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COMMUNITY ENGAGEMENT IN THE PEPFAR SPECIAL INITIATIVE ON SEXUAL AND GENDER-BASED VIOLENCE

AUGUST 2010

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by Elizabeth Doggett of the Health Policy Initiative, Task Order I.

Suggested citation: Doggett, E. 2010. *Community Engagement in the PEPFAR Special Initiative on Sexual and Gender-Based Violence*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

The USAID | Health Policy Initiative, Task Order 1, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Task Order 1 is implemented by Futures Group, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and Futures Institute.

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ACKNOWLEDGMENTS

The author would like to acknowledge and thank Myra Betron for her leadership of this project for Futures Group, Lori Michau and Evelyn Letiyo of Raising Voices for their invaluable partnership in providing technical assistance to the clinical partners; and Anne Eckman and Ken Morrison of Futures Group for their technical contributions on community engagement approaches. Likewise, the author is grateful to the clinical partners—International Center for AIDS Care and Treatment Programs, IntraHealth, Catholic Relief Services/AIDS Relief, Drew Cares International, Northern Uganda Malaria, Tuberculosis and HIV/AIDS Program, Mulago-Mbarara Teaching Hospitals’ Joint AIDS Program, and the Ugandan People’s Defense Force—for their dedication to the Initiative and beyond, and for the valuable information they contributed to inform this report. Also, Dr. Felix Kayigamba, Fernando Morales, Zara Ahmed, Eugene Zimulinda, and Mahita Mishra (Rwanda); Rhobbinah Ssempebwa, Steven Ssebagala, Vincent Bagambe, Sereen Thaddeus, and Premila Bartlett (Uganda); and Diana Prieto, Andrea Halverson, Debbie Cook Kaliel, Heidi Mihm, Zanele Mophosho, Madeline Short, Laura Skolnik, and Nomi Fuchs-Montgomery (USA) provided critical leadership and support from the U.S. government partners. Finally, thanks to Jill Keesbury and Mary Zama of the Population Council who provided ongoing feedback and support in the community engagement technical assistance and were of course critical in weaving together the clinical services and community engagement components of the Initiative.

EXECUTIVE SUMMARY

In 2007, the President's Emergency Plan for AIDS Relief (PEPFAR) launched a Special Initiative on Sexual and Gender-based Violence, which sought to strengthen clinical care for survivors of sexual and gender-based violence (SGBV) in 18 public health facilities in Uganda and Rwanda. While the creation and strengthening of clinical services was the main tenet of the Initiative, partners also undertook efforts to involve communities in the process of creating and providing those clinical services to survivors of SGBV. As part of this Initiative, the USAID | Health Policy Initiative provided technical assistance (TA) to local clinical partners to increase their capacity for engagement in the creation and provision of clinical services, and in linking clinical services and other available resources for SGBV survivors in the community.

Community engagement is a necessary part of working to prevent and respond to SGBV. Gender norms—especially gendered beliefs and practices—at the community level are among the root causes of SGBV and may support or reject the practice of SGBV. Changing attitudes at the community level is a promising way to decrease the incidence of SGBV. Community-level norms and practices also influence the institutional response to SGBV when it occurs. Because community-level institutions tend to be the most widely accessible, it is at this level that citizens may have the most influence over institutional responses to SGBV—to either promote and support appropriate responses to SGBV or neglect and undermine efforts to address it.

It is widely recognized that community engagement and community-level attitude change is a promising means of preventing SGBV. However, despite the evidence that community engagement interventions can be effective in changing norms to prevent SGBV, fewer evaluated interventions have engaged communities in the response—especially the clinical response—to SGBV. A few of the Initiative's clinical partners were already doing some work to engage communities in the context of HIV and other health services; however, in most cases these efforts were limited to transmitting health information to communities, rather than partnering with them in more reciprocal ways. Such reciprocal relationships can be extremely beneficial when working with health issues as culturally entrenched as SGBV.

To increase clinical partners' capacity to engage communities as a means to improve the quality and accessibility of SGBV services, the Health Policy Initiative teamed with an internationally recognized organization in Uganda, Raising Voices, to jointly provide technical assistance to the clinical partners through information exchange workshops, site visits, and one-on-one mentoring. Technical assistance included training in participatory community assessment and planning methodologies, awareness-raising strategies, communications strategies, community and social change processes, and referral network development.

Partners implemented a range of community engagement activities to improve the responsiveness and accessibility of clinical services for SGBV survivors, including community-based assessments that informed the development of clinical protocols for caring for SGBV survivors, awareness raising about SGBV and how to access SGBV services, and network building to coordinate SGBV services in the community and develop referral protocols to link survivors to the range of services they need.

The Initiative's experience suggests that community engagement can be integrated as part of an approach to improving the quality and accessibility of clinical services for SGBV survivors and that it may improve the community's acceptance and use of such services. The project also demonstrated the importance of long-term commitment to community engagement, as attitude and behavior change around SGBV is a slow process. Finally, the Initiative also confirmed that South-to-South technical collaboration is a

valuable way to share information and learn from others' experiences in projects challenging deeply held cultural norms and attitudes.

Looking into the future, this work has only begun: project partners expressed a strong desire and commitment to continue the work begun under the Initiative to engage communities in the response to SGBV.

