Improving the Provision of Services to Survivors of Sexual and Gender-Based Violence, including HIV Prevention: EngenderHealth's Experience in Ngozi Province, Burundi

BACKGROUND

Sexual and gender-based violence (SGBV) is a serious public health issue in Burundi. Nearly a quarter (23%) of Burundian women between the ages of 15 and 49 report having experienced sexual violence in their lifetimes and 13% reported having experienced sexual violence within the past 12 months (MPBGP et al. 2018). SGBV survivors require a comprehensive range of services that includes psychological trauma support, as well as support reintegrating into their communities. Survivors require medical services to mitigate the negative health consequences of SGBV, including the potential transmission of HIV. In Burundi, 1.2% of women and 0.6% of men ages 15 to 49 are living with HIV (MPBGP et al. 2018). Approximately 1,900 of annual deaths among adults and children in Burundi are attributed to AIDS and there are an estimated 73,000 orphans (ages 0 to 17 years) due to AIDS (UNAIDS 2018). HIV prevalence is extremely high among certain key populations; for example, HIV prevalence among sex workers is 21.3% (UNAIDS 2018).

Despite the large number of SGBV cases in Burundi and the will of the government to improve the availability and quality of services to survivors, the health system faces distinct challenges in responding adequately. These challenges include the insufficient capacity of health providers to offer quality services, the lack of safe and confidential spaces to treat survivors, the inconsistent supply of SGBV commodities to facilities (including post–exposure prophylaxis [PEP] for HIV, treatment for other sexually transmitted infections [STI], and emergency contraception [EC]), and gaps in SGBV data available in the national health information system, which informs programs and policies. A poorly functioning referral system, limited community support for survivors due to the lack of knowledge of required services, feelings of shame and fear of stigmatization among survivors and their families, and the lack of funds for transportation and a medico-legal certificate hamper the demand and uptake of essential services by survivors.

In 2014, the United States Agency for International Development (USAID) awarded EngenderHealth the five-year Burundians Responding against Violence and Inequality (BRAVI) project as part of the President's Emergency Plan for AIDS Relief (PEPFAR) strategy to accelerate progress toward UNAIDS' 95-95-95 goal[1] of ending the AIDS epidemic by 2030. The project aimed to strengthen the linkages between healthcare facilities and communities and to support survivors by improving the quality, availability, and awareness of SGBV services, including access to PEP and antiretroviral therapy (ART) for HIV prevention within SGBV services, thus contributing to the 95-95-95 goals. The project worked with communities in Ngozi province, in northern Burundi. BRAVI selected Ngozi for the intervention because of its accessibility and because it offered the opportunity to complement the ongoing HIV work of other PEPFAR partners (such as FHI360's HIV treatment work). BRAVI coordinated with the Ministry of Public Health and the Fight against AIDS (MSPLS) and the Ministry of Human Rights, Social Affairs, and Gender to complete this work.

Dr. Dieudonné Havyarimana, a medical physician at Kiremba hospital

PROGRAM

BRAVI accomplished its SGBV and HIV prevention and response efforts through implementation of an adapted Supply–Enabling Environment–Demand (SEED) Programming Model™ (see Figure 1). SEED is a framework developed by EngenderHealth that highlights the three major elements of

[1] The UNAIDS' 95-95-95 treatment targets—which include 95% of people living with HIV know their HIV status; 95% of people who know their status receive treatment; and 95% of people receiving treatment present with suppressed viral loads—inform PEPFAR and its implementing partners' programming goals.

supply, demand, and enabling environment within family planning and sexual and reproductive health programs. SEED employs a holistic approach to addressing the critical health issues that communities face. BRAVI employed the SEED approach to improve SGBV services by: (1) building the capacity of health providers to offer quality services, including ART, to SGBV survivors (supply); (2) promoting community awareness of improved facility-based services (demand); and (3) integrating SGBV into sustainable services and policies, including through addressing gender norms at the community level, and ensuring the capacity of the health system to provide a defined package of services (enabling environment).

