be respected even if it means not completing assessments	-	21	100%	0	0%
If a woman is experiencing mental health issues because of assault she may not present with obvious symptoms	+	16	76%	5	24%
Women will ask for more information on services if they want	-	4	19%	17	81%
Women who don't have signs of mental health issues should still be referred to a counsellor	+	11	52%	10	48%
If a woman reports abuse I should tell a family member that she came to the facility and what they discussed	-	4	19%	16	76%[2]
In a suspected case of IPV/ conjugal violence, it is advisable to talk with both the women and man together about the violence in their relationship	-	9	43%	12	57%

*Column indicates whether the question is phrased positively or negatively. For (+) questions, having high percentages of "True" answers demonstrate good practice. For (-) questions, having a high percentage of "False" answers demonstrate good practices.

The respondents were able to identify possible mental health symptoms and potential triggers for re-traumatization for survivors of GBV as reported in Table 7 in the GBV practices section. However, these questions were posed as 'yes' or 'no' answers which may have created some bias.

Health staff reported mixed care practices when asked in the survey about how they could show the patient that they were listening, and that they cared. Obvious physical signs to show they are listening, like maintaining eye contact and having good body language, were reported quite high at 91% and 91% respectively. However, respondents were poor to identify other appropriate listening techniques such as providing encouraging sounds (76%), not getting distracted by notes or phone (57%) and appropriate facial expressions (52%). In terms of responses when asked how they could show the patient they cared, 100% said to ask open-ended questions and 81% stated to provide appropriate comfort if upset. However, only 71% and 62% identified that paraphrasing what the patient said, and not interrupting the patient were techniques to show that they cared, respectively.

When given a scenario of a woman entering the health facility visibly upset and crying and shouting loudly, 67% of respondents stated that they would physically restrain her, 29% stated that they would leave her in a room alone to calm down, and 19% said they would provide a placebo pill and tell her it will make her calm so she thinks she feels better. Two-thirds (67%) encouragingly said they would try to calm her down by reassuring her where she is, and would go up to her and try to comfort her. 62% said they would refer to a psychologist, and only 62% said they would take her somewhere private and try different techniques like breathing, relaxation or asking about her day and children.[53]

Table 15: Patient Rating Agency[54]

Province	Facility	N	Mean	Standard Deviation
Kabul	Rabia Balkhi	17	4.18	.671
Kabul	Malalai	18	4.49	.171
Balkh	Mazar Regional	19	3.23	.395
Herat	Herat Regional	16	4.23	.326

53 Multiple responses allowed

54 F(3, 66)=30.50, p<.001

Patients were also asked some questions that explored some trauma screening practices of the health facilities. Nonetheless, In terms of agency, on a scale from 0 to 5, on average patients rated the health services they had received a 4.01,[55] suggesting a high level of perceived agency with the lowest score in Balkh. 74% agree or strongly agree that staff respect their privacy, and 69% that staff understand that they know what's best for them. 82% agree or strongly agree that staff can handle difficult situations.

ADMINISTRATION

Administrative support for trauma-informed services was found to be non-existent in all hospitals and it includes statements on the importance of trauma in policies; support of trauma leadership; whether program administrators monitor and participate actively in responding to the recommendations and activities of the trauma leadership; whether administrators work with a Patient Advisory Board (PAB) that includes patients who have had lived experiences of trauma; whether the program gathers data addressing the needs and strengths of patients who are trauma survivors and evaluates the effectiveness of the program and trauma- specific services; and whether administrators include at least five key principles of trauma-informed services in patient satisfaction surveys such as safety, trustworthiness, choice, collaboration, and empowerment.

TRAINING

Education/trainings of staff on trauma includes basic education on trauma; education involving trauma-informed modifications in staff's content areas; trainings in trauma-specific techniques; and whether direct service staff offering trauma-specific services are provided adequate resources for self-care, including supervision, consultation, and/or peer support that addresses secondary traumatization. It also captures whether staff participated in GBV sensitization activities, detection and management of GBV, whether staff received in-depth training on trauma-informed provision of health services; whether there is a mechanism to identify additional training or staff development needs related to specific gender-based violence issues; whether there is a mechanism to provide staff with support on a periodic basis. Hospital staff had limited participation in trainings on trauma, scoring around 20-30% on this section of the facility checklist, with Malalai Hospital scoring 0%

Based on the findings of the health staff KAP survey, 17 respondents (81%) reported receiving training on trauma prevalence, impact, and recovery. When asked about training specific to Creating Cultures of Trauma-Informed Care (CCTIC), the participants overall reported low levels (less than half) of training. 18 (86%) indicated being trained specifically on emotional safety and avoiding re-traumatization, 18 (86%) on maximizing trust and having boundaries with patients, 17 (81%) on enhancing patient choice, 17 (81%) on maximizing collaboration, and 17 (81%) on emphasizing empowerment in provision of services. Of those that had been trained, 52% had been to one or more peer support meetings since their training.

HUMAN RESOURCES

Human resource practices on trauma captures whether prospective staff interviews include questions on trauma and whether staff performance reviews include trauma-informed skills and tasks, including the development of safe, trustworthy, collaborative, and empowering relationships with patients that maximize patient choice. No hospital held any of these activities.

4.3 GBV TRAININGS, ATTITUDES, KNOWLEDGE, AND PRACTICE AMONG HEALTH STAFF

BACKGROUND OF HEALTH STAFF

The background of the respondents varied in terms of years working, specialty, unit and level of education. Of the 21 respondents, 81% (17) were female. 43% reported having a Masters degree, 19% a four-year degree, 24% a two-year degree, and 14% indicated high school as their highest level of education. Of those surveyed, 14% identified as general doctors; 14% as OBGYN; 14% as surgeons; 14% as nurses; 38% as midwives; and 5% as counsellors. The units that individuals identified working in as are follows: 43% in OBGYN; 14% in surgery; 5% (1) in the burn unit; 5% in paediatrics; 5% in OPD; 5% in mental health; and 5% as other.

In total, almost 50% of the respondents had been working in health care for less than 5 years, indicating a relatively new workforce. Additionally, 53% had been working in their current hospital for less than 5 years with 43% less than 3 years. This may be of particular interest as previous studies have shown that health workers who have worked for less time in the facility provide better quality of care for

55 N= 70, M=4.01, SD = .647

sexual assault.[56] Years working in current hospital compared to total time working in health care can indicate a high turnover which may impact on the THTP programme, as it will be expanded upon in the discussion. Other factors reported with high quality of care in this study were if the provider was over the age of 40, if their facility had a clinical management protocol for caring for survivors, and if the health worker perceived rape to be a serious medical issue.

Table 16: Health staff work experience in health care

Years	Working in Current Hospital (%)	Working in Current Hospital (n)	Total Time Working in Health Care	Total Time Working in Health Care (n)
<1	14%	3	5%	1
1-2	19%	4	24%	5
2-3	14%	3	10%	2
3-5	10%	2	14%	3
>5 and <10	10%	2	19%	4
>10	19%	4	19%	4

GBV TRAINING

Of those surveyed, 95% reported that they had completed training specific to GBV care. Of those, 38% (8) had completed that training within the last year, 71% in the last two years, and 2 respondents had received their training more than 2 years ago.[57] Of those who indicated receiving any training, only one respondent reported having no refresher, meaning 92% have had follow-up trainings. This may indicate that GBV training has been implemented for many years in total, but with infrequent refresher and/or primary trainings being deployed.

ATTITUDES

As seen in the following two tables, health workers' attitudes relating to SGBV are of concern. Health workers were asked specific questions relating to their overall attitudes towards SGBV (Table X) and other than one questions relating to socio-economic classes and GBV, no more than two thirds reported appropriate attitudes. Victim-blaming is apparent among health workers as 48% stated that if women experience violence is because they provoked it and according to 57% of health workers surveyed, a woman provokes a partners' violence because of her own behaviour. Of grave concern is that health care providers' attitudes to and beliefs regarding sexual and physical violence may be quite poor.

Table 17: Health worker attitudes towards GBV

Question	SA or A	Neutral	D or SD
Violence is a normal part of marriage	33%	-	67%
If a patient experienced violence, she provoked it	48%	4%	48%
Violence Against Women only happens amongst the poor and uneducated	24%	-	76%
A woman provokes a partners' violence because of her own behaviour	57%	10%	33%
There are times when a husband is justified in beating his wife	48%	4%	48%
A man who forces a woman to have sex cannot control his behaviour	62%	14%	24%
Question		True	False
If a woman doesn't want to get pregnant it is okay for a husband to get her pregnant		48%	52%

*SA = strongly agree, A= agree, D= disagree, SD= strongly disagree

Health workers surveyed were also asked about their beliefs specific to health care provider responsibilities. Four felt that preventing, detecting and managing GBV is not part of the work of a health provider (19%) and three that violence against women is a family matter and not a matter of public health policy (15%). Eight (38%) believe that health service providers do not have time to inquire about GBV, which was in line with time pressure that health professionals mentioned in all focus group discussions. Notable is the discomfort in health providers for addressing IPV as almost half do not feel comfortable discussing IPV or sexual violence with patients as over half (11 respondents, 52%) think that asking patients about IPV could offend them.

56 Christofides, Nicola J; Jewkes, Rachel K; Webster, Naomi; Penn-Kekana, Loveday; et al., "Other patients are really in need of medical attention"-the quality of health services for rape survivors in South Africa", World Health Organization. Bulletin of the World Health Organization 83.7 (Jul 2005): 495-502. http://search.proquest.com/openview/d7a591ab69f226fa8ed24c-9d5a09b66b/1.pdf?pq-origsite=gscholar&cbl=38034

57 4 respondents did not know or refused to answer

Table 18: Health worker attitudes towards GBV in the work-place

Question	SA or A	Neu-tral	D or SD
Preventing, detecting and managing violence against women is not part of a health providers job	14%	5%	81%
Most health service providers do not have time to inquire about suspected cases of IPV or sexual/physical violence	24%	14%	62%
I would not feel comfortable discussing IPV or sexual/physical violence with patients	19%	10%	71%
Asking clients about violence in their intimate relationships would offend them	52%	19%	29%
I do not believe I can help victims of violence	10%	10%	80%
Violence against women is really a family matter and not a matter for public health policy	14%	10%	76%

*SA = strongly agree, A= agree, D= disagree, SD= strongly disagree

From these responses, it appears that health care providers, though they may recognize that SGBV management is part of their job, they are sometimes uncomfortable with the topic in their work. This is important for training and policy implications, where focus needs to be put on making health workers more comfortable with the topic through practice-based training. Discussions with SGBV survivors to break down misconceptions could be also beneficial as 55% of women felt they would feel comfortable seeking treatment at a health facility if they experienced abuse from a family member and 51% if they experienced abuse from a non–family member.

KNOWLEDGE

GENERAL KNOWLEDGE

Health workers were asked general knowledge questions relating to SGBV in Afghanistan as outlined in Table 7. Other worrisome responses were related to knowledge of the prevalence of SGBV in Afghanistan consequences of GBV specifically related to HIV/AIDS, and risk factors related to women experiencing and reporting violence.

Table 19: Health provider's knowledge on SGBV

Question	True	False*
Often a woman stays in an abusive relationship because of depression, social isolation or lack of family support	95%	5%
Many cases of IPV/CV remain unreported because of shame to keep family together	95%	5%
Gender based violence contributes to HIV/AIDS	76%	19%
It has been found that approximately 8 out of 10 Afghan women have experienced violence in their lives	62%	19%
Afghanistan is one of the only countries in the world where women experience violence from family members and their husbands	43%	48%
War and conflict increases the threat of domestic violence and SGBV	91%	5%

*totals not equalling 100% had respondents answering don't know or refused to answer

RIGHTS

Only 52% of participants accurately identified that Afghanistan has specific laws on GBV/IPV. 62% of respondents knew that the MoPH has developed standards and protocols on management of sexual violence. 57% answered false to the statement 'health workers in government facilities are not required to report cases of IPV to the police'. Encouragingly, 86% properly noted that preventing women from getting an education, medical services or working is prohibited and regulated by law and 76% knew baad (or giving away girls for settling disputes) is illegal. 76% of the participants answered correctly that forcing a woman into isolation is not allowed and regulated by law, and the same that cursing intimidating or degrading a woman is not allowed and is regulated by law. 71% knew that it is illegal for girls until 15 to get married even if her parents consent, and 76% that it is a crime to shove or slap a woman even if no injury occurs. Of grave concern however, is that 57% reported that by law woman who run away from home are required to pass a virginity test in order to not be put in prison.

AWARENESS

Table 20: Knowledge institutions protecting survivors of GBV

Institution	Yes	No*
Department of Women	95%	5%
Family Resolution Units	86%	14%
EVAW Unit of Attorney General	76%	24%
Afghanistan Independent Human Rights Commission	91%	9%

Family Protection Centre at a healthcare facility	91%	9%
Women's Protection Centre	91%	9%
Family Guidance Centres	91%	9%

*reported as either No, Don't Know or refused to answer

When specifically asked about forms of violence against women, 95% stated that when a husband verbally humiliates a wife and if 100% that a man hits his wife, they are forms of VAW. 91% reported that a husband insisting on having sex with his wife when she does not want to, and 76% that a man who has sex with a woman or girl against her will is a form of VAW.

As for warning signs that someone may be at risk of or be a victim of VAW, the majority of respondents identified physical pain as warning signs, such as physical injury during pregnancy (86%), injuries that don't match the explanation of how they occurred (86%), chronic vague complaints that have no obvious physical cause (71%) and chronic pelvic pain (67%). Interestingly however, is that less than half (38%) noted depression or past attempts of suicide as potential warning signs of someone who may be at risk or be a victim of VAW, and only 48% recognized early entry into antenatal care as a potential warning sign.

MENTAL HEALTH SYMPTOMS

Health workers demonstrated varying degrees of knowledge relating to mental health and GBV.