ABBREVIATIONS

ACE	active community engagement
AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
CRS	Catholic Relief Services
DCI	Drew Cares International
DoD	Department of Defense
HIV	human immunodeficiency virus
ICAP	International Center for AIDS Care and Treatment Programs
IEC	information, education, and communication
MJAP	Mulago-Mbarara Teaching Hospitals' Joint AIDS Program
NUMAT	Northern Uganda Malaria, Tuberculosis and HIV/AIDS Program
PEPFAR	President's Emergency Plan for AIDS Relief
PEP	post-exposure prophylaxis
SGBV	sexual and gender-based violence
SV	sexual violence
UPDF	Ugandan People's Defense Force
USAID	United States Agency for International Development

I. INTRODUCTION

In 2007, the President’s Emergency Plan for AIDS Relief (PEPFAR) launched a Special Initiative on Sexual and Gender-based Violence (hereafter, “the Initiative”), which sought to strengthen clinical care for survivors of sexual and gender-based violence (SGBV) in 18 public health facilities in Uganda and Rwanda. The PEPFAR Sexual and Gender-Based Violence Initiative was envisioned to be implemented in a common fashion in Uganda, Rwanda and South Africa. However, after an initial assessment it was found that South Africa was further along in the development of services for survivors of sexual and gender-based violence and implementing the same model would not make sense there. Thus the initiative focused the original implementation plan and research on Uganda and Rwanda. Funding in South Africa went to provide additional trainings for three partners (one each from the Centers for Disease Control and Prevention (CDC), USAID and Department of Defense (DoD)) and complemented funding for ongoing research projects.

Objectives of the overall PEPFAR Special Initiative on Sexual and Gender-based Violence include the following:

- Develop and implement sexual violence service delivery models, building upon existing services in two selected PEPFAR focus countries (Rwanda and Uganda) with the aim of:
 - Strengthening the capacity of local partners and institutions to deliver quality healthcare services, including post-exposure prophylaxis (PEP) to victims of sexual violence; and
 - Establishing and strengthening linkages among health, law enforcement, legal, and community services for delivery of a coordinated response to sexual violence victims.
- Foster South-to-South technical exchange of programmatic experience, protocols, and tools through linkages across the three countries and with a network of partners implementing similar service delivery models in Zambia, Kenya, and South Africa and smaller sexual violence projects in Zimbabwe, Malawi, Ethiopia, and Senegal.
- Assess changes in the utilization and quality of services offered through these models to inform policy and program scale-up.

In this project, partners use the term “sexual and gender-based violence,” which actually refers to two terms. **Gender-based violence** is defined as “violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm... It includes that violence which is perpetuated or condoned by the state” (UNFPA, 1998).

Sexual violence is defined as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work” (Krug et al., 2002). Because of its focus on increasing access to HIV PEP, the Initiative focused primarily on sexual violence, but partners wanted to be deliberate in acknowledging that sexual violence is gender-based and linked with other forms of GBV.

Local partners in each country supported healthcare providers to undertake the following three sets of core interventions: (1) strengthen health services; (2) strengthen referrals from the health facility to other support services; and (3) strengthen linkages between clinical services and other stakeholder groups to facilitate access to health services. The Population Council provided technical assistance to the clinical partners related to the first core intervention of strengthening clinical services.

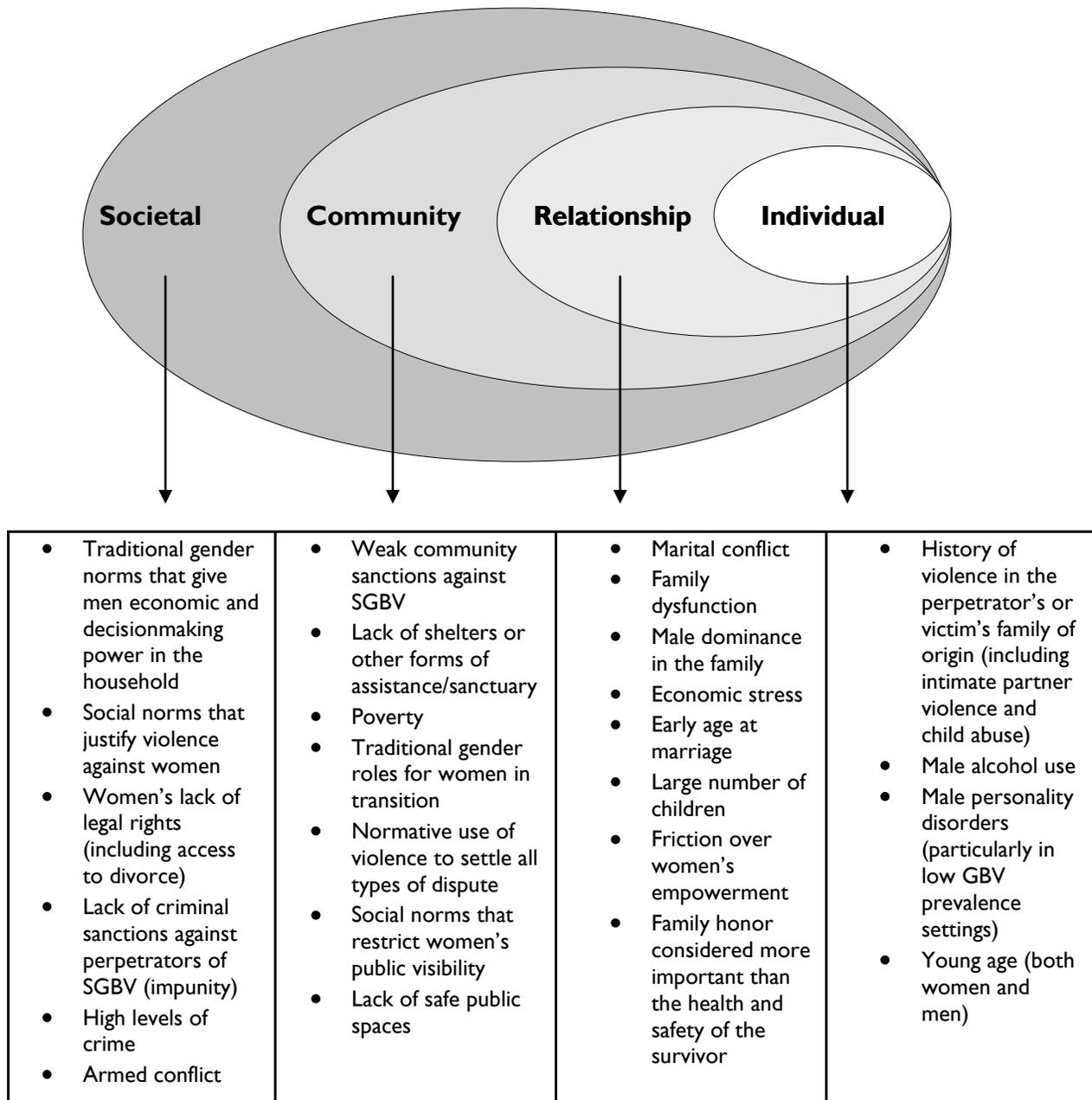
Community engagement is “the process of working collaboratively with a group of people who are affiliated by geographic proximity, special interests, or similar situation with respect to issues that affect their well-being” (CDC, 1997).

