THE respond PROJECT

PROJECT BRIEF
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Prevention of and Response to Gender-Based Violence in Two Provinces of Burundi

INTRODUCTION

Throughout Burundi's long civil war (1993–2005), gender-based violence (GBV)—defined as physical, psychological, and/or sexual violence—was pervasive. While available data are inadequate to estimate the prevalence of GBV in Burundi following the conflict, they suggest that sexual violence remains widespread (ACAT Burundi & OMCT, 2008). Not only is sexual violence a concern as a human rights issue, it is also associated with HIV infection and other adverse health outcomes (Ellsberg & Betron, 2001). Burundi faces a generalized HIV epidemic, with an adult HIV prevalence of 1.4% (ISTEEBU, MSPLS, & ICF International, 2012).

Addressing sexual violence is a priority of an initiative in Burundi funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). In 2012, with support from PEPFAR, the RESPOND Project began working with the Ministry of Public Health and the Fight Against AIDS (MSPLS) to strengthen GBV prevention and response efforts in two provinces—Kayanza and Muyinga. Project strategies included complementary interventions to strengthen the capacity of health facilities to provide services to GBV survivors, promote gender-equitable norms at the community level, and strengthen linkages between communities and the health care system to facilitate access to GBV response services.

These project strategies were informed by an assessment conducted in April 2012 by RESPOND at 19 facilities and among community leaders from selected townships[1] in Muyinga and Kayanza provinces (RESPOND Project, 2012). This baseline assessment included in-depth interviews with 19 facility managers and 30 providers, as well as structured observations of available equipment and supplies at each site. Results showed that most health facilities were ill-equipped or ill-staffed to respond to GBV. The great majority of providers lacked training related to the care of GBV survivors, who were typically referred to hospitals after receiving only minimal care. Referrals for other services (e.g., police, legal aid, psychosocial support) were rarely provided. Provider attitudes were also found to be a barrier to quality

[1] In Muyinga Province, Giteranyi and Butihinda townships were assessed. (In the second year of the project's interventions, Muyinga Center township was added.) In Kayanza, Kabarore and Muruta townships were initially assessed. (In the second year, Kayanza Center township was added.)

care; for example, 11 of 30 providers (37%) agreed with the statement "Rape is sometimes the fault of the victim."

In addition, focus group discussions conducted with community leaders—including local authorities, religious leaders, community health workers (CHWs), and members of grassroots associations addressing GBV—highlighted the pervasiveness of inequitable norms that contribute to GBV and that could discourage survivors from seeking care or help.

OVERVIEW OF PROJECT INTERVENTIONS

Strengthening Health Sector Response to GBV

As a first step in November 2012, RESPOND worked with the MSPLS to revise and update the national training curriculum for the management of GBV treatment. Following approval of the revised curriculum in February 2013, RESPOND trained 34 national trainers from MSPLS units and local nongovernmental organizations (NGOs). Over the next year, they trained health care providers in the four townships on the revised curriculum. Trainings included instruction on understanding GBV as a social and public health problem, holistic management of GBV cases (medical, psychosocial, legal), referral for other services, as well as knowledge of supplies and commodities essential for GBV treatment. Trainings included adaptations of selected activities from EngenderHealth's Men As Partners® (MAP®) curricula to engage male and female providers in confronting harmful stereotypes and in reflecting on challenges faced by GBV survivors.[2]

RESPOND trained a total of 322 providers and 18 supervisors. In 2013–2014, RESPOND also worked with the MSPLS and FHI 360 to increase the availability and accessibility of postexposure prophylaxis (PEP) against HIV for GBV survivors.

Promoting Gender-Equitable Norms at the Community Level

RESPOND adapted EngenderHealth's existing MAP® curriculum (ACQUIRE Project & Promundo, 2008) in November 2012 to draft two separate curricula addressing harmful gender norms and attitudes in the Burundian context—one for a two-day sensitization of community leaders and one for a four-day workshop for miners, tea plantation workers, and bicycle- and moto-taxi drivers. RESPOND trained 12 facilitators in the use of the adapted curricula. Overall, 396 community leaders were sensitized, including 172 CHWs, 89 members of the local administration, 69 members of local associations and NGOs, 41 health providers, 23 religious leaders, and two national police officers. The objectives were to catalyze reflection about harmful gender norms and support leaders to identify actions that they could take to address GBV and to improve access to services for survivors.