Table 21: Identification of potential mental health symptoms and triggers for re-traumatization for survivors of GBV

Potential Symptoms of GBV	Yes	No*
Changes in sleep patterns or appetite	100%	0%
Being easily started by noises or unexpected touch	95%	5%
Fear or anxiety	100%	0%
Grief, disorientation or denial	100%	0%
Hyper alertness or hyper vigilance	95%	5%
Irritability or outbursts of anger or rage	100%	0%
Emotional swings	100%	0%
Nightmares	100%	0%
Panic or feeling out of control	95%	5%
Having a need to control everyday experiences	71%	29%
Isolating oneself	100%	0%
Having a restricted range of feelings	91%	9%
Difficulty trusting others	95%	5%
Feeling of self-blame	95%	5%
Shame	100%	0%
Difficulty concentrating	100%	0%
Potential triggers of re-traumatization		
Touching parts of the body where violence was inflicted	100%	0%
Experiencing similar stress reactions to those experienced during the event	95%	5%
A sound that is similar to one experienced during the event	100%	0%
A scene that is similar to an experience	100%	0%
Returning to the place	100%	0%

*reported as either No, Don't Know or refused to answer

PRACTICE

Health workers demonstrated mixed competency in terms of practice related to GBV. There were mixed findings in terms of how providers should assess risks of GBV, with the majority of respondents (95%) indicating they should ask the client if she has ever been hurt, 86% asking if she is currently in danger, and concerning is that 81% indicated they could ask what she may have done to be abused as to avoid it in the future. However, only around half of the respondents indicated they could assess risk by asking the woman if violence has increased in the past year (52%) and asking if she worries about the safety of children (62%).

CARE FOR HEALTH WORKERS' PSYCHOLOGICAL WELLBEING

The health staff survey also assessed respondents in terms of their professional quality of life, which measures their level of compassion satisfaction, burnout, and secondary traumatic stress. Compassion satisfaction is about the pleasure the professional derives from being able to do their work well. For example, someone may feel like it is a pleasure to help others through their work or they may feel positively about their colleagues or their ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to one's ability to be an effective caregiver in their job. Where a score of 42 or more indicates a high level of compassion satisfaction, the average score was 46.52.[58] Only 3 respondents scored lower than 42.

Burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing one's job effectively. These negative feelings usually have a gradual onset.

58 N=21, M=46.52, SD=4.37

They can reflect the feeling that one's efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that the professional is at a higher risk for burnout. Where a score of 42 or more indicates a high level of burnout, the average score was 17.67.[59] No health workers surveyed scored higher than 27.

The second component of CF is secondary traumatic stress (STS). It is about work-related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, direct care professionals may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event. Where a score of 42 or more indicates a high level of compassion secondary traumatic stress, the average score was 29.45.[60] Only two health workers surveyed scored higher than 42.

59 N=21, M=17.67, SD=5.76

60 N=20, M=29.45, SD=8.90

CONCLU-SIONS

Health facilities scored low in terms of the CCTIC with some components scoring better than others. Patients consistently rated safety, trustworthiness, empowerment, choice and control, collaboration, and agency high, with health staff scorings lower in all of them. Health workers were not very strong in understanding the potential consequential role a health care worker can have on a survivor showing limited knowledge on re-traumatization and potential harm inflicted to a woman during an exam.

While knowledge on some SGBV topics is high, and many providers are aware of risks and procedure related practices, there appears to be difficultly with health workers seeing SGBV in more dimensional terms. Of particular concern is health workers' reported attitudes to SGBV, as indicated in Table 17. On questions that were more related to a woman's mental health or psychosocial issues, health workers often had less appropriate KAP answers. For example, less than half (38%) noted depression or past attempts of suicide as potential warning signs of someone who may be at risk or be a victim of VAW, and when provided with a scenario of a distress women, many had issues identifying an appropriate action. Additionally, staff knowledge on re-traumatization of survivors of SGBV showed a lack of understanding of the complex nature of such violence. This can be potentially linked to the attitudes of providers, where it appears that they remember facts and policies related to SGBV, but often still have limited in-depth understanding of SGBV. Additionally, while providers may know certain procedures and facts relating to SGBV, their attitudes concerning sexual based violence is of grave concern. It would appear that any previous training health workers have had was limited to basics of SGBV, without addressing systemic attitudes issues and working to create a change in health worker's perceptions and attitudes. Without this, policies might be followed in terms of treatment, but more personal aspects and interpersonal skills required for this sensitive job may be overlooked.

Health worker perception of GBV within their daily work responsibilities was also concerning, as many noted that they did not have time for it, or did not feel it was their place to discuss such issues. This highlights issues of mainstreaming GBV programming, where providers may see it as a separate task outside of their regular activities as opposed to one which should be integrated into daily practice for all women. Additionally, the high-turnover of health staff, as indicated by majority having worked in their current facility for less than 3 years, may have negative implications for the THTP programme in terms of sustainability. The training delivery model, refresher training courses and quotas for number of staffs trained within each facility need to be done in consideration with a likely high turn-over rate.

The preparedness of health facilities and the health staff will not be able to affect effective change in SGBV practices and treatment if survivors or those at risk of SGBV do not utilize their services. Under reporting to health staff was experienced in this survey and is well documented within the literature. Findings from the "Acceptability" component of the exit-survey also demonstrate some concerning trends from women regarding care-seeking practices or attitudes. For example, only 55% of women said they would feel comfortable seeking care for SGBV, 19% said it was strictly a family matter, 45% would be offended if their health worker

asked them about abuse, and 40% fear a health worker would report their abuse. Such concerns can deter a woman from seeking care. In order for the THTP programme to be maximally effective, the acceptability of services to potential users needs to be high.

Sustainability of the THTP programme may depend on the following: staff retention and attrition; frequency of trainings, refresher trainings and supportive supervision; collaboration and harmonization with other partners (for instance, WHO and the GBV Treatment Protocol) and programme embededdness within the MOPH. Though only the first two from the aforementioned list falls within the scope of this report, ensuring that the THTP programme is not implemented in a 'vertical' manner may be of importance. Well cited within health programming literature is the need for programmes to take holistic, systems thinking approaches that work in partnership with ongoing activities and a need for government buy-in. Vertical programmes implemented have raised concerns regarding parallel services, and averting resources from an already strained systems. More vertical interventions may also disproportionately affect systems that are already constrained by the human resources for health (HRH) crisis, lack of resources and poor infrastructure. This concern regarding vertical programming is also echoed in the seemingly lack of mainstreaming SGBV screening and treatment. Without acknowledging the systems that block uptake of SGBV services or provision, the full potential for the THTP programme cannot be actualized.

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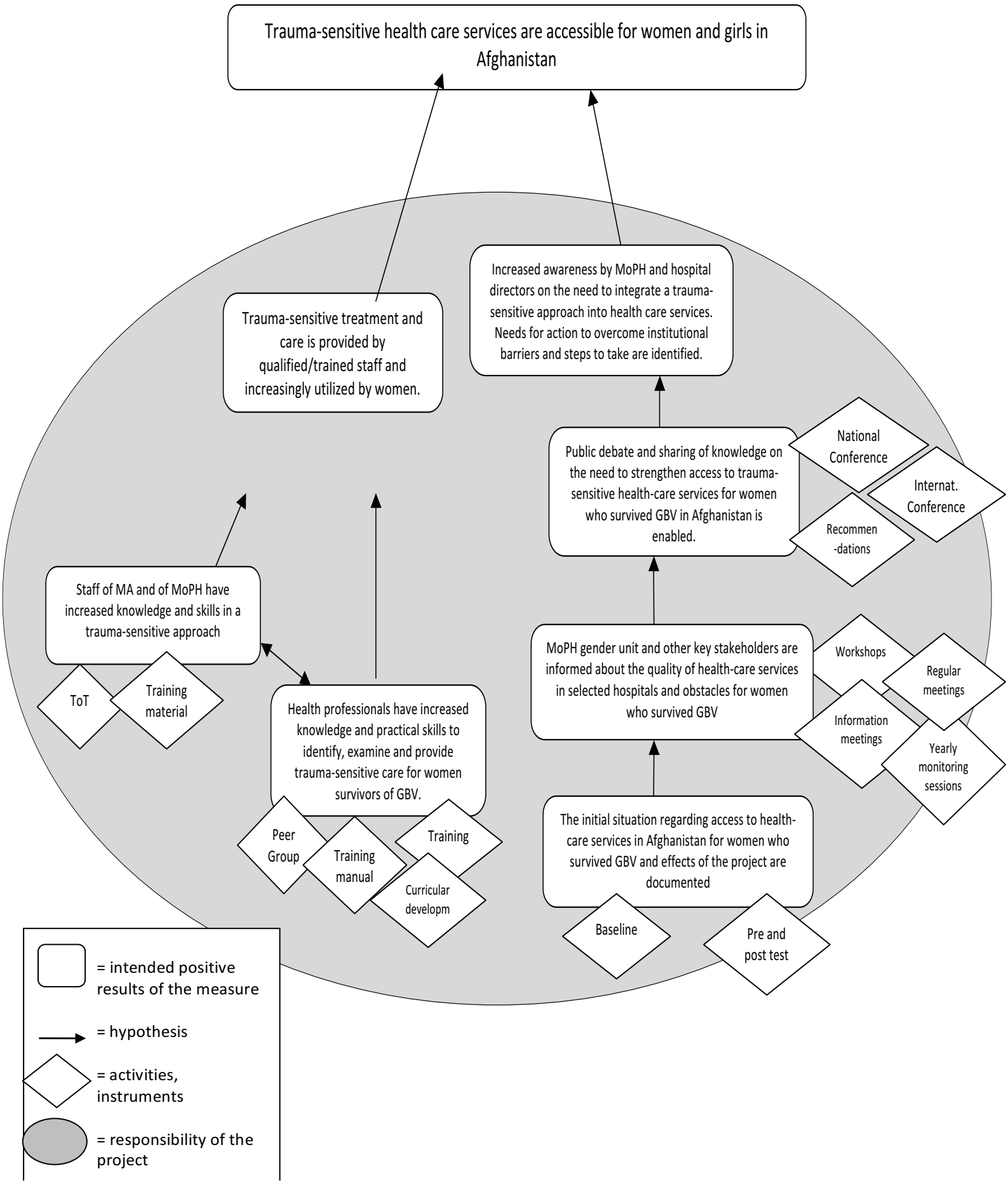
ANNEX A: LOGFRAME AND RESULTS CHAIN

*MH: Malalai Hospital in Kabul, RBH: Rabia Balkhi hospital in Kabul, HR: Heart Regional Hospital, BR: Balkh Regional Hospital

Hierarchy of Objectives	Key Indicators	Baseline Measurement Tool	Baseline Status
Impact (Overall Goal)			
The project contributes to enhancing access to healthcare for women and girls in Afghanistan by improving the quality of healthcare services	Documented improvement of women's access to counselling services in selected government run hospitals and clinics	▯ Facility checklist: number of mental health referrals in the past six months (within and outside the health facility) ▯ KAP survey: awareness of mental health services; referral scenarios (multiple response question) ▯ Patient survey: MHI-5 screening and referral data	▯ MH: unknown, RBH: 2, HR: 41, BR: 34 ▯ 62% of health staff would refer a woman visibly upset entering the health facility to a psychologist ▯ The average MHI-5 for all patients surveyed is M=2.977 (N=72, SD=1) where 1 indicates a very poor mental health and 5 good mental health. The finding indicates that patients scored average and these have nor poor nor good mental health. One patient (or 1.4% of all women surveyed) also received a referral for mental health services (after reporting an abuse to the health provider).
Outcomes			
Outcome 1: Trained health-care staffs provide trauma-sensitive treatment and care for women affected by GBV. Up to 300.000 female patients make use of trauma-sensitive health- care services in Kabul, Mazar-e Sharif and Herat.	Increased number of GBV cases reported by selected hospitals	▯ Facility checklist: number of GBV cases reported in past six months	MH: 5 to 6, RBH: 18, HR: 263, BR: 87
	# of beneficiaries with increased satisfaction with healthcare services and treatment	Cannot measure at baseline; refers to those who receive services from trained providers; would require satisfaction survey with all patients treated by trained healthcare providers	
Outcome 2: Increased awareness by MoPH and hospital directors on the need to integrate a trauma-sensitive approach into health-care services. Needs for action to overcome institutional barriers and possible steps to take are identified.	Increased satisfaction of beneficiaries with health care services and treatment	▯ End-line patient survey	/
	# of international advocacy events held with a focus on GBV, and relevant mental health policy in Afghanistan	NA; baseline is zero	

Outputs			
Output 1: 80 Health professionals have improved attitude, knowledge and practical skills to identify, examine and provide trauma-sensitive care for women survivors of GBV.	Curricula and manuals are available in Dari and English before the start of the trainings	NA; baseline is zero	
	Increased level of knowledge, skills, and attitudes of health staff by end of training cycle	Staff KAP survey (Also should be measured through pre- and post-training tests implemented by MA throughout the project)	
Output 2: 10 staff of Medica Afghanistan and 5 staff of MoPH have increased knowledge and skills in a trauma- sensitive approach.	Increased level of knowledge, skills and attitudes by the end of training	NA; will be measured by MA through pre- and post-training tests	
Output 3: The initial situation regarding access to health-care services in Afghanistan for women who survived GBV and effects of the project is documented.	Baseline study is available	Baseline study will achieve this indicator	45% of patients would feel offended if provider asked them about GBV; 55% would seek health-care after abuse from a family member and 50% if abused by a non family member; 51% would seek mental health treatment after abuse of family member and 68% if abused from a non family member.
	Monitoring reports are available	NA; baseline is zero	
	Evaluation report available.	NA; baseline is zero	
Output 4: MoPH, gender unit and other key stakeholders are informed about the quality of health-care services in selected hospitals and obstacles for women affected by GBV.	Number of training certificates validated by the MoPH	NA; baseline is zero	
	Regular meetings (every six months) with MoPH	NA; baseline is zero	
	Number of cases referred to MA counsellors by MoPH and trained hospitals in Kabul, Herat, and Mazar-e Sharif.	Review of MA 2015 database report	
Output 5: Public debate and sharing of knowledge on the need to strengthen access to trauma-sensitive health-care services for women affected by GBV in Afghanistan is enabled.	Action plan presented at National Conference in 3rd year of project	NA; baseline is zero	

RESULTS CHAIN



Source: Medica Afghanistan, internal document

ANNEX B: BASELINE TOOLS

FACILITY STAFF FGD

1. Name of Facility:_____
2. Address:_____
3. Date of Visit (dd/mm/yy): _____/_____/_____
4. Start time: __ __ : __ __ (am / pm)
5. End time: __ __ : __ __ (am / pm)
6. Name of Interviewer:_____
7. Participants:

Name	M/F	Position

Component 1: Care Pathway for GBV
The goal of Step One is to create a process summary of care for GBV survivors. It should help to gain a comprehensive sense of the experiences of both patients and staff members as they come to the setting and participate in its activities, relationships, and physical settings. The goal of this review is to capture for each of these groups—patient and staff—their experiences in detail from their very first to their very last contact with the program or agency. Though some programs accomplish this effectively by forming a representative workgroup to review the full range of contacts, others have found it very helpful to engage in a "walk-through." A walk-through is a process in which staff members come to the setting "as if" they are new patients and thus enter the setting with a patient-oriented perspective. For this part of the process, it is very important to take detailed notes on a flipchart that everyone can see. The activities, staff members, and settings will be revisited throughout the entire process, so it is important that they are thoroughly documented and that all participants can see them visually to revisit throughout the FGD. Instruct the FGD participants to begin from the GBV survivor entering the facility, and to outline each step in the screening, treatment, and referral process as applicable.