Although the creation and strengthening of clinical services for survivors, with a particular focus on expanding access to PEP, was the heart of the Initiative, the second and third core interventions arose from an acknowledgment that the norms and relations perpetuating SGBV and inhibiting responses to it exist at multiple levels. Thus, for the first core intervention to be successful, it was necessary to engage the communities—including other services and institutions in the communities—to ensure that clinical services met the community’s needs and to increase acceptance of and access to those services. To that end, the USAID | Health Policy Initiative, Task Order 1 provided technical assistance to the clinical partners related to community engagement. The Health Policy Initiative and the Population Council worked together to provide technical assistance related to linking clinical services and other available resources. This document specifically reports on the Initiative’s efforts to engage communities in the clinical response to SGBV to increase the acceptability and accessibility of clinical services.

Community Engagement in Response to SGBV

Gender-based violence is rooted in power inequity between women and men at multiple levels, from the relationships between individuals to community norms to broader, structural inequalities. The “ecological model,” shown in Figure 1, illustrates that multiple, linked factors contribute to SGBV; this shows that none of the risk factors alone—individual, relationship, community, or societal—can explain why SGBV persists. Causes of SGBV at different levels tend to reinforce one another; thus, interventions that seek to prevent or respond to SGBV are most effective when they challenge inequitable norms and practices at multiple levels (IGWG, 2008).

Figure I. The Ecological Model of SGBV



Adapted from Bott et al., 2005; Krug et al., 2002; and Heise, 1998.

Why community engagement in SGBV? Community engagement is an important dimension of SGBV interventions. First, community-level norms influence and are influenced by individual and relationship-level causes of SGBV. Evidence shows that those who experience SGBV are more likely to report the violence to a friend or family member than to a health facility or other services provider (WHO, 2005), which further supports the notion that community awareness and acceptance are essential to the accessibility and use of services.

Likewise, institutional norms and practices can either promote and support appropriate responses to SGBV or neglect and undermine efforts to address it. Because community-level institutions tend to be the most widely accessible, it is at this level that citizens may have the most influence over institutionalized support or rejection of SGBV.

It is widely recognized that community engagement and community-level attitude change is a promising means of preventing SGBV. However, despite the evidence that community engagement interventions can be effective in changing norms to prevent SGBV, few evaluated interventions have engaged communities in responses—especially clinical responses—to SGBV.

Certainly, community engagement is a critical part of SGBV response: if clinical and other services are not designed in culturally appropriate ways, they will not meet the needs of survivors. Survivors of sexual violence, in particular, often face intense social stigma that can inhibit them from seeking services (WHO, 2004). Community attitudes, both toward sexual violence and toward the clinical services themselves, are thus significant. If the community does not perceive the services to be necessary, important, or adequate, survivors will be even less likely to take advantage of them or refer their sisters, partners, daughters, or friends to them. Finally, community input can help to create and streamline referral processes to help survivors access the services they may need in addition to health services—especially legal aid, psychosocial support, economic assistance, or shelter.

Engaging communities in SGBV response also may potentially have the long-term effect of both preventing and responding to SGBV. As it is, some researchers classify services for survivors of SGBV as “secondary prevention” of violence (Krug et al., 2004). Moreover, when a community mobilizes to ensure compassion, care, and justice for those who experience SGBV, it is taking a stand that says violence is not tolerated. This kind of attitude change is likely to carry over into relationship- and individual-level attitudes to decrease the occurrence and acceptance of violence.

Approaches to community engagement. There are several modes of activities that clinical projects can use to engage communities when working to introduce or strengthen health services for SGBV survivors, as elaborated in the adapted Active Community Engagement (ACE) Continuum (see Annex A). For instance, a project may conduct community-level assessments by soliciting information and input from community members on SGBV and related services before designing an activity or intervention. A project may also provide information about SGBV and SGBV services to community members. A project may include the community in planning and decisionmaking about the design and provision of services. Finally, a project may build community-level capacity to participate in and advocate to institutions and hold those institutions accountable for responding appropriately to SGBV. These modes of engagement vary in their level of community input, control, and ownership. Specifically, they can be undertaken at a range of levels, from one-way transfer of information and services, to seeking input, to working with communities as full participants in planning, implementing, monitoring, and evaluating the project.