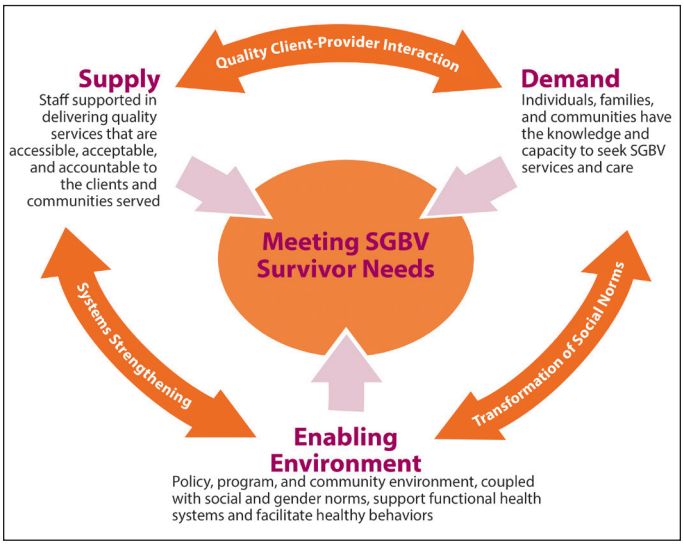

Figure 1. The Supply-Enabling Environment-Demand Model for Holistic Programming

Enhancing SGBV Services at the Facility Level

Facility strengthening. Capacity building activities targeted various categories of health facility staff including providers, supervisors, and nonmedical staff at 53 sites (9 hospitals and 44 health centers). At the provider level, BRAVI delivered a variety of trainings, provided material support, and conducted ongoing supportive supervision. In coordination with the MSPLS's National Reproductive Health Program (NRHP), BRAVI organized a six-day SGBV service provision training for 272 health providers (143 male and 129 female providers). This training used the national training guide, which BRAVI helped the NRHP develop by providing technical and financial support, and which included gender and SGBV definitions and concepts as well as service provision competencies in accordance with HIV and SGBV national protocols—specifically those related to case documentation, psychosocial services, documentation required for accessing legal services, and security planning.

Provider practicum. As an opportunity for providers to apply theoretical knowledge and improve their skills, BRAVI organized a practicum visit for 36 providers to the Seruka Center, a SGBV specialized care center that offers medical and psychosocial care. The practicum enabled trained health providers to improve their comfort and competence levels in serving SGBV survivors. This included the ability to employ nonjudgmental and empathetic listening, to conduct sensitive inquisitions and discussions about incidences of violence, to complete physical examinations, and to refer survivors to places like Seruka for other services—namely legal and psychological services, but also for health services if they were unavailable at supported sites, such as PEP (due to stock outs) or surgical services.

Site exchange visits. BRAVI also organized exchange visits between sites supported by the project. This allowed sites that were designated as "high performing" (based on the number of survivors served, the quality of reporting, the appropriate use of the national register and data collection tools, the availability of diagnosis kits, and the availability of at least two trained providers on site) to meet with peers from lower-performing sites to discuss successes and challenges and to develop strategies to overcome challenges. These visits allowed providers from facilities with weak performance to learn how to resolve barriers hindering provision of quality SGBV services.

Coaching and mentoring. Support of facility supervisors and directors is key to institutionalizing new practices. BRAVI provided SGBV service delivery training to 14 health supervisors in three districts, three district directors, and four health information system officers based at provincial and district levels. The training aimed to equip these individuals with sufficient knowledge and skills to deliver on-site coaching and mentoring to health providers to maintain service quality. BRAVI developed a comprehensive checklist to support on-site supportive supervision in collaboration with health providers and health authorities in Ngozi province. The supervision tool helped establish a performance score for each health facility in terms of the provision of SGBV care. This was based on the following factors: (1) availability of trained providers, (2) respect for client confidentiality, (3) availability of a dedicated room for interaction and treatment of survivors, (4) availability and quality of examination equipment, (5) availability of PEP commodities (i.e., STI/HIV prophylaxes, tetanus-diphtheria vaccines and anti-tetanus serum for tetanus prevention, and EC), and (6) correct use of case documentation and reporting tools. Each health facility received two visits by a team of coaches, comprised of supervisors and staff. BRAVI also created new and strengthened existing quality improvement teams comprising

three or four providers per site. These teams created a schedule for implementing recommendations to address identified gaps.

Job aids. BRAVI produced and disseminated job aids that summarize and support provision of the package of services required for SGBV survivors as per the national protocol; this included flowcharts, survivor-handling protocols, and client information, education, and communication materials—all available in French and Kirundi.

Nonmedical staff orientation. BRAVI organized a two-day SGBV orientation meeting for 133 nonmedical support staff, such as security personnel, cleaners, and receptionists. This helped ensure that facilities were equipped with skilled employees able to offer complementary support for SGBV service delivery, notably respectful interaction with survivors.