Component 2: Semi-Structured FGD

1. Are there any changes in GBV services at your facility in the past year?
    - If yes, please describe
2. Are there any changes in your GBV policies in the past year?
    - If yes, please describe
3. What procedure is in place for reporting data to MoPH on GBV?
4. Do you think GBV survivors need additional services other than what is offered at the health facility?
    - What types of services, and how do they get knowledge of them?

CCTIC:

For any areas that were not covered in the walk-through, address the following components of the facility's services:

- Physical and emotional safety of patients and staff
- How the facility's services foster trustworthiness for patients and staff
- How the facility's services and settings impact patient and staff experiences of choice and control
- How the facility's services influence collaboration between patients and staff, and between staff, supervisors and administrators
- How the facility's services prioritize patient empowerment, and empowering staff through skill building
- How formal policies reflect and understanding of trauma survivors needs, strengths and challenges, and the needs of staff
- How administrators integrate knowledge about violence and abuse into all facility practices

FACILITY OBSERVATION AND CHECKLIST

1. Name of Facility:_____
2. Address:_____
3. Date of Visit (dd/mm/yy): _____/_____/_____
4. Name of Interviewer:_____

CCTIC Checklist								
Criterion		**1**	**2**	**3**	**4**	**5**		
Safety								
1	The program has conducted a specific and systematic review of its physical setting and its activities in order to evaluate its physical and emotional safety and to make changes necessary to ensure patient and staff safety.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including both patient- survivor and line staff input.	In addition to (2), an action plan to maximize safety has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.		
	Notes:							
2	Incident Review: The program systematically reviews those incidents that indicate a lack of safety (e.g., verbal and physical confrontations, assaults) and makes changes to prevent their recurrence.	No incident reviews have occurred.	A plan has been developed for identifying and reporting incidents that indicate a lack of safety (incl. both patient and staff reports).	In addition to (2), a plan has been developed for clinical and administrative review of incidents that indicate a lack of safety.	In addition to (3), the plan has been implemented.	In addition to (4), the incident reviews are used to modify potentially unsafe practices or settings.		
	Notes:							
3	In program satisfaction surveys, patients rate program safety at the "agree" (or comparable, better than neutral) point on the rating scale or higher.	No patients rate program safety at the "agree" or higher point.	Fewer than 40% of patients rate program safety at the "agree" or higher point.	40-70% of patients rate program safety at the "agree" or higher point.	71-90% of patients rate program safety at the "agree" or higher point.	More than 90% of patients rate program safety at the "agree" or higher point.		
	Notes:							
4	In staff surveys, staff rate program safety at the "agree" or comparable point on the rating scale or higher.	No staff members rate program safety at the "agree" or higher point.	Fewer than 40% of staff members rate program safety at the "agree" or higher point.	40-70% of staff members rate program safety at the "agree" or higher point.	71-90% of staff members rate program safety at the "agree" or higher point.	More than 90% of staff members rate program safety at the "agree" or higher point.		
	Notes:							
Total Score Safety:	_____/20							

Additional Items		Yes	No	Don't Know (DK)	Not Applicable (NA)		
5	The program facility has a security system.						
6	Staff monitor who is coming in and out of the facility.						
7	Blank copies of "Risk Assessment and Safety Planning" forms are available to staff.						
8	The facility provides a space for children.						
9	There are safety protocols in place to ensure the safety of staff.						
10	There are protocols in place to ensure the emotional safety of staff.						
Trustworthiness							

11		Program Review: The program has conducted a specific and systematic review of its physical setting and activities in order to evaluate factors related to program trustworthiness (esp. clear tasks, consistent practices, and staff-patient boundaries) and to make changes necessary to ensure that trustworthiness is maximized. (Peer-run programs usually have different boundary concerns than those with professional staffs; they need to adjust the understanding of trustworthiness accordingly. See Self-Assessment and Planning Protocol.)	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including patient- survivor input.	In addition to (2), an action plan to maximize program trustworthiness has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.		
	Notes:								
12		Review of Alleged Boundary Violations: The program has a clear procedure for the review of any allegations of boundary violations, including sexual harassment and inappropriate social contacts.	No policy exists regarding review of alleged boundary violations.	A plan has been developed for identifying and reporting incidents that indicate possible boundary violations.	In addition to (2), a plan has been developed for clinical and administrative review of alleged boundary violations	In addition to (3), the plan has been implemented.	In addition to (4), the incident reviews are used to modify practices that may lead to boundary violations.		
	Notes:								
13		Patient Ratings of Trust and Clarity of Tasks and Boundaries: Patients rate the program and its staff as trustworthy—offering clear information and maintaining appropriate professional relationships—at the "agree" (or comparable, better than neutral) point on the rating scale or higher.	No patients rate program trustworthiness at the "agree" or higher point.	Fewer than 40% of patients rate program trustworthiness at the "agree" or higher point.	40-70% of patients rate program trustworthiness at the "agree" or higher point.	71-90% of patients rate program trustworthiness at the "agree" or higher point.	More than 90% of patients rate program trustworthiness at the "agree" or higher point.		
	Notes:								
Total Score Trust:			_____/15						

Additional Items		Yes	No	DK	NA
14	The facility has a clear organogram, which clarifies what will be done, by whom, when, why, under what circumstances, at what cost, with what goals.				
15	There are clear protocols in place for staff regarding boundaries with patients (i.e. related to touching, information sharing, meeting outside the facility, loaning money, etc.)				
16	The program provides clear information to patients regarding what services are provided, and which are not, and what patients' expectations should be.				
17	The consent process is structured, and consent can be said to be informed. The goals, risks, and benefits are clearly outlined and the patient has a genuine choice to withhold consent or give partial consent.				
18	All directors and supervisors are aware of the emotional impact of the work that direct care staff provide (i.e. burnout, vicarious trauma, compassion fatigue, etc.), and this understanding is clearly communicated.				
19	There are written directives regarding the limits of confidentiality (suicidal patients, if someone is a threat to another person, child abuse, etc.)				
20	There are policies and practices in place to encourage self-care.				
21	Direct care staff receive clinical supervision that attends to both patient and clinical concerns.				
22	There are clear policies and open channels in place for supervisees to communicate concerns to supervisors and administrators.				
Choice					

23		Program Review: The program has conducted a specific and systematic review of its physical setting and its activities in order to evaluate patient choice and control and to make changes necessary to maximize patient choice.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including patient- survivor input.	In addition to (2), an action plan to maximize patient choice has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.	
	Notes:							
24		Patient Ratings of Choice and Control: In program satisfaction surveys, patients rate their experience of choice and control in the program at the "agree" (or comparable, better than neutral) point on the rating scale or higher.	No patients rate patient choice at the "agree" or higher point.	Fewer than 40% of patients rate patient choice at the "agree" or higher point.	40-70% of patients rate patient choice at the "agree" or higher point.	71-90% of patients rate patient choice at the "agree" or higher point.	More than 90% of patients rate patient choice at the "agree" or higher point.	
	Notes:							
Total Score Trust:			_____/10					

Additional Items		Yes	No	DK	NA
25	Patients choose what services they would like to receive.				
26	Patients choose who the service is provided by.				
27	Patients choose when to start services.				
28	Patients can choose to stop services.				
29	Patients are provided with choices and options regarding when, what, and where services are provided.				
30	Patients are provided with a verbal explanation of their rights and responsibilities.				
31	Patients are provided with a written explanation of their rights and responsibilities.				
32	Policies are flexible, and built with an understanding of promoting staff experiences of choice and control.				
33	Staff members have had input into factors affecting their work.				

Collaboration								
34		Program Review: The program has conducted a specific and systematic review of its activities in order to assess the quality of collaboration in staff-patient relationships and to identify opportunities for enhancing this collaboration.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including patient- survivor input.	In addition to (2), an action plan to maximize patient-staff collaboration has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.	
	Notes:							
35		Patient Ratings of Collaboration: Patients rate the program and its staff as collaborative—sharing power and respecting patient perspectives—at the "agree" (or comparable, better than neutral) point on the rating scale or higher.	No patients rate program collaboration at the "agree" or higher point.	Fewer than 40% of patients rate program collaboration at the "agree" or higher point.	40-70% of patients rate program collaboration at the "agree" or higher point.	71-90% of patients rate program collaboration at the "agree" or higher point.	More than 90% of patients rate program collaboration at the "agree" or higher point.	
	Notes:							
Total Score Collaboration:			_____/10					

Additional Items		Yes	No	DK	NA
36	Procedures are in place and utilized for patients to evaluate the services provided.				
37	There is a Patient Advisory Board.				
38	The Patient Advisory Board has members who identify as trauma survivors.				
39	Patients are involved in service planning meetings.				
40	There are feedback mechanisms for staff.				

Empowerment

41		Program Review: The program has conducted a specific and systematic review of its activities in order to assess the extent to which the program facilitates patient empowerment and skill-building and to identify opportunities for enhancing this priority.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including patient- survivor input.	In addition to (2), an action plan to maximize patient empowerment and skill-building has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.	
	Notes:							
42		Patient Ratings of Empowerment: Patients rate the program and its staff as facilitating empowerment and skill-building at the "agree" (or comparable, better than neutral) point on the rating scale or higher.	No patients rate patient empowerment and skill- building at the "agree" or higher point.	Fewer than 40% of patients rate patient empowerment and skill-building at the "agree" or higher point.	40-70% of patients rate patient empowerment and skill-building at the "agree" or higher point.	71-90% of patients rate patient empowerment and skill-building at the "agree" or higher point.	More than 90% of patients rate patient empowerment and skill-building at the "agree" or higher point.	
	Notes:							
Total Score Empowerment:			_____/10					

Additional Items		Yes	No	DK	NA
43	Patients' strengths and resources are assessed.				
44	There are continuous training opportunities for staff.				
45	There are supervisory feedback mechanisms in place.				

Formal Service Policies								
46		Eliminating Involuntary Treatment: The program has developed written policies that seek to eliminate involuntary or coercive practices (seclusion and restraint, involuntary hospitalization or medication, outpatient commitment).	No relevant policies have been developed.	Policies designed to eliminate involuntary treatment have been developed.	In addition to (2), policies are consistently implemented.	In addition to (3), instances of involuntary treatment are regularly reviewed in order to improve practice.	In addition to (4), survivor- patients are routinely involved in this review of both policy and practice.	
	Notes:							
47		Patient Crisis Preferences (A): The program has a written policy and formal procedure for inquiring about and respecting patient preferences for responding in crisis situations.	No policy or procedure has been developed.	A relevant policy, specifying a procedure (e.g., a standard form) for inquiring about patient crisis preferences, has been developed.	In addition to (2), this procedure includes steps to ensure the staff's awareness of and attention to these preferences.	In addition to (3), instances of crisis response are regularly reviewed in order to ensure consideration of patient preferences.	In addition to (4), crisis response procedures are adjusted as necessary to maximize attention to patient preferences.	
	Notes:							
48		De-escalation Policy: The program has a written de-escalation policy that minimizes possibility of retraumatization; the policy includes reference to a patient's statement of preference for crisis response.	No written de-escalation policy exists.	The program has a written de- escalation policy that minimizes retraumatization and includes patient crisis preferences.	In addition to (2), this policy is regularly implemented.	In addition to (3), de-escalation situations are regularly reviewed in order to ensure attention to patient preferences.	In addition to (4), the de-escalation policy is adjusted as necessary to maximize attention to patient preferences.	
	Notes:							
49		Confidentiality (A): Policies regarding confidentiality (including limits) and access to information are clearly written and maximize legal protection of patient privacy.	No written confidentiality policy exists OR it is written in a way difficult for patients to understand.	A written confidentiality policy exists and is clearly written.	In addition to (2), the policy maximizes the legal protection of patient privacy.	In addition to (3), instances that reflect limits of confidentiality are routinely reviewed.	In addition to (4), confidentiality policy is adjusted to maximize clarity and patients' privacy within legal limits.	
	Notes:							

50		Patient Rights and Responsibilities (A): The program has a clearly written and easily accessible policy outlining patient rights and responsibilities.	No written patient rights and responsibilities policy exists OR it is written in a way difficult for patients to understand.	A written statement of patient rights and responsibilities exists and is clearly written.	In addition to (2), the statement is readily available for patients.	In addition to (3), the statement is reviewed for possible revision on at least an annual basis.	In addition to (4), patient- survivors are involved in the writing of the statement.	
	Notes:							
Total Score Formal Service Policies:			_____/25					

Additional Items		Yes	No	DK	NA
51	Consent is obtained in verbal form.				
52	Consent is obtained in written form.				
53	Patients are provided with a written consent form/information.				
54	Blank copies of "Consent Forms" are available to staff.				
55	There is a separate storage space (cupboard, drawer, file box), with a lock for keeping GBV survivors' documentation? (with only those directly involved with care having access).				
56	De-identification of personal data occurs in circumstances where no consent is given.				
57	Copies of the EVAW Law accessible to managers and staff.				
58	Copies of the GBV Treatment Protocol are accessible to managers and staff.				

