

Changing Gender Norms and Practices, Improving Sexual and Reproductive Health: Tools and Lessons from the RESPOND Project



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This publication is made possible by the generous support of the American People through the U.S. Agency for International Development (USAID), under the terms of cooperative agreement GPO-A-00-08-00007-00. The contents are the responsibility of The RESPOND Project/EngenderHealth and do not necessarily reflect the views of USAID or the United States Government.

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Printed in the United States of America. Printed on recycled paper.

Suggested citation: The RESPOND Project. 2014. *Changing gender norms and practices, improving sexual and reproductive health: Tools and lessons from the RESPOND Project*. New York: EngenderHealth (The RESPOND Project).

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Acronyms and Abbreviations

AGBEF	Association Guinéenne pour le Bien-être Familial
AGUIAS	Association Guinéene des Assistantes Sociales
BCC	behavior change communication
CDF	Family Development Centers
CONAG-DCF	Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes
FGD	focus group discussion
FOJASSIDA	Forum for AIDS Support and Solidarity
FP	family planning
GBV	gender-based violence
GBVIMS	GBV Information Management System
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IPV	intimate partner violence
IRC	International Rescue Committee
MAP	Men As Partners
MSNDPHG	Ministry of National Solidarity, Human Rights and Gender
MSPLS	Ministry of Public Health and the Fight against AIDS
NGO	nongovernmental organization
PEP	postexposure prophylaxis
PEPFAR	President’s Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission [of HIV]
PNPEC	National Program for People Living with HIV
RH	reproductive health
SEED	Supply–Enabling Environment–Demand
SOP	standard operating procedure/standards of practice
SRH	sexual and reproductive health
STI	sexually transmitted infection
ToT	training of trainers
UCF	União Cristã Feminina
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YWCA	Young Women’s Christian Association

Acknowledgments

This report was prepared by Alan Greig and Chloe Vaast. Staff from the RESPOND Project who provided input, revisions, and comments included Santiago Plata, Hannah Searing, and Fabio Verani. The authors would like to thank the United States Agency for International Development (USAID) for its support of RESPOND.

We also extend our thanks to the RESPOND and USAID staff who contributed with interviews, information, and discussions about the RESPOND Project's gender programming. This report was copy edited by Michael Klitsch and was formatted by Elkin Konuk.

Introduction

About RESPOND

Over the past six years, RESPOND Project has gained experience and expertise in addressing some of the most important determinants of sexual and reproductive health (SRH) problems, namely inequitable gender norms and the gender-based violence (GBV) that they fuel. RESPOND¹ is a Leader with Associates Cooperative Agreement awarded by the United States Agency for International Development (USAID) to EngenderHealth in 2008. The project has enabled USAID missions and global bureaus to draw upon EngenderHealth's technical leadership and assistance to strengthen and improve the outcomes of programs delivering SRH services in selected countries worldwide. RESPOND was designed to advance the use of reproductive health (RH) and family planning (FP) services, with a focus on informed and voluntary use of long-acting and permanent methods of contraception. Key to the achievement of this overall strategic objective has been RESPOND's emphasis on developing "holistic and evidence-based approaches to strengthen the supply of, demand for, and the enabling environment for RH/FP services" (Intermediate Result Area 3).

A central programmatic principle guiding RESPOND's work from its beginning has been ensuring gender equity in SRH decision making, services, and programs. The foundation for this programmatic emphasis was laid by EngenderHealth's ACQUIRE Project (also funded by USAID), which was recognized by USAID's 2007 Strategic Appraisal for its promising program model that holistically integrated supply, demand, and enabling environment interventions to increase access to quality RH/FP services. Under ACQUIRE, EngenderHealth embarked on the Male Norms Initiative (in Ethiopia, Mozambique, Namibia, and Tanzania) in collaboration with the Instituto Promundo (based in Brazil). Together, they developed a set of programming tools, based on both the Men As Partners[®] (MAP) approach and Program H,² to address the gender dimensions of SRH, with a particular focus on engaging men as allies and agents of change. The programming tools included:

- *Needs Assessment Package for Male Engagement Programming* [www.engenderhealth.org/files/pubs/acquire-digital-archive/7.0_engage_men_as_partners/7.2.3_tools/needs_assessment_final.pdf]
- *Engaging Boys and Men in Gender Transformation: The Group Education Manual* [www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Group_Education_Manual_final.pdf]³
- *Engaging Men in HIV and AIDS at the Service Delivery Level: A Manual for Service Providers* [www.engenderhealth.org/files/pubs/acquire-digital-archive/7.0_engage_men_as_partners/7.2.3_tools/service_manual_final.pdf]
- *Engaging Men at the Community Level* [www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Community_Engagement_Manual_final.pdf]

¹ The RESPOND Project is led by EngenderHealth, in partnership with FHI 360, the Futures Institute, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, Meridian Group International, Inc., and the Population Council.

² Both MAP and Program H are strategies to engage men and boys in promoting gender equality and preventing GBV. Both utilize group workshops with men and boys to reflect on gender norms and challenge gender-inequitable attitudes and work with communities to promote equitable norms.

³ This 11-module manual offers trainers an array of participatory experiential exercises to reach men (and their partners), exploring gender socialization and its impact on HIV prevention and care.

These programming tools reflect both organizations' prior experience with the gender dimensions of SRH. They also take into account evidence in the literature establishing the impact of gender inequality and GBV on women's reproductive choices and access to services (Alio et al., 2009; Okenwa, Lawoko, & Jansson, 2011; Miller et al., 2014), as well as women's heightened vulnerability to HIV and AIDS (Dunkle et al., 2004; Greig et al., 2008).

The development of these tools was also based on the growing international consensus on the importance of engaging men and boys in promoting gender equity. The landmark International Conference on Population and Development (held in Cairo in 1994) and Fourth World Conference on Women (held in Beijing in 1995) specifically called for policies and programming to more effectively engage men in efforts to secure SRH and rights, and more generally, for women's empowerment and gender equality. Over the past two decades, a significant body of evidence has attested to the effectiveness of male engagement programming in addressing gender equity in health (WHO, 2007; Barker et al., 2010; WHO, 2010).

RESPOND's gender programming also reflects the growing emphasis by the U.S. Government to address gender, as seen in USAID's Gender Equality and Female Empowerment Policy⁴ and in the policies of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which emphasize the need to design programs that integrate gender issues and work to advance gender equality throughout the HIV continuum of prevention, care, treatment, and support (PEPFAR, 2013). Indeed, the main components of RESPOND's gender programming over the last six years, as presented in this report, are evident in the recommended activities outlined in PEPFAR's Updated Gender Strategy (PEPFAR, 2013). They include a commitment to:

- Implement GBV prevention activities and provide services for post-GBV care
- Implement activities to change harmful gender norms and promote positive gender norms
- Provide gender-equitable HIV prevention, care, treatment, and support

RESPOND's Strategic Approach to Gender Programming

Addressing harmful gender norms and inequalities linked to SRH problems, including HIV and AIDS, emerged over the course of RESPOND's operations and was shaped by USAID country mission requests to address issues of specific national concern. From the outset, then, RESPOND's gender programming has been highly responsive to local conditions and nationally identified priorities with respect to the particular dynamics of the nexus among gender norms, GBV, and SRH problems in a given country. The opportunities identified in consultation between RESPOND and USAID missions in different countries have led to different emphases in RESPOND's gender programming, as follows:

- In Angola, Burundi, and Guinea, programming has emphasized implementing GBV prevention activities and providing services for post-GBV care. (EngenderHealth also engaged in such programming in Tanzania at this time, under the CHAMPION Project.)
- In Namibia and South Africa, activities have focused on changing harmful gender norms and promoting positive gender norms.
- In Côte d'Ivoire, the emphasis has been on providing gender-equitable HIV prevention, care, treatment, and support.

⁴ www.usaid.gov/sites/default/files/documents/1870/GenderEqualityPolicy.pdf.

RESPOND used EngenderHealth’s Supply–Enabling Environment–Demand (SEED™) programming model to design its programs, an approach that is based on the Supply-Demand-Advocacy model created under ACQUIRE. This holistic programming framework is based on the principle that SRH programs will be more successful and sustainable if they comprehensively address the multifaceted determinants of health and if they include synergistic interventions within the mutually reinforcing areas of supply, enabling environment, and demand.

SEED focuses on the following three areas of program intervention:

- *Supply*: to support the delivery of quality services (SRH, HIV, and GBV)
- *Enabling Environment*: to encourage a policy, program, and community environment that facilitates the provision of quality services and transformation of social and gender norms
- *Demand*: to help individuals, families, and communities gain increased knowledge and capacity to address the barriers that inhibit their demand for services.

To tackle the complexities of gender transformation, the SEED approach needed to be reinterpreted and adapted. To do this, RESPOND used the Social Ecological Model. This model, which has been widely applied in public health policy and programming, was extremely useful in designing interventions to address the prevention of and response to GBV (Fergus, 2012; Heise, 2012). The Social Ecological Model emphasizes the different levels of factors sustaining inequitable gender norms (individual, relationship, community, and society) and thus the different levels of the “social ecology” at which interventions must work if they are to be effective in promoting equitable gender norms and greater SRH. It served as an important model for the design of RESPOND’s gender and GBV program interventions. This report uses a modified social ecological framework to present and discuss RESPOND’s gender programming at the individual, service, and community levels.

EngenderHealth uses a gender continuum that was originally defined and proposed at the XIII International AIDS Conference in Durban (Gupta, 2000) as a framework within which to address the extent to which gender is integrated into various programs. Under EngenderHealth’s version of the continuum:

- “Gender exploitative” programs are to be avoided at all times, as they generally exploit gender inequalities.
- “Gender neutral” programs simply ignore the role of gender inequality and gender norms in health programming.
- “Gender sensitive” programs at least recognize the specific roles and realities of women and men based on the social construction of gender, but do not seek to change overall gender relations and inequalities in the intervention.
- “Gender transformative” programming actively strives to examine, question, and change rigid and harmful gender norms as a means of reaching health and gender equity objectives.

Experiences from RESPOND’s varied gender programming in Angola, Burundi, Côte d’Ivoire, Guinea, Namibia, South Africa, and Tanzania suggest that the distinction between “gender transformative” and “gender sensitive” remains useful for assessing programs’ effectiveness in relation to stated program objectives, but they also demonstrate that in reality the boundary between the two categories is porous. As is discussed in this report, gender-sensitive service delivery programming, as in the example of male-friendly HIV testing services in Côte d’Ivoire, has the potential to create opportunities to engage men in working to challenge the harmful gender norms that increase their

HIV risk behavior. At the same time, any gender-sensitive or gender-transformative programming needs to continuously analyze its approaches to ensure that they are truly promoting gender equality. For example, community-based interventions for addressing GBV that seek to transform harmful gender norms but work through male-dominated community leadership structures without questioning the basis of their patriarchal authority risk reinforcing a paternalistic desire to “protect women,” rather than beginning to transform the underlying gender inequalities of power that fuel such violence. These are difficult “lines to walk” for any gender program, no less in the seven countries in which RESPOND had specific gender programming where, notwithstanding many differences, male-dominated community (and national) leadership structures are the norm. How RESPOND walked this line, and what it learned on its journey, is the subject of this report.

About This Report

This report is based on a review of project documentation from RESPOND programs in Angola, Burundi, Côte d’Ivoire, Guinea, Namibia, and South Africa, and on interviews with selected key informants on the work in each country. The countries were selected because RESPOND carried out specific gender programming there, usually with field support from USAID missions. Other RESPOND countries where specific gender programming was not conducted are not included in this report. All but one of the country activities described in this report⁵ received field support funding under RESPOND. A list of published RESPOND tools (with URLs) is provided as Appendix 1.

⁵ The project in Guinea to integrate counseling on intimate partner violence into FP services was funded with core monies from USAID/Washington, not by field support.

Be the Change

Key Issues and Lessons

Personalizing the issues

The male engagement tools developed under ACQUIRE and adapted for the different country contexts in which RESPOND worked emphasize personal reflection by male and female participants on: the impact of harmful gender norms in their own lives; the ways in which they have facilitated or have refused to reinforce such norms; and the roles they could play in trying to transform these norms. Group discussions and community mobilization activities implemented when applying tools such as *Engaging Boys and Men in Gender Transformation: The Group Education Manual*⁶ and *Engaging Men at the Community Level*⁷ create spaces and processes for personalizing the issues of gender equality and discussing what it means to “be the change” by promoting positive gender norms that help to reduce violence and improve health.

Feedback from staff and volunteers who participated in training of trainers (ToT) workshops to prepare them to lead such activities attests to the importance and impact of personalizing the issues in this way. A young activist from União Cristã Feminina (UCF) in Angola who worked on RESPOND’s community campaign against intimate-partner violence (IPV) to promote more equitable gender relations said the following about the ToT in which she participated:

“It affected me in all parts of my life—the training on gender equality was like a bucket of cold water, a wake-up. All the other stuff I had learned made sense then. I knew before that I had to get good grades and study hard, but I didn’t know that men could do domestic chores too. I know more now about the causes and consequences of violence. I learned that you can’t just depend on men—you need your own education. My mom always said that ... you never know what will happen with a man and then if you’re left with nothing, you can’t support yourself. I need to be independent.”

The case study below describing the experiences of LifeLine/ChildLine in Namibia using RESPOND’s gender tools to train and support its staff to develop male engagement programming, provides information on the ways in which such tools helped to personalize the issues of gender equality and male involvement and the impact at both the individual and organizational levels.

Mentoring staff

Debriefs with staff and volunteers involved in implementing RESPOND’s activities also emphasized the need for continued support and capacity building. As one key informant said:

“So the main lesson learned is capacity building. If you hire staff to work on a gender project, unless they are known gender experts, there should be an ongoing process of capacity building. It can’t be a one-off, go out there and do a one-week training and say OK this person is a male engagement expert. Maybe we need some sort of ongoing process of capacity building for people working on gender. Because you can’t assume

⁶ www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Group_Education_Manual_final.pdf.

⁷ www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Community_Engagement_Manual_final.pdf.

that just because somebody accepted a position working on gender, that they actually espouse the norms and values that we want them to be promoting. It really has to start at home.”

This ongoing process of support and capacity building worked best when a mentoring relationship with an expert in gender equality and male engagement work was established for those coming into the work. For example, in Burundi, RESPOND developed an intervention targeting male occupational groups (including miners and tea plantation workers) using group education activities to foster a male peer culture promoting more equitable gender norms (RESPOND Project, 2012; RESPOND Project, 2014a). A RESPOND consultant led a ToT for a team of 12 trainers. Assessments before and after the ToT workshop revealed some of the challenges, emotional as well as technical, that the facilitator teams would face when implementing the gender equality and male engagement workshops for the targeted male workers. While nine of 12 participants said in the pretest that they felt “at ease discussing sexuality” with their partner and friends, only six of 12 reported feeling that way at posttest. Participants explained that at the beginning of the week, they thought that sexuality was simple, with not much to discuss. By the end of the week, they said they had realized how complex sexuality is and what types of conversations needed to happen to have a healthy relationship.

To support these facilitators in holding such conversations with the communities in which they would be working, the consultant took on a mentoring role by: providing the facilitators with refresher training on challenging topics, such as sexuality; stepping in, as needed, to facilitate discussions on these topics during workshops convened by the facilitators; and giving guidance to the facilitators during debriefing meetings that followed each day of their workshops. Such mentoring proved vital; it gave the newly trained facilitators confidence and a greater capacity to undertake their work.

However, the short and urgent timeframes within which RESPOND was often asked to operate did not always allow staff to be properly mentored and supported to do their best work. One key informant noted that sometimes the problem was also linked to language ability:

“I think one thing we could have done better as an organization was to get our experts from headquarters out there to build the capacity of our staff in gender. I think that if it was going to be a gender project, unless you’re hiring a local person who is a known expert in gender, they need training. I mean, Step 1 really needs to be about having one of our gender experts go out there and really work intensively with that person. Work through what a male engagement workshop looks like; what are the norms and behaviors that we want people to be adapting. However, I think that sometimes the reason why there wasn’t any capacity building prior to the project had a lot to do with language. It’s not that easy to send someone out there and work with translators, especially when things are very nuanced.”

Competencies

Key informants noted the need to clarify the basic competencies required by trainers and facilitators using RESPOND’s gender tools as a basis for identifying the mentoring support they would need. It was suggested that staff need:

- Prior experience or training in facilitation skills
- Experience with “reflective workshops” (i.e., gatherings in which participants reflect on gender norms)

- Training in and/or experience at facilitating gender-transformative workshops
- An ability to model gender-equitable behaviors
- An ability to identify and address gender-inequitable messages/comments
- A ToT followed by supervision and support of training conducted
- Opportunity to exchange experience with peers

Institutionalizing gender equality

Beyond the immediate challenge of adequately training and mentoring staff to be able to undertake this technically and emotionally challenging work over the long term, there is the challenge of putting structures and processes in place at an organizational level to ensure that gender equality is not merely a goal of particular interventions, but an overarching institutional commitment. Institutionalizing gender equality is about the organization as a whole, not just the individuals in the organization “being the change” they want to see in the world. The LifeLine/ChildLine case study presented below offers an inspiring example of how one organization involved with RESPOND used the gender tools to begin to create practices and a culture that more actively promoted gender equality.

As a result of its work on RESPOND, EngenderHealth recognizes the need to deepen its own work to institutionalize gender equality. It is currently engaged in the development of a set of Gender Standards and Practices to ensure that all programming is at least gender-sensitive, and to provide clear guidance on the minimum standards for gender-transformative (and -sensitive) programming.

Institutionalizing Gender Equality through Standards and Practices

A survey of staff conducted by EngenderHealth’s Gender/MAP Team in 2013 revealed wide variations in understanding of and comfort with key terms and concepts that are central to RESPOND’s gender programming in particular, and to EngenderHealth’s gender-related programming more generally. There was a lack of clear consensus among the staff surveyed concerning the definitions of and distinctions between “gender-transformative” and “gender-sensitive” programs. To address this lack of consensus and capacity at an institutional level, EngenderHealth has been refining a set of Gender Standards and Practices, with the following objectives and associated activities:

Primary Objective 1: Implement organization-wide gender mainstreaming

Primary Objective 2: Ensure that gender is integrated (at a minimum level) into all of the organization’s programming and operations

Primary Objective 3: Ensure that gender-transformative or gender-sensitive programming (including GBV programming) has minimum standards

Case Study: The Gender Journey of LifeLine/ChildLine in Namibia

Inequitable gender norms are one of the drivers of the HIV epidemic in Namibia, as is the case in many other countries around the world. Norms of masculinity that encourage multiple sex partners, equate male sexuality with assertions of male authority and control, and promote GBV put women and men at risk. Working with a local Namibian nongovernmental organization (NGO) partner, LifeLine/ChildLine, RESPOND helped to place such harmful norms of masculinity at the center of HIV programming, and in doing so, set LifeLine/ChildLine on its own journey of gender reflection and change.