The Health Policy Initiative views responding to SGBV as a process that requires social change. It thus grounds its approach to building enabling environments for policy implementation in more robust forms of community engagement. To do so, the Health Policy Initiative has adapted methods from a family of participatory approaches referred to by such terms as participatory learning and action, popular education, and citizen-centered advocacy (Clark et al., 2002; VeneKlasen et al., 2004). Using these methods, the project implements innovative processes that build communities’ capacity to critically analyze—and act to change—the gender and power relations that lie at the heart of many institutional and policy barriers to responding to SGBV. The project’s results suggest that such community engagement approaches can be effective in overcoming deep-rooted cultural barriers to implementing effective SGBV policy responses at the levels of local government planning and budgeting, traditional decisionmaking structures in the

community, and clinical protocols (Betron, 2009; Eckman et al., 2008; Eckman and Reilly, 2006; Health Policy Initiative, forthcoming; Nyong'o and Ongalo, 2005).

While the most robust level of community engagement is likely to have the most impact on preventing and responding to SGBV, this kind of engagement may not always be feasible or appropriate in any given context. Factors that influence feasibility include the amount of time and financial resources a project has, the skills project staff have related to community engagement, and the relationships and power dynamics existing between community members and the implementing institutions. The Health Policy Initiative's TA approach thus included presenting the range of community engagement approaches, as well as more in-depth training on the specific approaches that the project has used with communities to tackle gender and power relations.

Sexual and Gender-Based Violence Services in Rwanda and Uganda

In both Rwanda and Uganda, violence against women is alarmingly prevalent. According to Demographic and Health survey data, in Rwanda more than one-third of currently partnered women experience some form of physical or sexual violence at the hands of an intimate partner at some time in their lives. The prevalence is even higher in Uganda, with nearly 60 percent of women experiencing intimate partner violence. Sexual violence (not limited to violence from an intimate partner) is also quite prevalent: nearly 40 percent of women in Uganda have experienced sexual violence at some point in their lives. While comparable data are not available from Rwanda, existing data from smaller studies suggest that sexual violence against women is extremely prevalent (e.g., UNIFEM, 2008). Further, it should be noted that experience of gender-based violence—and especially sexual violence—is thought to be under-reported due to stigma, shame, and fear.

Table 1. Sexual and Gender-based Violence in Rwanda and Uganda

	Rwanda (INSR and ORC Macro, 2006)	Uganda (UBOS and Macro International, 2007)
Percentage of currently partnered women ages 15–49 who have ever experienced physical and/or sexual violence by their partner/husband	33.8	59.1
Percentage of women ages 15–49 who have ever experienced sexual violence	(not available)	39

As part of the Initiative, the Population Council conducted a baseline survey in each of the clinical sites in both countries to determine the status of existing services. This survey included qualitative data on providers' attitudes toward SGBV that were likely to affect their treatment of SGBV patients; such attitudes are likely affected by community norms. In both countries, all providers understood what SGBV is and stated that, although SGBV has long existed, people are increasingly likely to report it. Providers' attitudes toward SGBV in both countries were mixed, with some blaming women for being raped and others strongly disagreeing with the notion that a woman can provoke violence: nonetheless, all providers viewed SGBV as an emergency and said that it should be treated with the same care as any other emergency.

Other community norms affect the provision of quality SGBV services. For instance providers in Rwanda noted that survivors' and their families' attitudes of shame posed one of the most difficult challenges to providing services for SGBV, as these attitudes may keep some from reporting the violence or admitting

the cause of injury or ill health. In Uganda, providers noted that there was low awareness of the procedures (e.g., where to report first), time limitations, and locations of available SGBV services.

As noted above, few evaluated, clinically-driven SGBV interventions have made significant efforts to engage communities in the creation and maintenance of SGBV services or to develop linkages with other services in communities. In both countries, community engagement was relatively new to most clinical partners. The baseline survey showed that neither country had formal procedures to refer patients to any existing services outside of the clinics. With a few exceptions, community outreach and awareness raising were not normally undertaken by clinical partners prior to the Initiative. Further, in neither country were there formal mechanisms for patients or other community members to provide feedback about services. One of the suggestions raised most often at baseline in both countries for improving their services was awareness raising about sexual violence (SV) and about the procedures, locations, and time limitations for seeking care (Elson and Keesbury, 2010).

II. COMMUNITY ENGAGEMENT IN THE PEPFAR SPECIAL INITIATIVE ON SEXUAL AND GENDER-BASED VIOLENCE

The Initiative's clinical and TA partners recognized early on that, to effectively meet its objectives, the services developed must be responsive to the norms and priorities in the communities they serve. Following is a summary of the technical assistance that the Health Policy Initiative provided to partners to increase their engagement of communities to improve quality of and increase access to SGBV clinical services.

Timeline: Technical Assistance on Community Engagement

March 2008. Launch of SGBV Initiative in Pretoria, South Africa. Technical exchange meeting: partners present their projects to become familiar with each other's models of SGBV service provision.

July 2008. Health Policy Initiative and Raising Voices hold five-day exchange workshop for Rwandan and Ugandan partners in Uganda. Partners share their community engagement approaches, learn about the Health Policy Initiative and Raising Voices methodologies, and draft their community engagement workplans.

November 2008. Raising Voices learning center visit for Ugandan partners. Workshop focuses on community engagement strategies.

February 2009. One-day workshop with Rwanda partners in Kigali; one-on-one meetings with each partner. Health Policy Initiative and Raising Voices facilitate workshop community mapping and community awareness-raising strategies related to SGBV. Held subsequent meetings to refine workplans on community engagement in more depth and link to specific methodologies from Health Policy Initiative and Raising Voices.

June 2009. Joint Health Policy Initiative and Population Council workshop in Uganda. Health Policy Initiative trains partners on developing referral networks and holding focus group discussions to assess community attitudes and barriers to addressing SGBV. Population Council works with partners to develop operational guidelines/protocols for clinical response to SGBV (based on national guidelines). Population Council also trains partners on baseline data collection for Initiative evaluation.