Trauma Screening, Assessment, and Service Planning								
59		Universal Trauma Screening: Every patient is asked about exposure to trauma.	No patient has been asked about trauma exposure.	Fewer than 30% of patients surveyed were asked about trauma exposure.	30-60% of patients surveyed were asked about trauma exposure.	61-90% of patients surveyed were asked about trauma exposure.	More than 90% of patients surveyed were asked about trauma exposure.	
	Notes:							
60		Trauma Screening Content: The trauma screening includes questions about lifetime exposure to sexual and physical abuse.	No standardized trauma screening approach exists.	A standardized screening for trauma has been approved but not implemented.	A standardized screening approach has been implemented but does not include questions about sexual or physical abuse.	The screening includes questions about EITHER sexual OR physical abuse OR about abuse in general OR about a specific time period.	The standardized screening includes questions about lifetime exposure to both physical and sexual abuse.	
	Notes:							
61		Screening for Psychological Distress: The screening of patients includes psychological symptoms.	No patient has been asked about psychological symptoms.	Fewer than 30% of patients surveyed were asked about psychological symptoms.	30-60% of patients surveyed were asked about psychological symptoms.	61-90% of patients surveyed were asked about psychological symptoms.	More than 90% of patients surveyed were asked about psychological symptoms.	
	Notes:							
62		Trauma Screening Process: The trauma screening is implemented in ways that minimize patient stress; it reflects considerations given to timing, setting, relationship to interviewer, patient choice about answering, and unnecessary repetition.	No discussion of the screening process has occurred.	A plan for minimizing stress in screening has been developed.	A screening plan that includes flexible responses to patients has been implemented.	The screening process is routinely reviewed to ensure that it minimizes patient and staff distress.	Patients and staff report satisfaction with the screening process.	
	Notes:							

63		Trauma Assessment: Unless specifically contraindicated due to patient distress, the program conducts a more extensive assessment of trauma history and needs and preferences for trauma-specific services for those patients who report trauma exposure.	The program has conducted no trauma assessments.	A plan for conducting trauma assessments has been developed.	An assessment plan that includes both trauma history and service needs and preferences has been implemented.	The assessment process is routinely reviewed to ensure that it minimizes patient and staff distress.	Patients and staff report satisfaction with the assessment process.	
	Notes:							
64		Trauma-Specific Services: The program offers, or has identified other programs that offer, trauma-specific services with four "criterion" characteristics: effective, accessible, affordable, and responsive to the preferences of the program's patients.	No trauma- specific services are offered or identified.	Offered or identified trauma- specific services have one of the four criterion characteristics.	Offered or identified trauma- specific services have two of the four criterion characteristics.	Offered or identified trauma- specific services have three of the four criterion characteristics.	Offered or identified trauma- specific services have all four of the criterion characteristics.	
	Notes:							
Total Score Trauma Screening, Assessment, and Service Planning:		_____/30						

Additional Items		Yes	No	DK	NA
65	Client history forms are used for each client.				
66	Client history forms include psychological services.				
67	Client history forms include history of abuse.				
68	There is a mechanism for documenting whether a client has been screened for violence/ abuse.				
69	There is a form for documenting the details of a case of violence (for example, documenting information that can be used in court if a woman decides to pursue legal action)				
70	There are blank copies of "Medical Certificates for an Adult – GBV" and "Medical Certificates for a Child" forms available to staff.				
71	The facility has a directory of organizations that provide gender-based violence-related services.				
72	The directory has been updated in the last year.				
73	The directory includes organizations that provide legal aid services.				
74	The directory includes organizations that provide protection services.				
75	The directory includes organizations that provide protection shelter.				
76	The directory includes organizations that provide psychosocial services.				
77	Is there a mechanism to verify whether the client went to the gender-based violence-related service referral made inside the facility?				
78	Is there a mechanism to determine the client's satisfaction with referral?				

Administrative Support for Program-Wide Trauma-Informed Services								
79		Written Policy Statement: The program has adopted a formal policy statement that refers to the importance of trauma and the need to account for patient experiences of trauma in all aspects of program operation.	No senior level discussion has occurred.	Senior level administrators have participated in discussion of statement.	In addition to (2), administrators have reviewed draft statement.	In addition to (3), administrators have approved adoption of statement.	In addition to (4), statement is prominently displayed in program description.	
	Notes:							
80		Support for Trauma-Informed Leadership: The facility has named a trauma specialist or workgroup(s) to lead agency activities in trauma-related areas and provides needed support for trauma initiatives.	No trauma specialist or workgroup has been identified.	Specialist or workgroup has been identified and given a clear mission.	In addition to (2), resources (staff time, budget) have been allocated.	In addition to (3), action plan has been adopted and initial steps taken.	In addition to (4), initial action plan has been substantially completed.	
	Notes:							

81		Administrative Participation in and Oversight of Trauma-Informed Approaches: Program administrators monitor and participate actively in responding to the recommendations and activities of the trauma leadership.	No reporting or monitoring of trauma-related activities occurs.	Administrators are informed of trauma specialist or workgroup activities.	In addition to (2), administrators meet periodically with trauma specialist or workgroup.	In addition to (3), administrators routinely monitor implementation of trauma activities.	In addition to (4), administrators include trauma initiatives in formal reports and publications.	
	Notes:							
82		Trauma Survivor-Patient Involvement (A): Administrators work with a Patient Advisory Board (CAB) that includes patients who have had lived experiences of trauma.	No Patient Advisory Board exists.	Patient Advisory Board exists but has no self-identified trauma survivor-patients.	Patient Advisory Board has one member who self- identifies as a survivor- patient.	Patient Advisory Board has at least two members who self-identify as survivor- patients.	In addition to (4), administrators ensure that trauma initiatives are addressed in meetings with the CAB.	
	Notes:							
83		Needs Assessment and Program Evaluation: Program gathers data addressing the needs and strengths of patients who are trauma survivors and evaluates the effectiveness of the program and trauma- specific services.	No data are gathered.	The program has gathered data regarding prevalence of trauma and needs of survivors.	In addition to (2), the program has developed a plan to monitor the process (incl. patient satisfaction) and outcomes of trauma services. Two or three of the areas are included in surveys.	In addition to (3), the program regularly monitors process and outcomes.	In addition to (4), the program incorporates program evaluation results in its planning for trauma-related services.	
	Notes:							
84		Trauma and Patient Satisfaction: Administrators include at least five key principles of trauma-informed services in patient satisfaction surveys: safety, trustworthiness, choice, collaboration, and empowerment (see Domain 1).	None of the five areas is included in surveys (or surveys are not standardized).	One of the areas is included in surveys.	Two or three of the areas are included in surveys.	Four of the areas are included in surveys.	All five of the areas are included in surveys.	
	Notes:							
Total Score Administrative Support for Program-Wide Trauma-Informed Services:			_____/30					
Staff Trauma Training and Education								
85		General Trauma Education for All Staff (A): All staff (including administrative and support personnel) have participated in at least three hours of "basic" trauma education that addresses at least the following: a) trauma prevalence, impact, and recovery; b) ensuring safety and avoiding retraumatization; c) maximizing trustworthiness (clear tasks and boundaries); d) enhancing patient choice; e) maximizing collaboration; and f) emphasizing empowerment.	No trauma education designed for all staff has been offered.	Fewer than 30% of staff have participated in basic trauma education OR more than 50% of staff have received trauma education that includes only one of the content areas.	30-60% of staff have participated in basic trauma education OR more than 50% of staff have received trauma education that includes two or three of the content areas.	61-90% of staff have participated in basic trauma education OR more than 50% of staff have received trauma education that includes four or five of the content areas.	More than 90% of staff have participated in basic trauma education that includes all six content areas.	
	Notes:							
86		General Trauma Education for All Staff (B): All new staff receive at least one hour of trauma education as part of orientation.	No new staff have received trauma education in orientation.	Fewer than 30% of staff have received trauma education in orientation.	30-60% of staff have received trauma education in orientation.	61-90% of staff have received trauma education in orientation.	More than 90% of staff have received trauma education in orientation.	

	Notes:						
87	Education for Direct Services Staff (A): Direct service staff have received at least three hours of education involving trauma-informed modifications in their content areas (e.g., care coordination, housing, substance use).	No direct services staff have received this education.	Fewer than 30% of direct services staff have received this education.	30-60% of direct services staff have received this education.	61-90% of direct services staff have received this education.	More than 90% of staff have received this education.	
	Notes:						
88	Education for Direct Services Staff (B): Direct service staff have received at least three hours of education involving trauma-specific techniques (e.g., grounding, teaching trauma recovery skills).	No direct services staff have received this education.	Fewer than 30% of direct services staff have received this education.	30-60% of direct services staff have received this education.	61-90% of direct services staff have received this education.	More than 90% of staff have received this education.	
	Notes:						
89	Support for Direct Services Staff : Direct service staff offering trauma-specific services are provided adequate resources for self-care, including supervision, consultation, and/or peer support that addresses secondary traumatization.	No specific support for direct services staff is offered.	Administrators have developed a plan for offering support.	General support is offered but does not address secondary traumatization.	Trauma-focused support is offered and made accessible for staff.	Staff report that trauma-focused support is adequate to meet their needs.	
	Notes:						
Total Score Staff Trauma Training and Education:	_____/25						

Additional Items		Yes	No	DK	NA
90	Has all staff participated in gender-based violence sensitization activities?				
90a	When:				
90b	Where:				
90c	Who:				
90d	From whom:				
91	Has all relevant staff received in-depth training in the detection and management of gender-based violence? (Please note: relevant staff members are those who have direct contact with subjects of gender-based violence.)				
91a	When:				
91b	Where:				
	Who:				
91c	From whom:				
92	Has all relevant staff received in-depth training on trauma-informed provision of health services?				
92a	When:				
92b	Where:				
92c	Who:				
92d	From whom:				
93	There is a mechanism to identify additional training or staff development needs related to specific gender-based violence issues.				
94	There is a mechanism to provide staff with support on a periodic basis (i.e., staff discussion groups, supervisory sessions).				
94a	How often:				
94b	Who attends:				
Human Resources Practices					

95	Prospective Staff Interviews: Interviews include trauma-related questions. (What do applicants know about trauma, including sexual and physical abuse? About its impact? About recovery and healing? Is there a "blaming the victim" bias? Is there potential to be a trauma "champion?")	Interviews do not address trauma.	Fewer than 30% of interviews address trauma.	30-60% of interviews address trauma.	61-90% of interviews address trauma.	More than 90% of interviews address trauma.	
	Notes:						
96	Staff Performance Reviews: Staff performance reviews include trauma-informed skills and tasks, including the development of safe, trustworthy, collaborative, and empowering relationships with patients that maximize patient choice.	Performance reviews do not address trauma- informed skills.	Fewer than 30% of performance reviews address trauma-informed skills.	30-60% of performance reviews address trauma-informed skills.	61-90% of performance reviews address trauma-informed skills.	More than 90% of performance reviews address trauma-informed skills.	
	Notes:						

FACILITY PERSONNEL AND RECORD REVIEW

QUESTIONS YES NO			RESPONSES DK	 NA		
Workspace, and supplies (Must be observed in order to be recorded as 'YES.')						
1. 1	Is there a Family Guidance Center (FGC) at this health facility? (A family guidance center is a specific place where men and women can go for advice, legal support, and referrals regarding GBV and VAW)					
2. 5	5a.	Does the facility have IEC materials related to gender-based violence available for client distribution? If 'Yes,' what topics do they cover? (If no, skip to Q6.)				
	5b.	Gender-based violence services available at the facility				
	5c.	Gender-based violence services offered in other facilities				
	5d.	HIV/AIDS/STIs and gender-based violence				
	5e.	Women's rights to be free from violence				
	5f.	Emergency contraception				
3. 5	Does the facility provide a technical/clinical reference on care of clients who have experienced gender-based violence?					
Protocol for GBV screening and management (Must be observed in order to be recorded as 'YES.')						
	4a	Is there a GBV focal point or focal points at your facility? [If NO, go to 12}				
	4b	If so, how many?				
4. 1	5a.	Has there ever been an assessment of the flow of clients through the facility/clinic? (If no, skip to Q20.)				
	5b.	Were changes to the client flow implemented where necessary?				
	5c.	Has there been an evaluation of the effectiveness of the new client flow in the facility?				
Documenting information (Must be observed in order to be recorded as 'YES.')						
5. .	Is there a mechanism for analyzing and reporting screening data?					
6. .	Is there a mechanism for analyzing and reporting referral data?					
	Is there a mechanism in place to report data to MoPH					
	Last time data was reported to MoPH? (in months?)					