In 2007, during the ACQUIRE Project, EngenderHealth and LifeLine/ChildLine established a partnership, based on a shared commitment to addressing gender norms as a crucial component of an effective response to the HIV epidemic and to targeting HIV programs at men. EngenderHealth's MAP[®] program undertook training and technical assistance (TA) activities in Namibia as part of a regional Male Engagement Initiative. The National Director of LifeLine/ChildLine and a staff member attended the first male engagement workshop for PEPFAR partners in Namibia facilitated by EngenderHealth and Promundo staff under ACQUIRE. They recall the powerful impact the workshop had on them both:

“It was the first time that I felt engaged as a man on the subject of gender. As men, we had felt left out of the effort to end gender inequality. I think many men saw all this talk about gender equality as propaganda to disempower men.”

—*LifeLine/ChildLine staff member*

“

It was a huge eye-opener for me to hear men's perspectives on gender. That space had never existed before.”

—*LifeLine/ChildLine executive director*

What made the workshop so powerful, they recalled, was the emphasis on personalizing the issues and on creating emotional space and a sufficient sense of safety among the workshop participants to reflect on and discuss the workings of gender norms, roles, and inequalities in their own lives, as the basis for their being able to work with men and women in the community. In the words of one male staff member: “When we sit together as men, we make a lot of assumptions about women. The workshop opened up a space to listen to women directly.” In remembering this workshop as the beginning of LifeLine/ChildLine's development of male engagement strategies in its HIV programming, the executive director describes it as “a real breakthrough moment.”

The first step after the male engagement workshop was to train all LifeLine/ChildLine staff and volunteers in male engagement concepts and skills, with the aim of integrating gender analysis and male engagement strategies into all of the NGO's programming. Using activities from EngenderHealth's group education manual, two staff members led this initial training for staff and volunteers, who then worked to incorporate gender issues into their regional and youth training initiatives. A member of the LifeLine/ChildLine Training Team described how her unit was able to integrate gender into its work:

“Gender topics were mainstreamed in the Personal Growth manual in the following ways: the MAP[®] Group Education material offered more practical ways to present some of the topics we have in our Personal Growth manual, such as interpersonal relationships (healthy and unhealthy). The gender topics also helped to define issues people struggle with, such as gender equity, gender equality, sex, and sexuality. They helped us to talk in a more practical way about issues that are normally not talked about, like men's and women's bodies, as well as men's health. Gender topics also set a tone on topics covered in basic counseling, such as substance use, as well as GBV.”

Once again, this staff training proved to be an eye-opener. As staff recall, they had made assumptions about the gender competence of LifeLine/ChildLine staff; the training revealed some very entrenched, traditional views on men's “natural” authority and women's duty to respect this authority. For the first time the organization's history, the workshop allowed for an open discussion among staff and volunteers about such attitudes and their implications for their HIV prevention and care work. This

initial workshop, and subsequent refresher trainings on gender and male engagement, provided a platform to look at and talk about entrenched, harmful attitudes about gender and sexuality and to question them from the perspectives of both health and rights. The workshops also helped staff deepen their empathy for those who suffer most from these attitudes. A continuing challenge has been the issue of attitudes toward the lesbian, gay, bisexual, and transgender communities. As a result of this in-house training and discussion, LifeLine/ChildLine staff and volunteers made a collective agreement that whatever people's personal opinions are about sexual diversity, as staff members they have a responsibility to be nonjudgmental and professional in how they address these issues in their work.

As a result of this internal staff training and discussion on gender issues and male engagement strategies for HIV programming, LifeLine/ChildLine adopted a zero-tolerance policy on GBV as a strategic principle across all of its work, meaning that the organization actively speaks out against it in all of its manifestations, wherever and whenever such violence shows up. The organization has also created a regular space to continue the personalized reflection and discussion on gender and sexuality. In its regular "Friday chill" staff conversations, gender and sexuality issues have been prioritized as themes. Recently, LifeLine/ChildLine organized a Wellness Week, during which staff looked at men's roles in caregiving. From this, a monthly fatherhood group for male staff members and volunteers has been formed, to continue the conversation on men's roles in caregiving. Other adjustments to organizational practice have included changes in the recruitment process for new staff. Specific questions to probe for attitudes on gender and sexuality issues are now a feature of the interview process.

Another key lesson has been the importance of an organizational commitment, as demonstrated by LifeLine/ChildLine's commitment to gender equality across all of its programs, in such a way that it becomes foundational not additional. Reflecting on the lessons that have been learned from this experience with gender training for staff and volunteers, LifeLine/ChildLine personnel are keen to stress the critical importance of personalizing the issues, because change at the personal level is key to doing effective work on gender and sexuality issues in and with the community. The need to strengthen the competency of facilitators to hold space for these sometimes difficult conversations is also clear. As an organization, LifeLine/ChildLine has benefited from coaching and mentorship from EngenderHealth staff who cofacilitated workshops with staff members and then debriefed them afterwards. As a result, both key informants acknowledged that staff competency in facilitating discussions on gender and sexuality, especially with men, has definitely improved. Indeed, one staff member is now a recognized public spokesperson on male engagement issues in Namibia.

Situation Assessment

Tools Overview

RESPOND used different types of situation assessments. Assessments were usually undertaken at the beginning of gender-focused programming or at the request of a USAID mission. A range of tools were developed and adapted for use to conduct the situation assessments:

- A mix of secondary data review, key informant interviews, and focus group discussions (FGDs) were used to carry out national-level assessments of the problems of and responses to sexual violence and other forms of GBV in Angola, Burundi, and Guinea.
- Subnational/provincial-level formative research was conducted to identify the dynamics of sexual violence and gather baseline data to guide the design of an intervention to improve the prevention of and response to sexual violence in Burundi. This research study used a mix of methods, including FGDs, key informant interviews, and audits of health care facilities.
- City-level formative research was undertaken in Côte d'Ivoire, using FGDs and audits of health care facilities to design an intervention to increase men's uptake of HIV testing and prevention services.
- A quasi-experimental study was done in Cazenga, a large, low-income submunicipality of Luanda, Angola. The study design involved a baseline household survey (interviews) of men and women ages 18–49. The survey objective was to gather information about attitudes toward and experiences with GBV and gender inequality, to inform the design of a community awareness campaign and to set baselines against which to assess the impact of the campaign.
- Audits of health care facilities were used in several countries. In Guinea and Burundi, health facility audits assessed: services delivered to sexual violence survivors; service quality; availability of necessary equipment and supplies; knowledge and attitudes of medical care providers toward survivors; standard operating procedures (SOPs); confidentiality and record-keeping practices; referral practices; and infection prevention practices. In Côte d'Ivoire, facility audits were used to assess services, protocols, and practices already in place, and those that were needed, to ensure that HIV testing was male-friendly. Data collection tools designed by RESPOND for facility audits included a Health Facility Manager Questionnaire, a Health Provider Questionnaire, and checklists for services and supplies.

Country Experiences

Situation assessments underscored the need for integrated interventions across the “social ecology.” For example, the situation assessments of sexual violence conducted at the national and subnational levels in Burundi and at the national level in Guinea showed the need for a mix of interventions to work on individual-level change, in addition to health service delivery improvements and community engagement. RESPOND's programming in response to the findings of these situation assessments emphasized the need both to work across these different levels of the “social ecology” and to link different intervention components so that they could be mutually reinforcing. The development of the site walk-through methodology in Burundi is a good example of linking service-level and community-level interventions. (This methodology is described on page 53.)

Program priorities must respond to local conditions and opportunities

To inform the design of Angola's HIV prevention program, the USAID Mission there asked RESPOND to conduct an assessment of in-country structures and capacities for responding to GBV (Sloan et al., 2014). In particular, RESPOND was asked to look at: 1) law enforcement and health sector responses, including legal and policy frameworks, response procedures, and referral systems; and 2) the capacity of relevant staff to support survivors of GBV. Based on a review of secondary data and key informant interviews, the assessment team made several recommendations, including:

- Support the creation of a cadre of trainers on gender and GBV from different agencies: the Ministry of Family and Women (MINFAMU), the police, the Ministry of Health (MINSa), and civil society
- Ensure the development and implementation of police procedures and guidelines for dealing with survivors of GBV
- Build the capacity of police personnel to respond to GBV and follow procedures related to GBV
- Support the development of data collection systems at police stations, domestic violence counseling centers, and health clinics and centers
- Ensure that the safety of the survivors of violence is addressed as a primary concern in all response processes and mechanisms

The assessment team also emphasized that building the capacity of the police was only one step in a much larger societal response to GBV, especially since only a small fraction of women and girls (or men and boys) ever go to the police or to any other authority with GBV-related complaints. The team recommended a broader social ecological approach that would look at: social norms; effective prevention activities at the community and individual levels; the role of other government agencies in providing services; the legal framework for GBV; and the provision of social services for women (reception centers, psychosocial counseling, legal aid, and safe houses).

Ethical considerations are central to responsible formative research on sexual violence and other forms of GBV. FGDs were used in several countries to assess how health facilities could best address the needs of survivors. For example, in Burundi, FGDs were conducted with members of the communities around the health centers to understand social norms and attitudes regarding sexual violence, barriers that prevent sexual violence survivors from accessing services, and strategies to improve service delivery. With permission, RESPOND had adapted the data collection tool from one designed by the International Center for Research on Women for the Tanzania Multisectoral AIDS Project. In adapting the FGD guide and selection criteria, it was agreed that to reduce the likelihood of survivors being retraumatized by participating in a group discussion about sexual violence, the following criteria should be made clear to community leaders who assisted RESPOND in recruiting participants for the FGDs:

- Participants should not be selected based on a history of surviving or perpetrating sexual violence.
- Participants should meet the age and sex guidelines for their FGD category.
- Participants should be generally knowledgeable about the community.

The sample was not intended to be statistically representative of the broader community. The study did not include participants under age 18, due to the sensitivity of the topic.

Case Study: Planning a More Effective Response to Sexual Violence in Burundi

Addressing sexual violence is a priority of the PEPFAR program in Burundi. With the support of PEPFAR and in partnership with the Ministry of National Solidarity, Human Rights and Gender (MSNDPHG) and the Ministry of Public Health and the Fight against AIDS (MSPLS), in August 2011 RESPOND conducted a national-level assessment of the nature and extent of sexual violence and of the national response to such violence (RESPOND Project, 2012). Among its findings, the assessment identified the following challenges:

- A lack of systematic training for medical personnel in the response to sexual violence
- A lack of referrals and coordination between organizations and service providers across different sectors
- Underreporting of sexual violence as a result of its normalization, the impunity with which men used sexual violence against women, and the social stigma experienced by survivors

To deepen its understanding of the challenges identified by this assessment and to gather baseline data to guide the design of an intervention to improve the prevention of and response to sexual violence, a formative study was conducted by RESPOND in April 2012 in two provinces (Kayanza and Muyinga). The provinces were selected to allow RESPOND to build on the achievements of the maternal and child health program that PEPFAR was implementing in these provinces (RESPOND Project, 2014a). RESPOND identified four townships in the provinces: Kabarore and Muruta townships in Kayanza, and Butihinda and Giteranyi townships in Muyinga.

The study was conducted in close collaboration with the MSNDPHG, MSPLS, and administrative authorities in Kayanza and Muyinga. The specific objectives of the formative research were to:

- Assess the health services available for sexual violence survivors in the two provinces
- Identify other, nonmedical services available for sexual violence survivors in the two provinces
- Explore the factors that allow sexual violence to take place and prevent survivors from seeking help in the two provinces
- Develop recommendations for PEPFAR and the relevant ministries
- Guide RESPOND's strategy and activities

A mix of methods and tools were used to collect the data, including audits of health care facilities, FGDs, and key informant interviews. RESPOND audited 17 health centers and two hospitals, and interviewed the 19 facility managers and an additional 30 providers at the four research sites in Kayanza and Muyinga provinces. Key informant interviews were conducted with 24 administrative authorities, community leaders, and representatives of organizations that provide sexual violence services. FGDs were held with single-sex groups of nine to 11 community members each. A total of 158 community members participated in 16 FGDs.

Facility audits showed that health centers lacked the trained staff and equipment necessary to respond to sexual violence and that many providers held attitudes unsupportive of sexual violence survivors. Since they were unprepared to care for sexual violence survivors, providers at health centers typically referred cases to hospitals after providing very few services, such as treating wounds and providing antibiotics for the treatment of sexually transmitted infections (STIs). Given the significant barriers to pursuing these referrals, the study concluded that it was likely that many survivors received inadequate medical care for sexual violence, even after seeking it at health centers.

Outside the health system, the study found that services for survivors were similarly limited. In both provinces, some legal and psychosocial services existed, although they were not well-known by the communities. The study found no economic reintegration services or safe houses currently available to sexual violence survivors in the two provinces. The Family Development Centers (CDF), which are charged with coordinating sexual violence services, had insufficient staff and funding to fulfill their mandate. While women volunteers, called “baremeshakiyago” (peer educators) and “imboneza” (community relays), raised community awareness about health and social issues, which in theory included sexual violence, there appeared to be no structures with which to engage men in sexual violence prevention. The women volunteers were also clearly overburdened. The baremeshakiyago typically fulfill several different functions, including advocating for children’s rights, promoting FP, and addressing sexual violence. Some represent up to five or six NGOs at the same time. The study concluded that another major limitation of the effectiveness of the baremeshakiyago and imboneza in preventing sexual violence was that they were exclusively women.

The FGDs and key informant interviews revealed a range of factors fueling men’s sexual violence against women and preventing survivors from receiving help, including:

- Marital rape is widely considered acceptable. Participants in 15 of 16 FGDs reported that marital rape is common, and participants in six of 16 FGDs said that it is considered acceptable. They explained that a married woman is expected to be sexually available to her husband at all times; her consent is considered unnecessary. If a survivor were to report marital rape, she would be called an “ikimenabanga,” a pejorative Kirundi word for someone who reveals a secret.
- Sexual violence survivors fear retaliation by the perpetrator. When asked what types of sexual violence occurred in their communities, members of every FGD brought up examples in which perpetrators had power over survivors beyond physical strength. Given the imbalanced power dynamics, it is not surprising that participants in 15 of 16 FGDs said that survivors often fear what the perpetrator and those who are close to him would do if the survivor were to disclose an incident.
- The topic of sexual violence is taboo. Since discussion of sexual violence is rare, survivors feel uncomfortable and ashamed to tell others about what happened to them. All FGDs described shame as a barrier to seeking services. A major barrier to seeking help is that survivors fear that others will not believe them or will blame them for the incident.
- Survivors are stigmatized. All FGDs raised the concern that if others learned that a woman or girl had experienced sexual violence, she may be stigmatized and cast aside. Unmarried young women typically remain silent for fear of damaging their chances of finding a husband. By reporting sexual violence, a survivor risks harming not only her own reputation, but also the reputation of her parents, children, and spouse.

Pursuing justice through the court system was seen as difficult and futile. Participants in all FGDs named a number of barriers to bringing legal cases against perpetrators of sexual violence. First, court procedures are very long, meaning that they incur significant opportunity costs as well as financial costs. Survivors view the court system as corrupt and worry that their efforts will be in vain if the perpetrator bribes the judge. Furthermore, survivors often feel that they lack adequate proof to win their case. Not all survivors can afford sexual violence services. Across sectors, all of the key informants interviewed said that survivors typically face financial barriers to accessing care. Therefore, it is difficult to seek care without the husband’s knowledge. Participants in 11 of 16 FGDs cited cost as a barrier to seeking a medical certificate of forensic evidence.

On the basis of these findings, the RESPOND study team made the following recommendations:

- Prepare health centers to offer survivors at least a minimum package of sexual violence services, including counseling and referrals. Providers who work at first-line and referral facilities should be trained. It is very important for training to address attitudes around sexual violence.
- Provide CDFs with adequate resources to oversee the multisectoral coordination of partners in the care of sexual violence survivors and offer the services in their mandate, including psychosocial support and the facilitation of medical and legal services for survivors. CDFs should involve stakeholders in selecting and evaluating sexual violence services.
- Develop a national behavior change communication (BCC) strategy that includes a detailed road map for the MSNDPHG's BCC activities, target audiences, and messages to prevent sexual violence.
- Engage male champions in the fight against sexual violence. Male as well as female community volunteers should be trained to model equitable gender norms, speak out against sexual violence, and address barriers to seeking care. Groups of male champions could be recruited from mining companies, since miners were identified by communities as commonly perpetrating sexual violence.

Program Implementation: Changing Attitudes and Behaviors

Tools Overview

A recent body of research evidence attests to the effectiveness of the use of group-based, interactive, and experiential tools to change gender attitudes and behaviors so as to reduce GBV and improve SRH. Whether working with mixed-sex groups (Jewkes et al., 2008) or single-sex groups (Barker et al., 2010), it is clear that group-based interventions directed at attitudinal and behavioral change at the individual level are a critical component of programs seeking to transform harmful gender norms and inequalities.

Much of the work done to develop and refine group-based tools for engaging men in efforts to challenge and change inequitable gender norms was pioneered by EngenderHealth's MAP[®] workshop methodology for gender-transformative group education work with men and boys. This work was documented most recently in EngenderHealth's *Engaging Boys and Men in Gender Transformation: The Group Education Manual* (The ACQUIRE Project & Profamilia, 2008). This 11-chapter manual offers trainers an array of participatory experiential exercises to reach men (and their partners) and explore gender socialization and its impact on HIV prevention and care. Piloted in Ethiopia, Namibia, South Africa, and Tanzania, the manual is designed to assist master trainers in developing curricula to work with men and boys on gender, HIV and AIDS, and SRH issues. Following a short background section discussing the rationale and evidence for working with men on gender equality, chapter topics are: Gender and Power; Sexuality; Men and Health; Substance Use; Healthy Relationships; STI and HIV Prevention; Living with HIV; Fatherhood; Violence; and Making Change, Taking Action. RESPOND staff and partners made extensive use of this resource in developing interventions focused on attitudinal and behavioral change with specific male target groups. Where needed, they also drew on other, similar male-focused group education training packages. Interventions were implemented in:

- Burundi, targeting specific male occupational groups, including miners, tea plantation workers, and moto/taxi drivers.
- South Africa, targeting tertiary-level students at five universities in four provinces, in units of the South African Police Service in Gauteng province, as well as the South African National Defense Force. These interventions built on work dating back to 2004 under the ACQUIRE Project.
- Angola, targeting male and female gender activists who would be implementing a community campaign on GBV prevention. In this case, activities from Instituto Promundo's Program H⁸ and the White Ribbon Campaign–Brazil manual were adapted.⁹

Group-based interventions, both single-sex and mixed-sex, were also used with community members to increase GBV and HIV service uptake in Burundi and Côte d'Ivoire, respectively. This work is discussed in Program Implementation: Improving Service Delivery (page 25). Group-based training on gender equality and male engagement was also used to equip community-based GBV Prevention Committees to challenge inequitable gender norms fueling GBV in Guinea. This work is discussed in

⁸ See: www.promundo.org.br/en/activities/activities-posts/program-h-manuals-download/.

