USING REGIONAL CASE STUDIES FOR NATIONAL ACTION PLANNING: **USAID TRANSFORM'S LANDSCAPE ANALYSIS OF GENDER-BASED VIOLENCE IN ETHIOPIA**

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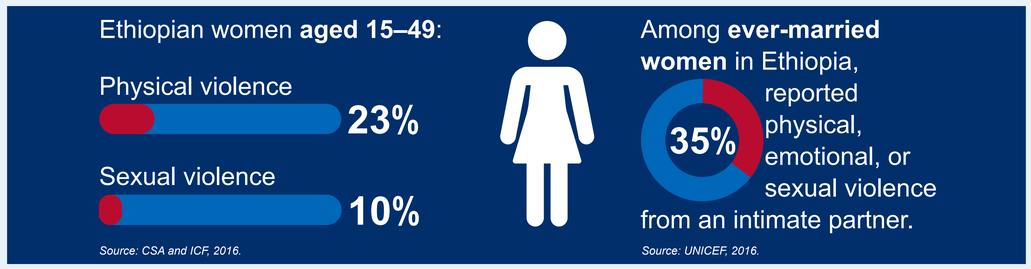
INTRODUCTION

In Ethiopia, girls and women face many forms of gender-based violence (GBV) rooted in unequal power dynamics between women and men, which hinder women's and girls' development, health, livelihood, and physical and mental well-being.



In response to knowledge gaps about the scope and quality of gender-based violence (GBV) prevention and response services, the USAID/Ethiopia Transform: Primary Health Care project conducted a GBV landscape analysis to comprehensively understand the health system's existing services. This landscape analysis was the first of its kind in Ethiopia and informed key actions that the project is currently implementing with Ethiopia's Federal Ministry of Health (FMOH) to improve the quality of GBV prevention and response services.