August 2009. Joint Health Policy Initiative and Population Council workshop in Rwanda. Health Policy Initiative trains partners on developing referral networks and holding focus group discussions to assess community attitudes and barriers to addressing SGBV. Population Council works with partners to develop operational guidelines/protocols for clinical response to SGBV (based on national guidelines).

October 2009. Ugandan information, education, communication (IEC) materials approved and finalized by partners.

November 2009. Raising Voices learning center visit for Rwandan partners. Workshop focuses on methods for awareness raising, mentoring, monitoring and evaluation of SGBV activities, and developing communications materials.

June 2010. Health Policy Initiative wrap-up visit. Project staff travels to Uganda and Rwanda to wrap up the community engagement portion of the Initiative and collect information about partners' community engagement activities.

July 2010. Rwandan IEC materials approved and finalized by partners.

Engaging Communities in the Context of Clinical Services for SGBV: Health Policy Initiative's TA Approach

Getting started: Assessment, site selection, Initiative launch. To gain insight into the context of SGBV and related services, introduce the Initiative in country, and identify clinical partners, a small team of PEPFAR, Health Policy Initiative, and Population Council staff visited Rwanda and Uganda in late 2007. During this trip, the team met with a range of stakeholders working to address the issue of GBV to gain an understanding of existing services and linkages between them and identify potential clinical partners. The team shared its findings, as well as the proposed project approach and clinical partners and clinical sites, to the PEPFAR teams in each country. Based on those recommendations, the PEPFAR teams chose the following partners and sites to implement the Initiative:

Table 2. PEPFAR SV Initiative Intervention Sites in Uganda and Rwanda

Country	Clinical Partner	Intervention Sites
Rwanda	International Center for AIDS Care and Treatment Programs (ICAP)/ Columbia University	Muhima District Hospital
		Gisenyi District Hospital
	IntraHealth HIV/AIDS Clinical Services Program	Byumba Hospital
		Kigogo Health Center
	AIDS Relief/ Catholic Relief Services (CRS)	Muyange Health Center
		Kibogora Health Center
		Bungwe Health Center
	Drew Cares International (DCI)	Kanombe Military Hospital
Uganda	Northern Uganda Malaria, Tuberculosis and HIV/AIDS Program (NUMAT)/JSI	Gulu Regional Referral Hospital
		Lira Regional Referral Hospital
		Kitgum District Hospital
		Anaka District Hospital
		Amolatar Health Center
		Pajure Health Center
	Anyeke Health Center	
	Mulago-Mbarara Teaching Hospitals' Joint AIDS Program (MJAP)	Mulago Hospital
	Uganda People's Defense Force (UPDF)	Bombo Military Hospital
		Gulu Military Hospitals

Most of the clinical partners selected had been doing at least some community outreach work. In most cases, however, this was one-way transmission of health information from the clinics to the communities. However, two groups (IntraHealth in Rwanda and NUMAT in Uganda) had established mechanisms for communities to communicate with clinical staff, especially by providing ongoing feedback about community needs and quality of services. Additionally, NUMAT had some experience in partnering with

community members in the design of health communications materials. Engaging communities as key stakeholders in the process of providing clinical SGBV services was thus relatively new to most clinical partners.

The Initiative was formally launched at a workshop for clinical partners in March 2008 in Pretoria, South Africa. During this workshop, partners noted the relevance of community participation models for responding to sexual violence and expressed interest in exploring these models in greater depth. Subsequent technical assistance on community engagement strived to respond to this interest.

The Health Policy Initiative's TA approach included three main forms of technical assistance: (1) information exchange workshops with all partners, (2) targeted workshops in both countries (including "learning center" visits), and (3) site visits for one-on-one capacity building and work planning. This technical assistance built the capacity of partners to conduct participatory community assessments, raise awareness about SGBV and related services (including an emphasis on developing communications materials on SGBV), and link clinical services with other SGBV services and resources in the community. To best meet the TA needs of the partners, the project partnered with the Ugandan organization, Raising Voices—one of the leaders in the area of community engagement against violence against women.

Information exchange workshops. The Initiative's first event was an exchange workshop, hosted by the Population Council in March 2008. In this workshop, partners shared information about models of medical management for sexual and gender-based violence. As noted above, it was here that partners first expressed interest and commitment in deepening their engagement of communities in the context of SGBV services.

In addition to the initial information exchange workshop, the Health Policy Initiative and Raising Voices held a workshop specifically on community engagement in clinical SGBV responses for partners from both countries in July 2008. In this five-day workshop, held in Uganda on the shores of Lake Victoria, partners set their intentions for community engagement activities in the Initiative (see Doggett and Betron, 2008, for more information).

Partners discussed what it means to engage communities at different levels (using the ACE continuum) and identified benefits and challenges to engaging communities. Partners shared their own prior and ongoing approaches to community engagement, demonstrating a range of experiences from minimal levels of engagement to long-standing partnerships with project communities. Recognition of the levels and types of their existing community engagement approaches in relation to the fuller range of activities and levels of engagement helped partners to set their intentions for community engagement in the Initiative.

The workshop trained partners in participatory community assessment and learning methods that help a project to partner with the community to identify and understand community norms and relations of power, inequality, gender, and SGBV, and to assess existing services and gaps in SGBV response in the community. They also learned and reflected on the processes by which individuals and communities go through change, acknowledging that changing a deeply rooted practice like SGBV requires a long-term commitment and engagement. The workshop presented tips for developing effective communications materials to raise awareness of SGBV and related services—with an emphasis on materials that employ positive role modeling and foster a sense of community identity and nonviolence, rather than sensationalizing violence or portraying men as evil and dangerous. Finally, the workshop discussed techniques for creating linkages between clinical services and other services for survivors in the community.