⁹ For more information, see: <http://lacobrancobrasil.blogspot.com.br/>.

Program Implementation: Engaging Communities (page 39) and looks more specifically at RESPOND's work on engaging communities in gender transformative work.

Key Issues and Lessons

Adaptation of tools to address the specific context and problems

The group education tools discussed above are generic resources. A critical first step for RESPOND when designing its interventions targeted at attitudinal and behavioral change was to adapt the tool, whenever possible, to address the specific determinants of gender-inequitable attitudes and behaviors within a particular target group of men in a given community. RESPOND staff and international consultants met with local stakeholders and consultants and drew on available research data to adapt tools. A theory of change logic model was used to identify the specific issues and topics to be addressed and skills to be developed in order to achieve the desired changes in attitudes and behaviors required by the overall goals of the program. The logic model developed for the male occupational groups in Burundi (Appendix 2) illustrates the thinking behind the selection of curriculum activities that were used in the five-day workshops with miners, tea plantation workers, and moto/taxi drivers. This logic model was informed by the findings from the baseline assessment conducted by RESPOND in the two provinces (Kayanza and Muyinga) in which interventions were conducted, as described above. Key adaptations done in Burundi included:

- Adapting case studies and examples with Burundian names and situations that are common in Burundi
- Adding a discussion of Kirundi proverbs that promote equitable and inequitable gender norms
- Focusing the curriculum more specifically on preventing sexual violence
- Adding pretest/posttest questions required for reporting on USAID gender indicators

When reflecting on such adaptation processes, key informants noted that RESPOND as a whole would have benefited from clearer guidance to staff and consultants on best practices in using theory of change logic models. An operational requirement that the use of such logic models be documented and shared, not only with national stakeholders but across RESPOND more generally, would also have helped to foster and improve their use.

Targeting group education strategically

The importance of being strategic in targeting which groups of men to prioritize for attitudinal and behavioral change emerged as a key lesson over the course of RESPOND's work. RESPOND staff and partners recognized the need to be more strategic so as to make the best use of limited resources. In Namibia, two adaptations of EngenderHealth's Group Education manual were developed by LifeLine/ChildLine, with support from RESPOND. The first was a supplement to the Group Education manual targeting religious leaders, because they were among the most important community leaders to either reinforce or challenge inequitable gender norms. The development of *Engaging Boys and Men in Gender Transformation: A Supplement Facilitating the Training in Christian Settings* is discussed in more detail in the case study on page 23.

The second adaptation was a gender-transformative group education resource targeted at young people. This was done because of the heightened vulnerability of young women to HIV infection and the greater receptivity of young people to attitudinal change interventions. *Stay Healthy: A Gender Transformative HIV Prevention Curriculum for Youth in Namibia* was developed as a school-based

curriculum designed to prevent HIV infection among Namibian youth aged 13–18. The curriculum focuses on affecting three key behaviors directly related to HIV infection:

1. Delaying the onset of sexual intercourse
2. Increasing the correct and consistent use of the male condom among sexually active youth
3. Decreasing multiple concurrent partners among sexually active youth

The association of harmful gender norms with risky sexual behavior is a major focus of *Stay Healthy*.

Connecting with men's interests

Group education work needs to find ways to connect with men's own interests in questioning and challenging gender norms. Many key informants commented on the importance of connecting with men's own interests and noted that in many cases this relates to issues of sexual health and sexuality more generally. According to a key informant in Côte d'Ivoire:

“In the current community manual, we have new sessions specifically addressing sexuality. So some of these sessions are in the EngenderHealth group education manual and other sessions I drew from CARE manuals. We have a session on the circle of sexuality and then it goes into explaining sexual rights as well as a piece on sexual identity/orientation, going into the diversity of sexuality. The other exercise was on pleasure brainstorming. It was kind of a way to get people more comfortable talking about sex and sexual pleasure. We have people list all of the different ways that they can provide sexual pleasure for a partner, without actual penetration. In general, the idea was de-medicalizing it, not just talking about sex always in relation to how we are preventing HIV and AIDS, but more of a holistic perspective.”

Concerns about HIV and AIDS and other STIs, or more broadly, about the quality of their intimate relationships with wives and/or girlfriends, meant that men often responded well when issues of harmful gender norms were linked explicitly to information on and conversations about the impact of such norms on sexual relations and behaviors. As RESPOND's local consultant in Burundi emphasized:

“The RESPOND tool was already very good because it addressed questions about gender, sexuality, violence, and action. Because we work on sexual violence, we must work from the root of the problem, we need to address gender inequality and its social construction. But for men, when you talk just about gender and norms, it doesn't always grab their attention. However, if you include sexuality issues, then the men are more attentive—so when proposing certain activities to participants, we adapted to their realities and our time frame to keep them most captivated. We mainly focused on sexual violence, sexuality issues and taking action.”

Focusing on personal attitudes and social norms

As already noted, the group education tools used by RESPOND relied on reflective, interactive, and experiential workshop activities to make the issues personal for participants—to “bring the issues home.” But at the same time, it proved critical to situate participants' personal experiences within the social systems reinforcing these norms. Linking the personal with the broader society in this way was essential for discussing with participants the range of actions for change across the social ecology that

were required to transform harmful gender norms and for identifying the roles they could play, individually and collectively, in such actions. A consultant in Burundi commented:

“Yes, of course I think our work was transformative. We trained peer educators to be able to discuss gender stereotypes and address sexual violence issues as well as become allies to survivors. The workshop activities make people think and evaluate themselves—people are often ignorant of how they fit into a larger system. These workshops create spaces for them to reflect. We help them see how gender norms affect both boys and girls. We look at the problems that affect women. We show them how our current social system isn’t working and stress that it is not equitable. We talk about the good norms that help women, girls, and boys. We talk about how we can work towards change.”

Holding a space for disclosure of trauma

Several key informants emphasized that the experience of using group education tools that explore gender attitudes and practices (especially when used with both women and men) suggests a need to pay more attention to issues of trauma and disclosure, both in terms of planning content for workshops and in preparing facilitators. A workshop for female police officers in Angola revealed very high levels of personal experience with violence among participants. A RESPOND consultant recalled:

“Some policewomen in the group talked about the experiences they had suffered inside their relationships and inside the police. It was an issue, because basically they were saying that all women inside the police force are victims of violence, sexual abuse, or harassment in Angola. All the women in the group were clear that they have suffered harassment inside the police, sometimes almost forced to go on dates with superior male officers or put into situations where they had to do this or were sent out or even sent to remote a location away from their family. It showed how common this issue is. The police have no campaigns, and no one in Angola is talking about this issue. At no moment did we put the women in situations inviting them to talk about their personal issues, because we knew this could be something tough, but one woman told of her experience and then after that all the women told very similar stories. I believe it was quite important for them to talk about their experience in this group. They felt safe and the feedback at the end of the workshop was very good overall.”

As already noted, exploring deeply held attitudes toward gender and sexuality, especially as they relate to GBV, is emotionally difficult work, and nowhere more so than in dealing with participants’ own disclosure of their experiences with such violence. Key informants noted that, in general, RESPOND’s interventions would have benefited from more guidance for project staff, and in particular, workshop facilitators, on how to hold space for disclosure of trauma and how to make appropriate referrals to needed services. In terms of facilitator training, more attention should be given in ToTs to skills building in handling issues of trauma and disclosure. Dealing with the emotional challenges presented by these issues further reinforces the need for ongoing mentoring of group education facilitators, as discussed in above.

Group education and reflection as a process, not an event

Feedback from key informants also makes clear the need to look beyond group education workshops as one-off events. Rather, they are part of a process of reflecting on and questioning of harmful gender norms and behaviors. As many noted, gender transformation does not happen quickly; it needs to be

understood as a process extending beyond the typical “life” of a project intervention. Given the short timeframes within which RESPOND tended to operate as a result of being funded by USAID country missions drawing on PEPFAR budgets, addressing the need to develop group education work as a process and not simply an event proved particularly challenging. Key informants emphasized the need to plan and budget for more follow-up activities with workshop participants and to heighten the emphasis in such workshops on planning actions that could be undertaken by participants for changes in their own lives and communities.

Case Study: Reaching Men in the Workplace

Recognizing the links between sexual violence and HIV risk, and with funding from PEPFAR, EngenderHealth worked to address sexual violence in Burundi under the RESPOND Project. A national needs assessment (described in the Situation Assessment, page 13) highlighted a number of challenges confronting the national response to sexual violence, among them the social acceptance of men’s sexual violence against women as an inevitable feature of gender relations (RESPOND Project, 2012). To address the normalization of men’s use of violence, RESPOND identified specific male occupational groups as an important target and opportunity for promoting gender-equitable norms to prevent sexual violence and for nurturing male peer cultures supportive of these norms.

A five-day MAP workshop was designed to work with groups of male tea plantation workers and with miners in Kayanza and Muyinga provinces (Kabarore and Muruta, and Butihinda and Giteranyi townships, respectively.) These occupational groups were identified in RESPOND’s baseline assessment as groups with a higher risk of abusing their male privilege in their sexual behavior towards women, including the use of sexual violence. This was partly because of their positions of authority and large amount of disposable income relative to others in their community. In the second year of RESPOND’s activities, the five-day MAP workshop strategy was expanded to moto- and bicycle-taxi drivers in the Kayanza Center and Muyinga Center townships (RESPOND Project, 2014a).

The curriculum for the five-day workshops was based largely on EngenderHealth’s *Engaging Boys and Men in Gender Transformation: The Group Education Manual*. Using a theory of change logic model (see Appendix 2), EngenderHealth’s Gender/MAP Technical Advisor and RESPOND’s Senior Program Associate worked with a local consultant to adapt the manual to the specific project objectives and context in Kayanza and Muyinga provinces. A five-day ToT workshop was held to train a team of facilitators to use the adapted MAP curriculum with miners and male tea plantation workers. Among the 12 participants were five women and seven men, all of whom had prior experience facilitating workshops to address GBV. Three of the male participants were members of the Coalition of Men Against Violence Against Women (Coalition des hommes contre les violences faites aux femmes, or CHOVIFF).

A pretest/posttest assessment of the ToT workshop revealed some of the challenges that the facilitator teams faced in implementing the adapted MAP curriculum for the targeted male workers, as noted earlier in this report. While nine of 12 participants said that they felt “at ease discussing sexuality” with their partner and friends in the pretest, only six of 12 reported feeling that way in the posttest. Participants explained that at the beginning of the week, they thought that sexuality was simple, with not much to discuss. By the end of the week, they had realized how complex sexuality is and what types of conversations need to happen to have a healthy relationship.

In response to this feedback, it was agreed that the Master Trainer would cofacilitate the MAP workshops with a rotation of facilitators in the two provinces. He provided facilitators with refresher training on challenging topics, such as sexuality, before the workshops, stepped in as needed to facilitate discussion of these topics during workshops, and gave guidance to facilitators during debriefing meetings that followed each day of the workshops. This mentoring proved vital in giving the newly trained MAP facilitators confidence and a greater capacity to undertake the work.

Over the course of the project, 699 men participated in the MAP workshops, of whom 14% (100) were tea plantation workers, 64% (449) were miners, and 21% (150) were taxi drivers. Their employers paid their wages while they attended, recognizing the value of the workshops in reducing HIV transmission. The workshops engaged men in confronting harmful gender stereotypes, discussing the concept of sexual consent, and practicing healthy communication in relationships through role plays and case studies. Participatory learning activities were used to examine the links between gender norms, sexuality, and violence, drawing on proverbs in the local language of Kirundi, where relevant, to share visions of more equitable gender relations. Participants identified the types of actions they could take, individually and collectively, to strengthen positive gender norms in their community and to prevent GBV and the negative effects associated with it.

Manweri¹⁰ works at a mine in Kabarore Township in the North-East region of Burundi, where he leads 1,500 miners who dig for coltan, a metallic ore used in electronic products. He was one of the participants in a MAP workshop held in January 2013 with 24 other male miners. Manweri has a wife and six children between the ages of 1 and 19. He had never received any type of training or education on gender and violence until he attended the MAP training organized by RESPOND. As Manweri says: “Lots of violent people are violent by ignorance and tradition. When you tell them this tradition is no longer valid, and that it hurts the well-being of their families, they change. Before, we often threatened our wives because we didn’t know it was bad. We thought a normal man behaves that way.” In the workshop, Manweri says that he learned “how to have dialogue and live in peace in the family. Now we make joint decisions. Before, if my wife said no, I’d take her by force. Like many, I’d say, ‘That’s what she’s there for.’ Now, we agree before having sex. I ask for her consent. If she’s not interested that day, I control myself.”

To assess the effectiveness of these MAP workshops for male workers, participants were asked to complete anonymous pretest and posttest surveys on attitudes and knowledge of gender roles, norms, and GBV. The facilitator administered the pretest on the first day of the workshop, before instruction began. The posttest was administered on the last day of the workshop. This methodology is inherently biased, due to courtesy bias and a lack of anonymity, but the results did show some trends, including improved gender-equitable responses in general, although responses regarding sexual consent did not improve. This latter finding suggests the need to address men’s understanding and attitudes in more depth in any revision to the MAP workshop curriculum.

In addition to the MAP workshops, 75 peer educators were selected for training from the group of miner and tea plantation MAP participants. These peer educators received a refresher training workshop on gender norms and inequalities. They were encouraged to lead discussions about gender norms, GBV, and related health issues at their workplaces. An endline assessment of this MAP initiative with male workers, which drew on a review of pretest/posttest workshop survey findings and interviews with RESPOND staff involved in the project, concluded that:

¹⁰ Due to the sensitive nature of sexual violence, all names have been changed.

- The MAP curriculum should be revised, particularly to allow for an increased emphasis on the issue of sexual consent within intimate partner relationships.
- Refresher workshops should be offered to the miners, tea plantation workers, and taxi drivers who have already participated in the project, to reinforce gender-equitable norms over time.
- Tea plantation and miner peer educators should be included in facility site walk-throughs, to increase their knowledge of local services for survivors of sexual violence and other forms of GBV, thereby enabling them to provide appropriate support and make suitable referrals for survivors.
- MAP workshops should be expanded to miners, tea plantation workers, and taxi drivers in other communities, as well as being extended to other groups within the communities, such as fishermen, police, and judicial staff.

Case Study: A Spiritual Path to Positive Masculinities in Namibia

LifeLine/ChildLine,¹¹ a PEPFAR partner in Namibia, turned to RESPOND for technical support in working with men to address gender norms as a crucial component of an effective response to the HIV epidemic.

Recognizing that the tenets and teachings of religion continue to be used, in Namibia as elsewhere, to legitimate ideas about male authority and female subordination and to sustain the social acceptability of gender inequalities and harmful norms of masculinity, one of the key LifeLine/ChildLine gender team members, as a commitment to his own faith, formed a network of religious leaders to champion more gender-equitable masculinities. This network created a training tool for use with religious leaders and their congregations, drawing on religious texts and arguments to support gender equality and positive masculinities. Development of *Engaging Boys and Men in Gender Transformation: A Supplement Facilitating the Training in Christian Settings* began in 2009; this tool was completed in 2011. RESPOND staff supported LifeLine/ChildLine in conceptualizing the content and organization of this training resource and in identifying ways to link the tool with EngenderHealth's Group Education Manual.

In 2010, LifeLine/ChildLine piloted this training tool with nearly 50 religious leaders, representing a wide array of Christian denominations. They were trained to better understand how harmful gender norms contribute to negative health outcomes, such as the risk of HIV infection, and to build skills in addressing the issue of gender equality in their work with their congregations. After the training, these religious leaders were tasked with conducting five discussion sessions with up to 15 participants drawn from their congregations and communities, using activities from the training tool as a way to extend the impact of the tool. For example, one of the leaders worked with a young men's group in his congregation to incorporate discussions on gender equality and positive masculinities, with a particular focus on GBV. One religious leader explained that this training tool helped the young men to better understand and take responsibility for their own behavior and the impact of their behavior on others.

¹¹ For more about LifeLine/ChildLine, see the case study on page 7.

Program Implementation: Improving Service Delivery

Tools Overview

RESPOND drew on EngenderHealth's long experience and recognized expertise in improving SRH service delivery as a significant focus for its gender-related work. Findings from RESPOND's formative research, as well as specific requests from USAID country missions, led RESPOND to focus its work in strengthening health service delivery on:

- Helping the health sector respond to survivors of sexual violence and other forms of GBV (Burundi and Guinea)
- Making HIV testing and HIV prevention services more male-friendly (Côte d'Ivoire)

RESPOND developed the following resource materials focused on improving health service delivery by addressing gender-related issues and concerns:

- A five-day training curriculum for health care providers to work with survivors of sexual violence in Guinea, including training modules, a facilitator's guide, and a participants' guide
- A protocol for integrating screening for IPV into FP services in Guinea. This was accompanied by a five-day training curriculum for FP providers in using the protocol, and the associated data management tools (RESPOND Project, 2014b)
- A MAP training curriculum for use with health providers to develop male-friendly HIV prevention and testing services in Côte d'Ivoire, accompanied by the provision of MAP information, education, and communication (IEC) materials
- A couples counseling manual on HIV testing and prevention for use by health providers in Côte d'Ivoire
- The piloting of mobile voluntary counseling and testing services in South Africa, to engage more men in HIV testing

RESPOND also worked with government and civil society partners to contribute to the development of a revised national curriculum for training health service providers to work with survivors of sexual violence and other forms of GBV in Burundi. (A ToT was used to train health care providers in two prioritized provinces.) A consultant in Burundi commented:

“What we cannot yet evaluate is how these workshops and trainings will have a larger impact. It is too soon to tell. However in the immediate run, we see that with the health providers, there have been changes in how they address the needs of victims, such as skipping the waiting lines in the clinic and really helping them out with the next procedures, like medical and legal.”

Key Issues and Lessons

Importance of addressing provider attitudes

Posttest workshop surveys and stakeholder interviews for midcourse assessments and endline evaluations across the countries in which RESPOND worked to improve health service delivery all emphasized the need to focus more attention on creating opportunities and processes for health care providers to reflect on the ways in which their personal attitudes affected their professional responsibilities.