The four-day MAP workshops were held with groups of male tea plantation workers, miners, bicycle- and moto-taxi drivers. During the workshop, participants examined gender norms, sexuality, violence, and the negative effects associated with it and discussed actions that they could take to foster positive gender norms and to prevent GBV in their community. The curriculum addressed gender, power, sexuality, and violence, including context-specific elements such as local proverbs. Overall, 699 men participated: 14% (100) tea plantation workers, 64% (449) miners, and 21% (150) taxi drivers.

[2] The MAP approach, which has been applied in more than 15 countries worldwide, stimulates dialogue around gender norms, encouraging men and women to reject harmful norms and to promote those that protect the health of men and their families.

Facilitating Access to GBV Response Services

To strengthen linkages among multisectoral partners, the project organized bimonthly meetings at the township level, bringing together institutions offering services related to GBV (e.g., Family Development Centers, health promotion workers, police, and prosecutors). At the provincial level, meetings convened once per quarter provided partners with opportunities to exchange information about services, establish referral mechanisms, and identify challenges and solutions to common issues. RESPOND also used the meetings as a forum to share information about improvements in GBV service availability at health centers. RESPOND led a total of 40 township-level and 11 provincial-level meetings. In addition to these meetings, the project supported selected health facilities in planning and hosting site walk-throughs (SWTs) for community leaders in their catchment area. These SWTs allowed community leaders participating in MAP workshops to learn about available GBV services and about how to facilitate GBV survivors' access to immediate care, as well as strengthen referrals to facilities where more advanced care and additional services were available. A total of 355 community leaders and 41 staff at health care facilities participated in the SWTs.

ASSESSMENT PURPOSE AND METHODS

An end-of-project assessment was conducted in May 2014 by local consultants to document changes in the capacity of the health care system to respond to GBV and to solicit participant feedback on project interventions. Identical interview guides were used for 2012 baseline and 2014 endline assessments; however, the endline assessment also collected feedback on RESPOND interventions at these facilities. The assessment consisted of individual interviews with health care facility managers (16) and service providers (17), as well as structured observations of available equipment and supplies at each site. The endline assessment was conducted at 16 of the 19 facilities assessed at baseline. It was not possible to compare baseline and endline responses at the individual level because respondents did not have unique identifiers.

Complementing these data, pretest and posttest scores for MAP workshop participants and trained health providers were analyzed. These written tests, completed anonymously, explored attitudes and knowledge related to GBV and gender norms. The pretest was administered on the first day of the workshop by the facilitator, and the posttest was given on the last day of the workshop. For literate participants completing the forms themselves, there may have been limitations in terms of their literacy level; for illiterate participants, their anonymity may have been compromised if they sought assistance to complete the test.

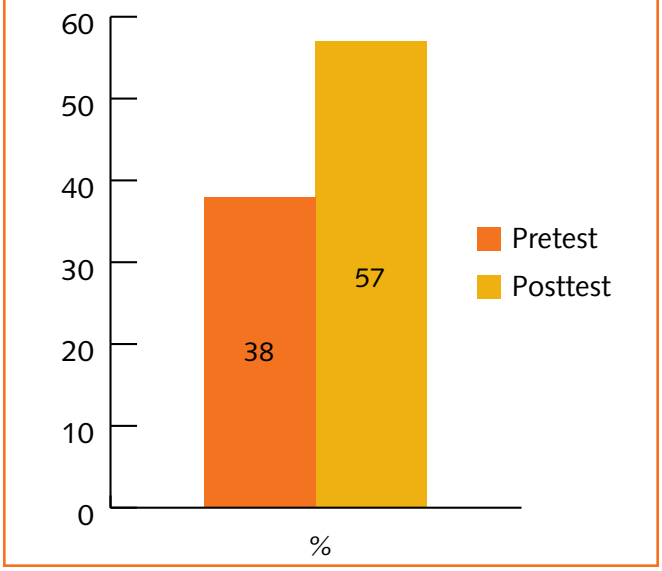
RESULTS

Health Sector Response to GBV

In endline interviews, the percentage of facility managers who felt that their providers have the knowledge and skills needed to provide holistic care for GBV rose from less than one-quarter at baseline to 100% at endline; facility managers reported, however, that there was still room for improvement in providers' GBV case management skills.