Awareness and Promotion of Available SGBV Services

Site walk-throughs (SWTs). Beyond building provider capacity, BRAVI introduced a number of activities to break the silence around SGBV, remove the stigma faced by survivors, increase awareness of available SGBV services, and promote the use of services from within communities. For example, the SWT activity aimed to raise awareness of existing health facility services, establish relationships between communities and facilities, and foster dialogues to ensure that facility services were responsive to community needs. Participants included male and female community representatives—including community health workers, religious leaders, local government authorities, and youth (ages 15–24) from various community-based organizations, community and family development centers (CDFCs), religious institutions, school clubs, and youth associations. These visits introduced services available for SGBV survivors and promoted discussions around the barriers to accessing services within the site and the community. Participants and health providers jointly devised action plans to address identified challenges, such as the lack of available commodities, fees associated with SGBV services (note: by law, these services should be provided for free, but the law is often disregarded), mistrust between health providers and community leaders, and extended wait times at sites. BRAVI facilitated 140 such visits in all 53 project-supported sites, engaging over 3,500 individuals.

Media programming. BRAVI also implemented various media activities to raise awareness of available SGBV services across the province. One such activity was an in-studio broadcast that BRAVI completed in collaboration with a local radio station (UMUCO FM), the CDFC provincial coordinator in charge of SGBV services, and the provincial health director, which aimed to emphasize the importance of each type of service (legal, medical, and psychosocial) and to provide guidance related where services were available. Experts highlighted other practical information, such as the importance of reporting to the nearest health facility within 72 hours of sexual violence in order to prevent and protect against HIV, other STIs, and unwanted pregnancy. The broadcast also incorporated messages that targeted young people with information about the existence and location of youth-friendly services. The call-in format allowed community members to raise questions and receive immediate responses from the experts.

Community events. With UMUCO FM, BRAVI also organized public gatherings that addressed SGBV and HIV service topics at the grassroots level; one gathering was held in each of the nine communes of Ngozi. These events were also interactive (similar to the radio show), with the radio host inviting participants to answer questions posed by the host, and awarding prizes to those who shared their opinions and ideas regarding SGBV and available services. The involvement of local experts (CDFC provincial coordinator and provincial health director) provided another opportunity for community members to ask questions and obtain information related to SGBV services and to raise issues related to barriers to accessing holistic SGBV services. Participants primarily asked questions related to service costs, referrals to providers offering complimentary services (such as psychosocial and/or legal assistance), and support for meals and transport. Between October 2018 and September 2019, BRAVI hosted meetings reaching nearly 3,000 community members (917 men, 892 women, 565 boys, and 551 girls).

Fostering a Favorable Enabling Environment

National strategy. As part of its holistic program strategy, BRAVI sought to foster a supportive enabling environment for service use, in part by tackling gender inequality, working to instill positive gender norms, and strengthening the national health system to address comprehensive SGBV service needs. For instance, BRAVI supported the MSPLS to integrate SGBV into the National Strategy for Maternal, Reproductive, Newborn, Child, and Adolescent Health (MRNCAH), 2019–2023. The updated strategy includes specific activities related to the provision of SGBV services, including building the capacity of health providers (doctors and nurses) to deliver services with a special focus and training on services that address the needs of children and adolescents—reflecting the reality that 68% of survivors attending BRAVI-supported facilities are between 2 and 24 years old. The updated MRNCAH strategy also provides guidance for on-site coaching and mentoring, harmonization of SGBV data collection tools, a specific register to record SGBV cases, and clarity about the

required components of the SGBV services kit (which now includes PEP, STI prophylaxes and treatment, and EC) for the national HIV supply chain system.

National training. As previously discussed, BRAVI worked with the MSPLS/NRHP to develop a national training guide to support provision of holistic SGBV services. BRAVI trained a cohort of national trainers using these materials, with the aim of building their capacity to cascade skills to health providers. Additional information related to some of the work that BRAVI completed at the community level on gender norms is the subject of a separate project brief (Nyamarushwa et al. 2019).

Best practices documentation. The establishment and documentation of best practices in the area of SGBV service provision in low-resource settings with high prevalence of HIV among certain groups and high prevalence of gender-based violence is a key legacy of the BRAVI project. BRAVI collaborated with the MSPLS/NRHP to document these best practices in a 2019 report entitled, *Paquet des meilleures pratiques des formations sanitaires de la province de Ngozi sur la prises en charge des survivants des VSBG* (Best Practices Package for Health Facility Care of SGBV Survivors in Ngozi Province). This document aims to provide operational guidance to different SGBV stakeholders around the provision of comprehensive care for survivors, including through a more robust network of referrals. The NRHP is disseminating the final validated document, which will serve as a resource for the national program on SGBV services.