Stigmatizing attitudes toward survivors of sexual violence and other forms of GBV emerged as an important topic on which health provider training must focus. In Burundi, the percentage of participants reporting supportive attitudes toward sexual violence survivors increased from 68% to 78%. Some attitudes, however, showed little to no improvement—for example, in relation to the statement “GBV survivors are too traumatized to make good decisions about their medical care.” The endline evaluation recommended that in future, providers should participate in workshops on gender norms and inequalities, allowing for more in-depth work using the MAP methodology to address stigmatizing attitudes toward survivors.

More broadly, issues of sexuality and sexual consent surfaced as critical issues on which to allow sufficient time to reflect in the health provider trainings, where misunderstandings about the concept of sexual consent, especially among male health providers, led to a minimization of some forms of sexual violence (e.g., rape within marriage) and, on occasion, of blaming women for suffering sexual violence.

Posttest workshop surveys and the stakeholder interviews in the midcourse assessment of RESPOND’s male engagement strategy for HIV prevention and testing services in Côte d’Ivoire also highlighted the need to look beyond the provision of IEC materials to address health care providers’ attitudes, so as to make clinics more male-friendly. As the MAP training curriculum for health providers was revised over time to take into account the findings from the midcourse assessment, greater attention was paid to addressing perceptions of the clinic as a “feminine” space, with the action planning component of the training looking at ways to change provider-client interactions to shift this perception.

The midcourse assessment finding that few men were coming for HIV testing through services for the prevention of mother-to-child transmission of HIV (PMTCT) led to a review of the curriculum used for training health care providers in couples counseling for HIV testing. This review concluded that much more attention should be given to working with providers on their attitudes about gender imbalances of power in the context of communication between couples about HIV testing. This led to the development of a new couples counseling curriculum based on the U.S. Center for Disease Control and Prevention’s *Couples HIV Counseling and Testing Intervention and Training Curriculum*,¹² with a greater focus on health care providers’ attitudes toward the concept of joint consent within the couple regarding decisions on HIV testing.

The need to respond to the emotional challenges of this work

Linked to the issue of providers’ attitudes is the question of how health care providers’ training on working with survivors of sexual violence and other forms of GBV can address the emotional challenges of this work. In general, endline assessments concluded that more attention should be given, within both initial training workshops and follow-up technical support, to issues of “secondary trauma” and emotional burnout when dealing with GBV survivors. This issue was raised, for example, in RESPOND’s work with the Association Guinéenne pour le Bien-être Familial (AGBEF) in Guinea on the IPV/FP screening protocol. Because of a personal emergency, one of two nurse-midwives who would have been responsible for IPV screening and counseling was absent for the duration of the pilot (Delamou & Samandari, 2014). As a result, the other nurse-midwife was responsible for all IPV screenings and counseling, in addition to her regular clinic duties. These tasks were burdensome not only because of the added workload, but also because of the emotional stress inherent in IPV screening. Even so, the strong technical support and frequent presence of the RESPOND consultants

¹² For more information, see: www.cdc.gov/globalaids/resources/prevention/chct.html.

helped to increase the providers' confidence and gave them an opportunity to continually improve their skills.

Capacity building as a process, not an event

As mentioned above, the frequency and quality of follow-up TA by RESPOND staff and consultants to AGBEF's staff on the use of the IPV screening protocol in its FP service delivery contributed significantly to health providers' skills in and comfort with the use of the screening protocol in Guinea (Delamou & Samandari, 2014). This lesson, that capacity building must be undertaken as a process and not a one-off workshop event, was addressed to a different extent in RESPOND's work on improving health service delivery. In Burundi, the national trainers who led the health care provider training on the revised national curriculum on the health sector's response to GBV survivors also provided on-site TA in their follow-up visits to health care providers who had participated in the training. Similarly, in Côte d'Ivoire, a key role for RESPOND staff was to conduct follow-up site visits to the clinics involved in developing male-friendly HIV testing, to support the implementation of facility action plans that had been developed at the health provider MAP workshops.

The need for postworkshop follow-up was reaffirmed in many cases in postworkshop feedback from participants. Despite the five-day duration of the training workshops, they were too packed with information to adequately prepare health care providers to deal with GBV survivors or screen FP clients for GBV. There was insufficient time for participants to absorb new information, especially on the concepts of gender norms and the causes and consequences of GBV, which were often new areas for participants. There was also little time for participants to practice new skills in talking with clients about GBV and related issues. The emphasis given in the second phase of RESPOND's work in Guinea on role-playing simulated client visits and practicing provider-client communication skills in the use of the IPV screening tools was particularly welcomed by the AGBEF staff involved.

Health sector responses to GBV in relation to a multisectoral response

A common lesson across all of the countries in which RESPOND worked to improve the health sector's response to GBV was that such work would only be fully effective if it was part of a multisectoral initiative to prevent and respond to GBV. This lesson was reflected in the creation of multisectoral steering committees to guide RESPOND's interventions in Burundi and Guinea. These committees helped guide some of the facility responses and community prevention interventions, but they did not specifically allow for capacity building across all prevention and response sectors. The Burundi endline evaluation concluded that more support should be provided for GBV survivors in terms of temporary shelter, as well as legal, financial, and psychosocial aid, and that referral mechanisms between health care facilities and services providing legal, financial, and psychosocial support needed to be strengthened.

In Guinea, a field-supported RESPOND activity addressed the medical, psychosocial, social, and economic reintegration needs of the survivors of the sexual violence on September 28, 2009. But the endline evaluation noted that the project did not address the provision of legal aid, protection services, and safe houses (Delamou & Samandari, 2014). Although a strength of the curriculum for health care providers was that it included a module on referrals for nonmedical services, it did not train providers to lead survivors through safety planning. The evaluation concluded that the health sector response to sexual violence would be strengthened if safety planning were added to the curriculum and protocols for providers.

Following that initial project, RESPOND received core funding to develop an IPV screening tool for FP providers at a Conakry clinic of AGBEF, the International Planned Parenthood Federation (IPPF) affiliate in Guinea. That curriculum and the subsequent training directly addressed the issue of safety planning. However, only one client out of a total of 137 clients who completed safety planning followed through on a referral for other nonmedical services. The case study on page 30 describes the reasons why this might be so. Nevertheless, it is clear that more support is needed to improve services outside of the health sector as well as within it. Nonmedical services for GBV survivors are extremely limited in Guinea, as elsewhere. A clear lesson emerging across RESPOND's work is that a holistic approach that seeks to ensure minimum standards for, and a coordinated approach among, law enforcement, legal aid, safe houses/shelters, and psychosocial counseling is crucial.

Linking GBV prevention and response

More fundamentally, RESPOND's experience with interventions to improve the health sector response to GBV highlights the need to link this response to community-wide GBV prevention efforts. In the case of Guinea, it was noted that the project could have been improved by linking its provider training more closely with the GBV Prevention Committees in Conakry that the project had created and supported under the previous project. More discussion of this work is addressed below.

Case Study: Building Health Sector Capacity to Support GBV Survivors in Burundi

As previously reviewed, findings from a provincial-level baseline assessment conducted by RESPOND in two provinces in Burundi (Kayanza and Muyinga) identified a need to strengthen the health sector's capacity to respond to the health care needs of survivors of GBV. With the support of PEPFAR, and in partnership with the Ministry for the Struggle against HIV/AIDS, RESPOND trained health care providers in a revised national curriculum.

As a first step, RESPOND supported the MSPLS to work with Burundian government agencies and civil society to revise and update the national training curriculum for the management of GBV in health service settings. Following the revision and approval of this curriculum by the MSPLS, with the assistance of a master trainer from the IRC, RESPOND trained 34 national trainers from MSPLS units, as well as local NGOs working in the field of GBV (RESPOND Project. 2014a). With TA from RESPOND, these national trainers trained health care providers in GBV care using the newly revised curriculum. Health care providers, both doctors and nurses, were drawn from the facilities where the baseline had been conducted, as well as other facilities in the four townships of Muyinga and Kayanza provinces, where RESPOND activities were focused. The curriculum focused on:

- Understanding sexual violence and other forms of GBV as a social and public health problem
- Holistic management of GBV cases (medical, psychosocial, legal), based on the national protocol for GBV case management
- Types of referrals for other services
- Essential supplies and commodities for GBV treatment

A total of 322 providers were trained during the project, of whom 165 (51%) were male and 157 (49%) were female. In addition, 18 supervisors were trained. In the second year, RESPOND began to work with the MSPLS and FHI 360 to ensure that postexposure prophylaxis (PEP) kits were more widely available at health care facilities and more accessible to GBV survivors.

In the months following the training, teams of national trainers conducted follow-up TA visits to the health care providers who had participated in the training. During these visits, challenges and successes in providing care to GBV survivors and implementing action plans were discussed. The TA focused on helping health care providers to problem-solve and on refreshing staff's knowledge and skills, as needed.

RESPOND also sought to strengthen referral networks to increase survivors' use of available services by using coordination meetings to build linkages across sectors. At the township and provincial levels, RESPOND helped organize meetings for organizations offering services on sexual violence and other forms of GBV across different sectors, including Centers for Family and Community Development, health promotion workers, police, prosecutors, women's groups, youth groups, local leaders, and those who provide psychosocial and legal aid. These meetings provided partners with an opportunity to exchange information about the services they offer, establish referral mechanisms, identify challenges, raise concerns, and find solutions to common recurring issues that they faced. RESPOND met with the MSPLS and PEPFAR partners over the course of the project to advocate for key changes to policies and procedures to foster an environment that supports services for survivors at the national, provincial, and township levels.

Endline interviews with facility managers showed an increase in their confidence in providers' ability to adequately manage cases of GBV, from four of 19 (21%) of the facility managers in baseline interviews to all 16 facility providers (100%) interviewed at endline. However, facility managers did report that there was still room for improvement in providers' GBV case management skills. The pretest and posttest scores of the 322 RESPOND-trained providers correspond with the managers' assessments, reflecting an increase in knowledge of the correct management and care for GBV survivors.

A comparison of the baseline and endline assessments of provider skills showed a general increase in the percentage of providers reporting, without prompting, the various steps that they would take when responding to a GBV case. However, some areas showed little or no improvement—for example, discussing security and establishing a medical certificate. Few providers in the endline mentioned that they would inform the client of his/her right to press charges against the perpetrator, test for pregnancy or STIs other than HIV, or administer vaccines. Given this, findings from the endline suggest that any further revision to the national training curriculum should pay more attention to strengthening participants' understanding of the full spectrum of treatment steps when dealing with survivors of sexual violence and other forms of GBV.

Also, there was a positive shift in attitudes toward GBV and survivors. As mentioned earlier in this report, the percentage of participants reporting supportive attitudes toward sexual violence survivors increased from 68% to 78%. Some attitudes, however, showed little to no improvement, for example, in relation to the statement: "GBV survivors are too traumatized to make good decisions about their medical care." Once again, this suggests a need for the health provider curriculum to focus more intensively on supporting attitudinal change among participants.

In addition to increased provider knowledge of GBV case management and improved equitable attitudes toward GBV survivors, there was also an increase in the number of facilities with essential medical products, equipment, instruments, and commodities from the baseline to the endline facility audit.

Lessons Learned

While the revised national curriculum proved effective in improving health care providers' knowledge in GBV case management, debriefs between RESPOND staff and project stakeholders highlighted the need to pay more attention to providers' attitudinal change. It was recommended that in future health care providers should participate in workshops on gender norms and inequalities, allowing for more in-depth work using the MAP methodology to address these issues.

It was also recommended that health care providers' skills in, and commitment to, GBV case management would be strengthened through increased supervision and follow-up TA. It was likewise clear that facilities needed more staff—both service providers and auxiliary staff—to be trained in GBV case management. They should also be better equipped with supplies and equipment to reduce the need for referrals, and therefore, barriers to services for GBV survivors. At the same time, RESPOND staff and project stakeholders acknowledged that a strengthened health sector response must be integrated into a more comprehensive multisectoral response, in terms of legal, financial, and psychosocial support services, as well as the provision of temporary shelter to meet immediate safety needs.

Case Study: Meeting the Care and Support Needs of Sexual Violence Survivors in Guinea

Guineans and international observers alike were shocked by the political violence, including brutal rapes, perpetrated on September 28, 2009, following a political demonstration in a stadium in Conakry. An International Commission of Inquiry established by the United Nations estimated that at least 109 women and girls were raped that day (UN, 2009). With support from the United Nations Population Fund (UNFPA) and the World Health Organization (WHO), local NGOs quickly identified as many survivors as they could and provided temporary support, through distribution of rice and cash and referral to health and psychosocial services. Approximately 50 women and girls were assisted in this way. It is believed that many more never received help because the profound stigma associated with rape prevented them from identifying themselves as survivors.

USAID/Guinea provided field support funding to RESPOND to support follow-up services to women who had survived the September 28 violence, strengthen local capacity for GBV prevention, and improve the health sector's response to sexual violence (Jackson, Camara, & Camara, 2012). With a no-cost extension, activities spanned 18 months, from January 2011 to June 2012.

Project Overview

At the outset of the project, RESPOND formed a multisectoral steering committee of stakeholders from key ministries and NGOs to oversee activities. This included the Ministry of Social Affairs and the Promotion of Women and Children, and the Ministry of Health and Public Hygiene, as well as two local NGO partners: the Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes (CONAG-DCF) and the Association Guinéenne des Assistantes Sociales (AGUIAS). RESPOND's efforts built on the work of UNFPA and other partners in Guinea (Jackson, 2012). Taking into consideration its short time frame and limited funds, the project focused on three areas of intervention:

- Immediate care for survivors of the September 28 sexual violence, including: assessing survivors' needs; referring survivors for medical services, psychosocial care, and social and economic reintegration services; and covering the costs of referral services
- Training health providers in the care of sexual violence survivors
- Provision of training and TA to community-level committees to lead GBV prevention efforts

Meeting the Immediate Needs of Survivors

RESPOND developed project-specific standards of practice (SOPs) for working with sexual violence survivors. The SOPs described internationally recognized guiding principles for working with survivors of sexual violence and other forms of GBV (IASC, 2005) and specified how RESPOND would obtain informed consent for referrals and maintain survivors' confidentiality. The SOPs were accompanied by a code of conduct that was signed by all RESPOND staff and partners before they interacted with GBV survivors under the auspices of the project.

Findings from the project endline evaluation indicated that project staff, partners, and referral providers followed the SOPs throughout the project (Delamou & Samandari, 2014). All 20 survivors interviewed reported that project staff and referral providers treated them with respect. Five specifically expressed their appreciation for the project's use of confidential identification codes. One survivor said: "Since I was contacted for this project, the staff and the providers of the project treated us well. They always supported and encouraged us to move forward, by listening to us and comforting us." All of the survivors interviewed said they had a positive experience with the project and would recommend it to a friend.

The CONAG-DCF Medical Officer conducted intake interviews with a total of 179 survivors of the September 28 sexual violence to assess their needs and make referrals for services that the project would cover. Using the local languages of survivors, she explained all steps of the project and advised them that CONAG-DCF social workers would accompany them on referral visits. Social workers helped survivors navigate the hospital system, to ensure that their visits went smoothly. With TA from IRC, RESPOND trained the CONAG-DCF Medical Officer to use the state-of-the-art GBV Information Management System (GBVIMS) to record data about the September 28 survivors served. The system included a database, informed consent forms, and referral forms that were designed to protect survivors' informed and voluntary decision making and improve data quality. The GBVIMS was developed by the IRC, in collaboration with UNFPA, the United Nations High Commissioner on Refugees, and the United Nations Children's Fund. (See <http://www.gbvims.org/> for more information about this system.)

All of the 179 survivors assessed were women or girls. They ranged in age from 6 to 64 years at the time of the incident in 2009. The median age of survivors at the time of the incident was 37 years. Of the 179 survivors, 60% experienced rape, while 38% experienced physical aggression, and 2% experienced sexual aggression other than rape. All of the forms of violence they experienced were severe, including bullet wounds and beatings that led to fractures. All of the survivors experienced violence at the hands of men who they did not know, and all but one of the aggressors were members of official armed groups.

RESPOND anticipated providing medical care for 20 survivors and succeeded in providing it for 87. Upon identifying the need for medical tests and treatment through intake interviews, the Medical Officer offered to refer survivors to a male provider at one hospital or a female provider at another. All 87 survivors chose to see the female provider.

- All 87 survivors referred for medical care received a gynecological examination and voluntary counseling and testing for HIV.
- Eighty-one survivors received blood tests for other STIs, including hepatitis B.
- Eighty-one received treatment for STIs.
- Thirty-four received tests for cervical cancer.
- One was identified as HIV-positive and began treatment, provided for free by the government.

In interviews, survivors expressed great appreciation for the free medical treatment they received. For example, one survivor reported: “At the beginning of the project, I was afraid to talk to the people at CONAG. But since I needed treatment, I told myself that maybe they could help me get it, because I didn’t have enough money. To this day, I don’t regret trusting the project, because they helped me a lot in my treatment.”

In its support of the September 28 survivors, RESPOND worked exclusively with providers and local organizations that had previous training and experience in the GBV response. The exception was trainers at the vocational and business skills centers, who were not informed that their clients were GBV survivors (to protect the survivors’ privacy and confidentiality). The CONAG-DCF Medical Officer, the referral physician, the referral psychiatrist, and AGUIAS and CONAG-DCF social workers all worked directly with GBV survivors immediately after the events of September 28.

Psychosocial care included therapy with a female psychiatrist who has training and experience working with GBV survivors. Of the 50 survivors who saw the psychiatrist as a result of a referral by RESPOND, all received a diagnosis and therapy. Of the 50, 49 received antidepressants or pain medication. The short time frame of the project posed a challenge to providing adequate psychosocial care, which often requires longer-term treatment. Several survivors expressed deep gratitude for the psychosocial care they received. A mother who received therapy and antidepressants from the psychiatrist said: “I wish to thank the project and tell the providers of the project that they changed our lives after that violence, because I even wanted to commit suicide after what happened to me, but it’s they who gave me the courage to continue to live.”

Through AGUIAS, 153 survivors requested and received home visits by trained social workers for mediation with family members. AGUIAS reported that almost all home visits succeeded in reconciling survivors with family members, although sometimes only after repeated sessions. Social workers provided support to survivors before, during, and after mediation meetings.

As a result of stigma, shame, and medical and psychological trauma, many survivors lost their jobs or livelihoods after September 28, and at least one dropped out of university. RESPOND sought to help these survivors build skills to provide for themselves and their families. RESPOND aimed to provide economic reintegration services to 25 survivors, but found that the demand for these services was much higher than anticipated. Services were given to 60 survivors on a first-come, first-served basis. More than 100 survivors who requested these services did not have the opportunity to receive them because of funding constraints.

Interviews with survivors showed that many lacked the capital to put their new skills to use. One survivor explained: “We received theoretical and practical training, but not the means to make use of it.” Survivors, RESPOND staff, steering committee members, and partners recommended that the project serve as a guarantor to allow these survivors access to microcredit.