Personnel:	**Count (Male)**	**Count (Female)**
1. General physicians		
2. Gynecologists-obstetricians		
3. Surgeons		
4. Nurses		
5. Midwives		
6. Auxiliary nurses/midwives		
7. Community personnel – volunteers		
9. Other (Type _____)		
10. Other (Type _____)		
11. Other (Type _____)		
12. Other (Type _____)		

Personnel:	Count (Male)	Count (Female)
1. General physicians		
13. Other (Type _____)		
14. Other (Type _____)		
15. How many staff do you have who are trained in Trauma Sensitive Care and GBV?		

QUESTIONS	RESPONSES		
YES	**NO**	**DK**	**NA**
Is there always at least one female staff member on shift?			
Have any of your staff in the last 6 months, been asked to give further evidence to the police or the court on a GBV case?			

	2015					
	July	Aug	Sept	Oct	Nov	Dec
1. Number of women who were treated for SGBV related issues?						
2. How many of these women came in specifically for SGBV related complaints?						
3. How many came in for other reasons (non-SGBV) and were identified by health worker as survivors of SGBV and given appropriate care?						
4. How many of these were under the age of 15?						
5. How many of these were pregnant women?						
6. Number of (new) clients identified as subjects of physical violence by intimate partner						
7. Number of (new) clients identified as subjects of sexual violence by intimate partner						
8. Number of (new) clients identified as subjects of emotional abuse by intimate partner						
9. Number of (new) clients identified as subjects of childhood sexual abuse						
10. Number of (new) clients identified as subjects of violence who received emergency contraception as needed						
(From total in a.): Number who came to facility for services related to:						
Rape						
Of these, how many had forensic evidence collected during the initial consultation?						
Of these, how many were referred for forensic evidence collection?						
Sexual assault						
Of these, how many had forensic evidence collected during the initial consultation?						
Of these, how many were referred for forensic evidence collection?						
Physical assault						
Of these, how many had forensic evidence collected during the initial consultation?						
Of these, how many were referred for forensic evidence collection?						
Forced marriage						

Attempted suicide							
Psychosocial support (suicidal)							
Psychosocial support (non-suicidal)							
Other non-GBV related services							
Total number of females who came to facility in last 6 months:							
11. How many received additional care at the health facility?							
Wound care							
Burn care							
Rape care							
Mental health care							
Other							
12. How many cases were reported to the authorities?							
13. How many times have staff testified to police or courts on a SGBV case?							
14. Number of clients identified as subjects of violence referred to other services within the health facility							
HIV/AIDS/STI treatment							
Child welfare/nutrition							
Mental health care							
Social services							
Employment/income-generation services							
Legal assistance							
Protection/shelter services							
15. Number of clients identified as subjects of violence referred to other services outside the health facility							
HIV/AIDS/STI treatment							
Child welfare/nutrition							
Mental health care							
Social services							
Employment/income-generation services							
Legal assistance							
Protection/shelter services							
16. Number who came for follow-up appointment/s							

FACILITY KAP SURVEY

Thousand Plateaus: Medica Afghanistan Baseline Consent Form

Introduction

My name is _____, and I'm working with Thousand Plateaus, a research company based in Kabul. I would like to ask you to participate in a survey for a baseline study we are undertaking for Medica Afghanistan regarding SGBV and health services. The entire interview will take no longer than an hour. The information you provide will be used to help us learn about the project and make recommendations for similar projects in the future.

There will be no financial or material compensation for your participation. Would you be interested in participating?

{*If respondent says yes, proceed with the consent form. If the respondent does not agree to participate, politely thank him/her for his/her time and ask them to leave the discussion.}*

Consent

Your answers will be treated with the utmost privacy and confidentiality. Your identity will remain anonymous at all times, and we will not be recording your name. That means that no one will be able to link your responses to your name, and your name will never be used in connection with any of the information you tell me.

Your participation is at all times voluntary. There is no obligation to answer the questions, and you are free to refuse any question you do not wish to answer. You have the right to withdraw your agreement to participate at any time during the interview.

Would you like to participate?

{*If respondent says yes, proceed with the survey. If the respondent does not agree to participate, politely thank him/her for his/her time and leave the discussion.}*

In case of any questions or concerns, or if you feel that your rights I have explained to you are violated, please contact:

Maryam Danish (0786012593) or Marie Huber (0784050769)

Medica Afghanistan Trauma-Sensitive Health Services Baseline

Health Staff Survey Questionnaire, Afghanistan 2016

(TO BE COMPLETED BY DATA ENTRY OFFICIAL) Survey ID Number: _____

{ THIS PAGE TO BE COMPLETED BY THE SURVEYOR—DO NOT READ OUT LOUD }

Respondent has been read the consent form and has agreed to participate?	1 = Yes 0 = No **{END THE INTERVIEW}**	|____|

0.1	Province name		0.2	Province code	1 = Kabul 2 = Balkh 3 = Herat	|____|
0.3	Facility name		0.4	Facility code	11 = Rabia Balkhi hospital 12 = Malalai Hospital 13 = Isteqlal hospital 14 = Wazir Akbar Khan hospital 15 = Jamhoryat hospital 16 = Ibni Sina hospital 21 = Balkh Regional Hospital 22 = Balkh 200 bed hospital 31 = Herat Regional Hospital 32 = Shaidai Hospital	|____|
0.7	Interviewer Name		0.8	Interviewer code	|____|	
0.9	Interviewer sex	1 – Male 2 – Female |____|	0.10	Date	___ /___ / ____ Day / Month / Year	
0.11	Start time	|___|___|: |___|___|		1 = AM 2 = PM	|____|	
0.12	End time	|___|___|: |___|___|		1 = AM 2 = PM	|____|	
0.13	Interview number					

CHECKED BY SUPERVISOR: Initials: _____

Signature: _____

Date: _____

Section A: Demographics			
A1	Gender of respondent:	**{DO NOT ASK, JUST FILL IN THE CODE FOR 'MALE' OR 'FEMALE'}** 1 = Male 2 = Female	|____|
A2	How old are you?	Age: _____ Years { 77 = Do not know } { 88 = Refused to answer }	|____|
A3	What is your ethnicity?	**{DO NOT PROMPT}** 1 = Pashtun 2 = Tajik 3 = Uzbek 4 = Hazara 5 = Turkmen 6 = Baloch 7 = Kirghiz 8 = Nuristani 9 = Aimak 10 = Arab 11 = Pashaye 12 = Sadat 13 = Qazelbash 14 = Other (specify) { 77 = Do not know } { 88 = Refused to answer }	|____| *If (14) Other (please specify)*:
A4	Which language/s do you speak?	**{DO NOT PROMPT}** 1 = Dari 2 = Pashto 3 = Uzbeki 4 = Turkmeni 5 = Balochi 6 = Pashayee 7 = Nuristani 8 = Shignee 9 = Pamiri 10 = Arabic 11 = English 12 = Urdu 13 = Other { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| If (13) other, please specify:
A5	Which of the following best describes your profession:	1 = Doctor 2 = Gynecologist/obstetrician 3 = Surgeon 4 = Nurse 5 = Midwife 6 = Counsellor 7 = Social worker 8 = Lab technician 9 = X-ray technician 10 = Other (please specify) {77 = Do not know} {88 = Refused to answer}	|____| If (10) other, please specify:

A6	Which of the following best describes the unit you work in:	1 = Gynecology 2 = Surgery 3 = Emergency room 4 = Burn Unit 5 = Pediatrician ward 6 = OPD 7 = Mental health ward 8 = Other (please specify) {77 = Do not know} {88 = Refused to answer}	|____| If (8) other, please specify:
A7	How many months have you worked at this facility?	_____ Months { 77 = Do not know } { 88 = Refused to answer }	|____|
A8	How many months have you worked in healthcare?	_____ Months { 77 = Do not know } { 88 = Refused to answer }	|____|
A9	How many months have you been working in provision of GBV-related services?	_____ Months { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply - I do not work in the provision of GBV-related services }	|____|
A10	When you were interviewed for this position at this facility, did your interview include trauma-related questions? (For example, (What do applicants know about trauma, including sexual and physical abuse? About its impact? About recovery and healing? Is there a "blaming the victim" bias? Is there potential to be a trauma "champion?")	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer }	|____|
A11	When you began your job at this facility, did you receive trauma education as a part of your orientation?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer }	|____|

A12	What is your level of education?	**{DO NOT PROMPT}** 1 = Illiterate 2 = Madrasa education 3 = Semi-literate (can read and write) 4 = Some primary school (classes 1 to 5) 5 = Completed primary school (finished class 6) 6 = Some secondary education (classes 7 to 8) 7 = Completed secondary education (finished class 9) 8 = Completed High school (classes 10 to 12) 9 = Completed two-year university degree (classes 13 to 14) 10 = Completed four-year university degree 11 = Completed masters degree 12 = Completed PhD/MD { 77 = Do not know } { 88 = Refused to answer }	|____|
A13	Have you completed any training specific to GBV care?	1 = Yes 0 = No **{SKIP TO A16)** { 77 = Do not know } **{SKIP TO A16}** { 88 = Refused to answer } **{SKIP TO A16}**	|____|
A14	How long ago was your training?	_____ Months { 77 = Do not know } { 88 = Refused to answer }	|____|
A15	How many refresher trainings or meetings have you been to since your training?	_____ Number { 77 = Do not know } { 88 = Refused to answer }	|____|
A16	Have you received training on:	**Training topics** { Read aloud one by one and mark the appropriate answer }	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer}
		Trauma prevalence, impact, and recovery	|____|
		Ensuring emotional safety and avoiding re-traumatization	|____|
		Maximizing trustworthiness and having clear tasks and boundaries with patients	|____|
		Enhancing patient choice in their treatment and services	|____|
		Maximizing collaboration in provision of services	|____|
		Emphasizing empowerment in provision of services	|____|
A17	How long ago was the most recent of these trainings?	_____ Months { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|

A18	How many peer support meetings have you been to since your training?	_____ Number { 77 = Do not know } { 88 = Refused to answer }	|____|

Section B: Beliefs/Opinions Related to VAW			
B1	To what extent do you agree or disagree with the following statements:	**Statements** {Read statements out loud one by one and mark the appropriate response}	**1 = Strongly disagree** **2 = Disagree** **3 = Neither agree nor disagree** **4 = Agree** **5 = Strongly agree** {77 = Do not know} {88 = Refused to answer}
		Violence is a normal part of marriage.	|____|
		If the patient experienced violence, she must have done something to provoke it.	|____|
		Violence against women only happens among the poor and uneducated.	|____|
		A woman provokes her partner's violence because of her own behaviour.	|____|
		There are times when a husband is justified in beating his wife.	|____|
		A man who forces a woman to have sex cannot control his behaviour.	|____|
		Preventing, detecting and managing (e.g., treatment, education and referral) intimate partner/conjugal violence is really not a part of a health service provider's job.	|____|
		Most health service providers do not have time to inquire into suspected cases of intimate partner/sexual or physical violence.	|____|
		I would not feel comfortable discussing intimate partner/sexual or physical violence with my clients.	|____|
		Asking clients about violence in their intimate relationships would offend them.	|____|
		I do not believe I can help victims of violence (e.g., to improve their situations).	|____|
		Violence against women is really a family matter and not a matter for public health policy.	|____|

Section C: Knowledge Related to VAW			
Rights and Institution Awareness			
C1	I am going to read a series of statements out loud. For each statement, please tell me whether you think it is true or false.	**{ Statement }** { Read each statement out loud one by one and mark the appropriate response }	**1 = True** **2 = False** { 77 = Do not know } { 88 = Refused to answer }
		Afghan Law includes specific laws on intimate partner/gender-based violence.	|____|
		The Ministry of Public Health has not yet developed standards and protocols for the management of sexual violence.	|____|
		Health workers in a government facility are not required to report to the police cases of suspected intimate partner violence.	|____|

C2	I am going to read a series of statements out loud. For each statement, please tell me whether you think it is true or false.	**{ Statement }** { Read each statement out loud one by one and mark the appropriate response }	**1 = True** **2 = False** { 77 = Do not know } { 88 = Refused to answer }
		Preventing a woman from getting education, from accessing medical services, or to work is allowed and it is not regulated by Afghan laws.	|____|
		Based on Afghan laws, Baad is illegal.	|____|
		Forcing a woman into isolation is allowed in Afghanistan and it is not regulated by laws.	|____|
		Cursing, intimidating, or degrading a woman is allowed in Afghanistan and is not regulated by Afghan laws.	|____|
		In Afghanistan's laws, it is illegal for any girl under the age of 15 to get married, even if her parents consent. (+)	|____|
		In Afghanistan's law, it is a crime to shove or slap a woman or girl, even if no injury occurs. (+)	|____|
		According to Afghan law, a woman is required to pass a virginity test if she runs away from home in order to not be put in prison.	|____|
C3	I am going to read a series of institutions out loud. For each institution, please tell me if you are familiar with it or not. By familiar, I mean that you have heard of it, know what it is for, and know how to access it.	**{ Institutions }** { Read the name of each institution out loud one by one and mark the appropriate response }	**1 = Yes** **2 = No** { 77 = Do not know } { 88 = Refused to answer }
		Department of Women's Affairs	|____|
		Family Resolution Units	|____|
		Special EVAW Unit of the Attorney General's Office	|____|
		Afghanistan Independent Human Rights Commission (AIHRC)	|____|
		Family Protection Center at a healthcare facility	|____|
		Women's Protection Center (shelter)	|____|
		Family Guidance Center	|____|
GBV-Related Knowledge			
C4	Which of the following is a form of violence against women? Please select all that apply.	1 = A husband who verbally humiliates his wife 2 = A man who hits his wife 3 = A husband who insists on having sex with his wife if she does not want it 4 = A man who has sex with a woman or girl against her will { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____|
C5	Which of the following are warning signs that a client might be at risk of, or is a victim of, intimate partner/conjugal violence? Please select all that apply.	1 = Physical injury during pregnancy 2 = Chronic pelvic pain 3 = Chronic vague complaints that have no obvious physical cause 4 = Early entry into antenatal care 5 = Injuries that do not match the explanation of how they occurred 6 = Depression or past attempts at suicide { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| |____| |____|