A comparison of the pretests and posttests for the 322 RESPOND-trained providers showed that their knowledge about the management and care of GBV survivors improved following the training, with the average score rising from 38% to 57% (Figure 1).[3] Interviews con-

FIGURE 1. AVERAGE PERCENTAGE SCORE AT PRETEST/POSTTEST FOR GBV CASE MANAGEMENT AMONG PROVIDERS (N=322)



[3] The pretests/posttests for providers consisted of 37 questions divided into three sections: Three questions on attitudes toward GBV and GBV survivors; 25 scored questions on aspects of GBV medical case management; and nine self-assessment questions regarding their capacity to treat GBV survivors. This figure reflects only the second section of scored questions on GBV medical case management.

Participants in the MAP training of facilitators practice leading others through exercises.

ducted at endline also showed improvements in providers' GBV case management knowledge. The percentage of providers able to mention, without prompting, the steps that they would take in managing a GBV case improved significantly. For example, the percentage mentioning that they would assure the client of confidentiality rose from 33% at baseline to 71% at endline. Providers who said that they would inform the client of his/her right to accept or decline any of the services offered rose from none at baseline to 53% at endline.

Additionally, the share of providers reporting that they would test survivors for HIV increased from 37% to 76%, while the percentage reporting they would treat sexually transmitted infections (STIs) climbed from 23% to 71%, and those mentioning that they would offer PEP increased from 13% to 53%. Nonetheless, for some areas, there was little improvement: Few discussed survivor safety (none at baseline and one at endline) or establishing a medical certificate (from none to two at endline). However, the populations of providers tested at baseline and endline were of different sizes (30 versus 17); this difference impacts the comparability of the data and limits the power to detect differences that may be statistically significant.

The percentage of providers stating that they would refer a client for other services improved only slightly from baseline to endline (from 67% to 76%). However, among providers who said that they *would* refer clients for other services, the percentage reporting that they would provide referrals to legal, housing, psychosocial, or financial services rose overall. The share of providers referring clients for social reintegration services increased significantly, from 30% to 76%, and the proportion referring for temporary housing also rose significantly, from 37% to 82%. The proportion of facility managers referring clients for social reintegration services also increased significantly, from 37% to 75%.

Results from pretests and posttests showed a positive shift among health care providers in attitudes about GBV and GBV survivors (Table 1). However, there is still room for improvement, as illustrated by the small percentage of providers disagreeing with the statement that "GBV survivors are too traumatized to make good decisions about their medical care."

At the facility level, the percentage of facilities with all essential medical equipment, supplies, and commodities for GBV increased from 0% at baseline to 25% at endline.[4] The number of facilities with pregnancy tests remained relatively unchanged (increasing from 75% to 81%). Facilities with tests for STIs (including HIV) in stock showed a statistically significant increase, from 13% at baseline to 94% at endline. PEP kits[5] remained one of the least-stocked items, although the number of facilities with them in stock doubled from baseline (four) to endline (eight).

MAP facilitators meet with the staff of Kabarore Health Center, Kayanza Province to plan for a Site Walk-Through (March, 2013).

[4] Since not all facility managers were available for endline interviews and for the purpose of comparison, the number of baseline facilities is reduced to include only the same 16 facilities audited at the endline.

[5] PEP kits in Burundi contain: antiretroviral medication (lopinavir/ritonavir [Kaletra], lamivudine, zidovudine), emergency contraception (Postinol), and antibiotics for treating STIs.