Training of Health Care Providers in the Care of Sexual Violence Survivors

RESPOND conducted a baseline assessment of health facilities’ readiness to respond to the needs of sexual violence survivors. Findings from this assessment were used to inform the development of a training curriculum for providers, as well as serving as a baseline for evaluation purposes.

RESPOND staff in New York and Guinea, working with an international consultant and with local sexual violence experts and a representative from the Ministry of Health, developed a curriculum on sexual violence for health care providers. The curriculum for a five-day training workshop aimed to strengthen providers' knowledge, attitudes, and skills on the provision of quality services to sexual violence survivors. The team reviewed existing training materials on GBV, including sexual violence, including materials developed by the Family Violence Prevention Fund, the IRC, IPPF, UNFPA, USAID, and WHO. Based on this review, the team produced training modules, a facilitator's guide, and a participants' guide for a five-day curriculum addressing the following topics:

- Discussion of the causes, forms, and consequences of GBV
- An overview of national laws and guidelines with respect to GBV
- A survivor-based approach to sexual violence care
- How to ensure informed and voluntary decision making
- Key steps for the treatment and follow-up care of sexual violence survivors
- How to care for child survivors of sexual violence
- The role of first-line service staff (e.g., receptionists) with respect to survivors
- Inventory management
- Improvement of the physical layout of medical facilities to better serve survivors
- Organization of the referral pathways for survivors
- Preparation of medical certificates for survivors
- Development of an action plan for each health care facility

RESPOND conducted two five-day trainings for health care providers. The first training took place in Conakry for 27 providers based in the capital. The second training took place in Labé and brought together 26 providers who work in Labé and Kissidougou. The providers came from 21 facilities: eight in Conakry, seven in Labé, and six in Kissidougou.

Four months after the training, RESPOND conducted supervision visits and endline interviews with trainees and with their facility managers. A team of RESPOND staff and consultants interviewed 20 of the 21 facility managers. In all, 34 providers out of 53 who had participated in the training were interviewed.

The number of facilities that reported having a program to respond to sexual violence increased from seven to 20. At baseline, fewer than half of the 21 facilities reported having at least one provider specifically trained to respond to sexual violence. At endline, all of them reported this. There were significant improvements in the use of guidelines for caring for sexual violence survivors and in the use identification codes to protect the confidentiality of survivors. Before the training, none of the 21 facility managers said they used identification codes for SV survivors. After the training, 18 of 20 facility managers interviewed said they now use identification codes, and all 18 were able to describe the coding system.

The training also improved providers' knowledge of the steps of care for survivors. The largest gain was in the percentage of providers who said they would comfort the client, which rose from 26% to 91%. The second largest increase was in the percentage who would offer PEP. Very large gains were also seen in the percentages who would treat STIs, administer vaccines, offer emergency contraception, and refer

the client for other services. Gains were the smallest for the steps of informing the client of her legal right to press charges against the perpetrator and for asking whether children in the family are at risk of violence (in cases of domestic violence). These results suggest the need to pay greater attention to these issues in revisions of and follow up to the health care provider training.

Referral practices also improved as a result of the training, with facility managers at endline being much more likely to precisely identify specific organizations to which survivors had been referred. One issue identified by the endline interviews as warranting greater attention for subsequent health care provider training related to providers' understanding of the forms, causes, and consequences of GBV. While the percentage of health facility managers who defined GBV accurately increased somewhat, the gains were not as large as expected. This suggests that the training could have done more to deepen providers' understanding of GBV.

Lessons Learned

The majority of September 28 survivors who were referred for each type of service pursued those referrals and received services. This high rate of acceptance of referrals was likely because the project covered the costs of services and offered to have a social worker accompany the survivor as she navigated to the referral site and met with providers. On the other hand, after receiving training in business and vocational skills, many survivors were unable to make use of their new skills due to a lack of start-up capital. Survivors' inability to fully benefit from the economic reintegration intervention reaffirms the need to address specific barriers to pursuing referrals and reintegration, including financial obstacles.

The project ended before some survivors were able to complete care, especially for psychological trauma. As a result, some survivors had to discontinue their use of antidepressants and other prescribed medications. A longer-term project would be better able to meet the needs of survivors for longer-term psychological care and support.

Time constraints limited the number of topics that could be covered by the curriculum for health care providers. At the same time, endline interviews suggested a need to expand the content of health care providers' training, including giving more attention to an in-depth discussion of gender norms and GBV, skills in providing emotional and psychosocial support to survivors, and action planning to address specific barriers to accessing high-quality care.

During their training, health care providers mapped available services in their catchment areas and increased their knowledge of where to refer survivors. Future trainings should give providers information on nearby referral services. Ideally, health facilities should develop relationships with organizations before referring survivors to them.

Facilities in the intervention areas adopted the RESPOND curriculum on care for sexual violence survivors as a protocol because they lacked access to the official Ministry of Health protocol. The endline evaluation recommended that the Ministry update this protocol, produce copies, disseminate it to all facilities, and train facility staff in its use to ensure that it is institutionalized.

Case Study: Integrating Screening for IPV into FP Services in Guinea

RESPOND received core funding from USAID/Washington in 2013 to pilot the integration of screening and counseling for IPV into FP services to improve RH services. RESPOND pilot tested a

curriculum and supportive supervision model that trained providers to screen and respond to IPV with FP clients (RESPOND Project, 2014b).

The project was implemented at an FP clinic in Conakry, capital and largest city in Guinea. The clinic is run by AGBEF, the Guinean Association for Family Welfare, an IPPF member association. Project activities included:

- Conducting formative research (consisting of facility audits and provider interviews at seven AGBEF clinics) to guide the approach and development of the training curriculum
- Preparing a curriculum that integrated IPV screening and counseling into FP services
- Field-testing the curriculum by training providers from the AGBEF FP clinic in Conakry
- Providing the clinic with follow-up facilitative supervision and TA to help it integrate IPV screening and counseling into existing FP services
- Evaluating the results of the training, facilitative supervision, and TA
- Revising the curriculum based on the pilot experience
- Disseminating the revised curriculum along with evaluation findings, lessons learned, and a write-up of the process

Development of the IPV/FP Integration Protocol and Training Curriculum

The development of a curriculum for training FP providers to integrate IPV screening and counseling into FP services was grounded in findings from formative research conducted at AGBEF's clinics across the country in May 2012. Undertaken through a series of FGDs with clients and interviews with service providers and managers, the research found that both clients and providers were in favor of integrating IPV screening into AGBEF's services. Concern was expressed by some AGBEF staff that asking screening questions about IPV in the course of FP service provision might alienate some clients. On the other hand, respondents felt that women had a high unmet need for IPV-related services, and that the FP setting would provide an easily accessible and confidential setting in which to try to meet such needs. The study identified several clinics as potential pilot sites. However, it was decided to test the intervention in AGBEF's only urban clinic for adults in Conakry, because referral services for IPV survivors were more available than in rural areas.

A multisectoral steering committee composed of representatives from ministries of health, social affairs, security, and justice, and from UNFPA and NGOs involved in work on GBV was created to guide and monitor project implementation. The steering committee provided input into initial drafts of the IPV/FP integration protocol, and authorized its piloting following the receipt of approval from the local Institutional Review Board. The steering committee reviewed the progress of the pilot, analyzed the results of the intervention, and contributed to a revised integration protocol on the basis of these results.

After validation of the IPV/FP integration protocol, a RESPOND consultant drafted the training curriculum. The curriculum for a five-day workshop provided participants with a general understanding of gender norms and inequalities, thereby enabling them to make the links between inequitable gender norms and IPV. After presenting the causes and consequences of IPV and the relationship between IPV and FP, the curriculum focused on strengthening participants' skills in delivering five key IPV services to FP clients, namely:

- Screening for IPV
- Education and counseling on IPV issues

- Exploration of FP options and provision of contraceptive methods to IPV survivors, taking into account the possible effect of IPV on method choice and use
- Delivery of other RH services needed by IPV survivors
- Referral of IPV survivors for other medical, psychological, and legal services

Training FP Providers on the Curriculum

RESPOND facilitated a training workshop for AGBEF clinic staff in Conakry in January 2014. Participants included the regional coordinator, two nurse/midwives, the clinic's FP counselor, and one laboratory assistant. Two representatives from Jhpiego-Guinea also attended the workshop. The workshop was facilitated by EngenderHealth's senior program associate for Gender/MAP and was cofacilitated by a local consultant hired by RESPOND (who had experience working with the previous Guinea GBV project under RESPOND).

Comparing results from pretest and posttest surveys, participants demonstrated improvements in several areas: understanding IPV and gender norms, defining a safety plan, and understanding the main elements of effective/active listening. Areas requiring further strengthening included: the impact of IPV on FP and SRH; the purpose of a safety plan; the clinic's responsibility for clients experiencing IPV; the definition of confidentiality; the positive and negative impact of provider attitudes and values on service delivery; and the integration of the five key services for IPV-FP clients into the existing FP counseling model.

The workshop evaluation made clear that participants struggled with the large amount of new information communicated in a relatively short period of time. Participants expressed the need for more time to review the information provided and to practice the newly acquired skills. It was also apparent from the evaluation that the providers would need close technical supervision during the first few weeks of the implementation of new activities.

Based on this evaluation, a two-day follow-up training was provided in March, to look in more depth at IPV/FP integration issues, practice a simpler and shorter safety plan format, and practice core skills. Participants reported that the follow-on session was very useful, as it gave them more time to practice the skills they acquired during the initial workshop.

Facilitative Supervision and TA

It was clear from the beginning that training by itself would never be enough to build provider capacity to conduct screening. The providers would need a substantial amount of facilitative supervision and TA as they transitioned into implementation. Close supervision was not only recommended by project staff but was also welcomed by clinic providers. The goal was to ensure a clear understanding of the IPV screening and counseling process and a smooth flow of service delivery for clients. After the two-day refresher training, four days of additional mock client visits were conducted, and after each simulation, the consultant provided feedback using a provider assessment tool developed by RESPOND on how to avoid mistakes, correct deficiencies, and improve skills. By the end of the additional mock visits, providers had made considerable progress.

TA visits by RESPOND staff and consultants were conducted twice a week for the first three months and then once a week for the following three months. With additional TA, providers were able to become more familiar with the approach at the beginning of implementation and to build their skills

and confidence once actual client visits began. To facilitate documentation, RESPOND developed a TA visit checklist. Local consultants used the checklist for the following purposes:

- Documenting how well AGBEF staff were following the IPV screening and counseling steps they learned during training
- Recording any challenges experienced by AGBEF staff when conducting IPV screening and counseling
- Documenting how well the clinic had institutionalized the IPV integration protocol
- Providing weekly programmatic monitoring data

By the end of the pilot, the two local consultants (either separately or together) had conducted more than 20 TA visits to the AGBEF clinic in Conakry.

Project Results and Evaluation

IPV screening and counseling started at the Conakry AGBEF clinic on March 25, 2014. As of June 2, 181 clients had visited the clinic, and 171 were screened for IPV. The 10 who refused screening reported that they did not have sufficient time for screening. Out of the 171 screened, 157 (91.8%) screened positive for IPV, meaning they had suffered one or more types of IPV (sexual, psychological, and/or physical). Eighty-five percent of clients who screened positive for IPV reported experiencing more than one form of violence. Of the three kinds of violence, psychological violence was the most prevalent (80%), followed by sexual violence (68%); about 48% of women suffered physical violence. A total of 137 clients completed safety planning. The remaining women did not complete safety planning because of time constraints or perceived lack of need. All women who screened positive for IPV received information about referral services, along with a list of contact numbers and addresses. However, the project documented only one case of a woman accepting referral.

Over the course of four weeks in May 2014, every client that received IPV screening and counseling was asked to participate in a brief exit interview at the end of their clinic visit. If the client agreed to participate, informed consent was obtained, and the client was interviewed privately by a data collector in a private room. In total, 59 women (out of 59 approached) agreed to be interviewed, and 53 completed the entire interview. Overall, women reported a very positive experience with IPV screening and counseling, although as with all client exit interviews, there is a possibility of a positive response bias. When asked whether they thought IPV screening and counseling should take place during FP visits, 100% of the participants responded affirmatively, which may indicate the fact that women have few places to discuss IPV and that simply being able to discuss this problem with a supportive and empathetic provider was perceived as a benefit.

As part of the evaluation, RESPOND project staff conducted in-depth interviews with the nurse-midwife who performed the IPV screening and counseling, the FP counselor who was trained and sensitized to the screening, and the independent consultant who cofacilitated the initial five-day training, led the follow-on training, and provided close supervision for the duration of the pilot. The two providers specifically cited the value and importance of both the original and follow-on trainings, supervision, simulated client interviews, and other practical experiences (e.g., filling out registration forms).

Lessons Learned

The integration of IPV screening and counseling into FP services was felt to be a feasible and acceptable approach both for providers and clients. Even though the project demonstrated successes, this type of programming would work best as part of a broader multisectoral IPV initiative, with IPV screening and counseling in FP clinics as only one element of a broader approach that would include IPV prevention and funding/training for the broad range of IPV services (psychosocial care, shelters, legal aid, etc.). During the project, several changes were made to adjust to the different concerns and challenges that providers experienced. The curriculum was revised to simplify it and allow for more skills practice. Moreover, certain areas were given more attention than was initially planned, such as practice filling out forms.

Despite the fact that very high numbers of women participating in the IPV screening disclosed one or more experiences of IPV and received a list of referral agencies available in the community, the project is aware of only one client who followed up on this referral. This lack of uptake of referrals was demoralizing to the provider, who viewed the result as a mark on her performance. We were unable to follow up directly with clients who had undergone the screening because of both time limitations and the need for Institutional Review Board clearance. However, debriefs between project staff and providers identified several possible explanations for why clients were reluctant to use referral services.

The sociocultural context, which is characterized by normalization of IPV and a taboo about discussing such violence, may stigmatize IPV survivors from visiting services that are aimed specifically at them. Furthermore, describing personal experiences of IPV can be difficult or traumatic for survivors; the prospect of repeating these descriptions at a second location may be a barrier to referral uptake. The additional cost in money and time may also be prohibitively burdensome for some clients, particularly women who are responsible for the care of multiple children. If some women were reporting incidents that occurred relatively long ago, they may not have perceived an urgent need to seek additional assistance. At the same time, women who were experiencing recent, acute incidents of IPV (such as rape or a recent beating) might not have sought help from AGBEF but may instead have chosen to go directly to CONAG-DCF, AGUIAS, or even the police. Even though there was only one documented referral visit, 88% of clients who screened positive for IPV completed a safety plan, which provided a basic tool to help them protect their personal safety. Providers and RESPOND project staff agreed that the provision of psychosocial support by a social worker at the clinic would facilitate clients' access to such support.

Program Implementation: Engaging Communities

Tools Overview

The third main area of RESPOND's gender program implementation related to engaging communities in challenging inequitable gender norms and promoting positive norms of masculinity supportive of improved SRH, reduced GBV, and greater gender equality. Reflecting RESPOND's commitment to work across the "social ecology" of factors that link gender inequalities with SRH problems, work at the community level was planned and implemented in relation to work at the levels of individual change and service delivery improvement such that interventions working at different levels were mutually reinforcing.

RESPOND developed a number of specific programming tools to guide and implement the work of engaging communities. Where relevant, these tools drew on the training activities included in the EngenderHealth resource developed under the ACQUIRE Project: *Engaging Men at the Community Level*. This interactive manual offers master trainers approaches for working with community-based health outreach workers and gender activists as a means to mobilize community members to take action related to HIV, AIDS, and gender.

The specific tools developed for this programming area included the following:

- A training curriculum was developed on gender norms, GBV, and community activism skills for youth activists to implement an awareness-raising campaign on GBV prevention in Angola. The youth activists were involved in designing the messaging for the IEC materials used in the campaign, including a newsletter and comic book, as well as campaign stickers, posters, notepads, and t-shirts.
- A two-day curriculum on gender norms and sexual violence was targeted at community-level resource persons in Burundi who could assist survivors in accessing needed services..
- A facility site walk-through methodology was used in Burundi to link trained community-level resource persons with local health facilities, to improve their understanding of and involvement in the health sector's responses to the needs of survivors.
- A training curriculum on gender norms, GBV, and community action planning was developed for GBV Prevention Committees.
- A training curriculum on gender norms and HIV vulnerability was created for community peer educators in Côte d'Ivoire to engage them in promoting men's uptake of HIV testing and prevention.

Key Issues and Lessons

Gender-synchronized approaches with gender-distinct spaces

There is a growing emphasis in male engagement work in the field of SRH on more closely synchronizing and integrating programming efforts to engage men and empower women (Greene & Levack, 2010). Gender-synchronized approaches aim to prevent problems that can arise when male engagement and women's empowerment programming in the same community or locality are conceived and implemented separately. RESPOND's community-level work was in some cases informed by the principles of the gender-synchronized approach. For example, in Angola, the community campaign on GBV was targeted at couples, with messaging focused on promoting

violence-free and more equitable relationships between women and men in the context of their intimate relationships.

Findings from the evaluation of the Angola community campaign, presented below, make clear, however, the value of a continuing effort to create distinct spaces and messages for men to ensure their receptivity to the gender equality goals of the intervention. The Angola evaluation found that, in general, women responded more positively to the campaign message than men and recommended that more emphasis be placed on working directly with men to discuss men's interests in and resistance to changing inequitable gender norms.

From community action planning to community action

The training curriculum for the GBV Prevention Committees in Guinea included participatory community mapping and problem-tree exercises to facilitate participants' identification of the "drivers" of GBV in their community, as well as the specific actions they could take to address these underlying causes. However, in the absence of postworkshop follow-up by RESPOND staff to work with the committee members on implementing these action plans, and problem-solve on issues being encountered in the course of trying to implement such plans, the tendency was for GBV Prevention Committees to revert to using awareness-raising activities with community members. A key lesson across the countries in which RESPOND implemented community engagement programming was that more attention and resources must be devoted to not merely training community members to take action on challenging inequitable gender norms, but also to supporting them with follow-up TA, as well as dedicated budgetary support to ensure that action plans are implemented.

Beyond awareness raising to targeting key determinants of norms

Linked to this is the recognition that awareness-raising activities can only be one component of any program seeking to transform harmful gender norms and inequalities. As social norms theory makes clear (Bicchieri, 2005), harmful gender norms are deeply entrenched sets of social expectations linked to unequal social relations of power. Changing such norms requires not merely new information or awareness, but a commitment by a sufficient number of people to want to transform these expectations based on a vision of more equal relations of power. Key informants, as well as community activists engaged in RESPOND's programming, emphasized the importance of using the right messengers and the right messages to move people to listen and begin to question prevailing social norms. Experience from Angola suggests that it is important to pay attention to issues not only of gender but also of age in selecting community activists. Given the age hierarchies in Angolan society, as in many other countries, the use of young people in their 20s as community activists proved to be a limitation of the campaign, especially when it came to young men's trying to work with older men in the community, as they had little credibility because of their youth.