Partners developed workplans and identified their needs for technical assistance to move forward on those plans. Common elements across partners' workplans included development of IEC materials, awareness raising in the communities and among service providers, and mapping GBV services in communities.

This workshop provided the foundation for future technical assistance and action on community engagement in the Initiative. Partners came with a limited awareness of what it means to engage communities in the clinical response to SGBV. They left with an understanding of engaging community members beyond the level of one-way information transfer and working with the communities in a partnership throughout the process of creating and providing appropriate services to survivors of SGBV. Partners also left equipped with tools that could be easily adapted to their contexts to provoke critical thinking about gender and SGBV in their communities and guide them through the process of change to become communities that do not accept violence.

Targeted workshops. One of the innovative forms of technical assistance provided under the Initiative was "learning center" visits, hosted by Raising Voices in Uganda. In these visits, partners traveled to the Raising Voices office in Kampala for capacity building on topics tailored to their needs, followed by visits to Raising Voices' project communities to observe the organization's approach in action.

The Ugandan partners did a four-day learning center visit in November 2008, focused on (1) refining terminology related to SGBV in local languages, deciding on phrases to describe SGBV in their local languages and practicing talking about SGBV to various stakeholders; (2) community asset mapping, practicing several different methodologies to identify resources in their project communities to engage in a coordinated SGBV response; and (3) communications materials development, focusing on positive messaging and adapting existing materials to their local contexts.

The Rwandan partners' four-day learning center visit took place in November 2009. In this workshop, partners reviewed and practiced awareness-raising techniques based on Raising Voices' methodology, discussed the meaning and process of mentoring, learned about and practiced using tools for monitoring and evaluating SGBV prevention activities, and practiced creating communications about SGBV that focused on benefits of nonviolence.

Other targeted workshops included two trainings jointly hosted by the Health Policy Initiative and Population Council in June and August 2009 in Uganda and Rwanda, respectively. These workshops focused on developing referral networks. Health Policy Initiative trained partners on using community mapping and focus groups to identify resources and barriers to addressing SGBV in the community, including attitudes and norms related to SGBV, as well as existing groups and services addressing SGBV. Population Council focused on developing operational guidelines for a clinical response to SGBV.

Targeted workshops allowed partners to learn about certain types of community engagement activities in more depth. They gave participants more time to work with the methodologies and materials and begin to adapt them for their own project context.

One-on-one technical assistance: Site visits and workplanning. Clinical partners in both countries worked individually with the project and Raising Voices staff to hone their skills and workplans on community engagement.

In February 2009, the Health Policy Initiative and Raising Voices staff traveled to Rwanda, holding a one-day workshop that further trained participants in community asset mapping, awareness raising, and developing communications materials. The project and Raising Voices then visited each partner to help them flesh out their workplans and more specifically link the planned activities to the methodologies learned in the workshops.

Because of the proximity of Raising Voices to the Ugandan partners, the latter benefitted from an ongoing relationship of technical assistance and support. Raising Voices visited and followed up with each partner, providing formal and informal technical assistance at many points over the last two years. For example, Raising Voices worked closely with MJAP to plan a regional stakeholder meeting and visited NUMAT in January 2010 to observe and provide feedback on NUMAT's adaptation of Raising Voices materials in the local context.

One-on-one technical assistance gave partners tailored support to refine their workplans and further refine their understanding of community engagement methodologies in the specific context of their own activities. Ugandan partners in particular benefitted from ongoing one-on-one support from Raising Voices that helped them implement activities using adaptations of Raising Voices' materials and methods.

III. OUTCOMES

The PEPFAR SGBV Initiative clinical partners took on an impressive range of community engagement activities for a relatively short project. Different partners had different start dates, with roll-out of activities beginning in 2008 in Uganda and early 2010 for Rwandan partners.

Though the evaluation study conducted by Population Council focuses on the clinical services, it does include a few quantitative and qualitative indicators that relate to community engagement. The forthcoming data from that evaluation will include (1) data on linkages with other SGBV services (number and types of referrals made measured on client assessment forms and knowledge of providers of community outreach activities and of partnerships with other community services measured by focus group discussions with providers); and (2) data on the Initiative's impact on the communities, measured at endline only through key informant interviews with representatives of multisectoral stakeholder groups and with randomly sampled community members. These data will measure (1) awareness and knowledge of the program, (2) referral practices, (3) assessment of greater community awareness of services, (4) assessment of program successes, and (5) service gaps in the community (Population Council, 2009). However, because the data are not yet available, this report relies primarily on information collected through interviews with clinical partners during June and July 2010.

Health Policy Initiative staff traveled to Uganda and Rwanda to interview each partner to identify the outcomes and impact of the technical assistance related to community engagement to improve the quality and accessibility of clinical SGBV services. Findings from these interviews revealed that community engagement efforts varied among partners, but activities have included community-based assessments, outreach to raise community awareness of the clinical services and how to access them, and stakeholder meetings to strengthen networks of SGBV services in communities.

Community assessments. Before starting its clinical services activities, NUMAT participants (Uganda) adapted the methodologies they learned in the Health Policy Initiative and Raising Voices workshops to conduct a participatory assessment on attitudes and services for SGBV in their communities. NUMAT conducted more than 40 focus group discussions in its seven districts. In the focus group discussions, NUMAT collected information about the frequency and common types of SGBV, survivors' access to services, and community members' recommendations related to interventions that would reduce SGBV and provide better services to those who experience it. Recommendations generated through this process included, but were not limited to: improve services for young girls, perceived as most vulnerable to SGBV; strengthen relationships between clinical service providers and clan or religious leaders, as these community leaders have the power to greatly influence community-level

attitudes toward GBV; raise awareness about the availability of services; and create support groups for survivors.