C6	Which of the following elements are a part of assessing the risk or danger of violence in a client's life? Please select all that apply.	1 = Asking a client if she has ever been hurt by her husband/ partner 2 = Asking a client if she is currently in danger of being hurt by her husband/partner 3 = Asking if violence has increased in the past year 4 = Asking a client what she may have done to deserve being beaten so that she can avoid this behaviour in the future 5 = Asking a client if she worries about the safety of her children { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| |____|
C7	I am going to read a series of statements out loud. For each statement, please tell me whether you think it is true or false.	**{ Statement }** { Read each statement out loud one by one and mark the appropriate response }	**1 = True** **2 = False** { 77 = Do not know } { 88 = Refused to answer }
		In a suspected case of intimate partner/conjugal violence, it is advisable to talk with both the woman and man together about the violence in their relationship.	|____|
		Often a woman stays in an abusive relationship because of depression, social isolation or lack of family support.	|____|
		Many cases of intimate partner/conjugal violence remain unreported because of shame to keep the family together.	|____|
		Violence contributes to HIV/AIDS.	|____|
		It has been found that approximately 8 out of 10 Afghan women have experienced violence in their lives.	|____|
		Afghanistan is one of the only countries in the world where women experience violence from family members and their husbands.	|____|
		If a woman does not want to get pregnant, it is OK for the husband to force pregnancy on her.	|____|
		War and conflict increases the threat of domestic violence and sexual gender-based violence .	|____|
Knowledge of Psychosocial Support			
C8	Which of the following are possible psychological/mental health outcomes of GBV? Please select all that apply.	1 = Post-traumatic stress 2 = Depression 3 = Anxiety 4 = Phobias 5 = Panic disorders 6 = Eating disorders 7 = Sexual dysfunction 8 = Suicide 9 = Low self-esteem 10 = Substance abuse { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| |____| |____| |____| |____| |____| |____|

C9	Which of the following are possible mental health symptoms associated with violence?	**{ Sign }** { Read each statement out loud one by one and mark the appropriate response }	**1 = Yes** **0 = No** { 77 = Do not know } { 88 = Refused to answer }
		Changes in sleep patterns or appetite	|____|
		Being easily startled by noises or unexpected touch	|____|
		Fear and/or anxiety	|____|
		Grief, disorientation, or denial	|____|
		Hyper-alertness or hyper vigilance	|____|
		Irritability or outbursts of anger or rage	|____|
		Emotional swings	|____|
		Nightmares	|____|
		Panic or feeling out of control	|____|
		Having a need to control everyday experiences	|____|
		Isolating oneself	|____|
		Having a restricted range of feelings	|____|
		Difficulty trusting others	|____|
		Feeling of self-blame	|____|
		Shame	|____|
		Difficulty concentrating	|____|
C9	Which of the following are possible triggers that could potentially retraumatize a who is a survivor (or suspected survivor) of GBV?	**{ Trigger }** { Read each statement out loud one by one and mark the appropriate response }	**1 = Yes** **0 = No** { 77 = Do not know } { 88 = Refused to answer }
		Touching parts of the body where violence was inflicted (for example, a vaginal examination)	|____|
		Experiencing similar stress reactions to those experienced during the traumatizing event such as shortness of breath, chills, fast Heratbeat, etc.	|____|
		A smell that is similar to one experienced during the traumatic event, such as the body odor of the perpetrator	|____|
		A sound that is similar to one experienced during the traumatic event, such as a loud bang or shouting	|____|
		A scene that is similar to one experienced during the traumatic event, such as someone wearing similar clothing to the perpetrator or who has a similar physical appearance to the perpetrator	|____|
		Returning to the same place where the traumatizing event occurred	|____|
TSA-Related Practice			

C10	I am going to read a series of statements out loud. For each statement, please tell me whether you think it is true or false.	**{ Statement }** { Read each statement out loud one by one and mark the appropriate response }	**1 = True** **2 = False** { 77 = Do not know } { 88 = Refused to answer }
		Before conducting a physical examination it is necessary to obtain voluntary informed consent from the patient.	|____|
		Before conducting a physical examination on a likely survivor of GBV, you should assess their mental health status.	|____|
		Survivors of GBV are only traumatized because the assault. (-)	|____|
		It is important for health workers to empower survivors of GBV by allowing them choice in their health decisions.	|____|
		During the examination I should act encouraging for the patient to tell me more information.	|____|
		A woman will tell me everything that she wants me to know during the examination without me asking her specific questions. (-)	|____|
		I cannot do any additional harm to the woman during the examination. (-)	|____|
		If I know the patient, I should refer her case to a co-worker and not be her health care provider.	|____|
		Some methods used during a physical exam can result in secondary traumatization of the woman.	|____|
		It will not do any harm to the woman if we make them tell us what happened during the assault so that it can be documented properly. (-)	|____|
		Patients should be referred immediately if they have life threatening conditions which your facility can't handle.	|____|
		The choices of survivors of GBV should be respected, even if it means not completing assessments.	|____|
		If a woman is experiencing mental health issues because of the assault, she may not present with obvious symptoms.	|____|
		Women will ask for more information on other services if they want it so it isn't necessary to tell them about other services unless they ask. (-)	|____|
		Women who do not have sings of mental health issues still should be referred to a counselor. (-)	|____|
		If a woman reports abuse, I should tell a member of the woman's family about her coming to the facility and what we discussed.	|____|

C11	What are ways can you show a patient who is a survivor (or suspected survivor) of GBV you are listening?	**{DO NOT PROMPT - MULTIPLE RESPONSE ALLOWED }** 1 = Maintain eye contact 2 = Good body language (keep body square to patient) 3 = Do not be distracted with notes, phones etc. 4 = Provide encouraging sounds (i.e. umm, ahh) 5 = Facial expressions 6 = Other (please specify) { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| |____| |____| *If (6) other, please specify:*
	What are ways can you show a patient who is a survivor (or suspected survivor) of GBV you are interested and care about their situation?	**{DO NOT PROMPT - MULTIPLE RESPONSE ALLOWED }** 1 = Ask open ended questions 2 = Paraphrase what they have told you to show you understand 3= Provide appropriate comfort if upset (i.e. give tissue, hold hand) 4 = Do not interrupt the patient 5 = Other { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| |____| *If (5) other, please specify:*
	Imagine that a woman enters the health facility and she is very upset, crying and shouting loudly. Which of the following actions would you be most likely to take?	**{MULTIPLE RESPONSE ALLOWED}** 1 = Physically restrain her immediately 2 = Give her a placebo pill and tell her it will make her calm down so she thinks she feels better 3 = Refer her to a psychologist 4 = Try to help calm her down by reassuring her of where she is and with whom 5 = Put your arm around her to try to comfort her 6 = Bring her to a room and leave her by herself so she can calm down by herself 7 = Escort the woman somewhere private and try different techniques to help calm her down such as breathing exercises, asking her simple questions about her day or her children, or a relaxation exercise. 8 = Ask her to leave the facility and come back once she has calmed down. 9 = Other { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| |____| |____| |____| |____| |____| *If (9) other, please specify:*
Section D: Compassion Fatigue, Burnout, and Secondary Traumatic Stress			
Professional Quality of Life			

D1	To what extent do you agree or disagree with the following statements:	**Statements** {Read statements out loud one by one and mark the appropriate response}	**1 = Strongly disagree** **2 = Disagree** **3 = Neither agree nor disagree** **4 = Agree** **5 = Strongly agree** {77 = Do not know} {88 = Refused to answer}
		1. I am happy.	|____|
		2. I am preoccupied with more than one person I *[help]*.	|____|
		3. I get satisfaction from being able to *[help]* people.	|____|
		4. I feel connected to others.	|____|
		5. I jump or am startled by unexpected sounds.	|____|
		6. I feel invigorated after working with those I *[help]*.	|____|
		7. I find it difficult to separate my personal life from my life as a *[helper]*.	|____|
		8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.	|____|
		9. I think that I might have been affected by the traumatic stress of those I *[help]*.	|____|
		10. I feel trapped by my job as a *[helper]*.	|____|
		11. Because of my *[helping]*, I have felt „on edge“ about various things.	|____|
		12. 1 I like my work as a *[helper]*.	|____|
		13. I feel depressed because of the traumatic experiences of the people I *[help].*	|____|
		14. I feel as though I am experiencing the trauma of someone I have *[helped]*.	|____|
		15. I have beliefs that sustain me.	|____|
		16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.	|____|
		17. I am the person I always wanted to be.	|____|
		18. My work makes me feel satisfied.	|____|
		19. I feel worn out because of my work as a *[helper].*	|____|
		20. I have happy thoughts and feelings about those I *[help]* and how I could help them.	|____|
		21. I feel overwhelmed because my case [work] load seems endless.	|____|
		22. I believe I can make a difference through my work.	|____|
		23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.	|____|
		24. I am proud of what I can do to *[help]*.	|____|
		25. As a result of my *[helping]*, I have intrusive, frightening thoughts.	|____|
		26. I feel „weighed down“ by the system.	|____|
		27. I have thoughts that I am a “success” as a *[helper]*.	|____|
		28. I can‘t remember important parts of my work with trauma victims.	|____|
		29. I am a very caring person.	|____|
		30. I am happy that I chose to do this work.	|____|

PATIENT EXIT SURVEY

Instructions: Participants will be selected where a woman has personally sought healthcare services for herself at the healthcare facility today. Do not select the woman to participate in the interview if she has accompanied someone else receiving treatment, or if she was at the facility to seek treatment for her child.

Section 0: Identifying the Participant	
Did you come to this facility today to personally seek healthcare services for yourself?	**Yes {Proceed with consent form}** **No {Go to next participant}** 77 = Do not know **{Go to next participant}** {88 = Refused to answer} **{Go to next participant}**

Thousand Plateaus: Medica Afghanistan Baseline Consent Form

Introduction

My name is _____, and I'm working with Thousand Plateaus, a research company based in Kabul. I would like to ask you to participate in a survey for a baseline study we are undertaking for Medica Afghanistan regarding SGBV and health services. The entire interview will take no longer than an hour. The information you provide will be used to help us learn about the project and make recommendations for similar projects in the future.

There will be no financial or material compensation for your participation. Would you be interested in participating?

{*If respondent says yes, proceed with the consent form. If the respondent does not agree to participate, politely thank him/her for his/her time and ask them to leave the discussion.}*

Consent

Your answers will be treated with the utmost privacy and confidentiality. Your identity will remain anonymous at all times, and we will not be recording your name. That means that no one will be able to link your responses to your name, and your name will never be used in connection with any of the information you tell me.

Your participation is at all times voluntary. There is no obligation to answer the questions, and you are free to refuse any question you do not wish to answer. You have the right to withdraw your agreement to participate at any time during the interview.

There are some potential risks to participating in this study. We will be asking questions about your participation in the Medica Afghanistan program and about traumatic experiences you have had, and some questions are sensitive in nature. You may feel some discomfort when responding to some of the questions. If you become uncomfortable at any time, you may ask to skip to the next question or ask to take a break. Because some questions are about past trauma you have experienced, there is a slight risk that you may experience emotions related to these events. Medica Afghanistan's counselors will be available at all times during our interview and can be called upon if you experience any uncomfortable emotions that you wish to discuss with a mental health professional. We cannot guarantee that you will not feel discomfort during this interview; however, we respect your privacy and emotional well being and will be responsive to any discomfort you may feel. Remember that your participation is voluntary and you may withdraw your participation at any time without consequence.

Would you like to participate?

{*If respondent says yes, proceed with survey. If the respondent does not agree to participate, politely thank him/her for his/her time and ask them to leave the discussion.}*

In case of any questions or concerns, or if you feel that your rights I have explained to you are violated, please contact:

Maryam Danish (0786012593) or Marie Huber (0784050769)

Medica Afghanistan Trauma-Sensitive Health Services Baseline

Patient Survey Questionnaire, Afghanistan 2016

(TO BE COMPLETED BY DATA ENTRY OFFICIAL) Survey ID Number: _____

{ THIS PAGE TO BE COMPLETED BY THE SURVEYOR—DO NOT READ OUT LOUD }

Respondent has been read the consent form and has agreed to participate?	1 = Yes 0 = No **{END THE INTERVIEW}**	|____|
Respondent was personally seeking services for herself at the health facility today?	1 = Yes 0 = No **{END THE INTERVIEW}**	|____|
Respondent has been provided with a referral information sheet?	1 = Yes	|____|

0.1	Province name		0.2	Province code	1 = Kabul 2 = Balkh 3 = Herat	|____|
0.3	Facility name		0.4	Facility code	11 = Rabia Balkhi hospital 12 = Malalai Hospital 13 – Isteqlal hospital 14 = Wazir Akbar Khan hospital 15 = Jamhoryat hospital 16 = Ibni Sina hospital 21 = Balkh Regional Hospital 22 = Balkh 200 bed hospital 31 = Herat Regional Hospital 32 = Shaidai Hospital	|____|
0.7	Interviewer Name		0.8	Interviewer code	|____|	
0.9	Interviewer sex	1 – Male 2 – Female |____|	0.10	Date	___ /___ / ____ Day / Month / Year	
0.11	Start time	|___|___|: |___|___|		1 = AM 2 = PM	|____|	