In reviewing the Angolan campaign, RESPOND staff and the community activists involved also observed that more attention should have been given to targeting highly influential people, such as religious leaders, and influential institutions (e.g., schools), to be able to motivate a greater number of community members to begin to question harmful gender norms.

The mass media were also identified as an important institution with which to work more closely to transform harmful gender norms. In Burundi, RESPOND consultant Joseph Mujiji emphasized the need to work more closely with journalists and seek the assistance of media campaigns:

“Media has to be sensitized so that they can become aware of gender issues and violence as well as help make these issues visible, like with ads. An example here in Burundi, there is an ad for men to buy a new motorcycle and it is suggested that they name them “la belle femme” (the beautiful wife). The media constructs and perpetuates a lot of the ideas about inequality and stereotypes. The media needs to become our allies.”

Organizational capacity building requires TA as well as training

From the beginning, and in recognition of the fact that the program would always be time-limited, RESPOND has sought to institutionalize the use of EngenderHealth’s MAP methodology by working at the national level to strengthen the capacity of key PEPFAR partners to integrate male engagement strategies into their programming. In Côte d’Ivoire, this included training and coaching support for training staff in the Ministry of Health, the National Program for People Living with HIV (PNPEC), and other ministries as well as international and local NGOs. During its 2013 program year, RESPOND trained 18 staff from PEPFAR partner organizations in Côte d’Ivoire, including Ministry partners, as MAP trainers to ensure institutionalization and sustainability of MAP efforts following the end of the project. More recently, RESPOND has sought to expand its reach by training 40 regional HIV trainers on revised MAP modules (including GBV-focused activities and couples counseling) to support the PNPEC, the Programme National de la Santé de la Reproduction (PNSR), and PEPFAR implementing partners to train health care providers and community health workers in male engagement, HIV prevention and testing, and GBV sensitivity.

Similarly, the Male Engagement Initiative implemented by RESPOND’s partner LifeLine/ChildLine in Namibia has led MAP trainings for PEPFAR partners to strengthen their capacity to integrate male engagement strategies into their HIV and AIDS work. An endline assessment of this work concluded that such training activities were successful in introducing key gender concepts into the discussion of how to address HIV and AIDS. But the endline also noted that LifeLine/ChildLine’s TA was slower to yield results. Training focuses on individuals, while TA influences organizations. The former played to LifeLine/ChildLine’s initial organizational strength. However, over the life of the project, LifeLine/ChildLine staff learned how to be more flexible and adjust to changing circumstances. Projects that ask organizations to use new skills need time to yield results.

From RESPOND’s experience in both Namibia and Côte d’Ivoire, it is clear that training in and of itself is not sufficient to expand the number of partners that incorporate gender into their work. The organizational level of the participants makes a difference. When partners’ chief executive officers or senior management recognized the importance and potential efficacy of gender work and participated in the training, the level of commitment to follow-up was generally stronger. It might also be useful to train teams of staff from any one organization who can support implementation of gender work at several levels.

From organizational capacity building to policy influence

The experience from Namibia also suggests that an emphasis on organizational capacity building also creates opportunities for influencing policy. As a result of its Male Engagement Initiative, LifeLine/ChildLine became a recognized authority on male engagement issues in Namibia. Increasingly LifeLine/ChildLine staff have been asked to facilitate government meetings that focus on gender and to review documents to ensure that gender concepts have been included. The team was active in various working groups that operate under the aegis of the Technical Advisory Committee on HIV Prevention.

LifeLine/ChildLine staff participated in the Alcohol Technical Working Group, the Multiple Concurrent Partnership Technical Working Group, and the national Inter-Personal Communication Technical Working Group. These groups focus on the main drivers of the epidemic and are given national-level responsibility to develop strategies and communication programs. As a testament to its success, LifeLine/ChildLine was asked by USAID/Namibia to continue male engagement activities as a direct partner with the Mission for the Country Operating Plan in fiscal year 2011.

Case Study: Ending GBV Is Everyone's Business in Angola

Gender inequality helps to drive the HIV epidemic in Angola and is at the root of SRH problems facing women. According to a national survey, approximately one-third of married women aged 15–49 in Angola have experienced physical violence (COSEP Consultoria 2012). In 2011, the government enacted a law criminalizing domestic violence, but awareness and enforcement of the law remain low.

During May to July 2012, in an effort to understand GBV prevention and response, and to identify potential future partners, RESPOND met several times with representatives of UCF, a Young Women's Christian Association (YWCA) member association located in Cazenga, a submunicipality of Luanda. UCF was beginning to develop a project to respond to GBV, presenting a significant opportunity for RESPOND to work with local organizations and build their capacity in GBV prevention activities that could potentially inspire other such programs in Angola.

With field support funding from USAID/Angola, RESPOND developed and implemented a GBV awareness campaign in Cazenga (Sloan et al., 2014). The campaign was created in partnership with two local NGOs: UCF and the Forum for AIDS Support and Solidarity (FOJASSIDA). The campaign, "Together We Can End Domestic Violence," adapted EngenderHealth's MAP approach, along with other gender-transformative approaches to develop a gender-synchronized approach that encourages men and women to jointly and individually question norms that encourage GBV.

Campaign Design

Running from March 30 to August 3, 2013, the campaign had the following specific objectives:

- Challenge norms and expectations that support the perpetration of GBV (especially those that blame the victim) and that keep women from seeking help or leaving abusive relationships
- Promote healthy (nonviolent) relationships, which can reduce vulnerability to GBV and to HIV
- Promote equitable norms that can reduce vulnerability to GBV and HIV
- Increase awareness of the costs (legal, relationship-related, and family-related) of GBV

A GBV Working Group consisting of representatives from local civil society was established in Cazenga to help inform the design and evaluation of the campaign and coordinate its implementation. Members of the working group included UCF (the YWCA), the Conference of Christian Churches of Angola, Norwegian Church Aid, the Baptist Church Hospital of Cazenga, and FOJASSIDA. Working group members participated in two separate full-day workshops on gender, GBV, and GBV prevention strategies, and they met several times afterwards to review program strategies.

Formative research was used to guide the design of campaign messaging and materials, and to set a baseline against which the campaign could be evaluated. In January 2013, RESPOND worked with COSEP, a local research agency, and an evaluation consultant to finalize a questionnaire and a research protocol. From January to March 2013, baseline data were collected in a random survey of 704

households in Cazenga. Endline data were collected after the completion of the campaign in July 2013. (See below and Monitoring and Evaluation [page 56] for the Angola evaluation.)

The baseline survey revealed that gender-inequitable views were pervasive among both men and women. More women than men agreed that violence was justified, such as “when a woman burns the food” or “when a woman refuses to have sex with her husband.” Nearly two-thirds (61%) of women agreed that violence was justified in at least one of the eight situations respondents were asked to consider, compared to one-third (34%) of men.

Training campaign activists

RESPOND worked with activists from UCF to prepare them for their roles in implementing campaign activities. The training for these campaign activists drew on activities from EngenderHealth’s *Engaging Boys and Men in Gender Transformation: The Group Education Manual* and other materials from the White Ribbon Alliance/Brazil. The training engaged participants in reflecting on gender norms, understanding their relationship to and experiences of GBV, and dispelling misconceptions about such violence.

A RESPOND international consultant and a local consultant cofacilitated the training. As the international consultant emphasizes, its participatory methodology was key:

“I’m not even from Angola and she isn’t from Cazenga, so we didn’t know people’s realities and what the community would think about these issues. We wanted to get the youth involved, so that we could work each step with them and get their feedback. So everything we did with the campaign was done with them—for example, the scripts for the newspaper, the comic books, or the posters and pamphlets, everything was done with them. They would tell us if a message we were working on made sense in Cazenga or no sense at all. So the training’s purpose was to make sure they would feel comfortable with us and have enough time to really give us information about how their neighborhood works. It was never like a university lecture, it was very collaborative, for some activities we got them to move around and put together theater plays, in order to get involve with the issues without having to put them into a position where they would have to talk about personal experiences of violence.”

Being community members themselves, the GBV activists revealed in the training both the challenge that the campaign confronted in terms of the gender-inequitable attitudes of both women and men as well as the potential to change these attitudes. For example, before the training, 72% of the activists agreed that “a woman who wears miniskirts can be held responsible for the violence she experiences.” While disappointing, this response was not surprising, given that many key informants, including some staff from government and civil society organizations, had made similar statements. After the workshop, the number of activists who agreed with the statement decreased to 22%. This was an important concept to address, and most of the participants showed significant changes in their views on statements related to sexual violence. One of the young male activists says:

“As a result of the workshop, I know more now about gender equality and domestic violence than before. I grew up with domestic violence with my father, and now I’m able to talk to him about these things and show him that they can’t turn to violence with my nephew, children there, it will only teach them to be violent, to act the same way. I learned to listen to the other side, to discuss instead of fighting. I also learned that men and women are equal, are capable of the same things.”

Campaign implementation

Based on the formative research, a three-stage campaign was developed, with each stage lasting about five weeks, focusing on a specific theme, and building on prior themes. The campaign combined distribution of print materials, radio spots on community radio, theater performances, and dissemination of a community magazine, along with smaller events to be developed and implemented by teams of GBV activists and local community-based organization partners on a weekly basis. The communication materials, campaign activities, and events reflected the theme for each stage of the campaign, under one overarching campaign title and logo, which focused on healthy relationships and speaking out against violence. The campaign was implemented in the following stages:

- Stage 1 (March 30–May 20) *Theme*: Question inequitable norms and promote healthy nonviolent relationships (including the ability to identify unhealthy and controlling relationships, knowledge of what is violence, ability to identify violence, etc.).
- Stage 2 (May 21–July 10) *Theme*: Challenge justifications for GBV and promote zero tolerance of GBV, including awareness of the law on GBV and knowledge of the costs of GBV, and reduce the justification of violence in any situation.
- Stage 3 (July 11–August 10) *Theme*: Speak out against GBV, including being willing to speak to friends/peers/family about violence, to question violent acts or harassment when they see it, to challenge a peer’s inequitable statements, and to provide support to survivors.

The campaign was launched in March 2013 with a large public event attended by an estimated 800 community members. Nearly 3,000 campaign materials were distributed during the launch. Eight issues of the newsletter *Cazenguinha*, or “Little Cazenga”, were produced and distributed over the course of the campaign, documenting campaign activities, highlighting positive role models in the community, and featuring interviews with community members, editorials, games, and vignettes that presented occasions on which violence might occur and prompted reader reflection about social norms and GBV.

Three editions of the comic book “Mica’s Day-to-Day Life” were also produced and distributed during the campaign. The comic book describes the life of an average Angolan family from Cazenga, demonstrating the disparities between men and women. The female character, Mica, goes through a process of reflecting on her situation and then wanting to change it. In the second and third editions of the comic book, the family goes through more difficulties, as the female character begins to challenge the inequities she faces, including verbal abuse from her partner, which leads to a conflict bordering on physical assault and a separation of the couple. During this separation, the male partner begins to change, in part from living with their more gender-equitable friends. Following her partner’s change, Mica takes him back after having considered going to the police. The comic book ends a year later with the couple living a more equitable relationship and happier life. The newsletter and comic book, as well as campaign stickers, posters, notepads, t-shirts, and hats were distributed in high schools, churches, beauty salons, barber shops, taxi stands, and markets, as well as door-to-door and at community events.

A radio competition ran from July 1 to August 10 on Radio Cazenga. The radio competition lasted 30 minutes and came on every day at 10:30 am, with call-in contestants who would win campaign materials (t-shirts, caps, pens, notebooks, key chains, etc.). The contest questions had to do with the campaign and the issue of domestic violence. For example, some questions were about the domestic violence law and different types of violence, and others were about the campaign itself. Radio spots for the campaign were designed and played on Radio Cazenga as well. On August 3, the campaign organized a “March in Solidarity with the Victims of Domestic Violence.” The march gathered an estimated 1,200 participants, who wore campaign shirts and hats and carried campaign posters. In

addition to the materials passed out during the previous months of the campaign, another 5,000 pamphlets were passed out, as well as 1,000 posters, hundreds of newsletters, and dozens of copies of the comic book.

Campaign evaluation

Most of the Angola campaign materials may be viewed on the RESPOND digital archive under BCC materials: www.respond-project.org/archive/pages/type/type-1-5.html.

The evaluation of the campaign was done using an endline survey, during which 415 men and 307 women (compared with 405 men and 299 women at baseline) were interviewed. Forty-eight percent of endline respondents stated that they were interviewed in the baseline survey. Details of the evaluation methodology are discussed in the next section. The evaluation found that over the course of their exposure to the campaign, at endline community members:

- Were more likely to oppose gender inequity
- Reported an increase in joint decision making about major household purchases and in family visiting
- Were more likely to share domestic chores as couples
- Were more likely to believe that women should have equal rights
- Reported a decrease in controlling behavior by male partners (as reported by women)
- Were less likely (women) to believe in justifications for domestic violence
- Were less likely (especially men) to believe in myths about rape
- Reported an increase in positive attitudes toward Angola's domestic violence law

In some cases, men's views in support of gender inequity and GBV increased after the campaign or showed little change. For instance, men were more likely to believe in the eight justifications for domestic violence after the campaign than before. Such findings, in the light of other positive findings, suggest that the campaign may have increased resistance among men. If resistance did increase, it may have been limited to reported attitudes, because certain behaviors appeared to improve after the campaign (e.g., shared decision making increased, and men were less likely to exhibit controlling behavior).

Lessons and implications

The conclusion reached by the campaign evaluation emphasized that short interventions, such as that implemented by RESPOND and its partners, can significantly and broadly improve attitudes and knowledge about GBV. While the project results indicate that the GBV campaign was broadly successful, longer intervention periods may help to increase success. What the campaign did do very effectively was break the silence and challenge the complicity that continues to surround men's violence against women, especially IPV. In making the violence visible and promoting a vision of more equitable, nonviolent gender relations, the campaign opened up conversations at the community level that had rarely been heard before.

Endline survey results and debriefs with campaign stakeholders also suggest that program planners should create spaces in which men can discuss and reflect on gender norms. The gender-synchronized approach, which focused on the couple as the target of the campaign messaging, had more of an impact on women than on men. In relation to justifications for violence, women responded more positively to the campaign message (a 15-percentage-point decrease in women's justifying violence, vs.

a 16-percentage-point increase in men’s justifying violence). Even given the benefits of a gender-synchronized approach (Greene & Levack, 2010), there is still a need for separate spaces and messages for women and men.

The campaign also made evident the need to take into account age as well as sex differences. It became clear that not only was there a need for the campaign to have more male champions to speak directly to men, but also that a larger age range of campaign activists was needed, because the young male activists often lacked credibility with older men. As a RESPOND TA consultant noted:

“The activists were really young, and we noticed, in comparison to Brazil or the United States, there is a hierarchy between older people and younger people, which is really strict.... Usually, young people aren’t really at ease talking to older people because they are seen as wiser and more experienced. Sometimes the older people really disregard what the younger people are saying. Our campaign was targeting domestic violence, especially among adult couples. The characters in the comic books were in their late 30s, a married couple with three kids. Most of our activists were young and not even married, so maybe it would have been better if we had also worked with older activists.”

The nature of hierarchical power relations within the community also suggests the need for campaigns such as this one to work more closely with key figures within the community, including religious leaders and medical and education professionals, whose status and influence make them important messengers to whom community members will listen. As one of the young female activists involved with the campaign reflected:

“People are conditioned to use violence by society. We need to look at the root causes, not just condemn people. Then people won’t just avoid violence because it’s the law, but also because their attitudes will change. It’s important to educate people from childhood, and talk to people so they understand why violence is bad and that no one wins.... It’s good to distribute materials in the communities but we also need to work a lot in schools and churches, for a long time with the same group, work with them in depth, explaining the reasons, causes, and consequences of domestic violence. Working with a group of children will grow seeds in their communities, they’ll go on to be lawyers and teachers and engineers and influence other people. I think it’s better to work in depth with one group and really change them than it is to work a little bit with a large group. Talking in schools is the most important part.... The way teachers talk to female students, asking them if they have boyfriends, talking to them about getting a husband, etc.—teachers need to be trained too.”

Case Study: GBV Prevention Committees in Action in Guinea

Mobilizing community involvement in responding to the needs of GBV survivors, and in contributing to the prevention of this violence, was a key component of RESPOND’s program to address the aftermath of events of September 28, 2009, when some 109 women and girls were raped following a political demonstration. RESPOND focused on providing immediate care for survivors and training health care providers in the care of survivors of sexual violence and other forms of GBV. This case study was presented on page 30. The third key strategy of this program in Guinea was the provision of training and TA to committees formed to lead GBV prevention efforts at the community level.

The strategy was modeled on the successful “comité villageois” (village committee) approach of EngenderHealth’s Fistula Care project in Guinea. In rural areas where Fistula Care works, village committee members are chosen by local leaders. The committees facilitate community discussions on RH, including fistula. RESPOND modified the committee approach to focus on gender norms and GBV rather than on RH more broadly. In addition, the project relabeled the committees as “comités de quartier” (neighborhood committees), because RESPOND’s GBV prevention work took place in the urban setting of Conakry, rather than in rural villages.

Community GBV prevention training curriculum

RESPOND developed a workshop curriculum to prepare the neighborhood GBV Prevention Committees to undertake their work. The curriculum drew on EngenderHealth’s experience and expertise in gender and MAP training along with organizational experience around community engagement. In this project, technical leads from gender and from community engagement worked together to adapt workshop activities from EngenderHealth’s *Engaging Boys and Men in Gender Transformation: The Group Education Manual* and *Engaging Men at the Community Level*, as well as with community engagement tools developed by EngenderHealth.

The first three days of the five-day training curriculum for GBV Prevention Committees focused on exploring key concepts, attitudes, and values related to gender norms and gender equality, and defining GBV and better understanding its causes and consequences. The remaining two days of the training concentrated on the external community environment and guided participants in prioritizing problems related to GBV in their own communities, mapping existing resources and support in their communities, and developing community action plans for addressing prioritized problems. Other sessions of the training focused on monitoring and evaluating efforts, developing gender-equitable messages for community campaigns, responding to resistance within the community, and defining roles and procedures for working effectively as committees.

Training of trainers in community GBV prevention

RESPOND trained trainers from the NGO CONAG-DCF to build the capacity of 10 GBV Prevention Committees in two neighborhoods of Conakry. A one-week ToT workshop for 10 CONAG-DCF master trainers (five men and five women) was led by EngenderHealth’s MAP technical advisor, together with two EngenderHealth/Guinea staff. The ToT participants had previous experience as trainers in related areas, such as women’s rights and legal aid for GBV survivors, although this workshop was their first training specifically focused on GBV prevention.