PROGRAM RESULTS AND BENEFITS

Increased provider capacity. BRAVI provided training to 272 providers, doctors, and nurses across 53 sites and documented enhanced knowledge about SGBV through pre- and posttraining tests that assessed understanding of gender and SGBV concepts, clinical services, and perceptions related to SGBV. By the time the project completed on-site trainings in 2017, each site had at least three health providers trained to support SGBV services. Furthermore, 26% of providers demonstrated greater knowledge of the minimum standards for SGBV service provision following the BRAVI training. These providers were equipped to offer a full package of health services to survivors (PEP, ART, STI prophylaxes and treatment, and EC), as well as to provide referrals to psychosocial and legal assistance. The number of survivors of sexual violence who received PEP more than doubled in the 53 BRAVI-supported sites from 2016 to 2018 (see Figure 2) as a result of BRAVI interventions at the facility and the community levels.

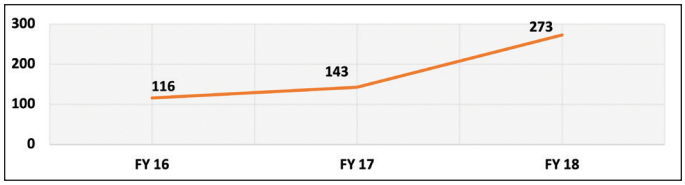

Figure 2. Number of Survivors Who Received PEP in BRAVI-Supported Sites

As Ndimwizinga Marguerite, a nurse at Ngozi hospital testified,

> *The increase of survivors of sexual and gender-based violence hosted in our hospital since 2016 is the result of BRAVI's support in building the capacity of care providers to provide services and non-provider staff to care for cases of SGBV through reception and orientation of the survivor. In addition, sensitized community leaders also play a vital role in supporting, accompanying survivors, and reporting rape cases to provide comprehensive SGBV services.*

Improved facility capacity. Individual site performance related to SGBV service provision was assessed twice in BRAVI's fourth year using the aforementioned performance assessment checklist. The majority of sites assessed (33 of 39, or 84.6%) received scores between 59% and 90.9%, indicating relatively high levels of performance. The six other sites scored between 36.4% and 45.5% due to a number of factors including: (1) lack of at least two providers trained to address SGBV, (2) absence of internal health teams dedicated to improving the quality of services, (3) commodity stock outs, and (4) incomplete case documentation. After the assessment, BRAVI supported the weaker performing sites in developing corrective plans to improve services and organized more on-site assistance through the trained coaches and mentors in the three relevant districts. The team of coaches visited each site three or four times; after each visit, providers updated their corrective plans. Repetitive coaching and mentoring visits, coupled with the quality improvement teams' efforts, supported the facilities in gradually improving their performance. For example, health providers demonstrated increased respect for minimum standards of SGBV service provision, including protection of confidentiality, creation of streamlined survivor circuits, dedication of private rooms equipped with all essential materials and commodities, and specific case documentation files with individual codes. Reflecting such improvements, Dr. Dieudonné Havyarimana, a medical physician at Kiremba hospital stated:

> *Today the survivor circuit has been reduced from seven rooms to only two to receive services: (1) reception service and (2) consultation cabinet for the rest of services… With BRAVI project support, the heads of the hospital became more sensitive*

and aware about the rights and the needs of survivors, and are authorized to provide emergency contraceptive to SGBV survivors. Inputs are gathered in one post-rape kit including ARV [antiretroviral medication] for HIV post-exposure prophylaxis, STI treatment, and emergency contraceptive and are kept in the SGBV dedicated room. The hospital has also made innovations by putting in place a code "Nje gusaba impanuro" (I come to ask for advice), to be said by survivors accompanied by community leaders, in order to protect and keep the privacy.

A patient consultation at Kiremba hospital

In addition, the new coaching and mentoring approach introduced by the project improved and streamlined site visits for supportive supervision. Previously, supervisors alone planned supervision visits, and health providers perceived the purpose of the visits to be to control rather than support them. Now, each district develops a monthly calendar for supervision and displays it in the office so that the schedule is available for everyone, including the providers. As a result, supervision has become more transparent and participatory.