TABLE 1. PERCENTAGE OF HEALTH CARE PROVIDERS DISAGREEING (DESIRED RESPONSE) WITH VARIOUS STATEMENTS ABOUT GBV AND GBV SURVIVORS				
	GBV case management training outcomes		Interviews	
Statement	Pretest (N=322)	Posttest (N=322)	Baseline (N=30)	Endline (N=17)
If a GBV survivor says that she was raped, but she does not want to go to the police, it's probably because she wasn't raped.	71	81**	13	94***
GBV survivors are too traumatized to make good decisions about their medical care.	31	37	73	71
Rape is sometimes the fault of the victim (if she wears a short skirt, goes to a nightclub, etc.).	51	77***	37	94***
*p<.05; **p <.01; ***p<.001				

Gender-Equitable Norms at the Community Level

A comparison of pretest and posttest results from the MAP workshops suggests a shift toward gender-equitable norms among the participants. In particular, among community leaders, there was a statistically significant increase in desired responses to most questions concerning domestic violence and equal access to opportunities for men and women (Table 2). Responses among miners, tea plantation workers, and taxi drivers who participated in MAP workshops also showed extremely significant increases, with the percentage-point increases among these men surpassing those shown among community leaders (Table 2).

The proportion of community leaders who gave the desired response to all six questions reflecting GBV knowledge increased by 7.2 percentage points, while

TABLE 2. PERCENTAGE OF MAP PARTICIPANTS REPORTING GENDER-EQUITABLE ATTITUDES BEFORE AND AFTER WORKSHOP, BY TYPE OF PARTICIPANT				
	Community leaders		Miners, tea plantation workers, and taxi drivers	
	Pretest (N=339)	Posttest (N=341)	Pretest (N=680)	Posttest (N=655)
% of participants who disagreed that a husband is justified in hitting or beating his wife if she:				
Goes out without telling him	60.8	68.0	53.4	65.5***
Argues with him	75.8	80.4	62.7	71.8***
Refuses to have sex with him	61.1	70.4*	61.6	75.4*
Burns the food	68.1	76.3*	68.1	76.6***
Neglects the children	50.7	58.9*	47.8	56.5**
% of participants who disagreed with all five questions	37.8	49.6***	18.1	36.0***
% of participants who disagreed that:				
Women should not have equal rights with men and receive the same treatment as men do.	77.3	83.9*	50.0	76.5***
On the whole, men make better political leaders than women and should be elected rather than women.	67.0	74.5*	36.2	56.6***
When jobs are scarce, men should have more right to a job than women.	66.4	73.9*	43.4	63.5***
% of participants disagreeing with all three statements	44.3	58.4***	13.8	38.2***
*p<.05; **p<.01; ***p<.001				

TABLE 3. PERCENTAGE OF MAP PARTICIPANTS GIVING DESIRED RESPONSES TO STATEMENTS ON KNOWLEDGE ABOUT AND ATTITUDES TOWARD GBV AND GBV SURVIVORS, BEFORE AND AFTER WORKSHOP, BY TYPE OF PARTICIPANT

Statement	Community leaders		Miners, tea plantation workers, and taxi drivers	
	Pretest (N=339)	Posttest (N=341)	Pretest (N=680)	Posttest (N=655)
% of participants disagreeing with the following statements:				
Women who carry condoms are easy.	52.5	56.6	36.9	53.4***
A man should have several girlfriends before getting married.	83.5	89.4*	65.3	77.3***
Rape is sometimes the victim's fault.	68.7	75.4	61.0	75.0***
If your friend goes out with a 16-year-old girl, it's not your problem, because she is not your child.	24.5	26.4	45.3	50.2
Domestic violence is a private matter.	87.0	88.9	74.4	85.6***
The roles of women in society should be determined by their biology.	55.6	67.5	35.9	58.9***
Because of their biology, men cannot control their sexual urges.	N/A	N/A	38.8	49.2***
Flirting with someone under your authority is a form of violence.	N/A	N/A	33.2	20.5***
I feel at ease discussing sexuality with my partner and my friends.†	N/A	N/A	64.9	83.2***
% giving desired responses to all of the above statements	5.3	10.6	0.4	0.5
% of participants giving desired responses to statements related to consent:				
It is the man alone who should decide when the couple will have sex.	77.8	83.9	60.9	80.9***
If a woman is drunk, she cannot truly consent to sex.†	52.8	51.0***	49.0	44.3
Women and men always have the right to say "no" to sex at any time, even after it has started.†	59.0	58.1	58.5	82.4***
% giving desired responses to all three questions	23.6	29.3	16.3	32.1***
% of participants giving desired responses to statements on GBV knowledge:				
Men and boys are among the victims of GBV.†	86.1	90.6	77.7	86.0***
Most rapes are committed by strangers.	86.1	90.3	62.5	76.0***
GBV is a major public health problem.†	89.1	92.7	82.2	90.4***
The structural cause of sexual violence is the inferior status of women in society.†	44.9	46.0	N/A	N/A
Socially constructed behaviors can be changed by individuals.†	N/A	N/A	79.3	89.2***
Men who abuse alcohol are at higher risk of contracting HIV.†	84.1	89.2	83.1	89.9***
Sexual violence only has consequences for the lives of the victims.	70.2	73.9	69.1	80.8***
% giving desired responses to all six questions	19.5	26.7*	26.2	47.6***