The ToT participants, who were later tasked with leading the trainings for GBV Prevention Committee members, responded enthusiastically to this exposure to GBV prevention concepts and programming lessons. As a result of the ToT, the CONAG-DCF participants reported an increased confidence and capacity to discuss topics that were previously taboo, to make compelling arguments to prevent GBV, and to lead the exercises that would be used in the trainings with GBV Prevention Committee members. A male trainer reported: “The training from RESPOND allowed us to distinguish the true difference between gender and sex. We wrote out characteristics of men and women and then underlined all that are biological. We saw that all other characteristics of men were from customs, not birth. We realized that all of those aspects of a man’s role, a woman could do.” He added that the facilitator “didn’t tell us the answers, he got us to generate them.” Many of the ToT participants felt that a longer training would have been even more beneficial. As a male participant explained: “There is more you could add to your training. I would have liked more arguments to respond to men who say that they earn money, so they should set the rules in their house.”

Forming GBV prevention committees

RESPOND worked with local community leaders to select members for 10 GBV Prevention Committees, established in two neighborhoods of Conakry—five in Ratoma Commune and five in Matoto Commune. Each committee represented one neighborhood. The commune mayors selected neighborhoods based on their judgment that those neighborhoods were at higher risk for GBV and/or would be easier to mobilize in terms of community action for GBV prevention.

Mayors of the two communes asked the chefs de quartiers to select 11 members for each committee, for a total of 110 committee members. The selection criteria emphasized that the committee members should be respected role models in their communities who are also good public speakers in the local languages. Each committee included representatives of religious organizations, women’s groups, and youth groups. Committee members were volunteers who received a small amount of money to cover their transportation to events. Involving local leaders in the process increased the acceptability of the committees and encouraged local ownership. All of the 16 local leaders who were interviewed at the end of the project approved of the process for selecting committee members. As one chef de quartier explained: “The process was good because the members of the committee weren’t imposed, but they were chosen by the community itself.” In a debriefing with stakeholders at the end of the project, it was noted that while this emphasis on local selection of GBV Prevention Committee membership had generated strong local ownership of the intervention, more care should be taken next time to ensure that those members who had been selected had a sufficient level of interest in and commitment to the gender equality goal of the intervention.

Training GBV prevention committees

CONAG-DCF’s 10 master trainers worked in pairs (one man and one woman) to train, coach, and supervise GBV Prevention Committee members, with each team of master trainers responsible for providing training and follow-up support to two committees. A total of 110 committee members received training. By the end of the five-day training sessions, each committee had developed a map of resources for GBV survivors in their community and an action plan outlining the GBV prevention activities to be implemented over six months. The launch of the committees’ activities was covered by the media in Guinea, including national public TV, national public radio, a private newspaper (*Lynx*), and a public newspaper (*Horoya*).

Of the 11 committee members interviewed, all gave positive feedback about the quality and value of the training. For all of them, it was their first training on GBV. A male committee member explained, “I hadn’t worked on [GBV] before, but I knew from the Koran that a woman isn’t a slave and she should be respected. I was looking to deepen my understanding of the situation. The trainer really inspired us. We were in good hands. Now we can teach others what we learned.” Several committee members expressed appreciation that the training allowed them to identify passages of the Koran that prohibit GBV.

A project debriefing with two CONAG-DCF master trainers who had been actively involved in ongoing follow-up and monitoring of the committees’ activities noted the powerful impact and importance of having such a mixed group of training participants, who ranged from market women to imams. As both noted, time was the major constraint. They recommended that six or seven days be allocated for the training, which would allow for more sharing among participants, and which would also better accommodate the need for participants to articulate and debate key concepts and values in

Guinea's national languages (e.g., Sousou, Poular, etc.), which is essential if the trainees are to be able to speak effectively and convincingly about GBV in their communities.

GBV prevention committees in action

After the training, each committee met with its respective chef de quartier, as well as with other community leaders, such as the Responsables des Femmes, to sensitize these key stakeholders and opinion leaders. Throughout their ongoing activities, the committees continued to involve such local leaders in their activities. The recordkeeping format used by the committees included the signature and stamp of the chef de quartier, who always participated in the activities, either in person or by appointed representative. Chefs de quartiers played an important role in funding the project, where possible providing financial support for the rental of chairs, tents, and sound systems and for the purchase of water and juice for special guests. When schools and heads of households hosted awareness-raising sessions, they often provided chairs, water, and juice for free. However, not all committees succeeded in leveraging local resources in these ways. Many committee members felt that they were unable to carry out some of the activities in their action plans, such as soccer tournaments with messages about GBV, due to a lack of resources. Each of the 10 committees conducted at least four awareness-raising sessions per month. In the four months between December 2011 and March 2012, they had reached 8,892 participants (3,564 men and 5,328 women). During awareness-raising sessions, committee members engaged community members in participatory discussions of gender roles, women's rights, the causes and consequences of GBV, and the need to end impunity for GBV perpetrators. Often, committee members shared information about where to seek help after a GBV incident. Some committees chose to focus on a different topic during each session, such as forced marriage or the relationship between substance abuse and GBV.

Awareness-raising sessions took place in public places, neighborhoods, and secondary schools. Committees decided which types of events would be the most effective in their communities. Some sessions included theater performances by committee members. Other sessions involved traditional singers and dancers who volunteered to help draw a crowd. Some committees preferred to address large groups in marketplaces, while others gathered smaller groups in courtyards. Each committee had at least one religious leader (a Muslim imam or a Christian pastor) who delivered messages about GBV during weekly sermons. CONAG-DCF trainers conducted regular follow-up with the committees they had trained and attended all of the sessions planned by these committees. When participants asked challenging questions that committee members struggled to address, trainers would step in and respond. At the conclusion of each session, committee members completed monitoring forms and wrote a short narrative report. The trainers collected these documents and submitted them to their supervisor at CONAG-DCF.

Lessons learned

In its short timeframe, the project sought to initiate the first steps of a longer process to prevent GBV. RESPOND did not measure change in social norms and in the incidence of GBV in the focus communities. Instead, information was gathered about how the intervention was perceived by those directly involved with it. A number of key informants—including CONAG-DCF trainers, committee members, local leaders, and community members who attended GBV prevention activities—reported that their own attitudes and behaviors had changed considerably as a result of the project. Although such self-reported changes are difficult to verify and may not be sustained over time, numerous respondents described how the project activities had made them reflect critically on their own attitudes and behaviors and to make changes in their personal relationships.

Interviews and observations suggested that the messages of the GBV Prevention Committees were largely consistent with those that the project intended to spread. However, a discussion with two committee members highlighted the challenges that some committee members may have had in internalizing and communicating equitable gender norms. In describing changes he had observed in his community, one committee member commented that “girls are now ashamed to dress vulgarly before us.” He said that he himself warns schoolgirls to “avoid rape by dressing in a way to cover up.” Another member of the same committee countered this highly inequitable view by adding, “But we tell them: Even if she’s walking naked down the street, you don’t have the right to touch her against her will.” The exchange highlighted the complexity of the challenge of changing attitudes and the fact that more training and follow-up support may be needed to enable the committees to send unequivocal messages about GBV. Changing deeply entrenched attitudes around gender and violence requires a significant investment of time.

At the end of the project, all 16 of the local leaders interviewed perceived the committees as effective. All 16 recommended scaling up the GBV prevention approach. Half of them specified that committees should be created across the country, not just in Conakry.

Full implementation of the action plans developed by committee members during their training with CONAG-DCF trainers was hampered by a lack of ongoing technical support. The debrief with CONAG-DCF trainers and committee members concluded that more emphasis should have been given to equipping the committees with the community mapping and action planning tools used in their workshop, translated into local languages so that these tools could have been incorporated into community conversations on actions to prevent GBV. In the absence of such tools, and more hands-on technical support in both conceiving and implementing actions to challenge the inequitable gender norms fueling GBV, the actions taken by the committees tended to default to awareness-raising activities, rather than more specific interventions focused on the particular community conditions related to GBV in their neighborhoods.

Case Study: Engaging Community Partners in Improving Services for Sexual Violence Survivors in Burundi

In partnership with the MSPLS, RESPOND worked to improve efforts to prevent sexual violence and to respond to the needs of sexual violence survivors in two provinces of Burundi—Kayanza and Muyinga. As described in earlier sections of this report, a national-level needs assessment and baseline provincial-level study highlighted a number of challenges confronting the national response to sexual violence (RESPOND Project, 2012). The identified challenges included: a social acceptance of men’s sexual violence against women as an inevitable feature of gender relations; a lack of systematic training for health providers in dealing with survivors of sexual violence; a lack of confidence among survivors that health, social welfare, and legal systems could meet their needs; and a lack of referrals and coordination among organizations and service providers across different sectors. RESPOND set out to address these challenges with three interlocking strategies, namely:

- Strengthen the public health sector’s response to sexual violence through training and TA
- Challenge the normalization of sexual violence and promote gender-equitable norms to prevent sexual violence through MAP workshops with men who work in mines and tea plantations
- Build the capacity of communities and civil society to address sexual violence

The first two strategies have been discussed in previous sections of this report. The latter objective is presented below.

Community workshops on gender norms and sexual violence

RESPOND worked to achieve the third objective, community capacity building, through a variety of activities, including community workshops on gender norms and sexual violence, coordination meetings for local organizations and community leaders, and grassroots advocacy. In addition, RESPOND adapted EngenderHealth's innovative facility site walk-through methodology, previously used to involve communities in addressing barriers to contraceptive choice and access, to meet the challenge of bringing together health care providers and community leaders to "walk the path" of a survivor through the health system and discuss how to overcome the barriers she faces in seeking and receiving care.

With the ultimate goals of increasing sexual violence survivors' uptake of medical, psychosocial, and legal support services, RESPOND developed and implemented a short two-day training curriculum on gender norms and sexual violence, targeting community-level resource persons who could assist survivors in accessing needed services. Formative research conducted in the four townships in which the project focused (Kabarore and Muruta townships in Kayanza Province, and Butihinda and Giteranyi townships in Muyinga Province) identified a number of potential community resource persons, such as "baremeshakiyago" (peer educators) and "imboneza" (community relays), who were involved in initiatives to raise community awareness about health and social issues, which in theory included sexual violence. As noted earlier in this report, one of the key findings from this formative research, however, was that these volunteers were clearly overburdened and lacked the necessary technical and emotional support to undertake their work. The baremeshakiyago typically fulfilled several different functions, including advocating for children's rights, promoting FP, and addressing sexual violence. Some represented up to five or six NGOs at the same time. The study also concluded that a major limitation of the effectiveness of baremeshakiyago and imboneza in preventing sexual violence was that they were exclusively women.

To address these issues, RESPOND developed its two-day workshop curriculum, focusing particularly on the ways in which men could partner with women in the community, not only to improve survivors' uptake of services, but also to begin to challenge the underlying gender norms that fuel sexual violence and other forms of violence against women. Drawing from EngenderHealth's MAP training curricula (*Engaging Boys and Men in Gender Transformation: The Group Education Manual* and *Engaging Men at the Community Level*), and selecting and adapting training activities to address the specific needs of community resource persons in the context of Burundian society and culture, the two-day workshop focused on participants' understanding of the:

- Links between gender norms, sexual violence, and the stigmatization of survivors
- Causes and consequences of sexual violence in their communities
- Importance of ensuring privacy and confidentiality of sexual violence survivors
- Medical, legal, and psychosocial services needed by sexual violence survivors and the importance of having immediate access to care and being able to name specific sources of such support for survivors in their community

A total of 396 community resource persons in the catchment areas of selected health care facilities participated in these two-day workshops. Of significance, the gender balance was almost even, with 51% (203) of participants being men and 49% (193) women. These community resource persons included 172 community health workers, 89 members of the local administration, 45 members of local associations for the promotion of women, 41 health care providers, 23 religious leaders, 24 members of local NGOs with GBV activities, and two national police officers.

The value and impact of these community workshops are apparent from the experiences of two community members from rural Giteranyi Township who participated in them. A 29-year-old schoolteacher named Rizabeti¹³ volunteers for a local women’s group. Women come to her seeking solutions to their problems, which are often linked to domestic violence. Across the township, Vigitori, age 34, volunteers as a community health worker. He counsels the population on reducing their health risks and links them with the local health facility.

In July 2013, Rizabeti, Vigitori, and 23 other community activists and leaders participated in a community workshop organized by RESPOND to improve the community response to survivors of sexual violence. Rizabeti said that prior to participating in the workshop, she and other women’s leaders “had participated in township meetings, only to hear that there is a case of violence and that we have to help them, but we had no training on how. Now we have confidence that we can help.” Thanks to the meeting with health providers, she said: “Now we know where to go when we bring a survivor to the health center. The survivor doesn’t have to wait in line but can go directly to the provider. The providers even gave their phone numbers and told us to call if a survivor is coming.” Rizabeti noted that she also learned the window periods for PEP against HIV and emergency contraception. Even Vigitori, who is affiliated with the health center as a community health worker, said that until the meeting, he did not know the services that the center offers to sexual violence survivors.

In addition to participating in the workshops, Rizabeti and Vigitori and the other community resource persons also met with health care providers at their local health centers, as part of the facility site walk-throughs described below.

To strengthen ties between the community and services for survivors, RESPOND also organized meetings for agencies and organizations across different sectors that were, or could be, providing services for survivors. This included CDFs, health promotion workers, police, prosecutors, women’s groups, youth groups, local leaders, and those who provide psychosocial and legal aid. These meetings provided partners with an opportunity to exchange information about the services they offer, establish referral mechanisms, identify challenges, raise concerns, and find solutions to common recurring issues. Moreover, RESPOND used the meetings as a forum to share information about increased service availability at health centers as a result of health provider training. A total of 40 township level meetings (665 participants) took place from 2012 to 2014.

Facility site walk-throughs

The second and complementary component of RESPOND’s community engagement strategy was the use of the facility site walk-through methodology, which informs community members about services available at health facilities for survivors of sexual violence and other forms of GBV. It also enabled the community resource persons who were trained in the two-day workshops to give feedback to health care providers on such services. The use of facility site walk-throughs in Burundi grew out of EngenderHealth’s experience, from 2010 onward, in piloting a facility site walk-through methodology in Bangladesh, Ethiopia, Ghana, Tanzania, and Uganda with RH providers to strengthen provider accountability and community participation in health, and to catalyze action to address access barriers at the facility and community levels.

¹³ Due to the sensitive nature of sexual violence, all names have been changed.

Adapted for use in Burundi and focusing on health service provision for survivors, the facility site walk-throughs involved:

- A briefing for community resource persons and health care providers on the goals and process of the facility site walk-through
- A “guided tour” of a health facility for community resource persons focusing on the “journey” of a survivor, from initial contact to treatment at that facility, including information about recent improvements made to ensure client confidentiality, to facilitate survivors’ access to immediate care, and to strengthen referrals to facilities where more advanced care and additional services were available
- Discussion and development of action plans by health care providers and community resource persons to identify and address barriers to survivors’ access to and uptake of services.

The emphasis of the facility site walk-throughs in this instance was on practical actions that could be taken, by both community resource persons and health providers, to increase survivors’ uptake of services.

Following the guided tour, community resource persons and providers analyzed facility- and community-level barriers to care and planned steps to address these. In both provinces, participants discovered that ambulances were not dispatched in cases of sexual violence, because sexual violence was not listed as a medical emergency. As a result, transportation posed a major barrier blocking survivors in rural areas from accessing PEP, emergency contraception, and other time-sensitive services. Facility site walk-through participants succeeded in advocating with senior health system managers at the provincial level to authorize the use of ambulances to bring sexual violence survivors to higher-level health care facilities.

A total of 396 facility staff and community resource persons participated in the facility site walk-throughs, of which 90% (355) were community leaders and 10% (41) were staff. An endline evaluation using information from survey forms completed anonymously by community resource persons at the end of their visit to the health facility highlighted the value of the facility site walk-through methodology. Eighty-seven percent (308) of community participants indicated that they found the activity very useful, with 95% (337) agreeing that the facility site walk-through should be replicated for resource persons in other communities. Eighty-eight percent (314) said that they learned something new about available services at the sites, and 100% (355) said they learned something new about barriers to service use by survivors. One hundred percent (355) of community participants also indicated that they would advise someone else in their community to avail themselves of the services talked about during the facility site walk-through. Of the facility staff who participated, 98% (40) indicated that they found the activity very useful, and 100% (41) agreed that the activity should be replicated in other communities. A consultant observed that:

“We also trained community leaders and thus established a network between them and the health providers. We organized a guided tour of the health clinics with the community leaders. This was truly a novelty, because in the past, community leaders would just bring the victims to the clinics without really knowing what actually happens afterwards. Now, the community leaders accompany the victims throughout all the procedures at the clinic. The health providers now know the community leaders better and when they come to the clinic with victims, they no longer need to wait in line.”

Experience with the facility site walk-through methodology in Burundi confirms what has been learned elsewhere—namely, that it is a promising approach for strengthening community participation in health service delivery, catalyzing action, and fostering teamwork between community and health facility staff to ensure access, availability, acceptability, quality, and informed choice. In turn, this collaborative work has enhanced accountability to communities among service providers, highlighting the need for action to address community concerns and improve client-provider interactions (staffing, logistics, service integration, etc.)

Monitoring and Evaluation

Tools Overview

A range of tools were developed and adapted by RESPOND to monitor and evaluate its gender-focused programming. These included:

- Pretest and posttest surveys to assess the impact of training workshops
- Follow-up technical support visits to monitor the implementation of learning from training workshops
- Client exit interviews to assess satisfaction with and quality of service provision
- Midcourse assessments and endline evaluations drawing on the above information, supplemented with facility audits, FGDs with project participants and community members, and key informant interviews with project stakeholders
- Quasi-experimental household surveys to assess the impact of community-level interventions

Key Issues and Lessons

Protocols for ethical project monitoring

Given that so much of RESPOND's gender-focused programming was concerned with issues of sexual violence and other forms of GBV, and in particular health service responses to survivor needs, it was essential to develop monitoring protocols and tools that protected client confidentiality. In Guinea and Burundi, this included the development of SOPs for processes of informed consent and for the design of codes and of data collection systems to protect client identities, referrals, and maintenance of data. An important focus of health provider training in both countries was in the use of these monitoring protocols.

Use of monitoring data to refine intervention design

Information gathered through monitoring systems and midcourse assessments was used to refine and improve intervention design. In Côte d'Ivoire, the midcourse assessment revealed the need to address issues of GBV more explicitly in the work on addressing harmful gender norms to promote men's uptake of HIV testing. To address this need, RESPOND partnered with UNFPA to add modules on GBV to its training of health providers in the health clinics being supported by the intervention. In Guinea, monitoring data on health providers' responses to training in sexual violence revealed a need to pay more attention to providers' own gender attitudes in their training. In designing the curriculum to train staff at a FP clinic in the use of a screening protocol for IPV, emphasis was placed on gender-reflective activities to enable participants to explore their own gender attitudes.