0.12	End time	|___|___|: |___|___|	1 = AM 2 = PM	|____|	
0.13	Interview number				

CHECKED BY SUPERVISOR: Initials: _____

Signature: _____

Date: _____

Section A: Demographics			
A1	Gender of respondent:	**{DO NOT ASK, JUST FILL IN THE CODE FOR 'MALE' OR 'FEMALE'}** 1 = Male 2 = Female	|____|
A2	Is the patient pregnant and/or breastfeeding?	**{MULTIPLE RESPONSE ALLOWED}** 1 = Pregnant 2 = Breastfeeding { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____| |____| If (13) other, please specify:
A3	How old are you?	Age: _____ Years { 77 = Do not know } { 88 = Refused to answer }	|____|
A4	What is your ethnicity?	**{DO NOT PROMPT}** 1 = Pashtun 2 = Tajik 3 = Uzbek 4 = Hazara 5 = Turkmen 6 = Baloch 7 = Kirghiz 8 = Nuristani 9 = Aimak 10 = Arab 11 = Pashaye 12 = Sadat 13 = Qazelbash 14 = Other (specify) { 77 = Do not know } { 88 = Refused to answer }	|____| *If (14) Other (please specify)*:
A5	Which language/s do you speak?	1 = Dari 2 = Pashto 3 = Uzbeki 4 = Turkmeni 5 = Balochi 6 = Pashayee 7 = Nuristani 8 = Shignee 9 = Pamiri 10 = Arabic 11 = English 12 = Urdu 13 = Other { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| If (13) other, please specify:

A6	What is your "main" occupation?	1 = Unemployed 2 = Day laborer 3 = Salaried worker (private sector) 4 = Salaried worker (public sector) 5 = Self-employed 6 = Unpaid family worker (work for family income generation such as agriculture or raising livestock) 7 = Working at home (domestic work, such as cooking, cleaning, care work, etc.) 8 = Other (specify) { 77 = Do not know } { 88 = Refused to answer }	|____| *If (8) Other (please specify)*:
A7	What is your level of education?	**{DO NOT PROMPT}** 1 = Illiterate 2 = Madrasa education 3 = Semi-literate (can read and write) 4 = Some primary school (classes 1 to 5) 5 = Completed primary school (finished class 6) 6 = Some secondary education (classes 7 to 8) 7 = Completed secondary education (finished class 9) 8 = Completed High school (classes 10 to 12) 9 = University education or above { 77 = Do not know } { 88 = Refused to answer }	|____|
A8	How many people live in your household, including both adults and children?	_____ people { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|
A9	How many members of your household over the age of 18 are male and how many are female?	_____ male _____ female { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____| male |____| female
A10	Is the head of your household male or female?	1 = Male 2 = Female { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|
A11	What is your average monthly household income?	1 = Less than 2,000 AFN 2 = 2,001 to 3,000 AFN 3 = 3,001 to 5,000 AFN 4 = 5,001 to 10,000 AFN 5 = 10,001 to 15,000 AFN 6 = 15,001 to 20,000 AFN 7 = 20,001 to 25,000 AFN 8 = 25,001 to 40,000 AFN 9 = More than 40,000 AFN {77 = Do not know} {88 = Refused to answer}	|____|

A12	Do you personally earn an income?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer }	|____|
A13	Do you have any long-standing illness, disability or infirmity? By long-standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time?	1 = Yes 0 = No **{SKIP TO A15}** { 77 = Do not know } **{SKIP TO A15}** { 88 = Refused to answer } **{SKIP TO A15}**	|____|
A14	Which of the following best describes your illness or disability?	**{DO NOT PROMPT}** 1 = Hearing-related 2 = Sight-related 3 = Speech-related 4 = Mental health disorder (i.e. depression, post-traumatic stress, trauma issues, etc.) 4 = Injury to or loss of limb 5 = Brain injury/mental disability 6 = Paralysis 7 = Disease or long-term illness 8 = Other { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|
A15	Does your household have any history of displacement?	1 = Yes 0 = No **{SKIP TO SECTION B}** { 77 = Do not know } **{SKIP TO SECTION B}** {88 = Refused to answer} **{SKIP TO SECTION B}**	|____|
A16	Are you and your household currently displaced?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|

Section B: Facility Visit Experience			
Current Visit			
B1	Have you previously visited this health facility?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer }	|____|

B2	What service/s did you come for today? Please name all that apply.	**{MULTIPLE RESPONSE ALLOWED}** 1 = Treatment for illness 2 = Regular checkup 3 = Antenatal care 4 = Postnatal care 5 = Family planning 6 = Nutrition-related services 7 = Immunization 8 = Child health 9 = Mental health/counseling 10 = Pharmacy 11 = Laboratory 12 = Treatment related to physical abuse 13 = Treatment related to sexual abuse 14 = Treatment related to emotional abuse 15 = Other {77 = Do not know} {88 = Refused to answer}	|____| |____| |____| |____| |____| |____| |____| |____| |____| |____| |____| |____| If (15) other:
Availability			
B3	To what extent do you agree or disagree with the following statements:	**Statements** {Read statements out loud one by one and mark the appropriate response}	**1 = Strongly disagree** **2 = Disagree** **3 = Neither agree nor disagree** **4 = Agree** **5 = Strongly agree** {77 = Do not know} {88 = Refused to answer}
		There are female staff members available when I need to seek health services at this facility.	|____|
		Sometimes, healthcare treatments and support that healthcare providers at this facility provide are not in line with cultural norms related to gender, religion, or society.	|____|
		The facility is always open and staff is present during its normal operating hours.	|____|
B4	How long did you wait to receive services at this facility today?	1 = Less than 10 minutes 2 = 10-20 minutes 3 = 20-30 minutes 4 = 30-45 minutes 5 = 45 minutes to 1 hour 6 = 1 to 2 hours 7 = 2 to 3 hours 8 = More than 3 hours {77 = Do not know} {88 = Refused to answer}	|____|
B5	Which type/s of healthcare provider did you see? Please name all that apply.	1 = Doctor 2 = Gynecologist/obstetrician 3 = Surgeon 4 = Nurse 5 = Midwife 6 = Other {77 = Do not know} {88 = Refused to answer}	|____|

B6	Was the provider/s male or female?	1 = Male 2 = Female 3 = Saw both male and female providers {77 = Do not know} {88 = Refused to answer}	|____|
B7	What type of room were you seen in?	1 = An open room where others could see me 2 = An open room partitioned by a sheet or screen 3 = A private room {77 = Do not know} {88 = Refused to answer}	|____|
B8	Which language/s were services provided in?	**{DO NOT PROMPT}** 1 = Dari 2 = Pashto 3 = Uzbeki 4 = Turkmeni 5 = Balochi 6 = Pashayee 7 = Nuristani 8 = Shignee 9 = Pamiri 10 = Arabic 11 = English 12 = Urdu 13 = Other { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| If (13) other, please specify:
Accessibility			
B16	In the past 12 months, has there been a time when you wanted to see a doctor, nurse or other healthcare worker, but your family member/s didn't allow you to seek treatment?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer }	|____|
Affordability			
B18	Was there any monetary cost for the services you received today?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer }	|____|
B19	What was the fee for? Please name all that apply.	1 = Fee for services 2 = Prescription/medication 3 = Test/laboratory fees 4 = Other (please specify) { 77 = Do not know } { 88 = Refused to answer }	|____| |____| |____| |____| If (4) other, please specify:
B20	How much was the fee?	_____ AFN { 77 = Do not know } { 88 = Refused to answer }	|____|
Acceptability			

Adequacy - CCTIC			
B23	The next set of statements are **also about your experience at this facility**. For each statement, please tell me whether you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the statement.	**Statements** {Read statements out loud one by one and mark the appropriate response}	**1 = Strongly disagree** **2 = Disagree** **3 = Neither agree nor disagree** **4 = Agree** **5 = Strongly agree** {77 = Do not know} {88 = Refused to answer}
		Safety	
		In my treatment at this facility, I felt physically safe.	|____|
		In my treatment at this facility, I felt emotionally safe.	|____|
		There are signs visible giving me helpful information (for example, bathrooms, emergency exits, etc.)	|____|
		Health concerns unrelated to abuse	|____|
		Trustworthiness	
		I trust the people who work at this facility.	|____|
		When I come to this facility, I am provided with good information about what to expect from its staff and services.	|____|
		I trust that people here at the facility will do what they say they are going to do, when they say they are going to do it.	|____|
		The people who work here at this facility act in a respectful and professional way toward me.	|____|
		Choice	
		When I come to this facility, health staff offer me a lot of choices about the services I receive.	|____|
		I have a great deal of control over the kinds of services I receive, including when, where, and by whom the services are offered.	|____|
		My priorities are taken into account when deciding what treatments I will receive.	|____|
		I am confident that if I didn't want to do a specific test or treatment, health facility would respect my choice and would provide me with alternative services.	|____|

B23		Collaboration	
		At this facility, the staff is willing to work with me (rather than doing things for me or to me).	|____|
		When decisions about my services or recovery plan are made, I feel like I am a partner with the staff, that they really listen to what I want.	|____|
		Patients play a role in deciding how things are done here at this facility.	|____|
		Staff at this facility really listen to what I have to say about things.	|____|
		Empowerment	
		Health staff at this facility recognize that I have strengths and skills as well as challenges and difficulties.	|____|
		The staff here at this facility are very good at letting me know that they value me as a person.	|____|
		The staff here at this facility help me learn new skills and information that are helpful in maintaining my physical and emotional health.	|____|
		I feel stronger as a person because of the support I have received when coming to this facility.	|____|
		Trauma Screening	
		The staff explained to me why they asked about difficult experiences in my life (like violence or abuse).	|____|
		The staff are as sensitive as possible when they ask me about difficult or frightening experiences I may have had.	|____|
		I feel safe talking with staff here about my experiences with violence or abuse.	|____|
		Agency	
		Staff respect my privacy.	|____|
		Staff are supportive when I'm feeling stressed out or overwhelmed.	|____|
		I decide my treatment priorities in the services I receive at this facility.	|____|
		Staff treat me with dignity.	|____|
		Staff understand that I know what's best for me.	|____|
		Staff respect the choices that I make.	|____|
		In this program, I can share things about my life on my own terms and at my own pace.	|____|
		Staff can handle difficult situations.	|____|
		I can trust staff.	|____|

SGBV

B24	Today, were you treated for:	**Items** {Read items out loud one by one and mark the appropriate response}	**1 = Yes** **0 = No** {77 = Do not know} {88 = Refused to answer}
		Abuse-related health concerns	|____|
		Injuries sustained during physical/sexual abuse	|____|
		Self-inflicted injuries	|____|
		Mandated virginity exam	|____|
		Health concerns unrelated to abuse	|____|
		Emotional consequences of abuse	|____|
B25	Did your healthcare provider ask you questions regarding whether you are experiencing physical or sexual abuse?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer }	|____|
B26	Did you report abuse to a healthcare provider today?	1 = Yes 0 = No **{SKIP TO SECTION C}** { 77 = Do not know } **{ SKIP TO SECTION C}** { 88 = Refused to answer } **{ SKIP TO SECTION C}**	|____|
B27	Which type of abuse/s did you report to your healthcare provider?	1 = Physical abuse 2 = Sexual abuse 3 = Emotional/psychological abuse 4 = Other (please specify) { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____| |____| |____| |____| If (4) other, please specify:
B28	Did your healthcare provider encourage you to report your abuse?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|

B29	Did your healthcare provider report your abuse to authorities?	1 = Yes 0 = No **{SKIP TO B31}** { 77 = Do not know } **{SKIP TO B31}** { 88 = Refused to answer } **{SKIP TO B31}** { 99 = Does not apply }	|____|
B30	Who was the abuse reported to?	**{MULTIPLE RESPONSE ALLOWED}** 1 = Family Response Unit 2 = Police (non-FRU) 3 = DoWA 4 = AIHRC 5 = Special EVAW Unit of AGO 6 = Other (please specify) { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____| |____| |____| |____| |____| |____| |____| If (6) other please specify:

B31	Did the healthcare provider provide you with information regarding laws that protect you from abuse?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|
B32	Did the healthcare provider provide you with information regarding physical consequences of abuse?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|
B33	Did the healthcare provider provide you with information regarding mental and emotional consequences of abuse?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|
B34	Did the healthcare provider provide you with information regarding supportive services?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|

B35	Did your healthcare provider make a referral or connect you to another agency?	1 = Yes 0 = No **{SKIP TO B40}** { 77 = Do not know } **{SKIP TO B40}** { 88 = Refused to answer } **{SKIP TO B40}** { 99 = Does not apply }	|____|
B36	For what were you referred?	1 = HIV/AIDS/STI treatment at this facility 2 = HIV/AIDS/STI treatment at another facility 3 = Collection of forensic evidence at this facility 4 = Collection of forensic evidence at another facility 5 = Psychosocial counseling at this facility 6 = Psychosocial counseling at another facility 7 = Legal assistance 8 = Protection/shelter services { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|
B37	To which type/s of facility were you referred?	1 = Public facility 2 = Private facility 3 = Non-governmental organization { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|
B38	Do you plan to attend this referral?	1 = Yes **{SKIP TO B44}** 0 = No { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|

B39	Why not?	1 = Too expensive 2 = Facility too far away 3 = Don't think the healthcare provider was right in their referral 4 = I don't like the facility I was referred to 5 = Other (please specify) {77 = Do not know} {88 = Refused to answer} { 99 = Does not apply }	|____|
B40	How comfortable were you seeking healthcare after your experienced SGBV?	1 = Very comfortable 2 = Somewhat comfortable 3 = Neither comfortable nor uncomfortable 4 = Somewhat uncomfortable 5 = Very uncomfortable {77 = Do not know} {88 = Refused to answer} { 99 = Does not apply }	|____|
B41	Would you recommend seeking care to another survivor of SGBV?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|