Increased community engagement. Building upon the success of BRAVI's SWTs and training activities—which resulted in increased community awareness of SGBV and available services—community leaders (including community health workers, religious leaders, and administrative authorities) have undertaken several initiatives. For example, during the community meetings organized by administrative authorities at the grassroots level, community leaders delivered information on the types of SGBV services available and where to access them. As a result, more than 25,000 people received SGBV messages emphasizing the link between SGBV and HIV and encouraging survivors to seek services. Additionally, community leaders became more engaged in directly supporting SGBV survivors to access services. Community leaders reported that they accompanied 267 of the 273 (98%) sexual assault survivors from their respective communities to health facilities for initial visits, and accompanied 125 of 267 (46.7%) survivors to follow-up visits for HIV tests on the 14th day, to ensure effective prevention of HIV.

LESSONS LEARNED, CHALLENGES, AND RECOMMENDATIONS

Several lessons learned, challenges, and recommendations emerged from BRAVI's experience. This information can advise improvements to future interventions.

Referral systems for medical care and psychosocial and legal services. To ensure comprehensive services, including psychosocial and legal support, health facilities should improve their referral systems. Only a limited number of survivors reach the CDFC to receive psychosocial and legal services. Referrals must be feasible for clients and support a continuum of care. Improved coordination between the MSPLS, the MHRSAG, and the Ministry of Justice (which currently work independently), could close gaps that prevent survivors from accessing a full package of services, including medical care, counseling to address psychological trauma, and legal services for protection and reintegration into the community. Furthermore, when survivors receive referrals, the feedback loop to the initial site needs to be strengthened to facilitate follow-up support.

SGBV care for children and adolescents. Health providers have been trained using the national training guide, which does not adequately address the skills needed to engage with child and adolescent SGBV survivors, including age-appropriate counseling and guidance on collecting case history information. This is crucial since, as mentioned previously, many survivors visiting BRAVI-supported sites are children or adolescents. Additionally, counseling rooms are not set up to comfortably serve young survivors after trauma. Updating the current manual to include targeted job aids and provider training resources for engaging with child and adolescent SGBV survivors could improve the quality of services and prevention of HIV for these specific groups. Further, given the prevalence of young SGBV survivors, the SGBV technical working group should advocate to apply a child and adolescent lens to reviewing and revising SGBV policies, provisions, training, services, and infrastructure.

Sustainability of community leader engagement. The engagement of community leaders has proven effective in increasing the number of SGBV survivors who visit facilities and receive PEP, in addition to other services. Sustaining the role of community leaders in this engagement requires the support

of local administrators. Community leaders need to advocate to their respective local administrators to incorporate SGBV prevention and response assistance in local five-year communal action plans; these plans also need to determine how to address problems that extend beyond the capacity of community leaders (i.e., the costs and logistics associated with transporting survivors to and from facilities, processes for bringing perpetrators to justice, support for family reintegration, and dissemination of SGBV prevention messages).

Continuation of SWTs. SWTs provide opportunities for connecting health providers with community leaders to discuss barriers and devise solutions to critical local health issues. Future SWT activities should ensure the inclusion of women, adolescents, and survivors to ensure their needs are considered and that facility recommendations are responsive to their needs.

Retention of trained service providers. As previously discussed (see Figure 2), BRAVI interventions have resulted in dramatic increases in access to and uptake of services for HIV prevention in supported sites. Recognizing the critical role that trained health providers play in providing these services, facility heads should ensure the retention of trained providers during staff rotations.

Project impact and scale up. Health facilities vary in terms of their ability to offer quality SGBV services, largely due to the weak integration of SGBV into the national health information system and lack of clear SGBV indicators, data collection tools, and case documentation tools, including a specific register that ensures confidentiality. Future interventions, as coordinated by the NRHP, should support the implementation of the national MRNCAH strategy and adopt the SGBV service provision best practices that BRAVI documented in collaboration with the MSPLS.

CONCLUSION

During its five years of implementation, BRAVI has been a leader in supporting SGBV service provision in Ngozi province. The results from Ngozi reflect how the project was able to address some of the health system challenges and reach an increasing number of survivors with PEP and other services through the mutually supportive project components of supply, demand, and enabling environment. BRAVI enhanced service quality by strengthening the capacity of providers to offer nonjudgmental, sensitive, comprehensive, and confidential care to meet the needs of SGBV survivors, while also ensuring the availability of inputs (such PEP/ART commodities) that encourage survivors to seek services. Community health workers and other community leaders were willing to raise awareness of SGBV. In addition, strengthened relationships and trust between health providers and community leaders encouraged community leaders to accompany survivors to facilities for needed services. The ownership of project strategies by the MSPLS/NRHP is reflected in the integration of SGBV into the national MRNCAH strategy, a promising step toward improving health services, including the quality of SGBV services and HIV prevention efforts at the national level. The project's positive experience suggests the potential for substantial impact through scale up.

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