Evaluating the longer term impact of training workshops remains a challenge

Workshop pretest and posttest surveys were used to evaluate the immediate impact of training workshops on participants' knowledge and attitudes. RESPOND staff and key informants acknowledge the limitations of this information to understand the long-term impact on participants' behavior. Where training workshops were focused on strengthening participants' skills, as in the training for FP providers in the use of the IPV/FP screening protocol in Guinea, follow-up TA visits proved to be critical in assessing the extent to which participants felt confident in the use of their new skills. In this instance, the follow-up TA visits made clear the need not only for follow-up refresher training, but also the use of simulated client interviews to practice the screening protocol and to

become confident and skilled in its use. A consultant in Burundi commented that “to really see if there was an impact, I would say maybe in another two years, we should revisit the health centers to evaluate how many men bring their children to the clinic, how many men accompany their wives. I’d also ask the community leaders, since these are close-knit communities and everyone knows everything about everyone.”

Measurement of attitudinal change indicated project progress

The most useful markers of project progress (except in the case of Angola, where a more ambitious quasi-experimental household survey was used) were the use of postworkshop and endline questionnaires to assess attitudinal change. Validated survey instruments, such as the Gender-Equitable Men (GEM) scale, were used to assess men’s gender-equitable attitudes¹⁴ and proved to be valuable in demonstrating project progress in shifting harmful gender attitudes. Surveys also helped to identify issues warranting further attention. For example, a midcourse assessment in Burundi reviewed attitudes and behaviors among three key population (male occupational groups, health providers, and community leaders), as well as self-efficacy among health providers. Findings of midcourse and endline assessments are instrumental for developing future trainings and community-based interventions.

Measurement of social norms change remains a significant challenge

RESPOND sought to develop gender-focused work that is not only gender-sensitive, but also gender-transformative. However, the tools and resources are lacking to adequately evaluate the gender-transformative impact. While measuring attitudinal change is undoubtedly important, social norms operate at the individual level as well as at the community level. Measuring community-level change is key to understanding the effectiveness and impact of gender-transformative programming. The quasi-experimental household survey used in Angola to evaluate the impact of the community awareness campaign on gender norms and GBV comes closest to measuring this level of change, but the findings were limited because there was no counterfactual. In addition, mixed-method studies provide the most robust data for assessing impact of such interventions, in particular because qualitative research methods can explore the nature of observed changes in depth.

¹⁴ For more information, see the article on the GEM Scale: <http://promundo.org.br/en/wp-content/uploads/2010/03/04.pdf>.

Appendix 1: Tools Overview

Situation Assessment

Title: *Household Survey*

Country: Angola

Language: Portuguese

Summary: A local-level quasi-experimental study, consisting of a baseline and endline household survey of men and women (between ages 18 and 49), was used to measure the impact of a community-based GBV prevention campaign. Data from the baseline survey about attitudes toward and experiences of GBV and gender inequalities informed the design of the community awareness campaign.

URL: See Angola Evaluation Report appendixes for full questionnaire (<http://www.respond-project.org>).

Program Implementation: Changing Attitudes and Behaviors

Title: *Engaging Boys and Men in Gender Transformation: The Group Education Manual*

Country: piloted in Ethiopia, Namibia, South Africa, and Tanzania

Language: English & French

Additional Materials: Observation and Feedback Tool, Pre and Post-test Questionnaire and GBV Resources

Summary: This 11-chapter manual offers trainers an array of participatory experiential exercises to reach men (and their partners), exploring gender socialization and its impact on HIV prevention and care. The manual is designed to assist master trainers in developing curricula to work with men and boys on gender, HIV and AIDS, and sexual and reproductive health issues.

URL: www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Group_Education_Manual_final.pdf

Title: *Synchronizing Gender Strategies - A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations*

Country: Global

Language: English

Summary: This paper explores gender integration approaches to sexual and reproductive health programs and policies to demonstrate why it is important to promote gender equality from a relational/harmonized perspective in sexual and reproductive health. It "takes gender transformation to the next step, to what we have communally termed 'gender synchronization.' By gender synchronization, the authors mean working with men and women, boys and girls, in an intentional and mutually reinforcing way that challenges gender norms, catalyzes the achievement of gender equality, and improves health." Further, it illustrates what separate but aligned programs and policies for both women and men and couple approaches look like; and, describes the value added from addressing both men and women from a relational perspective in programs and policies that improve health by challenging gender inequalities. This product was developed by the RESPOND Project at

EngenderHealth and the BRIDGE Project, at the Population Reference Bureau, in consultation with the Interagency Gender Working Group of the United States Agency for International Development.

URL: www.respond-project.org/pages/files/6_pubs/collaborative-products/Synchronizing%20Gender_final%20Oct%20%202010.pdf

Title: *Hommes comme partenaire dans la lutte contre les violence sexuelles au Burundi: guide des animateur pour le travail en équipe*

Country: Burundi

Language: French

Additional Materials: Observation and Feedback Tool, Pre and Post-test Questionnaire and GBV Resources

Summary: These five-day Men As Partners (MAP) Workshops were largely based on EngenderHealth's *Engaging Boys and Men in Gender Transformation: The Group Education Manual*. The MAP curriculum was designed to be used as both a training of trainers manual, and workshop activities for the mineworkers and male tea plantation workers in Kayanza and Muyinga provinces.

URL: Only available in draft. The following brief discusses the approach: www.respond-project.org/pages/files/6_pubs/project_briefs/Project-Brief-23-GBV-Burundi-August2014-FINAL-forweb.pdf

Title: *Engaging Boys and Men in Gender Transformation: A Supplement Facilitating the Training in Christian Settings*

Country: Namibia

Language: English

Additional Materials: Suggestions for Supplementing MAP Group Education Activities with Spiritual Perspectives, Guidance on Using this Supplement to Develop a Sermon, and Guidance on Using this Supplement for Pastoral Counseling

Summary: Supported by LifeLine/ChildLine and RESPOND, this network created a training tool for use with religious leaders and their congregations, which drew on religious texts and arguments to support gender equality and positive masculinities. EngenderHealth staff supported LifeLine/ChildLine in conceptualizing the content and organization of this training resource, identifying ways to link the tool with EngenderHealth's Group Education Manual.

URL: www.respond-project.org/pages/files/6_pubs/curricula-manuals/EngenderHealth-spiritual%20supplement-final.pdf

Title: *Stay Healthy: A Gender Transformative HIV Prevention Curriculum for Youth in Namibia*

Country: Namibia

Language: English

Additional Materials: Stay Healthy Theory of Change Logic Model and a Sample Parent/Guardian Consent Form

Summary: LifeLine/ChildLine also worked with RESPOND to develop as a school-based curriculum designed to prevent HIV infection among Namibian youth aged 13–18. The curriculum focuses on affecting three key behaviors directly related to HIV infection: 1) delaying the onset of sexual intercourse; 2) increasing the correct and consistent use of the male condom among sexually active youth; and 3) decreasing multiple concurrent partners among sexually active youth.

URL: www.respond-project.org/pages/files/6_pubs/curricula-manuals/HIV-youth-curriculum-16September2011-FINAL.pdf

Program Implementation: Improving Service Delivery

Title: *Responding to the Impact of Gender-Based Violence: An Annotated Bibliography for Integrated Family Planning and Gender-Based Violence Services*

Country: Global

Language: English

Accompanying Materials: IPV/FP Manual and Guinea IPV/FP evaluation

Summary: The goal for this annotated bibliography was to assist in the development of a clinic protocol and training curriculum to integrate intimate partner violence screening and basic crisis intervention services within a family planning and reproductive health clinic in Conakry, Guinea. It includes the following types of resources: evidentiary findings and lessons learned from previously implemented programs; suggested guidelines and standards for integrating a new program of care within an existing program of care; training modules to equip providers with the tools needed to respond to an issue; and tools and forms that could be adapted and implemented in a clinical setting.

URL: www.respond-project.org/pages/files/6_pubs/tools/Annotated-Bibliography-GBV-May2014-FINAL.pdf

Title: *Integration of Family Planning and Intimate Partner Violence Services: Trainer's Guide*

Country: Guinea

Language: French (draft) and English

Additional Materials: data management tools; provider training and supervision

Summary: RESPOND developed a five-day curriculum for training FP providers to integrate IPV screening and counseling into FP services based on the project's formative research. The workshop provides participants with a general understanding of gender as well as the norms and inequalities. The curriculum also focused on strengthening participants' skills in delivering IPV services to FP clients.

URL: See published report under Training Curricula and Manuals in the RESPOND project web site www.respond-project.org.

Title: *Integrating Intimate Partner Violence Screening and Counseling with Family Planning Services: Experience in Conakry, Guinea*

Country: Guinea

Language: English

Additional Materials: Integration of FP and IPV Services: Trainer's Guide

Summary: This is the evaluation of the IPV/FP integration project. It includes recommendations for the project.

URL: www.respond-project.org/pages/files/6_pubs/research-reports/Study16-Integrating-IPV-and-FP-Guinea-August2014.pdf

Title: *Training Health Care Providers on the Involvement of Men against HIV and AIDS*

Country: Côte d'Ivoire

Language: French

Additional Material: MAP IEC materials

Summary: This brief discussed the health provider training around engaging men in HIV in Cote d'Ivoire. The activities and exercises were adapted from Men As Partners (MAP) training curriculum

to train health providers to develop and provide male-friendly HIV prevention and testing services. RESPOND collaborated with JHU•CCP to develop information, education, and communication (IEC) messages and materials that challenge harmful gender norms and encourage men to participate in HIV and PMTCT services.

URL: www.respond-project.org/pages/files/6_pubs/project_briefs/Project-Brief-25-Male-Engagement-August2014-FINAL-forweb.pdf

Program Implementation: Engaging Communities

Title: *Engaging Men at the Community Level*

Country: Burundi, Guinea

Language: English

Summary: An interactive manual that offers master trainers the approaches for working with community-based health outreach workers and gender activists as a means of mobilizing community members to take actions related to HIV, AIDS, and gender. Uses the ecological model linked to the formation of “community action teams,” the manual offers strategies to reach various community members and sustain change specific to HIV, AIDS, and men.

URL: www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Community_Engagement_Manual_final.pdf

Monitoring and Evaluation

Title: *Household Survey*

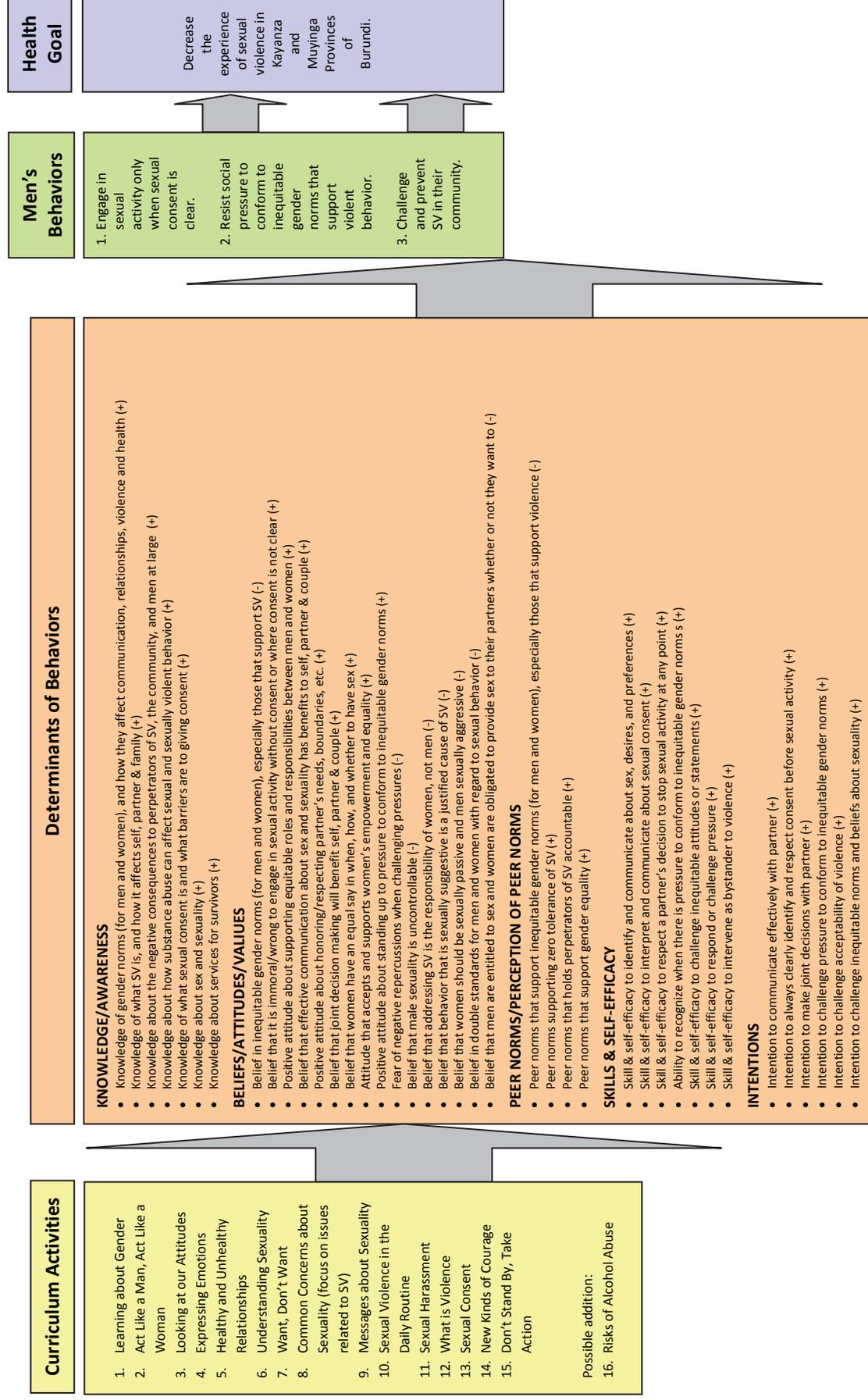
Country: Angola

Language: Portuguese

Summary: A local level quasi-experimental study, consisting of a baseline and endline household survey of men and women (between the ages of 18 to 49), which was used to measure the impact of a community-based GBV prevention campaign. Data from the baseline survey about attitudes towards and experiences of GBV and gender inequalities also informed the design of the community awareness campaign.

URL: See Angola Evaluation Report appendixes in the RESPOND site for full questionnaire - <http://www.respond-project.org>

Appendix 2: Theory of Change Logic Model Developed by RESPOND/Burundi for Use with Men As Partners Intervention



Curriculum Activities

1. Learning about Gender
 2. Act Like a Man, Act Like a Woman
 3. Looking at our Attitudes
 4. Expressing Emotions
 5. Healthy and Unhealthy Relationships
 6. Understanding Sexuality
 7. Want, Don't Want
 8. Common Concerns about Sexuality (focus on issues related to SV)
 9. Messages about Sexuality
 10. Sexual Violence in the Daily Routine
 11. Sexual Harassment
 12. What is Violence
 13. Sexual Consent
 14. New Kinds of Courage
 15. Don't Stand By, Take Action
- Possible addition:
16. Risks of Alcohol Abuse

Determinants of Behaviors

- KNOWLEDGE/AWARENESS**
- Knowledge of gender norms (for men and women), and how they affect communication, relationships, violence and health (+)
 - Knowledge of what SV is, and how it affects self, partner & family (+)
 - Knowledge about the negative consequences to perpetrators of SV, the community, and men at large (+)
 - Knowledge about how substance abuse can affect sexual and sexually violent behavior (+)
 - Knowledge of what sexual consent is and what barriers are to giving consent (+)
 - Knowledge about sex and sexuality (+)
 - Knowledge about services for survivors (+)
- BELIEFS/ATTITUDES/VALUES**
- Belief in inequitable gender norms (for men and women), especially those that support SV (-)
 - Belief that it is immoral/wrong to engage in sexual activity without consent or where consent is not clear (+)
 - Positive attitude about supporting equitable roles and responsibilities between men and women (+)
 - Belief that effective communication about sex and sexuality has benefits to self, partner & couple (+)
 - Positive attitude about honoring/respecting partner's needs, boundaries, etc. (+)
 - Belief that joint decision making will benefit self, partner & couple (+)
 - Belief that women have an equal say in when, how, and whether to have sex (+)
 - Attitude that accepts and supports women's empowerment and equality (+)
 - Positive attitude about standing up to pressure to conform to inequitable gender norms (+)
 - Fear of negative repercussions when challenging pressures (-)
 - Belief that male sexuality is uncontrollable (-)
 - Belief that addressing SV is the responsibility of women, not men (-)
 - Belief that behavior that is sexually suggestive is a justified cause of SV (-)
 - Belief that women should be sexually passive and men sexually aggressive (-)
 - Belief in double standards for men and women with regard to sexual behavior (-)
 - Belief that men are entitled to sex and women are obligated to provide sex to their partners whether or not they want to (-)
- PEER NORMS/PERCEPTION OF PEER NORMS**
- Peer norms that support inequitable gender norms (for men and women), especially those that support violence (-)
 - Peer norms supporting zero tolerance of SV (+)
 - Peer norms that hold perpetrators of SV accountable (+)
 - Peer norms that support gender equality (+)
- SKILLS & SELF-EFFICACY**
- Skill & self-efficacy to identify and communicate about sex, desires, and preferences (+)
 - Skill & self-efficacy to interpret and communicate about sexual consent (+)
 - Skill & self-efficacy to respect a partner's decision to stop sexual activity at any point (+)
 - Ability to recognize when there is pressure to conform to inequitable gender norms (+)
 - Skill & self-efficacy to challenge inequitable attitudes or statements (+)
 - Skill & self-efficacy to respond or challenge pressure (+)
 - Skill & self-efficacy to intervene as bystander to violence (+)
- INTENTIONS**
- Intention to communicate effectively with partner (+)
 - Intention to always clearly identify and respect consent before sexual activity (+)
 - Intention to make joint decisions with partner (+)
 - Intention to challenge pressure to conform to inequitable gender norms (+)
 - Intention to challenge acceptability of violence (+)
 - Intention to challenge inequitable norms and beliefs about sexuality (+)

Men's Behaviors

1. Engage in sexual activity only when sexual consent is clear.
2. Resist social pressure to conform to inequitable gender norms that support violent behavior.
3. Challenge and prevent SV in their community.

Health Goal

Decrease the experience of sexual violence in Kayanza and Muyinga Provinces of Burundi.

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