It is unclear, however, whether these recommendations did much to influence the design or provision of clinical services. This may be due in part to the fact that TA for community engagement took place earlier than TA for clinical services; potentially posing challenges for partners to fully integrate community engagement and clinical services as one cohesive program. Further, while all clinical partners were trained in methods for participatory assessment and for community input into program design, implementation, and monitoring, few chose to take on such assessments.

Community outreach and awareness-raising. The partners in both countries collaborated with Raising Voices and the Health Policy Initiative to develop a common set of four IEC posters that can be used to raise awareness about what SGBV is and how to access services.¹ The posters were drawn by an artist commonly used by Raising Voices; they incorporate the principle of positive or benefits-based messaging that partners learned in the TA workshops—emphasizing community support for nonviolence and empathy for survivors, rather than sensationalizing violence or shaming survivors or perpetrators. The posters were approved by all partners and validated in their respective communities. Partners printed the posters in English in Uganda and in Kinyarwanda in Rwanda. The Rwandan partners made additional small adaptations to the posters as to dress, styling, and architecture to ensure that they were fully relevant to the Rwandan context.

Building on the numerous TA sessions related to communicating about SGBV and SGBV services in the community, and especially making use of the principle of benefits-based messaging, partners have implemented other activities to raise awareness of the new SGBV services in various parts of the community. For example, ICAP (Rwanda) hosted a series of meetings with the police to alert them to the fact that they should refer survivors to the hospital before commencing a criminal investigation. ICAP also has focused on raising awareness of SGBV services in its “morning sessions,” wherein nurses deliver health-related talks to patients in the hospital waiting rooms.

Several partners have advertised their services on the radio, including CRS (Rwanda) and MJAP (Uganda). The Rwandan partners have a plan to develop one radio message that all the partners can use to advertise their services.

Other partners, including ICAP (Rwanda), IntraHealth (Rwanda), CRS (Rwanda), NUMAT (Uganda), and UPDF (Uganda) have used peer educators and small group discussions to raise awareness about SGBV services and how to access them. This awareness raising includes information about where to go for help, what services are offered, and time limitations for receiving PEP and emergency contraception.

Technical assistance related to developing communication materials and awareness raising helped partners to increase their efforts in these areas and improve the effectiveness of their communications, especially regarding the use of positive messaging, as evidenced by the common set of IEC posters that all partners created and used. While it is difficult to argue empirically, partners commented that an increase in SGBV cases reported in clinical settings is at least partly due to raising awareness of services and how to access them. In follow-up interviews, most partners also expressed that they had an increased appreciation of the need for awareness raising and had increased their commitment to continue to communicate with communities about SGBV and related services. Not only does awareness raising likely increase survivors’ access to and use of services, but positive messages like those the partners developed

¹ The four posters—“Time is Critical”; “You Can Talk With your Healthcare Provider about Sexual Assault”; “Our Community Responds to Sexual Violence!”; and “Women Have a Right to Live Free of Sexual Violence”—are available at www.healthpolicyinitiative.com.

may be an important step in communities' awareness that institutions are responsible for responding to SGBV and should be held accountable for those commitments.

Stakeholder meetings. Several partners indicated that they made use of the technical assistance related to creating links between clinical services and other SGBV services by identifying other services in the community, building relationships with these institutions, and creating referral networks to increase survivors' access to the full range of available services. A number of partners assembled the many groups in the community that offer services, including representatives from the legal/justice sector, the police, social workers, women's groups, other NGOs, and others. Such meetings can mobilize the community at the institutional level, build social capital in the community, and help to streamline referral processes.

In Rwanda, DCI and AIDS Relief hosted stakeholder meetings in their communities, and ICAP held more informal meetings with the police to garner their support for referring survivors to clinical services. In Uganda, MJAP brought together stakeholders in the Kampala area for the first time—this meeting resulted in a collaborative effort to draft referral protocols. In addition, NUMAT (Uganda) hosts monthly coordination meetings in most of its project communities with stakeholders, maintaining an ongoing commitment to multisectoral SGBV response.

Such meetings created and strengthened critical links between clinical services and the community that will likely increase survivors' access to the range of services they need. This work probably also builds social capital in communities, thus moving them toward a more coordinated and institutionalized commitment to take a stand against SGBV.

IV. CONCLUSIONS

Lessons learned. The PEPFAR Special Initiative on Sexual and Gender-based Violence generated many lessons about engaging communities in the process of improving clinical responses to SGBV, including the following:

1. Clinical projects can be well positioned to take on community engagement. The clinical partners, who previously had mostly viewed community engagement as one-way dissemination of health information, ably took on a range of activities, including participatory assessment and awareness-raising and network-building activities—and unofficially saw results in the number of SGBV cases reported to their facilities.
2. Community engagement is, by definition, a long-term process. It is very difficult to meaningfully engage communities and change norms and practices in a short project cycle. This difficulty is further compounded by staff turnover, whereby those who are trained in community engagement methodologies leave the projects. This means that ongoing training and support are critical for such an intervention to be sustained.
3. Partners highlighted the fact that community engagement and attitude change are extremely difficult to measure. This difficulty is related to the challenge of short program cycles. It is widely recognized that norms and attitudes related to gender and violence are slow to change. Measuring community engagement initiatives thus requires long-term engagement, as well as resources and commitment to measuring change from the beginning of the project.
4. South-to-South partnership and technical assistance are valuable to partners piloting new methods and services. Partners noted that they appreciated hearing about the work other partners were doing and expressed interest in keeping in touch and continuing to learn from one another. That said, in the context of community engagement, the South-South project model seemed more

successful in Uganda due to the proximity of the local TA partner, Raising Voices. Rwandan partners stated that, although they learned a great deal from Raising Voices, they would have benefited from a TA partner more intimately familiar with their specific socio-political context.