B42	The next set of statements are **also about your experience at this facility related to SGBV**. For each statement, please tell me whether you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the statement.	Information	
		In the services I received, I had the opportunity to learn how abuse and other difficulties affect responses in the body.	|____|
		In the services I received, I had the opportunity to learn how abuse and other difficulties affect people's mental health.	|____|
		In the services I received, I had opportunities to learn how abuse and other hardships affect people's relationships.	|____|
		In the services I received, I had opportunities to learn how abuse and other difficulties affect people's ability to think clearly and remember things.	|____|
		In the services I received, I am learning more about how to handle unexpected reminders of the abuse and difficulties I have endured.	|____|
		Strengths	
		Staff respect the strengths I have gained through my life experiences.	|____|
		Staff respect the strengths I get from my culture or family ties.	|____|
		The strengths I bring to my relationships with my children, my family, or others are recognized in this program.	|____|

B43	In Afghanistan, have you ever been treated at a public health facility for:	**Items** {Read items out loud one by one and mark the appropriate response}	**1 = Yes** **0 = No** {77 = Do not know} {88 = Refused to answer}
		Abuse-related health concerns	|____|
		Injuries sustained during physical abuse	|____|
		Self-inflicted injuries	|____|
		Mandated virginity exam	|____|
		Emotional consequences of abuse	|____|

Section C: Experiences of GBV and VAW			
Risk Factors			
C1	A woman provokes her partner's violence because of her own behaviour.	1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree {77 = Do not know} {88 = Refused to answer}	|____|
C2	There are times when a husband is justified in beating his wife.	1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree {77 = Do not know} {88 = Refused to answer}	|____|
C3	Did you ever witness your mother experiencing physical, psychological, or sexual abuse?	1 = Yes 0 = No { 77 = Do not know } { 88 = Refused to answer }	|____|
C4	What is your marital status?	1 = Unmarried **{SKIP TO D7}** 2 = Married 3 = Widow 4 = Divorced 5 = Separated { 77 = Do not know } **{SKIP TO A7}** { 88 = Refused to answer } **{SKIP TO A7}**	|____|
C5	At what age did you get married?	Age: { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|
C6	How long have you been married?	Length of marriage (in years): { 77 = Do not know } { 88 = Refused to answer } { 99 = Does not apply }	|____|

C7	How many children do you have?	_____ children { 77 = Do not know } { 88 = Refused to answer }	|____|
Rights and Institution Awareness			
C8	I am going to read a series of statements out loud. For each statement, please tell me whether you think it is true or false.	**{ Statement }** { Read each statement out loud one by one and mark the appropriate response }	**1 = True** **2 = False** { 77 = Do not know } { 88 = Refused to answer }
		Preventing a woman from getting education, from accessing medical services, or to work is allowed and it is not regulated by Afghan laws.	|____|
		There are laws in Afghanistan that protect women from physical abuse.	|____|
		There are laws in Afghanistan that protect women from sexual abuse.	|____|
		There are laws in Afghanistan that protect women from psychological abuse.	|____|
		Based on state laws in Afghanistan, the husband has no right to beat his wife, no matter what she did to him.	|____|
		In case of illness and injury a woman has the right to access health care in Afghanistan, even if male family members do not agree with it.	|____|
		In Afghanistan, there are shelters where women can go to escape violence.	|____|
C9	I am going to read a series of institutions out loud. For each institution, please tell me if you are familiar with it or not. By familiar, I mean that you have heard of it, know what it is for, and know how to access it.	**{ Institutions }** { Read the name of each institution out loud one by one and mark the appropriate response }	**1 = Yes** **2 = No** { 77 = Do not know } { 88 = Refused to answer }
		Department of Women's Affairs	|____|
		Family Resolution Units	|____|
		Special EVAW Unit of the Attorney General's Office	|____|
		Afghanistan Independent Human Rights Commission (AIHRC)	|____|
		Family Protection Center at a healthcare facility	|____|
		Women's Protection Center (shelter)	|____|
		Family Guidance Center	|____|
Hurt, Insult, Threaten and Scream (HITS) Scale			

C10	I am going to read you a series of questions regarding how your partner acts. There are no right or wrong answers. For each of the following actions, please tell me how often your partner/ household member acts in the way depicted—never, rarely, sometimes, fairly often, or frequently	**{Question }** { Read each question out loud one by one and mark the appropriate response }	**1 = Frequently** **2 = Fairly often** **3 = Sometimes** **4 = Rarely** **5 = Never** { 77 = Do not know } { 88 = Refused to answer }
		How often does your partner and/or household members physically hurt you?	|____|
		How often does your partner and/or household members insult or talk down to you?	|____|
		How often does your partner and/or household members threaten you with harm?	|____|
		How often does your partner and/or household members scream, yell, or curse at you?	|____|
MHI-5			
C11	I am going to read you a series of questions regarding how things have been for you during the last month. When I read each question, think about how you feel about it personally. There are no right or wrong answers. For each feeling, please tell me how much of the time during the last month you felt this way—all of the time, most of the time, some of the time, a little of the time, or none of the time.	**{ Statement }** { Read each statement out loud one by one and mark the appropriate response }	**1 = All the time** **2 = Most of the time** **3 = Some of the time** **4 = A little of the time** **5 = None of the time** { 77 = Do not know } { 88 = Refused to answer }
		During the past month, how much of the time were you a happy person?	|____|
		How much of the time, during the past month, have you felt calm and peaceful?	|____|
		How much of the time, during the past month, have you been a very nervous person?	|____|
		How much of the time, during the past month, have you felt downHerated and blue?	|____|
		How much of the time, during the past month, have you felt so down in the dumps that nothing could cheer you up?	|____|

PATIENT FGD WITH WOMEN IN SHELTERS

1. How common an experience do you think violence is in the lives of women in this community?

2. For women who do experience violence, what do you think might be the consequences for them?

3. Do you know anyone who has been a victim of some of the forms of violence I mentioned earlier?

4. How have these women dealt with the problem? What is the attitude of the women victims of gender-based violence? (Do they talk about it easily? Whom do they trust or speak to about their problem?)

5. Do you think most women in your community seek help after abuse? Why or why not?

Help for victims of violence

6. If a woman is living in a violent relationship or has experienced violence, who in this community could help her? What kind of help could she receive?

7. Are you aware of people or groups in the community who could help a woman who was living in a violent relationship?

8. Are you aware of organizations nearby that could help a woman who was living in a violent relationship?

9. What are some possible barriers to women seeking healthcare services after having experienced physical violence?

10. What are some possible barriers to women seeking healthcare services after having experienced physical violence?

11. Do you think that survivors of abuse would go to counselling and someone to talk to about what happened to her? Who could help her? What kind of help could she receive?

Health Service Facility

12. What usually happens when a woman goes to a health facility with an injury from having been beaten by her husband? Would she find any services or information to help her?

13. What usually happens when a woman goes to a health facility after a rape? Would she find any services or information that would help her?

14. What types of services could a health facility offer for victims of intimate partner or sexual violence that would help her?

15. Would a health facility offer victims other types of support besides physical treatment?

    - Referral for psychosocial support
    - Referral for legal aid
    - Referral for protection

Health Providers

16. What role might a service provider play, if any, in cases of physical or sexual violence?

17. Do you feel it would be possible for a woman to have a private and confidential discussion with a doctor or a nurse, or the other staff here, if the woman wanted to talk about violence in her life?

18. Do you think that it is a good or bad thing if a health service provider asks a client about physical or sexual violence? {Probe why it is a good or bad thing.}

19. If a woman told her health service provider (doctor or nurse) about being a victim of violence, what would be the doctor's or nurse's reaction? {Explore reactions.}

20. If you think a health service provider asking about physical or sexual violence is a helpful thing, would it be better to ask all patients, or only when the doctor or nurse suspected violence?

21. What might be some negative consequences if a service provider asked a client about suspected violence?

22. What might be some positive consequences if a service provider asked a client about suspected violence?

STAKEHOLDER INTERVIEW GUIDE

1. What role do you think that the health sector should play in addressing gender-based violence?
    a. [Probe on health sector role in: prevention of GBV, GBV screening, treatment of victims including sexual assault (post-exposure prophylaxis, or PEP), psychological counseling and referrals to other services.]

2. Is the health sector currently providing these services? If so, which ones? What are the biggest gaps?

3. What obstacles does the health sector face in providing gender-based violence services? What obstacles do women face in seeking gender-based violence services from the health care system?

4. Which women are most in need of gender-based violence services? Who are the most under-served?

5. What barriers do women face in seeking gender-based violence services?

6. To what extent do you think that healthcare professionals have knowledge of the causes and context of GBV and its consequences (traumatic reactions)

7. To what extent do you think that health professionals are able to recognize traumatic reactions of patients/clients or to take preventive action to keep traumatic stress of patients/clients to a minimum?

I'd now like to ask you a set of questions related specifically to the policy environment surrounding gender-based violence services.

1. What key policies, legislation, or law(s) exist to address gender-based violence?
    a. [Probe specifically on national policies/legislation, health policies governing GBV screening and treatment, HIV/AIDS policies, local government reform/decentralization. Obtain name of policy document, author/source, date, status of ratification/legislation, etc.]

2. Do these policies specifically address the role and expectations of the health sector in gender-based violence prevention and services? If so, what do they say? If not, what are the gaps?

3. Do these policies specifically address the provision of trauma-sensitive services to survivors of SGBV? Are there guidelines in place for health professionals to address the psychological trauma of SGBV?

4. Are there training programs or resources available for health professionals regarding body awareness, dealing with feelings and decreasing traumatic stress conditions, and dealing with re-traumatization for survivors of SGBV?

5. Are there guidelines and resources related to self-care for health professionals?

6. What structures or mechanisms have been established to ensure that these policies are disseminated and implemented?

7. What resources have been allocated or are available to support gender-based violence programs?

8. What are the biggest policy gaps or barriers? How should they be addressed?
    a. [To be asked of those familiar with operational health policies] What are some of the operational policy barriers to screening for gender-based violence and caring for gender-based violence victims? How might these be overcome/addressed?

ANNEX C: SAMPLING FRAME

FACILITY STAFF FGD AND KAP SURVEY

The KAP survey was administered to staff verbally by one female enumerator in each province at the health facility over the course of one day, simultaneous to the exit surveys conducted by the other three female enumerators. The survey with facility staff is not designed to be representative at the facility or the departmental levels, which is beyond the scope of the timeline and financial resources available for this project. At present, no data is available to TP regarding the facilities and staffing levels. If such data is provided the sample will be weighted accordingly.

Quantitative				
Interview	***Province***	***Facility***	***Departmental Focus***	***Number per facility***
	Kabul	Rabia Balkhi hospital	Gynecology ward, surgery ward, emergency room	5
		Malalai hospital	Gynecology ward	5
	Balkh	Balkh Regional Hospital	Gynecology ward, burn unit, surgery ward, emergency room, pediatrician ward	5
	Herat	Herat Regional Hospital	Gynecology ward, burn unit, emergency room and internal ward	5
	Total			**20**

Qualitative				
Interview	***Province***	***Facility***	***Departmental Focus***	***Number per facility***
	Kabul	Rabia Balkhi hospital	Gynecology ward, surgery ward, emergency room	1
		Malalai hospital	Gynecology ward	1
	Balkh	Balkh Regional Hospital	Gynecology ward, burn unit, surgery ward, emergency room, pediatrician ward	1
	Herat	Herat Regional Hospital	Gynecology ward, burn unit, emergency room and internal ward	1
	Total			4

PATIENT SURVEY

In health facility assessments, it is more sensible to determine a feasible number of clients to sample per facility, rather than base the overall sample size on a predetermined precision requirement. Controlling exactly the total sample size, not to mention the average size per facility, is also also very difficult because of the variability with which clients appear at the facility on a given day. This problem is exacerbated if clients are sampled by type of condition because there may be a conflict between number of clients by type and the frequency of their visits. The selection method is a crucial design feature in implementing a plan to interview a predetermined expected number of clients in each facility.

For each facility, client interviews were conducted over one full day of client interviewing, based on a target of 6 interviews per enumerator. The selection interval was selected based on the average daily volume of clients in the facility/departments of focus. Generally, the sampling of clients follows the guidelines provided in the "Sampling Manual for Facility Surveys" developed by MEAUSRE and USAID. The exit interview targeted both women, who have and have not specifically sought services related to SGBV in their visit to the facility, with a target quota for each. Many of the women surveyed did not sought treatment for SGBV, which is also compounded by the findings of a KAP survey conducted by UN women in 2013 that found that an average of 22 women visited health facilities as victims of GBV in the month prior to the survey.[1] Additionally, women seeking service due to SGBV are very unlikely to openly discuss about it (See Study Limitations).

Quantitative				
Interview	***Province***	***Facility***	***Departmental Focus***	***Number per facility***
Health Facility Exit Survey				
	Kabul	Rabi Balkhi hospital	Gynecology ward, surgery ward, emergency room	18
		Malalai hospital	Gynecology ward	18
	Balkh	Balkh Regional Hospital	Gynecology ward, burn unit, surgery ward, emergency room, pediatrician ward	18
	Herat	Herat Regional Hospital	Gynecology ward, burn unit, emergency room and internal ward	18
	Total			**72**

KEY INFORMANT INTERVIEWS

Key informant interviews were also conducted by the lead consultants with support from the Field Manager as required.

Interview	**Central/Provincial-level**	**Number of participants per interview**	**Number of interviews (total)**
DoPH	Provincial-level	1	3
CSO stakeholders (shelters)	Provincial-level	5 - 7	2
MoPH Mental Health Department	Central	1	1
MoPH Gender and Human Rights Department	Central	1	1
MoPH Policy and Planning Department	Central	1	1
Afghan Family Guidance Association	Central	2	1
UNFPA	Central	1	1
Total			**10**

1 Dr. Abdul Rasheed and Mr. Mokhlesur Rehman, "Assessment of Knowledge, Attitude and Practices (KAP) of Health Personnel on GBV Case Management in six provinces (Badakhshan, Balkh, Bamyan, Herat, Nangarhar, and Parwan provinces," UN Women and Youth Health and Development Organization (YHDO), 2013.