†Indicates that the desired response was agreement. All other desired responses are disagreement.
*p<.05; **p<.01; ***p<.001

similar responses among male workers increased by 21.4 percentage points (Table 3). Community leaders giving the desired response to all six questions related to GBV attitudes also showed an increase of 5.3 percentage points, while the percentage of male workers with desired responses to all of the nine GBV attitude questions on their test showed minimal change. Questions specific to consent indicate limited positive change and even the possibility of a shift toward harmful norms for both groups, although there was a positive shift in those giving the desired response to all three consent questions.

DISCUSSION AND RECOMMENDATIONS

Overall, results indicate that services for GBV survivors and gender-equitable norms in the community improved. The comparison of baseline and endline results indicates that providers were more knowledgeable about GBV case management, more likely to refer clients for other types of services, and more likely to have the appropriate supplies and equipment at their disposal. In addition, responses to almost all of the pretest/posttest questions among providers, community leaders, miners, tea plantation workers, and taxi drivers suggested a shift toward more gender-equitable norms. In general, tea plantation workers, miners, and taxi drivers showed the greatest improvement.

Despite these positive findings, there is still room for improvement in providers' knowledge and skills, in the stock of supplies and equipment necessary for treatment at facilities, and in gender-equitable attitudes, in particular regarding consent. In addition, since the participants completed the posttest just after the training or workshop, it is possible that they gave what they knew to be socially desirable responses. The lack of additional testing at later points in time after MAP workshops limits our ability to evaluate how long these changes may have lasted. Similarly, the success of GBV case management training would be more substantially demonstrated by follow-up clinical monitoring visits and tracking of trained providers at predetermined points in time after training. Overall, the results suggest that several steps should be taken to continue strengthening the health sector's response to GBV and reinforcing gender-equitable norms in the community.

Miner MAP workshop participants in Kayanza Province

In rural Giteranyi Township, a 30-year-old schoolteacher named Rizabeti (name changed to protect privacy) volunteers for a local women's group. Women and men come to her seeking solutions to their problems or raising concerns about community members, which are often linked to domestic violence.

In July 2013, the RESPOND Project brought together Rizabeti with 24 other community leaders for a two-day community leader workshop intended to improve services for survivors of sexual violence. After the workshop, Rizabeti and other participants met with health care providers at their local health centers to complete a site walk-through; at this time, they learned about the services that the health care staff now can offer to survivors of sexual violence after being trained by the RESPOND Project.

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 had also learned about the window periods for postexposure prophylaxis against HIV and emergency contraception.

As a schoolteacher, Rizabeti has integrated what she learned from RESPOND into the sexuality education classes that she teaches.

Strengthening the health sector's response to GBV

- Providers should participate in MAP workshops in addition to GBV case management training, to increase the depth of their sensitization toward gender-equitable norms.
- Increased supervision and follow-up is recommended for providers who have been trained in GBV case management.
- Health care facilities should be better equipped in terms of supplies and equipment to reduce the need for referrals to other facilities.

Promoting gender-equitable norms in the community

- Refresher workshops should be offered to those already sensitized to reinforce gender-equitable norms over time.
- Additional monitoring and evaluation efforts should be conducted to assess the endurance of shifts in gender-equitable norms after people's participation in MAP workshops.
- Workshops for community leaders should be adjusted to a four-day schedule similar to that for miners, tea plantation workers, and taxi drivers.

As efforts to reduce GBV and strengthen services for GBV survivors in Burundi continue, it is important to recognize that changing social norms and reducing GBV are gradual processes requiring reinforcement in the community and in health sector, as well as thorough monitoring and evaluation of these efforts.

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