Reflection on project design and management. The structure of the project posed some challenges and opportunities that affected the project's design and outcomes. As described above, the project was implemented by local clinical partners in two countries with technical assistance from Population Council and the Health Policy Initiative. While partners appreciated the ways in which this structure allowed for South-to-South exchange of ideas and inspiration, it also complicated lines of responsibility and accountability. For instance, the Health Policy Initiative provided technical assistance, especially at the beginning of the Initiative, but its role was not to manage the partners and it was not in a position to hold partners accountable. Therefore, while the Health Policy Initiative trained partners in areas such as incorporating community input into the design, monitoring, and evaluation of services; few partners took on this deeper approach to community engagement, but rather tended to limit their activities to awareness-raising and networking with other sectors. Further, the TA partner/clinical partner structure may have made it difficult for communities to plan for sustainability after the end of the Initiative funding, as clinical partners perceived the TA partners to be the leaders of the project, yet the TA partners did not have the mandate or contacts in the community to carry out that sort of planning. Future adaptations of this approach (clinical partner/TA partner) would do well to clarify that responsibility for sustainability planning on this initiative lies with the clinical partner (as they are closest to the community) and should be folded into sustainability plans for the overall partner interventions.

Conclusion. Community engagement was a critical component of the PEPFAR Special Initiative on Sexual and Gender-based Violence. From the beginning, all partners recognized the importance of linking communities to clinical services for people who experience SGBV. Yet, most partners previously understood and practiced community engagement as a more limited relationship, wherein clinics transferred information about health services to the community. Information exchanges among partners and ongoing technical assistance supported them in deepening their understanding of community engagement as a more reciprocal relationship with communities and other community-level institutions. They enthusiastically participated in capacity building around community engagement that drew on diverse tools and methodologies from the Health Policy Initiative, Raising Voices, and their own existing approaches. They created and strengthened critical links between clinical services and the community; this resulted in raising awareness of SGBV and related services, building social capital at the community level, and increasing accountability of institutions to communities' needs and priorities.

This is only the beginning: the Initiative's experience demonstrates the importance of long-term commitment to community engagement to improve quality and accessibility of clinical services for survivors of SGBV; this is a commitment the partners hope to sustain after the Initiative ends.

ANNEX A. ACE CONTINUUM

The **A**ctive **C**ommunity **E**ngagement Continuum (ACE) *modified***

Framework for Increasing Access, Quality, and Use of Services through Community Engagement

Elements of Engagement*	Level 1	Level 2	Level 3
Community involvement in assessment	Assessment is implemented by outside professionals, with minimal input from communities. Large-group meetings or focus groups may be included, with representatives from local communities.	As in Level 1, plus: Focus group discussions and key informant discussions are held with leaders and community members in the context of their communities to understand their perspectives on health issues.	As in levels 1 and 2, plus: Participatory community mapping and other activities are used to understand community services and critically explore power relationships and social context.
Access to information	Accurate health messages are disseminated on a one-way basis through public media and existing local government structures.	As in Level 1, plus: Messages are disseminated through community agents, such as peer educators; interpersonal interaction is also used but is limited to questions and answers.	As in levels 1 and 2, plus: Messages are disseminated by community agents in a way to facilitate dialogue and reflection on how information relates to daily life. Reflection often provides space to address underlying norms and power relations and to facilitate identifying alternatives and building confidence to act.
Inclusion in planning and decisionmaking	Influential leaders, such as chiefs and public health officials, are consulted at the beginning of the project, and their approval is sought.	As in Level 1, plus: Leaders and advisory groups are involved throughout the project as equal partners in program and policy planning and decisionmaking.	As in levels 1 and 2, plus: Advisory groups have expanded representation, and community-based organizations and networks include marginalized groups. Communities can initiate and decide actions.
Local capacity to participate in and advocate to institutions	Capacity of health delivery services is built, with support for healthcare providers to provide information and services outreach to communities.	As in Level 1, plus: Capacity of local leadership and existing health advisory groups is built to be able to participate in all phases of program development and implementation.	As in levels 1 and 2, plus: Capacity of community-based organizations and inter-organizational linkages is built, allowing a larger community “voice” to set priorities, demand high-quality services and improved policies, etc, with health and other institutions.

Accountability of institutions to the public, including governing structures and monitoring and evaluation

Health services/policies are developed based on what providers and governments determine is needed. Limited opportunities exist for community/civil society to contribute health concerns or to participate in monitoring.

As in Level 1, plus:

Health services/policies have systems in place that seek citizen participation (e.g., through health advisory groups). Systems can include community groups monitoring the quality of services and facility management.

As in levels 1 and 2, plus:

Health services/policies have systems in place for citizen oversight in systems-level decisions from resource allocation, to priority setting, to monitoring of policy and program impact (citizen monitoring).

* The five categories shown here, illustrating characteristics of community empowerment/engagement, are adapted from: Naryan, D. 2002. *Empowerment and poverty reduction: A sourcebook*. Washington, DC: World Bank. The adaptation benefited greatly from suggestions by Michael T. Hatcher, Chief of the Environmental Medicine and Education Services Branch (and former chair of the Committee for Community Engagement), Centers for Disease Control and Prevention, Atlanta, GA.

** Note: This is a slightly modified version of the continuum used by the Health Policy Initiative in June 2008.



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