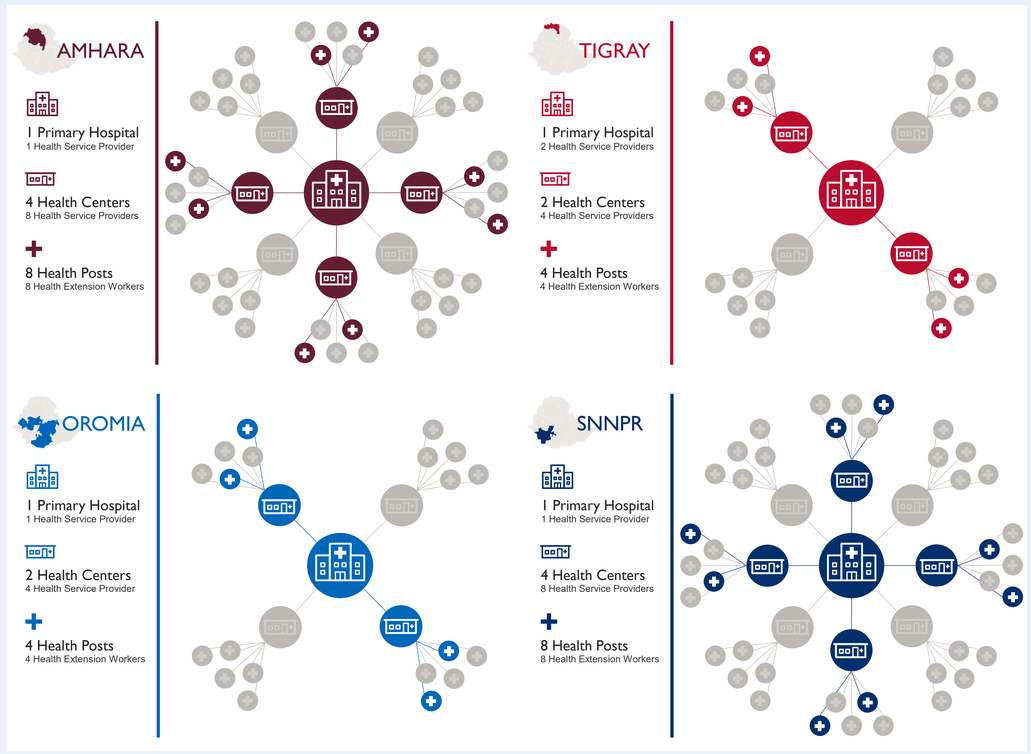
METHODOLOGY

The research team developed a mixed-methods design using qualitative and quantitative data collection tools and participatory data analysis to answer the study's overarching question: *What opportunities does the Transform: Primary Health Care project have to develop and implement innovative interventions to prevent and respond to GBV?* To construct a comprehensive picture of the availability and quality of services, the project conducted key informant interviews with healthcare providers (at primary hospitals and health centers) and health extension workers (at health posts). To complement this information, data collectors also completed observation checklists to assess the implementation of standard operating procedures (SOPs) at the health facilities where health care workers were interviewed. One healthcare network in each of the 4 project regions was visited for data collection to ensure a case study approach, which allowed for an in-depth, contextual understanding of GBV prevention and response services in each region. Appreciative inquiry (Preskill and Catsambas 2006) informed data collection and analysis as well, allowing a sensitive exploration of the complexities related to GBV discussions. Data collectors received comprehensive ethical training, and interview guides were carefully designed to capture challenges and successes of existing services to build upon what is working well within the health networks and referral systems. Data collectors completed a total of:

53 semi-structured interviews with health service providers and health extension workers

40 observation checklists at health facilities where semi-structured interviews were conducted

The research team coded and analyzed the resulting data from each region to develop context specific findings, which were further analyzed to develop synthesized findings. The research team hosted a data consultation meeting to validate findings and co-create conclusions and recommendations with the key stakeholders who would be responsible for acting upon them. The meeting also allowed for regional teams to identify priority action areas. This participatory approach allowed for inclusive evaluation that was in line with the views and needs of stakeholders (Institute for Development Studies 1998), resulting in a utilization focused study (Patton 1997) with concrete next steps.



RESULTS

Summary findings and conclusions suggested a number of key focus areas with direct implications for GBV prevention and response efforts in Ethiopia. These include that healthcare workers are aware of gaps in service delivery for GBV survivors and want additional resources, training, and guidance to deliver quality care to GBV survivors, such as knowledge of and access to job aids, standard operating procedures, and other GBV-related policies/guidelines/protocols. Additionally, while basic services exist, resource constraints, knowledge gaps among clients and healthcare workers, and weak multi-sectoral referral links create disjointed and incomplete pathways of care for GBV survivors. For instance, in addition to no formal mechanism or procedure to conduct follow-up with GBV survivors, the interview and checklist data indicated that connections between service delivery points were weak or nonexistent. Last, sociocultural norms that foster stigma for survivors and normalize violence within partnerships inhibit women's, men's, boys', and girls' access to comprehensive GBV care and treatment. Many healthcare workers noted that they and their greater communities did not identify and treat violence within marriage to be GBV, hindering both service access and provision.

RECOMMENDATIONS

Final recommendations focused on training and capacity enhancement for healthcare workers; service quality improvement for GBV screening and response; supply chain management to ensure healthcare facilities have essential supplies and equipment available; improved recording and reporting mechanisms; community mobilization to raise awareness and prevent GBV; and strengthened referral linkages to improve multi-sectoral response to GBV. In response to these recommendations, the project has taken specific actions such as engaging with the FMOH to support GBV strategic plan development; organizing multi-stakeholder SOP orientations; providing job aids inclusive of GBV care algorithms, SOPs, and clinical manuals; and integrating GBV prevention messaging into social and behavior change communication efforts.

This icon leads to the full synthesis report and regional case studies.

This icon leads to an infographic highlighting key findings and related recommendations.

REFERENCES

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